NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
AIR AMBULANCE TASK FORCE
CHICAGO , ILLINOIS
JULY 15, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Air Ambulance Task Force met at the Chicago Intercontinental Magnificent Mile Hotel on Saturday, July 15, 2017 at 8:15 a.m.

Representative Jeff Greer of Kentucky, Chair of the Task Force, presided.

Other members of the Task Force present were:

Rep. Greg Cromer, LA
Rep. George Keiser, ND
Asm. Will Barclay, NY
Asm. Kevin Cahill, NY
Sen Bob Hackett, OH
Rep. Bill Botzow, VT

Other legislators present were:

Rep. David Santiago, FL
Rep. Richard Smith, GA
Rep. Joe Fischer, KY
Rep. Jim Gooch, KY
Sen. Jonathan Casper, ND
Rep. Lois Delmore, ND
Sen. Jerry Klein, ND
Sen. Neil Breslin, NY
Rep. Glen Mulready, OK

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

CONTINUED DISCUSSION ON TASK FORCE ACTIVITIES

Rep. Jeff Greer (KY), Chairman of the Task Force, began by stating that the issue of balance billing in the air ambulance industry is a problem across the country and it needs to be solved. Rep. Greer stated that this is an important discussion for the Task Force because the people who need help the most cannot afford to have the status quo proceed.

Former Texas Insurance Commissioner and Director of the South Carolina Department of Insurance Eleanor Kitzman, now representing Air Evac Life team, a subsidiary of Air Medical Group Holdings (AMGH) stated that the charge to this Task Force is to address balance billing disputes with respect to air ambulance services. Cmsr. Kitzman stated that the air ambulance representatives here today: agree there is a problem; are willing to work in good faith towards a mutually acceptable resolution; and have some fresh ideas for a state based statutory framework that would survive a preemption challenge and will benefit consumers. Cmsr. Kitzman stated that things such as the Resolution adopted by the NCOIL Health Committee yesterday, Congressman Woodall's amendment to the FAA reauthorization legislation, and certain court cases on these issues are not a reason for this Task Force to stop its work – if anything they represent more reason for the Task Force to act because if any of those efforts

are successful and states are given express authority to regulate/legislate in these areas, they will need guidance.

Cmsr. Kitzman further stated that it is the air ambulance industry's experience that balance billing disputes are not a problem in all 50 states or with all insurers, and that the increased frequency of balance billing disputes seems to have coincided with implementation of the ACA, the narrowing of provider networks, and in states in which a single insurer may be dominant. Additionally, some states have laws in place that, while not expressly addressing air ambulance services, have served to minimize the occurrence of balance billing disputes with respect to air ambulance services.

Cmsr. Kitzman stated that the framework proposed today would establish a voluntary dispute resolution process that air ambulance providers would agree to participate in. In exchange for a fair, objective process for mediating disputed claims, participating air ambulance providers would waive their right to balance bill the patient. The air ambulance industry acknowledges their charges are high, as are their costs – they simply want an opportunity to explain and defend the costs in a fair and objective forum. Another significant new feature of the proposed framework is pricing transparency and data reporting. As a condition of access to this voluntary dispute resolution process, participating air ambulance providers would agree to provide an itemization of its charges and would agree to provide data to state insurance regulators on an annual basis. Likewise, insurers should report claim and payment data. As acknowledged in a cost-study report prepared by the Association of Air Medical Services (AAMS), the data to inform stakeholders about the true costs associated with providing air medical services is extremely limited and there is no publicly available standard cost data of air ambulance providers nationwide. The annual reporting to state insurance departments would be a giant first step toward having the type of meaningful information that consumers deserve. Cmsr. Kitzman stated that there is a lot of work to be done between now and the November NCOIL Annual Meeting in Phoenix to build the framework, and the air ambulance industry is willing to work with the Task Force.

Tim Pickering, Director of Government Affairs for AMGH, appearing on behalf of Save Our Air Medical Resources (SOAR), stated that air medical services are an emergency service and are obligated under state's emergency medical services licensure to be able to respond 24/7/365, and to treat and transport critically ill and injured patients regardless of their ability to pay. 50 air medical bases have closed in the past 5 years and in the same time, 80 hospitals have closed. Mr. Pickering stated that 95% of the time, air medical services are provided by private organizations and are flying intensive care units (ICU), staffed by critical care certified paramedics and nurses, flown by highly experienced pilots, and maintained by FAA licensed mechanics. The request for an air medical response comes from a first responder or a physician acting as part of a defined state regulated system or healthcare facility – they are generally acting under a prudent layperson standard in requesting aid. The team in the flying ICU has all the skills and equipment available to treat a patient in a grounded ICU, whether needed or not, and works to get the patient to the right hospital for their injury or illness. All of this comes at a high cost that must be spread across an average of less than 1 patient per day. Mr. Pickering stated that he looks forward to working with the Task Force and providing it with any information that would be helpful.

