NEW MEXICO | OFFICE OF SUPERINTENDENT OF INSURANCE

Air Ambulance Memorial

STUDY REPORT

Office of the Superintendent of Insurance | HM78/SM62 | January 2017

Introduction

New Mexico's Legislature, under House Memorial 78 and Senate Memorial 62, directed the New Mexico Office of Superintendent of Insurance (OSI) in consultation with the Department of Health, the Risk Management Division of the General Services Department, and the Workers' Compensation Administration to study the impacts and cost of air ambulance transports and related insurance policies and payments on consumers, beneficiaries, and payers in New Mexico.

Executive Summary

Data collected by OSI for workers' compensation and health insurance carriers between the years of 2005 and 2016 shows that:

- Air ambulance providers have increased in numbers since 2009, from approximately 13 in-state aircraft operating that year to 21 aircraft in 2016.

- The average charge per claim for air ambulance services increased 229% between 2006 and 2015.

- The average claim paid by health and workers' compensation insurance for air ambulance charges increased 50% from 2006 to 2015.

- The average portion of the claim unpaid by insurance carriers as of 2015 is $26,829. In some circumstances, providers may balance bill insureds for this unpaid balance.

- Prior to 2015, four air ambulance providers conducted approximately 55% of transports in the state. Three of these companies have recently been purchased by the largest air ambulance provider in the nation, Air Methods.

State regulation of the air ambulance industry has, historically, been limited. Courts have repeatedly ruled that the federal Airline Deregulation Act preempts state regulation of air ambulance industry practices. Recent legal developments, however, may provide a road to challenge this presumption of preemption. Texas recently had success arguing that the McCarran-Ferguson Act grants states sole, reverse-preemptory authority to regulate the business of insurance, including regulation of the rates paid by insurance companies to reimburse air ambulance providers.

Air Ambulance Industry Changes Overview

Until the late 1990's, Helicopter Emergency Medical Services (HEMS) programs in the United States were largely not-for-profit hospital or public safety operations. These programs were generally well integrated with state and local EMS systems.[1] However, as a result of the Balanced Budget Act of 1997, the federal Centers for Medicare and Medicaid Services changed the way they paid for air ambulance services for Medicare recipients. To effect this change, they implemented a fee schedule that provided more favorable reimbursement for air ambulance services. The national fee schedule redistributed, on a budget-neutral basis, payments among various types of ambulance services. Prior to 2002, Medicare reimbursement differed depending on the air ambulance provider's business model: Medicare reimbursed hospital-based providers based on reasonable costs, while it reimbursed independent providers based on reasonable charges. This policy contributed to wide variation in the reimbursement rates for the same service, with hospital based providers generally receiving higher reimbursement than independent providers for similar services. The new national fee schedule established one payment rate for fixed-wing transports and another rate for helicopter transports. The fee schedule also provides higher reimbursement rates for transports in rural areas, but does not differentiate payments according to the business model followed, the size of the aircraft used, or level of medical or safety equipment on board.[2]

The effects of this change in the reimbursement landscape was almost immediate. From 1999 through 2008, the number of patients transported nationally by air ambulance helicopters increased from just over 200,000 to over 270,000, or by about 35%. The data also shows that the number of air ambulance helicopters operating nationwide increased from 360 to 677, or by about 88%.[3]

With the change in the reimbursement structure for air ambulance procedures came a change in the make-up of the air ambulance industry. Prior to 1999, most air ambulance providers were hospital-based, whereas today, about half of the providers are private, independent companies with no support from hospitals in terms of ownership, risk, and financial support. Stakeholders interviewed by the federal Government Accountability Office attributed these changes to downsizing or closing of some community hospitals, leading to increased need for air transportation services in emergency situations, especially in rural areas. Additionally, the Government Accountability Office attributed some of these

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[1] National Association of State EMS Officials – Air Medical Services Committee, Brief Outline of the Federal Pre-Emption Issues in Regulating Air Medical Services (October, 2011) (available at https://www.nasemso.org/projects/airmedical/documents/HelicopterEMS.pdf)

[2] United States Government Accountability Office, Air Ambulance: Effects of Industry Changes on Services Are Unclear, 6 (September 2010) (available at http://www.gao.gov/assets/320/310527.pdf).

[3] Ibid.

changes to the establishment of regional medical facilities, such as cardiac and stroke centers that provide highly specialized care for critically ill patients, which encouraged the use of air ambulances, again, because they could transport patients more quickly from outlying areas. Finally, and most importantly, implementation of the Medicare fee schedule provided those wishing to provide air ambulance services a degree of predictability for Medicare reimbursement, which stakeholders noted enabled air ambulance providers to develop more accurate financial plans.[4] Nationwide data suggests that this increased stability in funding for air ambulance providers contributed significantly in the number of providers competing to serve this market. These trends may hold true in New Mexico, but, as noted below, the data is unclear.

