NEW HAMPSHIRE
Health Plan

THE NEW HAMPSHIRE HEALTH PLAN

Request for
Proposals

For:

A New Hampshire Ground Ambulance Cost Study And The Development of an Illustrative, Cost-Based Reimbursement Rate Schedule For Ground Ambulance Services

June 21, 2024

Table of Contents

SECTION 1 – Overview and Schedule

1.1 Goal of this procurement

Completion of a New Hampshire ground ambulance cost study and development of an illustrative, cost-based default reimbursement rate schedule for ground ambulance services in the state: Operating under the supervision of the New Hampshire Insurance Commissioner, and acting pursuant to the legislative mandate contained in SB 407 of the 2024 session of the New Hampshire legislature (attached as Appendix A), the New Hampshire Health Plan (the NHHP) is requesting proposals for a Vendor with actuarial and accounting expertise, relevant experience, and the ability to carry out the project on an abbreviated timeline, to conduct a cost study of ground ambulance providers in the state, to produce a report of the findings of the study, and to derive an illustrative, cost-based default rate schedule appropriate for fully-insured commercial payers for use in reimbursing nonparticipating ground ambulance providers for services provided.

The resulting contract must be for a Not to Exceed amount and will commence at the earliest practicable date subsequent to bid selection and extend at least until the final due date for this project of December 31, 2024.

1.2 Schedule

The following table provides a Schedule of Events for this RFP through contract finalization and approval. The NHHP reserves the right to amend this Schedule at its sole discretion and at any time through a published Addendum.

EVENT	DATE	LOCAL TIME
RFP Released (Advertisement)	6/21/2024	
Vendor Inquiry Period Ends	7/5/2024	4:30 PM
Final NHHP Responses to Inquiries	7/9/2024	4:30 PM
Proposals Due	7/23/2024	12:00 PM
Estimated Notification of Selection	7/26/2024	4:30 PM

1.3 Description of the New Hampshire Health Plan and the New Hampshire Insurance Department

The New Hampshire Health Plan (NHHP) was created pursuant to NH RSA 404-G and is a nonprofit corporation operating under the supervision of the Insurance Commissioner in service of the purposes set forth in New Hampshire law. The NHHP is statutorily authorized to collect assessments from health carriers which are used to support its operations and a number of programs that support health coverage in the state, including a reinsurance program that supports coverage in New Hampshire's individual market and the New Hampshire Granite Advantage health care program established in RSA 126-AA.

The board of directors of the NHHP consists primarily of representatives of assessable entities as well as representatives of health care providers and purchasers. SB 407 creates a new program that the NHHP is responsible for carrying out under its NH RSA 404-G authority.

The New Hampshire Insurance Department (NHID) is the primary regulator of the business of insurance conducted in New Hampshire. The laws that govern the responsibilities of the NHID are set forth in Title XXXVII, codified at RSA 400 through RSA 420-Q. The Insurance Commissioner is charged under Title XXXVII with the enforcement and execution of the insurance laws of New Hampshire, with the collection of premium taxes and fees, and the regulation of the insurance marketplace to ensure fair treatment of policyholders and claimants. The Department's mission is to promote the public good by ensuring the existence of a safe and competitive insurance marketplace through the development and enforcement of New Hampshire's insurance laws. SB 407 requires the NHID to oversee the process by which the NHHP will contract with a Vendor and to oversee and directly join in the management of the project. Thus, the contract established through this RFP will be jointly managed by the NHHP and the NHID.

1.4 Vendor Instructions

Interested Vendors must submit the required documents in the manner specified in the RFP. Vendors are responsible for reviewing the most updated information related to this RFP before submitting proposals. Vendors are also encouraged to review the NHID's "Report on the Ground Ambulance Summit Meetings Convened and Facilitated by the New Hampshire Insurance Department" for further background information. [1, 2]

SECTION 2 – Requirements and Scope of Work

2.1 Minimum Vendor Qualifications

The Vendor must be familiar with ground ambulance service systems, the typical governance, organizational, and regulatory structures associated with ground ambulance services, the various ground ambulance revenue sources and case mixes, ground ambulance provider accounting practices, all payer claims data relating to ground ambulance services, and the recent federal and state level efforts that have been and are currently being conducted to study ground ambulance costs and revenues, including especially the Medicare Ground Ambulance Data Collection System (GADCS) developed by the Centers for Medicare and Medicaid Services (CMS) and the Medicare Ground Ambulance Data Collection Instrument. The Vendor must possess demonstrated actuarial and accounting expertise as applied to ground ambulance services and ground ambulance reimbursement and rate development by

[1] See Appendix B.
[2] For information on the state's EMS system, see: https://www.nh.gov/safety/divisions/fstems/ems/documents/nhtsareport.pdf

third party payers and be well equipped to address issues of labor costs, facilities costs, vehicle costs, equipment and supply costs, miscellaneous costs, revenue, cost allocation, fixed vs. marginal costs, survey methodology, data validation, and quantitative methods of research. The Vendor must have capacity to manage large datasets used for their analyses. The Vendor must be sufficiently staffed to carry out multiple simultaneous tasks to complete this project by December 31, 2024. The Vendor must be well positioned to understand and respond to New Hampshire's unique regulatory and institutional environment as it relates to the goals of this project.

2.2 Scope of Work as Set Out in SB 407

Under SB 407, the Vendor is tasked to "conduct a study of the costs incurred and revenue collected by ground ambulance providers related to the provision of ground ambulance services in the state, including the cost of sustaining a reasonable operating margin in support of the expectation that ground ambulance providers in the state maintain readiness to meet demand for services."

The Vendor may make use of the Medicare ground ambulance cost reporting template if deemed appropriate by the Vendor or may use another template. In lieu of requiring redundant cost reports, and in view of the short timeline for this project, the Vendor may accept cost reports already submitted to CMS under the GADCS.

The Commissioner of the New Hampshire Department of Safety is required to collaborate with the Insurance Commissioner in enforcing this reporting requirement upon ground ambulance providers and in setting a deadline for ground ambulance providers to submit their cost reports. The Vendor will be expected to work in close coordination with representatives from the New Hampshire Department of Safety as well as the NHID and the NHHP.

Based on the information provided through the cost and revenue reports, the Vendor is expected to summarize the cost and revenue information collected and to derive an illustrative statewide cost-based default rate schedule appropriate for fully-insured commercial payers for use in reimbursing nonparticipating ground ambulance providers. The schedule may be based on a percentage of Medicare rates, it may be based on an update of the Medicare RVU scale and conversion factor, or it may be an independently developed schedule. Reimbursement under the illustrative schedule must be designed to cover the costs attributable to the provision of covered services *assuming that all public and commercial ground ambulance payers in the state are paying at the same rate and assuming that the rate of subsidization of ground ambulance services in the state through public funds remains constant*. Costs must include the full range of costs of pre-hospital care and the cost of sustaining a reasonable operating margin as necessary to fulfill the expectation that ground ambulance providers in the state maintain a prudent level of readiness to meet future demand for services. Cost estimates should utilize the assumption that services will be provided in a reasonably cost-effective manner.

The illustrative rate schedule is required to be accompanied by an actuarial estimate of the impact on premiums for fully-insured coverage in the state. For the purpose of this project, the Insurance Commissioner will provide the Vendor with access to New Hampshire's All Payer Claims Data.

The Vendor is expected to produce a final report by December 31, 2024. The report should contain analysis of the cost and revenue information collected, the illustrative cost-based rate schedule proposed, the estimated impact this rate schedule would have on fully-insured commercial health insurance premiums, and any other information required to be produced under this section, including other supplemental information as may be directed by the Insurance Commissioner. The Insurance Commissioner will utilize all available resources to assist the Vendor as necessary to complete the study and report in a timely manner.

Although SB 407 authorizes the Vendor to collect cost reports from every ground ambulance provider in the state, the Vendor is expected to use suitable sampling methods and existing GADCS cost reports from ground ambulance providers in the state as necessary to meet the short timeline for completing this project and as may be permitted under sound quantitative methods.

2.3 Organization of Work

Phase 1: Phase 1 of the project should include the following elements which may be adapted, modified or supplemented if deemed necessary and appropriate by the Vendor:

- environmental scan,
- literature review,
- outreach to stakeholders (including individual ground ambulance providers, the New Hampshire Ambulance Association, the New Hampshire Fire Chiefs Association, town managers, and health carriers),
- development of a Stakeholder Advisory Group,
- study design and survey tool selection,
- establishment of a ground ambulance provider sampling method as necessary to achieve a representative sample of the various ground ambulance provider types,
- development of a data submission method which may be a web portal or a secure SFTP or similar structure,
- development of data security tools and protocols,
- testing of study design and data submission method,
- mustering of support team for data submitters,
- development of FAQs and other written support for data submitters,
- coordination of data enforcement with Department of Safety, and
- establishment of the data submitting period.

Phase 2: Phase 2 of the project should include the following elements which may be adapted, modified or supplemented if deemed necessary and appropriate by the Vendor:

- carry out data collection during the data submitting period,
- activate the data submitter support team as necessary to meet the needs of data submitters, and
- confer closely with NHID staff to expeditiously resolve emerging data submission issues.

Phase 3: Phase 3 of the project should include the following elements which may be adapted, modified or supplemented if deemed necessary and appropriate by the Vendor:

- conduct data validation and follow up with data submitters where issues are identified,
- produce a draft report summarizing findings of the cost and revenue study,
- design a draft illustrative default rate schedule as specified in this RFP, and
- obtain feedback on draft findings and rate schedule from NHHP, NHID, the Department of Safety, and the Stakeholder Advisory Group.

Phase 4: Phase 4 of the project should include the following elements which may be adapted, modified or supplemented if deemed necessary and appropriate by the Vendor:

- Finalize the Report of Findings and the Illustrative Default Rate Schedule.

2.4 Points of Clarification

The purpose of determining ground ambulance costs under SB 407 is to provide the information needed to develop a cost-based reimbursement rate schedule that would provide the basis for future legislation (planned by the likely sponsors for the 2025 legislative session) that would prohibit ground ambulance balance billing and set a universal default rate schedule at least for all commercial, fully-insured payers and that would be sufficient to cover the costs of ground ambulance services if all payers (public and commercial included) used that same reimbursement rate schedule. The schedule is considered a default schedule because it is envisioned that providers and payers would still be free to contract for different rates with the default rates applying only when services are provided by an out of network provider. The illustrative, default rate schedule should be so designed that, with little modification, it could be used by the state in support of a federal waiver to establish an All-Payer Model Agreement under §1115A of the Social Security Act to implement an all-payer model system for reimbursing ground ambulance services in the state. It should also be so designed that it could be compared to the current Medicare fee schedule.

"Costs" in SB 407 should be interpreted as accounting costs, including all operating and capital costs. Included in the cost calculation should be the cost of maintaining a reasonable operating margin and the cost of "readiness." The vendor should seek relevant information from ground ambulance service providers in determining what a reasonable operating margin should be.

"Readiness," as a component of cost, is an ill-defined concept. In interpreting this concept, the Vendor should look to current market expectations, as well as any existing public health or regulatory standards that may give further meaning to this concept. "Readiness" should not be interpreted in such a manner as to override the public policy goal of achieving a cost-effective and efficient ground ambulance delivery system. Vendors should describe the cost component assigned for "readiness" in the rate schedule development.

A cost-based reimbursement schedule should not be construed as replacing the direct public

funding component of the revenue sources for ground ambulance services. The rate schedule should cover ground ambulance costs assuming that the rate of public funding (primarily revenue derived from local property taxes and not including reimbursements received from public payers) remains constant over time as a percentage of overall costs.

"Costs" should include costs that are frequently not reimbursed under the current ground ambulance financing milieu, such as the costs of emergency response services in the context in which the patient is treated but not transported for further facility-based treatment. Similarly, the illustrative, default rate schedule should include a billing code or codes providing reimbursement in the treat-no-transport context.

The illustrative default rate schedule should include an inflation adjustment methodology that would provide the basis for year-to-year adjustments in the rate schedule.

The illustrative default rate schedule is expected to vary based on geographic location with costs in rural and super rural regions being higher. The schedule may also vary based on other factors that significantly drive cost variability, such as level of care, provider organizational structure, frequency of transports that are scheduled or that are unreimbursed, and other factors.

