

A Report of the Air Ambulance and Patient Billing Advisory Committee

March 2022

Lisa Swafford, Deputy Assistant General Counsel for Operations, U.S. Department of Transportation (DOT), Chair.

Dr. Michael Abernethy, Clinical Professor of Emergency Medicine, University of Wisconsin School of Medicine and Public Health, as representative of physicians.

Elizabeth Battaglini, Chief Executive Officer, HealthyWomen, as representative of consumer advocacy groups.

Susan Connors, President and Chief Executive Officer, Brain Injury Association of America, as representative of patient advocacy groups.

Jon Godfread, Insurance Commissioner, State of North Dakota, as representative of state insurance regulators.

John Haben, Vice President for National Contracting, UnitedHealth Networks, as representative of health insurance providers (now retired).

Thomas Judge, Executive Director, LifeFlight of Maine, as representative of air ambulance providers.

Anne Lennan, President, Society of Professional Benefit Administrators, as representative of managers of employee benefit plans.

Kyle Madigan, Director, Dartmouth Hitchcock Advanced Response Team, as representative of nurses.

Rogelyn McLean, Senior Policy Advisor, Centers for Medicare & Medicaid Services, as the member appointed by the Secretary of Health and Human Services.

Asbel Montes, Vice President of Government Relations and Revenue Cycle, Acadian Ambulance, as representative of air ambulance providers.

Christopher Myers, Executive Vice President of Reimbursement, Air Methods Corporation, as representative of air ambulance operators.

Ray Pickup, President and CEO, WCF Mutual Insurance Company, as representative of the workers' compensation insurance industry.

Designated Federal Officer: Blane Workie, DOT Assistant General Counsel for Aviation Consumer Protection.

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Executive Summary

Section 418 of the FAA Reauthorization Act of 2018 directed the Department to establish an advisory committee to review options to improve the disclosure of charges and fees for air medical services, better inform consumers of insurance options for such services, and protect consumers from balance billing. In response to this directive, the Department established the Air Ambulance and Patient Billing Advisory Committee (Advisory Committee) in September 2019. The Department created three subcommittees to assist the Advisory Committee with its task. The Advisory Committee met three times throughout 2020 and 2021. Through these meetings, and with the invaluable assistance of its subcommittees, the Advisory Committee developed a total of 22 recommendations on a wide variety of topics relating to air ambulance and patient billing issues. These recommendations are directed to Congress, Federal agencies, States, air ambulance providers, and payors.

The Advisory Committee recognizes that the No Surprises Act, enacted in December 2020, has had a significant impact on the scope of the Advisory Committee's recommendations. For example, the No Surprises Act generally bans balance billing by air ambulance providers. The No Surprises Act also requires disclosures by air ambulance providers and employers; contains provisions for independent dispute resolution and data collection; and establishes a process for resolving billing disputes between air ambulance providers and payors. The Advisory Committee has carefully studied the requirements of the No Surprises Act and has tailored its recommendations in recognition of its requirements. While the No Surprises Act is a critical first step to resolving many difficult air ambulance and patient billing issues, the Advisory Committee is of the view that its recommendations will serve as a valuable addition and supplement to the work that Congress has begun.

The Advisory Committee's recommendations may be summarized as follows (with the full text of the recommendations appearing in Chapter 12):

Definitions (see Chapter 2). The Advisory Committee recommends that DOT and the Department of Health and Human Services (HHS) should define "surprise billing," "balance billing," and "network adequacy" when issuing rulemakings relating to air ambulance operations, using the definitions set forth in this Report.

Disclosures (see Chapters 3 and 4). The Advisory Committee recommends that:

- DOT should require air ambulance providers to provide certain disclosures on its web site.
- Congress should provide authority to HHS to expand the Statement of Benefits and Coverage (SBC).
- States should require insurers to disclose all air ambulance providers that are in-network (if applicable).
- States should develop requirements for insurers to disclose the maximum allowable rate for air ambulance services by plan, as well as any plan limitation.
- States should develop requirements for point-of-care disclosures and preauthorization in non-emergency situations.

- Payors should make claims-related disclosures to patients and air ambulance providers as set forth in this Report.
- Air ambulance providers should make claims-related disclosures to patients as set forth in this Report.
- States should develop recommendations on how to add clarity to the Explanation of Benefits (EOB) process.
- HHS should initiate rulemaking or issue guidance to make clear that the term “Emergency Services” under the Affordable Care Act specifically includes emergency air ambulance services.
- Air ambulance providers should not be required to distinguish air transport and non-air transport charges.

Federal and State Independent Dispute Resolution (IDR) (see Chapter 5). The Advisory Committee recommends that:

- HHS should issue a regulation addressing medical necessity within the IDR process.
- HHS should 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).

Data Collection (see Chapter 6). The Advisory Committee recommends that DOT should collect data from air ambulance providers and suppliers, as set forth in this Report.

Best Practices for Contract and Network Negotiation (see Chapter 7). The Advisory Committee recommends that 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 (see Chapter 8). The Advisory Committee recommends that DOT should 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 (see Chapter 9). The Advisory Committee recommends that legislation should 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.

DOT Hotline Funding (see Chapter 10). The Advisory Committee recommends that Congress should 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.

Airline Deregulation Act (ADA) and Preemption (see Chapter 11). The Advisory Committee makes the following recommendations (presented as alternatives from which Congress may choose):

- The ADA should be amended so it does not preempt State laws to the extent necessary to align the ADA with the No Surprises Act (NSA) (relating to network participation,

reimbursement and balance billing, and transparency for an air carrier that provides air ambulance service).

- The ADA should be amended so it does not preempt State laws relating to State regulation of workers' compensation insurance programs with respect to air ambulance services including monopolistic State funds in Ohio, North Dakota, Washington, and Wyoming.
- The ADA should be amended to exclude air medical transportation, to clearly identify that States and local units of government have the ability to regulate all aspects related to the medical services of ambulance providers, and to clearly identify that the DOT retains the ability to regulate all aspects related to the operational safety of vehicles, air and ground.
- The ADA should be amended so it does not preempt State laws relating to licensing of medical services of air ambulance providers, even if they have incidental effect on prices, routes, and services.

Chapter 1 – Overview of the AAPB Advisory Committee

1.1 Introduction

Air ambulances provide critical and sometimes life-saving transportation between the site of an accident and a health care facility, or between two facilities. Air ambulance providers are considered “air carriers” under the jurisdiction of the U.S. Department of Transportation (Department or DOT).¹ While the Airline Deregulation Act (ADA) generally prohibits regulation of “prices, routes, and services” of air carriers,² the Department does have the authority to prohibit unfair or deceptive practices of air ambulance providers.³

In July 2017, the U.S. Government Accountability Office (GAO) issued a report on the practice of balance billing by certain air ambulance providers.⁴ According to GAO, balance billing takes place when an air ambulance provider bills a privately-insured patient for the difference between the price charged to the insurer, and the amount paid by insurance. The financial impact to patients from balance billing can be severe. Balance billing does not take place with in-network air ambulance providers; it is also prohibited by Medicare, Medicaid, and state workers’ compensation programs.

On October 5, 2018, the President signed the FAA Reauthorization Act of 2018 (FAA Act), Pub. L. No. 115-254, 132 Stat. 3186 (2018). Section 418 of the FAA Act required DOT, in consultation with the Department of Health and Human Services (HHS), to establish an advisory committee to review options to improve the disclosure of charges and fees for air medical services, better inform consumers of insurance options for such services, and protect consumers from balance billing.

The FAA Act required that the advisory committee consist of various stakeholders, including but not limited to DOT, HHS, air ambulance operators, health insurers, patient advocacy groups, consumer advocacy groups, State insurance regulators, and physicians. It directed the advisory committee to develop recommendations on specific topics identified in the Act. Pursuant to the FAA Act, the committee must submit a report containing its recommendations to DOT, HHS, and the appropriate committees of Congress.

¹ An air carrier means a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation. See 49 U.S.C. § 40102.

² 49 U.S.C. § 41713.

³ See 49 U.S.C. § 41712 and <https://www.transportation.gov/individuals/aviation-consumer-protection/air-ambulance-service>. The Department processes complaints against air ambulance providers and publishes information about those complaints on a monthly basis.

⁴ See GAO, *Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight*, available at <https://www.gao.gov/assets/gao-17-637.pdf>. In 2019, GAO published a second report, titled *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk*. There, GAO reported that 69 percent of about 20,700 transports in the data set were out-of-network in 2017, with many balance bills being over \$10,000. See <https://www.gao.gov/products/gao-19-292>.

The FAA Act requires DOT, upon receipt of the report, to consider the recommendations of the advisory committee and issue regulations or other guidance as deemed necessary: (1) to require air ambulance providers to regularly report data to DOT; (2) to increase transparency related to DOT actions related to consumer complaints; and (3) to provide other consumer protections for customers of air ambulance providers.

The text of section 418 of the FAA Act is attached as Appendix A.

1.2 Background

In September 2019, DOT announced the formation of the Air Ambulance and Patient Billing (AAPB) Advisory Committee and the appointment of 13 members. Appointed members consisted of representatives from state insurance regulators; health insurance regulators; patient advocacy groups; consumer advocacy groups; physicians specializing in emergency, trauma, cardiac, or stroke; various segments of the air ambulance industry; nurses, managers of employee benefits plans, workers' compensation insurance industry, DOT and HHS. The DOT representative was selected as Chair of the Committee. The Department's Assistant General Counsel for Aviation Consumer Protection served as the Designated Federal Officer (DFO).

The Advisory Committee's charter was established in accordance with the provisions of the Federal Advisory Committee Act (FACA).⁵ The Advisory Committee charter provides that "a quorum must exist for any official action, including voting on a recommendation, to occur. A quorum exists whenever 75% of the appointed members are present. In any situation involving voting, the majority vote of members present will prevail, but the views of the minority will be reported as well. If there is no majority vote, the result 'No Consensus' must be reported, followed by the views of each voting faction."

The DOT and HHS representatives abstained from voting on any recommendation impacting Federal law.

The Advisory Committee charter is attached as Appendix B. The list of Advisory Committee members is attached as Appendix C. Additional information on the Advisory Committee can be found at <https://www.transportation.gov/airconsumer/AAPB> and on the Advisory Committee's docket at <https://www.regulations.gov/docket/DOT-OST-2018-0206>.

1.3 Summary of First Meeting

The first meeting of the Advisory Committee took place on January 15-16, 2020. The purpose of the meeting was to gather information about the air ambulance industry; air ambulance costs and billing; insurance and air ambulance payment systems; and disclosure and separation of charges, cost shifting, and balance billing.

The Advisory Committee heard presentations by the Department, HHS' Centers for Medicare and Medicaid Services (CMS), air ambulance operators, health care providers, private health

⁵ 5 U.S.C. App. 2, as amended.

insurers, ERISA⁶ and self-funded plans, the workers' compensation industry, academics, and other stakeholders on these issues.

Minutes of the first meeting are attached as Appendix E.

1.4 Creation of Subcommittees and Subcommittee Reports

In February 2020, following the first meeting, the Department created three subcommittees: (1) the Subcommittee on Disclosure and Distinction of Charges and Coverage for Air Ambulance Services (Disclosure Subcommittee); (2) the Subcommittee on Prevention of Balance Billing (Balance Billing Subcommittee); and (3) the Subcommittee on State and DOT Consumer Protection Authorities (State and DOT Authorities Subcommittee). Each subcommittee was created to address a specific set of issues identified in section 418 of the FAA Act.⁷ The subcommittees' task was to develop draft recommendations for the benefit of the Advisory Committee as a whole.

Each subcommittee comprised members of the plenary Advisory Committee, as well as additional stakeholders and subject matter experts. See Appendix D for the composition of each subcommittee.

Each subcommittee held monthly virtual meetings throughout 2020. In January 2021, each subcommittee filed a report with recommendations. The subcommittees' reports can be found at <https://www.regulations.gov/document/DOT-OST-2018-0206-0026>. The subcommittees' draft recommendations are discussed in Chapters 2 through 10 of this Report.

⁶ Employee Retirement Income Security Act of 1974, 29 U.S.C. Ch. 18, § 1001 et seq.

⁷ The Disclosure Subcommittee addressed: (1) disclosure of charges and fees for air ambulance services and insurance coverage (including GAO recommendations to consider consumer disclosure requirements for established prices charged, business model, entity that establishes prices, and extent of contracting with insurance); (2) improving explanations of insurance coverage and subscription programs to consumers; and (3) costs, benefits, practicability, and impact on all stakeholders of distinguishing clearly between charges for air transportation services and charges for non-air transportation services in bills and invoices, including the costs, benefits, and practicability of developing cost-allocation methodologies for air/non-air transportation charges and formats for bills to distinguish between air/non-air transportation charges.

The Balance Billing Subcommittee addressed: (1) options, best practices and identified standards to prevent instances of balance billing such as improving network and contract negotiation; (2) options, best practices and identified standards to prevent instances of balance billing such as improving dispute resolution between health insurance and air medical service providers (3) recommendations made by the Comptroller General study, GAO-17-637, to the extent they relate to balance billing; (4) definitions of terms related to balance billing that are not defined in statute or regulations; and (5) other matters as may be deemed necessary or appropriate.

The State Authorities Subcommittee addressed: (1) definitions of applicable terms that are not defined in statutes or regulations; (2) consumer protection and enforcement authorities of DOT and State legislatures, State insurance regulators, State attorneys general, and other State officials; (3) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate to protect consumers, consistent with current legal authorities regarding consumer protection; and (4) other matters as determined necessary or appropriate.

1.5 No Surprises Act

On December 27, 2020, the No Surprises Act (NSA) was enacted into law as part of the Consolidated Appropriations Act - 2021 (H.R. 133, P.L. 116-260). The NSA amends the Public Health Service Act (PHSA), with parallel amendments to ERISA and the Internal Revenue Code. The NSA contains many provisions that are relevant to the issues addressed by the Advisory Committee.

Most importantly, the NSA directly bans balance billing by out-of-network air ambulance providers, effective for plan years beginning January 1, 2022.⁸ The NSA also provides that if a patient receives air ambulance services from an out-of-network provider, and the patient's plan or coverage would have covered such services if provided by an in-network provider, then the patient's cost-sharing (copayment, deductible, and coinsurance) responsibility will be the same as if the provider were in-network.⁹

The NSA sets forth disclosure and transparency requirements for air ambulance providers and payors (see Chapter 2).

The NSA contains detailed procedures by which HHS, in consultation with DOT, must collect data from air ambulance providers and payors, and produce a comprehensive report about air ambulance services and payment (see Chapter 6).

Finally, the NSA creates an independent dispute resolution (IDR) procedure for resolving disputes between out-of-network air ambulance providers and payors (see Chapter 7).

HHS is actively developing regulations to implement the NSA.¹⁰ Specifically, on July 1, 2021, HHS published an Interim Final Rule titled "Requirements Related to Surprise Billing; Part I." This rule "restrict[s] surprise billing for patients in job-based and individual health plans who get emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers."¹¹ On September 10, 2021, HHS and other agencies issued a proposed rule titled "Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement."¹² On September 30, 2021, HHS published a second Interim Final Rule titled "Requirements Related to Surprise Billing; Part II." Among other things, this rule "establish[es] an independent dispute resolution process to determine out-of-network payment amounts between providers (including air ambulance providers) or facilities and health plans."¹³ On November 17, 2021, HHS published a third

⁸ NSA § 105(b); PHSA 2799B-5.

⁹ NSA § 105(a)(1); PHSA 2799A-2(a)(1-2).

¹⁰ <https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets>.

¹¹ *Id.*; see [Federal Register :: Requirements Related to Surprise Billing; Part I](#).

¹² *Id.*; see [Air Ambulance NPRM – Fact Sheet | CMS](#).

¹³ *Id.*; see [Federal Register :: Requirements Related to Surprise Billing; Part II](#).

Interim Final Rule setting reporting requirements related to prescription drug and health care spending.¹⁴

1.6 Summary of Second Meeting

The second meeting of the Advisory Committee took place on May 27-28, 2021, via Zoom Webinar. HHS-CMS presented on the NSA and its impact on air ambulance costs, billing, and insurance payment systems. Representatives of the three subcommittees also presented regarding their proposed recommendations, including the extent to which the NSA impacted those recommendations.

Following a discussion of the issues, the Advisory Committee adopted 18 recommendations relating to disclosures, the distinction between air transportation charges and non-air charges, IDR, data collection, definitions, best practices for network and contract negotiation, air ambulance subscription programs, a Medicare reimbursement study, and the funding of a DOT hotline. These recommendations are discussed in Chapters 2 through 10 of this Report. Minutes of the second meeting are attached as Appendix E.

1.7 Summary of Third Meeting

The third meeting of the Advisory Committee took place on August 11, 2021, via Zoom Webinar. The scope of the meeting was limited to whether (and if so, how) the Advisory Committee should recommend amendments to the ADA as a means of improving regulation of the air ambulance industry.

The Department presented on the express preemption provision of the ADA and the way that courts have applied that provision in the air ambulance context. Representatives of air ambulance operators, state insurance regulators, the workers' compensation industry, managers of employee benefit plans, and the National Association of State EMS Officials (NASEMSO) also presented at this meeting.

Following a discussion of the issues, the Advisory Committee voted to adopt four recommendations regarding ADA preemption in the air ambulance context. These recommendations are discussed in Chapter 11.

Minutes of the third meeting are attached as Appendix E. A list of all of the Advisory Committee's recommendations appears in Chapter 12.

¹⁴ *Id.*; see [Federal Register :: Prescription Drug and Health Care Spending](#).

Chapter 2 – Definitions

2.1 Background

Section 418(d)(5) of the FAA Act directs the Advisory Committee to make recommendations for “definitions of all applicable terms that are not defined in statute or regulations.” The Balance Billing Subcommittee and the State and DOT Authorities Subcommittee identified and defined several key terms relating to air ambulance billing and payment. The terms and definitions appear in the appendices of both subcommittees’ reports.

Both the Balance Billing Subcommittee and the State and DOT Authorities Subcommittee relied on knowledge of the industry, other statutory and regulatory definitions, and definitions provided by stakeholders and industry groups, to inform their discussions and the creation of the definitions. Most of the definitions in the appendices of both subcommittees’ reports are provided for context only. Both the Balance Billing Subcommittee and State and DOT Authorities Subcommittee recommended that the Advisory Committee define two terms (“balance bill,” and “surprise bill”) to fulfill the mandate in section 418(d)(5) of the FAA Act. The subcommittees chose these terms because they are highly germane to the topic of balance billing and are not already defined by statute or regulation. In addition, the State and DOT Authorities Subcommittee recommended defining “network adequacy” as part of its recommendation to the Advisory Committee.

2.2 Subcommittee Recommendations

The Balance Billing Subcommittee recommended that the term “balance bill” be defined 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 subcommittee’s definition is based on the definition of balance billing available at: <https://www.healthcare.gov/glossary/balance-billing/>. Balance billing may occur after receiving emergent or nonemergent care. However, balance billing does not apply to government health insurance programs, which prohibit balance billing as a condition of provider participation, or workers’ compensation insurance, which also prohibits balance billing to injured workers. It also does not apply to in-network contracts, where the contracted rate for covered services between the provider or supplier and health insurer is the mutually agreed upon amount paid by the insurer on behalf of the insured consumer.

The Balance Billing Subcommittee recommended that the term “surprise bill” be defined as an unanticipated bill received by the patient for the difference between an out-of-network provider or supplier’s charges and the amount covered by the patient’s health insurance. 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 recommended that the Advisory Committee adopt definitions for “balance bill” and “surprise bill,” as well as “network adequacy,” for the same

reason as the Balance Billing Subcommittee -- that is that these terms that are not currently defined in statute or regulation.

The State and DOT Authorities Subcommittee proposed definitions for these terms provided below for the Advisory Committee's consideration:

“Balance bill” means 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.

“Surprise bill” 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.

“Network adequacy” refers to a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network air ambulance providers.

2.3 Advisory Committee Discussion and Recommendations

At the second Advisory Committee meeting on May 28, 2021, Mr. Pickup presented the definitions for “balance bill” and “surprise bill” on behalf of both the Balance Billing Subcommittee and State and DOT Authorities Subcommittee. DOT Attorney Ami Lovell presented the definition for “network adequacy” proposed by the State and DOT Authorities Subcommittee. Mr. Pickup and Ms. Lovell both noted that the NSA does not expressly define these terms.

All Advisory Committee members voted in favor of defining the terms “balance bill” and “surprise bill,” with DOT and HHS abstaining from the vote. Nine Advisory Committee members (Abernethy, Connors, Battaglino, Judge, Lennan, Madigan, Montes, Myers, Pickup) voted in favor and two Advisory 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 Advisory Committee made the following recommendation:

Recommendation: 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. [For greater detail, see Section 2.2 above.]

Chapter 3 – Disclosures

3.1 Background

Section 418(d) of the FAA Act tasks the Advisory Committee with developing recommendations related to the disclosure of charges and fees for air ambulance services and insurance coverage. The Advisory Committee was also required to address the disclosure recommendations made by the Comptroller General study, GAO-17-637, which recommended that DOT consider the disclosure of the established prices charged by air ambulance providers, the business model and the entity that establishes prices, and the extent of contracting with insurance.

3.2 Subcommittee Recommendations

The above subjects were studied by both the Disclosure Subcommittee and the State and DOT Authorities Subcommittee. Both subcommittees developed recommendations for pre-care disclosures (i.e. those disclosures that should remain present on provider or payor websites or should otherwise be available to consumers prior to purchasing an insurance plan or service), while the Disclosure Subcommittee also developed recommendations for disclosures at a patient’s point-of-care, as well as following the receipt of care during the billing process.

The Disclosure Subcommittee discussed the possibility of information disclosures at different stages of a consumer’s process in obtaining insurance coverage and medical care. The Disclosure Subcommittee agreed upon recommendations for “pre-purchase disclosures” (disclosures to be made prior to a consumer’s selection and purchase of an insurance plan), “point-of-care disclosures” (disclosures to be made just before a patient is to be transported), “claims-related disclosures” (disclosures to be made after care is received), and disclosures that were recommended by GAO. The State and DOT Authorities Subcommittee made recommendations for States to develop programs to facilitate the disclosure of information by insurers and to incentivize the voluntary disclosure of information by air ambulance providers, and it also recommended that DOT require air ambulance providers to disclose similar information to consumers.

