



Air Ambulance Use and Surprise Billing

Available evidence suggests that air ambulance transport is increasing. Recent federal legislation and regulation address surprise billing and data gaps.

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KEY POINTS

- Air ambulances are typically used to transport patients from the scene of an injury or an accident to hospitals, or between hospitals, particularly in critical situations when the time to treatment is urgent or when patients cannot safely travel by ground ambulance transportation.
- While the number of air ambulance transports is low – roughly 1 per 4,000 privately insured people per year and 1 in 350 Medicare beneficiaries – available evidence suggests there has been an increase in bases (where aircraft are stationed, typically airports or helipads) and providers/suppliers* (particularly independently owned and operated companies) in recent years and a shift towards for-profit entities.
- Patients typically do not have a choice in air ambulance providers, and providers often do not inquire about insurance, leading to the potential for large out-of-pocket costs for privately insured or uninsured patients. Air ambulance providers are not allowed to send balance bills (when an out-of-network provider bills an individual for the difference between the billed charge and the amount paid by their plan or insurance) to Medicaid or Medicare patients but privately insured individuals do not have the same protections against balance bills for air ambulance transports.
- A Government Accountability Office Report found that in 2017 the median price charged for a rotary wing (e.g., helicopter) ambulance transport was \$36,400 versus \$40,600 for a fixed-wing (e.g., airplane) ambulance transport. The Airline Deregulation Act of 1978 prevents states from regulating prices charged by air carriers (which includes air ambulance transport).
- The No Surprises Act, a component of the Consolidated Appropriations Act, 2021, addresses surprise air ambulance bills, effective January 1, 2022. Privately insured patients will pay only the deductibles and copayment amounts that they would have paid for in-network air ambulance providers, and balance billing will not be allowed.
- Information has been limited on air ambulances and their charges. The No Surprises Act addresses this issue by requiring reporting by air ambulance companies and health plans on cost, quality and other data to the Departments of Transportation and Health and Human Services.

* The terminology providers/suppliers means those who deliver air ambulance services. As discussed on page 3, CMS defines an ambulance “provider” as being hospital-based, while an ambulance “supplier” is not institutionally based and can include privately owned suppliers, as well as those run by entities such as volunteer fire departments or state/local governments. For brevity, we generally refer to “providers” in this report.

BACKGROUND

Air ambulances are used to transport patients via helicopter or airplane in critical and life-threatening situations. Helicopters are typically used to transport patients from the scene of an accident or injury to the hospital and tend to transport patients shorter distances. Airplanes are more typically used to transport patients longer distances and between hospitals, particularly when time is critical or patients are too medically unstable to be transported by ground.¹ Patients generally do not have a choice about which air ambulance provider/supplier to use or information about whether their insurance will cover the trip, leading to concerns about surprise billing and balance billing.² When an individual with health insurance coverage gets out-of-network care (care from a health care provider that does not have a contract with the insurance plan provider), the provider may bill the patient for the difference between the billed charge and the amount paid by the patient's insurance, a situation known as "balance billing." A "surprise bill" is a balance bill that the patient did not expect, often because they unknowingly received care outside of their health insurance's network. This can happen in both emergencies and non-emergencies, but both balance bills and surprise bills may be particularly likely in emergencies when patients are vulnerable and less likely to have a choice of providers.* However, there is relatively little information available about how much air ambulance providers charge, how much of the cost is passed on to patients, and the costs of maintaining and running air ambulance services.³ At the same time, there have been longstanding legislative limits on regulating this industry. This has led to renewed interest in better understanding this industry and in legislating solutions to address surprise billing for air ambulance transports.

Recent policy attention to the issue of surprise billing renewed interest in charges for air ambulance transports, culminating in the passage of the No Surprises Act, as part of the Consolidated Appropriations Act, 2021. While the number of air ambulance transports compared to ground ambulance transports is very low, the costs and charges to patients are generally much higher, and in general, patients often do not have a choice of emergency service providers. In addition, air ambulance providers typically do not inquire into the health insurance coverage of patients before responding to an emergency (and in many cases should not, given the urgent nature of these transports). These issues have motivated several states to attempt to regulate prices charged by air ambulance providers, but these efforts have been struck down in courts based on the Airline Deregulation Act of 1978. In this context, Congress enacted several provisions related to air ambulances in the No Surprises Act.

Although there is limited information on the air ambulance industry, what data exists suggests that there has been an increase in the number of bases (where aircraft are stationed, typically airports or helipads) and providers over the past few years, although the distribution may lead to issues of oversupply in some areas and undersupply in others.⁴ In addition, there has been an overall shift away from non-profit providers associated with hospitals to for-profit providers that are unassociated with hospitals, as well as a growing number of providers owned by venture capital firms.⁵ These industry changes have the potential to exacerbate issues with high prices and balance billing to patients.