Assuming a sampling methodology will be used in carrying out the cost survey, the survey should adequately sample the diverse array of ambulance provider types, organizational structures, payer case mix, geographies served, provider financing structures, and service category mix (such as scheduled vs. unscheduled). The Vendor should be prepared to determine whether, through accessing already completed Medicare cost reports submitted through GADCS, a sufficient and usable array of cost reports from New Hampshire based ground ambulance providers might already exist.

At the time of issuance of this RFP, SB 407 has passed the New Hampshire house and senate and is in the process of enrolled bills and on its way to the Governor's desk. The selected Vendor would not be expected to sign the contract or begin work until the bill is signed into law by the Governor and effective.

SECTION 3 -- Contract Terms and Conditions

3.1 Award

A team of staff from the NHHP, the NHID, and the Department of Safety will evaluate and score the bids and select the winning bidder.

3.2 Contract Terms

The NHHP will require the selected vendor to execute a contract for the performance of the services set out in the bid proposal. The terms of this RFP and the selected vendor's Proposal will be used to form the terms of any resulting contract. The resulting contract may incorporate some or all of the selected vendor's Proposal.

SECTION 4 – Request for Proposal Process

4.1 NHHP Point of Contact/Restriction of Contact with NHHP and NHID Employees

The **sole point of contact** for this RFP, from the RFP issue date until the selection of the winning bidder is:

J. Michael Degnan	JMDegnan@helmsco.com
CC: Michelle Heaton	Michelle.C.heaton@ins.nh.gov

From the date of release of this RFP until an award is made and announced regarding the selection of a vendor, all communication with personnel employed by or under contract with the NHHP or the NHID regarding this RFP is prohibited unless first approved by the RFP Sole Point of Contact. NHHP and NHID employees have been directed not to hold conferences and/or discussions concerning this RFP with any potential contractor during the selection process, unless otherwise authorized by the RFP Sole Point of Contact. Vendors may be disqualified for violating this restriction on communications.

4.2 Vendor Inquiries

All inquiries concerning this RFP, including requests for clarifications, questions, and any changes to the RFP, shall be submitted via email to the NHHP Point of Contact specified above. Inquiries must be received by the end of vendor inquiry period (see Schedule of Events herein).

The vendor must identify the RFP name and date and include the vendor's name, telephone number, and e-mail address.

The NHHP will issue responses to properly submitted inquiries on or before the date specified in the Schedule of Events by causing the response to be posted on the NHHP and NHID web sites; however, this date is subject to change at the NHHP's discretion. The NHHP may consolidate and/or paraphrase questions for sufficiency and clarity. The NHHP may, at its discretion, amend this RFP on its own initiative or in response to issues raised by inquiries, as it deems appropriate. Official responses by the NHHP will be made only in writing by the process described above. Vendors shall be responsible for reviewing the most updated information related to this RFP before submitting a proposal.

SECTION 5 – RFP Terms and Conditions

5.1 Proposal Preparation Cost

By submitting a proposal, a vendor agrees that in no event shall the NHHP be either

responsible for or held liable for any costs incurred by a vendor in the preparation of or in connection with the Proposal, or for work performed prior to the Effective Date of a resulting Contract.

5.2 Validity of Proposal

Proposals must be valid for ninety (90) days following the deadline for submission of Proposals in Schedule of Events, or until the Effective Date of any resulting Contract, whichever is later.

5.3 RFP Addendum

The NHHP reserves the right to amend this RFP at its discretion, prior to the Proposal submission deadline. In the event of an addendum to this RFP, the NHHP, at its sole discretion, may extend the Proposal submission deadline, as it deems appropriate.

5.4 Non-Collusion

The vendor's signature on a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and work quoted have been established without collusion with other Vendors and without effort to preclude the NHHP from obtaining the best possible competitive Proposal.

5.5 Property of the NHHP

All material received in response to this RFP shall become the property of the NHHP and will not be returned to the vendor. Upon contract award, the NHHP reserves the right to use any information presented in any Proposal.

5.6 Proposal Confidentiality

The substance of a proposal must remain confidential until the Effective Date of any Contract resulting from this RFP. A vendor's disclosure or distribution of Proposals other than to the NHHP may be grounds for disqualification.

5.7 Public Disclosure

The information submitted in response to this RFP (including all materials submitted in connection with it, such as attachments, exhibits, addenda, and presentations), any resulting contract, and information provided during the contractual relationship are not subject to public disclosure under Right-to-Know law, including RSA 91-A.

5.8 Non-Commitment

Notwithstanding any other provision of this RFP, this RFP does not commit the NHHP to award a contract. The NHHP reserves the right, at its sole discretion, to reject any and all proposals, or any portions thereof, at any time; to cancel this RFP; and to solicit new proposals under a new acquisition process.

5.9 Ethical Requirements

From the time this RFP is published until a contract is awarded, no vendor shall offer or give, directly or indirectly, any gift, expense reimbursement, or honorarium, as defined by RSA 15-B, to any elected official, public official, public employee, constitutional official, NHHP staff member or contractor, or family member of any such official, employee, or contractor who will or has selected, evaluated, or awarded an RFP, or similar submission. Any vendor who has been convicted of an offense based on conduct in violation of this section, which has not been annulled, or who is subject to a pending criminal charge for such an offense, shall be disqualified from bidding on the RFP.

SECTION 6 – Evaluation of Proposals

6.1 Criteria for Evaluation and Scoring

The NHHP will evaluate each responsive Proposal using a scoring scale of 100 points, which will be distributed as set forth in the table below.

CATEGORIES	POINTS
TECHNICAL PROPOSAL, with the following potential maximum scores for each Technical Proposal category:	
PROPOSED APPROACH TO THE PROJECT	30
RELEVANT EXPERIENCE	30
QUALIFICATIONS AND TECHNICAL EXPERTISE	30
PRICE PROPOSAL, with the following potential maximum score:	10
TOTAL MAXIMUM POINTS	100

- Proposed Approach to the Project: The proposal must include a Work Plan and specify a timeframe in which the Vendor commits to specified project deliverables as they are developed. The proposal should be specific about the steps that will be taken by the vendor and about how the Vendor intends to meet the Goals of this RFP and the Scope of Work. The proposed project approach will be evaluated against the goals of this RFP specified in Section 1 and the Scope of Work specified in section 2 and the perceived likelihood that the project approach will achieve those goals and work requirements.

- Relevant Experience: The proposal should detail the relevant experience of the Vendor as an organization and of the individuals who will be assigned the work as outlined in the Vendor's proposal. The proposal should include a summary of experience, including a current resume for each individual expected to perform work under the proposal.

- Qualifications and Technical Expertise: The proposal should include a narrative description of the qualifications and technical expertise that the Vendor will bring to bear on the project, including, at a minimum, the qualifications listed in Section 2.1. The proposal should include a listing of at least 2 references from former Vendor engagements that reflect the skills appropriate for this project. The reference listing should include the email address and telephone number of the specific person to contact.

- Price Proposal: The proposal should include the hourly rate for each individual working on the project and an estimate of the amount of time each person is expected to expend on the project. The proposal must include a Not to Exceed maximum payment amount that the Vendor will accept for the entire project. Proposals will be evaluated with emphasis on the per hour rate, project timeline estimates, and the hours associated with staff possessing crucial expertise. The price proposal should be sufficiently detailed to create a reasonable expectation that the Vendor will be able to complete the tasks within the Not to Exceed amount stated.

The NHHP will select a vendor based upon the criteria and standards contained in this RFP and applying the category weighting described in this section. Oral interviews and reference checks, to the extent they are utilized by the NHHP, may be used to refine and finalize scores.

If the NHHP decides to make an award based on these evaluations, the NHHP will notify the selected vendor. Should the NHHP be unable to reach agreement with the selected vendor during Contract discussions, the NHHP may then undertake Contract discussions with the next preferred vendor and so on, or the NHHP may reject all proposals, cancel this RFP, or solicit new Proposals under a new acquisition process.

6.2 Planned Evaluations Steps

The NHHP plans to use the following process:

- Step 1. Initial screening to ensure that the Proposals are in compliance with submission requirements;
- Step 2. Preliminary evaluation of the Technical Proposals;
- Step 3. Oral interviews (only if deemed necessary);
- Step 4. Final Scoring of Technical Proposals;
- Step 5. Price Proposals review; and
- Final Selection: Select the highest scoring vendor(s) and begin contract execution.

6.3 Step 1: Initial Screening

The NHHP will conduct an initial screening to verify vendor compliance with the proposal submission requirements set forth in Sections 4 and 7. The NHHP may waive or offer a limited opportunity to cure immaterial deviations from the RFP requirements if it is determined to be consistent with the goals of this project.

6.4 Step 2: Preliminary Technical Scoring of Proposals

The NHHP will establish an evaluation team to review for compliance with the minimum requirements as set forth in Section 2. This evaluation team will then review the technical proposals and give a preliminary score to the technical proposals under the guidelines set forth in Section 6. Price proposals will not be reviewed by the evaluation team during the preliminary technical review.

6.5 Step 3: Oral Interviews

If the NHHP determines that it is appropriate, vendors may be invited to oral interviews. The NHHP retains the sole discretion to determine whether to conduct oral interviews, with which vendors, and the number of interviews. Vendors are advised that the NHHP may decide to conduct interviews with only some responsive vendors. The purpose of oral interviews and product demonstrations is to clarify and expound upon information provided in the written proposals. Vendors are prohibited from altering the basic substance of their proposals during the oral interviews and product demonstrations. The NHHP may ask the Vendor to provide written clarifications of elements in their technical proposal regardless of whether it intends to conduct oral interviews.

Information gained from oral interviews and product demonstrations will be used to refine technical review scores assigned from the initial review of the proposals.

6.6 Step 4: Final Technical Scoring of Proposals

Following oral interviews, product demonstrations, reference checks (if appropriate) and/or review of written clarifications of proposals requested by the NHHP, the evaluation team will determine a final score for each technical proposal.

6.7 Step 5: Price Proposal Review

Price proposals will be reviewed upon completion of the final technical scoring of proposals. The vendor's price proposal will be allocated a maximum potential score of 20 points. Vendors are advised that this **is not a low bid award** and that the scoring of the price proposal will be combined with the scoring of the technical proposal to determine the overall highest scoring vendor.

6.8 No Best and Final Offer

The Proposal should be submitted initially on the most favorable terms which the vendor can offer. There will be no last, best and final offer procedure.

6.9 Final Selection

The NHHP will conduct a final selection based on the final evaluation of the proposals and begin contract discussions with the selected vendor(s).

6.10 Rights of the NHHP in Accepting and Evaluating Proposals

The NHHP reserves the right, at its sole discretion, to:

- Make independent investigations in evaluating proposals;
- Request additional information to clarify elements of a proposal;
- Waive minor or immaterial deviations from the RFP and contract requirements, if determined to be consistent with the goals of this project;
- Omit any planned evaluation step if, in the NHHP's view, the step is not needed;
- Reject any and all proposals at any time; and
- Open contract discussions with the second highest scoring vendor and so on, if the NHHP is unable to reach an agreement on contract terms with the higher scoring vendor(s).

SECTION 7 – Process for Submitting a Proposal

Proposals submitted in response to this RFP must be received no later than the Proposal Due Date specified in the Schedule of Events in this RFP.

The Price proposal must be labeled clearly and submitted separately from the technical proposal.

Unless waived as a non-material deviation in accordance with Section 6, late submissions will not be accepted. Delivery of the Proposals shall be at the vendor's expense. The time of receipt shall be considered when a Proposal has been officially documented by the NHHP, in accordance with its established policies, as having been received at the email address designated below.

Proposals must be clearly marked as follows:
NEW HAMPSHIRE HEALTH PLAN

RESPONSE TO RFP DATED JUNE 21, 2024

Proposals must be submitted electronically, by email, and must be addressed to:

TO: JMDegnan@helmsco.com
CC: Michelle.C.Heaton@ins.nh.gov
Subject line must include: RESPONSE TO RFP DATED JUNE 21, 2024

Submissions must be submitted using the following criteria:

a. Searchable PDF Format
b. Files must be less than 10MB in size.

Exception: If files are greater than 10MB in size, the vendor will be required to submit their proposal in parts. It is the vendors responsibility to ensure a complete proposal is submitted.

