EMERGENCY MEDICAL TRANSPORTATION COSTS IN FLORIDA

Sha'Ron James
INSURANCE CONSUMER ADVOCATE
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MESSAGE FROM THE ADVOCATE

Protecting insurance consumers by ensuring a healthy consumer-insurance company relationship is the fundamental purpose of insurance regulation. This simple premise guides the actions of government regulators, stakeholders, and advocates at every step in the process. The Office of the Insurance Consumer Advocate was created in 1992 to provide a voice to the insurance consumer and to serve Floridians by actively engaging with stakeholders to find consumer-focused solutions to the challenges policyholders face. Over the past 25 years, the Office has initiated, supported, and advanced many legislative programs aimed at homeowners, automobile, health, and workers’ compensation insurance to promote and facilitate trust and balance in the industry. The work of the Office has compelled companies to treat consumers more fairly and make good on their promise to make consumers whole, especially when faced with unexpected peril.

In my role as Florida’s Insurance Consumer Advocate, I have been most vocal on issues where consumer trust has been eroded, or consumers are left without recourse and need innovative solutions to protect them in their time of need. One such issue relates to the surprise medical bills consumers face after receiving critical and life-saving emergency medical transportation by aeromedical and ground ambulance providers. In 2016, I formed the Emergency Medical Transportation Working Group to assess the impact of emergency medical transportation costs to Florida’s insurance consumers, gather information, and analyze data in a thoughtful, deliberative, and collaborative manner. The Emergency Medical Transportation Working Group brought industry stakeholders together in an effort to gain a balanced perspective on the air and ground ambulance industry and help provide solutions to protect consumers from financial distress after suffering from a medical emergency.

In this report, you will find an overview of the regulatory approaches currently in place related to emergency medical transportation, stakeholder feedback, and my office’s independent recommendations formed from the crucial information and input provided by stakeholders throughout the process. You will also find data and a trend analysis by one of our featured partners, FAIR Health, Inc., an independent and nationally recognized non-profit known for its robust repository of healthcare claims data and award-winning consumer tools that help bring clarity to healthcare costs and health insurance claims data. FAIR Health, Inc. was an integral partner in assisting the Office’s historic efforts to combat the practice of balance billing in the emergency medical services context. I am pleased that FAIR Health, Inc. has again partnered with our office to bring clarity to the issue of emergency medical transportation costs for Florida’s insurance consumers.

I would like to thank the members of the Emergency Medical Transportation Working Group for their transparency as well as their commitment to this issue and our mission of addressing the challenges impacting Florida insurance consumers. I would like to offer a special thank you to the first responders and emergency medical professionals that provide the life-saving services that are critical to the health, safety, and welfare of our state. I would also like to thank the many consumers who took the time to write, call, and share their personal experiences. I am proud of this office’s proactive, innovative, and resourceful approach to addressing consumers’ insurance issues and release this report to further focus this important public policy conversation back to the experience of the Florida insurance consumer, who we are all here to serve.

Sincerely,

Sha’Ron James
Florida’s Insurance Consumer Advocate
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Emergency medical transportation is a life-saving service that impacts all Floridians, including the uninsured, privately insured, and those covered by federal healthcare programs. In October 2016, the State of Florida’s Office of the Insurance Consumer Advocate formed the Emergency Medical Transportation Working Group (EMT Working Group) to gather information, analyze data, and assess the impact of emergency medical transportation (EMT) costs to Florida’s privately insured consumers. The EMT Working Group’s focus centered on addressing the needs of Florida’s insurance consumers by identifying solutions to address concerns faced by ground and aeromedical ambulance services, the insurance industry, state and local authorities, and ultimately the insurance buying public.

Before 2016, Florida families covered by private insurance were financially impacted by the practice of balance billing – where medical providers bill patients for the difference between insurer reimbursements and the charge for services in emergency situations. Although recently prohibited in Florida, balance billing protections do not extend to EMT services such as ground and air ambulances, for which consumers often face unexpected charges. By paying their premiums and deductibles, private insurance consumers have the reasonable expectation that they and their families will be covered if they need emergency medical transportation. Many Florida consumers are shocked to learn that air and ground EMT services are often considered out-of-network by their healthcare plans, and that they owe several hundred or, in some cases, thousands of dollars for the use of these services.

Since there are currently no explicit federal protections against balance billing, some states, such as Florida, have taken action to protect their citizens by passing their own balance billing laws or providing some protections with limitations. However, expenses associated with emergency medical transportation are not included in these protections.
Informed by the EMT Working Group’s year-long commitment to gathering information and data to assess the impact of EMT costs to Florida’s insurance consumers, the Insurance Consumer Advocate puts forth several recommendations to protect Florida’s insurance consumers from surprise emergency medical transportation costs:

**BAN AEROMEDICAL BALANCE BILLING**
Stakeholders must recognize the challenges consumers face when dealing with out-of-network aeromedical balance bills. Although this life-saving service is crucial for patients who need to quickly be transported to a facility for care, the cost of the service is extremely expensive and leaves consumers financially debilitated. Steps must be taken to deregulate the aeromedical industry from federal regulation, so that states may more appropriately regulate the market to address consumer needs.

**REFORM GROUND EMT BILLING MODELS**
The current billing model used for ground EMT should be reformed. By shifting to a value-based model for ground EMT, ambulance companies will be able to charge for medical services and treatments without the requirement of transporting the patient to a medical facility. This would be a significant change from the fee-for-service model which requires that the patient be transported in order for the provider to be reimbursed for the emergency medical care. The fee-for-service model prevents EMT services from billing an insurance company for the critical care without having transported the patient. Transforming the billing model would allow ground EMT services to recoup emergency medical costs from insurance companies and mitigate the need to balance bill consumers.

**INCREASE ACCESS TO IN-NETWORK EMERGENCY MEDICAL TRANSPORTATION PROVIDERS**
Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills. Providers and insurance companies must work together to improve value, efficiency, and use of health care services to reduce costs. Collaborative contracting efforts between EMT providers and insurance companies are integral in reducing the likelihood that consumers are left paying out-of-network prices for life-saving transportation to a medical facility. Regulators should also include and monitor emergency medical transportation in its network adequacy standards.

**IMPROVE TRANSPARENCY & CONSUMER EDUCATION**
Local governments, providers, and stakeholders should commit to educating the public in order to:

1. Combat perceptions about the role of taxes in funding local ground EMT services.
2. Explain the shift to for-profit, privatized EMT providers, especially for air ambulance services.
3. Make transparent the rate justifications and billing practices of EMT providers.
4. Provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages.

Emergency medical transportation services are a life-saving, fundamental part of the healthcare landscape for Florida citizens. These critical services preserve life and improve health and safety, but they must also be accessible and affordable to those with private insurance. Consumers should not be surprised with a substantial bill during the aftermath of a medical emergency. Solutions should center on the consumer experience and put the burden on EMT service providers and insurance companies to work out their differences concerning payment for this life-saving service. Dealing with a financial crisis after suffering an emergency medical event can be debilitating for Floridians and must be addressed.
The Office of the Insurance Consumer Advocate (OICA) was created by the Florida Insurance Commissioner in 1990. In 1992, the Florida Legislature codified the position under Section 627.0613, Florida Statutes. The Insurance Consumer Advocate reports directly to the Chief Financial Officer, but is not otherwise under the authority of the Department of Financial Services or any employee of the Department. The OICA generally represents the interest of the public and has the authority to intervene before the Division of Administrative Hearings (DOAH), the Department of Financial Services (DFS), the Office of Insurance Regulation (OIR), and any forum in matters that arise under the jurisdiction of either DFS or OIR. Specifically, activities of the OICA include:

- Representing the general public and insurance consumers and recommending specific action or findings to DFS or OIR in regulatory matters under consideration.
- Appearing in proceedings or actions before DFS, OIR, DOAH, or arbitration panel.
- Recommending to DFS or OIR any position deemed by the Insurance Consumer Advocate to be in the public interest and in the best interests of insurance consumers.
- Increasing consumer awareness and assisting consumers in matters affecting insurance issues.
- Serving as a member of statutory boards, commissions, or ad hoc entities related to Florida’s insurance markets.
- Performing legal research, seeking public input, and developing proposed legislation that serves the interests of Florida’s insurance consumers.
- Reviewing and analyzing proposed legislation for purposes of preparing public testimony to support or oppose legislation affecting insurance consumers.

To find out more information about the insurance issues that the OICA tracks, including relevant news, communications, and resources from the Department of Financial Services, please visit our website at myfloridacfo.com/division/ica/.
The Role of the Insurance Consumer Advocate

The Insurance Consumer Advocate (ICA), as an independent authority to the insurance regulatory bodies of the state, is uniquely positioned to recommend policy solutions on behalf of the consumers of the state of Florida. This independent structure allows the OICA to maintain its autonomy, enables it to raise concerns and directly examine issues impacting Florida’s insurance consumers. The ICA’s mission is to balance between a viable, competitive insurance market that responds to consumers’ needs for accessible and affordable insurance products that protect their lives, health, and safety.

In furtherance of this mission, the ICA formed the Emergency Medical Transportation Working Group (EMT Working Group) to gain a clear understanding on the scope of the issues concerning emergency medical transportation services and costs. The following issues and recommendations are the ICA’s independent analysis based on information and data presented at the year-long EMT Working Group meetings. The ICA also requested and solicited commentary from consumers which helped frame the issue and the ICA’s ultimate recommendations.
The Insurance Consumer Advocate (ICA) formed the Emergency Medical Transportation Working Group (EMT Working Group) in October 2016 to gather information, analyze data, and present perspective on the impact of emergency medical transportation costs to Florida’s insurance consumers. The members of the EMT Working Group consisted of stakeholders such as emergency medical transportation service professionals, the insurance industry, hospitals, medical professionals, public social services, regulators, and other consumer advocates. The EMT Working Group met over the course of a year to present information and recommendations to inform the work of the ICA in addressing consumer-focused solutions to the issue.

The EMT Working Group was successful in providing over nine hours of testimony for public use and consumption over the course of four separate meetings. The EMT Working Group’s introductory meeting was held on October 17, 2016, and featured consumer experience testimony and a presentation from the National Association of Insurance Commissioners on state responses to air emergency medical transportation regulation. The second meeting, focusing on ground emergency medical transportation, was held on February 28, 2017, and featured presentations on the operational landscape, pricing, and reimbursement. On June 13, 2017, the third meeting was held to highlight air ambulance emergency medical transportation in Florida and provided a robust discussion on patient care within the air ambulance context. The concluding meeting of the EMT Working Group was held on October 31, 2017, and focused on consumer testimonies and recommendations on both ground and air ambulance emergency medical transportation. Presentations and data were provided by stakeholders, industry presenters, national associations, and the non-profit, FAIR Health, Inc. (FAIR Health). Additionally, consumer comments and feedback were solicited in each meeting resulting in over 45 direct consumer experiences communicated to the EMT Working Group members. Each EMT Working Group meeting was publicly noticed and meetings two, three, and four were televised and available to view on the Florida Channel.
Members of the EMT Working Group

Office of the Insurance Consumer Advocate
Sha'Ron James, Insurance Consumer Advocate

Office of the Insurance Consumer Advocate
Jennifer Pettineo, Chief Counsel

Florida Department of Financial Services,
Division of Consumer Services
Tasha Carter, Director

Florida Office of Insurance Regulation
Chris Struk, Life & Health Policy Advisor

America’s Health Insurance Plans
Joy M. Ryan, Meenan P.A.

Florida Aero Medical Association
Jeffery See, Regional Vice President, Air Methods

Florida Ambulance Association
Joe Scialdone, EMS Billing Manager, Escambia County

Florida Association of Counties
Mac Kemp, Deputy Chief of Clinical Affairs, Leon County Emergency Medical Services

Florida Association of Health Plans
Wences Troncoso, Vice President and General Counsel

Florida Blue
David Pizzi, Director, Political and External Relations

Florida College of Emergency Physicians
Dr. Kristin McCabe-Kline, Chief of Staff, Florida Hospital

Florida Hospital Association
Lecia Behenna, Director of Finance

Florida League of Cities
Chief Dan Azzariti, Fire Chief, Plant City

Florida CHAIN
Anne Swerlick, Policy Director

Disclaimer
The ICA is appreciative of the EMT Working Group’s commitment to bring focus to this issue by presenting clear viewpoints and information for public use and consumption. Many important ideas and recommendations were exchanged on how to best assist the consumer who has suffered from an emergency medical event and trusts that their health insurance plan will cover the cost.

After analyzing all relevant information and input, the ICA identified several significant findings. These issues and recommendations are highlighted in this report in an effort to offer balanced solutions to the issue of emergency medical transportation cost and insurance coverage in Florida. It is important to note that while the materials and perspectives amassed by the EMT Working Group constitute the basis for this report, the presentation of information and any policy recommendations are solely the position of the Florida Office of the Insurance Consumer Advocate.

