State Policy Issue Brief: *Air Ambulance Services*

**Background**

**What Are Air Ambulance Services?**

Air ambulance services are the transporting of patients either from the scene of an accident to a hospital, or between hospitals so that a patient may receive more sophisticated medical care at a specialty facility such as a trauma, burn or cardiac center. Air ambulances themselves are either helicopters or fixed-winged aircraft that are specially equipped to transport ill or seriously injured persons requiring emergency or specialized treatment.

**How Do Air Ambulance Providers Operate?**

Air ambulance providers typically own and operate all aspects necessary to perform the provided service, including the aircraft, pilots, ground crew and emergency medical teams that staff air ambulance emergency transport. Air ambulance providers can be either hospital owned operations, privately owned companies that contract with hospitals or municipalities, or a government service. Those models are commonly referred to as:

- **Hospital-Based:** A hospital controls the business by providing medical services and staff while contracting out (usually long-term) with an air ambulance provider for the aviation component. This is also referred to as the "traditional" model or approach.

- **Independent:** Otherwise known as the “community based” model or approach. Operations are owned and operated by a private company rather than a specific medical facility. Under this model, an air ambulance provider operates on a fully-integrated basis either by directly employing or contracting with other parties to provide aviation, medical, dispatch, communications and billing and collection services. Both of the nation's largest air ambulance providers' operate predominately as independent providers.

- **Government Run:** A state or local government or military unit owns and operates the air ambulances.\(^1\)

Variations on these models exist, including hybrid models and joint ventures with hospitals.

**The Air Ambulance Services Market**

The U.S. market for air ambulance services is estimated to be approximately $4 billion and provides transport to nearly 550,000 individuals annually.\(^2\)

Air ambulance providers in the hospital-based and independent models compete largely

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based on safety, price, reliability, aircraft availability, experience, fleet configuration, aircraft medical capability and quality of service. They compete against both national and regional privately owned air ambulance companies as well as hospitals that maintain their own air ambulance capabilities. Most states have multiple air ambulance service providers operating either state-wide or in specific regions, the majority of which are often smaller regional providers. And while there is usually more than one competitor in each local market, legislative testimony and other reports have indicated that smaller, rural communities may only be serviced by one provider.

Under the independent provider model, companies vie for transport referrals on a daily basis with other independent operators in the same area. Under the hospital-based model, air ambulance providers engage in competitive bidding to secure long-term contracts with hospitals (so-called first-call privileges) in order to ensure a steady flow of patients and therefore a predictable revenue stream.

**Industry Costs**

Air ambulance provider costs are largely fixed, and typically include: the purchase and maintenance of aircraft and ancillary vehicles; the purchase, lease and maintenance of crew housing; crew transportation; medical equipment and supplies; fuel; flight simulators; and other administrative costs such as staff salaries, insurance and licensing and certification costs.

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**Industry Payor Mixes & Revenues**

Air ambulance service providers' "payor mix" is composed primarily of Medicaid, Medicare, commercial insurers and self-payers (i.e. individual patients).

The largest national air ambulance providers report that private insurers, which represent nearly a quarter of their overall payor mix, account for over three quarters of their revenues. One large provider reports that just a one percent shift in their payor mix from insured accounts to either Medicaid or uninsured accounts would result in a decrease of $15.5 million to $16.5 million in pre-tax operating results.

The air ambulance industry is characterized by inelastic pricing. In other words, the price of air ambulance services has no bearing on the overall demand for such services. Historically, private insurers have increased reimbursement rates in relative proportion to air ambulance providers' price increases. The air ambulance industry reports that the net benefit from air ambulance service price increases typically ranges from 8-12 percent annually.

Both hospital-based and independent air ambulance providers' revenues are driven by flight volume. The more patients a provider transports, the more revenue they generate. While the exact allocation will vary among providers, the largest national air ambulance service reports that approximately two-thirds of its flights are inter-facility (i.e. transporting patients between hospitals) and the remaining...
third are flights from the scene where an injury occurs.  