SECTION 8 – Proposal Content and Requirements

Proposals should follow the format outlined below and provide the required information set forth below:

- Cover page
- Transmittal letter
- Technical Proposal, including narratives that contain the following elements as described in Section 6 of this RFP and that respond to the Goals and Scope of Work as described in Sections 1 and 2 of this RFP:
    - Proposed Approach to the Project
    - Relevant Experience
    - Qualifications and Technical expertise
- Price Proposal, as described in Section 6 and stated separately from the Technical Proposal

Appendix A

SB 407-FN - VERSION ADOPTED BY BOTH BODIES

03/21/2024 0999s
04/11/2024 1422s
2May2024... 1641h
06/13/2024 2256CofC

2024 SESSION

24-3036
05/10

SENATE BILL ***407-FN***

AN ACT establishing a ground ambulance cost reporting program and a study by an independent actuarial and accounting expert of the cost of providing ground ambulance services in the state.

SPONSORS: Sen. Prentiss, Dist 5; Sen. Fenton, Dist 10; Sen. Watters, Dist 4; Sen. Altschiller, Dist 24; Sen. Perkins Kwoka, Dist 21; Sen. Soucy, Dist 18; Sen. Rosenwald, Dist 13; Sen. Whitley, Dist 15; Sen. Gannon, Dist 23; Sen. Innis, Dist 7; Sen. Birdsell, Dist 19; Sen. Carson, Dist 14; Sen. Chandley, Dist 11; Sen. D'Allesandro, Dist 20; Rep. Goley, Hills. 21; Rep. S. Pearson, Rock. 13; Rep. Stringham, Graf. 3; Rep. Wolf, Merr. 7

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill provides for a statewide ground ambulance cost reporting program and a study by an independent actuarial and accounting expert of the cost of providing ground ambulance services in the state. The study shall include an illustrative ground ambulance rate schedule which is such that, if fully insured health carriers were to use this schedule in reimbursing nonparticipating ground ambulance providers, it would be sufficient to cover the reasonable cost of providing efficiently delivered care and a reasonable operating margin, assuming all payers in the state are paying at the same rate.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.
03/21/2024 0999s
04/11/2024 1422s
2May2024... 1641h
06/13/2024 2256CofC 24-3036
05/10

STATE OF NEW HAMPSHIRE

Appendix A

In the Year of Our Lord Two Thousand Twenty Four

AN ACT establishing a ground ambulance cost reporting program and a study by an independent actuarial and accounting expert of the cost of providing ground ambulance services in the state.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Managed Care Law; Establishing a Ground Ambulance Cost Reporting Program and Providing for a Study by an Independent Actuarial and Accounting Expert of Ground Ambulance Costs and Ground Ambulance Reimbursement Rates.

I. Beginning on the effective date of this section, the commissioner shall oversee the process provided for in this section of contracting with an independent actuarial and accounting expert to conduct a study of the costs incurred and revenue collected by ground ambulance providers related to the provision of ground ambulance services in the state, including the cost of sustaining a reasonable operating margin in support of the expectation that ground ambulance providers in the state maintain readiness to meet demand for services. The commissioner of the department of safety shall collaborate with the commissioner in collecting cost and revenue reports, as designed by the actuarial and accounting contractor, from all ground ambulance providers in the state. The actuarial and accounting contractor may make use of the Medicare ground ambulance cost reporting template if deemed appropriate by the contractor for the purposes set out in this section. The commissioner of the department of safety shall have authority to enforce this reporting requirement upon ground ambulance providers under the general supervision and specific enforcement authority conferred by RSA 153-A and shall work with the commissioner to set a deadline for ground ambulance providers to submit their cost reports that is sufficient to facilitate the completion of the study and report provided for in this section in a timely manner.

II. Based on the information provided through the cost and revenue reports, the actuarial and accounting contractor shall be directed to summarize the cost and revenue information collected and to derive an illustrative statewide cost-based default rate schedule appropriate for fully-insured commercial payers for use in reimbursing nonparticipating ground ambulance providers. The schedule may be based on a percentage of Medicare rates, or it may be an independently developed schedule. The schedule may vary based on geographic region. Reimbursement under the illustrative schedule shall be designed to cover the costs attributable to the provision of covered services assuming that all public and commercial ground ambulance payers in the state are paying at the same rate and assuming that the rate of subsidization of ground ambulance services in the state through public funds remains constant. Costs shall include the cost of pre-hospital care and the cost of sustaining a reasonable operating margin as necessary to fulfill the expectation that ground ambulance providers in the state maintain readiness to meet future demand for services. Cost estimates shall be based on the assumption that services shall be provided in a reasonably cost-effective manner. The illustrative rate schedule shall be accompanied by an actuarial estimate of the impact on premiums for fully-insured coverage in the state. For this purpose, the commissioner shall provide the contractor with access to all payer claims data. The contractor shall produce a final report by December 31, 2024, detailing the information required to be produced under this section and such other supplemental information as shall be directed by the commissioner. The commissioner shall assist the contractor as necessary to complete the study and report in a timely manner. The report shall be submitted to the president of the senate, the speaker of the house of representatives, the house and senate policy committees with jurisdiction over commerce and health and human services issues, the governor, and the state library.

III. The cost of the ground ambulance cost and actuarial study and illustrative rate schedule development shall be financed by the New Hampshire health plan established under RSA 404-G. The New Hampshire health plan shall have authority to carry out a one-time special assessment of assessable entities as defined in RSA 404-G:2 to generate a funding level that is estimated to be

Appendix A

sufficient to retain a qualified actuarial vendor to carry out the tasks provided for in this section. With the approval of the commissioner, the New Hampshire health plan shall select a qualified actuarial and accounting vendor through a competitive bidding process to work with the commissioner and the commissioner of the department of safety to carry out the relevant provisions of this section. The performance of this special assessment and the selection and compensation of a qualified actuarial vendor shall be deemed to be a "program" of the New Hampshire health plan as defined in RSA 404-G:2, IX. The commissioner shall have the authority to waive the formal plan of operation requirement under RSA 404-G:5 as necessary facilitate the timely process of retaining a qualified contractor under this section and meeting the December 31, 2024 deadline for obtaining an expert study and report.
2 Effective Date. This act shall take effect upon its passage.

LBA
24-3036
Amended 5/8/24

SB 407-FN- FISCAL NOTE
AS AMENDED BY THE HOUSE (AMENDMENT #2024-1641h)

AN ACT establishing a ground ambulance cost reporting program and a study by an independent actuarial and accounting expert of the cost of providing ground ambulance services in the state.

FISCAL IMPACT: [ ] State [ ] County [ ] Local [X] None

METHODOLOGY:
The Office of Legislative Budget Assistant states this bill, as amended by the House, has no fiscal impact on state, county and local expenditures or revenue.

AGENCIES CONTACTED:
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Appendix B

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Report on the Ground Ambulance Summit Meetings

Convened and Facilitated by the New Hampshire Insurance Department

March 18, 2024

David J. Bettencourt, Insurance Commissioner

Table of Contents

Background and Purpose

The Problem of Balance Billing for Ground Ambulance Services

Most persons with private health insurance (which is 62% of New Hampshire residents[1]) are covered under a managed care plan. The essence of managed care is that the covered person has a financial incentive to use only the health care providers that participate in the health carrier's provider network—a network of health care providers that the carrier contracts with and which is designed to provide reasonable access to all covered health care services that the covered person might need. Through this contracting process, the health carrier acts as the bargaining agent for the covered person, negotiating for services to be reimbursed at rates (known as the "allowed amount") that represent a significant discount (often as much as 50% or more) from what is referred to as the provider's "charge rate." New Hampshire's Managed Care Law (RSA 420-J) requires that contracts between the health carrier and providers include a provision prohibiting providers from billing covered persons in managed care plans for any amounts other than cost-sharing amounts that may be due under the terms of the covered person's plan. This is known as the prohibition on balance billing and has served as an important consumer protection since the advent of managed care insurance in the early 1990s. Through this prohibition, the covered person's liability for the cost of their care is limited to the cost-sharing amounts specified in the covered person's health insurance policy.

A breakdown in this system occurs when the covered person, through no fault of their own (and often without their knowledge), ends up receiving health care services from a provider who is not in-network (variously referred to as "non-participating, out-of-network, or OON). For example, in recent years, it has been common for persons receiving services at an in-network hospital to be treated by a specialist, like an anesthesiologist or a radiologist, who is not in the health carrier's network even though the hospital is in-network. In such cases, the covered person may not be protected from balance billing. The health carrier will pay the provider the usual in-network allowed amount for the service, and the provider accepts that amount and then bills the covered person for the outstanding or balance amount—often a large sum of money. The balance bill that the covered person receives in this context has come to be referred to as "surprise billing," because it often comes as an unpleasant surprise to the covered person.

A review of ground ambulance balance billing complaints received by the New Hampshire Insurance Department's (NHID) Consumer Services Unit in 2022 and 2023 shows that the NHID received 30 complaints during that period, with the median balance billed amount being $3,570 and the low to high range being $455 to $11,319 and with 6 of the 30 complaints (20%) involving balance bills of over

[1] New Hampshire Insurance Department, 2022 Final Report of Health Premium and Claim Cost Drivers, Oliver Wyman Actuarial Consulting, Inc.

$8,000 and 9 of the 30 complaints (30%) involving bills of over $6,000. A separate NHID review of claims data shows a significant level of high-cost claims for ground ambulance services. Of note, in 2023, 10% of ground ambulance claims (90th percentile, approximately 214 claims) for non-emergency advanced life support (ALS1) were between $2,950 and $11,600. Similarly, in 2022 the top 10% of claims (approximately 347 claims) were between $2,380 and $7,600 in 2022. Information related to this claims data extract is attached as Appendix A. An older study based on claims occurring from 2013-17 appearing in the journal *Health Affairs* indicated that most patients undergoing ground ambulance transportation receive sizable out-of-network bills,[2] and that, of all the states, New Hampshire had one of the highest rates of potential surprise ambulance bills with 81% of covered persons receiving ambulance services from an out-of-network providers.[3] In addition, New Hampshire's median ambulance balance bill amount for that time period, at $717,[4] was in the highest quartile compared to all other states.[5] Surprise bills of this magnitude are especially destabilizing for the one in three New Hampshire residents who reported in 2023 that paying their usual household expenses was somewhat or very difficult. An estimated 27% of New Hampshire households had less than $2,000 in emergency savings, according to a 2019 survey.[6] This outsized threat to the financial stability of households of low or moderate income also constitutes a health equity issue.

The Contributing Problem of High Consumer Cost Sharing for Ambulance Services

Even when the ambulance provider happens to be in-network under the household's health insurance policy, health insurance coverage in New Hampshire increasingly includes substantial deductibles and other cost sharing requirements which contributes to the problem of financially vulnerable households in the state. A recent NHID report[7] indicates that the average deductible for single person coverage in the small employer health insurance market is over $3,000. Similarly, the average deductible for single person coverage in the large employer health insurance market is over $2,500. Deductibles for family coverage are higher. This cost sharing exposure, combined with the high likelihood of receiving a balance bill, leads to a problem of unaffordability of ambulance rides in New Hampshire for

[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01484
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01484 Appendix Exhibit 8
[4] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01484 Appendix Exhibit 7
[5] See also, "Emergency: The High Cost of Ambulance Surprise Bills, U.S. Pirg Education Fund, Dec. 2022 https://publicinterestnetwork.org/wp-content/uploads/2022/12/EMERGENCY-The-high-cost-of-ambulance-surprise-bills-USPIRG-Education-Fund-December-2022-Final.pdf
[6] See, New Hampshire Fiscal Policy Institute, FACT SHEET, October 16, 2023. https://nhfpi.org/assets/2023/10/Fact-Sheet-Living-Expenses-Financial-Vulnerability-and-Poverty-in-New-Hampshire_10.16.23.pdf
[7] https://www.nh.gov/insurance/media/documents/nhid-annualhearing-preliminaryreport-2023.pdf

many health care consumers. A recent report released by the Massachusetts Office of the Attorney General found that Massachusetts consumers are incurring significant medical debt in relation to ground ambulance services, that Massachusetts consumers who receive OON balance bills for ambulance providers often do not pay them, and that many Massachusetts consumers are likely sent to collection agencies for unpaid balance bills for ground ambulance services.[8]

Balance Billing Legislation in New Hampshire

In 2018, at the request of the NHID, the New Hampshire legislature enacted RSA 329:31-b and RSA 420-J:8-e, which prohibited balance billing for certain classes of providers[9] providing services at a hospital that is in-network under a person's coverage. The legislation also set up an administrative hearing process to resolve any disputes that might arise between the health carrier and the out-of-network provider as to the fair value of the services provided, effectively taking the consumer out of the middle. This legislation diminished the frequency of balance billing in the state but did not address balance billing by other provider types, including ground ambulance.