Additionally, research for this report, in part, is based on healthcare charge data compiled and maintained by FAIR Health. The Florida Department of Financial Services, Office of the Insurance Consumer Advocate, is solely responsible for the research and conclusions reflected in this report. FAIR Health is not responsible for the conduct of the research or any of the opinions expressed in this report.²

The EMT Working Group’s meeting dates, agendas, presentations, information, and other pertinent materials can be found on the ICA’s website at myfloridacfo.com/Division/ICA/EmergencyMedicalTransportation.htm.
EMT Landscape

Emergency medical transportation (EMT) services provide life-saving ground and air medical care, first aid services, and outreach to the community. The goal of most emergency medical providers is to provide treatment and access to hospitals, trauma centers, cardiac and stroke centers, burn centers, neonatal and pediatric intensive care centers, and other critical care facilities. Emerging in the 1960s in response to significant increases in automobile accidents, the EMT industry grew from merely moving patients to, from, and between medical facilities to providing life-saving, advanced medical services. Today, EMT technicians and paramedics receive more extensive education in the biological processes of the human body as well as certifications in various advanced medical treatment techniques.

The equipment and clinical staff necessary to provide the aforementioned array of critically-needed medical services in ground and air EMT industries results in massive annual costs to the healthcare system. The operation and financing of ambulance services are complicated and vary widely throughout the country. The idea that EMT is a free public service is a common misconception among consumers. In reality, EMT is rarely funded by local governments solely based on tax revenue. As healthcare becomes increasingly privatized, and services/equipment become more expensive, there is a greater concentration of independent providers. With the exception of Medicare and Medicaid, the rate is set by independent EMT providers and any reimbursement for that rate is determined by the insurer. This results in patients’ financial responsibility being reliant not only on the type of insurance coverage they have, but also on the terms agreed to by insurance companies and the providers, within applicable state and federal guidelines.

Ground Ambulances

In Florida, there are currently 240 licensed basic life support (BLS) and advanced life support (ALS) emergency medical services (EMS) providers. Data provided during the second meeting of the Emergency Medical Transportation Working Group (EMT Working Group) showed that the majority of ground ambulance providers are provided by local counties and cities and are non-profit. Over 50% of the licensed EMS transport agencies are fire departments, and 97% of the licensed EMS transport agencies are non-profit. The pricing for ground ambulance varies by location and by the medical services provided. Pricing also takes into account the EMT provider’s funding source. If the EMT provider is not subsidized by a municipality, the consumer could pay the full cost of the service.

In addition to transport, ground EMT providers offer several levels of emergency and non-emergency medical services. According to the Centers for Medicare & Medicaid Services Manual System, ground ambulance medical services can be categorized into seven different levels.
# Levels of Ground Ambulance Medical Services

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<tr>
<th>Level</th>
<th>Service Description</th>
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<tr>
<td>1</td>
<td><strong>Basic Life Support (BLS)</strong>&lt;br&gt;Non-Emergency&lt;br&gt;Transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state.</td>
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<td>2</td>
<td><strong>Basic Life Support (BLS)</strong>&lt;br&gt;Emergency&lt;br&gt;When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.</td>
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<td>3</td>
<td><strong>Advanced Life Support, Level 1 (ALS1)</strong>&lt;br&gt;Non-Emergency&lt;br&gt;Transportation by ground ambulance and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention. An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.</td>
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<td>4</td>
<td><strong>Advanced Life Support, Level 1 (ALS1)</strong>&lt;br&gt;Emergency&lt;br&gt;When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response.</td>
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<td>5</td>
<td><strong>Advanced Life Support, Level 2 (ALS2)</strong>&lt;br&gt;Transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including:&lt;br&gt;(1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids), or&lt;br&gt;(2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed&lt;br&gt;  a. Manual defibrillation/cardioversion;&lt;br&gt;  b. Endotracheal intubation;&lt;br&gt;  c. Central venous line;&lt;br&gt;  d. Cardiac pacing;&lt;br&gt;  e. Chest decompression;&lt;br&gt;  f. Surgical airway; or&lt;br&gt;  g. Intraosseous line.</td>
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<td>6</td>
<td><strong>Specialty Care Transport (SCT)</strong>&lt;br&gt;Interfacility transportation of a critically injured or ill patient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a patient’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.</td>
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<td>7</td>
<td><strong>Paramedic Intercept</strong>&lt;br&gt;Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.</td>
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In addition to the charge for services provided, there is often a mileage charge included. According to the data collected by FAIR Health, Inc. (FAIR Health), the average charge for BLS emergency transport in Florida was $557. In comparison, according to FAIR Health’s data, the average charge for BLS emergency transport was $824 in Georgia, $752 in New York, and $930 in Texas, all of which are higher than Florida’s average charge. While Florida’s average charge for BLS emergency transport was $557, pricing still varies across the state.

For instance, in the Lakeside/Lake City/Live Oak area of Florida, the average charge for BLS emergency transport was $463. However, in the Tallahassee/Pensacola/Panama City area, the average charge was higher at $680. Miami’s average charge was $630, and Tampa’s average charge was $590. The Spring Hill/Palm Harbor area of Florida had an average charge of $526, which was higher than the Lakeside/Lake City/Live Oak area, but still lower than Tallahassee/Pensacola/Panama City, Miami, and Tampa.

When looking at ALS1 emergency transport, Florida has an average charge of $653. In comparison to Georgia, New York, and Texas, Florida had the lowest average ALS1 emergency transport. ALS1 emergency transport was $938 in Georgia, $1,028 in New York, and $1,126 in Texas. As was the case with BLS emergency transport, Florida also had the lowest average for ALS1 emergency transport when compared to Georgia, New York, and Texas. Florida’s average ALS1 cost was $653, which was on the low end when compared to Georgia’s $938, New York’s $1,028, and Texas’ $1,126.

When looking at areas across Florida, the Lakeside/Lake City/Live Oak area had an average charge of $591. Unlike with the BLS emergency transport, of the five areas, Spring Hill/Palm Harbor had the lowest ALS1 average at $562. The Tallahassee/Pensacola/Panama City area reported an average charge of $827. Miami and Tampa had average ALS1 charges of $783 and $725, respectively.

Overall, looking at other states such as Georgia, New York, and Texas, Florida had the lowest average charge for both BLS and ALS1 emergency transport. However, while Florida may have a lower average than some states, it is important to remember that the average cost in different areas of Florida can vary greatly, as is evident by the Tallahassee/Pensacola/Panama City area having an average ALS1 emergency transport charge of $827 and the Spring Hill/Palm Harbor area having an average charge of only $562.
Air Ambulances

Situated in both the aviation and healthcare sectors, the air ambulance industry is regulated by a complex network of oversight authorities. Stakeholders list federal agencies such as the Federal Aviation Administration, U.S. Department of Health and Human Services, National Highway Traffic Safety Administration (NHTSA), and state-level regulators such as Bureaus of Emergency Medical Services, individual counties, and other blood carrier and pharmacological regulators. However, none of these referenced regulators oversee the financial or billing aspects of the services provided.

“When we’re talking about the actual aviation services, making sure that the aircraft is maintained, keeping the flight crew well trained, well equipped; especially trained pilots...all the licensed certification and training, those are all fixed costs. And whether we are flying a patient, flying 10 patients a day or 1 patient a day, or not flying at all that day, those costs continue and they remain each and every day that we’re in operation.” – Chad McIntyre, TraumaOne Flight Services

Pricing

Currently, the Florida Department of Health lists 37 companies as licensed air EMS providers in the state of Florida. Typically, there are three types of business models for air ambulance providers: (1) hospital-based, (2) independent, and (3) government operator. Hospital-based models are controlled by a hospital and government operators are controlled by a state or municipal government or military unit. However, the independent models are not run by any specific medical facility or government entity and are independent for-profit or non-profit providers.

In addition to the types of business models for air ambulance providers, there are also different categories of air ambulance services. According to the Centers for Medicare & Medicaid Services Manual System there are two categories of air ambulance services:

**Fixed-Wing (airplane)**

A fixed-wing air ambulance is furnished when the patient’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed-wing air ambulance may be necessary because the patient’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility.

**Rotary-Wing (helicopter)**

A rotary-wing air ambulance is furnished when the patient’s medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary-wing air ambulance may be necessary because the patient’s condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by rotary-wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.
According to the National Association of Insurance Commissioners, the average air ambulance trip in the U.S. is 52 miles and costs between $12,000 to $25,000 per flight. Taking that pricing into consideration, the Air Charter Guide, a directory for the air charter industry, reports that the average cost to rent a Boeing 737 is between $4,600 to $10,000/hour. A majority of air ambulance transports are for moving patients between hospital facilities, one-third are for transporting victims from the scene of an accident to a hospital, and the remainder are for other purposes such as organ transports or specialty care flights (for example, pediatric and neonatal patients).

FAIR Health provided the EMT Working Group data on the cost of air medical transportation. This data is indicative of information during the period of October 1, 2015 through September 30, 2016. The data shows the average bill for a fixed-wing airplane transport in Florida was $15,828, while the U.S. 80th percentile was at $22,500. When comparing Florida to other states, Georgia’s average charge was $11,661, New York’s was $17,226, and Texas’ was $18,238. Comparatively speaking, Florida has a lower average charge than New York and Texas, but Florida’s average charge was more than $4,000 higher than Georgia for a fixed-wing transport.

Delving further, FAIR Health provided fixed-wing data on four regions in Florida. Of the four regions, Miami reported the lowest average charge for a fixed-wing transport at $5,715. The Spring Hill/Palm Harbor area had an average charge of $12,911, and the Tallahassee/Pensacola/Panama City area’s average charge was $24,872. Tampa’s average charge was $30,000, though the data included only one flight in the area during the timeframe.

Using the FAIR Health data again, the average bill for a rotary-wing helicopter transport in Florida was $21,221. As with fixed-wing, this is also below the U.S. 80th percentile at $29,036. While Georgia had the lowest average charge for fixed-wing transport, Florida holds the lowest average charge for rotary-wing transport. Georgia’s average charge for rotary-wing transport was $24,660, New York’s was $25,857, and Texas’ was $22,652.

Data was provided on five areas of Florida for the average charge from a rotary-wing transport. The Tampa area had the lowest average charge at $17,443. Miami’s average charge was $18,169, and the Lakeside/Lake City/Live Oak area’s average charge was $23,359. The Tallahassee/Pensacola/Panama City area had an average charge of $24,378, and the Spring Hill/Palm Harbor area had the highest average charge at $32,024.

An air ambulance base houses the physical equipment and staff necessary to provide year-round, life-saving services. Air EMT providers are primarily concerned with maintaining quality, year-round operations of their bases in anticipation of any medical crises requiring their services, while simultaneously making a profit. The Air Medical Services Cost Study Report published March 24, 2017, found that the median annual cost for
a base was $2,969,360. When comparing the median annual cost of a base for for-profit and non-profit independent programs, there was not much of a difference, with for-profit bases having a median cost of $2,951,968, and non-profit bases having a median cost of $2,986,776. The majority of this cost (82%) is fixed and must be recovered in revenue each year for the program to maintain its service delivery. Air Methods, the largest air medical provider in the world, has 386 EMS and 62 tourism aircraft in the U.S. Air Methods services 48 states with 289 bases. According to Air Methods, the average direct cost to operate a 24/7/365 air medical base that performs 300 transports a year is $2,769,820.

The total operating costs for air medical services are not covered by payors in the aggregate.
Florida Blue also reported, as of the EMT Working Group’s June 2017 meeting, that there were no contracted emergency aeromedical transportation service providers in the state of Florida. Despite the network frailty, Florida Blue stated that they remained committed to entering into contracts with air ambulance providers when the terms include fair and reasonable allowances for services, offered protection to their members from balance billing, and enabled Florida Blue to offer affordable health care options. To date, Florida Blue has been unsuccessful at negotiating with aeromedical providers due to considerable differences between proposed contracted allowances and the related mileage. This has been the case for both rotary and fixed-wing transports.

Consumer Impact

Given all of the different variables and contracting considerations, one thing is certain in the purchase of health insurance – the benefits offered by a particular plan are determined at the time of purchase, and the consumer has very little, if any, negotiating ability over plan specifics. Consumers must be certain of the terms and conditions set by insurance companies when receiving medical treatment, and consumer education plays a major role in this understanding. There is great benefit for consumers when they are armed with a comprehensive understanding of how their deductible/copays are applied and what types of events/treatments are not covered by their insurance policy. During or after an emergency is not an ideal time for consumers to be educated on the coverage specifics of their insurance plan by either the provider or the consumer’s insurance company. Likewise, this is not an ideal time for the insurance company to explain their contract terms and potentially harm the relationship they have with their customer. It is also not an ideal business plan for medical provider’s funding goals, given that some consumers will not have the financial wherewithal to pay the balance bill.

