U.S. DEPARTMENT OF TRANSPORTATION
Air Ambulance and Patient Billing Advisory Committee

Meeting Summary
Second Meeting of the AAPB Advisory Committee
May 27-28, 2021
U.S. Department of Transportation, Washington, D.C.

The Air Ambulance and Patient Billing (AAPB) Advisory Committee (Committee) met on May 27 and 28, 2021, in a virtual meeting via the Zoom Webinar Platform.

Several topics were discussed at the meeting: (1) a recap of the first plenary session and AAPB Subcommittees. The three Subcommittees are the Subcommittee on Prevention of Balance Billing ("Balance Billing Subcommittee"), the Subcommittee on Disclosure and Distinction of Charges and Coverage for Air Ambulance Services ("Disclosure Subcommittee"), and the Subcommittee on State and DOT Consumer Protection Authorities ("State and DOT Authorities Subcommittee"); (2) a summary of the No Surprises Act (NSA) and its impact on air ambulance costs, billing, and insurance payment systems; and (3) recommendations by each Subcommittee in response to the mandates in section 418 of the FAA Reauthorization Act of 2018 (FAA Act) 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 meeting consisted of a morning and afternoon session each day, which included presentations and opportunity for discussion.

In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. Information about the meeting, including the agenda, is available at https://www.transportation.gov/airconsumer/AAPB. The webcast of the meeting will be available at: https://www.transportation.gov/airconsumer/AAPB/meeting-video.

Appendix A identifies the Committee members, agency employees, and others who attended the meeting. Appendix B is the master list of Committee recommendations. Speaker biographies and all presentation materials that were provided at the meeting are available for public review and comment at https://www.regulations.gov, docket number DOT-OST-2018-0206.

Day One
May 27, 2021

Welcome, housekeeping matters, and introductory remarks

The first day of the Committee meeting began at 10:00 a.m. on May 27, 2021. Blane Workie, Department of Transportation (DOT) Assistant General Counsel for the Office of Aviation Consumer Protection and Designated Federal Officer (DFO), gave welcoming remarks and provided meeting logistics. Ms. Workie stated that the meeting would be recorded, and that the recording would be available on the Committee's website following the meeting.

Lisa Swafford, Committee Chair and DOT Deputy Assistant General Counsel for the Office of Operations, then introduced herself and gave brief opening remarks, followed by the Committee members.

John Putnam, DOT Acting General Counsel, gave remarks. He thanked Committee members for their work to date and recognized the work of the Subcommittees in developing recommendations for the benefit of the full Committee. He noted that Congress passed the NSA just before the Subcommittees completed their work. He observed that while the NSA went far in addressing air ambulance balance billing and patient protection issues, the Committee's work remained vital. He explained that because some of the Subcommittees' recommendations are not covered by the NSA, and many regulations contemplated by the NSA have not yet been written. He stated that he looked forward to reviewing the Committee's final recommendations, which will be transmitted to DOT, the Department of Health and Human Services (HHS), and appropriate Committees of Congress.

Recap of First Plenary Session and Subcommittees

Following the welcome and introductory remarks, Rob Gorman, DOT Senior Attorney, and Ryan Patanaphan, DOT Senior Attorney, provided a recap of the first plenary meeting and an overview of the Subcommittees. Mr. Gorman's presentation provided a review of the topics covered at the Committee's first plenary meeting on January 15 and 16, 2020, including an overview of the air ambulance industry, payment systems, and consumer issues. Mr. Patanaphan's presentation discussed the three Subcommittees and their respective areas of responsibility.

No Surprises Act (NSA) – Presentation and Discussion

After the recap of the first plenary session and Subcommittees and prior to HHS giving a presentation on the NSA, a member of the Disclosure Subcommittee representing physicians discussed his views of the problems with air ambulance providers getting paid timely, noting that the number of days with revenue outstanding was sometimes 200 days. The member also discussed his views on the financial crisis that a patient faces following an emergency, and the patient's lack of understanding on how the insurance system functions.

Deborah Bryant, a senior advisor at HHS, Jeremy Rother, a social science research analyst at the Centers for Medicare and Medicaid Services (CMS), Meril Pothen, a presidential management fellow at CMS, and Shruti Rajan, a senior analyst at CMS, gave a presentation generally summarizing the NSA. The presenters discussed the definitions for "balance bill" and "surprise bill," and noted that the statute uses the term "non-participating" providers, rather than "out-of-network" providers, which was the term used by the Subcommittees. They noted that the NSA is generally applicable starting on January 1, 2022, and contains three main provisions that touch on air ambulance services: (1) consumer billing protections for services from non-participating providers, (2) the establishment of a dispute resolution process, and (3) an expansion of air ambulance provider reporting requirements. On the first main provision, the presenters discussed Section 105 of the NSA, which provides that patients that are transported by a non-

participating air ambulance provider will only owe the cost sharing amounts based on what they would have owed had the service been provided by a participating providers. The presenters noted that this provision only applies to services that are covered under a health plan and applies to both emergency and non-emergency air ambulance transports. The presenters then discussed the NSA's provision establishing an independent dispute resolution (IDR) process, which contains a description of the initiation of the process, a requirement that HHS and other agencies create a process of certifying IDR entities, and the criteria to be used in resolving disputes. On data collection, the presenters noted that HHS and other agencies are engaged in the rulemaking process to establish a methodology for determining the "qualified payment amount," the IDR process and payment amount determination, the form and manner of air ambulance reporting submissions, and the consumer complaints process.

After the presentation, members of the Committee and Subcommittees had an opportunity to ask questions.

- A member of the State and DOT Authorities Subcommittee asked whether the IDR process specified in the NSA is focused only on conflicts over the payment amount, or whether the process is also for settling conflicts about coverage issues, such as medical necessity. HHS responded that it anticipates clarifying this issue in the future.

- A member of the Committee and the State and DOT Authorities Subcommittee, representing air ambulance companies, commented that the IDR process should include ground ambulance services as well, noting that air transport often subsidizes ground transport in his state due to poor reimbursement rates. HHS responded that emergency services are an essential health benefit (EHB), and that states determine what is an EHB through the development of EHB packages (benchmark plans).

- A member of the Disclosure Subcommittee representing physicians noted that the NSA focused on a small number of patients, and that the NSA's IDR process may cause significant delay or drop in payments. The member noted that many businesses have a tight cash flow, and if a retraction in the market and coverage occurs, the retraction could be fast. The member commented that air ambulance providers could fail at a rapid pace if government agencies are not measuring the right data. Another member of the Disclosure Subcommittee and the Committee, representing physicians, commented that air ambulance base closures may not be a bad outcome, as he speculated that this might improve the quality of the service. The member added that 50% of new air ambulance programs between 2012 and 2017 were built in areas of existing coverage, and that studies are underestimating the service area of helicopter bases. The member noted that the placement of bases is often based on financial speculation and not dictated by quality of patient care, with many programs doing less than one patient transfer per day. He recognized that disparities existed in some areas, but that this was based on economics and not patient care. He indicated that additional data would be useful on this issue. Another member of the Committee and the Balance Billing Subcommittee, representing air ambulance companies, commented that his company opened 10 bases in underserved rural markets in the past year, and that agencies like HHS should look at population density where bases exist to analyze whether there is oversaturation.

- A member of the Committee and the Disclosure Subcommittee representing air ambulance companies asked HHS to explain its approach to data collection under NSA Section 106. HHS responded that the agency is communicating with the Government Accountability Office (GAO) and individuals about all data elements that the agency should be considering and modeling. The agency added that it is using all sources and pulling together what it thinks is the most appropriate and comprehensive data for this effort.