Air Ambulance Claims Data

PROCESS FOR GATHERING DATA

For purposes of this study, OSI requested air ambulance claims data from the four largest and longest operating major medical carriers providing fully-insured individual and small group plans. For the two youngest carriers, this data reached back to the beginning of Affordable Care Act coverage in 2014. For the two oldest carriers, this data reached back to 2005 and 2009, respectively. OSI was also able to longitudinally track data from workers' compensation claims information voluntarily provided by select employers. Additional data for the study came from the New Mexico Public Schools Insurance Authority, which provided air ambulance claims for its self-funded plans from 2011 to 2015.

OSI also sought information from the New Mexico Department of Health on state operations of air ambulance providers. The Department of Health provided the names of the companies operating in the state, as well as their base locations. This information, along with trends observed in air ambulance claims data, is outlined below.

AIR AMBULANCE PROVIDERS

According to a federal Government Accountability Office report, as of 2009, New Mexico had 13 air ambulance helicopters operating in the state.[5] The New Mexico Department of Health reports that there are currently 25 air ambulance agencies registered in the state, operating 35 rotary aircraft and 67 fixed-wing aircraft as a part of their multi-state operations. While these aircraft are registered in New Mexico, only eight of these air ambulance providers have home bases in New Mexico. The rest of these providers have a home base in other states, with locations throughout New Mexico and bordering states as extended base sites. The Department of Health estimates that each provider registered with

[4] Ibid. at 7-8.
[5] Ibid. at 8.

the state operates at least one air ambulance for an estimated total of 21 aircraft operating in New Mexico at any given time.

Air ambulances that transport New Mexico residents also may be registered in other states. As a result, it is difficult to pinpoint the exact number of air ambulance providers serving New Mexico residents. However, it generally appears that there has been an increase of approximately 8 providers operating in the state at any given time since 2009. As noted above, this is a trend observed nationwide as Medicare reimbursement rates for air ambulance providers stabilized.

CLAIMS PAYMENT

When an air ambulance provider charges for its service, it typically charges a base rate for liftoff and a separate rate for mileage. For example, an air ambulance company may charge $10,000 as a base liftoff charge, and then $100 per mile traveled. As a result, in its analysis of air ambulance claims data, OSI conducted a separate analysis of trends in base liftoff charges and mileage charges. Additionally, due to operational differences between rotary (helicopter) and fixed-wing (airplane) providers, where noted, OSI tracked payments to these types of providers separately.

Trends in Base and Mileage Paid by Carrier

In 2006, the first full year for which OSI has significant data on air ambulance charges, the average amount paid by insurance carriers for the base fee was $6,423. Fluctuations likely caused by changes in the amount of data we received for each year aside, the sum paid by insurance carriers for these base charges has steadily increased in the intervening years. As of 2015, the last year for which OSI has complete data, the average base charge amount paid by insurance carriers was $8,943, a 40% increase over the span of nine years. Likewise, for mileage charges, data shows that insurance carriers paid claims averaging $6,356 in 2006. By 2015, insurance carriers paid an average of $11,843 per flight. The average increase in mileage charges paid between 2006 and 2015 was $5,487, reflecting an 86% increase.

In total, insurance carriers in 2006 paid an average of $12,779 for base and mileage charges per flight. As of 2015, this amount had risen to an average of $19,194 paid per claim, for an average difference of $6,415 or a 50% increase in total paid charges for air ambulance services. These payments, however, may not include any amounts recouped from patients for air ambulance services. If the air ambulance provider has a contract with the health insurance carrier to provide services, the patient may pay an additional amount for the service via their deductible or other contractual cost-sharing obligations, such as a co-insurance or co-pay. If the insurance company does not have a contract with the air ambulance provider, the air ambulance provider may balance bill the patient, seeking additional payment for the charged services. OSI was not able to obtain direct information about average amounts charged directly to consumers in balance billing. However, we have collected the information below about insurance carriers' unpaid charges.

Charges Unpaid by Insurance Carrier

In 2009, the first year for which the most complete data is available, the average difference between the amount charged by air ambulance providers and the amount paid by health insurers was $13,518 per flight. As of 2015, this amount had risen an additional $26,829 per flight. This amount represents a 98% increase in the amount charged by air ambulance providers but unpaid by insurance carriers between 2009 and 2015. As noted above, whether and how air ambulance companies pass these charges along to patients depends on whether the health insurance carrier has a contractual relationship with the air ambulance provider.