Because flight volume dictates revenue, there is a higher concentration of air ambulance providers operating in dense urban areas compared to remote or rural areas. This occurs despite air ambulance providers receiving higher reimbursement rates under both Medicare and Medicaid for services conducted in remote or rural areas and air ambulance providers billing carriers and patients at higher rates in these areas.

Finally, in addition to revenue received from transports, independent air ambulance providers may generate income from membership programs that charge an annual fee. Membership programs, which can cost less than $100 annually, cover the patient’s cost in the event the member requires an air ambulance transport. To utilize membership benefits, the member must be transported by the company that sold the membership. The member does not pay for any cost of the transport that is not covered by insurance.  

Reimbursement for Air Ambulance Services
Air ambulance services are billed and reimbursed using a base fee plus mileage at a per mile rate. The Centers for Medicare and Medicaid Services maintains a national fee schedule for air ambulance providers, which includes adjustment factors for pick-ups occurring in rural areas (as much as 150 percent of Medicare urban rates). An air ambulance provider’s net reimbursement per patient transport is primarily a function of price, payor mix and timely and effective collection efforts. Reimbursement rates vary among payers, with commercial insurers typically reimbursing at a higher rate than other payer types.

Federal Preemption Limits State Regulatory Authority
Generally, federal laws prevent states from regulating either aviation safety or economic areas impacting price, routes and services. A long line of federal law, court decisions and federal agency opinion letters proscribe state regulatory authority over many aspects of the air ambulance industry. Instead, states have generally been limited to regulating medical standards of care for patients receiving air ambulance services.

Federal courts and agencies, including the U.S. Department of Transportation (DOT) and Federal Aviation Administration (FAA) have issued numerous opinions clarifying the scope and application of federal law on air ambulances and prevent states from regulating many aspects of the air ambulance industry, including:

- Certificates of need, public necessity, and convenience;
- Rates;
- Mandating universal availability of services provided under a carrier’s subscription or membership service;
- Passenger/third party flight accident liability insurance requirements;
- 24/7 availability requirements;
- Pilot training;
- Limitations on geographic service areas; and
- Weather-minimum performance standards.

11 GAO Rpt., p. 5, n. 7.

14 Those federal laws are primarily the Federal Airline Deregulation Act of 1978 (ADA) and the Federal Aviation Act.

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Where federal authorities permit state regulation of air ambulances are mostly related to medical and quality standards of care designed to serve a patient care objective, including:

- Requirements for appropriate medical supplies such as patient oxygen masks, litters, blankets, etc.;
- Adequacy of medical equipment;
- Medical personnel qualifications;
- Requirements for maintenance of sanitary conditions;
- Communication equipment for use with EMS officials;
- Medically dictated pickup and dispatch protocols; and
- Inspections for compliance with medically related regulations.\(^\text{16}\)

However even medical-based regulations may be preempted if enacted as a means of indirectly engaging in economic regulation.\(^\text{17}\)

**Recent State Activity**

Given the broad preemptive scope of federal laws, states have adopted various approaches aimed at curbing air ambulance costs and balance billing practices. The following is a sample of recent proposed or enacted legislation in various states.

**Regulating the Dispatch, Deployment & Transparency of Air Ambulance Services**

*North Dakota:* legislation enacted in 2015 (H.B. 1255), which was subsequently found to be preempted by the ADA, required the state’s Department of Health to establish and maintain a primary and a secondary call list of air ambulance service providers. That list was then to be provided to all dispatchers (i.e. EMS personnel, licensed hospitals, 911 coordinators and public safety answering points), which were to follow prescribed protocols for contacting listed air ambulance services. To be included on the primary call list, an air ambulance service would have been required to attest that it has a contract with the health insurers in the state that make up a combined 75 percent market share or more.

The law was designed to promote air ambulance cost transparency by requiring those providers to produce, upon request, their fee schedules, base and loaded mile rates and any usual and customary charges. In addition, the law sought to promote informed patient consent by requiring hospitals that refer a patient to an air ambulance service to undertake reasonable efforts to inform the patient of the air ambulance provider’s fee schedule – unless doing so might jeopardize the health or safety of the patient.