- Several members spoke to the state of in-network contract negotiations in light of the NSA. A member of the Committee and the Balance Billing Subcommittee representing insurance companies indicated that his company has had good interaction with air ambulance companies interested in coming in-network. Another member of the Committee and the Disclosure Subcommittee representing air ambulance companies stated that his company had seen anecdotal signs that there is a push to try to impact the qualified payment amount, and that some changes in claims data is appearing starting in October 2021. The member speculated that there may be manipulation occurring from either side. The member representing insurance companies disagreed with this speculation and noted that his company has seen aggressive negotiating tactics reappearing. Another member of the Committee and the Balance Billing Subcommittee representing air ambulance companies indicated that his company has seen large national payors have less movement to negotiate in-network agreements or to do anything that might increase the payors' internal median network payor rate. A Disclosure Subcommittee member representing payment processing systems commented that his company has seen negotiations with payors stall over the past 90 days, which he noted was noticeably longer than usual. He added that the delays are market-specific, with parties in some places more motivated to create an in-network relationship. One member of the Committee and the State and DOT Authorities Subcommittee representing air ambulance companies noted that his company already renegotiated every contract and most of their patients are in-network with a payor; he added that these renegotiations were a result of changes in state law and circumstances specific to his company, rather than an impact from the NSA.

- A Disclosure Subcommittee member representing physicians commented that considerations for the IDR process could include vehicle type, patient complexity, and whether the region is rural or urban, and he asked how HHS envisions developing standards for how air ambulance companies deal with these factors. HHS responded that the NSA gives direction on matters such as what must and may be considered and must not be considered. HHS is examining these factors that are potentially relevant and relying first on stakeholder input to tease out how these factors should be potentially considered as the agency looks to regulate. A State and DOT Authorities Subcommittee member representing payment processing systems mentioned that the agencies have a large amount of data already that can be mined. He noted as an example that the Federal Aviation Administration collects data on company aircraft and utilization rates, and that Medicare data exists by ZIP code for the last 10 to 20 years.

Following these remarks, the Committee adjourned for lunch.

Afternoon Session - Presentations and Committee Discussion

During the afternoon session, the Committee heard from speakers who presented recommendations developed by each Subcommittee on disclosures for insurers/payors and air ambulance companies. After each presentation, the Committee was invited to ask questions and make comments.

Federal and State Pre-Care Disclosures – Presentations and Discussions

Kyle Madigan, DHART; Ed Marasco, Quick Med Claims; Tom Judge, LifeFlight of Maine; Bill Bryant, Sierra Health Group; Rogelyn McLean, HHS; Asbel Montes, Acadian Ambulance

Kyle Madigan first gave a presentation on the Disclosure Subcommittee's recommendations for air ambulance website disclosures. Mr. Madigan noted that the recommendations came out of a provision in the FAA Act that tasked the Committee with examining the disclosure of charges and fees in light of the GAO's recommendations in GAO Report 17-637. Mr. Madigan discussed DOT's role in prohibiting unfair and deceptive practices in air transportation, a role that values consumers' access to accurate and timely information. Mr. Madigan then explained that the ability to make a timely decision in emergencies is not possible, and a consumer may not be able to make the choice of carriage and in what vehicle. He noted that the Subcommittee found that other stakeholders, such as EMS professionals and hospitals, would find certain air ambulance information like average prices and network status to be useful. As noted in GAO 17-637, the Subcommittee considered whether air ambulance providers should be required to disclose their business models on their website, and Mr. Madigan stated that the Subcommittee felt this information would not be useful to stakeholders. The Subcommittee did recommend that air ambulance providers disclose on their websites information on their in-network status and the charges for their services, including, at a minimum, the base rate, the loaded mileage rate, the five most expensive ancillary service charges, and the total price for sample transports. Mr. Madigan noted that the base rate and loaded mileage rate can vary greatly between providers, so the Subcommittee found it beneficial for consumers to have access to a table of sample total charges for different types of transports for each air ambulance provider, with the types of transports standardized to provide proper comparison between providers. Mr. Madigan showed an example table from the Subcommittee's report and noted that the table does not take into account the quality or safety of the operation, only the charges. He added that the NSA addressed quality and safety questions.

Thomas Judge then gave a presentation on the State and DOT Authorities Subcommittee's recommendations for federal disclosure requirements. Mr. Judge noted that the Airline Deregulation Act (ADA) limits the ability of states to act on this subject, and that the Subcommittee made recommendations on actions DOT could take within existing authorities. Mr. Judge said that two of the Subcommittee's disclosure recommendations for air ambulance providers involve balance billing and may become unnecessary if balance billing is eliminated under the NSA. Mr. Judge added that the Subcommittee's recommendations that providers disclose their rates and network composition are not part of the NSA's reporting provisions, and so the Subcommittee asks the Committee to continue with those recommendations. He noted that

the Subcommittee focused on rates and charges, while the NSA focused on prices and costs, which are different subjects.

Bill Bryant gave a presentation on the State and DOT Authorities Subcommittee's recommendations for state-level disclosures. He noted that the goal of the Subcommittee was to increase transparency on the provider and insurer side so the public could make decisions based on more information, thereby offering consumers more protection and providing control to balance billing. Mr. Bryant stated that the Subcommittee ran into two federal preemption issues: the ADA, which limits states' ability to regulate rates, routes, and services in air transportation, and federally regulated insurance plans, which comprise over half of commercial insurance. The Subcommittee wanted air ambulance providers to disclose network composition and everything about their rates, which is consistent with the recommendations of the Disclosure Subcommittee, but because of the ADA, the State and DOT Authorities Subcommittee found that states could not require air ambulance providers to disclose this information. Instead, Mr. Bryant noted that states would need to make their disclosure interests voluntary and incentivized. Mr. Bryant explained that the Subcommittee developed a carrot-and-stick approach. The "carrot" approach would provide that, if a provider wanted to participate in the state Independent Dispute Resolution (IDR) process, which might be more attractive than the NSA's IDR process, the provider needed to agree to make the disclosures. The "stick" approach would provide that the state would publish a list of providers that did not agree to disclose information and then publish the same rate and network information that they can obtain from insurance companies. Mr. Bryant also spoke to the Subcommittee's recommendations for state requirements for insurer disclosures. He said that the Subcommittee recommended that insurers disclose all air ambulance network agreements of which they are a part and what their maximum allowable rates are. Mr. Bryant noted that the maximum allowable rate may be zero if the insurer does not cover air ambulance services, which is possible while there is lack of clarity over whether air ambulance services are an EHB. Mr. Bryant added that insurers never specify what the maximum allowable rate is, and even after the purchase of a policy, the rate is not well-defined and may be based on whatever criteria the insurer dictates. Mr. Bryant said the Subcommittee wanted consumers to know what those rates are and the formulas they use, including historical data. A consumer purchasing a policy would then have a better idea of whether an insurer is actually processing and paying claims, or whether an insurer has a denial issue over other insurers. Mr. Bryant also stated that insurers should be required to disclose to consumers what providers are charged and the portion the insurer will cover.

Asbel Montes then gave a presentation on the Disclosure Subcommittee's disclosure recommendations for insurers at the plan pre-purchase stage. He noted that a representative from the America's Health Insurance Plans (AHIP) reviewed the Subcommittee's recommendations for insurers (referred to as "payors" in the Subcommittee's report), and that the Subcommittee recommended that such disclosures should be provided on the Statement of Benefits and Coverage (SBC), a form that already exists. Because the Subcommittee recommends modifications to the SBC form, administrative costs of implementation are limited. The disclosure recommendations include some of the same recommendations from the State and DOT Authorities Subcommittee. The Subcommittee also recommended that statutory authority be granted to HHS to expand the length of the SBC, and that HHS initiate rulemaking to require the payor disclosures of the Subcommittee. Mr. Montes showed the Committee a modified SBC

incorporating the elements recommended by the Subcommittee, including content on whether air ambulance services are covered, and a means for consumers to obtain a list of participating providers, the maximum allowable amount, and the average air ambulance bill for participating and non-participating providers. Mr. Montes added that the SBC should also be modified to clarify whether air ambulance emergency medical transportation is covered, whether it is considered an EHB, and whether prior authorization is required for air ambulance services during hospital stays.

