



Understanding the Truth About Air Medical Services

In recent testimony on Surprise Billing, several invited witnesses included comments about air medical services in their written testimony. The following document provides additional context not offered in the testimony to help understand the role of air medical services in protecting and serving gravely ill or severely injured patients.

James Gelfand, Senior Vice President for Health Policy at The ERISA Industry Committee (ERIC):

Written Statement: “The vast majority of health care providers rarely or never generate surprise bills. It’s almost exclusively confined to specific and small subsets of the health system that the patient does not have the ability to choose or shop for. Primarily, these are ancillary providers working in a hospital (such as pathologists, radiologists, anesthesiologists, assistant surgeons), emergency care providers such as ER doctors, neonatologists, ambulances and air ambulances whose service the patient cannot refuse or negotiate or surprise fees from the hospital itself.”

Additional Context: When an emergency transport is requested, a provider is prohibited from deciding whether a patient transport is medically necessary. Sixty percent of our flights are physician-ordered transfers, and 40% are EMS or first responders activating us, because of criteria they determine as the lead provider on scene.

Seven out of 10 patients are insured through government programs and are prohibited from receiving a balance bill. As a Medicare provider however, GMR’s air service companies are mandated by the federal government to make a good faith effort to collect the co-pay, deductibles and any balance bills from patients.

Written Statement: “ERIC and others in the business community urge Congress not to attempt to address surprise medical billing without including ground and air ambulances. Indeed, we believe that Congress will have done a disservice to patients if they only protect them from balance bills once they enter the hospital doors, but the patient might already be bankrupted from the ride there.”

Additional Context: Patients shouldn’t be penalized for receiving life-saving emergency medical care, and that’s why we support the process established by Congress in the FAA Reauthorization Act of 2018, Sections 418, 419, 420 to address balance billing.

At the direction of Congress, the U.S. Department of Transportation, which has a federal statutory role to oversee the air ambulance industry and the Department of Health and Human Services have been directed “to establish an advisory committee 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.”

Now is not the time to throw away the work that has already been done and potentially delay a solution to balance bills for air medical services even longer.

Written Statement: “Emergency medical transportation that is out-of-network should be treated exactly the same way out-of-network emergency room care would be treated. These services should be reimbursed based on a benchmark tied either to Medicare rates, or to comparable in-network rates in that of a similar geographic area.”

Additional Context: Insurance companies’ efforts to enact legislation to tie their reimbursement rates to 125% of Medicare rates will decimate the air ambulance industry, increase the pace of air medical base closures, and thus eliminate a critical health service for 87 million rural Americans. The Xcenda study, which is based on the most complete database of industry costs (based on 2015 dollars), found that Medicare base rates need to be increased by 263% and per mileage charges increased by 102% to cover the cost of air medical services.

Written Statement: “Ambulance or air ambulance providers’ participation in the Medicare and Medicaid programs should be conditioned upon their agreement to abide by reasonable billing practices – thus eliminating any Congressional jurisdictional concerns that may arise. If that is not feasible, insurers and group health plans should be prohibited from contracting with or directing payments to any ambulance or air ambulance provider that does not abide by said practices – providers will quickly adopt these rules in order to maintain access to third-party payment.”

Additional Context: Patients, no matter how they are covered – Medicare, Medicaid, commercial insurance, etc. – must receive a statement/explanation of costs and their benefits. In some instances, providers are required to collect co-pays and deductibles from patients with Medicare. As a provider of Medicare services, we are required by federal law to make a good faith effort to try and collect remaining balances from patients with commercial insurance. Balances are based on a person’s ability to pay – and we do have hardship forms. Our patient advocates work with patients and their families to secure payment for the air medical services in a manner that is respectful of the medical crisis the patient has just endured.

Written Statement: “Air ambulance providers have stated repeatedly that they are increasingly joining insurance networks. ERIC applauds this evolution, but ERIC member companies continue to hear from beneficiaries who are saddled with devastating surprise medical bills from air ambulance providers. If more air ambulance providers are participating in networks, this should supply a robust data reference that can be used to ensure air ambulance providers are compensated fairly once they are subjected to in-network matching, or a median in-network benchmark. Increased network participation also means that federal legislation will impose minimal disruption for providers, as in-network providers already cannot generate surprise bills.”

Additional Context: GMR is actively joining insurance networks and have increased our participation to roughly 30% in-network in the last year. We are actively negotiating fair and reasonable in-network insurance agreements in the interest of protecting our patients, stabilizing operations and easing the administrative burden of claims processing. Unfortunately, in some markets, commercial insurance carriers have made it a point to narrow their networks and exclude air medical services. Some insurers are simply unwilling to pay or contract at rates that cover a provider’s operating costs. These two factors place more burden on those who are covered by commercial insurance.

Being in-network will not end the confusion associated with payment for air medical services. When patients receive an insurance company's "Explanation of Benefits" or EOB statement, it contains the overall charges, often amounting to tens of thousands of dollars. This is commonly mistaken by patients as a bill or obligation, but frequently this is at the beginning of the process before commercial insurance plans have reviewed and determined their payment obligations. Rest assured, in every case, 100% of the time, all Global Medical Response (GMR) companies will work with patients to navigate the insurance reimbursement process and help find resolutions. Patients, no matter how they are covered – Medicare, Medicaid, commercial insurance, etc. – must receive an EOB.

We recognize the complexity of what happens after a significant illness or injury and have a dedicated team of Patient Advocates to assist our patients through these complexities. Some of our patient appeal processes take multiple months or even years. Our Patient Advocates do everything they can to work with the patients and their insurance companies to find a resolution. Once we have exhausted all appeals processes, these advocates also work with patients and their families to secure payment for air medical services. When patients receive statements with balances they cannot afford, we work with them to find equitable solutions.