The law was challenged in North Dakota federal district court by an air ambulance provider operating in that state, and, as noted above, the court held that the creation of the primary and secondary call lists as well as an accompanying regulation setting forth an applicable fees schedule were preempted by the ADA.\(^\text{18}\)

**Proposed Coverage Mandates and Reimbursement Rate Setting**

There have been recent attempts in state legislatures to either mandate coverage for air ambulance services and/or directly regulate air ambulance reimbursement rates, including:

*Florida:* In 2015, two bills (H.B. 681 and S.B. 516) were introduced but failed to pass, which would have required plans provide coverage for emergency services, including air

\(^{16}\) DOT Guidelines, pp. 12-15; GAO Rpt., p. 23, Table 3.

\(^{17}\) GAO Rpt., p. 24.

ambulance transports. The bills required coverage regardless of whether the emergency service was provided by a participating or nonparticipating provider. Both bills would limit reimbursements to nonparticipating providers to the greater of: 1) the amount negotiated with a participating or nonparticipating provider; 2) the usual, customary and reasonable amount calculated using the methodology generally used to determine nonparticipating provider reimbursements; or 3) the Medicare rate.

**South Carolina.** In 2015, the "Air Ambulance Affordability Act" ([H. 3448](#)) was introduced but failed to pass, which would have required all individual, group and HMO plans to provide coverage for air ambulance transportation to a medical facility for emergency treatment when determined as medically necessary by a physician. The bill set reimbursement for covered air ambulance services at the Medicare rate plus 15 percent, which would apply retroactively five years from the law's effective date.

**Data Reporting and Coverage Notice Requirements**

There have also been recent attempts in state legislatures to increase transparency around air ambulance costs. These efforts typically require air ambulance providers report claims and cost related data and carriers to provide notice to their enrollees regarding related coverage, including:

**Kentucky.** In 2016, two bills ([H.B. 273](#) and [S.B. 285](#)), which both failed to pass, would have required all air ambulance services licensed and operating in the state to submit all billed charges to the Board of Emergency Medical Services. Submitted data would be deemed proprietary information and not subject to public disclosure. The Board would then determine the average cost of all such services provided in the state and report that information to the Department of Insurance who would then provide that information to plans.

The bills prescribed specific notice language that indicates whether or not the plan covers air ambulance services, and if so, what the maximum coverage amount is. In all instances, the notice would include the average cost of air ambulance services as provided by the Department of Insurance.

In addition, S.B. 285 would have required an insurer to pay the usual and customary rate of the air ambulance service provider for required emergency air ambulance services. Claims would have been required to be paid directly to the air ambulance service provider.

**Policy Issues Related to Air Ambulances**

- **Balance Billing Practices:** Concerns regarding air ambulance providers balance billing patients continue to grow as billed amounts escalate. Hearings on the subject have recently been held in Montana and are scheduled in other states.

A 2005 MHCC study estimated that Maryland patients could expect to be balance billed an average of $2,889 by non-contracting air ambulance providers.\(^{19}\) Compare this to recent testimony provided in connection with air ambulance related legislation in Montana and North Dakota which indicate patients are currently receiving balance bills ranging anywhere from $14,500 to $39,000 in Montana, and $75.00 to $60,000 in North Dakota.\(^{20}\)

In North Dakota, the state's Deputy Insurance Commissioner testified that 20

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\(^{19}\) MHCC Rpt., p. 32.

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separate air ambulance balance bill complaints were received by the Insurance Department since January 2014 (when data is first available). The complaint data indicated that the average balance bill complaint amount is approximately $23,250. The Deputy Commissioner also testified that there were no indications insurance companies were inadequately reimbursing air ambulance providers. At the same hearing, a plan representative testified there were over 160 cases over a 12-month period where their members were balanced billed for air ambulance services, which averaged between $20,000 and $30,000.\textsuperscript{21}

\textbf{Air Ambulance Provider Contracting:}
Air ambulance providers are increasingly moving away from contracting with insurers and hospital-based contracts as a way to increase revenue. This creates significant cost challenges for insurers and hospitals, and ultimately consumers.

