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Fellowship Capstone | Policy Brief

Emergency Medical Services For All: A Case for Publicaly Funded EMS

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I. Executive summary

Emergency Medical Services (EMS) in the United States operate largely as a fee-for-service system, leaving millions of Americans, particularly those from low-income communities, unable to afford the cost of an ambulance when they need it most. The average ambulance transport costs over $2,600, a price that is out of reach for a significant portion of the population. This policy brief argues that EMS should be treated as an essential public service, fully funded through a coordinated federal, state, and local government framework, and made free at the point of use for all Americans regardless of income. Just as fire protection and law enforcement are publicly funded without a bill sent to citizens in crisis, EMS must be reimagined under the same model. Eliminating financial barriers to emergency care will save lives, reduce health disparities, and strengthen the overall public health infrastructure of the United States.

II. Overview

Emergency Medical Services encompass the emrgency response systems that provide pre-hospital care and transportation for individuals experiencing medical crises, accidents, or other life-threatening situations. In the United States EMS is funded through a complex and inconsistent patchwork of billing fees, insurance reimbursements, Medicare and Medical payments, local taxes, and in many rural communities, volunteer labor and fundraising. Unlike police and fire departments, EMS is not universally recognized as an essential government service at the federal level, and only about a quarter of states have designated it as such by statute. This fragmented funding model produces stark inequalities. Low-income individuals are disproportionately burdened by ambulance bills that can range from $1,300 to over $2,200 for a single ride. Many avoid calling 911 in emergencies due to fear of the financial consequences, a decision that can be fatal. Meanwhile, EMS response times in low-income neighborhoods are measurably slower, compounding the disadvantage faced by already vulnerable communities. This brief proposes that federal, state, and local governments jointly fund a universal, free-at-the-point-of-use EMS system, restructuring how emergency care is financed so that no American has to choose between their life and their financial survival.

A. Relevance

The cost of ambulance services in the United States has reached a crisis point. According to the Centers for Medicare and Medicaid Services, the average cost of an ambulance transport across all provider types is $2,673. In New York City alone, the FDNY has proposed raising the standard ambulance fee from $1,385 to $1,793 -

an increase of nearly 30% - citing rising operational costs. For low-income families already struggling to cover basic necessities, bills of this magnitude are simply unaffordable. The consequences of this financial barrier are measurable and deadly. Research by the CDC shows that EMS response times for cardiac arrest patients are 10% longer in low-income neighborhoods than in wealthier ones. When people delay calling for help or cannot pay for care after the fact, health outcomes worsen and the burden on emergency rooms increases. The United States spends a fraction of one percent of its GDP on EMS, far below what is necessary to run a high-quality, equitable system. Reforming EMS financing is not just a matter of fairness; it is a matter of public health and national priority. This issue is especially urgent for young Americans and future policymakers to understand. The generation entering the workforce today will shape the healthcare policies of tomorrow, and the decisions made now about how to fund emergency services will determine whether EMS becomes a true safety net for all, or remains a system that fails those who need it most.

III. History

A. Current Stances

The modern EMS system in the United States traces its origins to a landmark 1966 white paper published by the National Academy of Sciences, titled "Accidental Death and Disability: The Neglected Disease of Modern Society." This report exposed the nation's lack of a structured emergency response system and triggered federal action. The Emergency Medical Services Systems Act of 1973 provided initial funding for communities to develop EMS infrastructure and standardize training programs. However, by 1981, federal block grants replaced direct funding, and responsibility was largely shifted to states and localities, a decentralization that has contributed to the inequalities seen today.

For decades, EMS has been financed primarily through a fee-for-service model, in which agencies bill patients and their insurers for each transport. Medicare and Medicaid - which cover over 50% of EMS patients in most communities - reimbuse at rates far below the actual cost of service. A 2022 report found that the average Medicare reimbursement was only $390. This gap between cost and reimbursement has led to widespread financial instability among EMS agencies, with 55 communities losing their ambulance providers in just a two-year period according to the American Ambulance Association.