For pre-purchase disclosures, the Disclosure Subcommittee proposed disclosures by payors (defined as private health insurance companies or self-funded group health plans) to consumers in the form of modifications to the Statement of Benefits and Coverage (SBC), a form that is required by existing law. The subcommittee recommended that the U.S. Departments of Health and Human Services, Labor, and Treasury be given authority to initiate rulemaking to require these changes to the SBC. The specific recommendations impacting the content of SBCs were as follows:

- A new row should be added to the SBC table of important questions. In the “Important Questions” column of this new row, the text “Are air ambulance services covered?” should be displayed. In the column “Answers” on that same row, the payor should disclose whether the plan covers air ambulance services. If the plan covers air ambulance services, the payor should state “Yes” and list the air ambulance providers that are in-network or provide a

means for the patient/consumer to obtain such information (e.g., a web address or a toll-free phone number). If the plan's network does not include air ambulance providers, the payor should expressly state that no air ambulance providers are in-network. In the "Why this Matters" column on that same row, the payor should provide notice of the percentage of the maximum allowable amount for covered services that the plan will pay if the patient/consumer uses an air ambulance provider that is in-network. In the same column, the payor should provide notice to the consumer that if an out-of-network air ambulance provider is used, the plan will only pay what is considered the maximum allowable amount for the service and that the patient/consumer may be responsible for paying any amount owed that exceeds the maximum allowable amount. The payor should also provide a web link and phone number that the patient/consumer can use to obtain more information about the maximum allowable amount.

- A new row should be added to the SBC table of important questions. In the "Important Questions" column of this new row, the text "What is the average air ambulance bill?" should be displayed. In the column "Answers" on that same row, the payor should disclose the dollar amount of the average air ambulance bill charged by participating (in-network) providers and charged by non-participating providers based on the consumer's state or region. In the column "Why this Matters," the payor should provide notice that the average billed amount for the plan's in-network providers is not representative of what the consumer will pay, and that the most the consumer would pay is subject to the consumer's deductible and/or out-of-pocket limit for in-network providers. The payor should also provide notice that the average billed amount for non-participating providers includes only the average balance bill that is not included in the consumer's annual deductible or out-of-pocket limit.
- In the SBC's table of common medical events, in the row labeled "If you need immediate medical attention," under the column "Services You May Need," the text "Emergency medical transportation" should be revised to state "Emergency air and ground medical transportation." In the same row, under the column "Limitations and Exceptions," text should be added stating that emergency services, including emergency ground and air ambulance services, are an essential health benefit.
- In the SBC's table of common medical events, in the row labeled "If you have a hospital stay," under the column "Service You May Need," a new sub-row should be added with the text "Air Ambulance." In this sub-row, the payor should disclose in the appropriate columns information on costs that are the patient's responsibility for using a participating provider compared to a non-participating provider, and in the "Limitations and Exceptions" column, the payor should disclose that preauthorization of services may be required.

The State and DOT Authorities Subcommittee recommended that states should establish programs to facilitate insurer disclosure on a regular schedule of the following information:

- Disclosure of air ambulance network composition by insurers (who they have in-network relationships with);
- Disclosure of the maximum allowable amount for air ambulance services by insurers (in the form of a formula, actual price, and historical data); and

- Disclosure by insurers of information regarding the average amount of balance billing by air ambulance providers.

The State and DOT Authorities Subcommittee also recommended that States should establish programs to encourage voluntary disclosure by air ambulance providers of insurer network composition and in-network and out-of-network base rate, mileage rate, and any other amounts charged by air ambulance providers (“rates”).

On point-of-care disclosures, the Disclosure Subcommittee recommended that entities requesting transport for a patient (usually hospitals and other healthcare providers) disclose information to patients only in non-emergency situations, such as transports for the convenience of a patient or doctor, just prior to the patient receiving the transport. The subcommittee recommended that the patient be provided information on the service or procedure that may not be covered, the reason why the service or procedure may not be covered, and the estimated charges. The subcommittee used as a model an existing notice, the Advanced Beneficiary Notice of Noncoverage (ABN), which is a notice form used for Medicare patients. The subcommittee also recommended that the disclosures include the following information:

- When a non-emergency air ambulance transport is medically necessary and the patient can seek preauthorization for the transport’s coverage, the patient should receive information on the price of the air ambulance transportation.
- When an air ambulance transport is not medically necessary, but requested based on convenience (“Convenience Transfer”), the patient should receive information on the price of the convenience transfer and be notified in writing that he/she may be responsible for the full cost of the transport if it is not medically necessary.
- Contact information for the entity providing the form should be included. The form should also recommend the patient contact their payor.

The State and DOT Authorities Subcommittee also addressed preauthorization, recommending that States adopt preauthorization requirements for non-emergency air ambulance transports. The subcommittee specified that these requirements align the patient, the payor, and the air ambulance provider on the billed charge for the transport. The subcommittee recommended that the onus should be on the hospital or doctor to initiate the preauthorization process, arrange for the transport, and ensure that the patient is receiving pre-negotiated air ambulance transportation for non-emergency transports. The recommendation also called for encouraging advance express agreement between the insurer and air ambulance provider on the price, coverage, and medical necessity of the mode of transport, with disclosures from the insurer to the patient on the agreed price of the transport, the amount the insurer will cover and pay, and the amount of the patient’s responsibility broken down by deductible, co-pay and co-insurance amounts, and any balance bill.

For claims-related disclosures, the Disclosure Subcommittee recommended that both air ambulance providers and payors provide disclosures concerning payment, coverage, denial, appeal, and preauthorization of air ambulance bills. The subcommittee recommended that payors

provide disclosures when they deny a patient's claim for lack of medical necessity, when they cover only a partial amount of the charges, when they submit payment to the patient directly (i.e. send a check to the patient directly for the patient to use toward paying the provider), and when they deny a claim for lack of preauthorization. The specific disclosures that the subcommittee recommended payors provide patients are the following:

- Basic statements about why the payor denied the claim for lack of medical necessity or lack of preauthorization, or why the payor did not pay the claim in full;
- The amount the payor covered as an essential health benefit (EHB);
- The amount of the bill for which the patient is responsible for paying and can expect to receive a bill;
- A statement that the patient has the right to assistance from an authorized representative, which could include a family member, a lawyer, an organization, a health care or air ambulance provider, or any other person or entity the patient authorizes;
- A statement that the patient has the right to have his/her claim processed in a timely fashion and to be kept informed about the status of the claim at reasonable intervals; and
- A statement that any payment received by the patient directly from a payor is money owed solely to the air ambulance provider. It should also be written in large print that the payment represents a settlement payment in full with the patient's payor and the patient will be responsible for and can expect to be billed for the remainder of the air ambulance bill, which should be estimated on the disclosure. A statement that failure to use this settlement as intended can lead to possible legal, tax, and credit reporting implications should also be prominent.

The subcommittee also recommended that payors make certain disclosures to providers. Namely, that payors disclose to providers enough information to inform them of the nature and basis for the action being taken (i.e., denial or partial payment) and to allow providers an opportunity to challenge the action and to avoid unfair surprise.

In addition, the subcommittee recommended that air ambulance providers disclose the following information to patients:

- An explanation of the charge, including the mileage calculated, the rate per mile, other specific charges, and a statement that the patient has the ability to request documentation supporting these charges;
- The amount the air ambulance provider received from the insurance plan;
- The amount owed by the patient;

- A statement notifying the patient about his/her right to access medical records under the Health Insurance Portability and Accountability Act (HIPAA);
- Contact information if the patient has questions;
- Information regarding how to initiate an appeal of an adverse benefit determination;
- A statement notifying the patient that he/she may file a complaint with DOT, listing the hotline telephone number (when available) and a link to the DOT complaint website;
- A statement about any charity/assistance programs offered by the air ambulance provider and the potential for other sources of payment outside of the patient's health insurance policy, including information on payment flexibilities and any discounted rates available from the air ambulance provider; and
- A statement that the patient has the right to assistance from an authorized representative.

The Disclosure Subcommittee was also tasked with consideration of GAO's recommendations for disclosures by air ambulance providers in report GAO-17-637. GAO recommended that the DOT consider the disclosure of established prices charged, the business model and entity that establishes prices, and the extent of contracting with insurance. The Disclosure Subcommittee declined to recommend that air ambulance providers be required to disclose information regarding their business models because it did not believe that the information served any useful purpose to consumers. The subcommittee did recommend that DOT require air ambulance providers to list on their websites all payors with which they are in-network (or to disclose that the provider is not in-network with any payor). The subcommittee also recommended that air ambulance providers be required to disclose on their websites information on the charge for their services, including the base rate adjusted for specialty and geography, the loaded mileage rate, a list of the five most expensive ancillary services offered by the company and the charges for such services, and the total price for a sample set of transports based on varying scenarios as appropriate for the air ambulance program. The subcommittee's report referred to a sample chart illustrating how this information might appear.

The State and DOT Authorities Subcommittee developed similar recommendations for air ambulance disclosures. Noting that States are likely preempted by the ADA from requiring that air ambulance providers disclose rates, the subcommittee recommended that States adopt a voluntary program to incentivize air ambulance providers to disclose their base rate, mileage rate, and any other amounts charged. The subcommittee recommended that, if an air ambulance provider refuses to voluntarily disclose this information, States could publicize the refusal and also publish historical data obtained from insurers on the refusing air ambulance provider's average rates. States could also incentivize voluntary disclosure by air ambulance providers by allowing them to utilize the State's IDR program to resolve billing disputes. The State and DOT Authorities Subcommittee recognized that DOT has the statutory authority to require air ambulance disclosure of rate information, and the subcommittee recommended that DOT require providers to disclose the following information:

- Disclosure of network composition (which insurers the providers have in-network relationships with);
- Disclosure of rates;
- Disclosure of average and median amount of balance billing by each air ambulance provider on an annual basis; and
- Percentage of patients receiving a balance bill.

3.3 No Surprises Act Impact on Disclosures

Following the development of the subcommittees' recommendations, Congress passed the NSA, which contained several provisions that present implications for disclosure recommendations.

Section 116 of the NSA requires insurance plans to establish a verification process to ensure accurate provider directories, a response protocol for individuals inquiring about the network status of a provider, and a publicly accessible provider database. This requirement may, to an extent, impact the Disclosure Subcommittee's and State and DOT Authorities Subcommittee's recommendations that insurance companies provide information on in-network providers.

Section 102 of the NSA contains a requirement that payors cover emergency services without any prior authorization, whether the service is provided by a participating or a non-participating provider. This requirement may lessen the usefulness of the Disclosure Subcommittee's recommended disclosure on whether preauthorization may be required for air ambulance services, and the State and DOT Authorities Subcommittee's recommendations regarding State preauthorization and disclosure requirements.

Sections 111 and 112 of the NSA require the creation of an "Advanced Explanation of Benefits" from insurers, as well as a good faith estimate of charges from providers. Section 114 provides for an online price comparison tool, which must allow patients to compare expected out-of-pocket costs for items and services across multiple providers. The section also requires health plans to provide price comparisons over the phone. These three sections provide similar information as the Disclosure Subcommittee's point-of-care disclosure recommendations, at approximately a similar point in a patient's acquisition of a service. The sections also intersect with the State and DOT Authorities Subcommittee's recommendations on preauthorization.

The Disclosure Subcommittee had a number of recommendations for claims-related disclosures but various sections of the NSA also addressed such disclosures. For the subcommittee's recommendations for payor disclosures to patients, Section 105 of the NSA requires that an insured patient only pay the in-network cost-sharing amount for air ambulance services, which may obviate the need for certain disclosures about why the payor may have denied a claim and the amount the patient may be responsible for paying in a balance bill. Section 102 also requires payors to reimburse the provider directly, prohibiting the practice of routing the payment through the patient. This requirement negates the need for a disclosure regarding payments made from

the payor directly to the patient. For payor disclosures to providers, the Disclosure Subcommittee recommended that payors disclose enough information to give providers notice that is reasonably calculated to inform them of the nature and basis for the denial or partial denial of the claim. Under Section 110 of the NSA, payors must provide for external review of all adverse benefit determinations upon request of the patient.¹⁵ The Disclosure Subcommittee also recommended that air ambulance providers disclose to patients an explanation of their charges, including the amount owed by the patient and the contact information of the provider. In the meanwhile, NSA Section 104 requires providers to make publicly available information on patients' rights with respect to balance billing, Section 105 limits balance billing, and Section 112, requires a good faith estimate of charges from providers.

The remaining disclosure recommendations by the Disclosure Subcommittee and the State and DOT Authorities Subcommittee were less impacted by the NSA.

3.4 Pre-Care Disclosures: Discussion and Recommendations

At its May 27, 2021 meeting, the Advisory Committee heard from several members of the Disclosure Subcommittee and the State and DOT Authorities Subcommittee regarding subcommittee recommendations on disclosure.

Mr. Madigan presented the Disclosure Subcommittee's recommendations for air ambulance website disclosures, noting DOT's role in prohibiting unfair and deceptive practices in air transportation, a role that values consumers' access to accurate and timely information.

Mr. Judge discussed the State and DOT Authorities Subcommittee's recommendations for Federal disclosure requirements, and he acknowledged that the ADA limits the ability of States to act on this subject and 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 Advisory 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.

¹⁵ Under regulations amended by Interim Final Rule, "Requirements Related to Surprise Billing; Part II," 86 FR 55,980 (Oct. 7, 2021), the Departments of Health and Human Services, Treasury, and Labor require plans and issuers to provide a claimant the rationale for an adverse benefit determination sufficiently in advance of the date on which notice is required under the regulation in order to give the claimant a reasonable opportunity to respond prior to that date. The regulations also require that adverse benefit determinations include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. The plan and issuer are required to ensure that the reason(s) for the adverse benefit determination includes the denial codes and their corresponding meanings, and a description of the plan's or issuer's standard, if any, that was used in denying the claim. The regulations also require disclosure of appeals and external review processes, including information on how to initiate an appeal.

State and DOT Authorities Subcommittee member Bill Bryant gave a presentation on the 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 in the context of balance billing. Mr. Bryant also spoke to his subcommittee's recommendations for State requirements for insurer disclosures.

Mr. Montes 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 Disclosure 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 SBC, a form that already exists. Because the subcommittee recommends modifications to the SBC form, administrative costs of implementation are limited.

Following the four presentations, Ms. Workie 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 Advisory 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.

3.4.1 Federal Disclosure Recommendations

The Advisory Committee 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: 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: The Advisory Committee recommends that Congress provide authority to HHS to expand the 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. [For further detail, see section 3.2 above]

3.4.2 State Disclosure Recommendations

The Advisory 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 Advisory Committee instead agreed on the following recommendations regarding state action on pre-care disclosures:

Recommendation: 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: 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.

3.5 Point-of-Care Disclosures and Preauthorization: Discussion and Recommendations

The Advisory Committee heard from Disclosure Subcommittee members Dr. Abernethy and Dr. David Thomson on the 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 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 (EOB); 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.

State and DOT Authorities Subcommittee member Thomas Cook presented that subcommittee's recommendations for preauthorization. He noted that the recommendation applies only to non-emergency transports. The State and DOT Authorities Subcommittee determined 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 or 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 State and DOT Authorities 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, members discussed 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. Some members believed that disclosures in such situations would be helpful. Other members expressed their view that health care providers are under significant stress in emergency situations and that the Advisory 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 Advisory Committee was in general agreement that point-of-care disclosures should be provided in non-emergency situations. Some members of the Advisory Committee had discussed the possibility of whether disclosure recommendations should apply to more than non-emergency situations; however, the Advisory Committee did not agree to this change. The members approved the following recommendation:

Recommendation: 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.

3.6 Claims-Related Disclosures: Discussion and Recommendations

The Advisory Committee heard from Dr. Kevin Hutton, a member of the Disclosure Subcommittee, and Ms. Rogelyn McLean, a member of the Advisory Committee and the Disclosure Subcommittee, regarding 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 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. Ms. McLean informed the Advisory Committee 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 Advisory Committee. She agreed with Dr. Hutton that Section 102 of the NSA, 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 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 Advisory 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.

Several Advisory Committee 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. Some Advisory Committee members felt that the existing EOB is not clear for patients, and the members discussed whether the EOB could be improved and made more understandable to patients.

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

Recommendation: 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. [See Chapter 12 for the full text of Recommendation 2.4.1]

Recommendation: 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. [See Chapter 12 for the full text of Recommendation 2.4.2]

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

Recommendation: 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.

Chapter 4 – Distinguishing Between Air and Non-Air Transport Charges

4.1 Background

Section 418(d) of the FAA Act calls for the development of recommendations related to the disclosure of charges and fees for air ambulance services and insurance coverage. The section requires that, as part of these recommendations, the Advisory Committee must address 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 developing cost-allocation methodologies to separate charges for air transportation services from charges for non-air transportation services.

4.2 Subcommittee Recommendation

The Disclosure Subcommittee considered the mandate of the FAA Act and analyzed the benefits, costs, and practicability of distinguishing between air transport and non-air transport charges on various stakeholder groups. The subcommittee’s analysis is reproduced below:

Stakeholder	Costs/Benefits/Practicability
Patients/Consumers	<p>Positive Impact (Benefit)</p> <p>Patients and consumers could see some potential benefit from state oversight and regulation of medical costs, which in certain cases may reduce the amount they will be charged, and potentially improve transparency and clarity in billing. The result of these benefits and the extent of such benefits depends on the State regulation that is promulgated.</p>
	<p>Negative Impact (Cost)</p> <p>State regulation could increase costs to patients and consumers if providers increase rates to offset any increase in administrative and regulatory burdens.</p> <p>Increased operating costs could result in providers leaving certain markets, particularly in rural areas.</p> <p>In areas served by medical facilities and transport providers in multiple States with significantly differing regulation, there is the potential for a lack of clarity or billing complications.</p> <p>Consumers may receive services from an in-network hospital and an out-of-network air ambulance provider (or vice versa), resulting in uncovered</p>

		<p>charges, which exacerbates the surprise billing problem.</p> <p>Overall, this could result in increased costs for patients and consumers (passed on to them from operators), fewer transport options (if operators are not properly equipped for a particular State or do not have the proper personnel to operate in a neighboring State), and potentially worse patient outcomes (if operators had to transport patients to a distant medical facility in order to stay within a particular State, rather than to a nearer medical facility that may be in a different State).</p>
	Practicability	Patients and consumers could be confused about what the bill means and how to dispute payment denials for different categories of costs.
State Insurance Regulators	Positive Impact (Benefit)	State regulators could benefit by gaining oversight authority over certain aspects of the air ambulance industry and regulation of medical costs because such costs would no longer be lumped into air transportation costs.
	Negative Impact (Cost)	Future State regulation would be susceptible to increased advocacy/lobbying efforts and litigation, which may create uncertainty.
	Practicability	There is potential for the appearance of conflicts of interest from States setting rates and benefitting from their regulatory actions, such as in workers' compensation. States may also try to use licensing requirements to strictly limit operations in their borders to operators that are based in-state. These types of requirements are presently preempted.
Payors	Positive Impact (Benefit)	<p>Distinguishing charges would presumably result in increased transparency for payors.</p> <p>Payors would also be better positioned to negotiate network rates with individual providers for medical costs, rather than payors' current position negotiating with providers handling both medical and transport costs collectively.</p>
	Negative Impact (Cost)	Payors would potentially need to engage in multiple network negotiations with individual parties (for separate medical and transportation arrangements), increasing complexity and administrative costs.

		<p>The lack of expertise in air ambulance services would make it more difficult to determine what is a covered service and to negotiate and contract for transportation-related services.</p> <p>Distinguishing costs could increase payors' administrative burden and increase the potential for litigation, either between payors and patients or between payors and their in-network providers, for portions of the bill that are not fully covered, but now identified.</p>
	Practicability	<p>Payors would encounter increased billing complexity and contract difficulties from separating contracts for medical and transportation services, and payors would also have to rely on HHS, Labor, and Treasury to amend their regulations to allow payors to pay separately for essential air transport and medical services.</p>
Physicians (emergency, trauma, cardiac, or stroke)	Positive Impact (Benefit)	None identified.
	Negative Impact (Cost)	<p>For a hospital or physician, there would be increased administrative burden and cost from distinguishing the charges.</p> <p>Difficulties in arranging for transport would also result when medical care is in-network for the patient, but the air transport is not in-network.</p> <p>If distinguishing charges results in more charges going uncovered and potentially unpaid, hospitals and physicians might attempt to find ways to circumvent Emergency Medical Treatment and Labor Act (EMTALA) and refuse to accept some interfacility transfers, thereby negatively impacting patient care.</p>
	Practicability	<p>There could be a reduction in reliable air ambulance services (if increased costs reduce the availability of such services), which, for physicians looking to transfer patients, could delay medical care provided to patients.</p>
Air Ambulance Providers	Positive Impact (Benefit)	None identified.
	Negative Impact (Cost)	<p>There could be a high administrative burden, including from managing privacy concerns related to HIPAA, as amended by the Health Information</p>

<p>(includes both Part 135 operators and non-Part 135 operators)</p>		<p>Technology for Economic and Clinical Health Act (HITECH), and the increased time needed for separating and documenting costs into transport and non-transport categories.</p> <p>There is also the potential for increased litigation from disputes with consumers and payors over uncompensated portions of bills, a worse negotiating posture for air ambulance providers in relation to payors, and potential market disruption from changes in costs and the regulatory landscape, which could affect the number of operators and where they operate.</p> <p>Uncertainty about the rules that apply could lead to unintended violations of anti-kickback and Stark laws because compliance could become more difficult and lead to collusion and the appearance of kickbacks between different entities, where one entity might provide a service for another entity either without charging or by being compensated a non-market rate.</p> <p>Increased State regulation on the aspects of the air ambulance operation that attach to medical costs would enable States to impose state licensure requirements for on-board medical personnel and for on-board medical equipment. This could increase regulatory and operational complexity, as well as costs generally, for air ambulance operators that conduct interstate transports.</p>
	<p>Practicability</p>	<p>There could be practical complications with respect to billing (including during disaster assistance situations involving multiple entities and the Federal Emergency Management Agency (FEMA)) and contracting (where contracts may need to be separated for medical and transportation services). If medical costs are separated, then States could decide to only pay for medical care provided by state-licensed medical providers on-board an air ambulance and effectively force out-of-state operators to have on board state-licensed medical personnel or to avoid the State altogether.</p>
<p>DOT/HHS</p>	<p>Positive Impact (Benefit)</p>	<p>Distinguishing charges presents unclear benefits to the public and other stakeholders on whose behalf</p>

		DOT and HHS carry out their respective agency missions.
	Negative Impact (Cost)	There is a risk of introducing increased confusion in the industry.
	Practicability	A joint DOT/HHS effort would be needed to implement the task of distinguishing charges, and there might be competing agency missions. Both agencies would have to align their goals, determine which agency should take the lead, and make decisions regarding the agency(ies) responsible for enforcement and compliance. Significant monetary resources would need to be appropriated for such an effort, and the process for implementation would take a significant amount of time, including resolving Paperwork Reduction Act issues, conducting preliminary research, studying the issues, and developing an extensive work plan involving stakeholders prior to drafting a rulemaking.
Overall	Impact	<p>Distinguishing charges would have a negative impact on stakeholders.</p> <p>If medical services and aviation services are separated, it may lead to separate bills being sent to patients and consumers for medical and transport charges since State rules may govern the medical portion and Federal rules would govern the aviation portion. The requirements for such items as payment, balance billing, medical necessity, and licensure could be different. For example, if a State rule dictates that a particular air transport is or is not medically necessary while Federal rules hold the opposite, the two invoices could be handled differently for the same transport. The practical effect may be that a consumer may have only transport charges paid but not medical charges or vice versa.</p> <p>Separate bills also add complexity for consumers, payors, and other stakeholders.</p>
	Practicability	Distinguishing charges would require a wholesale structural change to billing and payment practices, which would necessitate changes to business and compliance processes, including discerning how much of the cost of the training, supplies, equipment, and maintenance is related to health or transport.