Charges for air ambulance transports are typically substantial and have been increasing, and for patients with private insurance, a large fraction of transports of privately-insured patients are out-of-network. An internal ASPE analysis of 2016 MarketScan data suggested that over 50 percent of air ambulance transports are out-of-network, while in a report using 2017 FAIR Health data, the GAO estimated that 69 percent of transports of privately-insured individuals were out-of-network.⁶ Information on reimbursement by private payers or how much is paid by patients is sparse. Reimbursement rates for air ambulance transports for patients with Medicare or Medicaid are typically significantly lower than provider/supplier charges, and these patients

* More information about the distinction between these terms is available: <https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period>.

cannot be balance billed for these services. Many air ambulance providers do not have contracts with hospitals or private insurance plans that specify the price of their services, which allows them to charge a higher price to privately insured and uninsured patients. Air ambulance providers, on the other hand, often point to challenges with contracting with payors. They note that operating air ambulance services has high fixed costs for maintaining fleets of helicopters/airplanes and medical staff to be constantly ready for emergencies, and argue that the reimbursements received for Medicaid and Medicare patients are lower than their costs.⁷ They argue that in many instances the rates offered by private insurance companies are inadequate,⁸ or that private insurance companies would rather face a rare high cost air emergency transport than invest resources in negotiations with air ambulance providers.⁹

This report summarizes key policies and legislation related to air ambulances, including the No Surprises Act, and provides an overview of data around the use and costs of air ambulance services.

PROVIDERS, SUPPLIERS, AND AIRCRAFT

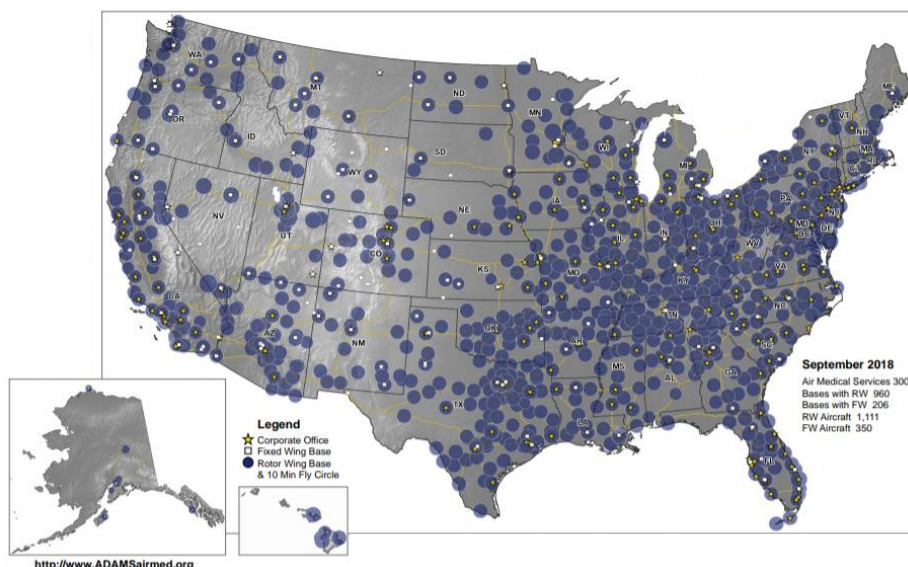
Air ambulance organizations typically fall into one of a few different models. CMS defines an ambulance “provider” as being hospital-based, while an ambulance “supplier” is not institutionally based and can include privately owned suppliers, as well as those run by entities such as volunteer fire departments or state/local governments.* For brevity, we generally refer to “providers” in this report.

In 2018, according to the Atlas & Database of Air Medical Services (ADAMS), there were 1,114 air ambulance bases in the United States. At these bases, there were 1,461 aircraft, including 1,111 rotary-wing (RW) aircraft (in this context, rotary-wing refers to helicopters) and 350 fixed-wing (FW) aircraft (i.e., airplanes). There were 300 providers of air ambulance services, including 188 RW only, 75 RW and FW, and 37 FW only. In their 2019 report using these data, the Government Accountability Office (GAO) found that there was an overall increase in bases between 2012 and 2017, but also a fair amount of turnover, with many bases closing during that time. The GAO found that approximately 60 percent of new RW bases and about half of new FW bases are in rural areas. Slightly less than half of new RW bases were in areas with at least 50 percent overlap with areas that already had an air ambulance provider/supplier servicing the area, suggesting they may not be moving into areas with the greatest need for services.¹⁰ Entry of a new air ambulance organizations within an area that already has a provider or supplier does not necessarily lead to lower prices because patients generally do not have a choice over which one they use (the choice is typically based on whichever is available the fastest) and are not provided with information on how much they will be charged before the transport. In addition, air ambulance companies have high fixed costs, so if they experience lower service volumes, they may need to raise prices to remain sustainable.¹¹ The GAO (as well as others such as the air ambulance industry and its advocacy/industry organizations, as well as academic researchers and medical professionals) has used ADAMS data in its reports on air ambulances but notes that this source is based on voluntary reporting. Thus, some of the increase in the number of providers, bases, and aircraft over time may be attributable to increased reporting, but it is difficult to know for sure or by how much. These data are also available from ADAMS by state.

