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Economic Affairs Interim Committee

64th Montana Legislature

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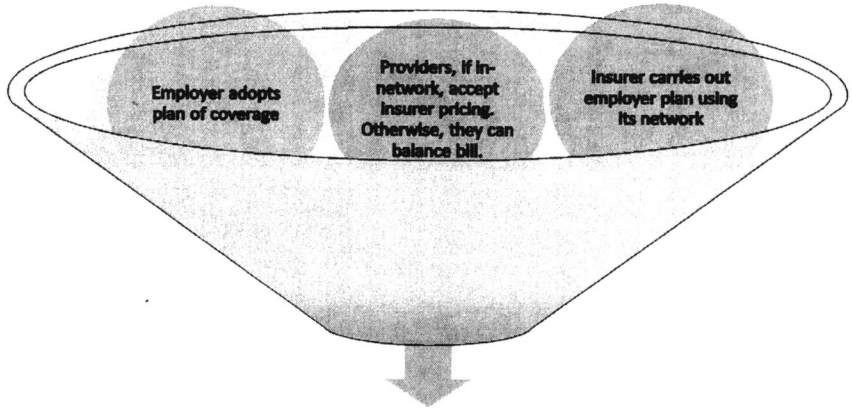
Background Information on Insurance and Air Ambulance Billing, Memberships

by Pat Murdo, Legislative Research Staff

Insurers base payments to providers according to a set allowed amount. The employer chooses what benefits will be in the plan document agreed to by the purchaser of insurance, whether that is an individual or an employer. In some cases the employer is the insurer. Often these self-insured employers use third-party administrators to handle their claims, with the handling instructions based on the plan document.



Outcome for employee:

1) Subject to scope of employer's coverage plan; knowable in advance

2) Subject to insurer's in-network providers; knowable in advance

For air ambulance bills, an insurance plan may provide in-network payment at a percentage of the allowable rural Medicare charge. Examples of the rationale that goes into payment processes may be found in Appendix A of the background information on HJR 29 handed out in June 2015. The document (a revised version is in the table below) shows billed charges, the amount allowed under rural Medicare rules, and two options -- in or out of network -- regarding allowable charges..

The first item relates to the air ambulance provider's billing. The column on Rural Medicare allowable charges in 2014 indicated the following base (or liftoff) rates:

- $4,444.68 for fixed wing;
- $5,245.13 for rotary wing.

Example of Air Ambulance Billing/Balance Bill as Related to Medicare Allowable

Sample Claim for Fixed Wing Charges	Charges Billed by Air Ambulance	2014 Rural Medicare Allowed	Depending on Insurer - Amount Allowed is % of Medicare or May be Based on a Set Fee Schedule	
			In-Network Allowable (e.g. 250% of Medicare)	Out-of-Network - Member responsibility ((Balance Bill)
Base Rate	$12,500	$4,444.68	$11,111.70	$52,878.11 plus the co-pay and other member responsibility under the plan
Mileage Rate	$67.649.31	$6,463.80	$16,159.50	
Total	$80,149.31	$10,908.48	$27,271.20	

The column showing the billed percentage of Medicare allowable in the background information on HJR 29, handed out in June, has a "wow" factor in the full document that showed billed charges ranging from a low of 236% of Medicare's rate to a high of 2,173%. Employers have a say in what types of coverages the plan document provides and, for example, whether co-pays are an 80-20, 75-25, 60-40 or 50-50 option. Self-insured employers, particularly, may work with the insurer to determine what percentage of Medicare they might provide for the allowable coverage. In most cases reviewed in Appendix A, the eligible charges defined by the plan document for air ambulances amount to 250% of rural Medicare. In two examples on page 6, "vendor A" received from insurance between 390% and nearly 490% of the rural Medicare allowable. These costs amounted to $23,348 and $53,540, respectively, either for a self-insured employer or for the insurer.

Plan Options for Air Ambulances

Among options before insurers and employers who are developing plans of coverage are the following, recognizing that some interpretations of federal law might require an insurer to treat all emergency transports as in-network:

- cover the cost of an annual membership with an eligible air ambulance provider as part of the insurance coverage;
- warn policyholders (the employee users of insurance) in readily readable type that air ambulance providers may be out of network and inform the policyholder to call in advance or find website information about whichever operator is first on their list. Also provide a note to say that preauthorization is not conclusive for who will provide service.
- require insurance plans to have an air ambulance provider in network that has reciprocity with other air ambulances and provide in statute a method for the insurance commissioner to determine a "usual and customary" amount not based on Medicare that insurance plans must pay without balance billing.

Payment Options

Employers that help to pay for insurance coverage more and more frequently are seeking cost savings through a variety of mechanisms. One example is called skinny networks, which narrows the provider choices that are in-network. Another example is called reference-based pricing, by which a self-insured employer sets a coverage plan indicating a maximum amount that will be paid for a service or group of related services. Often this maximum amount is similar to what Medicare pays, plus a percentage more. One business (rather than health care) definition of reference pricing is that reference pricing is just below that of the main competing brand. What reference pricing means for self-insured plans is to shift costs to the employee in cases where the employee's lack of attention or inability to determine who provides service results in higher cost providers.[1]

What the payment options do is to potentially narrow the choice that an employee has or expand the cost that the employee may bear for air ambulance services. The skinny network and reference pricing discussion is intended, in part, to show that consumers may find themselves being balance billed for more situations even if they are in-network.