After considering the above impacts and noting the complexity of distinguishing air transport and non-air transport charges, the Disclosure Subcommittee decided not to recommend that air ambulance providers distinguish charges and provide cost allocation between air transportation and non-air transportation costs.

4.3 Advisory Committee Discussion and Recommendation

The Advisory Committee heard from Mr. Ed Marasco, a member of the Disclosure Subcommittee, on the subcommittee's decision not to recommend that air transport and non-air transport charges be distinguished. Mr. Marasco noted that Section 106 of the NSA does require that air ambulance companies submit cost information to HHS, but he added that the NSA does not address charge differentiation, as considered by the Disclosure Subcommittee.

After consideration of the Disclosure Subcommittee's determination, the Advisory Committee agreed to the following position (with DOT and HHS abstaining):

Recommendation: The Advisory Committee agrees with the Disclosure Subcommittee's decision not to recommend that air ambulance providers 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.

Chapter 5 – Independent Dispute Resolution

5.1 Background

Section 418(d)(2) of the FAA Act directs the Advisory Committee to develop recommendations on “options, best practices, and identified standards to prevent instances of balance billing such as improving network and contract negotiation, [and] dispute resolution between health insurance and air medical service providers[.]”

Section 418(d) of the FAA Act also directs the Advisory Committee to make recommendations regarding the consumer protection and enforcement authorities of State officials, which shall address steps that State governments can take to protect consumers, consistent with current legal authorities regarding consumer protection.

GAO reports that, in part because of the “potentially devastating financial impacts”¹⁶ of receiving a balance bill, “there has been interest among federal and state policymakers and others in the issues of out-of-network air ambulance transports and potential balance billing.”¹⁷ Many States have attempted to limit or ban balance billing by requiring various dispute resolution approaches. For example, Montana requires “insurers to assume responsibility of the balance bill, and work with the air ambulance carrier to come to an agreed upon amount.”¹⁸ Prior to the passage of the NSA, several bills had also been introduced into Congress, which would provide various methods of dispute resolution for air ambulance bills, including H.R. 5800 (Ban Surprise Billing Act),¹⁹ H.R. 5826 (Consumer Protection Against Surprise Medical Bills Act of 2020),²⁰ and S. 4185 (End Surprise Medical Bills for Air Ambulance Services Act of 2020).²¹ These dispute resolution proposals generally included bans on balance billing.

5.2 Subcommittee Recommendations

Both the Balance Billing Subcommittee and the State and DOT Authorities Subcommittee developed recommendations relating to IDR.

5.2.1 Balance Billing Subcommittee

¹⁶ GAO-17-637, 2. GAO notes that “media reports of balance billing have included a provider placing a lien on a patient’s home as well as patients having their credit negatively affected or filing for bankruptcy.”

¹⁷ GAO-19-292, 2.

¹⁸ <https://csimt.gov/issues-reports/air-ambulance-what-you-need-to-know/>; See § 33-2-2301 of the Montana Code Annotated (MCA) for Montana’s “Air Ambulance Hold Harmless” statutes.

¹⁹ <https://www.congress.gov/bill/116th-congress/house-bill/5800>.

²⁰ <https://www.congress.gov/bill/116th-congress/house-bill/5826?s=1&r=1>.

²¹ <https://www.congress.gov/bill/116th-congress/senate-bill/4185?s=1&r=27>.

The Balance Billing Subcommittee reviewed the Federal IDR proposals listed above, along with various State IDR laws, before drafting its own IDR recommendation.

The subcommittee agreed to a set of general principles relating to IDR in the air ambulance context. First, IDR refers to a method of resolving billing disputes between insurers/payors and providers, rather than disputes between patients and insurers/providers. Second, there is no need for IDR with respect to in-network contracts, scheduled service, or pre-negotiated rates between a provider and a payor. Third, if structured appropriately, IDR is generally effective and useful both as a means of promoting in-network participation and preventing balance billing.²² Finally, the subcommittee determined that IDR is appropriate regardless of the type of private health coverage held by the patient (i.e., commercial insurance or self-funded employer health plan), while noting that the IDR process will not apply to those covered by Medicare/Medicaid because Medicare and Medicaid patients are not balance billed.

The key features of the subcommittee's IDR recommendations are its binding nature, and the "hold harmless" and balance billing provisions. Specifically, the subcommittee recommended that, if an out-of-network air ambulance provider and insurer cannot agree on the payment amount for an air ambulance bill, either party *may* request IDR, at which point both parties *must* engage in IDR to resolve the dispute. The decision of the IDR service is binding, final, and enforceable in a court of law. Moreover, as a condition of entering IDR, the insurer must hold the patient harmless by ensuring that the patient is not responsible for amounts charged by the air ambulance provider other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services. Similarly, the air ambulance provider must not attempt to collect payment from the patient for the air ambulance services, other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.²³ These provisions, in combination, effectively relieve the patient of responsibility for out-of-network air ambulance bills beyond the amounts set forth in the patient's insurance plan.

With respect to initiation of IDR, the subcommittee recommended that the parties have a period of 30 days to informally resolve a dispute before IDR is initiated; within 30 days after that time expires, either party may request IDR. The purpose of these provisions is to provide the parties adequate time to resolve the dispute without IDR while not unduly delaying the IDR process itself.

The subcommittee also discussed the qualification and selection of IDR services. Certain Federal proposals would require Federal agencies (such as DOT, HHS, and the Department of Labor) to maintain a list of qualified services, and to promulgate regulations setting forth the service's qualifications. In contrast, the subcommittee preferred an approach that relies on private IDR services and sets certain minimum qualifications relating to experience and conflicts of interest.

²² One Subcommittee member expressed disagreement with this statement, but concurred in the IDR recommendation.

²³ At different points in the IDR process, both the payor and the air ambulance provider must provide notice to the patient/insured of these protections.

Regarding pre-award procedures, the subcommittee recommended that the private IDR service's procedures govern, except to the extent they conflict with the subcommittee's recommendations. The subcommittee specifically included a provision stating that consent and/or authorization from the patient shall not be required before entering IDR. The representatives of air ambulance providers on the subcommittee explained that this provision is important for keeping patients out of the middle of air ambulance disputes.²⁴

With respect to the process for resolving the substantive dispute about payment of the claim, the subcommittee considered, but declined to recommend, a "baseball-style" approach, where both sides present their final offer and the arbitrator must choose one of those two offers. Instead, the subcommittee recommended that the parties present information supporting their positions to the IDR service, who will subsequently consider the information and make a determination based on a non-exhaustive list of factors. The subcommittee believed its recommended approach will ensure the prompt and efficient resolution of disputes, encourage the parties to present reasonable and well-founded information in support of their positions, and provide greater flexibility to the IDR service in making an appropriate decision.

In discussing the decision-making process, the subcommittee recognized that many air ambulance billing disputes result from determinations about the medical necessity of the transport. Based on concerns about requiring the arbitrator (who likely is not trained in medicine) to resolve complex questions about medical necessity, the subcommittee recommended incorporating a provision establishing as a rebuttable presumption that a transport *is* medically necessary, provided that certain typical conditions are met (e.g., that the decision to order the transport was made by a financially neutral medical provider who reasonably determined that the time necessary to complete emergency transport by land would endanger the patient's health). To rebut the presumption, the payor may present evidence that the conditions were not met.²⁵

²⁴ Air ambulance providers on the Subcommittee explained that, in many cases, they reach out to patients simply to obtain authorization to enter negotiations with the insurer; however, patients often resist those efforts. Air ambulance providers further assert that if they cannot reach the patient, they send a balance bill to the patient not as a true collection effort, but instead simply to get the patient to furnish the necessary authorization. See also Comment of Air Methods, <https://beta.regulations.gov/comment/DOT-OST-2019-0182-0209>, at 3.

²⁵ The Subcommittee modeled this recommendation on Medicare's approach to medical necessity in the context of rural air ambulance service:

PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES

42 U.S.C. § 1395m(1)(14)(B)

(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if— (i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or (ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

As noted above, the IDR award would be binding, final, and enforceable in a court of law. The subcommittee recommended that the IDR service be authorized to identify a non-prevailing party responsible for paying the cost of IDR (not including attorneys' fees). The subcommittee also recommended that the IDR service be authorized to impose sanctions for abuse of the IDR process if warranted, but opted not to recommend detailed criteria for sanctions to provide flexibility for the IDR service to exercise discretion in addressing situations as they arise.

Finally, the subcommittee recommended that the IDR process include a retrospective review mechanism. Specifically, after three years, data on IDR procedures and awards should be analyzed to determine the impact, if any, of the IDR process on charges, network status, use/abuse of the process, and reduction of balance billing. The subcommittee did not specify which agency or entity should conduct the review or how to collect the necessary information. The subcommittee did not discuss which agency or entity should oversee the IDR program, or whether an insured plan IDR process should be overseen by the States.

As noted above, the subcommittee believed its IDR recommendations would eliminate balance billing. The subcommittee also believed that the IDR provisions will encourage network participation to the extent that the efficiencies and certainties of in-network agreements are preferable to mandatory IDR procedures that may produce unfavorable results.

Balance Billing Subcommittee Recommendations

The Balance Billing Subcommittee recommended Federal legislation creating an IDR system for resolving contested covered claim reimbursements from out-of-network air ambulance providers.²⁶ The subcommittee recommended IDR as a means of both preventing balance billing and encouraging network participation between payors and air ambulance providers. The subcommittee recommended that Federal IDR legislation include the following provisions:

I. Initiation of IDR

If an air ambulance provider or supplier and payor are unable to resolve a disputed charge informally within 30 days after receipt of initial payment or denial, either party may initiate IDR. A party initiates IDR by providing notice to the other party that it intends to file a request for IDR with a qualified service (as provided below) if informal negotiations have not resolved the matter within 30 days of the notice. Upon filing the request for IDR, both parties shall be obligated to engage in IDR.

II. Conditions of IDR/Hold Harmless

As a condition of entering IDR:

²⁶ Two subcommittee members join this recommendation with reservations, reasoning that “existing arbitration processes reveal unintended consequences for consumers,” and citing <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/>.

The payor agrees that the patient is not responsible for amounts charged by the air ambulance provider or supplier other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services; and

The air ambulance provider or supplier agrees that it will not attempt to collect payment from the patient for the air ambulance services, other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.

III. Payment of IDR Filing Fee

The party requesting IDR is responsible for payment of the IDR service's filing fee.

IV. Qualifications and Selection of Arbitrator

The IDR process shall be conducted by a private IDR service with experience in health care matters.

To be included in the list of qualified arbitrators used by the IDR service, the arbitrators must have a minimum of 10 years of experience in health care matters and with providing mediation and arbitration services, but cannot have represented a payor or an air ambulance provider or supplier in the preceding 5 years.

To be eligible to serve as an arbitrator, an individual must not have a conflict of interest that would impact the individual's independence or impartiality in rendering a decision.

Upon receiving a request for IDR, the IDR service will promptly select an arbitrator from its list of qualified individuals, but no later than 30 days after receiving the request for IDR. Alternatively, the party requesting IDR may identify a particular arbitrator jointly selected by the parties, in which case the IDR service shall select that arbitrator if possible.

V. IDR Pre-Award Procedures

The IDR process shall be conducted in accordance with the procedures of the private IDR service, except to the extent that they deviate from the subcommittee's recommended procedures.

Consent and/or authorization from a patient shall not be required for the following activities, and such activities shall be deemed core health care activities, including payment and/or healthcare operations, pursuant to 45 CFR §§ 164.501 and 164.506:

- All communications between an out-of-network air ambulance provider or supplier and a payor relating to the payment of a bill for out-of-network emergency air ambulance services; and

- The IDR process under this section, including all communications exchanged during the IDR process between or among an arbitrator, an out-of-network air ambulance provider or supplier, and a payor.

No later than 30 days after initiation of IDR, the payor shall provide notification to the patient that the payor will work with the air ambulance provider or supplier to ensure that the patient is not responsible for amounts charged by the air ambulance provider or supplier other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.

No later than 30 days after initiation of IDR, the air ambulance provider or supplier shall provide notification to the patient that the air ambulance provider or supplier will work with the payor and will not attempt to collect payment from the patient other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.

Each party shall submit to the arbitrator material in support of its position within 30 days after selection of the arbitrator.

VI. Factors for the Arbitrator to Consider

Factors to consider in determining the appropriate amount to be paid on a disputed claim should include, but not be limited to:

The nature of the services provided, including the care capability of the medical personnel, costs attributed to medical services provided in-flight, medical complexity of the patient's needs, and the geographic complexities of transport.²⁷

The nature of the equipment used to provide services, including the vehicle type and capacity, and safety investments made to the aircraft.

Economic factors of the provider or supplier maintaining 24/7/365 air ambulance service, including compensation for pilots and flight crew, overhead costs such as maintaining the aircraft, hangar and crew facilities, and fuel.

A comprehensive accounting of the out-of-network air ambulance provider or supplier's costs, payor mix (including applicable Medicare rate of payment), revenue mix, and other economic factors of the out-of-network air ambulance provider or supplier's service.

The out-of-network provider or supplier's billed charges and the payor's allowed charges.

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

²⁷ During the report review process, one subcommittee member suggested adding the phrase "including any evidence that other closer facilities were capable of treatment" to this factor. This issue was not raised during subcommittee discussions.

area, including any relevant context such as type of business model (e.g., hospital based, hybrid, or independent).

Information provided by Federal data collection and reporting requirements, if and when available.

Whether the service was medically necessary.²⁸ During the IDR process, there is a rebuttable presumption that the air ambulance service is medically necessary if: (i) it was requested by a financially neutral physician or other qualified medical personnel (including, in the case of on-scene calls, EMTs and first responders) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or (ii) the service was requested consistently with a protocol that is established by a State or regional emergency medical service (EMS) agency under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service. A payor can overcome the presumption by presenting evidence demonstrating that the above factors are not satisfied.

VII. IDR Award and Procedures

Within 30-60 days of receipt of materials supporting both parties' positions, the arbitrator shall determine an amount to be paid on the disputed claim and issue an award.

Payment shall be made within 30 days of the arbitrator's award. If the arbitrator determines that a payment is due to the provider or supplier, the payment shall be made directly to the provider or supplier, rather than the patient.

The award shall be final, binding, not appealable, and enforceable in a court of law, subject to applicable state and federal law.

VIII. Costs of IDR

The arbitrator shall determine a non-prevailing party to the proceeding, and shall direct the non-prevailing party to pay the costs of the IDR proceeding. Each party shall bear its own attorneys' fees.

²⁸ During the report review process, one subcommittee member suggested striking this factor and replacing it with "Whether the service was a covered claim under the policy/plan," reasoning that "if a plan/policy denied a claim due to lack of medical necessity, there should be no IDR at all because it is not a covered claim. The issue of medical necessity is a threshold issue to resolve before the parties even discuss payment amounts." This issue was not discussed during subcommittee meetings.

IX. Sanctions

The arbitrator has the discretion to impose sanctions for abuse of the IDR process, and the amount thereof. Abuse of the process may include a party's frequent filing of non-prevailing claims.

X. Post-Award Procedures

No later than 30 days after the award, the payor shall provide notification to the patient that IDR is complete and that the payor ensures that the patient is not responsible for amounts charged by the air ambulance provider or supplier other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.

No later than 30 days after initiation of IDR, the air ambulance provider or supplier shall provide notification to the patient that IDR is complete and that the air ambulance provider or supplier will not attempt to collect payment from the patient other than the copayment amount, coinsurance rate, or deductible with respect to such air ambulance services.

XI. Review of IDR Procedures

The IDR process should include a retrospective review mechanism. Specifically, the first three years of data on IDR procedures and awards should be compiled and analyzed to determine the impact, if any, of the IDR process on charges, network status, use/abuse of the process, and reduction of balance billing.

5.2.2 State and DOT Authorities Subcommittee

As part of the State and DOT Authorities Subcommittee's discussion about disclosure, the subcommittee considered whether States could incentivize air ambulance providers to disclose their rates by coupling the disclosure with a voluntary IDR program made available exclusively to air ambulance providers that voluntarily agree to publish their rates. The subcommittee recognized that States likely can require insurers to participate in an IDR system, and though they likely cannot *require* air ambulance providers to participate, they may *incentivize* them to do so. Further, the subcommittee acknowledged that States may regulate only a portion of the insurance market and, therefore, a State-based IDR program cannot apply specifically to ERISA or self-funded health plans. However, the subcommittee believed that State-based IDR programs would still benefit many consumers, and agreed that States without existing IDR programs should create such programs and make them accessible to State-regulated insurers.

The subcommittee reviewed and discussed the elements of several different types of IDR programs, including the IDR system proposed in the NCOIL model legislation. The subcommittee also discussed the benefits of interim payments to air ambulance providers, whether and how to best incorporate "hold harmless" provisions, and the pros and cons of incorporating various "gating" mechanisms to deter abuse of the IDR program. In discussing the hold harmless provisions, the subcommittee reviewed and deliberated on the types of hold

harmless provisions some States have implemented, their potential ramifications, and whether States should impose a hold harmless requirement on insurers outside of any IDR program they establish.²⁹

In considering the issues bearing on each of these elements, the subcommittee remained cognizant of both the need to insulate consumers from payment disputes and to balance the equities between insurers and air ambulance providers. Based on these considerations, the subcommittee recommended that States adopt minimum interim payment, hold harmless, and medical necessity standards as integral parts of their IDR programs.

State and DOT Authorities Subcommittee Recommendations

The State and DOT Authorities Subcommittee recommended that States without existing IDR programs create such programs, and that such programs contain a specific process for resolving contested air ambulance provider bills. In States with existing IDR programs, the subcommittee recommended that States create a specific process within those programs for the resolution of contested air ambulance provider bills. The subcommittee recognized that States cannot require air ambulance providers, unlike insurers, to participate in IDR, but States can make the IDR system available exclusively to air ambulance providers that voluntarily agree to publish their rates and be subject to the IDR process for a specific period of time. This should incentivize air ambulance providers based on their desire to receive adequate compensation and resolve billing disputes for out of network emergency transports. As part of their agreement to participate in the IDR system, the air ambulance providers would agree not to balance bill patients.

The subcommittee recommended that State IDR programs incorporate minimum interim payment, hold harmless, and medical necessity standards, and function as follows:

First, if an insurer disputes a bill from an air ambulance provider that has agreed to participate in a State's IDR program, the insurer must notify the air ambulance provider of the dispute and make an interim initial payment. The insurer must provide the required notice and make the interim payment to the air ambulance provider, within a 30-day period, of (i) the median in-network rate to the extent there is network adequacy, (ii) the charge, or (iii) a negotiated charge. An insurer cannot deny a claim; it must pay the full charge or a reasonable interim payment as specified.

Second, participation in the IDR process requires the insurer to hold the patient harmless from the balance of the charged bill from the air ambulance provider, but this does not exempt the patient from paying the applicable co-payment, deductible, and/or co-insurance amounts. It also requires the air ambulance provider not to bill, collect, or attempt to collect the disputed balance from the patient.

Third, if a dispute as to the amount billed remains after the initial interim payment is made by the insurer, either party may invoke the IDR process.

²⁹ During these discussions, the subcommittee acknowledged that States cannot impose hold harmless requirements on some health insurance payors, such as ERISA plans, but noted that these payors are not prohibited from entering into hold harmless agreements if desired.

Fourth, during the IDR process, there is 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. If a neutral arbitrator finds that the air ambulance service was not medically necessary, the insurer either (i) does not pay the air ambulance provider or (ii) pays the air ambulance provider at the *ground* ambulance rate. But, if a neutral arbitrator finds that the air ambulance service was medically necessary, the arbitrator determines a reasonable rate to be paid by the insurer to the air ambulance provider.

5.3 Impact of No Surprises Act

The NSA contains a comprehensive IDR regime to resolve disputes between air ambulance providers and payors.³⁰ The NSA also directly bans balance billing, independent of any IDR provision.³¹ In contrast, the Balance Billing Subcommittee recommends that air ambulance providers ban balance billing as a *condition* of entering into IDR (along with a parallel provision that payors would hold patients harmless as a condition of entering IDR). The other key similarities and differences between the NSA's IDR provisions and the Balance Billing Subcommittee's recommended model are set forth below.

5.4 Advisory Committee Discussion and Recommendations

At the second Advisory Committee meeting on May-27-28, 2021, 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:

³⁰ NSA section 105.

³¹ NSA section 106.

NSA's IDR system	Balance Billing 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.
"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.	DRE may choose an appropriate award amount after considering numerous factors. DRE selects the party to pay costs.
When determining the amount of the award, the DRE <i>must</i> consider one set of enumerated factors; <i>may</i> consider a second set of factors; and <i>must not</i> consider a third set of factors.	When determining the amount of the award, the DRE <i>should</i> 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 Advisory Committee should recommend amendments to the NSA's IDR system.