Another way to look at the issue of charged amounts versus paid amounts is to analyze the amounts billed per mile versus the amounts paid per mile. Taken as a whole, for all claims between 2005 and 2016, the most frequent amount air ambulance providers billed per mile was between $274 and $294. Providers billed between $274 and $294 per mile for 1,224 claims out of the 6,825 claims OSI evaluated for this report. Conversely, health insurance carriers paid between $1 and $21 per mile for 2,959 claims out of 6,510 paid claims within the relevant data obtained by OSI. As a result, there is an average $273 difference in the most predominant billed charge per mile versus paid charge. Again, it is unclear from the data obtained by OSI how much of these costs are shifted onto consumers by air ambulance providers.

Total Average Charge by Provider

In 2006, the first year for which OSI has significant data, the average total charge billed by air ambulance providers for their services was $13,984. In 2015, the last year for which OSI has significant data, these charges amounted to an average of $45,937 per flight. This represents an average growth of $31,953 per flight, or 229% increase over a nine-year period.

In a meeting with OSI, Air Methods, the largest air ambulance service provider in the country, stated that this increase in charges is due to an upsurge in flights by patients covered by public programs that do not sufficiently reimburse for their services. Specifically, Air Methods cited that 78% of its flights in the State of New Mexico were transports of patients with Medicaid, Medicare or the uninsured. Air Methods estimated that the break-even cost of the average air ambulance transport, including medical services and maintenance costs, was about $10,000. Medicaid reimburses at a rate of $1,500 to $3,000 per flight. Medicare reimburses at a rate of $5,000 to $6,500 per flight. As a result, Air Methods argued, the air ambulance industry is forced to shift costs to the privately insured and workers' compensation insureds.

However, the figures provided by Air Methods do not support the costs currently charged per air ambulance flight. As an example scenario, using the percentages and costs provided by the air ambulance industry, we will assume that an air ambulance provider provides 100 flights per year. Additionally, we will assume that approximately 80 of these flights are for patients with public insurance, such as Medicaid or Medicare. At an even split of Medicaid

and Medicare patients, with Medicaid reimbursing approximately $2,000 per flight and Medicare reimbursing approximately $6,000 per flight, this pool of flights generates $320,000 in reimbursements. If the air ambulance industry's costs are currently an average of $10,000 per flight, this business leaves a $680,000 shortfall. The air ambulance industry admits that it shifts this shortfall to its privately insured payers, including workers' compensation payers. Assuming that the privately insured payers make up approximately 20% of flights, and that the air ambulance industry must generate at least $1 Million to break even on costs (100 flights x $10,000 in operating costs), an air ambulance provider must charge approximately $34,000 per flight to break even. This is approximately $12,000 short of the current $46,000 average charge per flight.

These figures, again, assume that the air ambulance industry has provided OSI with accurate data about their operations costs. As described by the air ambulance industry, operations costs include purchase and maintenance of aircraft, air ambulance staffing, including medical technicians, and medical equipment. It is worthwhile noting that as late as 2010, air ambulance providers were accepting an average of $10,500 per flight for payment of services, including operations costs and any profit expected to be made on flights. In contrast, as of 2015, air ambulance providers billed an average of $45,937 per flight and accepting an average of $19,194 from carriers for payment of services (this figure does not include amounts recouped from privately insured payments). While the issue of disparities in payment between public and private payers certainly contributes to the amount charged to break even, it does not explain why the break-even amount has increased in just six years to be an amount previously accepted as profitable. Air ambulance industry watchdogs have pointed out that this increase in operations costs may be due to a glut of providers in the market resulting in fewer flights per vehicle, which means fewer opportunities to recoup operational expenses.

Rotary Versus Fixed Wing

Air ambulance providers can be broken into two groups, providers that offer helicopter, or rotary services and providers that offer services via fixed-wing airplanes. While some air ambulance providers have both rotary and fixed-wing ambulances in their fleets, many concentrate on providing services via only one type of aircraft. Accordingly, OSI examined the billed and paid charges for these two types of providers to determine if there is any meaningful difference between these types of aircraft.

For the years for which data was collected, rotary wing aircraft provided more services to patients than fixed wing aircraft. Between 2005 and 2016, rotary wing providers flew 6,836 flights as opposed to fixed wing providers' 4,723 flights. The average paid claim for rotary flights per patient for the period of time covered in OSI's claims survey is $16,465 for base charges combined with mileage charges. The average paid claim for fixed wing flights during that same timeframe is $15,582. This accounts for an average difference of $883 between rotary flights and fixed wing flights. Accordingly, the data presented to OSI shows no meaningful difference between the charges for these flights.