The Federal No Surprises Act

Subsequently, Congress passed the No Surprises Act (NSA), which was signed into law in 2020 and went into effect for most consumers enrolled in individual and group health insurance plans on January 1, 2022. The NSA prohibited balance billing by all out-of-network provider types providing services at a hospital that is in-network and for all emergency services with the sole exception of ground ambulance services. The NSA also set up an Independent Dispute Resolution (IDR) process for resolving disputes between health carriers and providers as to the fair value of the out-of-network services rendered, again taking the consumer out of the middle. A recent survey sponsored by the Blue Cross Blue Shield Association and the American Association of Health Insurance Plans found that the NSA prevented more than 10 million surprise bills in the first nine months of 2023 protecting millions of Americans from crippling medical bills each year.[10] The survey also found that two-thirds of health insurance providers reported their provider networks have increased since the NSA became law, with none reporting an overall reduction in participating providers.

However, the NSA left ground ambulance services out of the bill's substantive provisions, including the provision prohibiting balance billing. This was partly due to a lack of cost data and partly to the fact that ambulance services tend to be

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[8] The Office of Attorney General Andrea Joy Campbell, Examination of Health Care Cost Trends, 2023. https://www.mass.gov/doc/examination-of-health-care-cost-trends-report-2023/download

[9] The services covered include anesthesiology, radiology, emergency medicine, and pathology services.

[10] https://ahiporg-production.s3.amazonaws.com/documents/202401-AHIP_SurpriseBilling-v02.pdf

provided locally and are part of a complex system of regional or, as in New Hampshire, municipal-based Emergency Medical Services (EMS) delivery.

The Work of the Federal Medicare Ground Ambulance Data Collection System

A federal process of gathering surprise billing and ground ambulance cost data began before the enactment of the No Surprises Act. Section 50203(b) of the Bipartisan Budget Act of 2018 amended section 1834(l) of the Social Security Act detailed requirements for ground ambulance service and supplier providers to submit cost information and other data. The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Ground Ambulance Data Collection System (GADCS) to meet this requirement and is in the process of collecting cost data nationwide from selected ground ambulance providers nationwide through the Medicare Ground Ambulance Data Collection Instrument. GADCS has selected ground ambulance providers and suppliers to participate in the GADCS 2020–2024. Organizations selected in Years 1 and 2 started collecting information in 2022 and will report information starting in 2023. Selected organizations in Year 3 will collect and report information at the same time as organizations that have yet to be selected in Year 4, with data collection starting in 2023 and data reporting expected in 2025.[11]

The Work of the Federal Ground Ambulance and Patient Billing Advisory Committee

In lieu of including ground ambulance in the NSA's broad prohibition on balance billing, the NSA established a Ground Ambulance and Patient Billing Advisory Committee (GAPB) which was tasked to collect information and make recommendations for protecting consumers from surprise billing for ground ambulance services. While the ground ambulance data collection work of the GADCS continues, the GAPB approved recommendations to federal policymakers late in 2023.[12] These recommendations, if adopted by Congress in legislation, would protect consumers from surprise bills and there would be a method to determine how much payers owe the providers. Consumers' cost-sharing amounts would be limited, and providers of ground ambulance services would be banned from billing for any higher amounts. The GAPB rejected the use of an IDR process of the kind created under the NSA in favor of a contingent, cascading set of potential payment standards that relies, in the first instance, on state and local rate setting, if these exist. In essence, the GAPB has recommended that there be a

[11] For more detail, see: https://www.mossadams.com/articles/2022/08/no-surprises-act-for-ground-ambulance-billing#:~:text=No%20Surprises%20Act%20Considerations%20for%20Ground%20Ambulance%20Billing&text=The%20No%20Surprises%20Act%20went,the%20patient%20has%20insurance%20coverage.

[12] https://www.cms.gov/medicare/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb

uniform payment standard that could be established either at the state level or at the federal level. According to the GAPB recommendations, the minimum required payment is recommended to be:

1. The amount specified in a state balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement), or

2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails, or

3. If there is neither a state balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier, or

4. If none of the above exist, then the amount is:

a. If Medicare covers the service, a Congressional set percentage of Medicare.

b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

The GAPB's final report with recommendations is expected to be submitted to the Secretaries of Labor, Health and Human Services, and Treasury, and Congress late in the first quarter of this year.

The NSA was designed to save federal dollars and reduce premiums below current trends. The approach recommended by the GAPB does not appear to be designed to similarly produce savings. There are concerns that the proposed guardrails would not sufficiently protect against high rates and that the use of state or locally set rates could raise premium costs.[13] Health plans have expressed concerns that when municipalities are allowed to name their own price in this way, the fact that it must be a public process is not a meaningful guardrail and would not deter municipalities from shifting a very disproportionate share of their costs onto the approximately 10% of patients using ambulance services that have fully insured commercial coverage regulated by the state. The GAPB passed the resolution of these concerns on to future deliberations by Congress or future action by states.

Efforts to Address Ambulance Balance Billing at the State Level

While the GAPB was doing its work at the federal level, states continued to act on their own. In 2023, Arkansas, California, Louisiana, and Texas passed laws to protect consumers from ground ambulance surprise bills. They join 10 other states with some form of protection in place.[14] Other states are exploring options,

[13] https://www.commonwealthfund.org/blog/2024/expanding-no-surprises-act-protect-consumers-surprise-ambulance-bills

[14] Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont, and West Virginia.

including Washington and Massachusetts, which recently published recommendations.[15, 16]

Almost all the states and the GAPB have rejected the IDR process set up under the NSA as a viable option for determining the fair value of services rendered. Thirteen of 14 states with ground ambulance protections have decided against using an IDR process. The most commonly cited reason is that local ground ambulance providers typically do not have the volume of services or administrative resources to pursue an administrative dispute resolution process. For both states and the GAPB then, the only other option is to devise a methodology for determining fair reimbursement in the context of commercial health insurance. The most difficult issue in establishing a uniform standard for setting rates is the challenge of balancing the need for public and private ambulance providers to be sufficiently funded with the need to control overall health and premium costs for consumers and payers. Four states do not address payment, but most have chosen to set a payment standard. The four states with laws passed in 2023 use rates set by local government entities as the first standard for a reimbursement rate, and five other states with ground ambulance protections tie the reimbursement rate to Medicare rates when no other rate has been set.[17]

The Origin of the New Hampshire Ground Ambulance Summit Meetings

In the summer of 2023, the NHID was continuing to receive regular consumer complaints and requests for assistance from covered persons who had received a balance bill from an out-of-network ground ambulance provider. The NSA had not resolved the issue, and a number of legislative attempts to address the issue in the New Hampshire legislature in 2023 had foundered.

At the same time, Insurance Commissioner David J. Bettencourt was approached by a number of ground ambulance providers and provider organizations with the concept of organizing a ground ambulance summit discussion among stakeholders with the aim of addressing both the balance billing issue and the question how to address the growing financial pressures that the ground ambulance service system in New Hampshire was experiencing. In July of 2023, the NHID issued a general invitation to all interested parties to participate in a series of ground ambulance summit meetings. A large number of persons responded to the invitation with good representation from the various stakeholders, including municipal ground ambulance providers, commercial ground ambulance providers, hospitals, health carriers, and New Hampshire legislators. A list of participants is attached to this report as Appendix B. The first meeting of the Ambulance Summit Group was held

[15] https://www.insurance.wa.gov/sites/default/files/documents/ground_ambulance_balance_billing_report_final.pdf

[16] https://www.mass.gov/doc/examination-of-health-care-cost-trends-report-2023/download

[17] https://www.commonwealthfund.org/blog/2024/expanding-no-surprises-act-protect-consumers-surprise-ambulance-bills

on July 28, 2023, and the last meeting was held on December 21, 2023. The group as a whole met monthly, and the three working groups met on an as needed basis.

The Work of the New Hampshire Ground Ambulance Summit Group

Discussion of the Issues to be Addressed

A number of general observations were made by participants in the summit group by way of providing context for the discussions to follow. These included the following:

- Commercial payers constitute only a small percentage of the total revenue collected by ground ambulance providers from third party payers. A representative of the health carrier industry estimated that commercial payers account for somewhere between 15% and 20% of ground ambulance revenues from third party payers. One municipal provider reported the following payer mix: Medicaid 12.54%, Medicare 64.33%, Commercial Insurance 19.05%, TRICARE 0.43%, Veterans Administration 1.72%, and Workers Compensation 0.43%. In New Hampshire, "commercial" coverage can be divided roughly in half, with one half consisting of fully insured coverage that is regulated by the state and one half consisting of self-funded coverage (offered mostly by large employers) that is regulated by federal law and not the state. The Medicare and Medicaid programs both pay set rates for ground ambulance, and both programs prohibit ambulance providers from balance billing patients. It was generally observed that both Medicare and Medicaid rates are significantly below costs. Some ambulance providers expressed the view that commercial payers also often reimburse at levels that are below costs and that commercial reimbursement rates should be brought up to a level that would cover costs. Other ambulance providers expressed the view that commercial payer reimbursement rates should be sufficiently above costs to compensate for the insufficiency of Medicare and Medicaid rates at least in part. Representatives of commercial health carriers were not in favor of this kind of cost-shifting and pointed out that, because only roughly half of commercial payers are regulated by the state, a state law that cost-shifted to commercial payers would fall on the backs of only approximately 10% of the ground ambulance payer mix. To compensate even partially for the insufficiency of Medicare and Medicaid rates, rates for this 10% of the payer mix would have to be extremely high and members would be exposed to greatly increased cost-sharing.

- It is significant that, in the 2023 legislative session, the New Hampshire legislature appropriated sufficient funds to increase Medicaid ground

ambulance reimbursement to a level that equals Medicare. This represents a significant economic boost to ground ambulance providers in the state.

- There is no established cost reporting program or protocol for EMS providers in the state, making it difficult to obtain an accurate picture of the actual costs for the different sectors of the industry.[18] Some help in this regard is expected from the federal Medicare Ground Ambulance Data Collection System, which may have information in 2025.

- Arriving at a reasonable commercial reimbursement standard is made more difficult by the fact that ground ambulance providers are divided into two significantly different types—municipal providers (which may also include fire departments and are often significantly subsidized by property tax dollars) and commercial ground ambulance providers. A 2019 report issued by the NHID indicates that commercial providers charge more than municipal providers, with base rates averaging approximately $1,200 for emergency transports and nearly $1,400 for non-emergency transports.[19] This is supported by a January 2023 Health Affairs study that focused on the ownership structure of ground ambulance organizations to compare pricing and billing between private- and public-sector ambulances, with a specific focus on organizations owned by private equity or publicly traded companies. The study concludes that being transported by a private-sector ambulance in an emergency comes with substantially higher allowed amounts, patient cost sharing, and potential surprise bills compared with being transported by a public-sector ambulance. Further, allowed amounts and cost sharing tended to be higher for private equity– or publicly traded company–owned ambulances than other private-sector ambulances.[20]

- The ground ambulance delivery system is also divided between emergency response services and non-emergency facility-to-facility transports. The NHID's 2019 study revealed that large differentials exist between non-emergency inter-facility transport and emergency transports in both distance traveled per transport and the mileage rate charged per mile with inter-facility exceeding emergency.[21] At the same time, a representative of the New Hampshire Hospital Association reported that hospitals are experiencing frequent shortages of facility-to-facility transport services (a service that is almost exclusively provided by non-municipal providers). With only four such providers in the state, transport problems are sometimes a barrier to patient

[18] See, the New Hampshire Ambulance Association May 2023 report at p. 9. https://the-nhaa.org/images/Final_Report_for_NH_EMS_1_.pdf
[19] https://www.nh.gov/insurance/reports/documents/ambul_study_2019.pdf
[20] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00738
[21] See, https://www.nh.gov/insurance/reports/documents/ambul_study_2019.pdf at p. 1.

discharge and are at a crisis level.

- The New Hampshire Ambulance Association recently conducted a member sentiment survey and reported in May 2023 that New Hampshire's EMS system is in crisis.[22] Two-thirds of survey respondents said that low reimbursement rates by Medicaid, Medicare, and commercial insurance companies are a "major contributor" to the EMS challenges in New Hampshire. According to this survey report, other factors contributing to the problem include:
    - Net increases in overall costs,
    - Disproportionately low reimbursements to rural ambulance providers,
    - The increasing proportion of New Hampshire residents who are age 60 and older,
    - Workforce shortages and wage competition with hospitals, and
    - Hospital backlogs in ER beds requiring patients to be held in the ambulance.