- *Costs and Qualifications of DRE*

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 Advisory Committee did not vote on these issues.

- *Factors for the DRE to Consider: Payments to Other Providers*

An Advisory 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 regulations implementing the NSA should include such a provision. A health care consultant on the State and DOT Authorities Subcommittee 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 Advisory 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 Advisory Committee did not reach consensus on this recommendation regarding payments to other providers.

- *Factors for the DRE to Consider: Medical Necessity*

An Advisory Committee member representing physicians and a health care consultant on the State and DOT Authorities Subcommittee noted that the NSA does not include a medical necessity provision. The Advisory Committee member representing physicians suggested that the Advisory 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 Advisory 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: 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.

- *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 Advisory Committee agreed that regulations implementing the NSA should define the appropriate initial payment. The Advisory 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 Advisory 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: 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 Advisory Committee discussed whether regulations implementing NSA should set IDR fees at an amount sufficient to disincentivize the use of IDR. An Advisory 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 Advisory 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. An Advisory 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 Advisory 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 Advisory Committee declined to issue recommendations relating to State IDR systems.

- Before concluding, an Advisory 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 Advisory Committee should take a broader look at total costs and consider amending the ADA.

5.5 Further Developments Relating to IDR

On October 7, 2021, the Departments of HHS, Labor, and Treasury and the Office of Personnel Management published a joint Interim Final Rule implementing the IDR provisions of the NSA.³² The preamble to the Interim Final Rule explains that “the certified IDR entity must begin with the presumption that the amount closest to the QPA [qualifying payment amount, defined as the plan's or issuer's median contracted rate] is the appropriate out-of-network rate for the air ambulance service under consideration and select the offer closest to the QPA, unless

³² <https://www.regulations.gov/document/CMS-2021-0156-0001>; 86 FR 55980 (October 7, 2021); Federal Register version available at <https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii>.

credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate.”³³

As noted above, the Advisory Committee recommended that the DRE consider questions of medical necessity. However, the preamble to the Interim Final Rule clarifies “that it is *not* the role of the certified IDR entity to determine whether the QPA has been calculated by the plan or issuer correctly, to make determinations of medical necessity, or review denials of coverage.”³⁴ The Advisory Committee also recommended that HHS define “initial payment” in its implementing rules. While the Interim Final Rule does not define initial payment, it provides that “the initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances, prior to the beginning of any open negotiations or initiation of the Federal IDR process.”³⁵

The Interim Final Rule includes a request for comment. The comment period closed on December 6, 2021.

³³ 86 FR at 55982. The Interim Final Rule sets forth the categories of evidence that a party may present which, if credible, could clearly demonstrate that the QPA is not the appropriate rate. *See* 45 CFR 149.520(b)(2); 86 FR at 56134.

³⁴ 86 FR at 55996 (emphasis added). Questions of medical necessity are reserved to external review processes. *Id.* at 55985.

³⁵ 86 FR at 55990 n.23.

Chapter 6 – Data Collection

6.1 Background

In July 2017, GAO issued a report indicating that data collection was necessary to enhance DOT’s oversight of the air ambulance market.³⁶ Accordingly, Section 418(d)(4) of the FAA Act directed the Advisory Committee to produce recommendations relating to “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[.]” The Act then set forth categories of data that may be the subject of Advisory Committee recommendations.³⁷ Also, Section 418(d)(6) of the FAA Act directs the Advisory Committee to make recommendations on “other matters as may be deemed necessary or appropriate.”

Recognizing that a key goal of the Advisory Committee was to develop recommendations relating to the prevention of balance billing, the Balance Billing Subcommittee produced data-collection recommendations relating to balance billing.

6.2 Balance Billing Subcommittee Recommendations

As part of the Balance Billing Subcommittee’s discussions about the challenges of network and contract negotiation and options for improvement, the subcommittee discussed the need for

³⁶ GAO-17-637, AIR AMBULANCE: Data Collection and Transparency Needed to Enhance DOT Oversight, published July 2017 and available at <https://www.gao.gov/assets/690/686167.pdf>.

³⁷ Specifically, the FAA Act indicated that the data-collection elements “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.”

transparency in the industry. The subcommittee discussed the proposition that increased transparency regarding the costs to provide air ambulance service and the manner in which providers bill for their services would be beneficial for network contract negotiations. The subcommittee also noted that publicly available data would help improve policymakers' understanding of the air ambulance industry.

The subcommittee began its examination of the types of data that could be collected for these purposes by reference to the data-collection provisions of the FAA Act. The subcommittee used these data elements as a starting point for its recommendations and noted that the purposes identified in the FAA Act (oversight and enforcement) differed from the purposes identified by the subcommittee (improved policymaking, transparency, and improved network and contract negotiation).

During these discussions, the subcommittee considered whether data collection would duplicate or conflict with current efforts by FAA to collect data on the number of air ambulance transports. The subcommittee also considered whether DOT should collect information concerning the market share of each air ambulance company and make the information publicly accessible.

Similarly, the subcommittee considered whether to collect data about the extent of competition in the industry and whether it is appropriate for a government agency to collect certain data, such as the financial information of privately held companies.

Subcommittee members expressed concern about disclosing the names of providers in data made publicly available, and generally agreed that DOT should provide public access for data in aggregate form. Some subcommittee members further expressed concern about making payment/reimbursement data available, even in the aggregate, stating that the only purpose for collecting this data is to inform regulators/lawmakers, not to influence the market.

The subcommittee's recommended categories of data to collect largely track and expand upon those identified in the FAA Act. Where the subcommittee's recommendations deviate from the categories listed in the FAA Act, an explanation is provided.

The subcommittee recommended that data 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/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.

The subcommittee recognized that Section 418(d)(4) of the FAA Act directs the Advisory Committee to make recommendations regarding “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*” (emphasis added). The data that the subcommittee recommended for collection was intended for the broader purposes set forth above.

Section 418(d)(4)(F) of the FAA Act suggests that the Department should collect data from air ambulance providers “indicating the extent of competition among air ambulance providers on the basis of price and service.” The subcommittee considered but decided not to recommend the collection of that data to avoid the risk of unintended consequences to the extent that collection of such data could encourage air ambulance providers and suppliers to set their rates based on their competitors' highest rates (a “race to the top”).³⁸

Section 418(d)(4)(G) of the FAA Act suggests that the Department collect data from air ambulance providers regarding the “prices assessed to consumers and insurers for air transportation and any non-transportation services provided by air ambulance providers.” The subcommittee declined to make any recommendations in this regard and noted that any such data collection is contingent on the ability of air ambulance providers to separate charges for air transportation services from charges for non-air transportation services, which the Disclosure Subcommittee considered.

³⁸ The Subcommittee expressed concern about unintended consequences, noting the prior efforts of HHS in disclosing cost and payment information of providers leading to price increases for consumers rather than competition.

Section 418(d)(4)(H) of the FAA Act suggests that the Department collect data regarding “financial performance of air ambulance providers.” The subcommittee considered but decided not to recommend collection of that data. The subcommittee did not believe this data is appropriate for collection because many air ambulance providers and suppliers are privately held corporations that are otherwise not required to reveal proprietary financial performance data. The subcommittee reasoned that as a matter of practice, air ambulance providers and suppliers share financial information with payors during network/contract negotiations on a confidential basis; therefore, publication of such financial performance data would not advance the goal of improved network and contract negotiation.

6.3 No Surprises Act Impact on Data Collection

The NSA requires both HHS and DOT to collect extensive data from air ambulance providers and group and individual health issuers, and for HHS to issue a comprehensive report regarding the air ambulance industry.

Specifically, the NSA requires *air ambulance providers* to provide the following information to both DOT and HHS:

- A) Cost data, as determined appropriate by the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services.
- (B) The number and location of all air ambulance bases operated by such provider.
- (C) The number and type of aircraft operated by such provider.
- (D) The number of air ambulance transports, disaggregated by payor mix, including—
 - (i) (I) group health plans;
 - (II) health insurance issuers; and
 - (III) State and Federal Government payors; and
 - (ii) uninsured individuals.
- (E) The number of claims of such provider that have been denied payment by a group health plan or health insurance issuer and the reasons for any such denials.
- (F) The number of emergency and nonemergency air ambulance transports, disaggregated by air ambulance base and type of aircraft, and

(G) Such other information regarding air ambulance services as the Secretary of Health and Human Services may specify.³⁹

DOT may use this data to help determine whether an air ambulance provider is committing an unfair or deceptive practice within the meaning of 49 U.S.C. § 41712.⁴⁰

Next, the NSA requires *group health plans and health insurance issuers offering group or individual health insurance coverage* to provide the following information to HHS:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

(C) Whether the transport in which the services were furnished originated in a rural or urban area.

(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively, and

(2) Such other information regarding providers of air ambulance services as the Secretary [of HHS] may specify.⁴¹

Finally, the NSA provides that HHS, in consultation with DOT, shall use the data collected (along with other sources of information, as appropriate) to produce a comprehensive report addressing:

(A) The percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program.

(B) An assessment of the extent of competition among providers of air ambulance services on the basis of price and services offered, and any changes in such competition over time.

³⁹ NSA Section 106(a)(2).

⁴⁰ NSA section 106(f).

⁴¹ NSA section 106(b)(2), adding section 2799A-8 to the Part D of title XXVII of the Public Health Service Act. This same data must also be provided to the Departments of Labor and Treasury to effectuate parallel provisions of ERISA and the Internal Revenue Code.

- (C) An assessment of the average charges for air ambulance services, amounts paid by group health plans and health insurance issuers offering group or individual health insurance coverage to providers of air ambulance services for furnishing such services, and amounts paid out-of-pocket by consumers, and any changes in such amounts paid over time.
- (D) An assessment of the presence of air ambulance bases in, or with the capability to serve, rural areas, and the relative growth in air ambulance bases in rural and urban areas over time.
- (E) Any evidence of gaps in rural access to providers of air ambulance services.
- (F) The percentage of providers of air ambulance services that have contracts with group health plans or health insurance issuers offering group or individual health insurance coverage to furnish such services under such plans or coverage, respectively.
- (G) An assessment of whether there are instances of unfair, deceptive, or predatory practices by providers of air ambulance services in collecting payments from patients to whom such services are furnished, such as referral of such patients to collections, lawsuits, and liens or wage garnishment actions.
- (H) An assessment of whether there are, within the air ambulance industry, instances of unreasonable industry concentration, excessive market domination, or other conditions that would allow at least one provider of air ambulance services to unreasonably increase prices or exclude competition in air ambulance services in a given geographic region.
- (I) An assessment of the frequency of patient balance billing, patient referrals to collections, lawsuits to collect balance bills, and liens or wage garnishment actions by providers of air ambulance services as part of a collections process across hospital-owned or sponsored programs, municipality-sponsored programs, hospital-independent partnership (hybrid) programs, tribally operated programs in Alaska, or independent programs, providers of air ambulance services operated by public agencies (such as a State or county health department), and other independent providers of air ambulance services.
- (J) An assessment of the frequency of claims appeals made by providers of air ambulance services to group health plans or health insurance issuers offering group or individual health insurance coverage with respect to air ambulance services furnished to enrollees of such plans or coverage, respectively, and
- (K) Any other cost, quality, or other data relating to air ambulance services or the air ambulance industry, as determined necessary and appropriate by [HHS or DOT].⁴²

⁴² NSA Section 106(c).

6.4 Advisory Committee Discussion and Recommendations

During the plenary session on May 28, 2021, Mr. David Motzkin of the Balance Billing Subcommittee summarized the subcommittee's recommendations and the data collection provisions of the NSA.

An Advisory 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 an Advisory 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 Advisory 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: The Advisory Committee adopts the recommendations of the Balance Billing Subcommittee report relating to data collection. [Specifically, that the Department collect data from air ambulance providers and suppliers regarding: (1) average cost per trip; (2) air ambulance base rates and patient-loaded statute mileage rates; (3) ancillary fees for specialty services; (4) reimbursement data aggregated by payor type and per transport, based on median rate and ZIP code, with data regarding private insurance further identified by provider type; (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; and (8) market share for health care, by looking at the program type for the FAA certificate holder. For further details, see section 6.2, above].

6.5 Subsequent Developments Regarding Data Collection

The NSA requires HHS to produce regulations relating to data collection, taking into account (as applicable and to the extent feasible) the data-collection recommendations of this Advisory Committee.⁴³ HHS issued an NPRM relating to data collection on September 16, 2021. HHS took into account the Advisory Committee's recommendation set forth above regarding data collection, recognizing that the Advisory Committee's final report had not yet been issued.⁴⁴ The comment period closed on October 18, 2021. As of the date of this Report, HHS's final rule on air ambulance data collection has not yet been issued.

⁴³ NSA section 106(d).

⁴⁴ 86 FR 51730, 51734 and n. 16, available at <https://www.federalregister.gov/documents/2021/09/16/2021-19797/requirements-related-to-air-ambulance-services-agent-and-broker-disclosures-and-provider-enforcement#citation-16-p51734>, file code CMS-9907-P; docket CMS-2021-0147.

Chapter 7 – Best Practices for Network and Contract Negotiation

7.1 Background

Section 418(d) of the FAA Act directs the Advisory Committee to make recommendations with respect to specific air ambulance and patient billing issues, including “options, best practices, and identified standards to prevent instances of balance billing such as improving network and contract negotiation.”

Because balance billing generally occurs when a patient is transported by an out-of-network provider, it is reasonable to conclude that one way to resolve the issue of balance billing is for providers and payors to establish in-network relationships. In its 2019 report, GAO wrote that air ambulance providers and insurers “reported they have recently been entering into more network contracts.”⁴⁵ GAO noted that increased contracting between large air ambulance providers and national insurers in five states could “decrease the extent of out-of-network transports and balance billing in the future for these states.”⁴⁶ GAO further wrote that “[t]hese contracts could decrease the extent of out-of-network transports and balance billing in the future....”⁴⁷

While 100-percent network participation would resolve balance billing concerns, many challenges to network negotiation exist. For example, GAO noted that “[t]he emergency nature of most air ambulance transports, as well as their relative rarity and high prices charged, reduces the incentives of both air ambulance providers and insurers to enter into contracts with agreed upon payment rates, which means air ambulance providers may be more often out-of-network when compared with other types of providers.”⁴⁸ Therefore, many providers and payors find it harder to reach agreements that each side finds acceptable. GAO notes that, “according to stakeholders we spoke to, if insurers offer payment rates that are much lower than the air ambulance providers’ charged amounts, the air ambulance providers may be less willing than other health care providers to accept those payment rates.”⁴⁹ Similarly, “given the relative rarity of air ambulance transports, patients may not anticipate needing air ambulance transports and may not choose insurance plans based on which or how many air ambulance providers are in insurers’ networks,”⁵⁰ thereby reducing the payors’ incentive to contract with air ambulance providers. The Advisory Committee also discussed the incentives and disincentives to network participation during the plenary session in January 2020.

⁴⁵ GAO-19-292, 17.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.* at 8.

⁴⁹ *Id.*

⁵⁰ *Id.*

7.2 Subcommittee Recommendations

The Balance Billing Subcommittee (which included representatives of air ambulance providers and health insurance plans) discussed their experiences with contract negotiation and described practices that they believed were helpful to the process. The subcommittee determined that any recommendations in this area should not dictate how to conduct negotiations, nor should they conflict with how negotiations are currently conducted. Rather, the subcommittee concluded that any recommendation should consist of a list of general best practices for negotiating parties to consider. For example, air ambulance providers, suppliers, and payors should engage in contract or network negotiations in a transparent manner for the purpose of agreeing on a fair, reasonable, and market-based reimbursement rate. The subcommittee agreed that insurers need to know about the finances of air ambulance providers; however, the negotiating parties are in the best position to determine exactly what information is helpful in a particular situation.

The subcommittee also recognized that, when entering network negotiations, payors may not know whether the prices charged by the provider reflect reasonable costs, or whether they are instead inflated due to poor management or inefficiencies. Accordingly, the subcommittee recommended that air ambulance providers and suppliers should present information to payors demonstrating sound business management and competitiveness with other market participants.

The subcommittee recommended, as best practices for improving network and contract negotiation between air ambulance providers or suppliers and payors, 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.
- Air ambulance providers and suppliers should present information to payors demonstrating sound business management and competitiveness with other market participants.

7.3 Advisory Committee Discussion and Recommendations

At the second Advisory Committee meeting on May 28, 2021, Mr. Motzkin (a Balance Billing Subcommittee member) presented the subcommittee's recommendation. The DFO then opened the issue to discussion.

An Advisory 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. An Advisory 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 Advisory Committee members suggested that various industry organizations (such as America’s Health Insurance Plans (AHIP), or the Association of Air Medical Services (AAMS)) 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 Advisory Committee’s work.

Following this discussion, the Advisory Committee voted unanimously to adopt the Balance Billing Subcommittee’s recommendation, with the addition of “good faith.”

Recommendation: 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. [For greater detail, see section 7.2 above.]

Chapter 8 – Best Practices for Air Ambulance Subscription Programs

8.1 Background

Section 418(d) of the FAA Act requires the Advisory Committee to develop recommendations that address 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. As referenced in the FAA Act, air ambulance subscription programs are programs that seek to offer consumers plans that may assist with defraying or avoiding out-of-pocket expenses for air ambulance transports. These programs usually are based on an annual fee to members, who will receive financial benefits, such as a write-off or reduction of out-of-pocket charges, should they need an air ambulance transport.

8.2 Subcommittee Recommendations

The Disclosure Subcommittee heard from industry experts on air ambulance subscription programs and learned about some practices of concern with regard to these programs. For example, some programs may sell subscriptions to consumers who may be unable to benefit from the program, either because the consumers already cannot be legally balance-billed or because the subscription plan only covers air transports that are operated by specific providers or in specific geographic areas. To assist consumers in understanding and navigating air ambulance subscription programs, the Disclosure Subcommittee recommended that relevant stakeholders (such as industry associations and consumer groups) work together to develop the best practices or standards for how air ambulance companies disclose the following information regarding air ambulance subscription programs to consumers:

- A statement about the potential for balance billing following the purchase of a subscription/membership.
- A statement about whether there is reciprocity with other programs.
- Specific information on rates and coverage (what is covered?).
- A list of any specific limitations on or exclusions from coverage, including:
 - Is the benefit limited to the use of participating providers?
 - Is the benefit only available in a particular service area?
 - Is there a requirement that the patient/consumer be insured and that the service be covered by insurance? Are uninsured individuals also eligible for the program, and if so, what benefits are available to them?
 - Are there consumers/patients who do not need this coverage? (e.g. in-network, Medicare, Medicaid beneficiaries)
 - Are there operational factors that may limit, cause discontinuation of, or otherwise affect the delivery of services under the subscription program, including

limitations related to patient age, size, or medical conditions; weather; base relocation or closure; or change in service area?

- An explanation of the cancellation policy and any waiting periods before coverage begins.
- Information on the complaint and dispute processes.
- Pre- and post-purchase notifications regarding substantial changes in coverage or service (including service area), refunds and cancellations, as well as potential remedies to consumers for these changes.

8.3 Advisory Committee Discussion and Recommendations

The Advisory Committee considered the Disclosure Subcommittee's recommendations. Although the NSA did not directly address air ambulance subscription programs, the Advisory Committee noted that provisions in the NSA may make some of the subjects recommended for disclosure unnecessary. The Advisory Committee discussed whether an explanation of such programs was still necessary if the NSA eliminates most balance billing, with some members asserting that subscription programs will continue to exist despite the NSA.

Some members expressed concern that the marketplace for such subscription services remains largely unregulated, and that the best practices proposed by the Disclosure Subcommittee do not go far enough in regulating the issue because there is no legal oversight. Other members disagreed that there was no legal oversight. One member noted that his State attempted to regulate subscription programs but was preempted by the ADA. The DFO affirmed that DOT has the authority to prohibit unfair or deceptive practices in air transportation, but it is unclear whether such programs qualify as insurance, which would open the possibility that such programs could be regulated by States.

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

Recommendation: 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.

Chapter 9 – Medicare Reimbursement Study

9.1 Background

Section 418(d) of the FAA Act directs the Advisory Committee to make recommendations with respect to specific air ambulance and patient billing issues, including “options, best practices, and identified standards to prevent instances of balance billing such as improving network and contract negotiation,” and “other matters as determined necessary or appropriate.”

The Centers for Medicare & Medicaid Services (CMS), an agency within HHS, sets rates and pays claims for Medicare. Medicare Part B covers ground (land and water) and air ambulance transport services furnished to a Medicare beneficiary. The reimbursement rates for these services are determined using the Medicare Part B Ambulance Fee Schedule (AFS).⁵¹ Specifically, Congress directed the Secretary of HHS to “establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process.”⁵² Congress set forth the considerations for establishing the fee schedule, which included: controlling increases in expenditures for ambulance services; establishing definitions for ambulance services that link payments to the type of services provided; considering appropriate regional and operational differences; considering adjustments to payment rates to account for inflation and other relevant factors; and phasing in the application of the payment rates under the fee schedule in an efficient and fair manner.⁵³ After conducting a negotiated rulemaking, HHS published the AFS Final Rule on February 27, 2002. The fee schedule is effective for dates of service on or after April 1, 2002.⁵⁴

The AFS amount is based on the level of service furnished and includes a base payment, a separate payment for mileage to the nearest appropriate facility, and a geographic adjustment factor (GAF).⁵⁵ There are two levels of service for air ambulance transports: fixed wing and rotary wing. There is also a permanent add-on payment of 50 percent to increase both the base and mileage rate for rural air ambulance transports. The AFS is adjusted annually based on an Ambulance Inflation Factor (AIF).⁵⁶ According to GAO, in 2014, “Medicare payments, including beneficiary co-payments, for helicopter air ambulance service totaled approximately \$460 million.”⁵⁷

⁵¹ See Section 4531(b)(2) of the Balanced Budget Act of 1997, adding Section 1834(l) of the Social Security Act, mandating the establishment of AFS; https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

⁵² Social Security Act, §1834(l)(1).

⁵³ Social Security Act, §1834(l)(2).

⁵⁴ 67 FR 9100.

⁵⁵ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf>

⁵⁶ *Id.*

⁵⁷ GAO-17-637, 8.