Dianne Bricker of American's Health Insurance Plans (AHIP) first stated that the Task Force can look to the answers AHIP provided to the questionnaire previously issued by the Task Force for some helpful information on these issues. AHIP acknowledges that the air ambulance servicers provide extremely important services to consumers, and agree that consumers need to be

protected from unreasonable balance billing that is largely out of their control. Ms. Bricker stated that AHIP looks forward to working with the air ambulance providers on their proposed framework as it has promise for reaching a compromise on these issues. Ms. Bricker stated that AHIP has seen, and expects to continue to see, proposed solutions to the balance billing problem that involve insurers paying full billed charges – AHIP has concerns with those solutions because it would continue to allow air ambulance providers to charge whatever they want for their services. Ms. Bricker stated that AHIP believes that a comprehensive solution to the balance billing problem needs to be at the Federal level, and that it supports the Resolution adopted yesterday by the NCOIL Health Committee.

Ms. Bricker further stated that air ambulance providers no longer can have free reign to charge whatever they want for their services. Further, holding consumers harmless for balance billing charges, while a generous gesture, would also put an end to consumer complaints regarding outrageous balance bills that eventually make their way to State regulators and legislators. It would also put an end to media attention regarding balance billed charges – attention that has recently put air ambulance companies under heightened scrutiny. Ms. Bricker urged Task Force members to: take the Resolution adopted yesterday back to their respective States and get it adopted; confer with their Congressman; support the Tester bill; support the Woodall amendment; and work with their respective Insurance Commissioners.

Ms. Bricker also supported the proposal mentioned earlier regarding price transparency – hospitals and consumers deserve to know what the actual cost drivers are behind the exorbitant air ambulance bills. Additionally, such transparency would be consistent with the obligations expected of air carriers by the FAA for other services such as disclosures of ticketing fees and fuel surcharges in the airline passenger industry. Ms. Bricker further stated that it is important to ensure the air transport is warranted – states should actively engage first responders, law enforcement and dispatchers on the proper circumstances to dispatch an air ambulance as a part of their continuing education requirements. Emergency service personnel should be encouraged to update or amend their protocols on a regular basis to use ground ambulances when possible – such services are a vital part of delivering care, often cost less than air ambulances, and are more readily available to deliver the quality of care that families must depend on. Ms. Bricker closed by stating that the document “An Arm and a Leg: Paying for Helicopter Air Ambulances” by Henry H. Perritt, Jr. and published in the University of Illinois Journal of Law, Technology & Policy, is a great source of information on these issues.

David Korsh, Blue Cross Blue Shield Association, agreed with Ms. Bricker’s statements and stated that there are three laws in conflict when dealing with these issues: a.) the McCarran-Ferguson Act, b.) the Airline Deregulation Act (ADA), and c.) the law of unintended consequences. The ADA has been interpreted by courts and the Department of Transportation (DOT), among others, that it preempts states from regulating rates, routes or services of any air carrier. BCBSA believes that air ambulances and other emergency air transportation is not a business trip or vacation – it is a vital and necessary emergency service. Mr. Korsh also urged the Task Force to look at the Consumers Union report on air ambulances from March 2017: “Up In The Air: Inadequate Regulation for Emergency Air Ambulance Transportation,” and also noted that the Government Accountability Office (GAO) is studying these issues and will be issuing a report at some point this year. Mr. Korsh stated that getting Congress to amend the ADA and to read the McCarran-Ferguson Act in concert with it should be the main priority in helping to solve these issues.

Ron Jackson of the American Insurance Association (AIA) stated that the issues surrounding air ambulance services has also impacted the workers’ compensation insurance industry. Mr.

Jackson stated that AIA believes that the presumption that the ADA preempts states' ability to regulate air ambulances is incorrect. The ADA was enacted to address and encourage competition for the traveling and shipping public, and prohibited states from regulating the routes, prices and services of air carriers. However, there are no routes for air ambulances and there is no ticket purchased in advance. The ADA was directed towards commercial air carriers – nobody wakes up and decides to buy an air ambulance ticket and searches what it may cost. Rather, air ambulances are summoned in emergency situations. Mr. Jackson stated that the McCarran-Ferguson Act preserves state regulation of insurance, absent Congress specifically enacting a law addressing the business of insurance – there is nothing in the ADA addressing the business of insurance. Mr. Jackson noted that the issue of the ADA preempting state workers' compensation insurance laws is currently being litigated in at least three Federal Circuit Courts, and AIA believes that said state laws will prevail.