- A representative of one of the commercial ambulance services emphasized that an important challenge to the task of developing a standardized rate schedule is that, under the current system of reimbursement for ground ambulance services by commercial payers, the out-of-state commercial payers frequently reimburse at rates that are much higher (often equal to the billed rate) than the rates paid by in-state commercial payers. Even if a New Hampshire ambulance rating law did not apply to out of state payers, the precedent of a statewide fee schedule might have the effect of suppressing payments by out-of-state payers. While this issue is not insurmountable, it would need to be considered in designing any new fee structure.

- Many summit participants observed that a problem in the current delivery and payment structure is the frequently occurring circumstance when an ambulance responds to a call and provides treatment to a patient, but in the end does not transport the patient to the hospital. Although there are commercial billing codes for what is called "treat-no-transport," it is frequently the case that ambulance providers do not bill for these services and therefore do not receive reimbursement for such services. This is due in part to a misconception that such services are not reimbursable by commercial insurers. Ambulance providers also stated that often they are

[22] https://the-nhaa.org/images/Final_Report_for_NH_EMS_1_.pdf

unable to collect sufficient patient information necessary to bill the patient's insurance.

- Summit participants observed that the low rate of network participation regarding ground ambulance providers is likely due to the current financial incentive structure. Ambulance providers have little incentive to negotiate rates with the health carrier or to join a network as the negotiated rate may be less than their current billed rate and they would be prevented from also billing the consumer to collect additional revenue.

- Many summit participants also observed that the current delivery and payment structure is inefficient in many ways, which contributes to cost pressures, and that there are delivery models such as Mobile Integrated Health that could reduce costs and abate the treat-no-transport problem.

- Some participants observed that non-participating ambulance providers sometimes fail to be reimbursed due to the New Hampshire law that permits health insurers to issue a check to the covered person that is written to the order of both the covered person and the non-participating ambulance provider. Others observed that this law was passed to provide an incentive for ambulance providers to contract to be in the health insurer's network, thus avoiding the risk of balance billing.

- A number of summit participants observed that a special challenge for the ground ambulance delivery system in New Hampshire lies in the rural nature of much of the state. Because of the low volume of calls in rural areas and the increasing costs of "readiness," it is particularly challenging for rural providers to maintain a financially viable operation without relying heavily on support through municipal tax revenues—typically property taxes. Others observed that there could be a more effective system for regional coordination of services in rural areas of the state.[23]

- Participants observed that there is very little competition in the "market" for ground ambulance services and that market-based solutions to issues involving the financing and delivery of ground ambulance services are inapplicable. Providers are often local government entities and generally have something close to a local monopoly on services. Consumers do not choose their providers and do not know the cost of services, and there are barriers

[23] See, the New Hampshire Ambulance Association May 2023 report at p. 9. https://the-nhaa.org/images/Final_Report_for_NH_EMS_1_.pdf

to market entry and exit. Indeed, far from seeing ground ambulance as a market-based commodity, some participants representing providers recommended that the state follow the example of a number of other states and designate EMS as an "essential service" provided by local government comparable to police and fire.

- There was a general consensus the ground ambulance financing and delivery system is inefficient and that some reform to the ambulance business and care delivery model is necessary to ensure that ambulance providers are available and properly equipped to provide these vital services going forward.

At the first meeting of the plenary group, it was determined that the challenge of addressing surprise ambulance billing requires in depth consideration of a cluster of related issues and that the Summit Group would benefit by forming three different working groups. (1) The first group was tasked with researching methods for ascertaining a fair standard (or a "commercially reasonable" standard) for reimbursing the different types of ground ambulance services and improve network adequacy. If balance billing is to be prohibited going forward, then that "system" must be replaced with a supportable method for determining ground ambulance reimbursement in the context of commercial health insurance. (2) The second group was to investigate ways to improve system efficiencies, as it was generally agreed that part of the problem of the growing cost of ground ambulance services can be addressed by improving the efficiency and effectiveness of the ground ambulance delivery system. (3) The third group was to examine the special case of facility-to-facility transfers, particularly non-emergent or "scheduled" transfers. The following is an account of the work of each group. Groups (1) and (3) were facilitated by NHID staff and group (2) was facilitated by Senator Prentiss, who also served on the federal Ground Ambulance and Patient Billing Advisory Committee.

The Working Group on Establishing a Reimbursement Standard

This group began with consideration of the approach to determining fair reimbursement taken in the NSA and by the other states that have already addressed ground ambulance balance billing in some way. It was agreed that there are two basic approaches available. The first is a system of price determination for persons covered by commercial health insurance. This approach would involve a single fee schedule that is required to be used by all commercial health insurers in reimbursing ground ambulance services.[24] The other basic approach is to establish an IDR process on the model of the NSA in which an independent third party determines fair reimbursement for services on a case-by-case basis by applying specified factors. As with the GAPB and most other states, the working group

[24] States can also establish an All-Payer Model in which all major payers, including Medicare, Medicaid, and commercial health insurance pay for ambulance services according to the same schedule. This model was not discussed by the working group.

generally agreed that an IDR process would be too cumbersome and costly to be a useful price determination process in the context of ground ambulance services.

On the other hand, the working group was not opposed in principle to the idea of a uniform fee schedule. Nearly every participant pointed out that a fee schedule can quickly go from being supportable in principle to anathema depending on where the fee schedule is set. A uniform fee schedule would also reduce the current administrative burdens associated with billing, ensure more timely payment for services, and eliminate the need for network adequacy requirements with respect to ground ambulance.

To inform the discussion on the establishment of a reasonable standard for reimbursement, the NHID presented information derived from the All-Payer Claims Dataset (APCD) regarding pricing activity, current reimbursement rates, and utilization. What follows is a discussion of some of this information.

The NHID produced the following tables detailing information about the amount billed and the amount paid by commercial carriers in New Hampshire for most of the billing codes used to bill for ground ambulance services.

Table 1: Descriptors for Ground Ambulance HCPCS Codes

Code	Description
A0425	Ground Mileage, Per Statute Mile
A0426	Ambulance Service, Advanced Life Support, Non-Emergency Transport, Level 1 (ALS 1)
A0427	Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 (ALS 1-Emergency)
A0428	Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS)
A0429	Ambulance Service, Basic Life Support, Emergency Transport (BLS)
A0432	Paramedic Intercept (PI), Rural Area, Transport Furnished by a Volunteer Ambulance Company which is Prohibited by State Law from Billing Third Party Payers
A0433	Advances Life Support, Level 2 (ALS 2)
A0434	Specialty Care Transport (SCT)

Table 1 lists the most commonly used billing codes for ground ambulance along with the description of the codes. All further price analysis was limited to the billing codes listed in this table.

Commercial claims among fully insured NH residents in CY 2022:

Table 2: Medicare Rates* VS Ground Ambulance Claims Among Commercial Insurers in NH**

	Medicare Rates			Allowed Amount			Billed Amount		
	NH_{urban}	NH_{rural}	$NH_{superrural}$	NH_{urban}	NH_{rural}	$NH_{superrural}$	NH_{urban}	NH_{rural}	$NH_{superrural}$
A0425	$8.02	$8.10	$9.93	$9.63	$9.31	$8.02	$39.99	$26.45	$20.00
A0426	$306.96	$309.97	$380.02	$340.48	$385.12	$305.00	$2,380.50	$1,711.68	$616.00
A0427	$486.03	$490.79	$601.71	$565.00	$492.81	$540.71	$1,690.00	$1,312.00	$967.16
A0428	$255.80	$258.31	$316.69	$280.03	$281.38	$284.58	$1,476.34	$1,476.34	$528.00
A0429	$409.29	$413.30	$506.71	$475.00	$420.00	$475.00	$1,205.00	$898.23	$827.00
A0432	$447.66	$452.05	$554.21	$720.86	$644.00	--	$923.23	$918.62	--
A0433	$703.46	$710.36	$870.90	$767.05	$755.00	$1,233.50	$2,229.13	$1,914.00	$1,856.00
A0434	$831.36	$839.51	$1,029.24	$2,344.53	$1,407.26	$1,029.24	$5,705.60	$2,100.00	$2,024.00
A0380	Insufficient frequency--[n=3]								
A0390	Insufficient frequency--[n=5]								

Claims from NH residents to Commercial insurers in CY 2022, from NH Comprehensive Healthcare Information System (NH CHIS)

**Values reported are median allowed amounts and billed amounts ($USD)

*National Government Services, Inc. - New Hampshire

Table 2 compares the median amount billed by the ground ambulance providers for the most common billing codes with the median allowed amount reimbursed by the health carriers and with the Medicare reimbursement rate for each service code.

The Medicare ambulance fee schedule has been used by other states in their ambulance balancing billing legislation because this fee schedule is a comprehensive, consistent reference point that takes costs of providing services into account. In Medicare, the ambulance fee schedule has two components: a base payment and a mileage payment, which are summed to arrive at the total Medicare payment for each ambulance transport. The base payment consists of the product of three distinct pieces: the relative value unit (RVU), which determines the relative intensity or service level of the ambulance transport; a conversion factor (CF), which is used to convert the RVU into a payment expressed in monetary terms; and a geographic adjustment factor to account for the geographic differences in the cost of providing ambulance services. The payment for the mileage component of the ambulance fee schedule reflects the costs attributable to the use of the ambulance vehicle (for example, maintenance, fuel, and depreciation), and is the product of miles traveled with the patient and a mileage rate determined by CMS. CMS establishes an annual ambulance inflation factor which was 8.7% in 2023. In recent

years, CMS has also implemented a "super-rural bonus" payment rate of 22.6%.[25] Other states that have used the Medicare ambulance fee schedule for a reference pricing system have typically used a multiple of the Medicare schedule to derive the schedule for commercial payers to use in reimbursing non-participating providers.

In reviewing Table 2, it is striking that the billed amounts are substantially higher than amounts allowed by the commercial carriers. This is another indicator that the exposure that covered persons have to significant balance billing amounts is considerable.[26] Note that the Medicare rates are different for services occurring in an urban versus a rural versus a super rural setting, with rates being more generous the more rural the setting. However, both the median allowed amount reimbursed by commercial payers, and the median amount billed for each code show the opposite trend where the rate is less generous the more rural the setting.

[25] The Balanced Budget Act of 1997 required establishment of an ambulance fee schedule payment system for ambulance services provided to Medicare beneficiaries, replacing a retrospective reasonable cost payment system for providers and suppliers of ambulance services because, under the prior system, such a wide variation of payment rates resulted for the same service. The Medicare Part B Ambulance Fee Schedule (AFS) is a national fee schedule for ambulance services that all ambulance services, including municipal, private, independent, and institutional providers and skilled nursing facilities. The Centers for Medicare and Medicaid Services (CMS) determines the final relative value unit (RVU) for each service billing code, which is then multiplied by the annual conversion factor (a dollar amount) to yield the national average fee. Rates are then adjusted according to geographic indices based on provider locality. Effective January 2024 - Ambulance Fee Schedule files can be found on the CMS Ambulance Fee Schedule & ZIP Code Files. For more detail on how the Medicare ambulance fee schedule is developed and updated, see: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf

[26] As with other researchers analyzing claims data in this context, the Department has used the median rather than the mean value to indicate the billed and allowed amounts. Statistically, this is required when, as here, the data do not conform to a normal distribution curve. In addition, when the data distribution is multi-modal (i.e. when there are several "peaks" in the distribution graph), this constitutes a second factor that militates in favor of the use of the median as a measure of central data tendency. See, Tukey, et. al 1977; Zar, J., 1999.