Between 2006 and 2015, the amounts insurance carriers paid for rotary wing flights increased an average of 54.7%. In contrast, the percent increase for fixed wing flights was slightly less at 43%. The difference between the increases in paid claims for these two types of services may be related to operating costs for the various types of fleets, differences in ownership and management practices of rotary and fixed wing fleets, or other factors such as flight distances and fuel costs.

INSURER NETWORKS

In October of 2016, OSI surveyed the six major medical carriers offering coverage in the fully-insured and small group markets in the state about their contracted air ambulance providers. Of these carriers, two do not have any preferred provider agreements with air ambulance providers. These carriers have stated that they pay claims for air ambulance services as incurred by enrollees. The remaining carriers do have contracts with air ambulance providers, however, these contracts are constantly evolving due to company buy-outs, mergers or movement from state to state. Other states' efforts to control the impact of air ambulance charges on insureds have been largely focused on educating hospitalists on how to ensure that air transport of patients is in-network for their insurance.

While OSI agreed not to share carriers' specific negotiated payment for services, it can report generally that there is no clear pattern linking patient volume to payments. As a result, the payers surveyed do not appear to necessarily be paying less for air ambulance services based on patient load. Additionally, there does not necessarily appear to be a distinguishable trend in the amount paid for services based on number of provider contracts. Unusually, the carriers reporting higher numbers of contracts with air ambulance providers do not necessarily see a lower price paid for their enrollees' care.

AIR AMBULANCE PROVIDER MARKET SHARE

As a part of its data request, OSI asked insurers to supply the names of the air ambulance providers serving their patients. This information allowed OSI to evaluate the market share of each provider and see if market share in any way correlates to average paid charges. However, it is important to note that there has been significant consolidation within the air ambulance provider industry. Namely, many of the top air ambulance providers in the state have been bought out or merged. For instance, Air Methods, the largest air ambulance provider in the nation, recently acquired Tri-State Care Flight, Rocky Mountain Holdings, LifeNet, and Native American Air, several of the major air ambulance providers in the state.

In total, prior to acquisition, Tri-State Care provided the most patient transports, with 1,969 flights provided in the survey period for the claims data received. The second largest air ambulance provider was Rocky Mountain Holdings/LifeNet at 1,881 transports. The third largest air ambulance provider is the nation's second largest air ambulance company, PHI Air, with 1,287 flights. PHI Air largely operates out of Texas. The fourth largest air ambulance

provider, Native American Air, at 915 transports, was also acquired by Air Methods. These four providers, prior to acquisition, made up approximately 55% of the air ambulance transports in the state.

Interestingly, the claims data shows that the four air ambulance providers with the largest market share also had amongst the highest billed charges for services. With the exception of two other transport companies, these companies charged more for their services than the 20 other named companies surveyed. Consequently, the conglomeration of three out of four of these companies and resulting decline in competition may have led to an increase in charges for air ambulance services for New Mexico residents.

Regulatory Authority

AIRLINE DEREGULATION ACT PREEMPTION OVERVIEW

Few states have attempted regulation of the air ambulance industry due to federal court interpretations of the preemption language in the Airline Deregulation Act (ADA) of 1978. This federal statute was designed to remove government control over air fares and routes and increase efficiency of airline operating costs. The ADA was passed after Congressional investigators compared fares of regulated airlines flying between states with fares of unregulated airlines within states. Investigators found that unregulated airlines charged lower fares. The Act was passed with bipartisan support, but was strongly opposed by the airline industry itself.[6] The Act states that through deregulation, the air transport industry should rely on "competitive market forces" to further "efficiency, innovation, and low prices" as well as "variety and qualify…of air transportation services."[7] To ensure that states would not undo federal deregulation with regulation of their own, the ADA included a preemption provision, prohibiting states from enforcing any law "relating to rates, routes, or services of any air carrier."[8]

This prohibition was interpreted extremely broadly by the U.S. Supreme Court in *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374 (1992). In this case, airlines sued to enjoin Texas from enforcing state deceptive marketing practice laws against airlines' advertising. The U.S. Supreme Court ruled that state regulation of air fare advertising was expressly preempted by the ADA. Over the years, various courts have further interpreted the ADA to directly preempt state regulation related to rates, advertising, scheduling, insurance

[6] Smithsonian National Air and Space Museum, *America By Air: Deregulation: A Watershed Event*, https://airandspace.si.edu/exhibitions/america-by-air/online/jetage/jetage08.cfm (last accessed October 26, 2016).
[7] *Morales v. Trans World Airlines, Inc*. et. al. 504 U.S. 374 (1992).
[8] Ibid.

coverage, routing, accounting and reporting systems, and air ambulance subscription programs.