Insurance

Health insurance is one of the most important investments Americans make. However, obtaining the proper type and level of coverage can be complex for even the most knowledgeable consumer. Within applicable federal and state guidelines, insurance plans and coverage amounts are determined by insurance companies and may not be uniform across plan types. There may be particular restrictions on medical care or procedure types depending on plan specifics. There may also be high costs associated with the coverages such as deductibles, copayments, and co-insurance rates required for benefits to be applicable. Florida Blue, one of the largest health insurance providers in Florida, reported that their allowed amount is the lesser of the provider’s billed amount for services or an amount established by Florida Blue based on several factors:

- Payment for services under Medicare and/or Medicaid
- Payment often accepted by providers in Florida or comparable markets
- The cost of providing the service
- Payment that does not encourage network non-participation

Provider Networks

Florida Blue reported that in the area of ground EMT, there is little to no network in place because of the lack of competition in the market. Usually, there are one to three providers in most counties, little negotiating opportunity over the cost of care, and, therefore, a resulting high volume of consumers balance billed for services rendered.

“A benefit of an insurance plan is determined at the time of purchase. So, when we submit our claim, it’s not up to the provider to determine how much of their cost share is, it’s truly up to the insurance company plan that dictates that.” – Joe Scialdone, Florida Ambulance Association
A Critical and Life-Saving Service

The services provided by the emergency medical services (EMS) and emergency medical transportation (EMT) industry are paramount in saving the lives of consumers every day. In 2011, the National Center for Chronic Disease Prevention and Health Promotion published a survey of nine states regarding EMS practices for heart disease and stroke. 76.7% of EMS providers contacted in Florida responded to the survey (this was the highest response rate of the nine states surveyed). The Florida respondents reported a total of 2,003,612 EMS calls in 2008. That amounts to an average of 5,474 calls each day in Florida during the 2008 leap year. Of these more than two million calls, 174,864 were for chest pain, 21,708 were for cardiac arrest, and 44,328 were for stroke. In total for the survey, almost 250,000 Floridians were saved or given critical medical treatment by EMT providers during 2008.

The Florida Department of Health’s 2014 Florida Emergency Medical Providers Licensure and Call Volume Report showed 3,466,736 incidents during 2014. When comparing the call volume against Florida’s 2014 population, an estimated 17.8% of Floridians needed the critical medical services EMT providers are trained to deliver.

Without the EMS/EMT industry, Floridians would be void of a critical health care service that is often the first point of contact for many people suffering an acute medical event. Every day, thousands of calls are responded to and life-saving measures are taken to ensure the health of the population.

“911, again, is a social safety net, and we have to be there to provide this level of service.” – Chief Dave Dyal, Fire Chief of Stuart, Florida
Balance Billing

Consumers buy private health insurance coverage to protect themselves and their families from the high-cost of health care. They expect that if they pay their premiums and use in-network medical providers and healthcare facilities, insurance companies will cover the costs of medically necessary care beyond consumers’ specified copayments, coinsurance, and deductibles. However, when patients are treated by out-of-network providers during visits to in-network hospitals or facilities, they may receive unexpected bills for the difference between what the medical provider charged for the service and what the insurance company reimbursed. This practice is called “balance billing.”

Balance billing typically occurs after a consumer suffers an emergency medical event. The consumer experiences a medical emergency and is transported to the nearest medical facility for care. The facility may have non-contracted, out-of-network providers that render care to the consumer in the emergency context. Providers such as radiologists, anesthesiologists, pathologists, and other emergency room doctors are generally identified in this scenario and balance bill the patient to recover the balance between the service charge and the amount reimbursed by insurers. Beyond the emergency context, consumers may also find themselves in scenarios in which they are treated unexpectedly by an out-of-network provider and billed beyond their applicable deductible, copay, or coinsurance amount.

The practice of a healthcare provider billing a patient for the difference between what the patient’s health insurance chooses to reimburse and what the provider chooses to charge is called “balance billing.”

In the examples below, the consumer would receive balance bills because some or all of the services rendered by out-of-network medical providers were not paid in full by their private insurance company:

- A consumer may visit an in-network physician and then be referred to a healthcare specialist for additional tests or surgery who may be out-of-network.
- A consumer who has scheduled surgery at an in-network facility, with an in-network surgeon might later find out that the anesthesiologist was out-of-network.
- A consumer who goes through a surgical procedure using in-network providers may find themselves being transported to another medical facility by an out-of-network ground or air EMT.

Of the three (or more) parties involved – consumers, insurers, and medical providers – the burden of interpreting and disputing balance bills falls exclusively on the consumer, adding financial stress to their already existing health crisis.
The incidence rate of balance billing is unclear because providers are not obligated to report many aspects of their operations or financial practices, thus making most data sources incomplete. For both government and academic publications, research on balance billing practices consistently point to data limitations as a barrier to providing rigorous examination of healthcare and insurance providers’ contracts and rates. Information on whether providers send their patients balance bills or seek to collect them is often withheld for proprietary reasons from regulators and consumers alike.

The balance billing war between providers and insurance companies has led to consumers being strapped with unanticipated health care bills and powerless to negotiate a resolution. Many consumer groups have called for proactive regulations to address this concerning phenomenon. With no explicit federal protections against balance billing, some states have passed consumer-focused legislation to combat the practice. However, many services such as air and ground emergency medical transportation remain out-of-network for healthcare plans and are not covered by these state reforms. Despite some states’ steps to protect patients against balance billing, consumers may still find they owe several hundred or, in some cases, thousands of dollars for the emergency medical transportation they took to the nearest medical facility for care.

### Balance Billing Legislation and State Approaches to an Important Consumer Issue

Federal law does not currently protect consumers from balance billing. Instead, states have worked to protect consumers in certain emergency scenarios where consumers are unaware they may be subject to unexpected charges. Currently, six states have passed legislation using a comprehensive approach for protecting consumers including California, Connecticut,

Given these limitations, two major nationwide studies have been published on the incidence rate regarding balance billing. These studies were conducted by Health Affairs and the New England Journal of Medicine. Both studies found that 20% of emergency department (ED) visits that resulted in admission to an in-network facility were likely to expose the patient to an out-of-network physician.

In 2015, a nationwide study from Consumers Union found nearly one-third of privately insured Americans received an unanticipated medical bill when their health plan paid less than expected for medical services within the past two years. Even if the consumer takes every precaution in selecting an in-network hospital or provider, there is no certainty that the specialists on staff, providers in the emergency department, or the emergency medical transport services are staffed by in-network providers.
Florida, Illinois, Maryland, and New York. Another 15 states offer protections with some limitations including Colorado, Delaware, Indiana, Iowa, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and West Virginia. Most states with laws or regulations that include limited balance billing protections are considering bills in future legislative sessions to expand consumers’ existing fundamental protections. While one may applaud the legislative process for assisting consumers in mitigating the challenges associated with balance billing, the need for regulatory remedies may significantly decrease if insurers and providers resolved billing differences without involving the consumer.

The remaining 29 states and the District of Columbia do not have consumer protection laws regarding balance billing. Some of these states have addressed it on a regulatory level by acting informally as arbiters when a dispute arises. In these cases, insurance and/or healthcare regulators mediate disputes between providers and insurers to determine acceptable payment levels or encourage insurers to pay balance billed charges to help consumers resolve billing disputes. However, informal approaches are notoriously inconsistent in application and effectiveness, and they do not offer long-term solutions as the healthcare industry continues to change.

Joining a handful of other states in comprehensive reform measures, Florida’s legislature passed House Bill 221 in 2016, which took effect on July 1, 2016. This significant, consumer-focused legislation helps to hold the consumer harmless in times of medical need and helps the consumer to better understand their health care coverage. The bill prohibited out-of-network providers from balance billing members of Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) networks when they receive emergency services or covered non-emergency services. Additionally, the bill required hospitals to publish information on their websites naming contracted insurance companies and providers. The legislation further required all insurers to publish a list of their network providers, including specified demographic information, and to update the list with reported changes monthly. Many consumer-centered protections were incorporated into the bill; however, it did not address costs associated with balance billing for emergency ground transportation or emergency air ambulance services.

• Researchers found that 14% of emergency room visits and 9% of hospital stays were likely to produce a surprise bill.

• The risk is even greater for patients admitted to the hospital via the emergency room, in which case 20% of such patients were likely to receive bills.27

In fact, there are very few state laws that protect consumers from emergency transportation bills. Passed in 2017, California's Assembly Bill 72, provides protection from surprise medical bills when consumers follow the rules of their insurance policy by going to an in-network facility for care. However, the law only applies to non-emergency transportation services if the transportation resulted from services provided at an in-network facility. In Washington, Senate Bill 6129 was proposed during the 2017-18 Session to create a ground ambulance transport fund to provide for additional payments to ambulance transport providers for Medicaid services. The monies in this fund may be used to enhance federal financial participation for ambulance services under the Medicaid program and to provide additional reimbursement to ambulance transport providers. New York's Assembly Bill 3338 (2017) aims to specifically reform the state's workers' compensation law by establishing a fee schedule for the costs of ambulance services provided to an injured employee. As state approaches to the overall balance billing question expand, more and more states will be looking to address all forms of unexpected medical bills, including those related to emergency medical transportation.
Stakeholder Perspectives

The passion with which stakeholders have supported or opposed the practice of balance billing is not new. News media in the U.S. have followed disputes and attempts to regulate balance billing practices since the mid-1980s. In the 1990s, when removing similar caps on Medicare billing was considered at the federal level, newspapers featured headlines stating:

- “Medicare Pay Shift a Sick Idea”
- “Worried Sick: Medical bills can bankrupt middle class”
- “Alarm letters’ scare retirees with false warnings of being cut from Medicare”
- “Doctors Charged 27% More Than Medicare Pays”

Over the years, news reports on hearings and committees concerned with balance billing describe citizens and stakeholders vying for leverage in the fight against escalating health care costs. In 1989, *The Palm Beach Post* described one such hearing held by the Florida Task Force on Elderly Access to Health Care where citizens urged stakeholders to recommend legislation that would require doctors to accept Medicare rates as payment in full for medical services. In accepting the Medicare rate, citizens argued that balance billing practices would be eliminated by establishing fee limitations for physicians and related medical services. Doctors responded with emotional appeals that their treatments and provision of services helped patients and saved lives. In sum, the arguments were “not about healthcare, but almost entirely about money, how much the doctors should have and how much the patients could spend.”

Debates on mitigating rising health care costs have continued for several decades and have included the complex, dynamic relationship between health insurance consumers and those who provide life-saving transport and medical services. In the 1990s, media interest in the cost of emergency medical transport and services increased when consumers voiced concerns over exorbitant billing practices. News reporters began to bridge the ongoing disputes about balance billing with new and mounting distress regarding the costs of EMT services, with stories about:

- “Unpaid bills at $700,000”
- “Ambulance bills upset residents”
- “Calling 911: Who Should Pay the Bill?”
- “10,000 ambulance bills unpaid: State learns River Rescue bills for advanced services”

This ongoing trend of matching consumer grievances with those of medical physicians, insurance companies, federal regulators, and EMT services providers continues to influence healthcare policy decisions today.

Similarly, during the course of the Emergency Medical Transportation Working Group’s engagement, the Insurance Consumer Advocate heard from representative stakeholders on their perspective regarding unexpected charges from emergency transport services in Florida. The main component of the balance billing dispute – a provider’s charges versus an insurance company’s reimbursement rate – was discussed from various respective viewpoints and with equally matched fervor.

“If a patient doesn’t pay the bill, or the insurance company in most cases refuses to pay the bill, or pays only a very, very small percentage, that is shifted over to the tax payers.” – Chief Dan Azzariti, Florida League of Cities

Most emergency transportation providers communicated great concern with the concept of prohibiting balance billing for EMT services. As all emergency services for Florida residents are not alike, emergency transportation providers expressed concern that cutting the ability to balance bill would severely impact the readiness, quality of service, and response time to residents. Most providers cited the ability to balance bill as crucial due to low reimbursement rates from
uninsured patients, federal payers, and private insurers. Ground EMT stakeholders argued that a prohibition on balance billing without an increase in insurer reimbursement may lead to an increase in the tax base requirement or a cut in services and equipment. Some stakeholders communicated a desire for legislation requiring insurers to pay a minimum amount on all EMT calls. Air EMT providers also communicated concern regarding base availability, readiness, and response time if a balance billing prohibition were implemented in Florida. Overall, providers suggested a holistic approach to the billing dispute issue and felt that the approach should be exclusive of prohibiting balance billing.

"Florida Blue has worked tirelessly to negotiate in good faith with all emergency service providers on behalf of our customers. And we will continue to do so. Unfortunately, these negotiations have not led to extensive agreements. Worse, in some cases, true negotiations, which we term as an exchange or debate over what we consider reasonable terms of reimbursement, has not occurred because some providers refuse to discuss future prices until old billing disputes are resolved." – David Pizzi, Florida Blue

From the health insurer perspective, stakeholders addressed a need for more economical, efficient, and competitive ways to charge for EMT services. For example, America’s Health Insurance Plans suggested that, as part of the requirements for continuing education, states should inform first responders, law enforcement, dispatchers, and others who may be responsible for deciding on a transportation method for a patient, of the appropriate circumstances for air ambulance dispatch. The more stakeholders are educated on patient care and emergency protocols, the more likely the most medically suitable and cost-effective transportation provider will be utilized. Other stakeholders addressed and emphasized the need for quality contract negotiations between insurers and EMT providers, so that consumers are not harmed by unexpected medical transportation bills. Some stakeholders involved in the process called for, and supported, a balance billing ban to be applied to the emergency services industry, including ground and air transportation.