Table 3: Allowed and Billed Amounts as a Percentage of Medicare Rates*

	Allowed Amount			Billed Amount		
	NHurban	NHrural	NHsuperrural	NHurban	NHrural	NHsuperrural
A0425	120.07%	114.94%	80.76%	498.63%	326.54%	201.40%
A0426	110.92%	124.24%	80.26%	775.51%	552.21%	162.10%
A0427	116.25%	100.41%	89.86%	347.72%	267.32%	160.74%
A0428	109.47%	108.93%	89.86%	577.15%	571.54%	166.73%
A0429	116.05%	101.62%	93.74%	294.41%	217.33%	163.21%
A0432	161.03%	142.46%	--	206.23%	203.21%	--
A0433	109.04%	106.28%	141.63%	316.88%	269.44%	213.11%
A0434	282.01%	167.63%	100.00%	686.30%	250.15%	196.65%

*Median Allowed and Billed amounts expressed as a percentage of Medicare rates

Table 3 permits an easy comparison of allowed and billed amounts to Medicare rates. In urban contexts, commercial payments generally sit somewhere between 100% and 300% of the Medicare rate with most payments coming in at the lower end of that range. Of note, commercial payments decline relative to Medicare as the service area becomes more rural. Except for one service (AO433-Advanced Life Support, Level 2), median allowed amounts were at or below the Medicare rate in regions classified as super-rural. These data suggest that the proposal of a standardized fee schedule indexed to the Medicare base rates (adjusted by urban-rural status) would be economically advantageous for municipal and private ground ambulance providers providing services in the more rural areas of the state.

At this point in the process, the NHID proposed for discussion the following conceptual framework for state legislation that would address balance billing, provider contracting, and commercially reasonable reimbursement for ambulance services. The legislation would constitute an interim solution and would:

1. Prohibit ground ambulance providers from balance billing patients, and

2. Implement a statewide uniform fee schedule for services covered by commercial insurers under the various billing codes associated with the provision of ground ambulance services. The uniform fee schedule would be:

a. Based on a percentage of the Medicare fee schedule,

b. Utilize a base percentage of the Medicare schedule that is sufficient to establish a rate that makes the rates paid to urban ground

ambulance providers generally equivalent to the current reimbursement rates being paid by commercial carriers to urban ground ambulance providers as reflected in New Hampshire's APCD,

c. Applies this same percentage of Medicare to rural and super rural providers, but also includes the rural and super-rural bonus amounts that Medicare currently pays but commercial payers do not, thereby increasing commercial reimbursement statewide to rural and super-rural providers,

d. Adds an additional increment to the fee schedule, expressed as an additional percentage amount of the Medicare schedule, that is calculated to be adequate to completely compensate for the lost revenue that ground ambulance providers experience as a result of the prohibition on balance billing patients,

e. Is the same whether the ground ambulance provider is in-network or out of network,

f. Requires insurers to directly pay ambulance providers who are certified by Medicare and properly licensed by the state, and

g. Removes ambulance services from the insurer network adequacy rule.

The implementation of this legislation would involve the creation of a statewide ground ambulance cost and revenue reporting system to gauge where the commercial payers currently stand as a percent of Medicare and to determine what additional increment to the Medicare fee schedule would be needed to compensate for the revenue lost due to the prohibition on balance billing. It would also require the state to retain actuarial experts to estimate the Medicare fee schedule multiplier that would be required to meet the above standards, and the schedule would need to be periodically reviewed to determine whether Medicare rate adjustments are keeping up with state level costs.

In principle, this concept would result in an overall increase in reimbursements from commercial payers to ground ambulance providers, particularly for services occurring in the rural and super rural service areas. A uniform fee schedule would also streamline the reimbursement process allowing ambulance providers to receive payment quickly with less administrative burden.

Recognizing that every ambulance provider has different call volumes, varying frequencies in the types of services provided, and services populations with varying

payers, the NHID developed a tool to assist ambulance providers in analyzing the fiscal impact of a uniform fee schedule that is based on a percent of Medicare. The tool allows an ambulance provider to enter the number of calls it has for a specific billing code, select the type of locality (urban, rural, or super rural), and select a percentage of Medicare to estimate the total amount of revenue that those calls would be expected to generate under a uniform fee schedule that was a percentage of Medicare. The Department made this tool available to all participants so that ambulance providers could use their own call frequency information to analyze what percentage of Medicare they would need to charge to generate the same amount of revenue they are currently collecting for commercially insured patients.

As the subgroup continued discussions about a uniform fee schedule and the data available in the APCD, it became apparent that there were gaps in the data. The APCD collects information on the billed and allowed amounts for every claim but does not capture any amounts collected due to balance billing. The amount of revenue collected by ambulance providers due to balance billing is an essential data element needed to ensure that a uniform fee schedule is developed at a rate sufficient to ensure that ambulance providers do not lose revenue if balance billing is prohibited. NHID developed and sent out an Ambulance Provider Billing Survey to collect some of this missing data.[27] The survey requested total revenue collected for calendar year 2022 broken down by payer type and the frequencies of the codes billed broken down by payer type.[28]

NHID only received 11 responses to the survey. Of those responses, only 9 surveys were completed in such a way as to provide usable information. Given the very limited data provided, the Department was unable to conduct any meaningful analysis. Multiple ambulance providers expressed concerns about the survey being too burdensome and complicated to complete. Some ambulance providers indicated that they do not track the requested information and that it would be difficult to compile the requested information by billing code and payer type.

The New Hampshire Association of Fire Chiefs submitted a letter to the Commissioner outlining their concerns with the proposed framework.[29] The Fire Chiefs expressed concern that the reimbursement amounts determined by the uniform fee schedule would be insufficient to cover all their operating costs and, without the ability to balance bill, the local property taxpayers would need to contribute even more to cover the increased shortfalls. The Fire Chiefs were specifically concerned that any uniform fee schedule should take the costs of providing services into account and be designed to cover those costs. Instead of focusing exclusively on compensating for the loss of revenue that would accrue from a prohibition on balance billing, the Fire Chiefs urged an approach that would

[27] The Department made the survey available to all participants in the summit and with the assistance of the Division of Fire Standards and Training & EMS the survey was sent to all ambulance providers licensed in the state.
[28] The survey can be found in Appendix C.
[29] See Appendix D.

look at ambulance service reimbursement wholistically. For example, they pointed out that certain commercial payers currently reimburse municipal ambulance providers at rates that far exceed government payers. They argued that any uniform fee schedule would need to consider that the precedential effect of that schedule is likely to cause certain payers to bring their reimbursement rates down to the level of the schedule, thus generating a loss in revenue. The Fire Chiefs concluded by expressing their interest in continuing the dialogue, further explaining their concerns, and learning more about potential solutions.

AHIP also responded to the proposed framework with their feedback. They expressed an openness to considering a uniform fee schedule as part of a solution to the problem of balance billing. At the same time, AHIP emphasized on a number of occasions that the state regulated commercial payers constitute only a small percentage of the payer mix for ambulance services in the state. They estimated the commercial payers generally constitute about 20% of an ambulance provider's payer mix, and that about half of this 20% is self-funded benefit plans that are not governed by state law. Any proposed fee schedule would need to take this limitation into account.

Anthem and AHIP both raised the possibility that a uniform fee schedule could negatively impact network participation. In addition to containing costs, networks also allow health carriers to oversee the quality of care being provided to their members and ensure proper billing practices are being followed to limit fraud, waste, and abuse. Under a uniform fee schedule, the current situation in which providers have little incentive to join networks could persist. This, in turn, could continue to limit health carriers' ability to manage quality of care and monitor billing practices. It is also unclear how this could impact a health carrier's ability to use utilization management.

The Working Group on Improving System Efficiency

This working group explored ways to make the healthcare system more efficient to reduce the strain on ambulance providers. Mobile Integrated Healthcare (MIH) is the provision of healthcare using patient centered, mobile resources in the out-of-hospital environment. According to the Division of Fire Standards and Training & Emergency Medical Services' "Mobile Integrated Healthcare Prerequisite Protocol,"

The MIH concept is envisioned to be an organized system of services, based on local need, which are provided by EMT's, AEMT's and Paramedics integrated into the local health care system, working with and in support of physicians, mid-level practitioners, home care agencies and other community health team colleagues, and overseen by emergency and primary care physicians. The purpose of the initiative is to address the unmet needs of individuals who are experiencing intermittent healthcare issues. It is not intended to address long-term medical or nursing case management.

The hope is that MIH programs can reduce the strain on ambulance providers and the healthcare systems by providing care in a patient's home to prevent the patient from needing emergency services. However, the main challenge is funding/reimbursement to make these programs sustainable.

The Centers for Medicare & Medicaid Services (CMS) started a pilot program called ET3 to test such a system and recommend a reimbursement model. Unfortunately, the program was cancelled in 2023 providing a major step backwards.

The NH Bureau of Emergency Medical Services has procedures in place governing how to operate these programs and is currently overseeing 12 programs. To date over 1700 visits have been recorded in NH's patient care reporting system from a mobile integrated health provider.

The subcommittee met with the SmartCare program based out of MA. This program uses the mobile integrated health structure to focus on preventing readmission by partnering with a healthcare system and being their mobile operation, with the find of flexibility that physician practices and patients need. Reimbursement is part of the package through the healthcare system/partner, not separately billed. Although SmartCare identified readmissions as a priority, like programs have focused on patients with diabetes, asthma, and falls.

The system efficiencies subgroup also discussed the issue of "treat-no-transport." "Treat-no-transport" refers to situations where emergency medical services respond to a call for help and provide treatment to the patient, but the patient is not transported. Currently, Medicare and Medicaid do not reimburse for services provided when the patient is not transported. Multiple ambulance providers were under the impression that commercial insurers also did not reimburse when services are provided, but the patient is not transported. However, health insurers in the commercial market represented that they do reimburse for services provided even when the patient is not transported. There are currently 2 bills (SB409 and HB1568) pending to amend the Medicaid plan to include reimbursement for treat no transport.

The Working Group on Facility-to-Facility Transfers

The facility-to-facility subgroup contained professionals representing the NH Hospital Association, the NH Ambulance Association, the NH Fire Chief's Association, private ambulance providers, Association of Health Insurance Plans (AHIP), and several of the major medical carriers writing health insurance plans in New Hampshire (Anthem, HPHC, CIGNA, UHC, Centene). The aim of this meeting was to identify opportunities to improve efficiencies in this unique segment of the emergency transport system. Attendees were asked to formally identify barriers to contracting (coming in-network) with each other.

The New Hampshire Ambulance Association's May 2023 report uses survey and interview data to depict and describe 'the root' of the problem and 'factors' of the problem. The issue, referred to, interchangeably, as: (the) 'problem', 'crises, and

'state of emergency', according to the reports is centered around insufficient reimbursement for services. Moreover, the report describes an evolution of the EMS system that is increasingly burdened by non-emergency transport—also referred to as 'facility-to-facility transport', or more recently, 'scheduled transport.'

The report cites two stark realities affecting this market in New Hampshire. Firstly, that Medicare and Medicaid reimburse well below cost to deliver the respective services that these providers are responsible to deliver; and that, especially in rural areas of the state, a significant age disparity drives increased demand on emergency services in New Hampshire.

Specific to non-emergency transports, a report published in 2019 by NHID shows that 99% of transports provided by municipal ground ambulance providers were emergency transports, whereas approximately 60% of transports on private ground ambulance providers are emergency transports.

Taken together, these realities suggest that the issue related to facility-to-facility transport affects private ground ambulance providers directly. Whether or not indirect impacts on municipal providers occurs as a result of this disparity has not been determined by this workgroup.

Carriers surveyed in this process have cited that, providers 'coming in-network', would help to mitigate this crisis. Representative from the NH Hospital Association cited that: "Interfacility Transports are a major barrier to discharge from the hospital for our member hospitals."

In summary, this heterogenous group explored their various positions on this domain of the ground ambulance/balance billing issue and failed to reach any consensus on policies moving forward.

Final Recommendations of the New Hampshire Insurance Department

As this report makes clear, the ground ambulance landscape in New Hampshire is complex, and the financing and delivery model for ground ambulance services needs reform. EMS plays a critical public health and safety role in the state's communities. Action by state policymakers is required to ensure sustainability and equitable access to this vital service while, at the same time, protecting consumers from untenable levels of consumer medical debt.

The NHID's recommendations are designed to promote a balanced approach in addressing potentially competing public policy goals and are premised on the following public policy principles:

1. Ground ambulance services in the state should be funded in a manner that is sufficient to maintain an adequate and sustainable ground ambulance system.

2. The burden of funding a sustainable and adequate ground ambulance system in the state should not fall disproportionately on commercially insured consumers.

3. All covered persons in the state should be protected from ground ambulance balance billing and from a heightened risk of untenable levels of consumer medical debt for ground ambulance services.[30]

In accordance with these principles, the NHID proposes the following measures which are designed of optimally balance the potentially competing public policy goals articulated in the above principles. Implementation of these recommendations would require state legislation.

1) **Prohibition on balance billing** – The NHID recommends enacting a prohibition on ground ambulance balance billing.