States are still able to require an air ambulance operator to be licensed as a medical services provider, but licensing requirements can apply only to the quality of medical services and equipment required for an ambulance service. However, the patchwork of federal Department of Transportation (DOT) and court opinions does not provide a clear picture of what state regulations of air ambulances are permissible. Although the DOT has indicated that state regulations serving primarily a patient care objective are properly within the states' regulatory authority, it has also indicated that a state medical program, ostensibly dealing with only medical equipment and supplies aboard the aircraft, could be so pervasive or so constructed as to be indirect regulation of prices, routes, or services, which is preempted. As a result, the line delineating where state regulation of public health constitutes impermissible economic regulation is not so bright. The DOT, however, recently issued a document outlining the "Guidelines for the Use and Availability of Helicopter Emergency Medical Transport (HEMS)" which outlines opportunities for permissible state regulation on the:

- Quality of emergency medical care provided to patients
- Requirements related to the qualification and training of air ambulance medical personnel
- Scope of practice and credentialing
- Maintenance of medical records, data collection, and reporting
- Medically related equipment standards
- Patient care environments
- EMS radio communications
- Medically related dispatch requirements
- Medical transport plans including transport to appropriate facilities
- Other medical licensing requirements[9]

Few states have attempted to enact laws, regulations, or policies regarding air ambulance safety for fear that it would conflict with ADA's preemptive powers. For example, states have tried to ensure that the number and location of air ambulance providers corresponds with patient need. However, in 1987, the Attorney General of Arizona concluded that the ADA precluded the state from asserting Certificate of Need (CON) regulation of the number and location of air ambulance services within its boundaries. Similarly, in 2006, the Attorney General of Hawaii also issued an opinion to the Hawaii State Health Planning and Development Agency and the Department of Health advising that the state cannot require a CON for air ambulances to operate in Hawaii. Hawaii's ruling resulted from a Federal Aviation Administration (FAA) advisory to the state declaring that it could not regulate air

[9] National Association of State EMS Officials, State Model Rules for the Regulation of Air Medical Services, 4 (September 2016).

carriers; even those involved in a specialized service that otherwise would be regulated at the state level. [10]

Most recently, in 2015, the North Dakota legislature passed a law requiring air ambulance operators to become participating providers with certain North Dakota health insurance companies to be listed on a "primary call list" for air ambulance services. The legislation assigned the state's Department of Health the task of housing this "primary call list." Specifically, North Dakota House Bill 1255 provided that:

1. The department shall create and maintain a primary call list and a secondary call list of air ambulance service providers operating in this state.

2. To qualify to be listed on the primary call list, an air ambulance service provider shall submit to the department attested documentation indicating the air ambulance service provider is a participating provider of the health insurance carriers in the state which collectively hold at least seventy-five percent of the health insurance coverage in the state as determined by annual market share reports.

3. The department shall provide the primary call list and the secondary call list for air ambulance service providers operating in this state to all emergency medical services personnel, each hospital licensed under chapter 23-16, each 911 coordinator in this state, and each public safety answering point operating in this state.

4. The department shall establish air ambulance service response zones for rotary wing aircraft which are based on response times and patient health and safety.

a. Upon receipt of a request for air ambulance services, emergency medical services personnel, a hospital licensed under chapter 23-16, or a public safety answering point operating in this state, shall make a reasonable effort to inform the requesting party of the estimated response time for the requested air transport versus the ground transport for that designated response zone. If at any point during the request for air ambulance services the requester withdraws the request, the receiving party is not required to complete that call for air ambulance services.

b. If emergency medical services personnel, a hospital licensed under chapter 23-16, or a public safety answering point operating in this state receives a request from emergency medical services personnel for air ambulance services, the recipient of the

[10] Maryland Health Care Commission, *Air Ambulance Study Required Under Senate Bill 770*, 11 (December 2006) (available at http://dlslibrary.state.md.us/publications/EXEC/DHMH/MHCC/AirAmbulance_2006.pdf).

request shall comply with the call priority under this subdivision in responding to the request.

(1) First, the recipient of the request shall call an air ambulance service provider listed on the primary call list which is within the designated response zone.

(2) Second, if each of the air ambulance service providers listed on the primary list is not available or is not able and willing to respond to the call, the recipient of the request shall notify the requester of this fact and shall call an air ambulance provider listed on the secondary call list within the designated response zone.

(3) Third, if each of the air ambulance service providers listed on the secondary list is not available or is not able and willing to respond to the call, the recipient of the request shall notify the requester of this fact and shall inform the requester of primary and secondary air ambulance service provider options outside the designated response zone.

