**STATE OF SOUTH DAKOTA**
**ONE HUNDRED AND FIRST SESSION**
**LEGISLATIVE ASSEMBLY**

BILL NO. _____

Introduced by:

An Act to prohibit balance billing by ambulance service providers and to establish reimbursement standards for out-of-network emergency medical services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. Title.
This Act shall be known and may be cited as the "South Dakota Ambulance Balance Billing Protection Act."

Section 2. Definitions.
Terms used in this Act mean:

(1) "Ambulance service," any ground ambulance service licensed pursuant to chapter 34-11;

(2) "Balance billing," the practice of a health care provider billing a patient for the difference between the provider's billed charges and the amount paid by the patient's health benefit plan, exclusive of copayments, deductibles, or coinsurance;

(3) "Emergency medical services" or "EMS," ambulance transportation and prehospital emergency medical care provided to a patient;

(4) "Health benefit plan," any health insurance policy, contract, or arrangement regulated under Title 58 that provides coverage for health care services;

(5) "Out-of-network provider," an ambulance service provider that does not have a direct or contractual agreement with the patient's health benefit plan.

Section 3. Prohibition on Balance Billing.
No ambulance service provider may bill, attempt to collect from, or otherwise seek reimbursement from a patient for emergency medical services rendered on an out-of-network basis, except for any copayment, deductible, or coinsurance amount required under the terms of the patient's health benefit plan.

This section applies only to health benefit plans regulated under the laws of the State of South Dakota.

Section 4. Reimbursement for Out-of-Network Ambulance Services.
(1) Each health benefit plan shall reimburse an out-of-network ambulance service provider for emergency medical services at a rate, the lesser of:

(a) The provider's billed charge; or
(b) Three hundred fifty percent of the applicable Medicare allowable rate for the same services.

(2) Reimbursement shall be made directly to the ambulance service provider no later than thirty days after receipt of a clean claim, unless otherwise agreed in writing by the parties.

Section 5. Rate Reporting and Public Database.
(1) The Division of Insurance shall establish and maintain a publicly accessible online database of ambulance reimbursement rates submitted by local governmental entities, effective no later than January 1, 2026.

(2) Each local governmental entity that regulates or establishes ambulance rates shall submit such rates annually to the Division.

(3) An ambulance service provider located in a jurisdiction that fails to submit local rates shall be reimbursed under subdivision 4(1)(b).

Section 6. Patient Protections.
(1) A patient shall not be held liable for any amount beyond the applicable copayment, deductible, or coinsurance required by their health benefit plan for emergency ambulance services, except for non-covered services.

(2) Ambulance service providers and health benefit plans shall furnish patients with a clear and concise explanation of benefits and any amounts owed by the patient.

Section 7. Enforcement.
(1) The Division of Insurance may investigate violations of this Act and impose administrative fines or sanctions in accordance with chapter 58-4.

(2) Any person aggrieved by a violation of this Act may file a complaint with the Division of Insurance for appropriate relief.

Section 8. Applicability.
The provisions of this Act apply only to health benefit plans regulated by the State of South Dakota. This Act does not apply to self-funded employer health plans, Medicaid, Medicare, or other federally regulated programs, except to the extent permitted by federal law.

Section 9. Effective Date and Sunset.
This Act is effective on July 1, 2027. It is repealed on December 31, 2030, unless extended by the Legislature or preempted by federal law.

Section 10. Severability.
If any section, subsection, sentence, clause, or phrase of this Act is held to be invalid for any reason, such decision shall not affect the validity of the remaining portions of the Act.

# Summary of State Patient Protection

## Balance Billing Laws

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# Forward

Across the United States, the issue of patient financial protection, particularly related to ambulance balance billing, has rapidly evolved into one of the most complex and consequential policy challenges facing the EMS profession.

While the federal No Surprises Act established important consumer protections for many healthcare services, ground ambulance services were notably excluded, leaving states to develop a patchwork of laws and regulations addressing balance billing and reimbursement methodologies.

As a result, EMS agencies now operate within a highly fragmented regulatory environment, where payment standards, patient protections, and payer obligations vary significantly by state.