Following the four presentations, Ms. Workie began the Committee's discussion by noting some subject areas where the Subcommittees had related recommendations, and she asked the members whether there was a benefit for air ambulance providers to disclose their rates in light of the NSA's prohibition on balance billing for emergency services. Members from the two Subcommittees making the rate disclosure recommendations generally were in favor of both sets of recommendations moving forward, with multiple members of the Committee commenting that they would support DOT collecting air ambulance rate information and making it available in a central location, so that the presentation of information could be standardized and entities can do a fair comparison of air ambulance rates. Other members suggested that DOT should also coordinate with HHS, so that the two agencies do not prescribe conflicting or inconsistent rules, and so that HHS can direct entities to DOT for air ambulance rate information. One member suggested that the information should be made useable with an explanation of what the data means and how one should interpret it. Several members also noted that HHS' hospital transparency rule and the experience of entities with that rule may provide insight on how to publish rates in an effective and consumer-friendly way. Members commented that the apples-to-apples comparison provided by the Disclosure Subcommittee's recommended approach to displaying sample trips will be useful, although imperfect because it may not account for cost shifting.

Following the discussion, the members agreed that air ambulance rates should be displayed on air ambulance provider websites. The members also approved the following recommendations, with the DOT and HHS representatives abstaining from voting on any recommendation impacting federal law:

Recommendation #1: The Advisory Committee recommends that DOT require air ambulance providers to display on their websites information on rates and a list of all payors with whom they are in network by state and by plan. If the provider is not in-network with any payor, the air ambulance provider should be required to state this fact. The Advisory Committee notes that the rate information that air ambulance providers are required to disclose should provide context to improve comprehension and usability such as the sample website disclosure tables for air ambulance providers prepared by the Disclosure Subcommittee. The Advisory Committee also recommends that DOT coordinate with HHS in issuing a rulemaking to avoid undue burden and confusion.

Recommendation #2: The Advisory Committee recommends that Congress provide authority to HHS to expand the Statement of Benefits and Coverage (SBC). The Advisory Committee recommends that HHS issue a rule requiring the SBC disclosures that are recommended by the Disclosure Subcommittee once it has authority.

Recommendation #3: The Advisory Committee recommends that states (through NCOIL [National Council of Insurance Legislators] and/or NAIC [National Association of Insurance Commissioners]) require insurers to disclose all air ambulance providers that are in-network by state and by plan, or to affirmatively state that they do not have any in-network agreements with air ambulance providers if that is the case.

Recommendation #4: The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop requirements for insurers to disclose the maximum allowable rate for air ambulance services by plan, as well as any plan limitation.

The Committee chose not to approve a recommendation that states should incentivize air ambulance companies to disclose rate information using the carrot and stick approach, as proposed by the State and DOT Authorities Subcommittee.

The Committee then adjourned for a ten-minute break.

Point-of-Care Disclosures and Preauthorization – Presentations and Discussions
Dr. David Thomson, East Carolina University/Vidant EastCare; Dr. Michael Abernethy, University of Wisconsin; Thomas Cook, Global Medical Response

Drs. Michael Abernethy and David Thomson then gave a presentation on the Disclosure Subcommittee's recommendations for point-of-care disclosures. As context for the recommendations, they explained what is considered an emergency, and noted that the Subcommittee only recommends that point-of-care disclosures be made in non-emergency contexts. The Subcommittee recommends that the disclosures be provided by the entity requesting the air ambulance transport and will contain a notice that the service may not be fully covered and information on the estimated charges to be paid by the patient. The Subcommittee recommends using the Advanced Beneficiary Notice of Non-Coverage (ABN) form as a model. The presenters noted that the point-of-care disclosure recommendations have some intersections with the NSA, including Section 111, which provides for an advanced Explanation of Benefits, Section 112, which requires good faith estimates from providers, and Section 114, which requires a cost comparison tool. They also noted that the NSA does not appear to make distinctions between emergencies and non-emergencies in the point-of-care context.

Thomas Cook then gave a presentation on the State and DOT Authorities Subcommittee's recommendations for preauthorization, and he noted that the recommendation applies only to non-emergency transports. The Subcommittee believes that preauthorization requirements might encourage insurers and air ambulance providers to negotiate and enter broader express contracts for preauthorized transports. The Subcommittee recommends that states adopt preauthorization requirements for non-emergency air ambulance transports that align the patient, payor, and air ambulance provider on the billed charge for the transport by including a provision that places the onus on the hospital/doctor to initiate the preauthorization process, arrange for transport, and ensure the patient is receiving pre-negotiated transportation. Mr. Cook also stated that the Subcommittee recommended requiring the insurer to disclose to the patient the agreed price of the transport, the amount the insurer will cover and pay, and the amount of the patient's

responsibility. The Subcommittee also recommended provisions to encourage advance express agreement between the insurer and air ambulance provider on price, coverage, and medical necessity of the mode of transport.

Following the presentations, the Committee had an opportunity to ask questions and discuss the recommendations.

- One member representing insurance companies asked whether the recommendations, which cover non-emergency situations, may exclude some situations which are considered emergencies but have sufficient lead time such that a patient could also be provided disclosures. The member expressed his view that disclosures in such situations would be helpful. A Subcommittee member representing physicians responded that the situation was not uncommon, and probably would need a cooperative agreement between clinicians in such settings. A member of the State and DOT Authorities Subcommittee noted that medical necessity and emergency are two different concepts. Other members expressed their view that health care providers are under significant stress in emergency situations and that the Committee should be cautious about adding point-of-care disclosures in emergency situations, which could inhibit care.

- Several members expressed concern with making state-level recommendations, and the difficulty in getting such recommendations through state governments. Members also expressed concern with making requirements applicable for multiple entities, which can increase complexity and the potential for lobbying and opposition.

As a result of the discussion, the Committee was in general agreement that point-of-care disclosures should be provided in non-emergency situations. Due to a lack of time, no specific recommendations were finalized on this subject on the first day of the meeting, and the Committee agreed to continue the discussion the next day.

At approximately 5:30 p.m., Ms. Swafford announced that the meeting was adjourned and that it would resume at 10:00 a.m. the following day.

Day Two
May 28, 2021

Welcome and Summary of Day 1

The second day of the Committee meeting began at 10:00 a.m. on May 28, 2021, via the Zoom Webinar Platform hosted by DOT. Ms. Workie and Ms. Swafford provided welcoming remarks and summarized the discussion and recommendations from the first day of the meeting before opening the floor to presentations and discussions.

Presentations and Committee Discussion

Point-of-Care Disclosures and Preauthorization (continued)
Dr. David Thomson, East Carolina University/Vidant EastCare; Dr. Michael Abernethy,

University of Wisconsin; Thomas Cook, Global Medical Response

In continuing the discussion from the prior day, some members of the Committee had discussed the possibility of whether disclosure recommendations should apply to more than non-emergency situations; however, the Committee did not agree to this change. The Committee approved the following recommendation:

Recommendation #5: The Advisory Committee agrees that point-of-care disclosures should be provided in non-emergency situations. The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop requirements for point-of-care disclosures and preauthorization in non-emergency situations.

Claims-Related Disclosures – Presentations and Discussions
Rogelyn McLean, HHS; Dr. Kevin Hutton, Retired Air Medical Executive

Dr. Hutton gave a presentation on the Disclosure Subcommittee's recommendations for claims-related disclosures. Dr. Hutton expressed his view that pre-purchase and point-of-care disclosures were not readily absorbed or understood by patients, and that the period after care during which claims are made is when a patient is more likely to read disclosures. He noted that the Subcommittee made recommendations for both air ambulance providers and payors to provide disclosures during the claims-related time period, including information on payment, coverage, full denial information, appeal rights, and preauthorization. Dr. Hutton said that the payor disclosures should be easy to understand and separate from the Explanation of Benefits, and payors should explain in more detail why claims are denied (including the reasons for denials of medical necessity and for partial payments). Dr. Hutton also noted that the Subcommittee made a recommendation regarding informing patients about direct payments to them (i.e. instances where the payor sends a check directly to the patient to pay the provider), but he also noted that the NSA may obviate the need for such a disclosure.