Figure 1 shows how air ambulance bases are distributed across the United States. These bases can have multiple aircraft as well as multiple providers who use them, so it is not a representation of service volume. In fact, the geographic distribution seems quite different from the service volume maps that are shown later in the paper.

* More information about these definitions and how Medicare processes air ambulance claims can be found: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf>.

Figure 1: Distribution of Air Ambulance Bases in the United States, 2018



Source: Atlas & Database of Air Medical Services, Association of Air Medical Services

CONTRACTING AND FINANCIAL INFORMATION

The traditional, or hospital-based model, is one in which the hospital provides medical services and staff while contracting out to the air ambulance provider/supplier for transport services or provides both their own air ambulances and staff. Hospital-based providers tend to be non-profit. The second is an independent or community-based model, in which a private company owns and operates services rather than a specific medical facility. For the community-based model, the owner may directly employ or contract with firms for all air ambulance services including aviation and medical. The largest air ambulance organizations in the United States operate as community-based providers and are typically for-profit entities. Government or military units may also operate air ambulances, representing a third model.¹² A final category is the hybrid model, in which hospitals provide the medical crew but do not make business or price decisions.

Between 1999 and 2008 there was a shift from providers being primarily hospital-based to almost evenly split between hospital-affiliated and independent, and that trend away from hospital affiliation has continued.^{13,14} In 2015, three for-profit, independent providers operated approximately two-thirds of helicopters in the industry.¹⁵ This shift has helped air ambulance providers increase revenue. Many air ambulance providers do not contract with providers or payers, in order to capture higher payments than they would command through negotiating prices. For example, in North Dakota, payments for non-contracting air ambulance services were 240 percent higher than what providers received when they contracted with insurers.¹⁶

Financial information about air ambulances (for instance, profit margins and costs to the air ambulance companies) is limited. Many of the companies are not publicly traded (there is also a trend toward ownership by equity firms) and what information might be available has not been gathered or is no longer recent. For instance, of the three companies who were the largest providers according to the GAO, two have recently been purchased by private equity firms and one is publicly traded but going through bankruptcy proceedings.¹⁷ In a presentation given in 2017, the largest of the three, Air Methods, reported having net revenue per transport of over \$12,000 in 2016 with margins for air medical services increasing from approximately 28 percent in 2013 to 31 percent in 2016. Whether this is representative of other, smaller providers is unknown.

The No Surprises Act, discussed below, when fully implemented, will make significantly more information about air ambulances available.

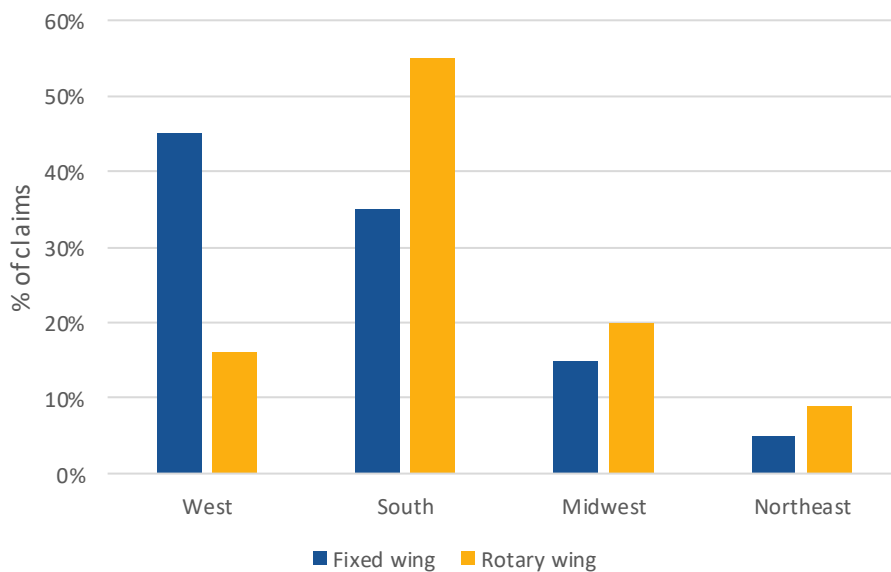
NUMBER AND DISTRIBUTION OF TRANSPORTS

Data on the number of air ambulance transports and characteristics of those transports are limited. Most analyses examining air ambulance utilization use either Medicare claims or private claims, which preclude a direct assessment of the number of air ambulance transports across all payers.