This variability creates both opportunity and risk for EMS providers, policymakers, and patients. On one hand, many states have taken meaningful steps to protect patients from unexpected bills. On the other, these protections often lack alignment with the true cost of delivering EMS, introducing financial pressures that can threaten system sustainability, access to care, and the ability of agencies to innovate and expand services.

The purpose of this document is to provide the EMS profession with a clear, concise, and actionable summary of state-level balance billing protections and associated reimbursement frameworks for ground ambulance services.

By organizing this information into a single, accessible resource, PWW Advisory Group aims to equip EMS leaders, policymakers, and stakeholders with a foundational understanding of how different states are approaching this critical issue.

This document provides the EMS community with a clear, concise, and actionable summary of state-level balance billing protections and associated reimbursement frameworks for ground ambulance services. This is a summary, not a complete statement of these laws, and users should consult with legal counsel on the impact of these laws on your EMS agency

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## Outlook

We hope this resource will assist the profession in several key ways:

- **Inform Advocacy Efforts:** Support national, state, and local advocacy by identifying trends, gaps, and best practices in existing laws.
- **Guide Strategic Decision-Making:** Help EMS agencies assess financial risk, payer strategy, and operational impacts within their respective regulatory environments.
- **Promote Policy Alignment:** Encourage the development of more consistent, sustainable reimbursement models that balance patient protections with the true cost of EMS delivery.
- **Advance EMS System Sustainability:** Provide a data-driven foundation for discussions around reimbursement reform, including future federal considerations and potential expansion of patient protections to ambulance services.

Ultimately, this document is intended to serve as both a reference tool and a catalyst for meaningful dialogue.

We believe that by bringing clarity to the current landscape, the EMS profession can more effectively advocate for policies that protect patients while ensuring the long-term sustainability and advancement of mobile healthcare.

**Sources:**

National Conference of State Legislatures -Emergency Medical Services Legislation Database
https://www.ncsl.org/health/emergency-medical-services-legislation-database
Commonwealth Fund Report: Expanding the No Surprises Act to Protect Consumers from Surprise Ambulance Bills
https://www.commonwealthfund.org/publications/maps-and-interactives/expanding-no-surprises-act-protect-consumers-surprise-ambulance

| State w/Link to Legislation | Does the state have balance billing protections for ground ambulance services? | Does the state require specific method for payment? | State specific method of payment | Do the protections apply to all private, state-regulated plans? | Do the protections apply to public and private ambulance services? | Do the protections cover nonemergency transport? |
|---|---|---|---|---|---|---|
| Arkansas | Yes | Yes | Minimum allowable reimbursement at: (1) **Rate set by local government entity**. If no such rate exists, **then the lesser of**: (i) **325% of Medicare or**, (ii) **the provider's billed charge.** | Yes | Both | Yes |
| California | Yes | Yes | The payment rate is based on (1) **a rate established or approved by the local government with jurisdiction** for the area or (2) if no local rate is available, a rate set under state regulations as the reasonable and customary value, considering various factors (e.g., provider training and qualifications, nature of services, usual charges, and prevailing provider rates in the local area). | Yes | Both | Yes |
| Colorado | Yes | Yes | The payment rate is based on (1) **325% of Medicare**; or if a private provider contracts with a government entity, then (2) a negotiated independent reimbursement rate. | Yes | Private Only | No |
| Delaware | Yes | Yes | In the absence of agreed upon or negotiated rates, the insurer and provider can seek arbitration. Prior to resolution, the insurer is required to pay the provider the highest allowable charge allowed by the insurer during the year before the date of service. | Yes | Both | No |
| Florida | Yes | Yes | The payment rate is based on the **lesser of three**: (1) **The provider's billed charges**; (2) The usual and customary provider charges for similar services in the community where services were provided; or (3) The charge mutually agreed to by the insurer and provider within 60 days of claim submittal. | Only HMOs | Both | No |
| Illinois | Yes | Yes | Either (1) **a locally-set rate** if the provider is subjected to the jurisdiction or a local government, or, if a provider is not subject to a local government's jurisdiction, then (2) **the lesser of** (i) the negotiated rate between the provider and the insurer, (ii) **85% of the provider's billed charges**, or (iii) the average gross charge rate for the service provided and a loaded mileage charge, if applicable. | Yes | Both | No |
| Indiana | Yes | Yes | The payment rate is based on the **lessor of the three**: (1) At a rate not to exceed local rate set; (2) **400% of Medicare**; or (3) according to the out of network ambulance provider's billed charges. | Yes | Both | Yes |
| Louisiana | Yes | Yes | Minimum allowable reimbursement rate to out-of-network provider at: (1) a rate set or approved by local government entity or; (2) If no such rate exists, then the **lesser of 325% of Medicare or the provider's billed charge.** | Yes | Both | No |
| Maine | Yes | Yes | Carriers are required to reimburse out-of-pocket network providers at **the lesser of** the provider's rate or **180% of Medicare** unless the ambulance service provider is in a rural or super rural area as determined by CMS. If based on being in a rural area the provider would be eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider in the same amount as the additional Medicare reimbursement. | Yes | Both | Yes |
| Maryland | Yes | Yes | Minimum allowable reimbursement rate is set to amount paid to an ambulance service provider under contract with the carrier for the same service in the same geographic region, as defined by CMS. | Yes | Public only if the ambulance service accepts an assignment of benefits from PPO and EPO plans; Private and public for HMO plans | Yes |