Regulators, consumer groups, and advocates have long stressed the need for the consumer to be left out of the fight between providers and insurers over the cost of emergency transportation services. As stakeholders communicated, balance billing effects can cause severe financial distress for many insurance consumers. As consumers pay more out-of-pocket for medical care than ever before, they should not be additionally burdened with surprise charges. These stakeholders advocated for the immediate removal of the consumer from the frustration of negotiating the balance billing issue, so that providers and insurers are better incentivized to come to a resolution.

These various perspectives formed the ultimate discussion points and basis for exploration into the impact Florida’s EMT services have on insurance consumers. Each perspective was critically examined, matched with information and data, debated, and passionately advocated.
In 2017, FAIR Health was privileged to assist the Florida Insurance Consumer Advocate’s Emergency Medical Transportation Working Group by presenting data on ground and air ambulance costs and claim frequency in Florida as compared to other states and the nation. Analysis of state-specific data to support consideration of policy on important issues, such as ambulance costs, is one of the services FAIR Health is able to offer states as a national, independent, nonprofit organization dedicated to bringing transparency to healthcare costs and health insurance information. This article will describe how FAIR Health has been active in helping Florida and other states; what the major issues are concerning ground and air ambulance costs; and what state and federal legislation is currently being proposed to address those issues.

FAIR Health and Florida

FAIR Health’s database of over 25 billion privately billed medical and dental claims, the largest collection of private insurance claims in the nation, is kept current with the addition of new claims at a rate of 2 billion per year. Contributed by approximately 60 insurers and claims administrators nationwide, the claims constitute the records of plans covering over 150 million individuals. In Florida alone, we have 1.3 billion claims from 2002 to the present, including 125 million records in 2016 alone, from 56 contributors.

Separately, FAIR Health holds extensive Medicare data. The Centers for Medicare & Medicaid Services (CMS) has certified FAIR Health as a Qualified Entity (QE), so that we now hold all claims under Medicare Parts A, B and D for all 55 million Medicare beneficiaries from 2013 to the present for use in nationwide transparency efforts. As part of the requirements for QE status, CMS determined that the FAIR Health private claims repository possesses data that are representative of each of the 50 states and the District of Columbia.

From the private claims data FAIR Health collects, we produce two lines of percentile benchmark products: charge benchmarks based on actual, non-discounted billed fees for services and allowed amount benchmarks that are imputed based on the actual, negotiated amounts that constitute the in-network fees for services. All FAIR Health benchmarks are geographically

Robin Gelburd, JD, is the president of FAIR Health, a national, independent, nonprofit organization with the mission of bringing transparency to healthcare costs and health insurance information. FAIR Health possesses the nation’s largest collection of private healthcare claims data, which includes over 25 billion claim records contributed by payors and administrators who insure or process claims for private insurance plans covering more than 150 million individuals. FAIR Health also holds separate data representing the experience of more than 55 million individuals enrolled in Medicare. Certified by the Centers for Medicare & Medicaid Services (CMS) as a Qualified Entity, FAIR Health receives all of Medicare Parts A, B and D claims data for use in nationwide transparency efforts.
specific, so the benchmarks for a given geographic area (called a geozip) are based on the claims data for services rendered in that specific geozip. FAIR Health has data for 493 geozips nationwide, including 23 geozips in Florida, allowing us to make granular analyses reflecting the healthcare market economy in a particular area and time.

For example, in one of our 2017 presentations to the Florida Department of Financial Services, we were able to compare average charge, 80th percentile charge and CMS rates for procedure code A0427 (advanced life support, emergency transport, level 1) in a subset of Florida geozips, including those for Lakeside, Lake City and Live Oak (320); Tallahassee, Pensacola and Panama City (323); Miami (331); Tampa (336); and Spring Hill and Palm Harbor (346).

While FAIR Health does not determine, prescribe or recommend any specific benchmark as a usual and customary rate (UCR), the payment standards for healthcare services in a number of jurisdictions reference FAIR Health benchmarks; UCR is instead determined by the relevant state or federal statute, health program or insurance plan design, as the case may be. Our independence and neutrality and the robustness and quality of our data enable us to help states with many policy issues, including those concerning ambulance costs.

**Ambulance Costs**

Costs for ambulance services can be high for several reasons. Ground ambulances and their crews must be available 24 hours a day, seven days a week. They carry sophisticated equipment and have stringent requirements for trained personnel. The costs of air ambulances, whether airplanes or helicopters, are often much higher than ground ambulances, because aircraft are more expensive to operate and maintain than ground vehicles and require flight personnel in addition to specialized medical crew.

Private or public insurers often bear a portion of the costs of ambulance services, but a substantial part of these costs is borne by uninsured patients or by insured patients who receive ambulance services from a provider outside their health plan’s network. Receiving services from an out-of-network provider can easily happen when a patient in a medical emergency calls 911 and the dispatcher sends an ambulance without regard to whether the provider is in the patient’s network. Often, the result is that the insurer pays only a small part, if any, of the ambulance bill, and the patient is left to pay the balance, in what is called balance billing.

Increasingly, state lawmakers are trying to address issues related to ambulance costs, including balance billing. One particularly thorny issue is how to reimburse ambulance services (and ensure continued access to these critical services) if consumers are held harmless for amounts exceeding their in-network costs. Those cost issues are difficult enough for ground ambulances, but particularly challenging when dealing with charges for air ambulances. The difficulty dealing with air ambulance rates is due to a long-standing federal law, the Airline Deregulation Act of 1978 (ADA), which prohibits states from regulating prices, routes or services of air carriers. To date, several federal courts have rejected state efforts to regulate air ambulance charges, ruling that the ADA preempts state regulation of air ambulances.

**Legislative Proposals on Air Ambulance Costs**

Currently, legislative proposals to address air ambulance costs are pending on both the state and federal levels. For example, on February 28, 2017, Senator Jon Tester of Montana introduced the *Isla Rose Life Flight Act (S471)*, federal legislation that would end ADA preemption of state or local laws or regulations related to air ambulances. The bill was referred to committee and no further action has been taken. Several state legislatures have passed or are considering legislation urging members of the US Congress to act to eliminate preemption of state action with respect to air ambulance rates so that states can regulate reimbursement for air ambulance services. Pennsylvania, Montana and Utah each
passed laws in 2017 urging the US Congress to amend the ADA, and similar legislation was just introduced in South Carolina. Colorado also passed a law in 2017 removing a state statutory prohibition on setting standards for air ambulance services preempted by the ADA.

In state legislatures, a number of different approaches are currently being considered with respect to air ambulance costs. Some ambulance-related bills were introduced this year; others remain under consideration from last year’s legislative session. In Michigan, HB5219, a bill that passed the state House of Representatives late last year and is now in committee in the state Senate, would impose transparency requirements on air ambulance services when dealing with nonemergency patients. The air ambulance services would have to inform patients or their representatives whether they are a participating provider or out of network with the patient’s health plan, give patients a good-faith estimate of the cost and let them know they have a right to be transported by a different method or by an ambulance service that participates in their plan. If the air ambulance service fails to provide this notice or if the patient is an emergency patient, the service must accept the amount covered by the patient’s health plan together with any required coinsurance, copays or deductibles as payment in full.

In Virginia, several pending bills would provide transparency for patients. HB777, for example, would require air ambulances to obtain written consent for air transportation from the patient, unless compliance might jeopardize the patient’s health or safety or the patient is unable to provide consent. HB778 would require hospitals, before arranging for air ambulance transportation in nonemergency situations, to provide the patient or patient’s representative with notice that the patient may have a choice between air or ground transportation and that the patient will be responsible for the charges if the air ambulance service provider is not in the patient’s insurance network. Similarly, SB663 would impose disclosure requirements for hospitals before arranging air ambulance transportation, and also would require a good-faith estimate of the range of typical charges for out-of-network air transport services in the patient’s geographic area.

Proposals in other states would provide a dispute resolution process to address fee disputes about air ambulance bills. In Hawaii, HB915 would require healthcare facilities, when transferring a patient to another facility via air ambulance, to request services first from an air ambulance provider contracted with the patient’s insurer. If such services are not available, the healthcare facility must notify the insurer of the use of a non-contracted air ambulance service. If the insurer and the facility disagree whether such use was appropriate, the bill calls for the two to attempt mediation, which, if unsuccessful, is to be followed by binding arbitration.

In Kentucky, HB395 proposes an independent dispute resolution (IDR) program for insurers and air ambulance service providers. To avoid ADA preemption, HB395 would make participation in the IDR program by air ambulance service providers voluntary (via a process of registration), and states that such voluntary agreement constitutes a waiver of the provider’s ability to challenge the IDR program based on federal preemption. Another provision of the bill would require an insurer’s health plan to have an adequate network of air ambulance service providers in the state, or the insurer will not be permitted to set air ambulance reimbursement at an amount that is less than the average rates published by registered air ambulance service providers. Under the proposed legislation, registered air ambulance service providers also would be prohibited from balance billing an insured person, reporting a payment delinquency to a credit agency, obtaining a property lien or taking “any other action adverse to the insured” with respect to the disputed amount.

Medicare payments for air ambulance services are the subject of other state legislative efforts. For example, in South Carolina, H4679 would require all individual and group health insurance
policies and health maintenance organizations to cover air ambulance services deemed medically necessary by a physician. The coverage must pay the Medicare rate for such services plus 15 percent, with the provisions retroactive five years from effective date. In Florida, **S1572** asks the US Congress to address “egregious underpayment by Medicare” for air ambulance services on the grounds that this “destabilizes the reimbursement environment for air medical providers.” The bill urges Congress to pass federal legislation, **HB3378/SB2121**, which would require reporting of certain data by air ambulance service providers for purposes of reforming Medicare reimbursement for such services.

**Legislative Proposals on Ambulance Services in General**

In New York, **S06363** would add “ambulance services” to the definition of “emergency services,” would expand the existing IDR process to include ambulance services and would prohibit balance billing of insured patients who have received ambulance services. A different New York bill, **A07717/S00363**, specifies that insurers who cover ambulance services must pay nonparticipating ambulance service providers at rates negotiated between them, or else “at the usual and customary charge, which shall not be excessive or unreasonable.”

In West Virginia, **SCR20** would request the federal government to review and update Medicaid rates for ground and air ambulance services, and to establish an annual process for reviewing those rates.

**Legislative Proposals on Ground Ambulances**

In Washington, **SB6129**, which specifically excludes air ambulances, would provide for the creation of an ambulance transport fund to be used to enhance federal financial participation for ambulance services under the Medicaid program, and to provide additional reimbursement to, and to support quality improvement efforts of, ambulance transport providers.

In New York, **A03338** would amend the workers’ compensation law to establish a fee schedule covering the costs of ambulance services provided to injured employees and to clarify that the employer or its insurer is liable for the payment of such services. The bill excludes air ambulance services “to the extent preempted by federal law.”

As legislators and other policy makers around the country consider the costs of ambulance services, FAIR Health is ready to help Florida, other states and the federal government by providing data that can enhance their understanding and consideration of the issues arising from ambulance costs.
The Office of the Insurance Consumer Advocate brought stakeholders together in an effort to gain perspective on the air and ground ambulance industry to help provide solutions to protect consumers from financial distress after suffering a medical emergency. After meeting with stakeholders over the course of a year, the Insurance Consumer Advocate (ICA) considered various issues presented, stakeholder viewpoints, and recommendations. Ultimately, the ICA identified four major findings that impact the issue of emergency medical transportation costs and consumers’ ability to rely on their health insurance plan to cover all medical costs when an emergency arises. The recommendations made here are the result of the ICA’s independent analysis of each issue after considering all input made by stakeholders, interested parties, and consumers.

Implicit in this document are assumptions about the nature and future of emergency medical transportation (EMT) services and the environment in which EMT will exist. These assumptions are that EMT services will continue in their present existence as a touchpoint between the public safety, public health, and healthcare systems, and that they will continue to exist in current form into the future. For purposes of this report, the assumption has also been made that EMT ground services will continue to be provided at the local level and that air ambulance services will still be regulated by federal authority. In terms of funding, the assumption is made that applicable federal and/or local funding and financial support for EMT services will remain either constant or decrease due to the trend in fiscal restraint in the foreseeable future. As such, this report only addresses private insurance consumers, and does not seek to address the concerns of the uninsured or those covered by federal healthcare programs.

