JANUARY 2019

POLICY BRIEF:

HEALTH COVERAGE FOR AIR AMBULANCE TRANSPORT

MISSOURIANS CAUGHT IN THE MIDDLE

MISSOURI DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS
& PROFESSIONAL REGISTRATION

DIFP Department of Insurance, Financial Institutions & Professional Registration

Introduction

Since 2014, the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) has received 115 complaints and inquiries related to air ambulance services. Nearly all complaints were related to claim settlements and they generally fell into one of two broad categories:

1. Claim denials – In some instances, claims were entirely denied. Claim denials may occur when an insurer believes that the transport wasn't medically necessary relative to alternative modes of transportation, that transport was to a destination other than the nearest appropriate medical facility, or that any transport was necessary at all (the originating facility had the capacity to render appropriate treatment, for example).

2. Balance billing – Much more common are instances in which an insurer refuses to remit the full amount billed by the air ambulance provider. When a provider in not in an insurer's network and therefore not bound by contractual reimbursement rates, insurers will typically apply various caps to the amounts that will be reimbursed. For example, an insurer may cap payment based on a "reasonable, customary and usual" standard, or apply a ceiling pegged to some percentage of the Medicare reimbursement rate.

When seeking care or services from an insurer's "in network" provider, reimbursement rates are governed by contract, and members are generally "held harmless" with respect to unpaid balances. Out-of-network providers, however, are not bound by these contractual provisions. In such instances providers may bill insureds for outstanding balances that often amount to tens of thousands of dollars.

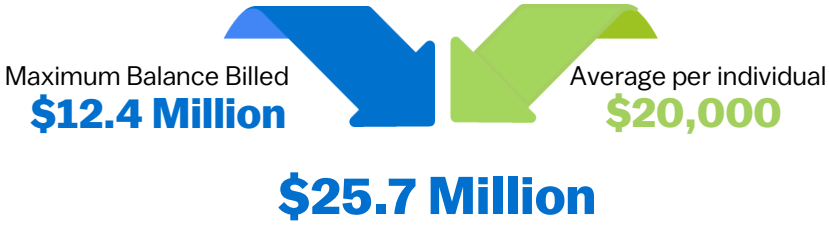
Examples of complaints received by the DIFP include:

- *An individual seeking treatment for a traumatic eye injury resulting from a horse kick was transferred by an out-of-network air ambulance to a more appropriate facility. The claim was denied as the air ambulance transportation was not considered medically necessary as the term was defined in the insurance policy. The individual was billed for the entire cost of the flight - $25,000.*
- *An individual suffering from encephalitis was transferred across state lines in a fixed wing transport. The claim was denied as not medically necessary, under the rationale that the originating facility had the appropriate level of expertise to treat the condition. The patient received a bill in excess of $100,000.*
- *An individual involved in motor vehicle accident resulting in numerous open fractures was air-lifted to nearby hospital. The insurer reimbursed the out-of-network provider $4,500 for charges exceeding $27,000. In this case, the reimbursement rate was based on a cap equal to 125*

percent of Medicare reimbursement rates. The injured party remained liable for the unpaid balance of $22,500.

- *Other complaints involving denials or balance bills reveal that insureds are often stuck with bills totaling tens of thousands of dollars. These individuals may be subject to wage garnishments, liens on bank accounts, homes or other assets, and other vigorous collection efforts.*

In July of this year, the DIFP convened a roundtable that brought together regulators and representatives from health insurers. Among areas of concern that were discussed at this meeting was the growing problem of air ambulances and balance billing. To better assess the scope of the problem, the DIFP initiated a data call for all large insurers in Missouri.



$25.7 Million

Billed for air ambulance services in 2017

Estimates derived from these data indicate that of the $25.7 million billed for air ambulance services in 2017 alone, Missourians could have been balanced-billed a maximum of $12.4 million, or an average of nearly $20,000 per individual. In reality, the DIFP has no way of knowing how much of the $12.4 million in unpaid bills was ultimately collected directly from individuals by air ambulance providers. However, these data indicate that the problem is widespread and impactful on Missourians.

Regulatory Environment

In investigating complaints filed by Missouri consumers regarding air ambulances, the department's jurisdiction is limited to ensuring that the insurer is in compliance with relevant statutes as well as their own contractual language.

The department has no authority to assist consumers who are covered under self-funded group health plans. Additionally, the department is in many instances unable to assist consumers who have been saddled with unpaid air ambulance bills when the insurers' actions do not clearly run afoul of insurance regulatory standards. Indeed, states generally have very limited regulatory authority over air ambulances in general.