Non-contracting paid charges are typically higher than contracting allowed charges. Recent testimony related to legislation in North Dakota stated that non-participating air ambulance services were on average 240 percent higher than participating providers' charges.

Compare that to a 2005 study by the Maryland Health Care Commission (MHCC) that found private payer in-network air ambulance allowed charges to be approximately 113 percent of the Medicare allowed amounts. By contrast, non-contracting air ambulance providers charged about 180 percent of the average Medicare fee including the patient balance bill.\textsuperscript{22}

The study found that the difference between in-network and out-of-network payments was magnified because payers with relatively high reimbursement levels had no in-network providers. Non-contracting air ambulance providers recovered only about 52 percent of their total potential charges from the payer. The remaining amount was the responsibility of the patient.\textsuperscript{23}

\textbf{Industry Consolidation:} Air ambulance providers have noted hospital provider consolidation as a potential demand driver.\textsuperscript{24} To the extent hospital provider consolidation results in fewer specialty care centers (either due to closures or consolidation based realignment across facilities) there may be a corresponding increase in demand for transporting patients by air. Conversely, to the extent existing hospital facilities expand operations to include additional specialty care centers, demand for air ambulance transportation would be expected to decline.

However, air ambulance providers have also noted that payer and hospital consolidation also brings certain risks, including increasing those integrated entities' leverage to apply discounts to reimbursement rates.

\textbf{Transparency and Network Adequacy:} In 2005, the Maryland Health Care Commission issued a legislatively mandated report studying the costs and reimbursement of air ambulance services in the state. None of the Commission's recommendations were enacted.

\textsuperscript{21} See, North Dakota House Standing Committee on Human Services, Meeting Minutes and Attachments, Jan. 26, 2015, Jan. 27, 2015; see also, North Dakota Senate Standing Committee on Human Services, Meeting Minutes and Attachments, Mar. 16, 2015, Mar. 23, 2015, Mar. 30, 2015, Apr. 1, 2015 and Apr. 10, 2015.

\textsuperscript{22} MHCC Rpt., p. 35.
\textsuperscript{23} MHCC Rpt., p. 35.
The central conclusion reached by the Commission was that due to the broad preemptive sweep of the ADA, the state had limited authority to remedy significant air ambulance balance billing practices, including passing any law that would set rates for only one provider type.\(^{25}\)

The Commission found that whatever regulatory actions the state could enact would be limited to promoting transparency through the use of improved market information to encourage air ambulance providers, hospitals and payers to negotiate in good faith. The Commission believed that increased transparency would have an indirect impact on inter-hospital transfers by leveling variations in price, improving quality and incentivizing air ambulance providers to participate in networks. Information would be gathered and reports published with information on air ambulance providers, billing rates, patient volumes and network participation.\(^{26}\)

In addition, the Commission rejected requiring insurers to provide air ambulance services under network adequacy standards on the basis those services were not commonly used and therefore were not properly addressed in a network adequacy context.\(^{27}\)

**Healthcare Reform:** There is a general recognition within the air ambulance industry that the migration of uninsured individuals into private health insurance coverage has been a positive development resulting in increased revenues.

The nation's largest air ambulance carrier has estimated that not only will its average collections rate increase as more people gain coverage, but that potential revenue growth resulting from just one percent migration from uninsured to covered could be on the order of:

- $1.2 million from uninsured to Medicaid;
- $4.6 million from uninsured to Medicare;
- $6.6 million from uninsured to government insured; and
- $21.5 million from uninsured to commercial insured.\(^{28}\)

Conversely, efforts to control spending in Medicare and changes in payer mix due to the establishment of government programs such as state exchanges may impact provider reimbursement rates.

For additional information about this *Issue Brief*, please contact David Kennedy, Deputy Director at 202.380.8514 or dkenney@ahip.org.

\(^{25}\) MHCC Rpt., pp. 1, 37-39, 42-44.  
\(^{28}\) See Air Methods Corp., Form 10-K, 2014 Annual Report, pg. 8; Air Methods Corp., Corporate Presentation, August 2015, pg. 24.