Currently, there is no federal consensus on how to fix EMS funding. Some policymakers advocate for expanded Medicaid reimbursement rates, while others support Ground Emergency Medical Transportation (GEMT) programs that allow states to draw additional federal funds to close funding gaps. Advocates for privatization argye that market competition can improve efficiency, though critics point out that private equity-owned EMS agencies have been linked to longer response times, outdated equipment, and lower wages. A growing movement, supported by EMS unions and public health advocates, calls for EMS to be reclassified and funded as an essential government service at the federal level - the model this brief endorse

Public opinion increasingly supports treating emergency services as a public good. As debates over healthcare affordability contiue to dominate

national politics, the conversation around EMS reform is gaining momentum. Several states have begun exploring legislation to expand public funding for EMS, and the CMS's Medicare Ground Ambulance Data COllection System (GADCS), launched in 2024, represents the msot comprehensive effort yet to hatjer nationwide EMS cost and revenue data - a necessary step toward informed federal policy reform.

IV. Policy Problem

A. Stakeholders

The primary stakeholders in EMS reform are patients, particularly low-income individuals, uninsured Americans, and communities of color who are most likely to be unable to afford emergency transport or to live in areas with slower response times. These are the people whose lives are most directly at risk when EMS is treated as a billable service rather than a public right. EMS agencies and their workers are also critical stakeholders. Paramedics and EMTs are often underpaid and overworked, operating within agencies that are chronically underfunded due to inadequate Medicare and Medicaid reimbursements. Reforming the funding model would stabilize these agencies and improve working conditions for the emergency responders communities depend on. Local and state governments are heavily invested in this issue, as they currently shoulder much of the financial burden for EMS operations without consistent federal support. Insurance companies and private EMS providers also have a significant stake, as a shift to public funding would fundamentally change how they operate. Finally, federal lawmakers and the Centers for Medicare and Medicaid Services (CMS) are key stakeholders, as any national reform would require their leadership and legislation.

B. Risks of Indifference

The risks of ignoring the EMS funding crisis are severe and concrete. First, preventable deaths will continue to occur. When people in low-income communities avoid calling 911 because of the cost, conditions like cardiac arrest, strokes, and severe injuries go untreated in the critical minutes that determine survival. The 10% longer response times already documented in low-income neighborhoods compound this danger further. Second, the financial instability of EMS agencies will worsen. If the reimbursement gap between actual costs and Medicare/Medicaid payments continues to grow, more agencies will close or consolidate, leaving rural and underserved communities with even less coverage. The 55 communities that lost their ambulance provider in a two-year span is a warning sign of a larger collapse to come without intervention. Third, the downstream costs to the healthcare system will grow. When people cannot access timely emergency care, conditions worsen and require more expensive hospital treatment. Emergency rooms become more overwhelmed, and the total cost of care rises for everyone. Inaction is not a neutral choice, it is a choice to let the crisis deepen.

C. Nonpartisan Reasoning

EMS reform is not a partisan issue, emergencies do not discriminate by political affiliation, and every American, regardless of party, benefits from a reliable emergency response system. There are compelling reasons for people across the political spectrum to support publicly funded EMS:

1) Fiscal responsibility: Investing in EMS upfront reduces the far greater costs of delayed treatment, extended hospitalizations, and overburdened emergency rooms. A publicly funded EMS system, modeled on fire and police departments, is more cost-efficient at scale than the current fragmented billing system.

2) Public safety: Law enforcement and fire protection are universally accepted as public goods that the government must provide. EMS is the third pillar of emergency response and should be treated the same way. Leaving it to a fee-for-service model creates dangerous gaps in the safety net.

3) Economic equity: The current system disproportionately punishes low-income Americans for medical emergencies they cannot control. A universal system ensures that where you live or how much money you have does not determine whether help arrives in time.

4) Local community impact: In cities like New York, where FDNY ambulance fees are already among the highest in the nation, the burden on low-income neighborhoods in the Bronx, Brooklyn, and Staten Island is especially acute. A reformed system would directly strengthen the safety net in these communities.