An analysis of private insurance claims from 2016 MarketScan data, representing roughly 43.5 million people (less than one-sixth of the full U.S. population),* indicated a total of 9,928 air ambulance transports, of which 11 percent were FW and 89 percent were RW. In general, FW transports tended to be much longer (median of 138 miles compared to 31 for RW). An equal proportion – approximately 40 percent of RW and FW transports – were in rural areas, but there was regional variation between the two types of transports.

Figure 2 shows the regional distribution of air ambulance transports, by type. FW trips were predominately in the West (45 percent) and South (35 percent), with smaller shares in the Midwest (15 percent) or Northeast (5 percent). RW trips were more heavily concentrated in the South (55 percent) with a smaller proportion of transports taking place in the Midwest (20 percent), West (16 percent), or Northeast (9 percent). A number of factors such as distance to appropriate care and factors influencing driving time, such as terrain, likely play a role in these regional patterns.

Figure 2: Distribution of Private Air Ambulance Claims by Region and Type, 2016



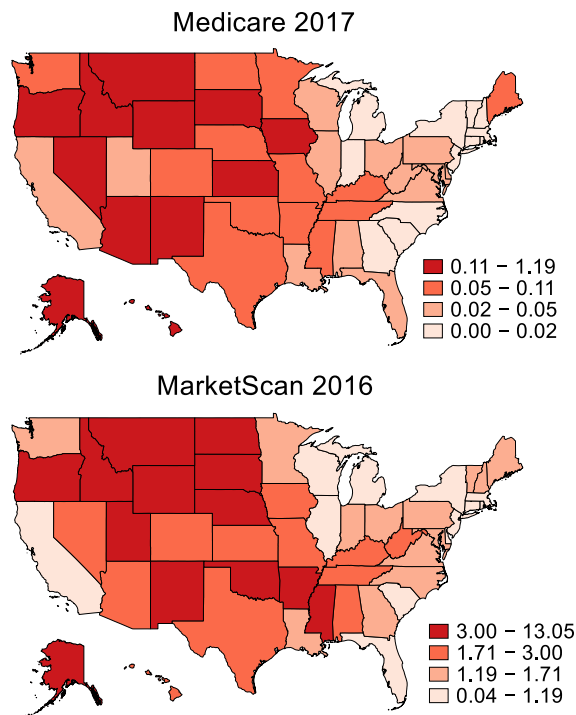
Source: MarketScan (Truven) private insurance air ambulance claims (2016)

In a GAO analysis of FAIR Health claims data from 2017, representing approximately 150 million people, or just under half the U.S. population, GAO reported 33,800 air ambulance transports but did not report geographic distribution. Figure 3 shows air ambulance transports as a percent of total ambulance transports by state,

* MarketScan data from Truven includes claims data primarily received from large employers (those covered by the individual market and most small employers are not included). Reports from GAO on air ambulances use an alternative source of private claims from FAIR Health. Each of the possible sources of private claims coverage can give some sense of usage but does not provide a complete picture.

comparing Medicare (2017) and MarketScan private claims (2016). The same figures for RW and FW separately are in Appendix B.

Figure 3: Air Ambulance Transports as a Percentage of Total Ambulance Transports, by State



Based on the approximate population size in each dataset, both the MarketScan and FAIR Health claims data point to a utilization rate of roughly 1 air ambulance transport per year per 4,000-4,500 privately insured people. An analysis of Medicare claims data from 2014-2018 described in more length below showed a higher utilization rate, roughly 1 transport per year per 350 people. By comparison, there were approximately 23 million ground ambulance visits to hospitals in 2016, for an approximate rate of 1 per year per 14 people.¹⁸

The utilization of air ambulances also varies by rurality of residence. Table 1 shows the number of Medicare beneficiaries utilizing air ambulances, the number of air ambulance transports, and Medicare payments over 2014-2018, comparing urban, rural, and super rural zip codes, based on our analysis of Medicare claims data.* In general, rural areas have the highest number of air ambulance transports and beneficiaries, followed by super rural areas, and these numbers have been slightly increasing over these years. Although the percent of beneficiaries who take an air ambulance transport in a given year is small, it is higher in rural areas and has been increasing over time.† Average Medicare payments for transports in super rural areas were higher than in rural areas or urban areas, likely reflecting longer transport times in the former.