Air ambulance services are governed by the federal Aviation Deregulation Act (ADA) of 1978, which carved out broad federal preemptions to state regulation of aviation. The act specifies that states may not regulate in any way the "price, route or service of an air carrier." This federal preemption has been broadly interpreted in numerous court cases.

Under the ADA, states have the most regulatory authority in relation to the provision of medical services, and the least with respect to aviation itself or the mode of operation or business practices of such providers. For example, a state statute regulating training requirements for medical personnel associated with air transport could possibly survive legal challenge, but state attempts to regulate training of pilot staff would almost certainly not survive challenge (see for example Scarano and Bryant, 2009 for a detailed discussion). In general, business practices such as balance billing, or requirements to participate in networks are beyond states' regulatory reach. Even statutes to steer patients to in-network air ambulance providers have been determined to run afoul of the ADA preemption.[1]

Air Ambulance Providers in Missouri

There are thirteen providers of air ambulance services with rotary aircraft scattered over 36 bases in Missouri, and one additional fixed wing base (Atlas and Database of Air Medical Services, 2018). **Most areas in Missouri are located within a 20 minute flight radius from at least one of these bases** (see map on following page), though some rural areas have a bit more spotty coverage.

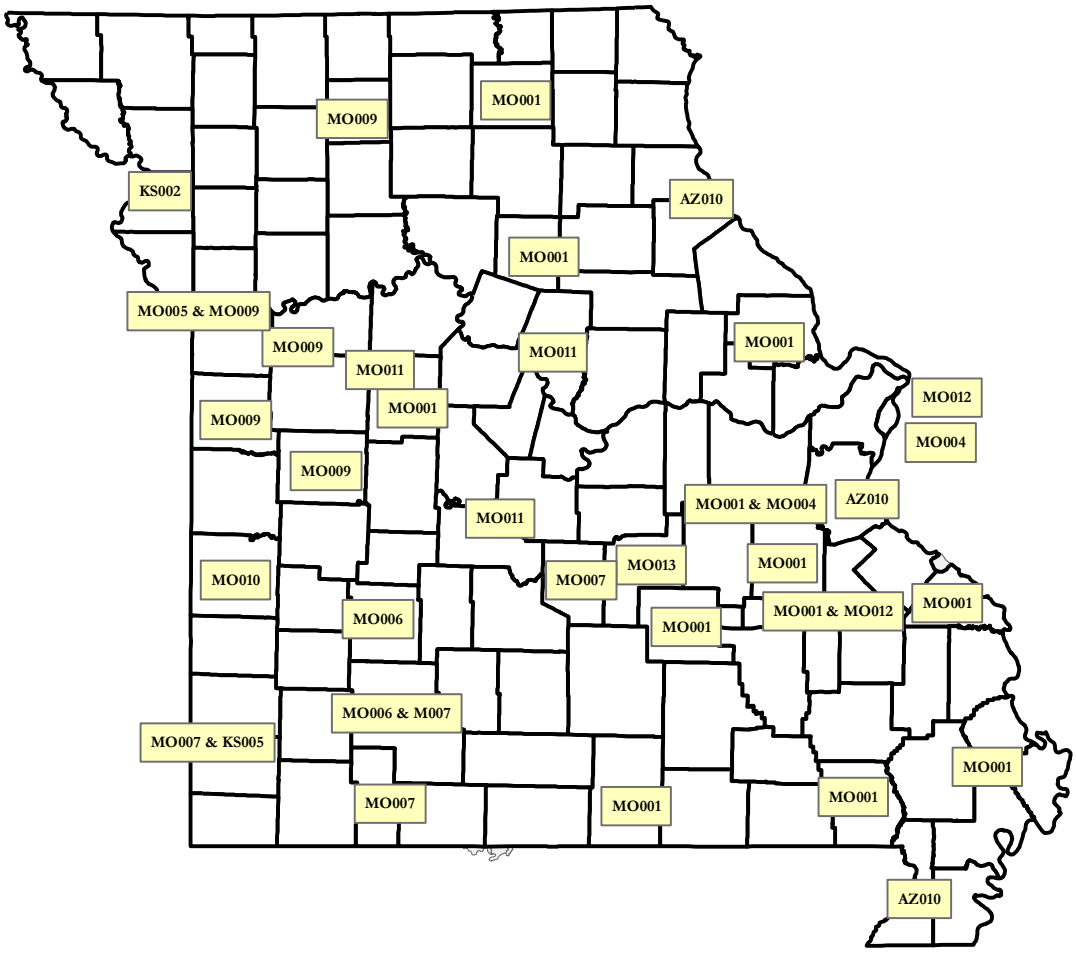
Air Ambulance Transports in Missouri, 2015-2017			
	2015	2016	2017
Air Methods	676	704	780
Survival Flight	740	820	910
Staff for Life	740	685	722
Children's Mercy	433	453	516
Air Evac	3663	3701	3570
Mercy Life Line	1755	1938	2024
Cox Air Care	293	280	398
Life Flight Eagle	1137	1251	1242
Other (5)	436	374	396
Total	9,873	10,206	10,558