| State w/Link to Legislation | Does the state have balance billing protections for ground ambulance services? | Does the state require specific method for payment? | State specific method of payment | Do the protections apply to all private, state-regulated plans? | Do the protections apply to public and private ambulance services? | Do the protections cover nonemergency transport? |
|---|---|---|---|---|---|---|
| Mississippi | Yes | Yes | Minimum allowable reimbursement rate is **a locally set rate**, or, without that, **the greater of** (i) **325% of Medicare** or (ii) **the provider's billed charges**. | Yes | Both | Yes |
| New Hampshire | Yes | Yes | The payment rate is differentiated between a provider's status as enrolling / participating and nonparticipating. (1) For enrolling/participating providers: (i) from 2026-2027, the rate is temporarily set at **3.25 times the Medicare rate**; then (ii) **beginning in 2028, the rate will be a state-wide rate established by the commissioner**, based on recommendations from an independent study conducted by an independent consulting expert; and (2) **for nonparticipating providers**, the **rate is the greater of**: (i) the out-of-network rate, or (ii) the **Medicare rate**. | Yes | Both | Yes |
| New York | Yes | Yes | In the absence of agreed upon rates, the usual and customary rate, which cannot be excessive or unreasonable. | Yes | Both | No |
| North Dakota | Yes | Yes | The minimum allowable reimbursement rate is **the lesser of** (i) **250% of Medicare** or (ii) the **provider's billed charges**. | Yes | Yes | Yes |
| Ohio | Yes | Yes | The payment rate is based on **the greater of**: (a) In-network rate, or if more than one amount, the median rate; if no per-service amount exists, then this option is disregarded; (b) the same amount the health benefit plan generally uses to determine the payments for out of network health care services, such as **the usual, customary, and reasonable amount**; or, (c) **the amount that would be paid under Medicare**. If disagreement on rate, the disputing parties can enter arbitration | Yes | Both | No |
| Oklahoma | Yes | Yes | Minimum allowable reimbursement rate is **a locally set rate**, or, without that, **the lesser of (i) 325% of Medicare**, or (ii) **the provider's billed charges.** | Yes | Both | Yes |
| Oregon | Yes | Yes | Either (1) **the established local rate**, or (2) **325% of the Medicare rate** in the absence of a local rate. | Yes | Both | Yes |
| Texas | Yes | Yes | The payment rate is based on (1) **an amount set by a political subdivision and filed with the state** or; (2) **the lesser of**; (i) **325% of Medicare** or; (ii) **the provider's billed charge.** | Yes | Both | No |
| Utah | Yes | Yes | The payment rate is based on a base rate corresponding to the type of ambulance provider. The bureau of insurance will establish a mileage rate for ground ambulance providers and paramedic providers that is just and reasonable. | Yes | Both | Yes |
| Washington | Yes | Yes | The payment rate is based on (1) Either (a) **a rate set by a local government entity for public-sector organizations**; or (b) a **contracted rate for private-sector organizations**; (2) If (1) is not established, then then the lesser of (a) 325% of Medicare; or (b) the ground ambulance services organization's **billed charges.** | Yes | Both | Yes |
| West Virginia | Yes | Yes | (A) At the rate of **400% of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services** under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.) for the same ambulance service provided in the same geographic area; or (B) According to the nonparticipating emergency medical service agency's **billed charges; whichever is less.** | Only HMOs | Both | No |

# About Us

**PWW Advisory Group** is widely respected leader in education, consulting, and thought leadership for EMS and mobile healthcare organizations throughout the United States. We provide transformational EMS consulting for our clients.