* Urban and rural are defined as either inside or outside of a metropolitan statistical area. Super-rural is a term unique to Medicare’s ambulance fee schedule and is defined as zip codes located in a rural county that is among the lowest quartile of all rural counties in terms of population density. More information is available: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_ambulance_final.pdf?sfvrsn=0.

† To account for beneficiaries who are enrolled for only part of a year in our calculation of total number of beneficiaries, we added the number of months each beneficiary was enrolled in Part B (excluding those enrolled in Medicare Advantage) and divided by 12, to annualize our total number of beneficiaries.

Table 1: Air Ambulance Utilization of Medicare Beneficiaries by Rurality of Zip Code, 2014-2018

	Number of beneficiaries (% of all beneficiaries)				Number of transports				Total Medicare payments (\$ million)			
	Urban	Rural	Super Rural	Total	Urban	Rural	Super Rural	Total	Urban	Rural	Super Rural	Total
2014	19,274 (0.08%)	39,009 (0.53%)	27,673 (1.18%)	85,956 (0.26%)	19,713	40,451	30,168	90,332	\$68.5	\$213.0	\$172.7	\$454.2
2015	20,492 (0.09%)	40,591 (0.55%)	29,848 (1.27%)	90,931 (0.27%)	20,943	42,049	32,623	95,615	\$75.2	\$221.5	\$190.3	\$487.0
2016	24,519 (0.10%)	40,078 (0.62%)	29,746 (1.25%)	94,343 (0.28%)	25,091	41,695	32,341	99,127	\$89.3	\$225.1	\$188.3	\$502.7
2017	24,824 (0.10%)	40,506 (0.63%)	30,803 (1.28%)	96,133 (0.29%)	25,358	42,170	33,898	101,426	\$91.2	\$230.8	\$200.7	\$522.7
2018	24,735 (0.10%)	39,405 (0.62%)	31,474 (1.30%)	95,614 (0.29%)	25,269	41,010	34,561	100,840	\$92.6	\$228.6	\$207.8	\$529.0

Note: Urban and rural are defined as either inside or outside of a metropolitan statistical area. Super-rural is a term unique to Medicare’s ambulance fee schedule and is defined as zip codes located in a rural county that are among the lowest quartile of all rural counties in terms of population density.

CHARGES AND REIMBURSEMENT

Air ambulance transports (both RW and FW) are generally covered by private insurance, Medicare, and Medicaid only when ground ambulance transportation is inappropriate. The health insurance payer typically makes the determination of whether an air ambulance transport was medically necessary. Particularly in emergency situations where advance approval is not possible, this decision is often made retroactively and creates additional risk of a patient receiving a surprise balance bill. Charges for air ambulance services typically include both a fixed, service-level charge and an additional variable charge based on mileage. Other add-on payments may also apply, such as geographic adjustments used by Medicare, based on whether the pick-up location is urban or rural.

Using FAIR Health data from 2017, the GAO found that the median price charged for a RW transport was \$36,400 and the median price charged for a FW transport was \$40,600, compared to \$23,824 for a RW transport and \$24,344 for a FW transport in 2016 MarketScan data.¹⁹ A recent study, analyzing Medicare utilization data, found that average air ambulance charges in 2016 were approximately \$39,000.²⁰ This study also stratified median charges by the fixed service-level charge (\$24,946 for rotary-wing; \$17,838 for fixed-wing) and by mileage (\$238 per mile for rotary-wing; \$104 per mile for fixed-wing). Providers in the northeast generally had the lowest rates, but otherwise there was not a clear pattern across geographic areas.

Public programs reimburse air ambulance services at rates that are substantially less than typical charged amounts (as is the case for most health care services). In 2016 the median Medicare service-level rate for rotary wing aircraft was \$4,814 and the mileage rate was \$33.²¹ These numbers include both the Medicare payment amount as well as deductibles and coinsurance amounts. In fee-for-service Medicare, Part B covers 80 percent of the Medicare-approved amount. Medicare Advantage is required to cover at least the same services as the traditional Medicare fee-for-service program, including ambulance services. However, the cost structure of how MA reimburses may vary. Meanwhile, a study of Medicaid found that average payments for providers ranged from \$240 to \$4,240 in 2016 (2017). Enrollees of Medicare and Medicaid cannot be balanced billed for these services. Table 2 shows air ambulance and ground ambulance usage in 2017 in commercial MarketScan claims and Medicare claims, and compares the charges in the private claims to the allowed charges in Medicare. Medicare allowed charges (including the amount paid by Medicare as well as deductibles and coinsurance) for ground and air ambulance combined were over \$6 billion in 2017 for over 15 million

transports. For all types of ambulance transports, the charges for commercial claims is higher than the Medicare allowed amount, but generally the ratio of commercial charges to Medicare allowed charges is considerably higher for air ambulance claims than for most categories of ground ambulance claims. However, these data do not indicate the negotiated rates actually paid by commercial payers, and it is likely that in many cases for private insurers the charges may be higher than paid rates.