The 2019 Medicare base rates for air ambulances were \$3,119.83 for air fixed wing—urban, \$4,679.75 for air fixed wing—rural, \$3,627.27 for air rotary wing—urban, and \$5,440.91 for air rotary wing—rural.⁵⁸ However, GAO noted that, “[i]n 2017, the median price charged by air ambulance providers for a transport was approximately \$36,400 for a helicopter transport and \$40,600 for a fixed-wing transport,”⁵⁹ which is well above the Medicare rate, even with the addition of the mileage rate. Federal law generally prohibits air ambulance providers from sending balance bills to Medicare patients.

In 2017, GAO reported that air ambulance providers generally have seen a shift in their payor mix from private insurance toward Medicare as the population ages.⁶⁰ GAO also solicited the views of various stakeholders in the air ambulance system regarding whether raising Medicare reimbursement rates would be effective in addressing the problem of high air ambulance prices. GAO reported mixed opinions: some stakeholders took the view that raising rates would be effective, while “some of these stakeholders noted that increasing Medicare rates could incentivize further growth in the industry, which could reduce the average number of transports per helicopter, putting pressure on providers to increase prices charged—thereby exacerbating the problem.”⁶¹

The Advisory Committee discussed the possibility of revising Medicare reimbursement rates during the plenary session held on January 15, 2020. During the meeting, representatives of CMS indicated that CMS currently lacks statutory authority to review or amend the AFS; accordingly, any review or adjustment of the AFS would require Federal legislation.

9.2 Subcommittee Recommendations

The Balance Billing Subcommittee noted that there is general agreement across the industry that Medicare reimbursement rates are too low to meet the actual cost of service. The members also agreed that the under-reimbursement of Medicare rates impacts the business decisions of air ambulance providers, as does the increasing number of Medicare enrollees. The subcommittee considered a recommendation for CMS to revise the AFS to provide increased reimbursement for air ambulance services, reasoning that increased reimbursement could benefit contract negotiation indirectly because an increase to Medicare reimbursement rates will significantly alleviate the need for cost shifting. With less Medicare under-reimbursement, the financial burden is spread more evenly across all programs and payors, resulting in less cost-shifting. Consequently, the rates for commercial providers should decrease if the reimbursement rate is closer to a true rate.

⁵⁸ http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_ambulance_final_sec.pdf?sfvrsn=0

⁵⁹ According to GAO’s analysis of FAIR Health data. GAO-19-292, 17.

⁶⁰ GAO-17-637, 17.

⁶¹ GAO-17-637, 23.

Alternatively, the subcommittee debated whether to recommend a study on air ambulance cost and Medicare reimbursement, and identified similar studies that were conducted. For example, CMS is studying the End State Renal Disease Prospective Payment System payment model and has recently contracted with a data contractor to refine the case-mix adjustment model.⁶² Similarly, the subcommittee noted that CMS is collecting data from ground ambulance providers and suppliers on cost, utilization, revenue, and other service characteristics.⁶³ CMS notes on its web site that the “information collected will be used to evaluate the extent to which reported costs relate to payment rates under the Medicare Part B Ambulance Fee Schedule (AFS), as well as to collect information on the utilization of capital equipment and ambulance capacity, and the different types of ground ambulance services furnished in different geographic locations, including rural areas and low population density areas (super rural areas).”⁶⁴

The subcommittee ultimately found it appropriate to recommend Federal legislation requiring HHS to study the issue of increasing Medicare rates, given that even a study of the issue is currently not authorized by law. The subcommittee did not directly recommend an increase of Medicare reimbursement rates; rather, the subcommittee recommended an increase only “if warranted” upon conclusion of the study. The subcommittee further recommended basing the study on actual air ambulance cost data. The subcommittee defined “cost” as:

The whole of financial liabilities incurred by the provider or supplier, including, but not limited to:

1. Vehicle and equipment to provide the service;
2. Maintenance of assets to ensure safety and serviceability;
3. Medical supplies, equipment, and pharmaceuticals to meet the standard of care;
4. All labor needed to carry out the enterprise (to include, but not limited to medical staff, aviation staff, administrative staff, etc.);
5. Liabilities incurred from the delivery of uncompensated and under-compensated care;
6. Facilities needed to appropriately station required vehicles and staff; and
7. Amounts incurred ensuring overall regulatory compliance.

In formulating its recommendation, the subcommittee recognized the differences between Medicare and Medicaid. Medicaid is a joint Federal-State health care financing program for certain low-income and medically needy individuals. Because Medicaid rates are set by States, the recommendations of the subcommittee focused on Medicare. The subcommittee believed that any recommendations and/or changes to Medicare will be persuasive to the States.

⁶² https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Educational_Resources.

⁶³ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Ground-Ambulance-Services-Data-Collection-System>.

⁶⁴ *Id.*

9.3 No Surprises Act Impact on Medicare Reimbursement Study

The NSA contains no provisions relating to adjustment of Medicare reimbursement rates for air ambulance services. However, the NSA does have a provision relating to the reporting of air ambulance cost data, which became part of the Advisory Committee’s final recommendation relating to the Medicare reimbursement study (see section 9.4 below). Specifically, pursuant to Section 106 of the NSA, air ambulance providers must submit data to HHS and DOT regarding many aspects of their operations, including but not limited to “cost data, as determined appropriate by [HHS], for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services.”⁶⁵

9.4 Advisory Committee Discussion and Recommendations

At the second Advisory Committee meeting on May 28, 2021, Ms. Connors presented the Balance Billing Subcommittee’s recommendation. The DFO then opened the issue to discussion.

An Advisory 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 Advisory Committee member representing air ambulance companies remarked that per-transport costs are inflated as a result of a greater number of helicopters in use. An Advisory 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 to adjust those rates absent Congressional authorization.

Following this discussion, the Advisory Committee voted to adopt the Balance Billing Subcommittee’s recommendation, using a broad definition of “cost” (with DOT and HHS abstaining):

Recommendation: 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 Advisory 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

⁶⁵ NSA section 106(a)(2)(A).

Act; and (3) volume of transports. [For further detail, see section 9.2 above and Chapter 12 below.]

9.5 Ongoing NSA Rulemaking Relating to Cost Data

On September 16, 2021, HHS and other agencies jointly published proposed rules titled “Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement.”⁶⁶ In that document, HHS sets forth proposed cost data to be collected from air ambulance providers under Section 106 of the NSA.

HHS explained that “the service delivery or organizational model of a provider of air ambulance services, the designation of the service area of a base (rural or urban), and the identification of fixed and variable costs are all important factors affecting the costs and revenues of providers of air ambulance services. Because these factors vary at the air ambulance base level, HHS proposes ... to require submission of detailed cost and revenue data at the air ambulance base level, as well as at the regional and corporate level, for each air ambulance base, if applicable. The data HHS proposes to collect would enable the separation of fixed and variable costs of providers of air ambulance services, as well as medical costs as opposed to air transportation costs.”⁶⁷

Accordingly, HHS proposed that the required cost data be reported in the following categories:

Labor costs by type of staff;

Facility costs by facility (including annual lease, rental, or mortgage costs, other costs of ownership, insurance, maintenance and improvements, utilities, taxes, computers and software, and other facility costs);

Vehicle costs by vehicle (including vendor fees, depreciation, safety enhancements, non-medical equipment (such as communications technology), registration and license, taxes, insurance, maintenance equipment and parts, fuel, and capital medical equipment);

Equipment and supplies; and

Overhead and vendor costs (including insurance, training, billing, accounting and finance, human resources, travel, marketing, sales, dispatch or call center, IT support, legal, medical direction, fees, fines, and taxes).⁶⁸

The comment period for the proposed rule closed on October 18, 2021. The Advisory Committee notes that the second prong of its recommendation with respect to cost (i.e., “cost

⁶⁶ 86 FR 51730.

⁶⁷ *Id.* at 51738.

⁶⁸ *Id.*

elements set forth in Section 106 of the No Surprises Act”) will depend on the elements that appear in HHS’s final rule on this topic.

Chapter 10 – DOT Hotline

10.1 Background

Section 418(d) of the FAA Act directs the Advisory Committee to make recommendations with respect to specific air ambulance and patient billing issues, along with “other matters as determined necessary or appropriate.”

The FAA Modernization and Reform Act of 2012 directed the Secretary of Transportation to “establish a consumer complaints toll-free hotline telephone 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.”⁶⁹ Subsequently, Section 419 of the FAA Act amended this section to require 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.”⁷⁰

DOT has not established a toll-free consumer complaint hotline due to a lack of funding. Currently, consumers may contact the Department’s Office of Aviation Consumer Protection (OACP) through a local telephone number—(202) 366-2220—during normal business hours regarding air travel service problems that they may have encountered. However, to be accepted, complaints must be submitted in writing via an online complaint form or by mail.

A hotline could enable OACP to take complaints over the phone in real time. Funding (e.g. for human resources and technical support) would be required to staff and maintain the hotline.

10.2 Subcommittee Recommendations

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 subcommittee reasoned that “this hotline number would be a way for consumers to directly complain to DOT, and for States to refer complaints to DOT.”

10.3 Advisory Committee Discussion and Recommendations

At the second Advisory Committee meeting on May 28, 2021, Ms. Battaglini presented the subcommittee’s recommendation. She noted that the recommendation would benefit both air ambulance consumers and consumers of general air transportation services. Following an opportunity for discussion, the Advisory Committee adopted the recommendation unanimously (with DOT and HHS abstaining).

⁶⁹ See 49 U.S.C. 42302.

⁷⁰ *Id.*

Recommendation: The Advisory Committee recommends adopting the recommendation of the State and DOT Authorities Subcommittee relating to funding of the DOT hotline. [Specifically, 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.” For greater detail, see section 10.2 above.]

Chapter 11 – Airline Deregulation Act

11.1 Background

The express preemption provision of the ADA provides that, in general:

a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under [49 U.S.C. §§ 41101-42304].⁷¹

The preemption provision applies to State laws “having a connection with, or reference to,” air carrier prices, routes, or services.⁷² Preemption applies even to laws with only “indirect” effects and to “laws of general applicability” that are not “specifically addressed to the airline industry,” at least insofar as such laws have a “significant impact” on prices, routes, or services.⁷³

Preemption does not apply to contract claims seeking recovery for an air carrier’s “breach of its own, self-imposed undertakings.”⁷⁴

An air ambulance operator is an “air carrier” covered by the ADA preemption provision if it has received economic authority from DOT to provide interstate air transportation. This is true even if the operator provides some flights within a single State, and even if the operator has received economic authority through an exemption under 14 CFR Part 298 rather than through a certificate of public convenience and necessity.⁷⁵

Courts have held that the ADA preempts various types of State laws with a significant impact on the prices, routes, or services of covered air ambulance operators.⁷⁶ Courts in some of these cases have also addressed whether State laws are saved from ADA preemption by the McCarran-Ferguson Act, which provides that “[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.”⁷⁷

⁷¹ 49 U.S.C. § 41713.

⁷² *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992).

⁷³ *Id.* at 386, 390.

⁷⁴ *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 228 (1995).

⁷⁵ *Scarlett v. Air Methods Corp.*, 922 F.3d 1053, 1060-61 (10th Cir. 2019); *Air Evac EMS, Inc. v. Cheatam*, 910 F.3d 751, 763-66 (4th Cir. 2018).

⁷⁶ *See, e.g., Guardian Flight LLC v. Godfread*, 991 F.3d 916 (8th Cir. 2021) (statutes banning air ambulance balance billing and air ambulance subscription agreements).

⁷⁷ 15 U.S.C. § 1012(b).

Courts in recent years have been repeatedly called upon to address the ADA’s applicability to disputes regarding the amounts billed by air ambulance operators to patients or insurers. As noted above, the ADA generally does not preempt breach of contract claims; this means that air ambulance operators, patients, and insurers may enforce agreements that are either express (i.e., manifested by a writing) or implied-in-fact (i.e., manifested by conduct). Even if the parties to an express or implied-in-fact contract do not agree on a price, the ADA may not preempt attempts to enforce a default price term supplied by State law.⁷⁸

A more complicated situation may arise when non-contractual State law obligates a patient or insurer to pay for air ambulance services while also limiting the amount of the required payment. For example, State law equitable doctrines such as *quantum meruit* may require the recipient of air ambulance services to pay a reasonable amount for those services. Or State workers’ compensation laws may require private insurers or a “monopolistic” State fund to pay air ambulance operators based on a fee schedule or other standard.

A number of different approaches to ADA preemption have been proposed in this area:

- Some air ambulance operators have argued that only they—and not patients or insurers—can rely on ADA preemption. These operators contend that any payment obligation imposed by non-contractual State law is binding on patients and insurers, but that the ADA preempts any limits that the same State law sets on the amount of payment.⁷⁹ In other words, these operators contend that they are legally “entitled to recover [their] full billed charges.”⁸⁰
- Some patients have argued that the ADA prevents air ambulance operators themselves from relying on non-contractual State law to demand payment. These patients contend that air ambulance operators have no enforceable right to payment in the absence of a contract.⁸¹
- The United States has proposed a middle ground, in which air ambulance operators may rely on non-contractual State law principles to demand payment, but “cannot at the same time prevent plaintiffs from relying on those same principles to argue that [their] charges are unreasonable.”⁸²

⁷⁸ See *Scarlett*, 922 F.3d at 1065-66.

⁷⁹ See, e.g., Answer Brief of Air Methods Corp. at 61, *Scarlett v. Air Methods Corp.*, No. 18-1247 (10th Cir. Nov. 21, 2018), 2018 WL 6167726 (“[S]tate law can establish a **right** to recovery by an air carrier even as it cannot regulate the **amount** of that recovery due to the ADA’s preemptive reach.”) (emphasis in original).

⁸⁰ *Id.* at 60.

⁸¹ See, e.g., *Dyer v. Air Methods Corp.*, No. 9:20-cv-2309, 2020 WL 7398711, at *10 (D.S.C. Dec. 17, 2020) (holding that to the extent an air ambulance operator’s claimed right to payment was based on an equitable “implied-in-law contract” theory, “any court enforcement of [the] bills would run afoul of the ADA”).

⁸² Brief for the United States of America at 21-22, *Scarlett v. Air Methods Corp.*, No. 18-1247 (10th Cir. Nov. 21, 2018), 2018 WL 6200633; see also *Ferrell v. Air Evac EMS*, 900 F.3d 602, 609-10 (8th Cir. 2018) (noting that if an air ambulance operator provides services without a contract, it “can assert an equitable claim to . . . recover the fair

Because Section 105(b) of the NSA generally prohibits air ambulance operators from balance billing patients who are covered by private insurance, there may be a decrease in the amount of ADA preemption litigation involving such patients. The NSA, however, does not cover workers' compensation, and ADA preemption litigation in that area may very well continue.⁸³

11.2 Advisory Committee Discussions and Recommendations

None of the subcommittees made recommendations regarding ADA preemption. During the Advisory Committee's second meeting in May 2021, however, Advisory Committee members expressed an interest in exploring such recommendations. The DFO indicated that DOT would determine whether the Advisory Committee had authority to consider such recommendations. The DFO said that a supplemental meeting would be held if DOT determined the Advisory Committee had authority.

DOT subsequently scheduled a supplemental meeting for August 2021 after it determined that the Advisory Committee had authority to consider recommendations regarding the ADA. Certain stakeholders had argued that the Advisory Committee lacked such authority because Section 418(d)(3) of the FAA Act directed the Advisory Committee to make recommendations regarding "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*" (emphasis added). DOT determined, however, that the Advisory Committee had authority pursuant to Section 418(d)(6), which directed it to make recommendations regarding "other matters as determined necessary or appropriate." DOT concluded that while Section 418(d)(3) required the Advisory Committee to make recommendations regarding steps States could take consistent with the ADA, Section 418(d)(3) did not prohibit the Advisory Committee from also making other recommendations.

At the supplemental meeting, the Advisory Committee heard five presentations.

- Charles Enloe, an attorney in DOT's Office of the General Counsel, provided background on ADA preemption and its applicability to the air ambulance industry.
- Charlotte Taylor, an attorney at the law firm Jones Day, spoke on behalf of air ambulance operators. Ms. Taylor urged the Advisory Committee not to recommend changes to the ADA. She contended that carving out air ambulance operators from ADA preemption would create a burdensome patchwork of State regulations, and that such a carveout would increase uncertainty by leading to disputes about the implied preemption of State law.

value or reasonable value of the services provided," that a court in such a case will "necessarily look to governing principles of state law," and that "[t]his is not contrary to the marketplace principles adopted in the ADA").

⁸³ See, e.g., *Air Evac EMS v. Sullivan*, 8 F.4th 346 (5th Cir. 2021) (holding that the ADA preempts Texas law setting limits on amounts that workers' compensation insurers are required to pay for air ambulance services); *Tex. Mut. Ins. Co. v. PHI Air Medical, LLC*, 610 S.W.3d 839 (Tex. 2020) (holding that the ADA does *not* preempt the same Texas law).

- Brian Webb, Assistant Director for Life and Health Policy and Legislation at the National Association of Insurance Commissioners (“NAIC”), spoke on behalf of NAIC. Mr. Webb urged the Advisory Committee to recommend amendments to the ADA similar to those proposed in a bill introduced in 2017 (S. 471 during the 115th Congress), which would have provided that the ADA does not preempt State laws “relating to network participation, reimbursement and balance billing, and transparency for an air carrier that provides air ambulance service.” Mr. Webb argued that such amendments would clarify that the ADA does not prevent States from enforcing certain requirements of the NSA, as contemplated by Section 2799B-4 of the Public Health Service Act.
- Matthew Baumgartner, an attorney at the law firm Armbrust and Brown, spoke on behalf of two groups: the workers’ compensation industry and the managers of employee benefit plans. Mr. Baumgartner urged the Advisory Committee to recommend that the ADA be amended to carve out air ambulance operators. He noted that the NSA does not cover workers’ compensation, and he argued that the workers’ compensation system could be seriously disrupted if States are preempted from regulating the amount of workers’ compensation payments to air ambulance operators.
- Joseph House, Executive Director of the Kansas Board of Emergency Medical Services and a board member of the National Association of State EMS Officials (“NASEMSO”), spoke on behalf of NASEMSO. Mr. House urged the Advisory Committee to recommend that the ADA be amended to carve out air ambulance operators. He argued that the ADA’s free market principles should not govern emergency situations in which patients do not have choices, and in which decisions are based on medical imperatives rather than economic factors.

The Advisory Committee also heard brief remarks from three members of the public. William Bryant and Bernard Diedrich, both members of the State and DOT Authorities Subcommittee, urged the Advisory Committee not to recommend amending the ADA. Michael Baulch of the Association of Critical Care Transport urged the Advisory Committee to recommend that the ADA be amended to establish State regulatory oversight of the medical aspects of air ambulance service, even if such regulation would have an indirect economic impact on prices, routes, or services.

The Advisory Committee then discussed the presentations and voted on five recommendations. The Advisory Committee adopted four recommendations to Congress for amendments to the ADA:

- **Recommendation**– In order to ensure that States can carry out the enforcement role assigned to them by the NSA, the ADA should not preempt State laws relating to network participation, reimbursement and balance billing, or transparency for an air carrier that provides air ambulance service.

- **Recommendation**– The ADA should not preempt State laws relating to State regulation of workers’ compensation insurance programs with respect to air ambulance services including monopolistic State funds in Ohio, North Dakota, Washington and Wyoming.
- **Recommendation**– The ADA should be amended to exclude air medical transportation, to clearly identify that States and local units of government have the ability to regulate all aspects related to the provision of ambulance service, and to clearly identify that the DOT retains the ability to regulate all aspects related to the operational safety of vehicles, air and ground.
- **Recommendation**– The ADA should not preempt State laws relating to licensing of medical services of air ambulance providers, even if they have incidental effect on prices, routes, and services.

Seven Advisory Committee members supported all four of these recommendations: Dr. Abernethy (a representative of physicians), Mr. Godfread (a representative of state insurance regulators), Mr. Haben (a representative of health insurance providers), Mr. Judge (a representative of air ambulance operators), Ms. Lennan (a representative of managers of employee benefit plans), Mr. Madigan (a representative of nurses), and Mr. Pickup (a representative of the workers’ compensation insurance industry). Two Advisory Committee members were opposed to all four recommendations: Ms. Connors (a representative of patient advocacy groups) and Mr. Myers (a representative of air ambulance operators). Mr. Montes (a representative of air ambulance operators) supported the recommendation related to workers compensation programs but opposed the other recommendations. Ms. Battaglini (a representative of consumer advocacy groups) was not present for the votes. The Advisory Committee’s representatives from DOT and DHS abstained from voting, as they did with all recommendations for Congressional or Federal agency action.

The Advisory Committee rejected a fifth proposed recommendation, which was that the ADA be amended to enable the Advisory Committee’s May 2021 recommendations to be implemented to the extent the ADA would otherwise preempt their implementation. This recommendation was supported by four Advisory Committee members (Judge, Madigan, Montes, and Pickup).

The Advisory Committee recognizes that its recommendations to amend the ADA overlap, and it does not intend that Congress would adopt all the recommendations. For example, adoption of the recommendation to exclude air medical transportation from the scope of the ADA altogether would obviate the need for the other three recommendations. But if Congress is not inclined to adopt that recommendation, the Advisory Committee has presented the other three recommendations as potential alternatives.

Chapter 12 – Recommendations

The Advisory Committee has issued a total of 22 recommendations on a wide variety of topics. The recommendations are directed to Congress, Federal agencies, States, air ambulance providers, and payors. Where the Advisory Committee’s recommendations make reference to subcommittee reports, the relevant sections of those reports are included for reference. The recommendations are listed in the order in which they are addressed in the body of this Report.

Definitions (see Chapter 2)

Recommendation #1: 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.

For reference, the Balance Billing Subcommittee recommended:

- The term “balance bill” be defined 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 term “surprise bill” be defined as unanticipated bill received by the patient for the difference between an out-of-network provider or supplier’s charges and the amount covered by the patient’s health insurance. 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 recommended:

- “Balance bill” means 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.
- “Surprise bill” 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.

- “Network adequacy” refers to a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network air ambulance providers.

Disclosures (see Chapter 3)

Federal and State Pre-Care Disclosures

Recommendation #2: 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 #3: 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.