2) **Requirement of direct pay to providers** – The NHID recommends amending existing law to require insurers to directly pay ambulance providers who are certified by Medicare and properly licensed by the state.

3) Data Collection on Ground Ambulance Costs and Revenues – The NHID recommends that a cost and revenue reporting program be established for ground ambulance providers in the state. This would most likely be administered by the Department of Safety under their EMS supervision authority. This information should in turn be made available to the independent entity charged with recommending a default payment methodology (as described below). Data collection from ambulance providers should be ongoing to ensure that the necessary data is available for future market analysis. Any cost data that eventually becomes available from the Federal Medicare Ground Ambulance Data Collection System should also be taken into account.

4) **Implementation of an Out-of-Network Default Rate Schedule for Commercial Payers** – For the reasons discussed above, the NHID recommends implementing an out-of-network default rate schedule for all ground ambulance services. This could be expressed as a percentage of Medicare rates or as an independently developed rate schedule. An independent vendor with actuarial expertise should be commissioned to

[30] See the Massachusetts Attorney General report for a similar articulation of principles for reform of EMS services. https://www.mass.gov/doc/examination-of-health-care-cost-trends-report-2023/download

review the cost data and other market data, consult with the municipalities regarding their rate development process, review the Medicare rate development process, and recommend a payment methodology that would then form the basis of rulemaking through the NHID establishing an out-of-network default rate schedule with public and legislative input.

The payment methodology would be developed based on the following standards:

a. The methodology must be evidence driven. Data and empirical evidence must be the driving force in determining an appropriate rate schedule given the current market conditions, including cost and revenue data, supply and demand information, geographical factors, specific community health needs present in the state, and municipal priorities with respect to ambulance services.

b. The methodology must balance the need to contain costs to ensure the affordability of healthcare and commercial health insurance with the need to fund ground ambulance services in a manner that is adequate and sustainable.

c. The methodology would include the concept of rural and super-rural bonus amounts, similar to the concept currently in use for Medicare.

d. The methodology must be aimed at building a default rate schedule that is sufficient to cover the reasonable cost of providing efficiently delivered care and a reasonable operating margin. This schedule must be derived based on a definition of sufficiency that is independent of any consideration of Medicare or Medicaid rate schedule shortfalls.

e. The methodology should also include, if it is practicable, incentives to improve efficiencies in the delivery system.

5) **Continued Monitoring and Default Rate Schedule Adjustment** – Once implemented, the NHID would be required to commission a study and report analyzing the market impact of the default rate schedule including the fiscal impact on ambulance providers for the first two years. The Insurance Commissioner would be required to make additional actuarially based changes to the schedule if it was determined that the schedule negatively impacted ambulance providers with respect to covering the reasonable cost of care. In addition, as the Medicare program completes its cost review work, it is possible that there will be corresponding adjustments to the Medicare fee schedule. If the default rate schedule is based on a percent of Medicare, then this would then trigger an actuarial review overseen by the Insurance Commissioner to

determine whether corresponding changes in the state-based schedule are warranted.

Although the default rate schedule would likely change annually as Medicare rates are adjusted, the Insurance Commissioner would be required to retain an independent actuarial expert to periodically review the payment methodology using the above guiding principles to determine whether any additional adjustment to the schedule is warranted.

6) **Creation of a Commission or Study Committee on Continuing System Reforms** – The NHID recommends that the New Hampshire legislature create a commission or study committee to continue the discussion on advancing some of the concepts and ideas identified in the summit that are not included in the above recommendations. The concepts and ideas to be evaluated by the commission should include at least the following:

    a. Evaluating the feasibility of expanding Mobile Integrated Health services in the state as appropriate to improve health system efficiency and quality of care and promote "treatment in place" where appropriate.

    b. Evaluating the feasibility of developing regional services coordination systems or regional EMS networks for the rural areas of the state to share the cost of readiness and disperse workloads.

    c. Evaluating the feasibility of implementing an improved system for delivering and compensating facility-to-facility or scheduled transfers of patients.

    d. Evaluating the feasibility of implementing a system for compensating care provided in the treat-no-transport context that would at least include commercial payers and Medicaid.

    e. Evaluating the feasibility of requiring standard provider contracts for ambulance providers and standard utilization review standards.

    f. Facilitating the development of an education program for ambulance providers relating to billing and reimbursement of ambulance services by health carriers.

    g. Evaluating the option to create an All Payer Model System for ground ambulance services in the state in which federal waivers are sought to create a uniform reimbursement schedule for ground ambulance services that includes Medicare, Medicaid, and all commercial payers.

h. Evaluating options to improve the funding mechanisms for ground ambulance services other than commercial health plan reimbursement.

The above recommendations are put forth by the NHID as package. The NHID does not recommend piecemeal implementation of these measures.

Appendix A:

Individual Ground Ambulance Claim Summaries from 2022 and 2023 NH CHIS

The result of this output shows that, for **ALS-1 emergency services** incurred on January 16th, 2022, that one individual (unique member key: [redacted]) was Billed $33,498.50, and that the mileage associated with this service, on this date was 2.0:

```
. tab IncurredDate ClaimStatus if MemberKey[redacted] Procedure=="A0427 - ALS1-emergency"
```

Incurred Date	Claim Status PAID	Total
20220116	1	1
Total	1	1

```
. sum Billed if MemberKey[redacted] Procedure=="A0427 - ALS1-emergency"
```

Variable	Obs	Mean	Std. dev.	Min	Max
Billed	1	33498.5	.	33498.5	33498.5

```
. tab ServiceUnits if MemberKey[redacted] Procedure=="A0425 - Ground mileage"
```

Service Units	Freq.	Percent	Cum.
2.00	1	100.00	100.00
Total	1	100.00	

The next example occurred on September 9th, 2022, which shows that for member key [redacted] (parent payer code: NHC0213—HPHC), that a claim was submitted, billing $10,250.65 for **ALS1—emergency**, with 7 miles of transport associated with this claim:

```
. tab IncurredDate ClaimStatus if MemberKey=[redacted] & Procedure=="A0427 - ALS1-emergency"
```

Incurred Date	Claim Status PAID	Total
20220906	1	1
Total	1	1

```
. sum Billed if MemberKey=[redacted] & Procedure=="A0427 - ALS1-emergency"
```

Variable	Obs	Mean	Std. dev.	Min	Max
Billed	1	10250.65	.	10250.65	10250.65

```
. tab ServiceUnits IncurredDate if MemberKey=[redacted] & Procedure=="A0425 - Ground mileage"
```

Service Units	Incurred Date 20220906	Total
7.00	1	1
Total	1	1

This example shows that, for member key: [redacted] (parent payer code: NHC0065; Anthem), in 2022 there was one PAID claim for "Specialty care transport", with two different service dates (January 7th, 2022 (1 claim line) and December 7th, 2022 (2 claim lines). The total Billed amount for this service seems to include (3) Specialty Care Transports, totaling $62,500 (average Billed amount of $20,833/transport), with 10, 10, and 11 miles billed, respectively.

```
. tab ClaimStatus Billed if MemberKey=[redacted] Procedure=="A0434 - Specialty care transport"
```

Claim Status	Billed 62500	Total
PAID	1	1
Total	1	1

```
. tab IncurredDate ServiceUnits if MemberKey==[redacted] Procedure=="A0425 - Ground mileage"
```

Incurred Date	Service Units 10.00	11.00	Total
20220107	0	1	1
20221207	2	0	2
Total	2	1	3

Summary Statistics on non-emergency ground ambulance billing codes (BASE RATES)

We queried the 2022 and 2023 Medical Claims in the NH All-Payors Claims Database – otherwise known as the New Hampshire CHIS. For the non-emergency ground ambulance billing code, A0426—ALS 1 (advanced life support), we observed 3,478 and 2,144 unique claims for this service in 2022 and 2023 (Q1-Q3), respectively. The median amount BILLED was $1,968 and $2,380 for those respective years. However, we did notice that there was one claim of $11,600 in 2023 and another in 2022 of $7,600. As a note, in 2023, 10% were between $2,950 and $11,600, and in 2022 between $2,380 and $7,600.

```
. sum Billed if Procedure=="A0426 - Als 1" & IncurredYear=="2023", detail

                          Billed
-------------------------------------------------------------

      Percentiles      Smallest
 1%      -2380.5       -3418.34
 5%       333.21       -3418.34
10%          616       -3295.48       Obs                2,144
25%         1022       -3295.48       Sum of wgt.        2,144

50%       2380.5                      Mean             1820.82
                       Largest        Std. dev.        1197.768
75%       2380.5       3948.85
90%         2950       4851.32       Variance          1434647
95%         3000         11600       Skewness         -1.225469
99%      3418.34         11600       Kurtosis          10.76247

. sum Billed if Procedure=="A0426 - Als 1" & IncurredYear=="2022", detail

                          Billed
-------------------------------------------------------------

      Percentiles      Smallest
 1%      -2569.9          -7600
 5%      -2380.5       -4319.58
10%          175       -4192.91       Obs                3,478
25%          877          -3500       Sum of wgt.        3,478

50%       1968.43                     Mean             1456.442
                       Largest        Std. dev.        1376.881
75%       2380.5        4621.1
90%       2380.5          7600       Variance          1895801
95%      2870.63          7600       Skewness         -1.434476
99%      3460.26          7600       Kurtosis           5.70425
```

We performed the same analysis on a second, more commonly-used non-emergency ground ambulance billing code, A0428—BLS (basic life support), in which we observed 20,695 and 11,148 unique claims for this service in 2022 and 2023 (Q1-Q3), respectively. The median amount BILLED was $1,283.77 and $1,983.75 for those respective years. For this code, we did notice that there was a narrower range of upper Billed amounts. 10% of these billed amounts ranged from $1,983-$4,565.55 in 2023 and $1,983-$3,630 in 2022.

```
. sum Billed if Procedure=="A0428 - bls" & IncurredYear=="2023", detail

                            Billed
-------------------------------------------------------------

      Percentiles      Smallest
 1%     -1983.75       -4565.55
 5%       277.68       -3387.32
10%          500       -3387.32       Obs                11,148
25%         1200        -3318.7       Sum of wgt.        11,148

50%      1983.75                      Mean               1512.856
                        Largest       Std. dev.          897.3575
75%      1983.75        4019.25
90%         2100        4565.55       Variance           805250.5
95%      2482.13        4565.55       Skewness          -2.034166
99%       3318.7        4565.55       Kurtosis           8.756986

. sum Billed if Procedure=="A0428 - bls" & IncurredYear=="2022", detail

                            Billed
-------------------------------------------------------------

      Percentiles      Smallest
 1%     -1983.75       -3526.75
 5%        -1235       -3526.75
10%          350          -3500       Obs                20,695
25%          823       -3253.02       Sum of wgt.        20,695

50%      1283.77                      Mean               1235.768
                        Largest       Std. dev.           946.749
75%      1983.75        3526.75
90%      1983.75        3526.75       Variance           896333.6
95%      2256.48        3526.75       Skewness          -1.627534
99%         2850           3630       Kurtosis           6.332321
```

Appendix B:

Participants in the 2023 New Hampshire Ground Ambulance Summit Meetings Hosted by the New Hampshire Insurance Department

Jason Aziz	NHID
Keith Nyhan	NHID
Jason Dexter	NHID
DJ Bettencourt	NHID
Michelle Heaton	NHID
AJ Kierstead	NHID
Alex Feldvebel	NHID
Morgan Harris	NHID
Ben Bradley	New Hampshire Hospital Association
Justin Van Etten	Stewart Ambulance / Municipal Resources
Sabrina Dunlap	Anthem
Anita Burroughs	NH House
Stefani Reardon	Harvard Pilgrim
Donald Pfundstein	Gallager, Callahan & Gartrell; AHIP
Scott Sebastian	United Healthcare
Scott Hunter	Town of Bedford Fire Department
Lindsay Nadeau	Orr & Reno Law; Cigna
Heidi Kroll	Gallager, Callahan & Gartrell; AHIP
George Roussos	Orr & Reno; Cigna
Frederick Aumann	New London Hospital
Chris Coates	Cheshire County
Michael W. Sitar, Jr.	Tilton-Northfiel Fire & EMS
David Tauber	Fire Chief; Linwood Ambulance
Brooke Belanger	New Hampshire Hospital Association
Chris Stawasz	Global Medical Response
Adam Schmidt	JG Strategic Solutions
Jack Wozmak	Municipal Resources, Inc.; Cheshire County
Jeff Sedlack	Harvard Pilgrim Health Care
Paula Minnehan	NH Hospital Association
Michele Favre	DOS Training Division Manager
Lawrence D. Best	Salem NH Fire Department
Derick Aumann	New London Hospital
Suzanne Prentiss	NH Senate
Chris Kennedy	Centene
Melissa Medor	Centene
Joseph Spicuzza	Harvard Pilgrim Health Care
Tiffany Lingenfelter Pierce	Cigna
Christine Cooney	Cigna
Sean Lyons	Cigna
Adam Schmidt	JP Strategies
Jerry Stringham	NH House

Appendix C:

Ambulance Provider Billing Survey

1: Using the Revenue sheet, insert your Calander Year 2022 revenues for each revenue source listed.