Table 2: Ground and Air Ambulances – Fee-for-Service Medicare Allowed Charges Compared to Commercial Charges per Transport, 2017

Outcome	Medicare	MarketScan* (1% sample)	Ratio of MarketScan charge per transport to Medicare allowed charge per transport
	Mean allowed charge	Mean charge	
<i>Ground</i>			
Basic life support, non-emergency transport	\$191/transport	\$312/transport	1.63
Basic life support, emergency transport	\$334/transport	\$596/transport	1.78
Advanced life support, non-emergency, level 1 transport	\$244/transport	\$628/transport	2.58
Advanced life support, level 1 transport	\$404/transport	\$911/transport	2.26
Advanced life support, emergency, level 2 transport	\$576/transport	\$899/transport	1.56
Specialty care transport	\$676/transport	\$2,349/transport	3.47
Paramedic intercept	\$95/transport	\$572/transport	6.05
<i>Air</i>			
Fixed wing transport	\$3,916/transport	\$16,112/transport	4.11
Rotary wing transport	\$4,499/transport	\$13,287/transport	2.95

Note: The Medicare allowed charges and MarketScan charges only include base per transport charges, not per mile additional charges. For Medicare, for both base and mileage payments, there are add-on payments that vary by location (urban, rural, and super-rural). In this table, these add-on payments are incorporated into the reported allowed charge. Medicare allowed charges include the amounts paid by Medicare as well as deductibles and coinsurance. The charges from private insurers in MarketScan are likely in many cases higher than the paid rates, which cannot be observed in these data.

* The charges from private insurers in MarketScan are likely in many cases higher than the paid rates, which cannot be observed in these data.

Information on reimbursement by private payers is sparse. One analysis of claims from 2013-2017 covering a large private insurer showed that while potential balance bills for ground ambulances were more common, the median potential balance bill for air ambulance transportation was much larger (\$21,698 for an air ambulance versus \$450 for ground ambulance).^{22,*} Some anecdotal evidence and information on balance bills suggests that some insurers have negotiated rates with air ambulance providers and suppliers that are less than stated charges, although higher than Medicare and Medicaid rates. An analysis of air ambulance services in Missouri by the state’s Department of Insurance, Financial Institutions, and Professional Registration found that the average insurance payment plus out-of-pocket spending for an air ambulance service was \$23,087 in 2017, compared to the average amount charged which was \$41,321.²³ How much of the balance was sent to patients or how much the patients ended up paying is unknown. Internal ASPE analysis using 2016 MarketScan data suggests that approximately half of both FW and RW transports in this dataset were out-of-network, while the GAO report using FAIR Health data suggested that in 2017, 69 percent of those with reported network status were out of network. These episodes may result in balance billing by the provider. Other balance bill amounts analyzed by GAO in North Dakota, Maryland, and Montana were generally over \$10,000 with one as high as \$66,600.²⁴

* These are potential surprise bills because they are a comparison between out-of-network charges versus in-network prices for services. The authors do not observe actual bills sent to patients or have knowledge about what, if anything, patients end up paying.

LEGISLATION ADDRESSING AIR AMBULANCES

Federal Aviation Administration (FAA) Reauthorization Act

The Airline Deregulation Act of 1978 prohibits states from regulating the prices air carriers charge and their routes and services. Any state law passed to regulate the prices of air ambulance services is preempted by this law. In the private insurance sector, air ambulance transports are relatively rare events. There are few incentives for either air ambulance providers and suppliers or insurers to enter into contracts with fixed rates and fixed cost-sharing for enrollees. Thus, when an air ambulance incident occurs for privately insured individuals, the air ambulance provider/supplier is frequently out-of-network, which can result in enrollees receiving large bills to cover the costs. This situation does not occur with Medicare or Medicaid beneficiaries since air ambulance services are covered, and balance bills for charges above what Medicare or Medicaid will pay are prohibited. Prior attempts at the state level to address the issue of balance billing for privately insured individuals have been unsuccessful in court due to federal preemption under the Airline Deregulation Act.

The FAA Reauthorization Act of 2018 (FAA Act) was signed into law October 5, 2018. Section 418 of the FAA Act requires the Secretary of Transportation, in consultation with the Secretary of Health and Human Services, to establish an advisory committee to “make recommendations with respect to disclosure of charges and fees for air ambulance services and insurance coverage, consumer protection and enforcement authorities of both the Department of Transportation and State authorities, and the prevention of balance billing to consumers” (see Appendix A for more detail).