Source: Data provided by the Missouri Department of Health & Senior Services.

By far the largest air ambulance service in Missouri is Air Evac, which has thirteen bases located in Farmington, Kirksville, Moberly, Perryville, Poplar Bluff, Potosi, Salem, Sedalia, Sikeston, Sullivan, Troy and West Plains. Air Evac alone was responsible for one-third of all air ambulance transfers in 2017.

[1] For example, a North Dakota statute that required 911 operators to prioritize in-network air ambulance services was struck down under the ADA in 2017.

Air Ambulance Bases in Missouri



ID	Provider	ID	Provider
MO001	Air Evac Lifeteam	MO011	Staff for Life (Columbia)
MO004	ARCH Air Medical Svc.	MO012	St. Louis Children's Hospital KidsFlight
MO005	Children's Mercy Critical Care Transport	MO013	Phelps Air
MO006	Cox Air Care	AZ010	Survival Flight, Inc. (AZ)
MO007	Mercy Life Line	KS002	LifeNet Heartlands
MO009	Lifeflight Eagle	KS005	Midwest AeroCare
MO010	Air Methods (MEDFLIGHT)		

Source: Atlas & Database of Air Medical Services
http://www.adamsairmed.org/public_site.html

Balance Billing

Because the air ambulance industry has very high fixed-costs in relation to variable (or per trip) costs, the amounts charged for even short flights can run to tens of thousands of dollars. Air ambulance reimbursement rates are fixed by Medicare and Medicaid, and providers that participate in these programs must accept these rates as payment in full – they cannot "balance bill" patients for amounts charged in excess of the reimbursement rates. In addition, providers that participate in private insurers' networks will generally be prohibited by contract from balance billing patients for amounts above insurer reimbursement rates.

However, while hard data do not exist, it appears that many air ambulance providers, particularly providers not affiliated with a hospital, do not participate in insurer networks and have little incentive to do so. And even if an insured has an in-network air ambulance provider, there is no guarantee that an out-of-network provider won't be called in the event of an emergency.

Individuals subject to balance billing can receive demands for payment from air ambulance providers totaling tens of thousands of dollars. While there is no data available to estimate the true prevalence of balance billing in such circumstances, there is some evidence that it is pervasive.

One source of information consists of complaints received by the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP). Since 2013 (the first year the DIFP began tracking such complaints), 128 individuals have contacted the department with questions or complaints involving their insurance coverage for air ambulance services.

Nearly all of the complaints pertained to either claim denials or, much more commonly, insurer reimbursement at rates well below the amount charged.

> *Consumers received some form of recovery in 23 cases, such as when a denial was overturned, or insurers increased their settlement offer. As a result, consumers recovered over $560,000 since 2013.*

Complaints Re: Air Ambulance Coverage Missouri Department of Insurance, Financial Institutions & Professional Registration			
Year Received	Complaints & Inquiries	Complaints with Recovery	Total Recovery Amount
2013	13	2	$ 5,536
2014	10	2	$ 39,823
2015	8	0	
2016	45	10	$ 356,013
2017	31	6	$ 64,667
2018 (as of 11/30)	21	3	$ 94,921
Total	128	23	$ 560,960

A second available indicator of the prevalence of balance billing can be found in public court records. Many air ambulance providers have adopted fairly aggressive collection strategies, such as placing liens on homes or garnishing wages. A quick search of Missouri's court records[2] returned over 184 records since 2012 for one of Missouri's largest air ambulance providers. While a few of these cases pertained to matters other than bill collection (such as medical malpractice actions, for example), most were collection efforts upon individuals or their estates.