Of particular importance to the lens through which these recommendations are made is the assumption that there is currently a lack of comprehensive, available information regarding emergency medical transport systems and outcomes. Because of the diverse nature of its makeup, EMT research is fragmented and is often conducted on one particular emergency medical services system. Additionally, the emergency medical services industry has rapidly expanded in the last 30 years, despite slow progress in developing related research. The time and resources required to complete the research necessary are beyond the scope of the Emergency Medical Transportation Working Group’s (EMT Working Group) mission and beyond the scope of the Florida Office of the Insurance Consumer Advocate’s dedicated purpose. Therefore, it will be necessary for the purposes of this report to rely on the information presented at the EMT Working Group meetings and other limited information in order to make recommendations in the best interest of Florida insurance consumers.
Issue #1: Consumer Hardship

Consumers continue to express frustration over balance billing of emergency medical transport charges. This practice occurs when consumers are in a vulnerable, emergency state with no time to make choices or have options presented in the fight to save their lives. Because of this, policymakers have taken measures to remove consumers from the industry fight over the notion of “fair” compensation for services rendered. However, consumer feedback solicited during the Emergency Medical Transportation Working Group (EMT Working Group) highlighted the drastic financial strain that consumers face when saddled with an emergency transport bill.

Direct feedback from consumers solicited by the Insurance Consumer Advocate’s EMT Working Group showed a high general lack of knowledge over the funding mechanisms for the emergency health care services provided at the local level. Feedback also showed that consumers were frustrated over the coverage restrictions in their insurance plan and did not understand why their insurance plan was not reimbursing the total charges. Generally, consumers did not express frustration over the amount of the charge itself or whether the charge seemed “fair” for the service provided. However, many expressed the notion that they would have expressly denied transport if they had known they would be out-of-pocket for some, or all, of the cost of transport.

With regards to ground transportation, the general lack of knowledge over the funding mechanisms and reimbursement measures impacts consumers frequently. According to EMT Working Group stakeholders, consumers can expect to be balance billed for services when the provider requests payment of services and is reimbursed according to the insurer’s usual, customary, and reasonable rates (UCR). As FAIR Health reports, the average Florida charge for a ground ambulance service with Basic Life Support is $557. From an affordability standpoint, many consumers have expressed frustration over being responsible for the balance of the costs, and are under the impression that either local taxes or healthcare insurance should have covered them in their time of need.

Direct feedback from consumers on emergency air medical transport centered largely on the frustration of being saddled with an extremely high bill after experiencing a very traumatic medical event. Consumers again seemed to lack a general understanding of current funding models for private air ambulance transport. The current, privatized business model of air medical transport relies on being able to bill for service, aircraft, and staff. Air ambulance companies will often charge above what insurance companies will pay, resulting in many insurance consumers being unable to cover the difference. Air ambulance companies want to increase the consistency of reimbursement for their billed amounts, while retaining a margin of profit in order to maintain or expand their services and quality. Without the assurance of payment paired with what many air ambulance companies deem inadequate, and with low reimbursements from Medicare and Medicaid, meeting operating costs and making a profit create an urgency that sustains aggressive billing practices.

Air ambulance companies frequently lobby for immediate financial relief from increases in government reimbursements for the transportation of Medicare and Medicaid patients. However, in pursuing these alternative financial solutions, air ambulance companies do not decry their aggressive balance billing practices against private insurance consumers – who pay 231% of the median cost per transport. Nationwide, for-profit air ambulance companies seek the highest possible government reimbursements and pursue balance billing payments to a degree that can result in bankruptcy and foreclosure for those consumers billed.
The air medical transportation industry was once provided primarily by local municipalities, similar to ongoing ground medical transport, and billing issues were not as prevalent as they are now. The *Aviation Deregulation Act of 1978* (ADA) created an environment where invoking federal preemption has prevented efforts for collaboration and contracting with other stakeholders in the broader emergency medical transportation (EMT) landscape. States that attempt to pass consumer protection legislation are immediately challenged using the ADA as precedent, making regulation of the air medical transport industry and protection of insurance consumers largely unsuccessful. Passage of the ADA, although intended for increasing competition among commercial airlines, has attracted tremendous capital from private investors seeking to harness the inability of regulation by states for financial gain.

As an essential health care service, however, air ambulance companies face escalating healthcare costs, along with training pilots and clinical crews, maintaining licensures and certifications, acquiring new technologies for emergency services, and more. The financial motivation for privatizing a public health service fundamentally changes the intent of providing those emergency medical services, which leads to aggressive billing practices and collections. While members of the air medical transportation industry recognize that this type of billing is unsustainable for meeting operational and healthcare costs, there is no indication that they intend to discontinue balance billing insurance consumers.

In 2017, Senator Jon Tester of Montana introduced the *Isla Rose Life Flight Act (S471)*. This federal legislation would end ADA preemption of state or local laws/regulations related to air ambulances. The bill was referred to committee and no further action was taken in 2017, however, the bill was reintroduced in 2018. Several state legislatures are considering or have passed legislation urging members of the U.S. Congress to eliminate preemption of state action with respect to air ambulance rates so that states can regulate reimbursement for air ambulance services. Pennsylvania, Montana, and Utah each passed laws in 2017 urging the U.S. Congress to amend the ADA, and similar legislation was introduced in South Carolina in 2018. Colorado also passed a law in 2017 removing a state statutory prohibition on setting standards for air ambulance services preempted by the ADA. Until federal attempts at deregulation are successful, consumers will continue to have little recourse when saddled with an extremely high, unexpected bill.

The Insurance Consumer Advocate remains concerned over the frequency and severity of both air and ground balance bills given the diverse and often income constrained population of Floridians. From an affordability standpoint, consumers cannot continue to be saddled by unexpected medical bills while navigating other issues that impact their financial stability. Other socioeconomic issues such as the rising cost of housing, transportation, child care, and food are straining the working Floridian who struggles to earn enough to provide stability to their family. The United Way of Florida, a network of 31 community based organizations, has studied this issue. From 2007 to 2012 alone, Florida became less affordable and the cost of basic housing, child care, transportation, food, and health care increased by 13%. In Florida, 67% of jobs pay less than $20 per hour, with three-quarters of those paying less than $15 per hour. Geographically speaking, nearly 50% of Central Florida families do not earn enough to consistently cover the basic living expenses highlighted by the United Way’s definition of asset limited, income constrained, employed (ALICE)
In Miami-Dade County, when the basic needs of families are accounted for (housing, child care, food, transportation, health care, taxes, etc.), the budget for a family of four is $56,760 per year (for a single person that amount is $22,488). Floridians simply cannot continue to afford any surprises in the form of medical bills after utilizing their already strained budgets to provide for health care coverage for their families.

**Ground EMT Collections: Best Practices**

Due to the frequency of balance bills experienced by Florida consumers in the ground emergency transport landscape, the Insurance Consumer Advocate recommends that steps be taken to better engage with the consumer on billing and collection practices by providers. Providers must be more transparent in dispelling the myth of full tax funding and provide consumers with more information about the EMT service costs in their area. Still, more can be done to assist the consumer after they have suffered an emergency medical event and are billed for their transport service. After contacting their insurance company and finding that the bill will not be satisfied, consumers may feel lost in the negotiation process. To complicate matters, some ground EMT providers contract with collection agencies to seek payment on balance bills, inserting another player into the maze of resolving the bill. Some providers may even send unresolved bills to collections, negatively impacting a consumer’s credit in the process.

Some comments received directly by consumers expressed a lack of knowledge of the collections process while expressing frustration over the amount of the cost. One way to provide information to consumers is to directly publish any and all third-party collection agencies that the provider works with for accounts receivable. Second, providers should clearly designate on the balance bill a contact number for the provider, collection service, or third-party that has the authority to resolve the bill as well as a notice about available financial hardship program. Providers should also clearly outline any financial hardship policies, programs, or collection practices (such as payment plans and credit card policies) commonly made with patients on their website for review. Clarity about the best point of contact, and information on the most common resolution methods and/or financial assistance programs available to consumers will lessen the financial/emotional response to the balance bill and likely result in positive outcomes.
Recommendation: Ban Aeromedical Balance Billing

Due to the severity in financial hardship experienced in the air emergency transport landscape, the ICA recommends that steps be taken to deregulate the air ambulance industry from coverage under the federal ADA, giving states the authority to prohibit the practice of balance billing consumers. This position has been supported by many stakeholder groups, including the National Association of Insurance Commissioners, consumer advocacy groups, various state regulators, and more. Some states have already taken measures to alleviate unexpected medical bills for emergency medical transportation services. For example, during their 2016 session, West Virginia enacted air ambulance legislation that applied exclusively to the state’s public health employee insurance plan. Their legislation used the Medicare reimbursement rate for various services as a cap on the amount that non-contracted air ambulance services may collect. This effectively prohibited balance billing in the air EMT context, but only as applied to state employees or their dependents.

In a report published by the U.S. Government Accountability Office on July 27, 2017, it was recommended that federal collection of air ambulance data be analyzed to study objectives and address risks. Such risks include unfair or deceptive practices. While transparency and study are important, the most effective remedy to provide consumers with robust protection is through clarification of the ADA to allow any state to enact or enforce a law or regulate relations to network participation, reimbursement, price transparency, and balance billing for an air carrier that provides air ambulance services. Therefore, the ICA joins with other state regulators in supporting data collection at the state level and ultimately deregulating the air ambulance industry from coverage under the federal ADA.

“The majority of the problems we have here are not based on the EMS provider, it’s based on the insurance industry’s unwillingness to pay what they should be paying. High deductibles, raising of insurance premiums, and all those others things do leave a negative impact on the consumer.” – Chief Dan Azzariti, Florida Leagues of Cities

Federal deregulation will help states address their population’s needs, address state level market concerns, and ban the practice of balance billing to protect consumers from extreme financial hardship after suffering a medical event. As with most healthcare issues, inadequate payment from federal payers and uninsured patients impact the industry’s ability to thrive and play a role in the rates charged to insured consumers. Medical professionals use air EMT services to transport critically ill patients to the nearest facility for care without regard for the patient’s ability to pay. The ICA supports the industry’s ability to continue providing services to all patients. However, the funding challenges should not be placed on the backs of insured consumers who purchase insurance to protect them from high medical costs. It is up to both providers and insurers to work out the billing dispute reasonably through contracting and not involve the consumer struggling to regain their medical and financial footing.
Issue #2: Fee-For-Service Modeling in Ground EMT Services

The ground emergency medical transportation (EMT) industry has been built on its primary role – providing transport from the place of medical emergency to the nearest facility for care. This role is the centerpiece to its billing structure that has existed since the industry’s inception. EMT providers bill based on a fee-for-service model. That is, services provided are itemized and paid for separately. However, most payers require that the patient be transported to a facility in order for the provider to receive payment. Fee-for-service revenue comes from five main sources: Medicare, Medicaid, private insurance companies, private paying patients, and special service contracts.47

Treatment by a first responder without transport can be an effective means to deliver necessary care to a patient. The emergency transport industry has expanded to provide first responder type services combining life-saving technology, medical training, equipment upgrades, and other available medical services folded into its transport capabilities. The transport vehicle that shows up to take care of an individual is an outfitted, mobile life-saving device. The individuals that come to a patient’s aid are no longer transport personnel, they are highly skilled health care providers.

As ground EMT transportation has expanded in its offerings, the billing structure for the service has remained unchanged. Largely, ground EMT providers only bill for their services when a transport is completed. This means that a large number of emergency calls can end up with no patient transport, even though some services (responding to the call, providing health care services on site, etc.) may have been provided. As one of the Emergency Medical Transportation Working Group (EMT Working Group) members reported for his area, over 20% of the dispatched ambulance responses end in treatment but no transport of the patient, which means the EMT provider will not receive any payment for these calls and treatments.48 Overall, it is estimated that 25% to 30% of all dispatched ambulances in Florida involve treatment but no transport.49

Stakeholders and members of the EMT Working Group have identified this billing scheme as an antiquated model of reimbursement. The current EMT payment scheme is not reasonably aligned with its self-proclaimed mission to be faster and more efficient first contacts in patient health care. Continuing in a fee-for-service model and subscribing to a comprehensive first responder mission are incompatible, and leave EMT services unable to adequately fund their programs without relying on cost shifting to consumers. The funding system of emergency medical services needs to therefore adapt to realign with the current goals and mission of the industry.

The Insurance Consumer Advocate (ICA) finds that the existing ground EMT model has not evolved as community needs for emergency and non-emergency health care have changed. This evolution will continue to be necessary as trends in increasing health care costs, overuse of emergency rooms, and the need for long-term care services rise. Increasingly, emergency medical services are becoming the social safety network for many communities in that they provide some level of primary care for patients that experience any type of medical, emotional, or mental health issue. Often, EMT transport services are dispatched along with police when an unknown

“But out of all these services and medical care options that are provided by EMS agencies across the state of Florida, insurance only pays for transport. Only when we transport.”
– Mac Kemp, Florida Association of Counties

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issue is reported by a 911 caller. The unknown factor when this dispatch occurs is whether the transport service is actually rendered, or whether the emergency medical service providers will be called on to assist a 911 reporter with whatever personal, and maybe not physical, need arose for the call. EMT and its medical services are becoming more fully integrated into the overall healthcare system, and the need exists for the EMT billing structure to change accordingly.