5. Upon request of the department, a potential patient, or a potential patient's legal guardian, an air ambulance service provider shall provide that provider's fee schedule, including the base rate, per loaded mile rate, and any usual and customary charges.

a. The department shall compile and distribute this fee information to each hospital licensed under chapter 23-16, each hospital emergency department in the state, each physician the department determines is likely to generate an air ambulance transport, each emergency medical services operation, each emergency medical services professional, emergency medical services personnel, each public safety answering point in this state, and each 911 coordinator in this state.

b. Before a hospital refers a patient to an air ambulance service provider, the hospital shall make a reasonable effort to inform the patient or the patient's legal guardian of the fees for the air ambulance service providers licensed under this chapter, for the purpose of allowing the patient or legal guardian to make an informed decision on choosing an air ambulance service provider. A hospital is exempt from complying with this subdivision if the hospital determines compliance might jeopardize the health or safety of the patient.

6. The state health council shall adopt rules establishing air ambulance service provider requirements that must address transport plans, including auto launch protocol and auto launch cancellation protocol; transporting to the nearest appropriate medical facility; medical necessity; and informed consent. As necessary, the state health council shall adopt rules relating to quality of care standards and other appropriate requirements regarding air ambulance service providers.[11]

[11] N.D.C.C. § 23-27-04.10

The intention of North Dakota's legislation was to curb the billing of consumers for out-of-network air ambulance charges. Air ambulance industry practices often result in "out-of-network," surprise medical bills for patients needing emergency air transportation. The air ambulance industry, however, promptly sued the state for running afoul of the Airline Deregulation Act. Valley Med, the air ambulance carrier suing North Dakota, asserted that because the law in question has a significant impact on the prices, routes, and services of air ambulance service providers, the law was preempted. In March of 2016, the U.S. District Court for the District of North Dakota sided with Valley Med and applied a broad reading of the ADA's preemption authority. The court reasoned that because an air ambulance provider must accept the reimbursement rates offered by the predominant insurance carriers of the state in order to be placed on the "primary call list," the state was essentially forcing air ambulance providers to accept an insurer's rates or discontinue operating in the state. Accordingly, the law impacted the air fare rates and services deregulated under the ADA, and thus was preempted.[12]

North Dakota's governing body is not alone in its concerns with the practices of the air ambulance industry. Growing concerns about the impact of air ambulance billing on patients has led to the introduction of federal legislation to limit the ADA's preemption authority. Spring of 2016 saw the introduction of federal legislation allowing state insurance regulators the flexibility to protect consumers from excessive out-of-network charges by regulating how air ambulance carriers are reimbursed. Specifically, members of Congress attempted to introduce an amendment to Federal Aviation Authority reauthorization legislation that would remove federal preemption of state regulation of air ambulances. This legislation would allow states to regulate air ambulance participation in health insurance networks, balance billing of patients, and allow states to require increased transparency for consumers. The legislation stated that:

Nothing in this subsection shall be construed as affecting or in any way interfering with the ability of any State or Territory to enact or enforce a law, regulation, or other provision having the force and effect of law related to network participation, reimbursement, and balance billing, or transparency for an air carrier that provides air ambulance service.

Diverse groups such as the National Association of Insurance Commissioners (NAIC) and the Association of Health Insurance Plans lobbied for the change. However, the Senate Commerce Committee Chair blocked the amendment, and it did not advance to the Senate floor. Legislation to remove federal preemption of states regulation of air ambulance services has not been reintroduced.[13]

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[12] *Valley Med Flight, Inc. v. Dwelle*, 171 F.Supp.3d 930 (2016).

[13] National Association of Insurance Commissioners, *Air Ambulance Regulation Issue Brief* (April 2016) (available at http://www.naic.org/documents/government_relations_air_ambulance_regulation_issue_brief.pdf).

REVERSE PREEMPTION OVERVIEW

Recent litigation between the state of Texas and the air ambulance industry has shed light on another potential path for legal regulation of air ambulance services. Texas's Department of Insurance, Division of Workers' Compensation, set guidelines regarding what insurers must pay for air ambulance transport of injured workers. These guidelines then required insurers to pay the full, billed charges of these set payments. Texas' Workers' Compensation Division set these charges at 125% of the Medicare-approved fee for air ambulance services.

The air ambulance industry promptly sued the state of Texas and its Workers' Compensation Division, claiming that the state had violated the ADA. The Workers' Compensation Division, however, made the relatively novel legal argument that the state had the authority to regulate air ambulance reimbursement, as it related to insurance, under states' authority to regulate the business of insurance via the federal McCarran-Ferguson Act. The McCarran-Ferguson Act, which was passed by Congress in 1945, provides that,

> No 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: Provided, [federal antitrust statutes]…shall be applicable to the business of insurance to the extent that such business is not regulated by State Law."[14]

The legal concept for the effect of the McCarran-Ferguson Act is called "reverse preemption." Reverse preemption occurs when states are given the exclusive or near exclusive authority to pass laws and regulate an issue area. Its practical effect is to bar federal action on issues given solely over to states for regulation.