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[1]The larger insurance question is whether there is a way to control costs, not just for the insurance plan but for patients, if certain providers of services are bundled or otherwise not within the patient's ability to choose. This includes anesthetists who might be outside of a hospital's network but required for surgery or air ambulances who are called by the hospital and not the patient.

Membership Options

Some, not all, of the air ambulances serving Montana offer memberships. The idea is much like the AAA membership card (for the American Automobile Association) that people might use for roadside or other travel assistance in which a set membership fee covers local towing, battery charging, or other emergency use. Basically the person needing service shows the membership card and the provider of the service waives the charge to that person and collects based on a contract with the auto club. A person selling motor club services must be licensed by the Insurance Commissioner, as provided under Title 61, chapter 12, part 3, MCA. (See Appendix.)

Regulating memberships may be a moot point, however, if that, too, is considered preempted under the Airline Deregulation Act. Even if not preempted based on membership services being a voluntary option for air ambulance providers, regulations might serve only to increase costs of membership.

As with other aspects of regulating air ambulances, the U.S. Department of Transportation (DOT) has issued opinions as to whether memberships or subscription services are preempted by the Airline Deregulation Act. Each of these opinions is based on specific facts that may not correspond directly to Montana's membership statute, allowed under 50-6-320, MCA.

One such case is a November 2008 letter to the Texas Attorney General related to membership subscriptions for air ambulances. That letter notes (on p. 9) that the Texas Department of State Health Services must "adopt a rule that requires an emergency medical services provider to secure a surety bond in the amount of sums to be subscribed before soliciting subscriptions and creating and operating a subscription program." The preapproval factor drew the U.S. DOT's disapproval.

Montana's statute regarding memberships does not require preapproval, however. That statute reads that a private air ambulance service membership program "must have arrangements with other air ambulance service providers," sometimes called reciprocity, except that 50-6-320(3) also provides that this arrangement be done "to the extent reasonably possible":

> (3) Any private air ambulance service membership program must have arrangements with other air ambulance service providers in Montana to the extent reasonably possible to ensure maximum geographic coverage within the state for the subscribers to the program.

A specific letter from the DOT to Montana would be necessary to determine whether Montana's membership approach is acceptable. The Economic Affairs Interim Committee could request a letter. Other options for legislators looking at whether more specific requirements ought to be imposed for memberships or removing memberships completely from 50-6-320, MCA, include:

- remove all references to a membership program regarding reciprocity;
- remove all references to a membership program;
- revise the language regarding membership programs not being regulated by the insurance commissioner to state that a membership program contains insurance risk but, while an air ambulance provider is not an insurer, it is the offeror of a product for which the insurance commissioner may require a license, similar to a license used by

automobile clubs, such as AAA. The provisions could allow the insurance commissioner some rulemaking authority for memberships but not for the operation of the air ambulance. However, another concern about membership programs is that they may run afoul of the antikickback provisions related to Medicare in the Social Security Act if the subscriptions do not bring in enough money to offset the costs of waived expenditures (at least for Medicare-reimbursed services). The opinion was by the Office of Inspector General for the U.S. Department of Health and Human Services. Additional information about memberships is in an email attachment following the Appendix.

An overall Options report for HJR 29 is available separately. Some of the information in that report is the same as mentioned here.