Ms. McLean followed Dr. Hutton's presentation by addressing the intersections between the claims-related disclosure recommendations and the NSA. She stated that there was no direct NSA corollary for the payor-to-patient disclosure recommendations explaining claim denials, but she added that under NSA Sections 102 and 105, insured patients will only need to pay the in-network amount, so the Subcommittee's recommendation might need to be adjusted before adoption by the full Committee. She agreed with Dr. Hutton that Section 102, which prohibits payments to patients, supersedes the Subcommittee's recommendation for disclosures regarding direct-to-patient payments. On payor-to-provider disclosure recommendations, Ms. McLean noted that the Subcommittee's recommendation is for the plan to disclose enough information to providers to allow them to understand the payor's action and how to challenge the action. She noted that a possible corollary exists in NSA Section 110, which provides for an external review of all adverse benefit determinations, but she added that this external review may be focused on benefiting the patient and less the provider. Ms. McLean commented that the Committee may want to consider the extent this may be relevant to medical necessity disputes after the patient is taken out of the middle and air ambulance providers challenge medical necessity denials with the payor. Ms. McLean also noted that on the Subcommittee's recommendations for air ambulance provider disclosures to patients, NSA Section 105 might have an impact due to its prohibition on

balance billing. She added that Section 112 also requires good faith estimates for non-emergency services, and Section 104 requires providers to make publicly available information on patient rights regarding balance billing.

Following the presentation, the Committee engaged in a discussion on the Subcommittee's recommendations.

- Several members commented that they were supportive of a more detailed disclosure regarding a medical necessity denial going to both the patient and provider. They suggested that, instead of the Subcommittee's recommendation that different disclosures with differing levels of information be provided to patients and providers, the same level of detail should be provided to both entities. The members noted that a uniform disclosure for both could add clarity and decrease the administrative burden.

- There was some agreement that the existing document provided by payors, the Explanation of Benefits (EOB), is not clear for patients, and there was discussion about whether the EOB could be improved and made more understandable to patients.

- Members also discussed EHB and whether air ambulance services should be specifically included as an EHB. According to one member representing air ambulance providers, if air ambulance services are considered an emergency service that is an EHB, then a disclosure explaining a denial of medical necessity would not be required. Other members disagreed and indicated that there still could be medical necessity denials.

- Several members then recommended that the Committee consider the Disclosure Subcommittee's claims-related disclosures as a whole and not piecemeal.

Following the discussion, the Committee approved the following recommendations, with the DOT and HHS representatives abstaining from voting to the extent the recommendations impacted federal law:

Recommendation #6: The Advisory Committee adopts the Disclosure Subcommittee's recommendations for payors to make claims-related disclosures to patients and air ambulance providers, as set forth in Recommendation 2.4.1 of the Disclosure Subcommittee Report, with a slight modification: the payor disclosures recommended by the Disclosure Subcommittee to air ambulance providers and patients should be the same. The Disclosure Subcommittee had recommended the content of the disclosure differ depending on whether the disclosure is to the patient or provider.

Recommendation #7: The Advisory Committee adopts the Disclosure Subcommittee's recommendations for DOT (or HHS) to issue rulemaking requiring air ambulance providers to make claims-related disclosures to patients as set forth in Recommendation 2.4.2 of the Disclosure Subcommittee Report.

Recommendation #8: The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop recommendations on how to add clarity to the Explanation of Benefits (EOB)

process. The Advisory Committee further recommends that states submit these recommendations to HHS, and that HHS consider these recommendations for potential rulemaking.

Recommendation #9: The Advisory Committee recommends that HHS initiate rulemaking or issue guidance to make clear that "Emergency Services" under section 1302(b)(1)(B) of the Affordable Care Act specifically includes emergency air ambulance services.

Distinction Between Air Transportation and Non-Air-Transportation Charges – Presentations and Discussions

Kyle Madigan, DHART; Ed Marasco, Quick Med Claims

Mr. Marasco gave a presentation on the Disclosure Subcommittee's decision not to recommend that air transport and non-air transport charges be distinguished, noting the impact on all stakeholders. Mr. Marasco noted that the NSA does require air ambulance companies to submit cost information, but the NSA does not address charge differentiation, as considered by the Subcommittee.

The Committee then agreed to the following position (with DOT and HHS abstaining):

Recommendation #10: The Advisory Committee agrees with the Disclosure Subcommittee's decision not to recommend that air ambulance provider distinguish between air transport and non-air transport charges. The Advisory Committee recommends that air ambulance providers not be required to distinguish air transport and non-air transport charges.

Federal and State Independent Dispute Resolution (IDR) – Presentations and Discussions

Chris Myers, Air Methods; John Haben, UnitedHealth Group; Ray Pickup, WCF Insurance; Jon Godfread, State of North Dakota

Mr. Myers, Mr. Haben, and Mr. Pickup summarized the Balance Billing Subcommittee's recommendation for a comprehensive federal IDR system to resolve disputes between out-of-network air ambulance providers and payors. They also noted that the NSA contains a comprehensive IDR system.

They explained that in general, under both systems, if a payor disagrees with the out-of-network air ambulance provider about the amount to be paid, then the payor must provide either an initial payment or a notice of non-payment. Both systems then allow for a negotiation period; if negotiations fail, then either party may initiate IDR. During the IDR process, the dispute resolution entity (DRE) determines the amount to be paid after reviewing each party's proposals and a number of enumerated factors. Both systems explain how the DRE is chosen, set a mechanism for paying the DRE's costs, and provide that the DRE's decision is generally legally binding. Both systems would not apply to Medicare, Medicaid, or workers' compensation insurance, all of which already ban balance billing.

The presenters explained the key differences between the two systems as follows:

NSA's IDR system	**Subcommittee's Proposed IDR System**
Balance billing is prohibited directly by statute, not as part of IDR.	As a condition of entering IDR, the air ambulance provider must agree to not balance bill the patient; likewise, the payor must agree to hold the patient harmless for amounts beyond the patient's copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.
DRE may choose an appropriate award amount after considering numerous factors. DRE selects the party to pay costs.	"Baseball-style" IDR system where the DRE must choose one of the two sides' proposals. The non-prevailing party is responsible for the DRE's costs.
When determining the amount of the award, the DRE *must* consider one set of enumerated factors; *may* consider a second set of factors; and *must not* consider a third set of factors.	When determining the amount of the award, the DRE *should* consider a non-exhaustive list of factors.
No provision for determining whether the transport was medically necessary.	DRE should consider whether the transport was medically necessary. A transport is presumed medically necessary if it meets certain criteria. The payor may overcome the presumption by establishing that the criteria were not satisfied.

Next, Commissioner Godfread summarized the State and DOT Authorities Subcommittee's recommendation for state-level IDR systems as an alternative to federal IDR. Mr. Godfread explained that States have the authority to compel IDR participation by insurers, but not by air ambulance providers. He noted that the State and DOT Authorities Subcommittee's DRE would award a "reasonable rate" after considering the presentations of both parties.

After the presentations, the DFO opened the discussion with the question of whether the Committee should recommend amendments to the NSA's IDR system.

- <u>Costs and Qualifications of DRE</u>

  A member of the Disclosure Subcommittee stated that under the NSA as it stands, it will be difficult to find qualified DREs. He also argued that if starting up the IDR program is lengthy or expensive, then the parties will have to continue with their negotiation practices. He argued that IDR generally delays payment, which has a large effect on a provider's DRO (Days Revenue Outstanding). He argued that during the IDR process, payors should put their payments into escrow, rather than holding on to the money directly, as a means of incentivizing the payor to pay sooner. The Committee did not vote on these issues.