Courts have interpreted the McCarran-Ferguson Act's grant of reverse preemption to states broadly. In a 1993 case, *U.S. Treasury v. Fabe*, the U.S. Supreme Court defined the concept of the "business of insurance" as "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement - these were the core of the 'business of insurance." The Court then went on to clarify that a state directly regulates the "business of insurance" if it "prescribes the terms of the insurance contract." The Court also stated that there can "also be no doubt that the actual performance of an insurance contract falls within the business of insurance."[15]

In support of its regulation of air ambulance reimbursement fees, Texas' Workers' Compensation Division argued that setting the fee schedule was legally within its authority to regulate the business of insurance. As a result, its actions were protected under the McCarran-Ferguson Act's reverse preemptory authority given to states. Texas argued that

[14] 15 U.S.C. § 1012(b)
[15] Id. at 502-503.

since the ADA did not explicitly remove states' reverse preemptory authority to regulate the business of insurance, its authority to regulate insurers' payments for air ambulance services were intact and not preempted. In December 2016, a Texas district court judge agreed with the Texas Department of Insurance, Workers' Compensation Division, and upheld the state's authority to set air ambulance fees. Appeals are expected in the case.

OTHER FEDERAL PREEMPTION

In addition to the ADA, other federal laws may impact state action on air ambulance regulation. The first, the Emergency Medical Treatment and Active Labor Act (EMTALA), applies to all hospitals receiving Medicare payments. This law states that hospitals must not transfer an individual with an emergency medical condition that has not been stabilized unless several conditions are met, including arranging appropriate transfer. This requirement directly impacts air ambulance transport from the sending hospital, and creates liabilities for the sending hospital to ensure appropriate care.[16]

Secondly, the Federal Employee Retirement Income Security Act (ERISA), exempts self-insured companies or entities from state insurance laws. This statute has a preemptive effect similar to the ADA in that self-insured entities may ignore any state-imposed insurance coverage mandates, required reimbursement floors for specific services, e.g. coverage for out-of-network service providers, as well as any other insurance requirement that a state enacts. Employers that self-insure their employees' health cannot be compelled to offer a benefit (i.e. air ambulance service) under state law. The preemption applies regardless of whether an employer self-administers the insurance benefits or pays an insurance company "administrative services only" to administer the benefit on behalf of the employer.[17] Notably, more than half of New Mexico's employers who provide health insurance are self-insured.

Lastly, as mentioned elsewhere in this report, federal Medicare and Medicaid provisions have definite implications for the provision of air ambulance services for patients covered by these program. Significantly, Medicare has developed extensive rules for appropriate use of ambulance services, including air ambulance services. Medicare pays for use of air ambulance services when medically necessary, time is essential, and/or other modes of transport are not available or not appropriate. Transport is only provided to the nearest hospital offering the treatment needed by the patient.[18] Medicare, as a major payer for air ambulance services, can and has shaped many of the operations of the air ambulance industry. Accordingly, while Medicare provisions may not have preemptive authority, their impact cannot be understated.

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[16] 42 U.S.C. § 1395dd
[17] 29 U.S.C. § 1001 et seq.
[18] Medicare.gov, Ambulance Services (available at https://www.medicare.gov/coverage/ambulance-services.html) (last accessed October 2016).

CURRENT STATE REGULATION

Department of Health Regulation

Current New Mexico state regulation of air ambulance providers was enacted in 2006, pursuant to the state's Emergency Medical Services Act, N.M.S.A. 1978, § 24-10B-4-H. The regulations, which can be found at 7.27.5 NMAC, were drafted to achieve compliance with federal guidance on ADA preemption. New Mexico's Department of Health has noted that these regulations will likely be updated to incorporate additional federal Department of Transportation guidance issued in 2015, and model law developed by the National Association of State EMS Officials.

New Mexico Department of Health air ambulance regulations delineate processes for state certification of air ambulance services, fees for operation in New Mexico, medical standards, radio communications operations, and complaint procedures. Notably, these regulations avoid topic areas preempted by federal law, per DOT guidance. Current recommendations for regulation by the National Association of State EMS Officials expand upon some areas currently not covered by the Department of Health's regulation. As a result, the Department of Health has indicated that it is considering revising its current state regulation of air ambulance services.

Superintendent of Insurance Regulation

Currently, there are no laws or regulations flowing from New Mexico's Insurance Code that directly regulate air ambulance providers. However, the Insurance Code does require coverage for emergency services. More specifically, the Patient Protection Act requires insurance companies to pay for emergency services for health insurance policy holders, including emergency services provided outside the network, at no additional cost to consumers.[19] OSI has interpreted this provision to include coverage for air ambulance services and has required carriers to pay air ambulance charges, even when they are out of network. However, OSI does not have control over whether air ambulance providers accept payments by the carriers, or the amount.