Some insurers have already taken steps to change their billing practices so that medical services rendered at the scene are covered regardless of transport. Starting January 1, 2018, Anthem Blue Cross Blue Shield (Anthem BCBS) will begin reimbursing some emergency medical services (EMS) providers for medical treatments even if the EMS provider does not transport the patient. For Anthem BCBS, this program will be offered for Healthcare Common Procedure Coding System (HCPCS) A0998-coded 911 responses in 14 states: California, Colorado, Connecticut, Georgia, Indian, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. The ICA encourages other providers, insurance companies, and healthcare professionals to closely study the effects of the Anthem BCBS decision and promote the growth and evolution of the EMT industry by providing real comprehensive reimbursement for the life-saving services rendered to patients.

“EMS is not a business; EMS is health care.”
– Mac Kemp, Florida Association of Counties
Insurance companies and ground EMT service providers should move to a value-based billing model. By shifting to a value-based model for ground transportation, providers can charge for treatment that does not specifically include transportation of the patient. Treatment by a first responder without transport can be an effective means of delivering necessary care to a patient. This would be a reversal of the current fee-for-service model which requires that the patient be transported and prevents EMT services from billing an insurance company for care if no transport is provided. As an emerging healthcare trend, value-based reimbursement is a comprehensive payment model that bases a provider’s payment on the value of care delivered.\textsuperscript{51} Often, this model includes an incentivized payment structure that is tied to improved patient experience and clinical outcomes. This type of coordinated care creates a system that values quality over the quantity of services provided.\textsuperscript{52}

“This really do believe and our association does believe that we need to move to a value-based contracting system. To move to a value-based contracting system you have to hit that last word, contracting.” – Wences Troncoso, Florida Association of Health Plans

“A lot of patients don’t need to be transported to the emergency room, they don’t need that ambulance bill to be transported, that don’t need that huge emergency room bill. They need other services that actually provide better care for them in the long run.” – Mac Kemp, Florida Association of Counties

Revamping the fee structure would allow EMT services to recoup costs from insurance companies. It would also allow EMT services to continue expanding and raising the standards for health care by implementing the services necessary to benefit a community’s population. Greater access to health care at all levels is a way to increase affordability and sustainability for the future. If billing models provide reimbursement to EMS providers for on scene care, there may be a long-term cost savings to insurers, ultimately benefiting consumers. As insurers like Anthem BCBS begin to apply the value-based model to EMT services, further evaluation is needed to determine the long-term effectiveness and impact on the quality of care. Although critics may argue that there may be a lot of administrative strife in revamping the system to fit changes in how EMT services are currently being delivered, the ICA finds that Florida consumers will benefit from the transition to a value-based, or more comprehensive modeling structure, for emergency medical transportation services.
Issue #3: Out-Of-Network Providers

Emergency medical transportation (EMT) providers and insurance companies should engage in meaningful, good-faith contract negotiations in order to keep services in-network with improved oversight by regulators to ensure greater network adequacy for consumers. Testimony provided at the Emergency Medical Transportation Working Group (EMT Working Group) meetings identified plans with a limited number of available in-network providers, otherwise known as “narrow network” plans, as a major issue. The effect of narrow network participation results in consumers being balance billed for services. The balance billing issue exists primarily because EMT providers are unwilling to negotiate the terms of what they consider a fair price, and insurance companies are unwilling to negotiate the terms of what they consider a fair reimbursement rate for service. Although Florida’s legislation dealing with balance billing, House Bill 221, prohibited balance billing for care received at emergency facilities and in-network hospitals by out-of-network providers, patients transported via ground or air ambulances may still receive unexpected bills. This places consumers and their families directly in the middle of a fight between two very powerful industries.

Network Adequacy

Network adequacy is the ability of an insurer to provide consumers with timely access to a sufficient number of in-network providers. Insurers generally define the number of providers in their networks, while regulators are tasked with overseeing network adequacy requirements and exploring access disparities among communities. Historically, oversight of network adequacy has varied significantly from state to state, and in many cases, has not kept up with changes in health plan designs. With the emergence of the Affordable Care Act, many insurers offered health plans with lower premiums in exchange for limited access to healthcare providers. This trend created complex challenges for regulators responsible for ensuring that consumer interests and access to care were protected. In 2015, The National Association of Insurance Commissioners (NAIC) published the Health Benefit Plan Network Access and Adequacy Model Act, which lists standards for the creation and maintenance of in-network providers by insurers to help ensure network adequacy. According to the Health Benefit Plan Network Access and Adequacy Model Act, “A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.” The Act goes on to include the network adequacy recommendation that, “Covered person shall have access to emergency services twenty-four hours per day, seven days per week.”

Network adequacy is not regulated at the federal level and only a handful of states provide regulation at the state level. The primary tool regulators use to monitor network adequacy is through consumer complaint data. States monitor and
track the number and details of complaints in an effort to supervise network adequacy among insurers. In Florida, general network adequacy oversight is not under the purview of the Florida Office of Insurance Regulation. The Agency for Health Care Administration licenses Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) and has been tasked with network adequacy oversight. For plans offered through the Affordable Care Act health exchange, network adequacy is not governed on a state level.

While regulating network adequacy at the state or federal level comes with its own hurdles, consumers are shouldering the burden of this issue. When consumers are faced with an inadequate network, they are forced to use out-of-network providers which may lead to their insurer not paying a medical bill and the consumer receiving a large balance bill that they are now responsible for, even though they have health insurance. Regulators, insurers, and medical providers all have a responsibility to their consumers to ensure they have reasonable access to the health care for which consumers are paying premiums. If medical providers and insurers are not willing to reasonably negotiate, the consumer is stuck in the middle paying both an insurance premium and out-of-network medical costs. Insurers and medical providers should strive to achieve the network goals provided by the NAIC in its Health Benefit Plan Network Access and Adequacy Model Act, and regulators and policymakers should ensure that consumers have a medical network that is reasonably accessible and able to meet their needs, including access to emergency services and transportation.

The contracting challenge centers around a differing perspective on how the rate is initially derived. In Florida, all providers seeking to provide basic life support and/or advanced level life support need a Certificate of Public Convenience and Necessity (COPCN) license. Due to COPCN license requirements, all provider fee schedules are approved by the local county or governing municipality. The fee schedule established is the same for each patient in a “one price fits all” scenario and is applied equally regardless of the payment source. Therefore, considerations are made for both insured and uninsured patients when setting rates. For insured consumers, requests for payment of services using approved fee schedules are adjudicated per the patient’s health plan and may result in a balance that is then passed on to the consumer for reimbursement.69

It is common practice for providers to balance bill consumers because of revenue shortfalls experienced by servicing Medicaid and Medicare subscribers. Stakeholders commented that before 2002, the Medicare base schedule reflected rates that more aligned with a provider’s usual and customary charges. However, after 2002, the reimbursement shifted away from the provider’s
cost for service to the insurer’s usual, customary, and reasonable rates. EMT providers point to the significant losses in revenue they experience from federally-regulated caps on Medicaid and Medicare payments as one justification for balance billing privately insured patients to recoup their losses. While the industry must adhere to Medicaid and Medicare requirements for ground and air EMT services, there are no standardized rate regulations for providing services to privately insured consumers.

EMT providers also commented from a rate and reimbursement perspective regarding attempts to contract with insurers to become in-network providers. If a provider becomes in-network and contracts with an insurer, the total reimbursement is defined by the contract and is paramount to all applicable state statutes, rules, and billing regulations. Contracted reimbursements may lead to complexities for providers and may not encourage contracting efforts given the matrix of reimbursement schedules and billing regulations via Medicaid, Medicare, Florida statutory rates, and others. For example, if an EMT provider responds to an automobile accident and provides a patient service, the reimbursement rate for that service may be different based on whether the patient is uninsured, insured through a federal program, or insured commercially. Under the Florida Personal Injury Protection (PIP) statutory guidelines, rates for certain services are set at an allowable rate. If the EMT provider’s mileage rate for that service call is lower than the allowable rate under the Florida Statute, the provider is essentially giving up needed dollars. The EMT provider may give up more if it is a contracted provider, because insurers typically pay 80% of the statutory rate. Essentially, by maintaining its non-contracted status, the EMT provider saves a rate setting inconvenience because the insurer will determine reimbursement per the patient’s health care plan. Any remaining balance is then passed to the consumer for collection.

“In Leon County, we recently conducted a certified study of our billing and receipts from insurance, and we found that among patients that actually have insurance, and not all patients do, that insurance pays only on average, about 50% of the actual cost of providing services.” – Mac Kemp, Florida Association of Counties

Air Ambulances

The Air Medical Services Cost Study Report showed that in 2015, the annual cost for 191 air medical providers, with a total of 545 bases, was funded by multiple payment sources. The bill for service is priced differently based on the patient’s payment method. On average, Medicare patients are billed 59% of the cost for services, Medicaid is billed 34%, uninsured patients are billed 3%, and insured patients are billed 231% of the costs. This data was based on a $10,199 median cost per transport for all payers. Privately insured payers are paying almost four times more than Medicare and almost seven times more than Medicaid.

In 2015, one-third of air ambulance companies reported negative profit margins (meaning, they did not make a profit nor receive payment enough to maintain their operations). In this case, cost containment measures shift the burden of treating
uninsured patients and receiving inadequate payment from governmental payers onto other payers (the private insurers and self-pay market). Without regulations on rates, routes, or billing practices, air ambulance companies are free to establish varying rate structures for different types of payers – urban, rural, Medicare, Worker’s Compensation, uninsured, privately insured, self-payers – to support the recoupment of costs.

The picture is much the same for Air Methods when looking at their 2014 numbers. The Air Medical Services Cost Study Report reported the sample payer mix was comprised of 37% of payers being Medicare, 24% being Medicaid, and 26% being commercial insurers. The remaining 12% were comprised of Other and Self-Pay payers. During 2014, Air Methods reported a similar mix of payers, with 28.1% of their payers being commercial insurers, and 33.3% and 23.1% from Medicare and Medicaid, respectively. For both the Air Medical Services Cost Study Report and Air Methods, more than half of their patients are paying with Medicare and Medicaid. Stakeholders report that this has a negative effect on their operating margins, due to the low reimbursements rates for Medicare and Medicaid.

Air ambulance companies around the country have been excluded from legislation prohibiting balance billing because of current federal preemption regulations on rates, routes, and services resulting from the Airline Deregulation Act of 1978 (ADA). The ADA aimed to increase competition in air passenger service by giving consumers the option to select their flights based on criteria including ticket prices, travel routes, and schedules. This act was passed prior to the development of emergency air transportation; therefore, it lacks any differentiation between current air ambulance systems and commercial airline practices. Unlike the commercial travel sector and most economic theories in general, air ambulance competition may increase costs. This is because the high fixed cost of business – aircraft, pilots, and trained medical staff – remains the same regardless of competition levels. However, the demand (i.e., patient transports) in an area may remain relatively constant even though competition and the number of providers may have increased. When competition in the industry increases, the fixed costs remain and must be paid from a smaller number of flights completed per provider, which in turn, can lead to higher prices billed to patients by the provider.
An air ambulance base needs a particular volume of patients to transport in order to meet the financial requirements of keeping a base open. Adding competition between aeromedical bases may decrease the number of patients transported for each base, which in turn decreases revenue for each base. As a result, the same patients are being served by an overpopulation of providers in a given area – driving up the cost of service in order for the bases to meet their operating revenue needs and remain open. A combination of increased bases and the current centralized federal regulations governing the industry may have helped air ambulance service costs to skyrocket. The current cost of air ambulance services has caused a myriad of problems for patients as they receive immense bills and often incur severe debt, despite having insurance coverage.

One consumer provided testimony to the Insurance Consumer Advocate (ICA) and shared that her husband was air lifted from an emergency room to a hospital due to a massive heart attack. The decision to airlift was made by the emergency room physicians based on the patient’s medical condition at the time. The insurance carrier paid the ambulance provider $6,000 for the transport, and the air ambulance provider balance billed the consumer for the remaining $54,000 of the $60,000 transport bill. Another consumer had an accident which required air transport to the nearest trauma hospital. The consumer paid $3,540.71 towards their deductible, and their insurance carrier paid $1,909.62. However, the remainder of the air transport bill, which was $27,447.66, was balance billed to the consumer. All consumers who submitted air ambulance experiences to the ICA for consideration expressed frustration and shock over the high bill, as they were unaware of the likelihood they would be balance billed for the service.

The Atlas & Database of Air Medical Services (ADAMS), a database created by the Association of Air Medical Services and CUBRC’s Public Safety and Transportation Group out of Buffalo, New York, covers 92.5% of air medical services in the U.S. with 1,411 aircraft operating from 1,065 bases. ADAMS data shows that from 2010 to 2014, medical Helicopter Emergency Medical Services (HEMS) nationwide increased by more than 10%: from 900 to 1,020. Meanwhile, over the same time period, a report done by the Health Care Cost Institute (HCCI) does not show a proportionate increase in the number of transports per Medicare or private health insurance consumer. During that same timeframe, the number of air ambulance transports per 10,000 members for Medicare Advantage was 0.87 for fixed-wing and 14.07 for rotary-wing air ambulance. By 2014, the numbers had decreased to 0.43 for fixed-wing and 12.00 for rotary-wing air ambulance.
**Impact on Rural Communities**

Based on the current network of ground and air ambulances, most Floridians are within an hour of a Level I or Level II trauma center. However, it is Florida’s rural communities that most rely on emergency air medical services. Across the nation, rural hospitals have been closing at a rate of nearly one per month since 2010, putting those who live outside of metropolitan areas beyond the reach of trauma centers. As of January 2018, in Florida, there are 36 state-verified trauma centers, all of which are located in the most densely populated areas of the state. Even under the best circumstances, a ground ambulance is unlikely to reach the closest trauma center.