- <u>Factors for the DRE to Consider: Payments to Other Providers</u>

A Committee member representing air ambulance providers noted that the Balance Billing Subcommittee included a recommendation that the DRE should consider "amounts paid to other providers or suppliers, both in- and out-of-network, by or on behalf of the payor, provided confidentially, for similar services in the same geographic area, including any relevant context such as type of business model (e.g., hospital based, hybrid, and independent)" when determining the appropriate amount of an award. He argued that the NSA should include such a provision. A member of the State and DOT Authorities Subcommittee representing providers of payment systems agreed, and stated that the DRE should also consider whether or not the air ambulance provider is subsidized (e.g., by taxes, charity/foundations, or by a hospital system as part of a "loss-leader" program). The initial vote was seven "yes" (Abernethy, Connors, Godfread, Haben, Montes, Myers, and Pickup) to three "no" (Judge, Lennan, and Madigan). At the conclusion of Day 2, as the recommendations were printed and displayed for the Committee, Mr. Haben and Mr. Godfread changed their vote and objected to the recommendation, to the extent that it included consideration of payments to out-of-network providers. Mr. Myers then objected to the extent that the recommendations would exclude consideration of payments to out-of-network providers. Ultimately, the Committee did not reach consensus on this recommendation regarding payments to other providers.

- Factors for the DRE to Consider: Medical Necessity

A Committee member representing physicians and a member of the State and DOT Authorities Subcommittee representing providers of payment systems noted that the NSA does not include a medical necessity provision. The Committee member representing physicians suggested that the Committee should adopt the provision regarding medical necessity, found in both the Balance Billing Subcommittee and State and DOT Authorities Subcommittee, that there should be a rebuttable presumption that a transport was medically necessary so long as the transport met certain neutral criteria. A majority of the Committee voted "yes," with Mr. Montes and Dr. Abernethy voting "no," and with DOT and HHS abstaining as the recommendation implicated changes to federal law.

Recommendation #11: The Advisory Committee recommends that HHS should issue a regulation addressing medical necessity within the IDR process. Specifically, within the IDR process, there should be a rebuttable presumption that the air ambulance service was medically necessary, but an insurer can overcome that presumption by first presenting evidence that either the third-party first responder/medical professional who requested the transport was not a neutral third party, or that the air ambulance provider did not act in good faith.

The Committee then adjourned for lunch.

Afternoon Session

The afternoon session commenced at 1:30 p.m. with the Committee resuming their discussion of IDR issues.

- Initial Payment

The DFO asked if the NSA clarified the amount or method for calculating the payor's initial payment. The speakers responded that the NSA was silent on this point. The Committee agreed that regulations implementing the NSA should define the appropriate initial payment. The Committee discussed several options, including (1) the median in-network rate; (2) the "usual and customary" reimbursement amount; (3) the median of all air ambulance payments from the payor; and (4) an unspecified fixed amount.

The Committee did not come to a consensus as to its own proposed definition of initial payment, but recommended that HHS define the term (with DOT and HHS abstaining as the recommendation implicated changes to federal law):

Recommendation #12: The Advisory Committee recommends that HHS define "initial payment" in its IDR rulemaking (relating to the provision that after receiving a bill, the payor must provide an initial payment or a notice of denial of payment). The Advisory Committee did not reach consensus on its own proposed definition of initial payment.

- IDR Fees

Next, the Committee discussed whether regulations implementing NSA should set IDR fees at an amount sufficient to disincentivize the use of IDR. A Committee member representing health insurers contended that private equity firms are building DREs and pushing high volumes of cases through IDR, so high fees could be expensive for both employer groups and smaller air ambulance providers. The Committee did not agree to a recommendation on IDR fees.

- State IDR

The HHS representative noted that it was an open question whether the NSA's federal IDR system would permit state IDR systems. A Committee member representing air ambulance companies remarked that one problem with State IDR systems would be that 30% of air ambulance transports are interstate. The Committee member representing state insurance regulators remarked that in light of the federal IDR system set forth in the NSA, State IDR systems are not advisable because no State would implement such a program. The Committee declined to issue recommendations relating to State IDR systems.

- Before concluding, a Committee member representing managers of employee benefit plans observed that consumers are harmed not only by high out-of-pocket costs, but also by high total costs of air ambulance service. She noted that even though the NSA bans balance billing, high total costs adversely affect consumers because employers must pay higher insurance premiums, which in turn leads to employers being unable to provide larger wage increases. She argued that the Committee should take a broader look at total costs and consider amending the Airline Deregulation Act.

Data Collection – Presentation and Discussion
David Motzkin, PHI Air Medical

Mr. Motzkin noted that the Balance Billing Subcommittee developed extensive recommendations for data to be collected at the federal level to: (a) advance the understanding of

the air ambulance industry by policymakers; (b) increase transparency of market conditions impacting air ambulance services; and (c) improve, indirectly, network and contract negotiation between payors and air ambulance providers and suppliers.

The Subcommittee recommended that DOT collect the following data from air ambulance providers and suppliers:

1. Average cost per trip.

2. Air ambulance base rates and patient-loaded statute mileage rates.

3. Ancillary fees for specialty services, like neonatal, cardiac, and "other" (e.g., specialized medicines like snakebites in rural areas).

4. Reimbursement data aggregated by payor type (Medicare, Medicaid, self-funded, private insurance) and per transport, based on median rate and ZIP code. Data regarding private insurance should be further identified by provider type (hospital-sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program).

5. Alternate revenue sources (e.g., subsidies or membership programs) broken down per transport for reporting purposes.

6. Volume of transports, segregated by aircraft type (fixed wing and rotary wing) and takeoff ZIP code for government purposes, or for public use when aggregated with other data.

7. Market share for air transport, obtained from the FAA certificate holder and identifying the certificate holder's parent company.

8. Market share for health care, by looking at the program type for the FAA certificate holder.

Mr. Motzkin explained that the Balance Billing Subcommittee started with the suggested data collection elements found in Section 418 of the FAA Act, but then amended those elements as necessary to meet the purposes listed above. Mr. Motzkin noted that the Balance Billing Committee recommended that any public display of the data should be aggregated in ways that avoid antitrust concerns. He noted that a 2012 public release of disaggregated Medicare allowed providers to see each other's charges, leading to an unintended "race to the top."

Next, Mr. Motzkin explained that the NSA also requires HHS, in conjunction with DOT, to collect data on many aspects of air ambulance service and payments, with the results published in a unified report.

The DFO opened the issue to discussion.

- A Committee member representing managers of employee benefit plans noted that the NSA requires the development of a shopping tool. In response to a question by a Committee member representing air ambulance companies, Mr. Motzkin noted that the Balance Billing Subcommittee's recommendation calls for collection of more data than is required by the NSA, because the primary purpose was to educate lawmakers.

The Committee voted unanimously to adopt the Subcommittee's data collection recommendations in full, with DOT and HHS abstaining because the matter implicated federal law:

Recommendation #13: The Advisory Committee adopts the recommendations from Chapter 5 of the Balance Billing Subcommittee report relating to data collection.

Definitions – Presentations and Discussion
Ray Pickup, WCF Insurance; Ami Lovell, DOT

The Committee heard presentations from Ray Pickup, WCF Insurance, and Ami Lovell from the U.S. Department of Transportation, regarding definitions that the Balance Billing Subcommittee and State and DOT Authorities Subcommittee recommended that the Advisory Committee should advance as part of the Committee's final report.

In his presentation, Mr. Pickup explained that Section 418(d)(5) of the FAA Act requires the Committee's recommendations to include "definitions of all applicable terms that are not defined in statute or regulations." He noted that all three Subcommittees included appendices with "contextual definitions" of terms used in their recommendations, but that the Subcommittees only recommended that the Committee adopt definitions of three terms.