The Department of Transportation, the parent organization of the FAA, has established this committee and it has met three times, in January 2020, May 2021, and most recently in August 2021.*

No Surprises Act

The No Surprises Act, a component of the Consolidated Appropriations Act, 2021, addresses air ambulance issues in two ways. First, in section 105,[†] it addresses the issue of surprise billing. Under the Act, plan participants (individuals insured through employer-sponsored and commercial plans) are only required to pay the in-network cost-sharing amount for out-of-network emergency care services, as well as for certain other services. The Act also requires that any out-of-network expenses for the services covered under the Act accumulate towards a plan participant’s in-network deductible and out-of-pocket maximum. These requirements explicitly apply to providers of air ambulance services. The Act establishes an independent dispute resolution process for resolution of differences between service providers and insurance plans and issuers. However, the patient is not part of this process and cannot be balance billed. These provisions take effect in January 2022, and HHS, together with the Department of Labor (which oversees self-insured employer plans), the Department of Treasury (which oversees church plans), and the Office of Personnel Management (OPM) (which oversees the Federal Employee Health Benefits Program) are developing rules to implement these provisions. On July 1, 2021, HHS, the Department of Labor, the Department of the Treasury, and OPM released an interim final rule with comment period (IFC) on the “Requirements Related to Surprise Billing, Part 1.” This IFC implemented many of the No Surprises Act’s requirements relating to surprise billing and cost-sharing for emergency services, including air ambulances services.²⁵

Another requirement of the No Surprises Act affecting air ambulances is an expanded information collection effort. The elements of these information collections are to be established through rulemaking by HHS in consultation with the Department of Transportation, taking into account the recommendations of the FAA’s

* See: <https://www.transportation.gov/airconsumer/AAPB>

[†] Consolidated Appropriations Act, 2021, No Surprises Act Section 105, <https://www.congress.gov/bill/116th-congress/house-bill/133/text>

Advisory Committee on Air Ambulance and Patient Billing, and will include information on items such as costs, locations of air ambulance bases, numbers and types of aircraft, number of transports by payer type, number of claims denied and reasons for denial and any additional information required by the HHS Secretary. Reporting will go into effect to cover the first full year after reporting requirements have been finalized, with civil money penalties for non-compliance.

Reporting by plans, issuers and providers will be summarized into a comprehensive report by HHS in consultation with the Secretary of Transportation. The two Departments are also tasked with establishing an Advisory Committee on Air Ambulance Quality and Patient Safety.

CONCLUSION

The use of air ambulances is a rare but high cost event, with the potential of leading to large balance bills for privately insured and uninsured patients. Patients do not generally have a choice about whether to use an air ambulance or a choice of air ambulance providers. In addition, air ambulance providers typically do not inquire about a patient's insurance status, and patients do not know ahead of time whether or how much of the cost of the transport their insurance will cover. Limited research and some anecdotal reports suggest the potential for balance bills is tens of thousands of dollars for a given transport.

Over the past few years, the air ambulance industry appears to be changing, with fewer non-profit and hospital-based providers and more for-profit providers, and an increase in the overall number of air ambulance bases. There have also been concerns expressed by state insurance commissioners, among others, about geographic maldistribution of air ambulance providers, although this, like many aspects of the industry, has been hard to evaluate with existing data. For many years, there have also been legislative restrictions on state regulation of the industry. The No Surprises Act addresses several of these concerns by adding important surprise billing protections for patients for emergency services, as well as requiring collection of data on air ambulance use and costs. The data collection will enable more comprehensive assessment of the industry than was possible in this report as well as analysis of the impact of the balance billing protections in the No Surprises Act.

APPENDIX A:

The Advisory Committee established in the 2018 reauthorization of the Airline Deregulation Act of 1978 shall address, at a minimum—

(1) the costs, benefits, practicability, and impact on all stakeholders of clearly distinguishing between charges for air transportation services and charges for non-air transportation services in bills and invoices, including the costs, benefits, and practicability of—

(A) developing cost-allocation methodologies to separate charges for air transportation services from charges for non-air transportation services; and

(B) formats for bills and invoices that clearly distinguish between charges for air transportation services and charges for non-air transportation services;

(2) options, best practices, and identified standards to prevent instances of balance billing such as improving network and contract negotiation, dispute resolution between health insurance and air medical service providers, and explanation of insurance coverage and subscription programs to consumers;

(3) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection;

(4) recommendations made by the Comptroller General study, GAO–17–637, including what additional data from air ambulance providers and other sources should be collected by the Department of Transportation to improve its understanding of the air ambulance market and oversight of the air ambulance industry for the purposes of pursuing action related to unfair or deceptive practices or unfair methods of competition, which may include—

(A) cost data;

(B) standard charges and payments received per transport;

(C) whether the provider is part of a hospital-sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program;

(D) number of transports per base and helicopter;