Moreover, air ambulances are not just used for emergency services. These companies also transport medically fragile patients from one critical care unit to another. These circumstances are not typically considered an emergency as there is time to receive authorization for transport from the insurance company. Nonetheless, while the flight may be authorized by the insurance company, this authorization does not necessarily preclude an outcome resulting in balance billing. If the only available air ambulance provider is one that is out-of-network, this out-of-network provider may balance bill a patient where the provider deems the insurer's reimbursement for its services insufficient. Currently, New

[19] N.M.S. A. 1978 § 59A-57-4

Mexico's Insurance Code does not preclude out-of-network providers from balance billing patients in non-emergency circumstances.

Workers' Compensation Regulation

Like many other states, New Mexico sets a maximum amount workers' compensation insurers can pay health care providers to care for injured employees.[20] These compensation amounts are called a fee schedule, and are established by the Workers' Compensation Administration. This fee schedule does not set an absolute reimbursement amount, but an acceptable range for payment of services, and providers and insurers are permitted to negotiate for payment of services within that range.[21] This range is set based on an evaluation of health care providers' usual and customary charges for services typically provided to injured workers.[22] Unfortunately, however, air ambulance services are excluded from this fee schedule.

Under Workers' Compensation regulations, services that are not on the fee schedule are "billable and payable on a by-report (BR) basis," meaning that the fee for these services is subject to negotiation between the provider and the payer. Current Workers' Compensation regulations dictate that this negotiation process is triggered by the filing of a report that describes why an established fee schedule code was not used to bill for the services.[23] The provider and workers' compensation carrier then negotiate payment for the services rendered outside the fee schedule, including, as relevant here, air ambulance services. Should there be a dispute as to the reasonableness of the fee charged for the BR service, Workers' Compensation regulations provide for a dispute resolution process.[24] In the event of a billing or payment dispute, any party may submit a request to the Workers' Compensation Cost Containment Bureau for a director's determination of reasonable charges for the service. The Bureau director's determination of reasonable payment for the service is deemed final, but subject to appeal under workers' compensation law procedures.[25] Regardless of the outcome of fee negotiations or any resulting dispute resolution process for BR services, New Mexico law prevents balance billing of injured workers for any claims charges unpaid by workers' compensation insurers.[26]

Air ambulance companies providing services in New Mexico have begun to challenge the authority of the state's Workers' Compensation Administration to resolve fee disputes and prohibit balance billing of injured workers under state law. Air ambulance providers are arguing that the ADA preempts the state from deciding these disputes. As a result, it has

[20] N.M.S.A. 1978, § 52-4-5
[21] NMAC 11.4.7
[22] N.M.S.A. 1978, § 52-4-5
[23] NMAC 11.4.7.8(B)
[24] NMAC 11.4.7.11 (A)
[25] N.M.S.A. 1978, § 52-5-8
[26] NMAC 11.4.7.8(B)(13)

been reported to OSI that New Mexico's Workers' Compensation Administration is dismissing these cases due to lack of jurisdiction.[27] Furthermore, New Mexico's workers' compensation insurers and self-funding groups are reporting an uptick in litigation on this issue, with at least two claims reported as having been filed in state district court on this issue.

RECOMMENDATIONS

Based on the data collected, feedback provided by stakeholders, and legal research, OSI makes the following recommendations to policymakers and officials to protect New Mexico consumers and businesses against unfair practices and billing by the air ambulance industry:

- Consider intervention in lawsuits challenging the Workers' Compensation Administration's jurisdiction to settle air ambulance fee disputes under the Airline Deregulation Act

- Consider proactive legislation/regulation under the states' McCarran-Ferguson authority to regulate the business of insurance. Proactive legislation or regulation may include, like Texas, setting a fee schedule for workers' compensation claims or dictating health insurer policy language governing fees paid by health insurers for these claims.

- Enact surprise or balance billing legislation that prohibits balance billing of insureds by health care providers, including air ambulance companies.

- Educate health care providers, including emergency doctors and hospitalists, on the impact of air ambulance charges on consumers. Provide training on the selection of in-network providers for patients needing transport.

- Evaluate the impact of any legislative or regulatory action on the provision of air ambulance services provided in the state.

- Centralize and continue communications with other states about litigation related to unfair practices by the air ambulance industry and monitor opportunities for federal class action suits.

[27] *See Gallup Med Flight v. Builders Trust of New Mexico*, D-1113-CV-2016-00394