For reference, the Disclosure Subcommittee recommended:

- A new row should be added to the SBC table of important questions. In the “Important Questions” column of this new row, the text “Are air ambulance services covered?” should be displayed. In the column “Answers” on that same row, the payor should disclose whether the plan covers air ambulance services. If the plan covers air ambulance services, the payor should state “Yes” and list the air ambulance providers that are in-network or provide a means for the patient/consumer to obtain such information (e.g., a web address or a toll-free phone number). If the plan’s network does not include air ambulance providers, the payor should expressly state that no air ambulance providers are in-network. In the “Why this Matters” column on that same row, the payor should provide notice of the percentage of the maximum allowable amount for covered services that the plan will pay if the patient/consumer uses an air ambulance provider that is in-network. In the same column, the payor should provide notice to the consumer that if an out-of-network air ambulance provider is used, the plan will only pay what is considered the maximum allowable amount for the service and that the patient/consumer may be responsible for paying any amount owed that exceeds the maximum allowable amount. The payor should also provide a web link and phone number that the patient/consumer can use to obtain more information about the maximum allowable amount.
- A new row should be added to the SBC table of important questions. In the “Important Questions” column of this new row, the text “What is the average air

ambulance bill?” should be displayed. In the column “Answers” on that same row, the payor should disclose the dollar amount of the average air ambulance bill charged by participating (in-network) providers and charged by non-participating providers based on the consumer’s state or region. In the column “Why this Matters,” the payor should provide notice that the average billed amount for the plan’s in-network providers is not representative of what the consumer will pay, and that the most the consumer would pay is subject to the consumer’s deductible and/or out-of-pocket limit for in-network providers. The payor should also provide notice that the average billed amount for non-participating providers includes only the average balance bill that is not included in the consumer’s annual deductible or out-of-pocket limit.

- In the SBC’s table of common medical events, in the row labeled “If you need immediate medical attention,” under the column “Services You May Need,” the text “Emergency medical transportation” should be revised to state “Emergency air and ground medical transportation.” In the same row, under the column “Limitations and Exceptions,” text should be added stating that emergency services, including emergency ground and air ambulance services, are an essential health benefit.
- In the SBC’s table of common medical events, in the row labeled “If you have a hospital stay,” under the column “Service You May Need,” a new sub-row should be added with the text “Air Ambulance.” In this sub-row, the payor should disclose in the appropriate columns information on costs that are the patient’s responsibility for using a participating provider compared to a non-participating provider, and in the “Limitations and Exceptions” column, the payor should disclose that preauthorization of services may be required.

Recommendation #4: 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 #5: 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 Advisory 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.

Point-of-Care Disclosures and Preauthorization

Recommendation #6: 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

Recommendation #7: 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.

For reference, Section 2.4.1 of the Disclosure Subcommittee Report provides:

Content for Payor Disclosures

- The Subcommittee recommends that payors should provide disclosures when they deny a patient's claim for lack of medical necessity, when they cover only a partial amount of the charges, when they submit payment to the patient directly, and when they deny a claim for lack of preauthorization.
- The content for this disclosure will differ depending on whether the disclosure is made to the patient or to a provider.
 - a) The disclosure to patients should include the following in layman's terms:
 - i) basic statements about why the payor denied the claim for lack of medical necessity or lack of preauthorization, or why the payor did not pay the claim in full;
 - ii) the amount the payor covered as an essential health benefit (EHB);
 - iii) the amount of the bill for which the patient is responsible for paying and can expect to receive a bill;
 - iv) a statement that the patient has the right to assistance from an authorized representative, which could include a family member, a lawyer, an organization, a health care or air ambulance provider, or any other person or entity the patient authorizes;
 - v) a statement that the patient has the right to have his/her claim processed in a timely fashion and to be kept informed about the status of the claim at reasonable intervals; and
 - vi) a statement that any payment received by the patient directly from a payor is money owed solely to the air ambulance provider. It should also be written in large print that the payment represents a settlement payment in full with the patient's payor and the patient will be responsible for and can expect to be billed for the remainder of the air ambulance bill, which should be estimated on the disclosure. A statement that failure to use this settlement as intended can lead to possible legal, tax, and credit reporting implications should also be prominent.

b) The disclosure to the provider should contain enough information to give providers notice reasonably calculated to inform them of the nature and basis for the action being taken (i.e., denial or partial payment) and to allow an opportunity to challenge the action and to avoid unfair surprise. Specifically, the payor should provide not only the code for the denial, but also the credentials of the reviewer and more detailed information about the basis for the denial.

- For example, if the denial is because the patient was not taken to the nearest hospital, the disclosure should identify the hospital that was closer to the patient and could have appropriately treated the patient at the time of the transfer. If the payor only makes a partial payment, the disclosure should include information explaining the basis for the amount of the payment, and whether the amount was based on usual and customary rates.

Form for Payor Disclosures

- The Subcommittee recommends that the payor disclosures to the patient should accompany the EOB as a separate document.

Review for Payor Disclosures

- The Subcommittee recommends that HHS conduct a retrospective review after five years to ensure disclosure requirements of insurance providers are working as intended.

Implementation of Payor Disclosures

- The Subcommittee recommends that HHS, Labor, and Treasury initiate rulemaking to promulgate regulations requiring the claims-related disclosures recommended by the Committee for payors. If the rulemaking is not initiated within one year of adoption of the recommendation by the full Committee, the Subcommittee recommends that Congress require the Departments to do so through legislation.

Recommendation #8: 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.

For reference, Recommendation 2.4.2 of the Disclosure Subcommittee Report provides:
Content for Air Ambulance Provider Disclosures

- The Subcommittee recommends that air ambulance providers disclose the following information to patients:

- i) An explanation of the charge, including the mileage calculated, the rate per mile, other specific charges, and a statement that the patient has the ability to request documentation supporting these charges;

- ii) The amount the air ambulance provider received from the insurance plan;

- iii) The amount owed by the patient;
- iv) A statement notifying the patient about his/her right to access medical records under HIPAA;
- v) Contact information if the patient has questions;
- vi) Information regarding how to initiate an appeal of an adverse benefit determination;
- vii) A statement notifying the patient that he/she may file a complaint with DOT, listing the hotline telephone number (when available) and a link to the DOT complaint website;
- viii) A statement about any charity/assistance programs offered by the air ambulance provider and the potential for other sources of payment outside of the patient's health insurance policy, including information on payment flexibilities and any discounted rates available from the air ambulance provider; and
- ix) A statement that the patient has the right to assistance from an authorized representative.

Form for Air Ambulance Provider Disclosures

The Subcommittee recommends that the air ambulance disclosures accompany the bill.

Review for Air Ambulance Provider Disclosures

The Subcommittee recommends that DOT conduct a retrospective review after five years to ensure disclosure requirements of air ambulance providers are working as intended.

Implementation of Air Ambulance Provider Disclosures

The Subcommittee recommends that DOT initiate rulemaking to promulgate regulations requiring the claims-related disclosures recommended by the Committee for air ambulance providers. If the rulemaking is not initiated within one year of adoption of the recommendation by the full Committee, the Subcommittee recommends that Congress require DOT to do so through legislation.

Recommendation #9: 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 #10: 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 (see Chapter 4)

Recommendation #11: 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) (see Chapter 5)

Recommendation #12: 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.

Recommendation #13: 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 (see Chapter 6)

Recommendation #14: The Advisory Committee adopts the recommendations from Chapter 5 of the Balance Billing Subcommittee report relating to data collection.

For reference, the Balance Billing Subcommittee’s recommendation is for DOT to 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.

Best Practices for Contract and Network Negotiation (see Chapter 7)

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.

For reference, the other recommendations from the Balance Billing Subcommittee are:

- 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.

Best Practices for Air Ambulance Subscription Services (see Chapter 8)

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.

Medicare Reimbursement Study (see Chapter 9)

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.

For reference, the Balance Billing Subcommittee’s definition of cost is:

The whole of financial liabilities incurred by the provider or supplier, including, but not limited to:

1. Vehicle and equipment to provide the service;
2. Maintenance of assets to ensure safety and serviceability;
3. Medical supplies, equipment, and pharmaceuticals to meet the standard of care;
4. All labor needed to carry out the enterprise (to include, but not limited to medical staff, aviation staff, administrative staff, etc.);
5. Liabilities incurred from the delivery of uncompensated and under-compensated care;
6. Facilities needed to appropriately station required vehicles and staff; and
7. Amounts incurred ensuring overall regulatory compliance.

Pursuant to Section 106 of the NSA, air ambulance providers must submit data to HHS and DOT including but not limited to “cost data, as determined appropriate by [HHS], for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services.”

DOT Hotline Funding (see Chapter 10)

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.

For reference, 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. This hotline number would be a way for consumers to directly complain to DOT, and for States to refer complaints to DOT.”

ADA and Preemption (see Chapter 11)

Recommendation #19 – The Advisory Committee recommends that the ADA be amended so it does not preempt State laws to the extent necessary to align the ADA with the NSA (relating to network participation, reimbursement and balance billing, and transparency for an air carrier that provides air ambulance service).

Recommendation #20 – The Advisory Committee recommends that the ADA be amended so it does not preempt State laws relating to State regulation of workers’ compensation insurance programs with respect to air ambulance services including monopolistic State funds in Ohio, North Dakota, Washington and Wyoming.

Recommendation #21 – The Advisory Committee recommends that the ADA be amended to exclude air medical transportation, to clearly identify that States and local units of government have the ability to regulate all aspects related to the medical services of ambulance providers, and to clearly identify that the DOT retains the ability to regulate all aspects related to the operational safety of vehicles, air and ground.

Recommendation #22 – The Advisory Committee recommends that the ADA be amended so it does not preempt State laws relating to licensing of medical services of air ambulance providers, even if they have incidental effect on prices, routes, and services.

The Committee did not adopt a fifth proposal, which was to amend the ADA to enable the Committee’s May 2021 recommendations to be implemented to the extent the ADA preempts their implementation.

Appendices

A. Text of Section 418 of the FAA Act

SEC. 418. ADVISORY COMMITTEE ON AIR AMBULANCE AND PATIENT BILLING.

(a) **IN GENERAL.**—Not later than 60 days after the date of enactment of this Act, the Secretary of Transportation, in consultation with the Secretary of Health and Human Services, shall establish an advisory committee for the purpose of reviewing 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.

(b) **COMPOSITION OF THE ADVISORY COMMITTEE.**—The advisory committee shall be composed of the following members:

- (1) The Secretary of Transportation, or the Secretary’s designee.
- (2) The Secretary of Health and Human Services, or the Secretary’s designee.
- (3) One representative, to be appointed by the Secretary of Transportation, of each of the following:
 - (A) Each relevant Federal agency, as determined by the Secretary of Transportation.
 - (B) State insurance regulators
 - (C) Health insurance providers.
 - (D) Patient advocacy groups.
 - (E) Consumer advocacy groups.
 - (F) Physician specializing in emergency, trauma, cardiac, or stroke.
- (4) Three representatives, to be appointed by the Secretary of Transportation, to represent the various segments of the air ambulance industry.
- (5) Additional three representatives not covered under paragraphs (1) through (4), as determined necessary and appropriate by the Secretary.

(c) **CONSULTATION.**—The advisory committee shall, as appropriate, consult with relevant experts and stakeholders not captured in (b) while conducting its review.

(d) **RECOMMENDATIONS.**—The advisory committee shall 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. The recommendations 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.

(e) REPORT.—Not later than 180 days after the date of the first meeting of the advisory committee, the advisory committee shall submit to the Secretary of Transportation, the Secretary of Health and Human Services, and the appropriate committees of Congress a report containing the recommendations made under subsection (d).

(f) RULEMAKING.—Upon receipt of the report under subsection (e), the Secretary of Transportation shall consider the recommendations of the advisory committee and issue regulations or other guidance as deemed necessary—

(1) to require air ambulance providers to regularly report data to the Department of Transportation;

(2) to increase transparency related to Department of Transportation actions related to consumer complaints; and

(3) to provide other consumer protections for customers of air ambulance providers.

(g) ELIMINATION OF ADVISORY COUNCIL ON TRANSPORTATION STATISTICS.—The Advisory Council on Transportation Statistics shall terminate on the date of enactment of this Act.

B. Charter

CHARTER OF THE AIR AMBULANCE AND PATIENT BILLING ADVISORY COMMITTEE U.S. DEPARTMENT OF TRANSPORTATION

1. **COMMITTEE’S OFFICIAL DESIGNATION:** The Committee’s official designation is the Air Ambulance and Patient Billing Advisory Committee (AAPB Advisory Committee).
2. **AUTHORITY:** Section 418 of the FAA Reauthorization Act of 2018, Pub. L. No. 115-254, 132 Stat. 3186 (2018), requires the establishment of an advisory committee on issues related to air ambulance services and patient billing. The AAPB Advisory Committee is also established in accordance with the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. **OBJECTIVES AND SCOPE OF ACTIVITIES:** The AAPB Advisory Committee shall advise the Secretary of Transportation on issues relating to air ambulance services and patient billing. The AAPB Advisory Committee shall 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. It shall also 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.
4. **DESCRIPTION OF DUTIES:** The AAPB Advisory Committee will carry out the following tasks:
 - (a) Make recommendations to the Secretary with respect to 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;
 - (b) Make recommendations to the Secretary with respect to 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;
 - (c) Make recommendations to the Secretary with respect to 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;
 - (d) Make recommendations to the Secretary with respect to 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 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;

(e) Make recommendations to the Secretary with respect to definitions of all applicable terms that are not defined in statute or regulations;

(f) Make recommendations to the Secretary with respect to other matters as determined necessary or appropriate; and

(g) Submit a report of its recommendations to the Secretary of Transportation, the Secretary of Health and Human Services, and the appropriate committees of Congress.

5. **OFFICIALS TO WHOM THE COMMITTEE REPORTS:** The AAPB Advisory Committee shall report to the Secretary of Transportation through the Department's General Counsel or designee.

6. **SUPPORT:** The Department's Office of the General Counsel will sponsor the AAPB Advisory Committee.

7. **ESTIMATED ANNUAL OPERATING COSTS AND STAFF YEARS:** The estimated annual cost to the Government is \$144,555. The AAPB Advisory Committee will require the support of approximately 0.8 full-time DOT employee.

8. **DESIGNATED FEDERAL OFFICER (DFO)**

(a) The Assistant General Counsel for Aviation Consumer Protection, or designee, will serve as the Designated Federal Officer (DFO) for the AAPB Advisory Committee.

(b) The DFO, or designee, approves or calls all of the AAPB Advisory Committee and subcommittee meetings, develops and approves the agenda in advance of consultation with the Chairperson, and must be present at each AAPB Advisory Committee and subcommittee meeting. The DFO chairs meetings when directed to do so by the Secretary and has the authority to adjourn meetings whenever such action is deemed to be in the public interest. The DFO works with the Chairperson to maintain order.

9. **MEETINGS:**

(a) Frequency: It is anticipated that the AAPB Advisory Committee will meet at least once before its charter terminates. Additional meetings and subcommittee meetings may be called as necessary.

(b) Voting: A quorum must exist for any official action, including voting on a recommendation, to occur. A quorum exists whenever 75% of the appointed members are present. In any situation involving voting, the majority vote of members present will prevail,

but the views of the minority will be reported as well. If there is no majority vote, the result ‘No Consensus’ must be reported, followed by the views of each voting faction.

10. **DURATION:** Continuing.

11. **TERMINATION:** The AAPB Advisory Committee will terminate upon the issuance of the report required by section 418(e) of the FAA Reauthorization Act. Unless renewed by appropriate action prior to expiration, the charter for the AAPB Advisory Committee will expire two years from the date it is filed.

12. **MEMBERSHIP AND DESIGNATION:**

(a) The AAPB Advisory Committee shall be comprised of at least 13 members, including:

- i. The Secretary of Transportation, or the Secretary’s designee;
- ii. The Secretary of Health and Human Services, or the Secretary’s designee;
- iii. One representative of each of the following:
 1. Each relevant Federal agency, as determined by the Secretary;
 2. State insurance regulators;
 3. Health insurance providers;
 4. Patient advocacy groups;
 5. Consumer advocacy groups;
 6. Physician specializing in emergency, trauma, cardiac, or stroke;
- iv. Three representatives of the various segments of the air ambulance industry;
- v. Three additional representatives not covered under sections (i) through (iv), as determined necessary and appropriate by the Secretary of Transportation.

(b) The Chairperson of the AAPB Advisory Committee shall be designated by the Secretary of Transportation from among the individuals whom he or she appoints to the AAPB Advisory Committee. Members’ terms shall commence when they are appointed by the Secretary of Transportation.

(c) Members serve at the pleasure of the Secretary of Transportation and may be replaced at any time for any reason, including non-participation.

(d) A vacancy in the AAPB Advisory Committee shall be filled in the manner in which the original appointment was made.

(e) Members of the AAPB Advisory Committee shall serve without pay but may receive travel and per diem expenses in accordance with 5 U.S.C., chapter 57, subchapter I.

(f) Members appointed solely for their expertise shall serve as special Government employees.

13. **SUBCOMMITTEES:**

(a) The DFO may establish subcommittees to perform specific assignments.

(b) Subcommittees shall not work independently of the chartered AAPB Advisory Committee and shall report all of their recommendations and advice to the full AAPB Advisory Committee for deliberation and discussion. Subcommittees must not provide advice or work products directly to the Department or any Federal agency.

14. **RECORDKEEPING:** The records of the AAPB Advisory Committee, formally and informally established subcommittees, or other subgroups of the AAPB Advisory Committee shall be handled in accordance with General Records Schedule 6.2 or other approved agency records disposition schedule. These records shall be available for public inspection and copying, subject to the Freedom of Information Act, 5 U.S.C. § 552. An agency docket will also be established for AAPB Advisory Committee documents. To the extent that there is a discussion of issues concerning ongoing rulemaking proceedings during an AAPB Advisory Committee meeting, the minutes of that meeting will be placed in the appropriate docket.
15. **FILING DATE:** The filing date of this charter is September 13, 2021. Unless renewed, the charter will expire on March 13, 2022, or upon the issuance of the report required by section 418(e) of the FAA Reauthorization Act, whichever comes sooner.

C. AAPB Advisory Committee Members

The Secretary selected committee members for their expertise as well as their willingness and ability to actively participate in meeting the AAPB Advisory Committee's objective. The committee members are:

1. Dr. Michael Abernethy, Clinical Professor of Emergency Medicine, University of Wisconsin School of Medicine and Public Health, as representative of physicians.
2. Elizabeth Battaglino, Chief Executive Officer, HealthyWomen, as representative of consumer advocacy groups.
3. Lisa Swafford, Deputy Assistant General Counsel for Operations, U.S. Department of Transportation, as DOT representative and Chair of the AAPB Advisory Committee.
4. Susan Connors, President and Chief Executive Officer, Brain Injury Association of America, as representative of patient advocacy groups.
5. Jon Godfread, Insurance Commissioner, State of North Dakota, as representative of state insurance regulators.
6. John Haben, Vice President for National Contracting, UnitedHealth Networks, as representative of health insurance providers (now retired).
7. Thomas Judge, Executive Director, LifeFlight of Maine, as representative of air ambulance providers.
8. Anne Lennan, President, Society of Professional Benefit Administrators, as representative of managers of employee benefit plans.
9. Kyle Madigan, Director, Dartmouth Hitchcock Advanced Response Team, as representative of nurses.
10. Rogelyn McLean, Senior Policy Advisor, Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services, as the member appointed by the Secretary of Health and Human Services.
11. Asbel Montes, Vice President of Government Relations and Revenue Cycle, Acadian Ambulance, as representative of air ambulance providers.
12. Christopher Myers, Executive Vice President of Reimbursement, Air Methods Corporation, as representative of air ambulance operators.
13. Ray Pickup, President and CEO, WCF Mutual Insurance Company, as representative of the workers' compensation insurance industry.

D. AAPB Advisory Committee - Subcommittee Members

Subcommittee on Disclosure and Distinction of Charges and Coverage for Air Ambulance Services

1. Dr. Michael K. Abernethy, University of Wisconsin School of Medicine and Public Health
2. Dr. Kevin Hutton, Retired Air Medical Executive
3. Kyle Madigan, Dartmouth Hitchcock Advanced Response Team
4. Edward R. Marasco, Quick Med Claims
5. Rogelyn McLean, HHS
6. Asbel Montes, Acadian Ambulance Service
7. Dr. David P. Thomson, East Carolina University

Subcommittee on Prevention of Balance Billing

1. Susan Connors, Brain Injury Association
2. John Haben, UnitedHealth Group
3. Anne Lennan, Society of Professional Benefit Administrator
4. David Motzkin, PHI Air Medical
5. Christopher Myers, Air Methods Corporation
6. Ray Pickup, WCF Mutual Insurance Company

Subcommittee on State and DOT Consumer Protection Authorities

1. Elizabeth Battaglino, HealthyWomen
2. William Bryant, Sierra Health Group
3. Thomas Cook, Air Medical Group Holdings, LLC
4. Bernard F. Diederich, Retired
5. Jon Godfread, North Dakota Insurance Group
6. Thomas Judge, LifeFlight of Maine

E. Minutes of meetings

Meeting Summary First Meeting of the AAPB Advisory Committee January 15-16, 2020 U.S. Department of Transportation, Washington, D.C.

The Air Ambulance and Patient Billing (AAPB) Advisory Committee met on January 15 and 16, 2020 in the Media Center at the U.S. Department of Transportation (DOT) Headquarters, 1200 New Jersey Avenue, SE, Washington D.C. 20590. The attached appendix identifies the Committee members, agency employees, and others who attended the meeting. In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. The webcast of the meeting is available at: <https://www.transportation.gov/airconsumer/AAPB/meeting-video>.

Several topics were discussed at the meeting: (1) an overview of the air ambulance industry; (2) air ambulance costs and billing; (3) insurance and air ambulance payment systems; and (4) disclosure and separation of charges, cost shifting, and balance billing. The meeting consisted of a morning and afternoon session each day which included presentations and opportunity for discussion. The 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. The agenda for the meeting is attached as an appendix.

Day One January 15, 2020

Welcome, introductory remarks, and agenda overview

The first day of the AAPB Advisory Committee (Committee) meeting began at 9:30 AM on January 15, 2020. Blane Workie, DOT Assistant General Counsel for Aviation Enforcement and Proceedings and Designated Federal Officer (DFO), gave welcoming remarks and provided meeting logistics. Ms. Workie stated the meeting would be live cast and a recording would be available on the DOT website following the meeting.

The committee members introduced themselves and gave brief opening remarks.