(E) market shares of air ambulance providers inclusive of any parent or holding companies;

(F) any data indicating the extent of competition among air ambulance providers on the basis of price and service;

(G) prices assessed to consumers and insurers for air transportation and any non-transportation services provided by air ambulance providers; and

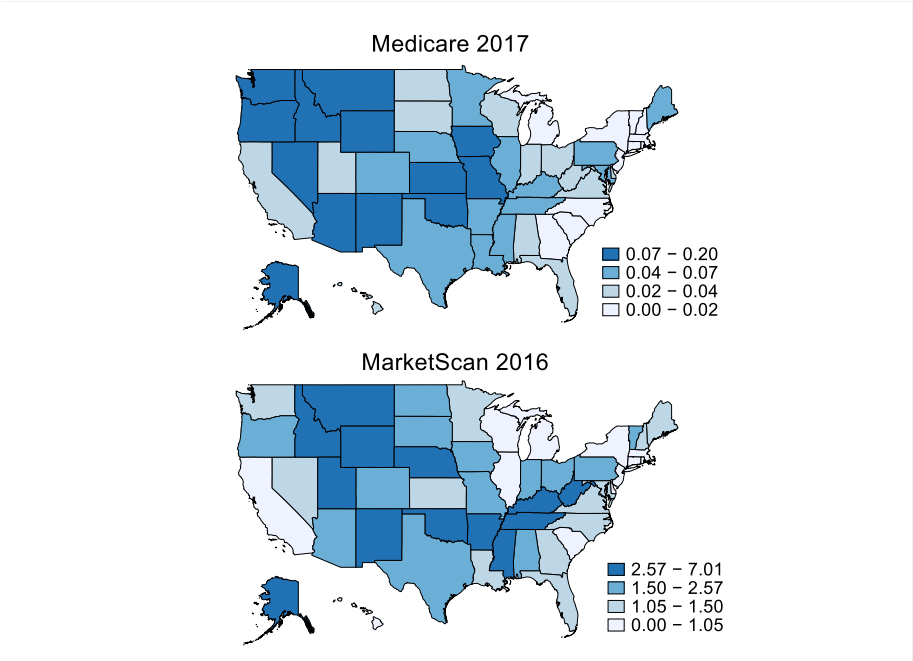
(H) financial performance of air ambulance providers;

(5) definitions of all applicable terms that are not defined in statute or regulations; and

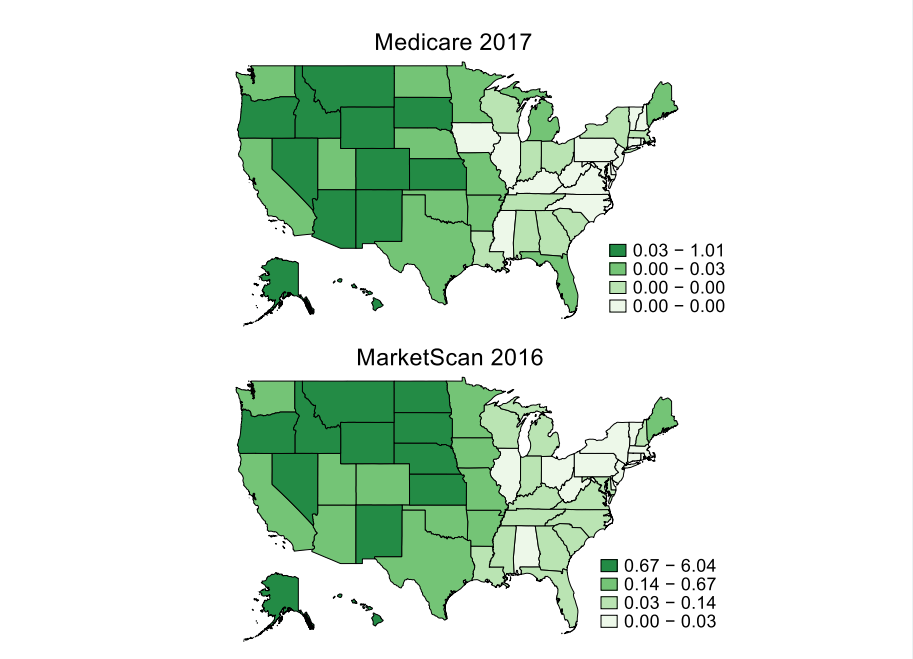
(6) other matters as determined necessary or appropriate.

APPENDIX B:

Rotary-Wing Transports as a Percentage of Total Ambulance Transports by State



Fixed-Wing Transports as a Percentage of Total Ambulance Transports by State



REFERENCES

- ¹ GAO (2017). AIR AMBULANCE: Data Collection and Transparency Needed to Enhance DOT Oversight.
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