V. Tried Policy

Several approaches have been attempted to address EMS funding gaps, with mixed results. One notable effort is the Ground Emergency Medical Transportation (GEMT) program, which allows states to draw additional federal Medicaid funds to supplement EMS reimbursements. While GEMT has provided some financial relief in states like California, it is complex to administer, inconsistently implemented across states, and does not address the fundamental gap between what EMS costs and what Medicaid pays. It is a patch, not a solution. Another approach has been the expansion of community paramedicine programs, in which EMS providers deliver non-emergency health services to reduce hospital readmissions and lower overall healthcare costs. States like Minnesota and Texas have piloted these programs with some success, but they rely on existing EMS infrastructure and do not resolve the underlying funding crisis. At the federal level, the No Surprises Act of 2022 was intended to protect patients from unexpected medical bills, including ambulance charges. However, a critical loophole exempted ground ambulance services from the law's protections, leaving patients still vulnerable to large out-of-pocket EMS bills. A federal advisory committee was established to study the issue, but as of 2024, no comprehensive federal fix has been enacted. These partial measures demonstrate the limits of incremental reform and underscore the need for a more fundamental restructuring of how EMS is funded.

VI. Policy Options

Option 1: Federal Essential Service Designation with Block Grants

The most direct solution is for Congress to designate EMS as an essential government service and create a dedicated federal funding stream — similar to how federal highway funds flow to states, that covers the cost of EMS operations. States and localities would receive block grants based on population and call volume, eliminating the need to bill patients for transport. In a community like New York City, this would mean that the FDNY's EMS division, which currently generates revenue through patient billing, would instead receive direct federal and state funding to cover operational costs. The $1,793 ambulance fee proposed by the FDNY would be eliminated, and New Yorkers in the Bronx, Harlem, or Staten Island would receive emergency care without financial fear. Implementation would require a federal-state matching formula, oversight by CMS, and a multi-year transition period for agencies currently dependent on billing revenue.

Option 2: Expanded Medicaid and Medicare Reimbursement Reform

A less sweeping but still impactful option would be to significantly increase Medicare and Medicaid reimbursement rates for EMS to match the actual cost of service. Currently, Medicare reimburses an average of $390 for a transport that costs over $940, a gap that forces agencies to shift costs onto privately insured and uninsured patients. Closing this gap would stabilize EMS agencies financially and reduce the need for high out-of-pocket billing. This option is more politically feasible than full federal designation and could be implemented through existing CMS rulemaking authority. However, it does not fully eliminate patient bills and still leaves uninsured individuals vulnerable. It is best understood as an important first step rather than a complete solution.

Option 3: State-Level Public EMS Authority Models

Some states are exploring the creation of regional EMS authorities, public agencies modeled on transit authorities, that consolidate fragmented local EMS providers under a single publicly funded entity. This model has shown promise in parts of Texas and Colorado, where regional consolidation has improved response times and financial stability. In New York, this could mean creating a statewide EMS authority that absorbs both FDNY EMS and volunteer agencies across the state, funded through a combination of state appropriations and federal Medicaid matching funds. While implementation would be complex given the diversity of EMS providers across New York's urban, suburban, and rural areas, it represents a viable path toward a more equitable and stable system.

VII. Conclusions

The United States faces a preventable crisis in emergency medical services. A system that sends patients a bill for calling 911 in a life-threatening emergency is not a safety net, it is a trap. Low-income communities, people of color, and rural Americans pay the highest price for a funding model that prioritizes billing over care, and the human cost is measured in lives lost and emergencies delayed. This brief has argued that EMS must be reimagined as a fully public service, funded through a coordinated commitment from

federal, state, and local governments. The comparison to fire and police departments is not rhetorical, it is the logical foundation of the argument. No one receives a bill after a house fire. No one is charged for a police response to a robbery. Emergency medical care deserves the same treatment. Of the policy options presented, the strongest long-term solution is federal essential service designation combined with dedicated funding streams that eliminate patient billing entirely. In the near term, significantly increasing Medicare and Medicaid reimbursement rates would stabilize the system and reduce the financial burden on patients and agencies alike. State-level public EMS authority models offer a promising middle path for states willing to lead before federal action arrives. In New York City and communities like it across the country, the reform cannot come soon enough. The generation of young Americans entering civic life today has the opportunity, and the responsibility to demand that emergency medical care be treated as the public good it has always been. No one should have to choose between calling for help and paying their rent. EMS for all is not just a policy proposal. It is a moral imperative.

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