Greg Cote, DOT Associate General Counsel, gave remarks and thanked those present for attending. Mr. Cote reviewed the tasks assigned to the Committee by the Committee Charter and the FAA Reauthorization Act of 2018. Mr. Cote stated the intent of the meeting is to provide foundational background information and to begin a discussion on the issues for which the Committee must make recommendations. Mr. Cote reviewed the agenda and encouraged committee members to participate with a spirit of collaboration and a willingness to hear and respect alternative perspectives.

Presentations and Committee Discussion

Following the welcome and introductory remarks, the morning session of day one began. The Committee heard from speakers who presented overviews of the air ambulance industry and air ambulance costs and billing reports. After each presentation, the Committee was invited to ask questions and make comments.

Overview of Air Ambulance Industry: History, Models, Locations

Roxanne Shanks, Association of Critical Care Transport

The Committee first heard from Roxanne Shanks of the Association of Critical Care Transport and David Motzkin of the Association of Air Medical Services who provided an overview of the air ambulance industry. Ms. Shanks and Mr. Motzkin provided information on the history and evolution of the industry; models, business structures, and locations of air ambulance providers; ownership types; operation costs; and billing procedures.

Ms. Shanks gave a short history of the use of air transport to provide medical evacuation. Ms. Shanks described various models of service and medical team configurations and described that critical care standards vary from state to state. Ms. Shanks described the variation of medical helicopter capability in the U.S. fleet and noted that some states require accreditation to operate. Ms. Shanks discussed changes to the air ambulance industry over time, using data from the Atlas and Database of Air Medical Services (ADAMS) database. Ms. Shanks then presented information about the different air medical service delivery models as well an overview of air medical base locations and related changes over time.

Overview of Air Ambulance Industry: Ownership, Operation Costs, Billing Procedures

David Motzkin, Association of Air Medical Services

Mr. Motzkin talked about conditions that must be present to launch an air ambulance. Mr. Motzkin addressed accessibility and other trends affecting the air medical services industry. Mr. Motzkin presented information about the costs of providing air medical services and discussed billing and collection practices. Mr. Motzkin discussed the different bills consumers might receive for air medical services. Mr. Motzkin also provided information on different air medical service provider ownership structures.

Remarks by General Counsel Steven G. Bradbury

After Ms. Shanks' presentation and prior to the presentation by Mr. Motzkin, DOT General Counsel Steven G. Bradbury gave remarks. Mr. Bradbury discussed the complex nature of air ambulance regulation and noted DOT's authority to take enforcement action against air transportation providers engaged in unfair and deceptive practices. Mr. Bradbury discussed the congressional directives to the Committee and noted his interest in following the Committee's progress and reading the resulting report.

Air Ambulance Costs and Billing Reports

John Hargraves and Aaron Bloschichak of the Health Care Cost Institute (HCCI)

Marla Kugel, Kugel HPC

The Committee then heard from John Hargraves and Aaron Bloschichak of the Health Care Cost Institute (HCCI) on their study titled *Air Ambulances-10 Year Trends in Costs and Use*.

Mr. Hargraves began by providing the Committee with some background information on HCCI, including its mission and data sources. Mr. Hargraves noted that the goal of HCCI's report was to gather data on the commercially insured to help fill in the gaps and provide a broader view to support stakeholders – including media and legislators. Additionally, Mr. Hargraves noted that the goal of the study was to report and benchmark data and that the report was not intended to suggest policy, but rather to suggest where more research might be done. Mr. Bloschichak noted that the report used a specific sample of the population and used four (4) specific Current Procedural Terminology (CPT) codes for air ambulance services for data points. Mr. Bloschichak discussed the study's findings and noted that the price and overall spending for air ambulances has increased.

Next, the Committee heard from Marla Kugel of Kugel HPC, on a study titled *Air Medical Services Cost Study Report*. The report was prepared for the Association of Air Medical Services and Members by Xcenda and Ms. Kugel was the main author of the report. Ms. Kugel presented the study and walked through its key findings. Ms. Kugel walked through the methods used by the study and noted that the study used information from responses to a form designed by industry CFOs. Ms. Kugel discussed the data that was collected and how the study made projections based on the data.

Following these presentations, the Committee adjourned for lunch.

During the afternoon session, the Committee heard presentations on different insurance and air ambulance payment system models. As in the morning, after each presentation the Committee was invited to ask questions and make comments.

Insurance and Air Ambulance Payment Systems: Medicare/Medicaid

Carol Blackford and Andrew Badaracco from the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS).

The Committee heard presentations on Medicare and Medicaid reimbursement in the context of air ambulance services, from Carol Blackford and Andrew Badaracco from the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS).

Ms. Blackford provided an overview of the different Medicare services. Ms. Blackford discussed the requirements for Medicare Part B reimbursement and provided an overview of the Medicare Part B ambulance transport benefit. Ms. Blackford further described air ambulance transport coverage criteria and described air ambulance reimbursement amounts and calculations. Finally, Ms. Blackford presented the current base rates and mileage payments for air ambulance services.

Mr. Badaracco provided an overview of Medicaid's Division of Reimbursement Services. Mr. Badaracco discussed that the Medicaid program is a joint federal and state program and described the roles of the states in administering Medicaid. Mr. Badaracco also discussed the relationship between the federal government and the states regarding Medicaid rate setting and noted that CMS cannot require a state change its rates after they have been approved.

Insurance and Air Ambulance Payment Systems: Private Insurance

Myra Simon, America's Health Insurance Plans (AHIP)

Wanda Lessner, CareFirst

The Committee next heard from Myra Simon from America's Health Insurance Plans (AHIP) and Wanda Lessner from CareFirst. Ms. Simon and Ms. Lesser were asked to present to the Committee about private insurance in the context of air ambulance payment systems.

Ms. Simon described the basics of in- vs. out-of-network approaches, and the responsibilities and incentives of each approach. Ms. Simon provided information on how consumers and patients can learn more about their insurance coverage, but noted that most consumers do not think to look for their air ambulance coverage until after the service has been rendered.

Ms. Simon also discussed the Federal coverage requirements to which private health insurance providers are subject, such as a prohibition on emergency medicine preauthorization. Ms. Simon discussed sources of consumer cost and discussed the variation in emergency and non-emergency situations and how those affect consumer cost. Finally, Ms. Simon discussed air ambulance and other provider disclosures.

Ms. Lessner noted that air ambulance service is covered under most private insurance contracts. Ms. Lesser stated that in non-emergency situations, a prior authorization by the insurance company is usually required for the service to be covered. Ms. Lessner described CareFirst's experience working with air ambulance providers and noted that CareFirst has recently gone in-network with most of the air ambulance service providers in Maryland. Ms. Lessner described pressures from the State legislature, other companies, and the Governor as contributing factors that led to an in-network agreement.

Insurance and Air Ambulance Payment Systems: Other Perspectives

Brett Edwards, Health Scope Benefits

Mary Nichols, Texas Mutual Insurance Company

The final presentations of the first day were given by Brett Edwards from Health Scope Benefits, and Mary Nichols from the Texas Mutual Insurance Company.

Mr. Edwards was asked to present about employee benefit plans in the context of air ambulance payment systems and Ms. Nichols was asked to present about workers' compensation insurance in the same vein.

Mr. Edwards began with background on laws to which private employers are subject. Mr. Edwards briefly discussed the Employee Retirement Income Security Act of 1974 (ERISA) as an

important statute in this area. Mr. Edwards discussed that employee benefit plans are uniquely affected by air ambulance billing issues due to the source of the funds that pay these claims. Mr. Edwards noted that employee benefit plans are funded by employee premiums and/or employer assets and employee plans sometimes buy reinsurance to prepare for catastrophic claims.

Mr. Edwards stated that most of the air ambulance claims filed with employee benefit plans are related to inter-facility transfers, and Mr. Edwards noted how the cost of this service differs depending on whether the transfer is scheduled or emergent. Mr. Edwards concluded his presentation by discussing the extensive disclosure requirements that apply to employers because of ERISA and suggested that some of these ideas might be borrowed to improve the disclosures made by private insurers.

Ms. Nichols described some of the ways that workers' compensation insurance differs from other types of insurance, such as the requirement that the workers' compensation insurance provider pay the entire amount of a claim. Ms. Nichols noted workers' compensation insurance liabilities are unique as they extend for the lifetime of the worker and cover more than just health care claims. Ms. Nichols noted that because workers' compensation insurance covers the entire claim, there is no balance billing. Ms. Nichols discussed some of the tradeoffs of the highly-regulated workers' compensation system and noted that the employee and the employer each give up certain rights or protections to have the security of specific benefits and liability limitations.

Open Discussion and Closing Remarks

Following the presentations, the Committee members had the opportunity to make final remarks. Ms. Workie reviewed some of the data requests raised by the Committee throughout the day and noted that all the information presented to the Committee would be available on the AAPB Advisory Committee docket.

The meeting was adjourned for the day by Mr. Cote around 4:45 PM and scheduled to reconvene at 9:00 AM the following day.

Day Two January 16, 2020

Welcome and Outline of Day Two

The second day of the meeting of the Air Ambulance and Patient Billing Advisory Committee began at 9:00 AM on January 16, 2020 in the Department of Transportation (DOT) Conference Center.

Presentations

The morning session of day two consisted of presentations on consumer issues. The Committee heard from speakers who presented on cost shifting and balance billing, disclosure of charges

and insurance coverage, distinguishing between air transportation and medical charges, and consumer choice and determination of medical necessity. After each presentation, the Committee was invited to ask questions and make comments.

Consumer Issues: Cost Shifting and Balance Billing

Jack Hoadley from the Georgetown Center on Health Insurance Reforms

The Committee first heard from Jack Hoadley from the Georgetown Center on Health Insurance Reforms. Mr. Hoadley was asked to present to the Committee about cost shifting and balance billing from the consumer perspective. Mr. Hoadley began by providing an overview of key terms (surprise medical bill, balance bill, cost shifting) to be used throughout his presentation. Mr. Hoadley discussed surprise medical bills and situations where they might arise. Mr. Hoadley then discussed balance billing and conditions in which balance billing might be a strategy for increasing profits.

Mr. Hoadley discussed approaches for protecting consumers from surprise and balance bills. Mr. Hoadley provided a review of recent state legislative activity aimed at increasing consumer protections. Mr. Hoadley concluded his presentation with a discussion of proposed provisions and a look ahead to potential actions by Federal and state governments in 2020.

Consumer Issues: Disclosure of Charges and Insurance Coverage

Troy Oeschner, New York Department of Financial Services

Next, the Committee heard from Troy Oeschner of the New York Department of Financial Services who was asked to present about the disclosure of charges and insurance coverage from the perspective of a state regulator. Mr. Oeschner discussed ways in which advance notice of insurance coverage and/or air ambulance charges might help to eliminate or reduce balance billing. Mr. Oeschner noted that many air ambulance trips occur in emergent situations, and thus notice of insurance coverage or potential charges might not be particularly useful in combatting balance bills.

Mr. Oeschner discussed how the documents that are sent to consumers explaining their insurance coverage and explaining their benefits are helpful, but again noted that these documents are sent after the air ambulance services have been rendered. Mr. Oeschner noted other challenges for state regulators, such as the ADA and ERISA.

Consumer Issues: Distinguishing Between Air Transportation and Medical Charges

Shawn Gremminger, Families USA

Ed Marasco, Quick Med Claims

Following the presentation by Mr. Oeschner, the Committee heard from Shawn Gremminger of Families USA who was asked to present from the consumer advocate perspective about distinguishing between air transportation and medical charges.

Mr. Gremminger first provided an overview of the average family liquid savings compared with the average medical billing costs. Mr. Gremminger described how the air ambulance services market could be viewed as failing since the cost of the service has not decreased even though the supply of the service has increased. Mr. Gremminger discussed potential effects on consumers of splitting an air ambulance bill into transportation charges and medical charges. He noted that the split might increase transparency in the charges, but it would likely not affect the consumer

as they would still be concerned with the total amount of the bill.

The Committee next heard from Ed Marasco of Quick Med Claims who presented about distinguishing between air transportation and medical charges from the billing services perspective. Mr. Marasco presented on the different organizational structures of air medical service providers and how the different structures could present challenges to the feasibility of distinguishing charges. Mr. Marasco described some challenges in cost analysis, including that medical transport has a high fixed cost, which makes it difficult to determine the actual cost of a transport. Mr. Marasco noted that cost can be affected by many factors such as the weather and transport volume.

Mr. Marasco then presented an overview of claims processing trends and suggested that distinguishing between charges in a bill might have the effect of confusing consumers instead of providing transparency as they may not understand the difference between the bills or how their insurance applies. Mr. Marasco described challenges for the service provider and the consumer in submitting two claims for an air ambulance trip and noted potential challenges to adjudicating multiple claims for one trip. Mr. Marasco highlighted other potential issues with payment processing and noted the potential of a general increase in administrative burden because of distinguishing charges for air ambulance trips

Consumer Issues: Consumer Choice and Determination of Medical Necessity

Dr. Ed Racht, Global Medical Response

The final morning session presentation was given by Dr. Ed Racht of Global Medical Response. Dr. Racht was asked to present to the Committee from the medical professional perspective on the issue of consumer choice and the determination of medical necessity.

Dr. Racht presented an overview of the current state of medical services practice and discussed clinical advantages of emergency air ambulance service. Dr. Racht described the importance of a system of decision making and walked the Committee through the decision-making processes of Emergency Medical Technicians when deciding what kinds of services are medically necessary. Dr. Racht discussed the evolution of out-of-hospital care and the resulting impact on impacts air emergency medical services.

Following these presentations, the Committee adjourned for lunch.

During the afternoon session, the Committee heard presentations from DOT's Office of General Counsel. As in the morning, after each presentation the Committee was invited to ask questions and make comments.

Consumer Issues: Consumer Complaints

Rob Gorman, DOT Office of Aviation Enforcement and Proceedings

The Committee heard from Rob Gorman from DOT's Office of Aviation Enforcement and Proceedings about DOT's involvement and response to consumer complaints which are received regarding air ambulance services or billing practices.

Mr. Gorman provided the Committee with an overview of the Office of Aviation Enforcement and Proceedings, including its organizational structure, employees, and enforcement practice. Mr. Gorman described DOT's relevant statutory authority found in section 41712 of title 49 of the United States Code and how that authority is interpreted and enforced by the office. Mr. Gorman described the DOT complaint handling process in general and then provided specific information about how air ambulance complaints are handled. In addition, Mr. Gorman provided information on where DOT houses complaint information and data that is available to the public. Mr. Gorman presented an overview of the kinds of complaints DOT receives relating to air ambulance and discussed other avenues and potential repositories for consumer complaints.

Air Ambulance Litigation, Airline Deregulation Act, and Preemption

Paul Geier and Charlie Enloe, DOT Office of Litigation and Enforcement

The Committee then heard from Paul Geier and Charlie Enloe of DOT's Office of Litigation and Enforcement. Mr. Geier and Mr. Enloe were asked to present about DOT involvement in, and a general discussion of, air ambulance litigation, as well as an overview of the Airline Deregulation Act of 1978 (ADA) and related preemption issues.

Mr. Geier provided a description of the Supremacy Clause of the Constitution and explained that it functions as displacement of state law in deference of federal law. Mr. Geier then provided an overview of the ADA and the "regulated era" of aviation. Mr. Enloe explained that the ADA prohibits the regulation of anything "related to" air transportation price, and further explained that "related to" has been interpreted expansively by the Supreme Court. Mr. Enloe discussed how the ADA has interpreted "air carrier" to include air ambulances. Mr. Enloe also discussed the McCarran Ferguson Act and how it allows states to regulate the business of insurance. Mr. Enloe described several principles of state law which require payment to air ambulances who provide service and provided an overview of cases litigating payment issues. Finally, Mr. Enloe presented on evolving body of law related to cases challenging the application of the ADA to various state efforts to regulate air ambulance services.

Opportunity for Final Comment and Adjournment

The meeting concluded with the opportunity for final comments from the Committee and the public in attendance. The first meeting of the AAPB Advisory Committee was adjourned by Mr. Cote around 4:00 PM.

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

Gregory D. Cote

Chairman

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 rate 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 <i>must</i> consider one set of enumerated factors; <i>may</i> consider a second set of factors; and <i>must not</i> consider a third set of factors.	When determining the amount of the award, the DRE <i>should</i> 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 Godfreed summarized the State and DOT Authorities Subcommittee’s recommendation for state-level IDR systems as an alternative to Federal IDR. Mr. Godfreed 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.

- Costs and Qualifications of DRE

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.

- Factors for the DRE to Consider: Payments to Other Providers

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 health care consultant on the State and DOT Authorities Subcommittee 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 health care consultant on the State and DOT Authorities Subcommittee 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.

Wrap Up / 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

Meeting Summary
Third Meeting of the AAPB Advisory Committee
August 11, 2021
U.S. Department of Transportation, Washington, D.C.

The Air Ambulance and Patient Billing (AAPB) Advisory Committee (Committee) met on August 11, 2021, from 1:00 to 4:00 p.m. Eastern time, in a virtual meeting via the Zoom Webinar Platform.

The Committee discussed the impact of the Airline Deregulation Act (ADA) on States' ability to regulate air ambulance operations, and whether to recommend that the ADA be amended as a means of improving the oversight of air ambulance providers.

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 is 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 list of Committee recommendations. 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.

Welcome, housekeeping matters, and introductory remarks

The Committee meeting began at 1:00 p.m. on August 11, 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.

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 introductions of the Committee members.

Presentation by Charles Enloe, DOT – Background

Charles Enloe, an attorney in DOT's Office of the General Counsel, presented on the express preemption provision of the Airline Deregulation Act of 1978 and the way that courts have applied that provision in the air ambulance context.

Mr. Enloe read the text of the ADA preemption provision, which is codified as amended at 49 U.S.C. § 41713(b)(1). He discussed several interpretations of the provision that the courts have provided. He then described certain State air ambulance laws that courts have held to be

preempted by the ADA, including State laws banning balance billing and State laws banning subscription or membership programs.

Mr. Enloe then discussed the ways in which the ADA might apply to a dispute over the amount of payment that a patient or insurance company owes to an air ambulance provider. He explained that the ADA would not prevent enforcement by a provider, patient, or insurance company of an express contract or an implied-in-fact contract (which is an actual agreement manifested by the parties' conduct rather than a writing). And he noted that courts have suggested that this is true even if the parties to the contract do not agree on a price, but State law imposes a default price term that the parties could have contracted around.

Mr. Enloe then discussed two situations in which there might not be any sort of contractual agreement. First, he discussed the transportation of an individual patient without an agreement. He explained that in that context, State law equitable theories—such as unjust enrichment, *quantum meruit*, and implied-in-law contract—often provide that a party who provides a benefit is entitled to compensation. Second, he discussed State worker's compensation laws that entitle providers to compensation from a State fund or private insurers.

Mr. Enloe noted that both State law equitable theories and State worker's compensation laws limit the amount of compensation to which a provider is entitled, and that it could be thought that the ADA preempts these limits as applied to air ambulance operators. He noted, however, that such a conclusion could impact the entitlement of a provider to *any* compensation, that this is an unsettled area of law, and that the courts have explored a number of approaches.

Mr. Enloe explained that some air ambulance operators have argued that non-contractual State law principles can give air ambulance operators the *right* to payment, and that the ADA prohibits patients or insurers from contesting the *amount* of payment. He discussed recent litigation in which the U.S. Court of Appeals for the Tenth Circuit held that the ADA preempted limits imposed by Wyoming on the amounts paid to air ambulance providers by the State worker's compensation fund, and the Wyoming Supreme Court then held that the preempted provision was severable from the State law giving providers an entitlement to compensation.

Mr. Enloe stated that the opposite view would be that the ADA prohibits patients, insurance companies, *and* air ambulance providers from relying on non-contract State law principles, meaning that air ambulance providers might not have a legal entitlement to payment in the absence of a contract. He explained that some courts have expressed a willingness to consider this argument, especially in recent months.

Mr. Enloe then explained that the United States took a middle ground position in the *Scarlett* litigation in the Tenth Circuit: if an air ambulance provider relies on non-contractual State law principles to claim an entitlement to payment, the patient or insurer may rely on the same State law principles to argue that the provider is claiming more than the amount to which it is entitled. He noted that the Eighth Circuit endorsed a similar position in *dicta* in 2018.

Mr. Enloe noted that the enactment of the No Surprises Act, which generally bans balance billing by air ambulance providers, should make payment disputes between providers and patients less likely. He noted, however, that worker's compensation disputes will likely remain.

Mr. Enloe described two recent cases involving the Texas worker's compensation system: a Texas Supreme Court case holding that the ADA does not preempt limits on the amount worker's compensation insurers are required to pay to air ambulance operators, and a decision of U.S. Court of Appeals for the Fifth Circuit holding that the ADA *does* preempt those limits.

Presentation by Charlotte Taylor – Perspective of Air Ambulance Providers

Ms. Charlotte Taylor, an attorney at the law firm Jones Day, spoke to the Committee on behalf of air ambulance operators. She noted that air ambulance operators recommend against carving out air ambulance operations from ADA preemption. She added that exempting air ambulance operators would create more legal uncertainty and have unintended consequences that would be detrimental to the market for air ambulance services.

On the issue of uncertainty, Ms. Taylor discussed the possibility that Federal field preemption could still displace State law if the ADA's express preemption were repealed, as courts have held that field preemption applies in other aviation subjects, such as airline safety (including the safety of air ambulance operators), and airline consumer protection. She also noted the possibility that conflict preemption could apply where an operator's compliance with both State and Federal law were an impossibility due to conflicting requirements. Ms. Taylor argued that these other forms of preemption would create uncertainty for the industry.

Ms. Taylor also discussed potential unintended consequences of exempting air ambulance operators from ADA preemption. She stated that air ambulance operators based close to State borders often provide a lot of services in neighboring States, and with the repeal of preemption, States could pass burdensome route requirements that would prevent operators from providing transportation to other States. She noted that this could create a complex patchwork of State requirements on certification, staffing, and other subjects, which would create barriers for operators and competition.

Ms. Taylor concluded her presentation by noting that the AAPB Advisory Committee's work is a reflection of Congress' efforts to set in motion solutions to air ambulance issues, and recommending appeal of ADA preemption at this late date would undermine Congress' efforts.

Presentation by Brian Webb, National Association of Insurance Commissioners – Perspective of State Insurance Regulators

Mr. Webb noted that NAIC has worked on the issue of air ambulance balance billing since 2013. NAIC saw more complaints coming in from consumers in recent years. Mr. Webb stated that NAIC saw prices of air ambulance services increase significantly recently, and some up to 2 to 3 times. He noted that this was burdensome to consumers since they are billed.