Sen. Bob Hackett (OH) asked if there could be some type of usual and customary standard for air ambulance services. Mr. Korsh stated that one example is that Medicare has established a fee schedule for air transportation services, with a sliding scale for urban and rural areas. Mr. Korsh also stated that BCBSA members have made a concerted effort to contract with air ambulance companies. Ms. Bricker stated that it is important to note that when determining what is usual and customary, you are starting with the air ambulance companies' current charges, which AHIP questions. Sen. Hackett asked what the breakdown of the market is – how much is paid by commercial insurance and how much is paid by the government? Mr. Pickering stated that the general breakdown provided by AAMS is approximately 1 out of 10 patients are private pay/uninsured, 2 to 3 out of 10 have Medicaid, 3 or 4 out of 10 have Medicare, and 2 or 3 out of 10 have commercial insurance – all depending on the geographic area.

Rep. Glen Mulready (OK) asked how many of the commercial payers are in-network? Mr. Pickering stated that he does not have access to such information but that 95% of AMGH patients are out of network. Rep. Mulready asked what the average commercial charges are as a percentage of Medicare. Mr. Pickering stated that there are different mileage charges, but as an average of 70 miles of air transport, the estimated commercial charges – not what the air ambulance company receives – is between $35,000 and $40,000. Thus, as a multiple of Medicare, which pays on average $5,900, it's approximately 7 times over. Rep. Mulready then asked Mr. Pickering for information regarding an update to the Medicare fee schedule. Mr. Pickering stated that today, a House Bill is set to be introduced to amend Medicare's rates – predicated on mandatory cost reporting, and mandatory quality metrics, both of which will have penalties for failure to report. Mr. Pickering stated that the air ambulance industry believes that Medicare currently pays 49% below cost.

Asm. Kevin Cahill (NY) stated that any Model Law drafted by the Task Force on these issues needs to recognize, among other things, the different landscapes and circumstances that exist in different states, and the different kinds of air ambulance companies, i.e. private vs. non-profit. Asm. Cahill stated that the work of this Task Force could be incorporated into the more general Model Law that Sen. James Seward (NY) is working on in the NCOIL Health Committee. Asm. Cahill urged the Task Force to continue to work on these issues and gather as much information as possible and noted that the Task Force should not forget about the implications of these issues on workers' compensation insurance. Asm. Cahill then encouraged insurers and air ambulance companies to enter into as many contracts as possible. Asm. Cahill closed by asking the panelists to submit information regarding how best to determine initial air ambulance charges and to look at Sen. Seward's draft Model Law and suggest improvements.

Rep. David Santiago (FL) asked why workers' compensation insurance was affected by these issues, and what a sample network contract looks like. Mr. Jackson stated that the fee schedules adopted by some states' workers compensation divisions have been argued by air ambulance companies to be preempted by the ADA. Ms. Kitzman stated that the process for determining a fee schedule inherently has to address the costs involved. It is important to remember that you cannot regulate costs – they are what they are. Mr. Pickering stated that network contract details are proprietary and private but generally, they are built around what Medicare has established as the base rate which is required to be built around readiness costs and mileage rates.

Rep. Santiago stated that based on that answer, the price should essentially be the same for everyone. Mr. Pickering stated that because the air ambulance companies are a receiver of federal health care money, the price charged has to be the same to avoid violation of the anti-kickback statutes. However, the variable is the payment the companies receive – mostly always below costs. Ms. Bricker cited a report from the AAMs which contains a table that lists the reported median revenue per air ambulance transport and the percentage of costs covered by Medicare, Medicaid, self-pay/uninsured, and commercial insurance -the reported median revenue for a patient with commercial insurance was $23,518, with the insurance carrier covering 231% of the costs. Ms. Bricker noted that such a structure results in higher premiums. Mr. Pickering stated that like the rest of healthcare, there is cost-shifting to recoup costs.

Rep. Greg Cromer (LA) asked if there are markets with multiple providers in them. Mr. Pickering stated that there are and that it is based on demographics and demand – the denser the population, there is generally a higher demand. Rep. Comer asked whether a lower multiplier of private pay in relation to Medicare reimbursement would be adequate to cover costs and profit margins. Mr. Pickering stated that just because a price is at a certain point does not mean the company receives payment for that price – when you average payments across 10 patients with 7 out of 10 paying below costs, then the receipts may be in the range of 6 or 7 times Medicare. Rep. Cromer asked how air ambulance companies quantify the assertion that their services account for less in-patient costs. Mr. Pickering stated that studies show that with heart attacks and strokes, when a patient is transported rapidly and received by the appropriate medical center, they are discharged within 24 to 48 hours vs. having a potential lifetime disability. There are studies underway to more concretely show the costs saved.

ADJOURNMENT

There being no further, business, the Task Force adjourned at 9:25 a.m.