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**Hospital ER Trauma Center Levels**

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<tr>
<th>Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>I</td>
<td>Level I Trauma Center is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation.</td>
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<tr>
<td>II</td>
<td>A Level II Trauma Center is able to initiate definitive care for all injured patients.</td>
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<tr>
<td>III</td>
<td>A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.</td>
</tr>
<tr>
<td>IV</td>
<td>A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support prior to transfer of patients to a higher level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.</td>
</tr>
<tr>
<td>V</td>
<td>A Level V Trauma Center provides initial evaluation, stabilization and diagnostic capabilities and prepares patients for transfer to higher levels of care.</td>
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Data From: American Trauma Society

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A somewhat similar trend is seen for the commercially insured, with 2010 having fixed-wing air ambulance transports at 0.28 and rotary-wing air ambulance transports at 3.01. Data from 2014 showed fixed-wing air ambulance transports increasing to 0.33 but rotary-wing transports decreasing to 2.58. This industry’s expansion has improved access to air medical care – increasing the U.S. population coverage within a 15 to 20-minute response area from 71.2% in 2003 to 86.4% in 2016. Across the 50 states and the District of Columbia, 71.9% of interstate, 67.1% of principal arterial miles, and 58.5% of minor arterial miles are now within a 20-minute air medical rotary-wing response. The growth and expansion of emergency air medical services requires higher overhead costs to maintain bases and aircraft, ensure aircraft availability, and provide staffing when emergencies arise.

There has been a very notable expansion of air ambulance providers over the past 15 years. This increase in air ambulance providers has had a profound effect on the cost consumers pay for the service. Some believe the closure of more than 80 rural hospitals since 2010 has helped drive the increase in the number of air ambulance providers. With the increase in for-profit air ambulance bases, the pressure on financial performance has also increased. The pressure for aggressive business models creates an environment that supports air ambulance providers staying out-of-network and not contracting with insurers.

One common argument against regulation of the air ambulance industry, including network adequacy, is the ADA. Due to the ADA, states are unable to regulate the rates, routes, or services of any air carrier, including air ambulance providers. However, network adequacy is still an area regulators and policymakers need to study. Having reasonable access to necessary emergency medical transportation services can best be achieved when both providers and insurers work together.
According to physicians and EMT providers, this is the hour immediately following a traumatic injury when medical treatment to prevent irreversible internal damage and optimize the chance of survival is most effective. The addition of air ambulances increases the likelihood that all Floridians will have access to a trauma center within 60 minutes.

Network adequacy can be especially crucial in rural areas where emergency medical services (EMS) have traditionally been handled by volunteers. Over the years, the number of healthcare facilities in rural areas have declined. Since January 2010, the Cecil G. Sheps Center for Health Services Research found that 87 rural hospitals have closed. In turn, this has placed a greater reliance on EMS.

A study done in July 2017 by the American College of Emergency Physicians showed that the average interval between a call to 911 and EMS arriving on the scene was 7 minutes in the U.S. However, if you live in a rural area, you could be waiting much longer for EMS. The study found that the average wait time in urban and suburban areas for EMS was 6 minutes, but the average wait time increased to 13 minutes for those in rural areas. As of 2016, the Florida Department of Health’s State Office of Rural Health lists almost half of Florida’s counties as rural, meaning per the 2010 Census there were 100 persons or less per square mile. That puts 30 of Florida’s 67 counties as rural with the potential for longer EMS wait times for critical, life-saving services. The study by the American College of Emergency Physicians also made a very critical point, stating that when a consumer is suffering from a severe bleed, life-threatening allergic reaction, or cardio-pulmonary arrest, the time it takes for EMS to arrive on the scene can mean life or death.

These statistics highlight the scarcity of available EMT resources and the critical need for patients in rural communities to be able to timely access emergency care. It is undeniable that emergency ground and air medical transportation save lives, and consideration of these services are crucial in evaluating the best interests of Florida consumers.
The Insurance Consumer Advocate finds that emergency air and ground medical providers and insurers should successfully negotiate contracts that provide fair and reasonable compensation for services, allow Floridians timely access to care, and protect insurance consumers from balance billing. The data presented during the EMT Working Group has shown differing approaches to this recommendation when considering ground versus air notions of fair and reasonable rates.

Ground Ambulances
Data provided by FAIR Health, Inc. shows that on average, Florida EMT charges were comparable to that of other selected state charges. As mentioned earlier, for basic life support emergency transport, Florida had an average cost of $557, while Georgia’s average was $824, New York’s was $752, and Texas’ was $930. However, data also showed a lack of general competition among providers, which is a touchpoint in the conversation over fair and reasonable price points for services. Also, prevalent from the EMT Working Group’s discussions is the need for additional rural service providers, and increased reimbursement to fund those operations so they continue to run to benefit the community. Ultimately, a holistic approach to the issue is warranted, with each side presenting their best data points to come to an ultimate, compromised, and fair compensation rate for differing parts of the state.

Air Ambulances
The notion of fair and reasonable air EMT rates dictates a different approach for a few reasons. According to the U.S. Government Accountability Office, air providers’ median prices for helicopter air ambulance services have increased substantially over the last four years. The responsibility to cover these rising costs largely falls on the consumer. Ambulance providers demand an enormous high fee, while insurers refuse to pay above their cap for the services. To the surprise of the consumer, the entire outstanding difference is expected to be covered out-of-pocket through balance billing. Due to the high profile of these charges and consumer stories, many states are looking to protect consumers. In 2016-17, the Montana State Auditor’s Office put together an air ambulance working group and drafted legislation which would require out of network providers and insurance companies to negotiate with each other directly, rather than using the patient as the middleman. “It’s not enough for us to say we’re going to ignore this and handle these on a case by case basis where these families are miserable not just because of the health scare, but now because of the financial scare,” explained Jesse Laslovich, Montana State Auditor’s Office Chief Counsel.

The pricing matrix for air ambulance rates is not transparent and not willingly disclosed by the industry. It is therefore unreasonable to assume that all stakeholders hold the necessary transparent data to be able to discern what constitutes a reasonable rate versus compensation. In fact, the

"People buy insurance for a reason, and we believe in that. Or employers’ provider insurance which is a larger majority of the people that are insured, fully insured, in the state of Florida, for a reason. And that is because they expect their insurance to pay bills when they come or when they need services, and we agree with that. However, that requires contracting." – Wences Troncoso, Florida Association of Health Plans
U.S. Government Accountability Office identified this problem as a hindrance in the evaluation of air ambulance rates and recommended that the Department of Transportation “assess available data and determine what information could assist in the evaluation of future complaints” as well as “consider air ambulance consumer disclosure requirements.” Without stakeholder commitment to increased transparency on the cost and other components forming their rates, no meaningful contracting negotiations will be able to take place.

**Collaboration & Network Adequacy Considerations for Both Ground & Air**

Contracting that encourages collaboration among stakeholders is an emerging trend in the healthcare landscape. A growing number of healthcare organizations and insurers are beginning to form these partnerships and recognize that their efforts ultimately improve value, efficiency, and the use of health care services. It also reduces overall health care costs by keeping people healthier and encourages the patient to engage in their health care because expectations are clear and consistent across services. While most would agree that the healthcare system should be accessible with quality care at a low cost, competing priorities and the traditional “win-lose” approach to contracting may interfere in reaching a collaborative goal. Additionally, when there is not a trusting relationship between stakeholders and there are varying viewpoints on the reasonableness of rates, it is easy to understand why traditional methods of contracting can break down. Using a collaborative approach, stakeholders must be more trusting and transparent in the process. They must feel capable of disclosing their organizational strategies, goals, cost of services, and comparative reimbursement rates among provider groups. As attempts to contract using this model unfold, stakeholders may find that they need a neutral third-party to evaluate transparent data, identify any inconsistencies, and promote the successful contracting process. An impartial voice may be needed to identify areas of opportunity, mediate areas of concern, and move parties forward in a manner that yields the best result for policyholders.

Collaborative contracting also promotes network adequacy and provides greater access to care for Floridians, both rural and urban. If stakeholders can effectively manage expectations and create a consensus about what constitutes adequate payment, stability in the EMT landscape can be achieved. Reaching a consensus regarding the reimbursement rate also benefits providers who will know how much they will be paid for various services and can budget accordingly.

It also allows the marketplace to self-regulate instead of pushing regulators to create policies or mechanisms to intervene in disputes between providers and insurers over payment rates, as some states have already done. Consumers should not have to shoulder the burden of analyzing, identifying, and arguing for appropriate charges or reimbursements in order to take themselves out of the balance billing equation. Successful and collaborative contracting among stakeholders who understand the benefits of compromise is a viable solution to this important consumer issue.

**Establish Network Adequacy Standards**

Florida regulators should include and monitor emergency medical transportation in its network adequacy standards. State regulators have a responsibility to provide meaningful oversight of insurer networks and protect consumers’ health and financial wellbeing. Limited information exists with regards to the adequacy of Florida’s EMT networks, and further exploration of this issue by regulators is warranted given the fact that there are areas in the state with limited or no providers. If stakeholders are unable to make contracting efforts a priority in the name of consumers’ best interests, regulators should address this issue to ensure the best outcome for consumers. Therefore, regulators must ensure adequate access to providers, maintain affordability of coverage, and ensure that there is sufficient transparency for consumers to make fully informed decisions when deciding on their health care options.
Issue #4: Transparency & Consumer Education

Without comprehensive regulation requiring increased industry transparency, consumers with private insurance discover that it can be very difficult to know how much their health care services will cost. The only recourse for the consumer is to price out all possible emergency medical transporation (EMT) providers in their area in advance. Unfortunately, it is virtually impossible for individuals in emergency medical crises to anticipate: (1) when and where an emergency will occur, (2) which provider will arrive, (3) the extent of the medical services they will need, or (4) the hospital, trauma-center, or specialty facility where they will be transported. Florida consumers have reported their frustration to regulators and insurance companies because their out-of-pocket charges range from hundreds of dollars for ground ambulance to thousands for air transport. Most EMT providers charge a base or flat rate for medical services and additional per mile or per minute fees. The charges for these services vary by provider.

While it is impossible to foresee the circumstances of any emergency medical event, consumers have expressed a need for access to information about types and availability of services in their area and how those services are funded. Members of a community should be able to easily access the necessary information to see how their emergency service providers are budgeted, staffed, and utilized when services are needed. Community members should also be educated on the readiness levels, equipment, training, operations, and administrative costs of these services. An important piece of information for community members to know is how the local government budget applies to these critical services and whether a portion of the emergency services budget is attributable to private collection using balance billing.

“In my experience with critically ill patients that end up with a big bill because of a pre-hospital or inter-facility transport, and they don't understand how this could possibly be happening. You know, for those patients, what's not transparent to them is that it's not covered by their insurance. That's what's not clear. Because they think this is the very reason that they buy an insurance product, is because if the unthinkable happens, that then they're covered, and they're safe and taken care of, and they're not in financial ruin.” – Dr. Kristin McCabe-Kline, Florida College of Emergency Physicians

Policymakers have addressed the issue of transparency in healthcare in an effort to educate consumers about the overall cost of health care. In 2016, Florida lawmakers passed House Bill 1175 titled “Transparency in Health Care” to require hospitals and surgery centers to provide access to searchable service bundles on their websites. In addition, the law required insurers to provide on their websites a method for plan members to estimate their cost-sharing responsibilities, including both in-network and out-of-network providers. Consumers must also be placed on notice, at the point-of-service, of the potential out-of-network costs. In 2017, Florida lawmakers passed transparency legislation in prescription drug pricing, giving consumers a frequently updated resource with pricing information on prescription drugs in Florida. In the 2018 legislative session, Florida policymakers passed further reform in the area of prescription drug transparency requiring pharmacists to inform customers of less expensive, generically equivalent drugs and advising customers if cost-
sharing obligations exceed the retail price of their prescription.\textsuperscript{83} The law also set registration and financial disclosure requirements for pharmacy benefit managers, otherwise known as “PBMs” (an intermediary that negotiates drug prices on behalf of insurers and HMOs), to promote transparency in how PBMs, Health Maintenance Organizations (HMOs) and insurers deliver the best value to patients.\textsuperscript{84}

Stakeholder transparency and consumer education are important components in establishing and maintaining a relationship of trust between the policyholder, provider, and insurer.
Recommendation: Improve Transparency and Consumer Education

All stakeholders should work to improve transparency and consumer education in the area of emergency medical transportation. The Insurance Consumer Advocate finds a general lack of consumer understanding of ground and air EMT pricing, billing, and health insurance coverage. Inquiries related to all three were found to be common amongst consumers, with the majority being unable to utilize information to determine the services available in their area, the pricing for the service, or the coverage terms found in their healthcare plan. All stakeholders should commit to educating the public in order to combat misconceptions about the role of taxes in funding local ground EMT services, explain the shift to for-profit/privatized EMT providers especially for air ambulance services, make transparent the rate justifications and billing practices of EMT providers, and provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages. This lack of information and the inability to access it hurts consumers and prevents competition, quality, and efficiency in the marketplace. Insurers and medical providers should therefore make a commitment to be more transparent so consumers can appropriately shop their healthcare options, determine the existence of in-network providers in their area, and anticipate any potential out-of-network costs associated with emergency medical transportation services.