Mr. Webb observed that air ambulance operators typically do not enter into contracts with patients and that States tried to step in to address this issue of a patient being put in the middle between air ambulance providers and insurers with balance billing. States looked at imposing requirements on air ambulance operators related to reporting, price disclosures, and dispatch lists. Some States were successful in encouraging out-of-network agreements, and some States tried to impose balance billing restrictions as applied to air ambulance providers. But courts, as discussed by other presenters, found preemption under the ADA and limited States' ability to regulate in this area.

Mr. Webb stated that he worked with Congress on the 2018 FAA Reauthorization Act. He mentioned that NAIC worked with Senator Tester and other members to try and secure language that enables States to address air ambulance balance billing issues and regulate in this specific area. Mr. Webb added that the issue of safety, rates, routes, services are understandably a concern under the ADA, but those changes are not being recommended by NAIC. According to Mr. Webb, NAIC recommended language that was narrow to let States protect consumers. He emphasized that the AAPB Advisory Committee was created under the 2018 FAA Reauthorization Act through the efforts of NAIC working with Congress.

Mr. Webb stated the work of the AAPB Advisory Committee is to look at the problems with patient billing for air ambulance services. He recommended that this Committee report back to Congress that there is a problem under ADA preemption and States are part of the solution. He noted that NAIC supports the passage of the No Surprises Act (NSA) because it does a great job at protecting the consumer. However, he explained that there is an issue of States being the primary regulators of air ambulances under NSA and then States being preempted in this role under the ADA. Mr. Webb asserted that the NSA protects against balance billing, but introduces a possible conflict with the ADA on enforcement. Mr. Webb said NAIC is looking for language that allows States to regulate air ambulance services. However, Mr. Webb cited to Section 2799B-4 of the Public Health Service Act that each State may require a provider or health care facility (including a provider of air ambulance services) subject to the requirements of this part to satisfy such requirements. Mr. Webb indicated that NAIC believes this provision indicates the role of States to enforce regulations under the NSA and to protect consumers. He acknowledged that the ADA would still preempt this role for the States.

Mr. Webb stated that NAIC would recommend at the very least that the Committee recognize the problem of ADA preemption in this area and it should be clear in advocating for that States to regulate in the narrow areas of network participation, reimbursement and balance billing, and transparency. He further underscored his point from earlier not to include other elements of ADA preemption such as safety. Mr. Webb said that Congress needs to provide direction on aligning the ADA with the NSA that allows States to enforce the NSA. Mr. Webb suggested that States would assist consumers that have complaints by working with insurance companies licensed in the State, and air ambulance providers licensed in the State. Mr. Webb declared that the consumer should be out of it and should not receive balance bills. Mr. Webb stated that this language was offered by NAIC to Congress..

Mr. Webb also asked that as DOT implements regulations under the NSA regarding air ambulance providers, that DOT work with the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury. Mr. Webb contended that only when a State law does not apply, should DOT be the regulator. He advocated for States being the primary regulators, as he believes this was the intended purpose of the NSA. Mr. Webb stated that NAIC is proposing this regulatory recommendation and it should be supported with a legislative recommendation as well to address ADA preemption. According to Mr. Webb, to ensure adequate enforcement of the NSA, a narrow change to the ADA is NAIC's recommendation to the Committee.

Presentation by Matthew Baumgartner, Armbrust and Brown – Perspectives of Workers' Compensation Industry and Managers of Employee Benefit Plans

Mr. Baumgartner provided the perspective of the workers' compensation industry and the perspective of managers of employee benefit plans.

Workers' Compensation

Mr. Baumgartner stated that the ADA is a deregulation statute which ended the authority of the Civil Aeronautics Board (CAB) to set rates for commercial airlines. He explained that rate setting was thought to be necessary when the industry was getting established, but by the late 1970s it was apparent that there was a viable consumer market. Mr. Baumgartner added that the air ambulance marketplace is very different from commercial aviation. He noted that workers' compensation is a purely State-level insurance and labor regulatory system which runs largely independent of Federal law; it is designed to spread the risk and cost of workplace accidents among employers and to replace tort suits.

Mr. Baumgartner stated that workers' compensation for air ambulance transport was obviously beyond the intended scope of the ADA. He stated that the preemption argument currently being adopted by courts (*i.e.*, that the ADA preempts States from regulating workers' compensation for air ambulance transports) is based on textual literalism and not on statutory intent. He stated that he has made the same anti-preemption arguments to various courts, but with varying degrees of success. He stated that some courts consider the consequences of preemption, and some do not. He elaborated that some courts say that the default State standard (quantum meruit or implied-in-fact standards) would "obviously" apply to fill the gap that appears if preemption exists, but other courts say that there is a void in the law regarding the proper amount of payment.

Mr. Baumgartner argued that a statutory or regulatory solution would restore the proper balance of State and Federal interests. Specifically, he argues that ADA preemption of State workers' compensation serves no Federal aviation interest. He observed that the ADA promotes deregulation, but in practice air ambulance operators are using the ADA as means to *require* State workers' compensation carriers to pay the operators' billed charges: this is "super-regulation," not deregulation.

Mr. Baumgartner also explained that the ADA deregulated pricing for commercial air transportation, and preempted State regulation so that States would not replace Federal

regulation with regulations of their own. However, he stated that there has never actually been Federal deregulation of pricing for air ambulance service. Mr. Baumgartner stated his belief that, to the contrary, Medicare and Medicaid regulate Federal rates for that service, and prohibit balance billing; thus, there is no Federal deregulation purpose as to air ambulance insurance payments. He noted that after the passage of the NSA, there is now Federal regulation of air ambulance pricing for Medicare, Medicaid, and private health insurance: if there is ADA preemption in the workers' compensation context, then workers' compensation would be the only unregulated payor group left.

Mr. Baumgartner stated that there is no real danger of air ambulance providers being subject to a "dizzying array" of State rules, as air ambulance providers attest. States have an interest in ensuring care to its employees. State workers' compensation systems are carefully balanced plans that control costs to employers, ensure employees' access to cost-free care, and eliminate costly lawsuits by employing administrative solutions, including dispute resolution systems. Mr. Baumgartner contended that ADA preemption in the air ambulance context threatens to break this balance by siphoning off funds for the unique benefit of air ambulance providers at the expense of every other participant in the system. Moreover, he argues that the ADA provides no Federal alternative to the carefully balanced State system. Mr. Baumgartner cites as evidence the lack of process under the ADA by which parties can bring rate disputes to DOT. He noted that the "nightmare scenario" for States is "Federally sanctioned air piracy" where air ambulance providers charge what they please, with no enforceable State payment standard, and balance bill injured employees for amounts that could easily exceed the employee's annual pay.

Employee Benefit Plans

Mr. Baumgartner stated that self-funded employee benefit plans are governed by ERISA and are not State-regulated (in contrast to workers' compensation). He noted that, unlike workers' compensation, in the ERISA context there is no fallback State standards for appropriate rates.

Mr. Baumgartner explained the billing process for air ambulance service in the ERISA context. According to Mr. Baumgartner, after transport is provided, a bill is sent to the health plan along with a demand for payment of full billed charges, sometimes using the ADA as a justification. The employee is balance billed. The employee then complains to the employer and health plan. He explained that this puts the plan fiduciary in a difficult position because the fiduciary wants to cover the costs, but exorbitant costs can jeopardize the solvency of the plan as a whole, particularly for small businesses and transports in rural areas. Mr. Baumgartner stressed that this business model is not the free-market outcome that Congress intended through the ADA.

Mr. Baumgartner added that the No Surprises Act may help, but it is unclear how it will work in practice. He noted that, under the HHS interim final rule's cost-sharing provisions, the qualifying payment amount would be determined by "the lesser of the billed charge or the plan's or issuer's median contracted rate," which is problematic in the air ambulance context because there are not many contracted rates and the ones that do exist have been forced upon plans to avoid balance billing to employees. Mr. Baumgartner also noted that, with other health care services, the NSA defers to State law to determine a recognized amount or out-of-network rate, but these do not exist in the air ambulance context because of ADA preemption.

Proposed Solution

Mr. Baumgartner stated that for the workers' compensation industry, the solution is to carve out ADA preemption for air ambulance service. In the ERISA context, he stated that the provisions of the NSA would apply, but the ADA's preemption provisions take away the incentives to set in-network agreements and take away applicable State payment standards. He added that removing that obstacle would also create more network agreements by eliminating the business model that is based on surprise billing and balance billing. He also noted that States would have no incentive to enforce unfairly low payments that would lead providers to reduce access to care. Instead, Mr. Baumgartner suggested that air ambulance providers would have to work within the parameters of State systems, just like other health care providers. He concluded by stating that removing ADA preemption may change the way air ambulance providers do business, but on balance this would solve far more problems than it creates.

Presentation by Dia Gainor and Joseph House – Perspective of National Association of State EMS Officials

Ms. Gainor is the executive director of the National Association of State EMS Officials (NASEMSO). She introduced Mr. Joseph House, the executive director of the Kansas board of emergency medical services and a member of the NASEMSO board of directors who gave the presentation and spoke on behalf of NASEMSO.

Mr. House indicated that NASEMSO represents State EMS offices in all 50 States, DC, and U.S. territories. He explained that State EMS offices are charged with the sole responsibility of protecting the public through effective oversight of EMS, including EMS provided by ground and air ambulances. Mr. House specified that NASEMSO works to ensure clinic safety, clinical quality, and minimal standards are met to protect the public during care and transport.

Mr. House stated that ADA preemption has negatively impacted States' ability to regulate medical care. He emphasized that the inclusion of air ambulance service within the ADA and treating an air ambulance similar to an air carrier rather than a medical resource effectively removes the States' ability to regulate how health care occurs within a State's borders.

Mr. House discussed the certificate of need, as presented earlier, and how it is impacted by preemption under the ADA. He said that States do not have the ability to say whether a need occurs in a State as the ADA prioritizes and promotes competition over appropriate medical care. Mr. House explained that certificates of need arose because of ambulance services racing to handle calls, or if a specific provider received a call for transport, the company may send it to another part of their operations even if it was not the closest location. He said he observed this in the State of Kansas.

Mr. House also discussed preemption and the requirement for air ambulances to maintain accreditation as a permit requirement. He indicated that the ADA hinders States' ability to establish a minimal set of standards that were generally accepted within the industry since preemption does not allow for States to require accreditation for air ambulance services.

Mr. House discussed preemption of State legislation as it is applied to insurance and State workers' compensation law. He contended that the ADA leaves States and the consumers with the burden of covering the increased charges for air ambulance services.

Mr. House said NASEMSO believes that ADA preemption should be amended to exclude air medical transportation because marketplace regulation is only effective when the consumer has a choice. Mr. House noted that consumers/patients do not have an opportunity to make that decision in the EMS world, where it is a medical decision. He asserted that transportation should be based on what is clinically sound and appropriate to transport a patient to a facility that can provide care.

Mr. House said the fundamental economic theory that prices should decrease when demand decreases has not proven true in air medical transportation industry. He cited to data from the Health Care Cost Institute that the cost of rotor wing and fixed wing transportation both went up even if the rate of use did not. He said it is not a proportionate change and marketplace forces are not appropriate for medically necessary air transportation.

Mr. House discussed memberships with air ambulance companies and the ability of memberships to adversely influence the decision of transportation toward incentives as opposed to clinical needs. He elaborated that subscription plans influence the availability of health services and also increase the costs of air medical transportation for non-members.

Mr. House discussed numerous laws that are in effect to protect patients where delays can impact mortality and morbidity. His first example was the Emergency Medical Treatment and Labor Act (EMTALA), which he stated requires anyone coming to an emergency department to receive treatment that would stabilize the patient, and includes a prudent layperson standard that improved patient mortality and morbidity outcomes. Mr. House then mentioned the Veterans Reimbursement for Emergency Ambulance Services Act (VREASA), which he explained requires the Veterans Administration (VA) to pay EMS claims by also utilizing the prudent layperson standard. He noted that this law enabled veterans to get emergency transport to the closest medical facility in an emergency and not to a VA facility. Now, according to Mr. House, the No Surprises Act dictates the medical necessity of emergency services and what facilities provide transport. Mr. House indicated how CMS recognizes these issues, citing to Section 10.4.1 of the Medicare Benefit Policy Manual that states the medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance.

Mr. House stated that air ambulances are being used when time is not of the essence when the patient condition is stable and can be transported safely through other means. He said the disparity does require stringent utilization review and regional oversight. Any time this matter is brought up by States, they are met with an "elephant gun" of ADA preemption preventing the States from doing such things.

Mr. House said the time a patient spends in a facility may not be shorter utilizing air medical resources, but the time for the patient's definitive care is shorter. He provided statistics that on

average, a patient receiving ground ambulance transportation between facilities is 90 minutes. Rotor wing transportation for a patient between facilities is on average 110 minutes, and fixed wing is 195 minutes. He stated, however, that the transport times to enable the ability to go greater distances is not proportionate. Mr. House discussed how States attempted to perform utilization review on addressing the issue of time response of ambulance services. He noted that the States have consistently been met with challenges on their authority to take action based upon preemption.

Mr. House stated that NASEMSO believes that DOT should absolutely remain with the authority over safety for vehicles in the air and on the ground. Also, Mr. House shared NASEMSO's belief that States should have responsibility for all other matters to the provision of air ambulance services. States have broad authority over the delivery of health care, licensing of health care professionals, standards for hospitals and other health care facilities, establishment of time sensitive systems of care, and regulation of health insurance. Mr. House stated that for these reasons listed and various regional capacities and capabilities, it is States and local units of government that are the entities that have the capability to provide effective oversight of air ambulance and ground ambulance services.

Mr. House said that State EMS offices design plans for effective delivery of EMS services. He remarked that the plans include quality review, peer review, and regional performance improvement to achieve better patient outcomes. He stated his belief that oversight should remain as close to the consumer as possible and stressed, he said that States have the capacity to carry out this function. He mentioned statistics that show the effectiveness of State regulation over interstate boundaries that are crossed by ambulances indicating that a State can regulate effectively in this area. He used the State of Kansas as an example.

Mr. House offered the following three recommendations: (1) amend the ADA to exclude air medical transportation; (2) state clearly that States and local units of government have the ability to regulate all aspects of air ambulance services; and (3) retain DOT's operational safety authority over air medical transportation.

Prepared Remarks by Members of the Public

Remarks by William Bryant

Mr. Bryant, a health care consultant, said that he has worked on three kinds of air ambulance cases: (1) cases where the air ambulance provider charged too much or far too much; (2) cases where the insurance company paid far too little or nothing at all, leaving the consumer with a balance bill; and (3) cases where creative outside law firms found "little, unique arguments" to argue about for months and years.

Mr. Bryant said that he thinks everyone shares the goal of trying to protect consumers. He asked rhetorically whether the way to do that is to "throw out 30 years of the ADA working," or whether instead it is best to rely on the No Surprises Act. He expressed the view that the NSA does a good job of solving the problem of protecting consumers and resolving rate disputes, by allowing providers and insurers to either agree on a contractual price, work out disputes on a

case-by-case basis, or utilize a nationally-consistent independent dispute resolution program. He expressed concern about allowing 50 different State systems of rate regulation, especially since States only regulate half of insurance products.

Mr. Bryant responded to the presentation by Mr. House by saying that he was not sure the Committee has the authority to opine on anything beyond billing issues.

Remarks by Michael Baulch, Association of Critical Care Transport

Mr. Baulch, a nurse and board member of the Association of Critical Care Transport (ACCT), told the Committee that ACCT strongly supports the No Surprises Act, and said that Congress in enacting that legislation had adopted many of ACCT's recommendations.

Mr. Baulch expressed the opinion that the ADA applies differently in the context of the air medical industry than in the context of commercial passenger airlines; for example, air medical patients do not choose their air ambulance provider the way that customers can choose their airline flights. He also said that patients have no ability to choose a provider that is in their insurance network, and no ability to choose ground ambulance over air ambulance. He argued that we should not trust the competitive air medical marketplace to protect consumers in the absence of adequate State and Federal oversight.

Mr. Baulch argued that the air medical marketplace is not working in the best interest of consumers. He provided statistics regarding the growing number of air ambulance helicopters and bases over the last 40 years and the growing saturation of markets.

Mr. Baulch said ACCT recommended that the Committee recommend amending the ADA to enable State regulatory oversight of the medical aspects of air medical service, even if those regulations are related to, or have an indirect economic impact on, prices, routes, or services. He said that if the Committee did not make that recommendation, or if Congress does not make such an amendment, DOT can and should provide economic oversight to avoid oversaturated markets and high prices that bankrupt families.

Remarks by Bernard Diederich

Mr. Diederich told the Committee that he worked for the Civil Aeronautics Board for 15 years, that he then worked on air ambulance deregulation at DOT from 1985-2010, and that he has been engaged in the private practice of air ambulance law for the last 10 years.

Mr. Diederich argued that there would be nothing beneficial to amending the ADA, and that marketplace forces are preferable to State regulation. He said that States already have a number of non-preempted controls over air ambulance operations, including: (1) State regulation of the medical aspects of air ambulance services; (2) State selection of prices, routes, or services through commercial contracts; and (3) State regulation through Medicare and Medicaid, under which they act as agents of a blanket Federal program. He also noted that the ADA's preemption provision does not have an infinite reach, as it does not cover State laws with a tenuous, remote, or peripheral effect on prices, routes, or services.

Mr. Diederich said that if ADA preemption is removed, States and courts will have to face implied preemption arguments, which he contended would not be preferable.

Mr. Diederich noted that some have argued that Congress did not mean for air ambulances to be covered by the ADA preemption provision. But he said that as a former regulator, he could assure the Committee that Congress did not act so haphazardly. He noted that the courts have issued repeated rulings consistent with DOT's position on ADA preemption, and that Congress has never chosen to amend the ADA as applied to air ambulances. Finally, he said that although the Subcommittees found problems, they also offered specific solutions, none of which involve an overhaul of the ADA.

Following these remarks, the Committee took a brief recess.

Committee Discussion and Recommendations

Ms. Workie initiated the Committee's discussion by summarizing the arguments that had been raised by the presenters. She noted that there was general agreement among the members that the safety of aircraft and operations should remain preempted and addressed by DOT (through the FAA).

Workers' Compensation Programs

One member representing air ambulance operators agreed with the assertion that the NSA addresses most issues around self-funded plans, but that workers' compensation programs might not be addressed by the law. Mr. Baumgartner, who earlier spoke on workers' compensation plans, responded that if workers' compensation programs, particularly their payment standards and patient balance billing protections, were subject to ADA preemption, then workers' compensation programs become the only unregulated payor group. Mr. Baumgartner noted that this would be a big issue to state insurance regulators. He also stated that air ambulance operators have been defeating workers' compensation balance billing prohibitions in court, based on an ADA preemption theory. A member representing state insurance regulators noted that the Advisory Committee, when it considers recommendations regarding workers' compensation programs, should also ensure that such recommendations cover "monopolistic" states like North Dakota and Washington, which require employers to purchase workers' compensation coverage from a government-operated insurance fund, rather than from private insurers.

Aligning ADA with the NSA

Ms. Workie then noted that the NAIC presenter suggested that to align the ADA with the NSA, there should be a narrow carve-out regarding network participation, billing practices, and transparency. She recalled that the presenter had added that states will be the primary enforcers of the NSA, but that, according to this presenter, it is unclear whether a state can take any action against an air ambulance operator for failure to follow the NSA, due to the ADA. Ms. Workie asked the members for their thoughts. Mr. Baumgartner responded that in courts, air ambulance operators are defeating balance billing prohibitions, including those applicable to workers'

compensation programs, on a preemption theory. He added that if the balance billing ban is preempted, individuals could end up being balance billed, with particular provisions of the NSA no longer enforceable by state authorities. A member representing state insurance regulators responded that, although the NSA is designed with the expectation that States would regulate network participation, ADA preemption creates a hole for private insurance. He added that the Committee should clearly define that states have the authority given to them under the NSA.

State Regulation of Medical Services

A member representing air ambulance operators asserted that States need the authority to be able to preserve access and wholly oversee licensing of medical requirements that may be related to economic regulation of air ambulance services in the post-transport context. Mr. House, who gave a presentation from the perspective of State EMS officials, suggested that the Committee consider a recommendation that the ADA be amended to exclude air medical transportation, to clearly identify that states and local units of government have the ability to regulate all aspects related to the provision of ambulance services, and to clearly identify that DOT retains the ability to regulate all aspects related to the operational safety of vehicles, air and ground. A Committee member representing the workers' compensation insurance industry agreed with the suggestion. Another member, representing air ambulance operators, disagreed, noting that the focus on amending the ADA should be narrow. He added that the Committee only needed to make sure that its recommendations can withstand a challenge under the ADA, and if they do not, then Congress should narrowly amend the ADA to allow the recommendations to move forward.

The Committee then voted on five recommendations. Ms. Workie reminded the Committee that, as a quorum existed (75% of the members were present), a recommendation receiving a majority of the votes of the members present is adopted by the Committee. The four recommendations that obtained majority support of the Committee are as follows:

Recommendation #1 – The ADA should not preempt State laws to the extent necessary to align the ADA with the NSA (relating to network participation, reimbursement and balance billing, and transparency for an air carrier that provides air ambulance service).

Recommendation #2 – The ADA should not preempt State laws relating to State regulation of workers' compensation insurance programs with respect to air ambulance services including monopolistic State funds in Ohio, North Dakota, Washington, and Wyoming.

Recommendation #3 – The ADA should be amended to exclude air medical transportation, to clearly identify that States and local units of government have the ability to regulate all aspects related to the provision of ambulance service, and to clearly identify that the DOT retains the ability to regulate all aspects related to the operational safety of vehicles, air and ground.

Recommendation #4 – The ADA should not preempt State laws relating to licensing of medical services of air ambulance providers, even if they have incidental effect on prices, routes, and services.

The Committee did not adopt a fifth proposal, which was to amend the ADA to enable the Committee's May 2021 recommendations to be implemented to the extent the ADA preempts their implementation.

Ms. Workie noted that members who dissented with the recommendations would have the opportunity to express their views in the report.

Conclusion

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

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

The third meeting of the AAPB Advisory Committee was adjourned by Ms. Swafford around 4:00 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