We like to work directly with our patients so we can find a good solution for them. Our goal is to help them advocate with their insurance company to get the insurer to cover the service that a physician or emergency responder felt was critical for that patient. When the patient's insurer fails to provide their customers with adequate coverage resulting in a "devastating medical bill", they should be reported to the appropriate authorities with jurisdiction. Additionally, GMR supports ERIC or any other similar organization taking patient complaints directly to the U.S. Department of Transportation's Aviation Consumer Protection Division, which has full authority to protect patients and investigate unfair and unreasonable billing by insurers.

Written Statement: "As such, the perceived impediments to including both ground and air ambulance in the Committee's surprise medical billing solution are quite surmountable – and final legislation should protect patients from surprise medical bills generated by both ground and air ambulances."

Additional Context: We agree that achieving a solution to air ambulance balance bills is solvable, which is why we support the process established by Congress in the FAA Reauthorization Act of 2018 to address balance billing. Now is not the time to throw away the work that has already been done and potentially delay a solution to balance bills for air medical services even longer.

Tom Nickels, Executive Vice President of the American Hospital Association (AHA):

Written Statement: "Some of our hospital and health system members have raised concerns about the increase in surprise billing for air ambulance services and the need for federal engagement on this issue. The Federal Aviation Administration (FAA) regulates air ambulances, and federal law preempts states from regulating rates, routes and services of air carriers. This has limited state governments' ability to address air ambulance balance billing issues. The Government Accountability Office recently released a report on air ambulance surprise bills that found that, between 2010 and 2014, the median prices charged by air ambulance providers for helicopter transports doubled, and the number of air ambulance helicopters grew by more than

10 percent. In addition, the agency found that, in 2017, about two-thirds of air ambulance transports for privately insured patients were out of network, insurers typically paid only a portion of the out-of-network services, and almost all of the consumer complaints involved balance bills greater than \$10,000.

As required by the FAA Reauthorization Act of 2018, the Secretary of Transportation has formed an advisory committee on air ambulance patient billing. The advisory committee is directed to recommend ways to protect consumers from surprise air ambulance bills. While this issue is not in the jurisdiction of the Committee, we encourage the Congress to address air ambulance service issues while developing legislation solutions related to surprise medical billing. More specifically, we ask that the Congress extend similar consumer protections from out-of-network billing to air ambulance services and include air ambulance services in network adequacy requirements.”

Additional Context: Since the Affordable Care Act was implemented, we have seen insurance companies that traditionally paid quite well and recognize our charges arbitrarily and unilaterally decrease their payments to air medical providers, dropping what they would pay sometimes up to a 72% reduction.

We are actively negotiating fair and reasonable in-network insurance agreements in the interest of protecting our patients, stabilizing operations and easing the administrative burden of claims processing. Unfortunately, in some markets, commercial insurance carriers have made it a point to narrow their networks and exclude air medical services. In several states such as Texas, Arkansas and Illinois, some insurers have gone so far as to specifically state that they have no intention of entering into network agreements. Some insurers are simply unwilling to pay or contract at rates that do not cover a provider’s operating costs. These two factors place more burden on those who are covered by commercial insurance.

Jeanette Thornton, Senior Vice President, Product, Employer, and Commercial Policy America’s Health Insurance Plans (AHIP):

Written Statement: “We have provided recommendations for strengthening this draft legislation, focusing on the importance of addressing surprise billing by ground and air ambulance operators, recognizing median contracted rates as an appropriate, market-based payment benchmark, and applying the median contracted rate approach to self-funded plans regulated under ERISA.”

Additional Context: Any effort to tie, or index, commercial insurance reimbursements to Medicare rates will eliminate air medical services and destroy the only emergent care option for millions of Americans, especially those living in rural areas. Proposals by health insurers to index commercial insurance to Medicare reimbursement rates are an effort to implement price controls by an industry that is notorious for routinely declining claims, erecting unnecessary barriers to patient care and looking for ways to avoid caring for individuals with high cost, complex conditions.

More than one-third of providers in sample studies already report losses for air medical services, so proposals for controls on air reimbursement rates indexed to a percentage of Medicare would continue unsustainable losses, further reducing access for patients in life-threatening, emergency situations.

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Claire McAndrew, MPH, Director of Campaigns and Partnerships, Families USA

Written Statement: "Air ambulance services are particularly likely to lead to surprise medical bills. Nearly 70 percent of air ambulance patient transports that people often require in life-or-death situations are out-of-network, and balance bills from these air ambulance providers are rarely below \$10,000.

Whether in this bill or in future legislation, federal protections should hold consumers harmless from paying more than in-network cost-sharing for both ground and air ambulance transport when they have no option for in-network ambulance transport. Additionally, federal preemptions that prohibit state regulation of air ambulance rates and networks should be eliminated."

Additional Context: Approximately 75% of the patients we transport are underinsured because they are covered by Medicare, Medicaid, VA benefits, Tricare, auto medical or they are uninsured individuals. Medicare and Tricare only reimburse about 60% of the cost for a flight, and Medicaid reimburse even less, about 33% of the cost. No matter the patient's insurance status, we are obligated to transport them as medically necessary. Patients insured through government programs are prohibited from receiving a balance bill, but because we are a Medicare provider, GMR's air service companies are mandated by the federal government to make a good faith effort to collect the co-pay, deductibles and any balance bills from patients.

Because air medical services often cross state lines to care for patients, eliminating federal pre-emptions that prohibit state regulations will create a patchwork of up to 50 confusing and contradictory state regulations, which will increase costs and, potentially, eliminate bases critical to patient care.

We believe any solution to balance billing should remove the patient from the negotiations between insurers and providers.