As legislators continue to craft policy to promote healthcare price transparency, efforts to compel access to price information must expand specifically to the EMT landscape. Consumers deserve access to information in order to evaluate their emergency medical needs and lessen the impact of surprise medical bills. Florida policymakers have a responsibility to comprehensively address all forms of health care, including ground and air EMT.

Consumer Testimonials

My wife fell and broke both kneecaps. She was taken to a hospital 4.5 miles away. The Fire Rescue bill was $681.

I was air lifted to a hospital due to a massive heart attack. My insurance paid the air ambulance provider $6,000, and I received a bill for the remaining balance of $54,000.

I had to call 911 for my husband who was incoherent. While my husband was in a coma, I received a bill for $735 for ambulance services. I found out my insurance doesn’t pay for ambulance services.

My husband was taken by air ambulance to a hospital following a seizure and a stroke. Our insurance paid $2,512 of the $28,320 bill.
CONCLUSION: Commitment to the Consumer Voice in all EMT Policy Decisions

Emergency medical transportation (EMT) is a critical life-saving service provided to all Floridians. Families covered by private insurance are financially impacted when air and ground EMT providers bill patients for the difference between insurer reimbursements and the charge for service. A ground ambulance bill that amounts to a month’s worth of rent, or an air life flight that may wipe out a college fund or years of saving for retirement results in a lasting financial hardship that deserves a balanced public policy solution and sound industry best-practices. Stakeholders on all sides have passionate viewpoints on the rising cost of health care, including costs related to emergency medical transportation. Each have a valid perspective on patient quality of care, pricing, billing, and funding. Unfortunately, each individual perspective fails to protect the consumer from surprise emergency medical transportation bills.

All stakeholders must work collaboratively to address this critical issue. Due to the severity in financial hardship experienced in the air emergency transport landscape, steps should be taken to deregulate the air ambulance industry from coverage under the federal Aviation Deregulation Act, giving states the authority to prohibit the practice of balance billing. Insurance companies and ground EMT service providers should move to a value-based billing model. By shifting to a value-based model, providers can charge for on-scene care that does not require the patient to be transported. Emergency air and ground medical transportation providers and insurers should engage in collaborative contracting in order to bring providers in-network and provide a fair and reasonable rate for services. Regulators must establish standards to ensure that adequate networks exist, that include emergency medical transportation, providing sufficient access to care for consumers.

Florida, like many states, has a dynamic and complex landscape which requires different emergency medical service models that rely on different funding mechanisms in order to provide quality care. Consumers need a strong voice at the table when discussing emergency medical transportation services. The policy solutions included in this report place the burden on medical providers and insurers to resolve billing disputes and lessen the impact of emergency medical transportation costs to consumers. Florida’s Insurance Consumer Advocate is committed to facilitating communication and collaboration among all stakeholders in an effort to develop sound public policy solutions that are in the best interest of Florida’s insurance consumers.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAMS</td>
<td>Association of Air Medical Services</td>
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<tr>
<td>ADA</td>
<td>Aviation Deregulation Act</td>
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<td>ADAMS</td>
<td>Atlas &amp; Database of Air Medical Services</td>
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<td>ALICE</td>
<td>Asset Limited, Income Constrained, Employed</td>
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<td>ALS</td>
<td>Advanced Life Support</td>
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<td>ALS1</td>
<td>Advanced Life Support, Level 1</td>
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<tr>
<td>ALS2</td>
<td>Advanced Life Support, Level 2</td>
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<tr>
<td>Anthem BCBS</td>
<td>Anthem Blue Cross Blue Shield</td>
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<tr>
<td>BLS</td>
<td>Basic Life Support</td>
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<tr>
<td>COPCN</td>
<td>Certificate of Public Convenience and Necessity</td>
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<tr>
<td>DOAH</td>
<td>Division of Administrative Hearings</td>
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<tr>
<td>DFS</td>
<td>Florida Department of Financial Services</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>EMT</td>
<td>Emergency Medical Transportation</td>
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<td>EMT Working Group</td>
<td>Emergency Medical Transportation Working Group</td>
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<td>EPO</td>
<td>Exclusive Provider Organization</td>
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<td>FAIR Health</td>
<td>FAIR Health, Inc.</td>
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<td>GCPI</td>
<td>Geographic Practice Cost Index</td>
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<td>HCCI</td>
<td>Health Care Cost Institute</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>HEMS</td>
<td>Helicopter Emergency Medical Services</td>
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<td>HH</td>
<td>Household</td>
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<td>HMO</td>
<td>Health Maintenance Organizations</td>
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<td>ICA</td>
<td>Florida’s Insurance Consumer Advocate</td>
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<td>NAIC</td>
<td>National Association of Insurance Commissioners</td>
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<td>NHTSA</td>
<td>National Highway and Traffic Safety Administration</td>
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<td>OICA</td>
<td>Office of the Insurance Consumer Advocate</td>
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<td>OIR</td>
<td>Florida’s Office of Insurance Regulation</td>
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<td>PBM</td>
<td>Pharmacy Benefit Manager</td>
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<td>PE</td>
<td>Practice Expense</td>
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<td>PI</td>
<td>Paramedic Intercept</td>
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<td>PIP</td>
<td>Personal Injury Protection</td>
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<td>PPO</td>
<td>Preferred Provider Organization</td>
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<td>SCT</td>
<td>Specialty Care Transport</td>
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<tr>
<td>UCR</td>
<td>Usual, Customary, and Reasonable Rates</td>
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Sources

1. The representative from Florida CHAIN participated in the EMT Working Group’s meeting held on October 17, 2016.

2. Data copyright © 2018, FAIR Health, Inc. All rights reserved. Used by permission. Copying, use, and further distribution prohibited.


FAIR Health data modules report benchmarks for medical charges and are updated twice a year based on twelve months of claims data. The modules are structured to report benchmark values for charges anywhere from the 50th through the 95th percentiles. The 80th percentile of FAIR Health would mean 80 percent of the charges for a given procedure are at or below that cost. The 80th percentile has been utilized by some state governments to set fee schedules or define typical medical charges for various health policies and programs. However, those utilizing the database may select the benchmark value they so choose. www.fairhealth.org/


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34 Reinstein, A. (1989, Feb 8). Make Doctors Accept Medicare Payment. The Palm Beach Post, p. 5E.

35 Reinstein, A. (1989, Feb 8). Make Doctors Accept Medicare Payment. The Palm Beach Post, p. 5E.


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68 Florida Trauma Centers. Retrieved April 06, 2018, from Florida Committee on Trauma website: [https://florida.cot.org/florida-trauma-centers](https://florida.cot.org/florida-trauma-centers)


78 Trauma Center Levels Explained. Retrieved April 06, 2018, from American Trauma Society website: www.amtrauma.org/?page=traumalevels


Policy Resources

• Consumer Testimonials

• Office of the Insurance Consumer Advocate Recommendations Summary Sheet
<table>
<thead>
<tr>
<th>Consumer Testimonials</th>
<th>Description</th>
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<tr>
<td>“They still keep billing us”</td>
<td>My wife fell in a parking lot, and soon an EMS unit appeared. They insisted on treating her and told her she must go to a trauma center. She said that I was coming and was going to drive her to the Urgent Care. They insisted she go in the ambulance, they found that she had a broken bone in the wrist. She was treated, and I drove her home. We have been billed numerous times for that unwanted ride to the hospital $903.60. Medicare paid $255.20 but they still keep billing us for $648.40.</td>
</tr>
<tr>
<td>“Insurance doesn’t pay for ambulance services”</td>
<td>I had to call 911 for my husband who was incoherent, and they sent me the Paramedics. To my shock and horror while my husband was in a coma, I received a bill for $735.00 for ambulance services. I called our insurance company BCBS of Florida, we have Blue Options and told them about it, and I found out that the insurance doesn’t pay for ambulance services.</td>
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<tr>
<td>“It seems they are getting paid by taxes and individuals”</td>
<td>My Ford Expedition was hit by a Ford F250 truck that ran a red light and had no lights on and proceeded to hit other cars and end up in someone’s front yard. I had to be cut out of the car. I received a bill of just over $900 from the Fire and Rescue. I provided them with my health insurance information. They said they submitted a claim but they are still trying to get me to pay them. It seems they are getting paid by taxes and individuals that don’t want their credit ruined.</td>
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<tr>
<td>“I wish I had just called a taxi”</td>
<td>I had a severe asthma attack and I called 911. I was taken to the hospital, where I spent the next four days. At this time, I was covered by BCBS medical insurance. Two years later, I received a bill for $784.00 since EMT provider was “out of network”; BCBS explained the cost bounced back to my deductible which had not been met for that year therefore I was responsible for the emergency transport. It is the only time in my life I have ever required the assistance of 911, and I wish I had just called a taxi.</td>
</tr>
<tr>
<td>“Ambulance services, public or private need to come up with a reasonable fee”</td>
<td>I slipped and hit my head and was transported by the hospital. An approximately 10 minute drive to the emergency room cost $800.00. Insurance only covered $150 leaving me responsible for the remainder. I understand that cities need to cover the cost of equipment and staff however, the insurance companies and ambulance services, public or private need to come up with a reasonable fee based on service rendered and distance.</td>
</tr>
<tr>
<td>“It becomes a factor in future reactions to consider cost”</td>
<td>My son has severe food allergies. He needed an EpiPen for a reaction and his emergency care plan says to use an ambulance post EpiPen. We did that. Unfortunately our insurance company (BCBS) said the only available ambulance service was ‘out of network’. We were charged $850. I am so disappointed as it becomes a factor in future reactions to consider cost and hesitate to use an EpiPen.</td>
</tr>
<tr>
<td>“We are 22-year tax paying residents, I do not understand the difference.”</td>
<td>My wife fell at the entrance to a clubhouse and broke both kneecaps and could not walk. The Clubhouse staff called 911 and a Fire Rescue vehicle took her to the hospital, 4.5 miles away. The Fire Rescue bill was $681.25. After a one night stay, she was discharged and a private Ambulance Service took her to a rehab facility, 10 miles away and charged her $70. We are 22-year tax paying residents. I do not understand the difference.</td>
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Office of the INSURANCE CONSUMER ADVOCATE

Sha’Ron James

RECOMMENDATIONS

BAN AEROMEDICAL BALANCE BILLING
Stakeholders must recognize the challenges consumers face when dealing with out-of-network aeromedical balance bills. Although this life-saving service is crucial for patients who need to quickly be transported to a facility for care, the cost of the service is extremely expensive and leaves consumers financially debilitated. Steps must be taken to deregulate the aeromedical industry from federal regulation, so that states may more appropriately regulate the market to address consumer needs.

REFORM GROUND EMT BILLING MODELS
The current billing model used for ground EMT should be reformed. By shifting to a value-based model for ground EMT, ambulance companies will be able to charge for medical services and treatments without the requirement of transporting the patient to a medical facility. This would be a significant change from the fee-for-service model which requires that the patient be transported in order for the provider to be reimbursed for the emergency medical care. The fee-for-service model prevents EMT services from billing an insurance company for the critical care without having transported the patient. Transforming the billing model would allow ground EMT services to recoup emergency medical costs from insurance companies and mitigate the need to balance bill consumers.

IMPROVE TRANSPARENCY & CONSUMER EDUCATION
Local governments, providers, and stakeholders should commit to educating the public in order to:
(1) Combat perceptions about the role of taxes in funding local ground EMT services.
(2) Explain the shift to for-profit, privatized EMT providers, especially for air ambulance services.
(3) Make transparent the rate justifications and billing practices of EMT providers.
(4) Provide useful, comparative information for consumers considering purchasing insurance plans with emergency transport coverages.

INCREASE ACCESS TO IN-NETWORK EMERGENCY MEDICAL TRANSPORTATION PROVIDERS
Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills. Providers and insurance companies must work together to improve value, efficiency, and use of health care services to reduce costs. Collaborative contracting efforts between EMT providers and insurance companies are integral in reducing the likelihood that consumers are left paying out-of-network prices for life-saving transportation to a medical facility. Regulators should also include and monitor emergency medical transportation in its network adequacy standards.

https://www.myfloridacfo.com/Division/ICA/