Mr. Pickup discussed definitions for two of those terms— "balance billing" and "surprise billing"—that were proposed by the Balance Billing Subcommittee and the State and DOT Authorities Subcommittee. Mr. Pickup noted that the NSA does not use an exact definition for either of those terms.

A definition for "balance billing" was proposed by both Subcommittees. The Balance Billing Subcommittee defined "balance billing" as a medical bill from an out-of-network provider or supplier for the portion of the provider or supplier's charge that is not covered by the patient's commercial health insurer or self-funded employer health plan, calculated as the difference between the provider or supplier's charge and the amount allowed by the payor and the patient's coinsurance and/or deductible. The State and DOT Authorities Subcommittee stated that "balance billing" is when an out-of-network provider sends a bill to a commercially-insured consumer for the difference between (a) the out-of-network provider's billed charge for covered services rendered and (b) the allowable amount for such covered services under the commercially-insured consumer's health insurance plan.

A definition for "surprise billing" was also proposed by both Subcommittees. The Balance Billing Subcommittee defined "surprise billing" as when a patient receives an unanticipated bill for the difference between an out-of-network provider or supplier's charges and the amount

covered by the patient's health insurance. The Subcommittee noted that in the case of air ambulance services, a surprise medical bill can arise in an emergency when the patient does not have the ability to select the air ambulance provider. The State and DOT Authorities Subcommittee stated that "surprise billing" means (a) with respect to an emergency air medical transport, either (i) a balance bill received by a consumer or (ii) a provider's bill received by a consumer for air medical transport that was denied by the consumer's health insurance; or (b) with respect to a non-emergency air medical transport, either a balance bill or a provider's bill received by a consumer after a pre-authorization for the air medical transport has been obtained.

Ms. Lovell, in her presentation, noted that the State and DOT Authorities Subcommittee recommended that the Committee adopt a definition of the term "network adequacy." Ms. Lovell explained that the Subcommittee defined "network adequacy" to refer to a health plan's availability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network air ambulance providers. Ms. Lovell noted that the NSA does not define "network adequacy."

Following these presentations, Ms. Workie moderated a discussion among the Committee members as to whether the definitions should be advanced as part of the final report and what agency(s) should be responsible for promulgating rules defining these terms.

- Two Committee members advocated in favor of adopting all of the "contextual definitions" contained in the Subcommittees' glossaries, in addition to the specific definitions the Subcommittees had asked the committee to adopt.

- A Committee member asked whether the Affordable Care Act defines "network adequacy" and the HHS representative said that it does not, but that the statute and regulations include network adequacy standards that would inform a definition.

- A representative of air ambulance providers noted that both insurance companies and providers had to be incentivized to reach in-network agreements and recommended that the Committee define "network adequacy" for that reason. A State insurance regulator argued against adopting a definition of "network adequacy."

All Committee members voted in favor of defining the terms "balance billing" and "surprise billing," with DOT and HHS abstaining from the vote. Nine Committee members (Abernethy, Connors, Battaglino, Judge, Lennan, Madigan, Montes, Myers, Pickup) voted in favor and two Committee members (Haben and Godfread) voted against defining the term "network adequacy," with DOT and HHS abstaining from the vote. At the conclusion of the discussion, the Committee made the following recommendations:

Recommendation #14: The Advisory Committee recommends that DOT and HHS define "surprise billing," "balance billing," and "network adequacy" when issuing rulemakings relating to air ambulance operations, using the definitions set forth in the reports of the Balance Billing Subcommittee and the State and DOT Authorities Subcommittee.

Best Practices for Contract and Network Negotiation – Presentations and Discussions
David Motzkin, PHI Air Medical

Mr. Motzkin provided a presentation on the Balance Billing Subcommittee's recommendation for a set of voluntary best practices for improved contract and network negotiation payors and air ambulance providers. Mr. Motzkin explained that Section 418 of the FAA Act directed the Committee to develop recommendations on "options, best practices, and identified standards to prevent instances of balance billing such as improving network and contract negotiation." The Subcommittee recommended that:

- Air ambulance providers, suppliers, and payors should engage in contract or network negotiations for the purpose of agreeing on a fair, reasonable, and market-based reimbursement rate;

- Air ambulance providers, suppliers, and payors should negotiate in a transparent manner by sharing their financial information on a confidential basis, to validate the financial baseline needed to establish a fair, reasonable, and market-based reimbursement rate; and

- Air ambulance providers and suppliers should present information to payors demonstrating sound business management and competitiveness with other market participants.

The DFO opened the issue to discussion.

- A Committee member representing health insurers noted that under the NSA, one of the factors for the DRE to consider is the extent to which the parties have entered into good faith network negotiations.

- A Committee member representing air ambulance operators suggested that the recommendation should include the phrase "good faith."

- The DFO asked how these recommended best practices should be transmitted to payors and providers. Certain Committee members suggested that various industry organizations (such as the American's Health Insurance Plans, or the Association of Air Medical Services) could relay the recommendation. Other members expressed the view that identifying organizations to transmit the message was not necessary in light of extensive industry interest in the Committee's work.

The Committee voted unanimously to adopt the Balance Billing Subcommittee's recommendation, with the addition of "good faith."

Recommendation #15: The Advisory Committee adopts the recommendations from Chapter 4 of the Balance Billing Subcommittee report relating to best practices for network and contract negotiation, with the inclusion of the phrase "good faith" in the first recommendation: Air ambulance providers, suppliers, and payors should engage in *good faith* contract or network

negotiations for the purpose of agreeing on a fair, reasonable, and market-based reimbursement rate.

Best Practices for Air Ambulance Subscription Services – Presentations and Discussions
Asbel Montes, Acadian Ambulance

Mr. Montes presented on the Disclosure Subcommittee's recommendations for disclosures on air ambulance subscription services. He noted that the Subcommittee recommended that relevant stakeholders develop best practices for disclosures on several subjects related to such programs, but he added that the NSA may make some of the subjects unnecessary.

Following the presentation, the DFO opened the discussion by asking the members whether an explanation of subscription services was still necessary if the NSA eliminates most balance billing.

- A member representing air ambulance companies responded that subscription programs will continue to exist despite the NSA. He added that the larger issue is that there is a marketplace for such services that is completely unregulated. The member noted that the best practices proposed by the Disclosure Subcommittee do not go far enough in regulating the issue because there is no legal oversight. He also said that due to the ADA, only DOT can oversee such programs. He also pointed to the problem of biased sales of memberships, where, for example, an air ambulance provider could sell subscriptions to fire departments so that those departments will call on the provider in emergencies. The DFO responded that subscription programs could be part of DOT's mandate to consider unfair or deceptive practices on this subject.

- A member of the Balance Billing Subcommittee, representing air ambulance companies, disagreed that subscription programs are unregulated. He commented that most states have governance over these programs.

- Another member, representing state insurance regulators, responded that his state attempted to regulate subscription programs but were preempted by the ADA. He added that he would be supportive of DOT defining such programs as insurance or otherwise excluding such programs from ADA preemption. Other members agreed that such programs need to be regulated. The DFO reiterated that DOT has the authority to prohibit unfair or deceptive practices in air transportation, but does not have the expertise or authority to dictate whether such programs qualify as insurance. In response to the Balance Billing Subcommittee member's assertion that states regulate these programs, the DFO invited the member to submit information on what states are doing in this area to the Committee's report.

Following the discussion, a majority of the Committee agreed to the following recommendation, with four members, including the DOT and HHS representatives, abstaining.

Recommendation #16: The Advisory Committee recommends that DOT clarify whether states are preempted from taking action on airline subscription programs. If states are preempted in this area, the Advisory Committee recommends that DOT conduct oversight over these programs.

After the vote, the Committee took a 10-minute break.