> *The four most legally active providers together had 427 actions over the same time period, with recoveries commonly in the tens of thousands of dollars.*

Indeed, avoidance of insurance network participation combined with aggressive collection practices has been described as a business strategy of some providers (Consumers Union, 2017). Providers have little incentive to join insurer networks in which they would be subject to negotiated reimbursement rates (usually based on "reasonable and customary" standards) as well as contractually prohibited from seeking any additional amounts from insureds. While the DIFP lacks data regarding how many providers participate in insurer networks, evidence presented above suggests that network participations rates are fairly low. Part of this is due to a lack of meaningful competition in the market (as is the case in general for emergency services) in spite of the relatively large number of providers.

> *In addition, because of the relatively low reimbursement rates from Medicare and Medicaid, costs are shifted onto private insurers and ultimately, their insureds, both through unpaid balances and increased health insurance premiums.*

[2] Via *Case.net*, a web based application to track court actions in Missouri, available at https://www.courts.mo.gov/casenet/base/welcome.do Searches were performed on 11/30/2018.

Competition

Like emergency services generally, there is little competition generated by consumer choice of air ambulance providers. Unlike routine care, where insureds can ensure that providers are in-network prior to seeking treatment, provider choice not readily available to insureds in most emergency transport situations. In some cases their insurer may not even have air transport available within their network.

In most instances of emergency transport, patients are required to sign agreements to pay unspecified future costs prior to transport. As such, there is little downward pressure on prices that would normally be associated with consumer choice. Further, as illustrated on the map on page 4, some locales have only a single nearby air ambulance provider, creating what are essentially localized monopolies in some Missouri counties.

Further, air ambulance services have very high fixed costs –the cost of purchase and maintenance of the aircraft and providing trained aviation and medical staff that are available 24 hours a day. These fixed costs must be recouped over all flights. If fewer flights are available to a given provider due to the presence of competitors, the provider then must recoup the same fixed costs over fewer flights, resulting in higher costs per transport (see GAO, 2017 for a fuller discussion).

Nor is there significant regulatory oversight over costs. As noted above, jurisdiction for air ambulance falls to the federal Department of Transportation (DOT). However, even the DOT has limited authority to regulate price. The intent of the ADA was that prices of air transport services would be controlled primarily by market competition (though it is not clear that air ambulance services were even contemplated in 1978 when the act was passed). A search produced no indication that the DOT has ever pursued regulatory action in relation to air ambulance pricing.

Reimbursement Rates

A common refrain from many stakeholders is that low reimbursement rates from Medicare and Medicaid have forced air ambulance providers to recoup their costs from those insured under private plans. The Balance Budget Act of 1997 implemented a Medicare fee schedule for air ambulance providers, and prohibits providers from balance billing covered individuals for any additional payments above the scheduled amounts.

The Medicare fee schedule fully implemented in 2006, and is increased each year by the rate of inflation (CPI). Similar provisions also protect Medicaid enrollees from balance billing. Available data indicate that reimbursement rates vary significantly by payer. For rotary aircraft, reimbursement rates are as follows:

Air Ambulance Reimbursement Rates by Source of Coverage
Medicare Reimbursement: Varies by geographic location, with rural areas having generally higher rates. *Urban Areas* – Base rate ranges from $3,368 to $4,269, plus $23.62 per mile *Rural Areas* – Base rate ranges from $5,051 to $6,404, plus $35.43 per mile *Source: CMS, 2016, Ambulance Fee Schedule Public Use File*
Medicaid in Missouri: In 2017, the maximum allowable base rate is $2,253.51, plus $2.50 for each mile in excess of 50 miles *Source: Information provided by Missouri Department of Health and Senior Services*
Private Insurance: In 2017, the average charge amount per trip to private insurers was $41,321. The average insurance payment plus deductibles and copays was $23,087, while the average charged was nearly double this amount, or $41,321 *Source: Private insurer data collected by DIFP*

Given the discrepancy in reimbursement rates, it is clear that private insurers and their insureds are paying for the bulk of the costs of air ambulance services, with considerable cross-subsidies occurring to public insurance programs.

In total, private insurers processed 622 air ambulance claims in 2017. Of these, 45 were denied outright (typically as "not medically necessary"). Of the 577 remaining claims, insurers paid a total $13,101,835, and an additional $219,617 was paid in the form of copays, and deductibles.

Air Ambulance Claims in 2017 from Private Health Insurers		
Row	Data element	Amount
A	Total Claims	622
B	Total claims with some insurer payment	577
C	Total claims denied	45
D	Total billed on paid claims	$23,842,727
E	Total Insurer Payments	$13,101,835
F	Coinsurance, copays, & deductibles	$219,617
G	Total charged on denied claims	$1,878,829
H	Total unpaid balance on paid claims (D – E - F)	$10,521,275
I	Total possible balance billed (G + H)	$12,400,104

Source: Data collected by DIFP.