PWW|AG offers the most comprehensive suite of consulting services in the EMS and mobile healthcare industry. Our services are client-focused and precisely tailored to your needs. Most importantly, our services are practical and our advice is actionable. We provide our clients not only with advice and analysis, but with highly practical solutions that you can implement to improve your services and ensure your agency's sustainability.

Email us at **contact@PWWAG.com**

Our services include:

- EMS System assessment, design, and transformation
- EMS Revenue Cycle Management Assessment and Improvement
- Compliance Program Implementation
- EMS Human Capital Consulting

We are also well known for helping leaders transform their systems into evidence-based, sustainable models that elevate their people from EMS or transport providers to full-fledged, indispensable partners in the community healthcare system. We also work with EMS clients to implement performance measures that focus on clinical excellence recalibrated that focus on metrics that are truly impactful for patient care.

NAAC®

The National Academy of Ambulance Compliance offers multiple certification courses designed to specifically help EMS agencies improve their revenue cycle management, documentation, compliance, and financial management.

Courses are available online and in person.

Visit **AmbulanceCompliance.com** for more information.

CAC® Certified Ambulance Coder

CACO® Certified Ambulance Compliance Officer

CADS® Certified Ambulance Documentation Specialist

CAFO™ Certified Ambulance Financial Officer

CAPO® Certified Ambulance Privacy Officer

CAPRO® Certified Ambulance Public Relations Officer

| Charge Description | Commercial Payer 2021 Allowable Fee | SD Medicaid Effective for Dates of Service After 7/1/2021 | Medicare Urban Allowable 2022 | Medicare Rural Allowable 2022 | Medicare Super Rural Allowable 2022 |
|---|---|---|---|---|---|
| A0425 – ALS/BLS MILEAGE | $18.00 | $4.09 | $8.02 | $8.10 | $12.15 |
| A0426 - ALS NON EMERGENCY | $900.00 | $179.19 | $299.01 | $301.94 | $370.18 |
| A0427 - ALS EMERGENCY | $1,250.00 | $266.06 | $473.43 | $478.08 | $586.13 |
| A0428 - BLS NON EMERGENCY | $600.00 | $145.29 | $249.18 | $251.62 | $308.49 |
| A0429 – BLS EMERGENCY | $950.00 | $224.39 | $398.68 | $402.59 | $493.58 |
| A0433 – ALS2 | $1,450.00 | * | $685.23 | $691.95 | $848.33 |
| A0434 – SCT | ? | * | $809.82 | $817.76 | $1,002.57 |
| A0998 – AMBULANCE RESPONSE/TREATMENT | $250.00 | * | * | * | * |

Other Supply Charges

| | | |
|---|---|---|
| ALS ROUTINE DISPOSABLE SUPPLIES | $150.00 | * |
| BLS ROUTINE DISPOSABLE SUPPLIES | $75.00 | * |
| DEFIBRILATION, ALS | $150.00 | $27.49 |
| DEFIBRILATION, BLS | ? | $27.49 |
| ECG 12 LEAD | $125.00 | * |
| ECG 3 LEAD | $85.00 | * |
| ESOPHAGEAL INTUBATION, INCL SUPPLIES | $50.00 | $48.44 |
| EXTRA ATTENDANT ALS/BLS | ? | $39.05 |
| IV ACCESS VIA I/O | $120.00 | * |
| IV FLUIDS AND SUPPLIES | $150.00 | $38.79 |
| OXYGEN SUPPLIES | $100.00 | $21.00 |
| | | |

Medicare allowable rates published do vary slightly from actual payment due to a calculated rate as determined by the origin Point Of Pickup (POP) zip code.
1 – Based on known payer allowable amounts 2021.
2 – Based on fee schedule for Rural Base Rate & 1-17 Ground Miles.
3 – Based on CMS definition of Super Rural Bonus (SRB). See IOM 100-04, Ch 15, Sec 20.1.