The Other payers column must be based on ambulatory/EMT services and not any other form of revenue, including fundraising, donations, taxes, etc.

2: Using the Frequency sheet, insert the frequency of each procedure code broken up by Medicare, Medicaid, Commercial Insurance, and Other payers.

For code A0998 (treat no transport) please provide us with the frequency of calls received, even if you did not bill for this code.

For the frequency of A0425, please use the total number of miles traveled instead of how many calls were placed for this code.

3: After both sheets have been filled out, please email this Excel file to doi.healthcareanalytics@ins.nh.gov no later than November 15th

When emailing the survey, please include the name of the survey and your location in the state. Ex: Ambulance Provider Billing Survey Tilton Fire & EMS.

Revenue Source	CY 2022 Revenue
Medicare	
Medicaid	
Commercial Insurance	
Balance Billing	
Other Payers	
Total	0

Description	Code	Medicare	Medicaid	Commercial Insurance	Other Payers
Ground Mileage (Total miles)	A0425				
Ambulance Service, Advanced Life Support, Non-Emergency Transport, Level 1 (ALS 1)	A0426				
Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 (ALS 1-Emergency)	A0427				
Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS)	A0428				
Ambulance Service, Basic Life Support, Emergency Transport (BLS - Emergency)	A0429				
Paramedic Intercept (PI), Rural Area, Transport Furnished by a Volunteer Ambulance Company which is Prohibited by State Law from Billing Third Party Payers	A0432				
Advances Life Support, Level 2 (ALS 2)	A0433				
Specialty Care Transport (SCT)	A0434				
Treat and no transport	A0998				

Appendix D:

Letter from New Hampshire Association of Fire Chiefs, Inc.

NEW HAMPSHIRE ASSOCIATION OF FIRE CHIEFS, INC.

Working Together to Make a Difference

547 Charles Bancroft Hwy.
Litchfield, NH 03052
www.nhafc.org
Email: nhfirechiefs@gmail.com

November 17, 2023

Commissioner D.J. Bettencourt
NH Insurance Department
21 South Fruit Street, Suite 41
Concord, NH 03301

Dear Commissioner Bettencourt:

Initially, our Association would like to compliment the Department's pro-active steps to address concerns regarding balance billing for ambulance services in New Hampshire. As you know, ambulance services were expressly and purposely left out of the federal "No Surprise Billing Act" due to the complexities involved in providing these services. The last several attempts to ban balance billing for ground ambulance services at the state level, via legislation at the State House, have not resulted in meaningful dialogue or consideration of this issue. By convening the working group at the Department, you and your staff have demonstrated a commitment to engage stakeholders to develop a solution. We appreciate being included in this discussion and all your efforts to date.

Our Association has had three members participate in the working group, Chief Larry Best (prior to his retirement from the Salem Fire Department, Chief Mike Sitar (Tilton/Northfield), and Chief Scott Hunter (Bedford). They have shared with our membership the discussions at the working group to solicit feedback. At the last full working group meeting, the Department asked for written comments in advance of the next meeting in December. Our Association held a full membership meeting last week. We have heard some concerns from our members which we wanted to ensure we shared with you and your staff. The concerns are as follows:

Uniform Fee Schedule: Our understanding of the proposed concept of a uniform fee schedule is that it would be based on Medicare re-imbursement fees. There would be consideration for rural and super rural providers. Further, private health insurance carriers would be required to reimburse providers directly. For municipal ambulance service providers, the most basic question we have received is simply about the specific rate. Our members understand the parameters of the proposal, but need to know if the fee schedule will be sufficient to cover their costs. If not, any costs which are not met by the fee schedule will be passed on to local property taxpayers. While this can and does happen currently, our concern is that an inadequate fee schedule would only make this worse, especially if balance billing is prohibited. The fee scheduled that has been discussed as part of the "Commercially Reasonable Rate Subgroup" has been a fee based on the delta of the current Medicare rate and the average of the commercial insurance payments, minus deductibles and co-pays. The percentage over Medicare, as proposed, would be an amount that would make the provider's income equal to its current income. Patients would still receive a "balance bill" for any co-pay or deductible that may be owed to a provider according to their insurance policy. This proposal does not consider

the actual cost of providing the service. At the same time, the proposal would still require municipalities to bill for a portion of the service provided.

Changes in Private Carrier Reimbursement. There are not many fire based ambulance providers who have contracts with private carriers. Many of our members cannot recall the last time they were contacted by a carrier regarding a potential contract. For those who have, the rates which were offered would not have covered costs associated with service provision. At the same time, there are carriers who currently pay for the cost-of-service provision at rates which far exceed government payors. Our concern is that once a fee schedule is developed, all carriers will be incentivized to use it, potentially lowering current revenues received by local departments. The challenge with developing a fee schedule to help cover costs, based on current revenues, is determining how revenues will change once a fee schedule is developed and put into the marketplace. We believe most, if not all carriers who currently reimburse local providers at a higher level will switch to the lower cost option for their covered lives. This would reduce revenues for municipalities who offer ambulance services. **Further, it is not yet clear how a state based fee schedule will alter how auto insurance carriers currently reimburse providers for ambulance services.**

Future Alterations of Fee Schedule. The provision of ambulance services is regulated by the New Hampshire Department of Safety. On occasion, the Department will propose rules which alter the requirements associated with ambulance provision in the State. This can alter the costs associated with providing this service. Moving forward, are there plans for altering the fee schedule as the Department of Safety changes the scope and costs of providing service? Our concern is that one state agency will be mandating costs, while another is capping reimbursement. We will need to ensure there is alignment within state government to avoid worst case scenarios of increased costs without the ability to recover it. Further, many municipalities create the fee levels for ambulance service at their local governing board. Will a future fee schedule created by the Department consider the input of local elected officials or will it be "take it or leave it" for the communities?

Acceptance by Municipalities. Our members work for local government. They routinely communicate with Select Boards, Town Councils, and Boards of Alderman. Our goal is to try to recover sufficient revenue, from all payors, to cover costs associated with service provision. Ambulance services have never been a revenue generator for communities and our data shows most communities are currently subsidizing ambulance services with local property tax dollars. Any proposal which the working group develops must be accepted by local government. Our members are responsible for updating their communities about potential changes to ambulance reimbursement revenues. If the municipal leaders remain concerned that future changes to the existing system could add additional costs to local property taxpayers, we believe those concerns will be shared the elected officials at the State level. This will impact the ability of meaningful reforms to be adopted.

From our Association's perspective, it would make more sense to look at ambulance service reimbursement wholistically. While everyone would prefer to eliminate balance billing, there are concerns, as we have detailed, about moving forward with that as a near-term goal without considering the potential long-term effects. Most fire departments that provide ambulance services have already examined their costs and provided those details to the federal government. As Chief Hunter has explained in the working group meetings, this was an exhaustive effort by local departments to provide data to CMS. A reimbursement model, based on cost-of-service provision, rather than an existing federal fee schedule would likely relieve many our of members' concerns.

Moving forward, if you are interested, we would be willing to gather additional Chiefs to meet with the Department to further explain our concerns and learn more about your concepts. We sincerely appreciate the time and effort the Department continues to commit to this issue and we look forward to working with you further.

Thank you.

Respectfully,

Brett T. Lemire, MPA
Executive Director
New Hampshire Association of Fire Chiefs

Appendix E:

Glossary of Terms

Advanced life support (ALS): The most advanced level of care that can be provided by first responders or paramedics. It is provided in the event of a life-threatening illness or injury until full medical care can be provided. Can perform all BLS and ILS services as well as intubate patients in the field and perform chest decompression. This care can only be provided by certified paramedics.

All-Payer Claims Database (APCD): New Hampshire's database (also known as the Comprehensive Healthcare Information System or CHIS) that includes anonymized medical, pharmacy, and dental claims, as well as eligibility and provider files reported directly to the state by insures.

Allowed amount: This is the maximum amount the plan will pay for a specific covered health care service (i.e., x-ray, flu shot, office visit).

Balance billing: The practice of a provider billing a patient for the difference between the provider's charges for services and the allowed amount that was already paid to the provider by the health carrier. Also known as surprise billing.

Basic life support (BLS): The basic level of care provided by first responders in the event of a life-threatening illness or injury until full medical care can be provided. Can perform CPR, take vitals, control bleeding, provide certain medications, etc.

Billed charges: The total amount charged and submitted by the provider to the health carrier for reimbursement.

Co-insurance: The percentage of a healthcare bill that patients pay for health care services that are not fully covered by health insurance. Co-insurance can vary by type of service.

Commercial insurance: This term refers to health benefits provided and administered by nongovernmental entities. It can include both fully funded and self-funded health plans.

Copayments (Copays): A fixed dollar amount that a patient pays to a medical provider for services in addition to what is paid by the insurance provider. This amount varies by service.

Cost: This term is most commonly used by providers and refers to the calculation of total cost of their service based on supplies used, mileage traveled, hourly rate of response team, etc.

Cost-sharing: The amount patients pay for health care services that aren't fully covered by insurance, including copayments and co-insurance.

Current Procedural Terminology (CPT): The language used by health care professional and health carriers for uniform coding of medical services and procedures. Used to streamline reporting and increase accuracy and efficiency.

Deductible: The amount paid by the individual or family before insurance covers a part of the services. Deductibles vary for individuals and families.

Emergency medical services (EMS): Services that provide emergent pre-hospital services for life-threatening illnesses or injuries. Including transportation to the nearest emergency department.

Emergency services: Also known as emergency care or emergent care, these are services given in an emergency room to prevent death or serious damage to the patient. This includes mental health crisis stabilization services.

Fee for service: The most common type of health care payment method based on a fee schedule established by a health care provider for each service and procedure that they provide.

Fully insured plan: An insurance product in which a licensed health insurance company assumes the risk associated with a health insurance plan. These plans are regulated by the New Hampshire Insurance Department.

Ground ambulance: An ambulance used to transport patients with a traumatic illness or injury that require emergency medical services, or an ambulance used to transport patients in nonemergent situations who require extra assistance for interfacility and specialty care transport.

In-network or participating provider: A provider or facility who is contracted with your health insurance plan.

Interfacility transport: Transport of a patient between two healthcare facilities via ground ambulance. Examples include transport between hospitals and hospice care centers, transportation to dialysis centers, etc.

Loaded miles: Miles driven by a ground ambulance with a patient in the vehicle being transported to a hospital or alternative destination.

No Suprises Act (NSA): Act passed by Congress and took effect in January 2022. Bans balance billing in a variety of settings.

Non-emergent services: Care or services provided in any setting that are not an emergency or medically necessary to prevent death or serious damage to the patient. This includes planned surgeries and scheduled appointments in a provider's office.

Out-of-network (non-participating) (OON): A provider or facility who does not have a contract with your health insurance provider.

Private health insurance: Insurance coverage by a health plan provided through an employer or union or purchased by an individual from a private health insurance company. This term may include fully insured and self-insured plans. It does not include health benefit plans administer by the government such as Medicare and Medicaid.

Rate: Fixed amount established by the health insurance carrier.

Self-insured plan: An employee health plan provider by an employer to cover the health costs of its employees. The employer assumes all the risk associated with providing the health benefits. These plans are not regulated by the New Hampshire Insurance Department.

Specialty care transport: Interfacility transport for critically injured or ill patients that requires care beyond EMT-Paramedic level care, such as a critical care nurse.

Surprise billing: When a patient unknowingly or unavoidably receives health care services from a provider outside of their health insurance provider's network. Then they are billed the difference between the provider's charged amount for the care and the allowed amount.

Unloaded miles: Miles driven by a ground ambulance without a patient being transported in the vehicle.