The maximum amount that could have been balance billed is the different between the charged and paid amounts. This amounts to $12,400,104 for 622 individuals, or an average of $19,936 per person. Of course, there is no way to know how much of this per person maximum was actually sought by air ambulance providers, nor how much was ultimately collected.

Airline Deregulation Act of 1978 (ADA)

Federal law narrowly circumscribes state regulatory authority over air ambulance companies. The Airline Deregulation Act of 1978 (ADA) includes a preemption provision related to state laws governing prices, routes, or services of air carriers that provide air transportation.[3] Under the preemption provision of the ADA, "a State…may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart."[4] Under the provisions of the ADA, an "air carrier" is "a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation;" and "air transportation" is "foreign air transportation, interstate air transportation, or the transportation of mail by aircraft."[5]

Air ambulances meet the definition of "air carrier" for purposes of the ADA and therefore state laws governing the price of transportation via air ambulance, the routes traveled by air ambulances, and the services provided by air ambulances are preempted by federal law.[6] The U.S. Supreme Court interpreted the preemption provision of the ADA very broadly in Morales v. Trans World Airlines, Inc., 504 U.S.374 (1992), finding that state regulation of advertisements of air fare rates was preempted under the ADA. Courts around the country have followed this broad interpretation holding that the ADA directly preempts state regulatory efforts regarding rates, advertisements, scheduling, insurance coverage, routing, accounting and reporting systems, air ambulance subscription services, and the cost of air ambulance services.[7]

Few efforts by the states to regulate air ambulance operations, beyond a narrowly defined province of medical regulation, have survived legal challenge. The Texas Division of Workers Compensation established a fee schedule that capped reimbursements to air ambulances at 125 percent of Medicare rates and prohibited balance billing, which was subsequently declared preempted under the ADA and is currently being appealed. A similar provision from Florida governing automobile insurance was recently struck down, as have similar laws in West Virginia, and Kansas. A North Dakota statute that created a preferred dispatch list of air ambulance providers for those providers that participated in a majority of insurance networks was also recently voided.

The ADA does not preempt state regulatory authority with regard to licensing air ambulances, qualifications for medical personnel, requirements for adequate medical supplies, maintenance and sanitary standards. In Missouri, state law outlines licensing

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[3] 49 U.S.C. §41713
[4] 49 U.S.C. §41713(b)
[5] 49 U.S.C. §40102.
[6] *Med-Trans Corporation v. Benton,* 581 F Supp. 2d 721 (E.D. N.C. 2008). The plaintiff, an air ambulance company, is considered an "air carrier" for purposes of the Airline Deregulation Act, and therefore state laws requiring the air ambulance company to obtain a Certificate of Need from the State of North Carolina are preempted.
[7] See, for example, *Eaglemed LLC v. Cox, 868 F. 3d 893 (10th Cir. 2017); Valley Med Flight, Inc. v. Dwelle, 171F. Supp. 3de 930 (D. N.D. 2016); Guardian Flight LLC v. Godfread, 1:18-CV-00007 (D. N.D., filed 1/12/2018)*

and regulation requirements for ambulances, including air ambulances. These statutes are under the purview of the Department of Health and Senior Services. Section 190.108, RSMo (2016) gives DHSS the authority to regulate air ambulances according to the regulatory requirements outlined in sections 190.001-190-245, RSMo (2016) related to ambulances.

In September 2018, Congress reauthorized the Federal Aviation Act, which includes the ADA. Included in the reauthorization were provisions related to air ambulances and the concerns about balance billing and other consumer protection issues. Among these provisions is the creation of an advisory committee whose purpose is to review "options to improve the disclosure of charges and fees for air medical services, better inform consumers of insurance options for such services, and protect consumers from balance billing." The FAA Reauthorization Act of 2018, H.R. 302, 115th Cong. § 418 (2018).

In addition to the advisory committee, the Reauthorization Act included requirements that Air Ambulance providers include contact information for the Airline Consumer Advocate on their websites, invoices, bills, and other consumer communications, and a requirement that the Secretary of Transportation provide a report to Congress on Air Ambulance Oversight.

The National Association of Insurance Commissioners (NAIC) recently requested the removal of the preemption entirely to authorize states to regulate "…network participation, reimbursement, price transparency and balance billing…" in relation to air ambulance providers (NAIC, 2017). However, no action has been forthcoming with respect to the underlying issue of preemption of state law related to air ambulance services.

Sources

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