Medicare Reimbursement Study – Presentations and Discussions
Susan Connors, Brain Injury Association of America

Ms. Connors provided a presentation on the recommendation of the Balance Billing Subcommittee regarding a Medicare reimbursement study. She explained that Medicare set its air ambulance fee schedule in 2002, and that HHS has expressed the view that it currently lacks the statutory authority to adjust that schedule. She noted that Medicare's reimbursement rates are generally considered to be below the provider's cost, and that Medicare prohibits the provider from balance billing the patient. She also explained that under-reimbursement by Medicare is widely understood to drive increased prices elsewhere in the air ambulance payment system. As a result, the Balance Billing Subcommittee recommended "that legislation be enacted to require the U.S. Department of Health and Human Services to: (i) study Medicare rates for air ambulance services; and (ii) take steps to increase the reimbursement rates for air ambulance services, if warranted, upon conclusion of the study. The Subcommittee also recommends that the study should be based on actual cost data."

The DFO then opened the issue to discussion.

- A Committee member representing air ambulance companies asked about the definition of "actual cost data." The DFO responded that the Balance Billing Subcommittee's definition of cost is set forth in its report. Another Committee member representing air ambulance companies remarked that per-transport costs are inflated as a result of a greater number of helicopters in use. A Committee member representing patient advocacy groups suggested that cost should be interpreted broadly to include the NSA's definition, the Subcommittee's definition, and volume of transports. The DFO noted that the Balance Billing Subcommittee already broadly defined cost as "the whole of financial liabilities incurred by the provider or supplier, including, but not limited to" seven enumerated elements.

- The HHS representative stated that at present, HHS is empowered to conduct research on Medicare reimbursement rates using existing data, but that HHS lacks authority to collect new data or adjust those rates absent Congressional authorization.

The Committee voted to adopt the Subcommittee's recommendation, using a broad definition of "cost" (with DOT and HHS abstaining):

Recommendation #17: The Advisory Committee recommends that legislation be enacted to require HHS to: (i) study Medicare rates for air ambulance services; and (ii) if warranted, for HHS to take steps to increase the reimbursement rates for air ambulance services upon conclusion of the study. The Committee also recommends that the study should be based on actual cost data, with "cost" including (1) the definition of cost as set forth in the Balance Billing Subcommittee's recommendation; (2) cost elements set forth in Section 106 of the No Surprises Act; and (3) volume of transports.

DOT Hotline Funding – Presentations and Discussions
Elizabeth Battaglino, HealthyWomen

Ms. Battaglino made a presentation regarding a recommendation proposed by the State and DOT Authorities Subcommittee regarding DOT Hotline funding. She summarized the scope of the DOT Hotline as stated in 49 U.S.C. § 42302, which requires the Secretary of Transportation to "establish a consumer complaints toll-free hotline number for the use of passengers in air transportation and shall take actions to notify the public of— (1) that telephone number; and (2) the Internet Web site of the Aviation Consumer Protection Division of the Department of Transportation." She also discussed the amendment to this section provided by Section 419 of the FAA Act, which requires that air ambulance providers include the hotline number on "(1) any invoice, bill, or other communication provided to a passenger or customer of the provider; and (2) its Internet Web site, and any related mobile device application."

She noted that DOT has not set up a toll-free consumer complaint hotline because Congress has not appropriated funds for the hotline. Accordingly, the State and DOT Authorities Subcommittee recommended that Congress appropriate money to DOT to fund the hotline number referenced in section 419 of the FAA Act, and codified at 49 U.S.C. § 42302. The rationale for the recommendation is that the hotline number would be a way for consumers to directly complain to DOT, and for States to refer complaints to DOT.

Ms. Battaglino stated that the recommendation would benefit both air ambulance consumers and consumers of general air transportation services. The hotline would allow DOT to take complaints over the phone in real time. This requires human resources to staff and maintain the hotline. Ms. Battaglino concluded by noting that the No Surprises Act does not address the DOT hotline.

Following this presentation, Ms. Workie moderated a brief discussion among the Committee members as to whether the Committee should advance the Subcommittee's recommendation. At the conclusion of the discussion, the Committee agreed by consensus to advance the Subcommittee's recommendation, with DOT and HHS abstaining from the vote.

Recommendation #18: The Advisory Committee recommends adopting the recommendation of the State and DOT Authorities Subcommittee contained in Chapter 6 of the State and DOT Authorities Subcommittee Report relating to funding of the DOT hotline.

Wrapup / Summary of AAPB Committee Recommendations; Q&A for Public; Next Steps

The meeting concluded with the opportunity for final comments from the Committee and the public in attendance.

The DFO then displayed a written summary of all of the Committee's recommendations. As noted above, during this process, the Committee determined that it lacked consensus regarding

whether the DRE should consider payments to other air ambulance providers when determining an IDR award. In all other respects, the Committee confirmed its recommendations.

Before the Committee adjourned, Committee members urged the DFO to allow the Committee to vote on the issue of whether to recommend an amendment to the Airline Deregulation Act as a means of improving the regulation of air ambulance providers. The DFO explained that it was unclear whether this topic fell within the scope of the Committee's statutory authority and charter. She promised the Committee that DOT would re-examine question of whether recommending amendments to the ADA fell within the scope of the Committee's authority: if it did, then DOT would hold a separate supplemental plenary committee meeting dedicated to that topic.

Ms. Swafford thanked the Committee for its collegiality, hard work, and its extensive thoughtful recommendations. She noted that she would follow up with the Committee regarding production of its report.

The second meeting of the AAPB Advisory Committee was adjourned by Ms. Swafford around 5:07 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

Lisa Swafford
Chair
Air Ambulance and Patient Billing Advisory Committee

Appendix A - Attendees

Committee Members

Lisa Swafford, Chair, representing the Department of Transportation.

Dr. Michael Abernethy, University of Wisconsin School of Medicine and Public Health, representing physicians.

Elizabeth Battaglino, HealthyWomen, representing consumer advocacy groups.

Susan Connors, Brain Injury Association of America, representing patient advocacy groups.

Jon Godfread, State of North Dakota, representing state insurance regulators.

John Haben, UnitedHealth, representing health insurance providers.

Thomas Judge, LifeFlight of Maine, representing air ambulance operators (community/state/government owned).

Anne Lennan, Society of Professional Benefit Administrators, representing managers of employee benefit plans.

Kyle Madigan, Dartmouth Hitchcock Advanced Response Team, representing nurses.

Asbel Montes, Acadian Ambulance Service, representing air ambulance operators (fixed wing).

Christopher Myers, Air Methods, representing air ambulance operators (rotary wing).

Ray Pickup, WCF Insurance Group, representing the workers' compensation insurance industry.

Rogelyn McLean, Centers for Medicare & Medicaid Services, representing the Department of Health and Human Services.

Subcommittee Members, with affiliation and Subcommittee membership

William Bryant, Sierra Health Group (State and DOT Authorities)

Thomas Cook, Air Medical Group Holdings (State and DOT Authorities)

Bernard F. Diederich, Retired (State and DOT Authorities)

Dr. Kevin Hutton, Retired Air Medical Executive (Disclosure)

Edward R. Marasco, Quick Med Claims (Disclosure)

David Motzkin, PHI Air Medical (Balance Billing)

Dr. David Thomson, East Carolina University/Vidant EastCare (Disclosure)

DOT and Other Governmental Representatives

Blane Workie, Designated Federal Officer

Robert Gorman, Department of Transportation

Charlie Enloe, Department of Transportation

Ryan Patanaphan, Department of Transportation

Ami Lovell, Department of Transportation

Registered Attendees

LAST NAME	FIRST NAME	ORGANIZATION
Christianson	Mike	Sanford Air Transportation
Cohen	Jason	Boston MedFlight
Cools	Joshua	Memorial Hermann Life Flight
Curtis	Cameron	AAMS + MedEvac Foundation International
Dawson	Kirstin	CVS Health
Dhokai	Andy	Global Medical Response
Doughty	Brian A.	HealthNet Aeromedical Services, Inc.
Eastlee	Christopher	Association of Air Medical Services (AAMS)
Frazier	Jeff	Sentinel Air Medical Alliance
Godden	Kim	Superior Air - Ground Ambulance Service, Inc.
Grabowski	Robert	Metro Health Medical Center
Hall	Christopher	PHI Health, LLC.
Hall	Hunter	Picard Group
Hawke	Lisa	Holland & Knight
Hughes	Maura	Boston MedFlight
Kaiser	Alyssa	HHS
Katz	Bennett	Washington Analysis
Khromer	John	NHTSA
Koontz	Mandi	Highmark
Kulczak	Stacey	ProMedica
Laible	Mark S	Highmark Western and Northeastern New York
Larkin	Jason	Digitech
Lawyer	Michael	
Mack	Dennis	Atrium Health
Mayle	Carolyn	Air Methods Corporation
Mendilian	Norma	Boston MedFlight
Mills	Lisa	Indiana University Health
Morrow	Kenneth	Metro Aviation, Inc.
Mulhern	Michael	
Munk	Jeffrey W.	Munk Policy & Law
Nolan	Julie E.	Akin Gump LLC
O'Brien	Madeline	Georgetown University Health Policy Institute

Paul	Jincy	Tufts Health Plan
Peek	Roxanne	Emprize
Pepping	Cherie Leigh	Superior Air - Ground Ambulance Service, Inc.
Pharr	Alison	Acadian Ambulance
Pothen	Michele	Cornell University
Ramirez	Ray	California Fire Chiefs Association
Reynolds	Kevin	Careflite
Ross	Becky	Metro Aviation
Schultz	Jacob R.	Gundersenair
Schumann	Beth	USDOL
Sheehan III	Leo J.	America's Health Insurance Plans
Sorrentino	Justine	USDOL
Stamey	Heather	MedSTAR Transport/MedStar Health
Stanberry	Todd	Metro Aviation, Inc.
Stearns	Jeffrey	Mayo Clinic
Steindecker	Beth	Washington Analysis
Touschner	Joe	Nat'l Assoc of Insurance Commissioners
Turner	Chrisandrea L.	Stites & Harbison PLLC
Weber	Holly	Metro Aviation, Inc.
Whipple	Richard	Mission Hospital
Wijetunge	Gamunu	NHTSA

Appendix B – Recommendations

AAPB Advisory Committee – RECOMMENDATIONS

DAY 1

Pre-Care Disclosures

1. The Advisory Committee recommends that DOT require air ambulance providers to display on their websites information on rates and a list of all payors with whom they are in network by state and by plan. If the provider is not in-network with any payor, the air ambulance provider should be required to state this fact. The Advisory Committee notes that the rate information that air ambulance providers are required to disclose should provide context to improve comprehension and usability such as the sample website disclosure tables for air ambulance providers prepared by the Disclosure Subcommittee. The Advisory Committee also recommends that DOT coordinate with HHS in issuing a rulemaking to avoid undue burden and confusion.

2. The Advisory Committee recommends that Congress provide authority to HHS to expand the Statement of Benefits and Coverage (SBC). The Advisory Committee recommends that HHS issue a rule requiring the SBC disclosures that are recommended by the Disclosure Subcommittee once it has authority.

3. The Advisory Committee recommends that states (through NCOIL [National Council of Insurance Legislators] and/or NAIC [National Association of Insurance Commissioners]) require insurers to disclose all air ambulance providers that are in-network by state and by plan, or to affirmatively state that they do not have any in-network agreements with air ambulance providers if that is the case.

4. The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop requirements for insurers to disclose the maximum allowable rate for air ambulance services by plan, as well as any plan limitation.

Point-of-Care Disclosures and Preauthorization

5. The Advisory Committee agrees that point-of-care disclosures should be provided in non-emergency situations. The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop requirements for point-of-care disclosures and preauthorization in non-emergency situations.

DAY 2

Claims-Related Disclosures

6. The Advisory Committee adopts the Disclosure Subcommittee's recommendations for payors to make claims-related disclosures to patients and air ambulance providers, as set forth in Recommendation 2.4.1 of the Disclosure Subcommittee Report , with slight modification: the payor disclosures recommended by the Disclosure Subcommittee to air ambulance providers and patients should be the same. The Disclosure Subcommittee had recommended that content of the disclosure differ depending on whether the disclosure is to the patient or provider.

7. The Advisory Committee adopts the Disclosure Subcommittee's recommendations for DOT (or HHS) to issue rulemaking requiring air ambulance providers to make claims-related disclosures to patients as set forth in Recommendation 2.4.2 of the Disclosure Subcommittee Report.

8. The Advisory Committee recommends that states (through NCOIL and/or NAIC) develop recommendations on how to add clarity to the Explanation of Benefits (EOB) process. The Advisory Committee further recommends that states submit these recommendations to HHS, and that HHS consider these recommendations for potential rulemaking.

9. The Advisory Committee recommends that HHS initiate rulemaking or issue guidance to make clear that "Emergency Services" under section 1302(b)(1)(B) of the Affordable Care Act specifically includes emergency air ambulance services.

Distinction Between Air Transportation and Non-Air Transportation Charges

10. The Advisory Committee agrees with the Disclosure Subcommittee's decision not to recommend that air ambulance provider distinguish between air transport and non-air transport charges. The Advisory Committee recommends that air ambulance providers not be required to distinguish air transport and non-air transport charges.

Independent Dispute Resolution (IDR)

11. The Advisory Committee recommends that HHS should issue a regulation addressing medical necessity within the IDR process. Specifically, within the IDR process, there should be a rebuttable presumption that the air ambulance service was medically necessary, but an insurer can overcome that presumption by first presenting evidence that either the third-party first responder/medical professional who requested the transport was not a neutral third party, or that the air ambulance provider did not act in good faith.

12. The Advisory Committee recommends that HHS define "initial payment" in its IDR rulemaking (relating to the provision that after receiving a bill, the payor must provide an

initial payment or a notice of denial of payment). The Advisory Committee did not reach consensus on its own proposed definition of initial payment.

Data Collection

13. The Advisory Committee adopts the recommendations contained in Chapter 5 of the Balance Billing Subcommittee Report, relating to data collection.

Definitions

14. The Advisory Committee recommends that DOT and HHS define "surprise billing," "balance billing," and "network adequacy" when issuing rulemakings relating to air ambulance operations, using the definitions set forth in the reports of the Balance Billing Subcommittee and the State and DOT Authorities Subcommittee.

Best Practices for Network and Contract Negotiation

15. The Advisory Committee adopts the recommendations from Chapter 4 of the Balance Billing Subcommittee report relating to best practices for network and contract negotiation, with the inclusion of the phrase "good faith" in the first recommendation: Air ambulance providers, suppliers, and payors should engage in *good faith* contract or network negotiations for the purpose of agreeing on a fair, reasonable, and market-based reimbursement rate.

Air Ambulance Subscription Programs

16. The Advisory Committee recommends that DOT clarify whether states are preempted from taking action on airline subscription programs. If states are preempted in this area, the Advisory Committee recommends that DOT conduct oversight over these programs.

Medicare Reimbursement Study

17. The Advisory Committee recommends that legislation be enacted to require HHS to: (i) study Medicare rates for air ambulance services; and (ii) if warranted, for HHS to take steps to increase the reimbursement rates for air ambulance services upon conclusion of the study. The Committee also recommends that the study should be based on actual cost data, with "cost" including (1) the definition of cost as set forth in the Balance Billing Subcommittee's recommendation; (2) cost elements set forth in Section 106 of the No Surprises Act; and (3) volume of transports.

DOT Hotline

18. The Advisory Committee recommends adopting the recommendation of the State and DOT Authorities Subcommittee contained in Chapter 6 of the State and DOT Authorities Subcommittee Report relating to funding of the DOT hotline.