Appendix -- Montana's Motor Club Service Companies Statutes

61-12-301. Terms defined. As used in this part, unless the context requires otherwise, the following definitions apply:
(1) "Agent" means a person who solicits the purchase of service contracts or transmits for another a service contract or application for a service contract to or from the company or who acts or aids in any manner in the delivery or negotiation of any service contract or of the renewal or continuance of a service contract.
(2) "Bail bond service" means any act or acts by a company the purpose of which is to furnish or procure for any person accused of violation of any law of this state a cash deposit, bond, or other undertaking required by law in order that the accused might enjoy the accused's personal freedom pending trial.
(3) "Buying and selling service" means any act or acts of a company whereby the holder of a service contract with the company is aided in any way in the purchase or sale of an automobile.
(4) "Commissioner" means the commissioner of insurance of the state of Montana or the commissioner's assistants or deputies or other persons authorized to act for the commissioner.
(5) "Company" means any person, firm, partnership, company, association, or corporation engaged in selling, furnishing, or procuring, either as principal or agent, for a consideration, motor club service.
(6) "Discount service" means any act or acts by a company resulting in the giving of special discounts, rebates, or reductions of price on gasoline, oil, repairs, insurance, parts, accessories, or service for motor vehicles to holders of service contracts with the company.
(7) "Emergency road service" means any act or acts by a company consisting of the adjustment, repair, or replacement of the equipment, tires, or mechanical parts of any automobile so as to permit it to be operated under its own power.
(8) "Financial service" means any act or acts by a company whereby loans or other advances of money, with or without security, are made to holders of service contracts with the company.
(9) "Legal service" means any act or acts by a company consisting of the hiring, retaining, engaging, or appointing of an attorney or other person to give professional advice to or represent holders of service contracts with the company in court as the result of liability incurred by the right of action accruing to the holder of a service contract as a result of the ownership, operation, use, or maintenance of a motor vehicle.
(10) "Map service" means any act or acts by a company by which road maps are furnished without cost to holders of service contracts with the company.
(11) "Motor club service" means the rendering, furnishing, or procuring of towing service, emergency road service, insurance service, bail bond service, legal service, discount service, financial service, buying and selling service, theft service, map service, and touring service, or any three or more enumerated services to any person or persons in connection with the ownership, operation, use, or maintenance of a motor vehicle by the other person or persons in consideration of the other person or persons being or becoming a member or members of any company rendering, procuring, or furnishing the services, being or becoming in any manner affiliated with the company, or being or becoming entitled to receive membership or other motor club service from the company by virtue of any agreement or understanding with the company.
(12) "Service contract" means any agreement or understanding whereby any company for a consideration promises to render, furnish, or procure for any other person or persons, whether they be members of the company or otherwise, motor club service.
(13) "Theft service" means any act or acts by a company the purpose of which is to locate, identify, or recover a motor vehicle owned or controlled by the holder of a service contract with the company that has been or may be stolen or to detect or apprehend the person guilty of the theft.
(14) "Touring service" means any act or acts by a company by which touring information is furnished without cost to holders of service contracts with the company.
(15) "Towing service" means any act or acts by a company consisting of the drafting or moving of a motor vehicle from one place to another under other than its own power.

61-12-302. Companies and agents to be licensed. No company or any agent, as herein defined, doing business in this state shall execute, issue, or deliver any service contract to any person or persons owning

or operating motor vehicles without first having obtained a license from the commissioner as provided for in this part, nor shall any such company or agent collect or receive from any person or persons in advance of the execution, issuance, or delivery of any such service contract any money or other thing of value upon any promise or agreement to execute, issue, or deliver any such service contract without first having obtained a license from said commissioner as provided for in this part.

61-12-303. Requirements for license. (1) The commissioner may not issue a license to a company until the company has filed the following:
(a) a formal application in the form and detail that the commissioner may require, executed under oath by its president or other principal officer;
(b) a copy of the form of its contract;
(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;
(d) a financial statement in the form and detail that the commissioner may require, executed on oath by its president or other principal officer;
(e) a certificate from the commissioner that it has complied with 61-12-304 in all cases in which a deposit of cash or a bond is required by this part;
(f) if the company is a corporation, a certificate from the secretary of state that the company has complied with this state's corporate laws.
(2) The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee or the pro rata portion of the $100 necessary to be paid to the end of the current calendar year from the date of the application for the license.
(3) The commissioner may not issue a license to a company until the company has satisfied by an examination and evidence that the commissioner may require that the company has complied with the laws of the state, that its management is trustworthy and competent, and that the company is financially responsible.

61-12-304. Deposits required. The commissioner may not grant a license to a company until it has deposited with the commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part. However, when any company proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the services promised to them, and is financially responsible, the commissioner may not require a cash deposit or bond while the company remains in that condition. The cash deposit or bond is not a penalty but is for the protection of the public only.

61-12-305. Continuance of license. Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license continues in force as long as the company is entitled to the license under this part or until the license is revoked, suspended, or otherwise terminated.

61-12-306. Revocation of license. If the commissioner at any time for cause shown and after a hearing determines that a company has violated any provision of this part, that it is insolvent or that its assets are less than its liabilities, that it or its officers refuse to submit to an examination, that it is transacting business fraudulently, or that its management or business methods are improper or hazardous to the holders of its service contracts, the commissioner shall revoke or suspend its license and shall give notice of the suspension or revocation to the public in a manner that the commissioner considers proper.

61-12-307. Financial statement to be filed. A company shall annually, on or before February 1 of each year, file with the commissioner a financial statement in the form and detail that the commissioner may prescribe, executed on oath by its president or other principal officer, showing its financial condition on December 31 of the preceding year.

61-12-308. Service contract to be filed with commissioner. A service contract may not be executed, issued, or delivered in this state until a copy of the form of the contract has been on file for 30 days with the commissioner, unless before the expiration of 30 days the commissioner has approved the form in writing. A service contract may not be executed, issued, or delivered at any time in this state if the commissioner notified the company in writing within the 30-day period that in the commissioner's opinion the form of the contract does not comply with the laws of this state, specifying the reasons for the opinion.

61-12-309. Contracts to be in duplicate. Every service contract executed, issued, or delivered in this state shall be made in duplicate, and shall be signed by the company issuing the same, or by its duly authorized agent, and by the party purchasing the same, and one copy thereof shall be kept by said company, and the other copy shall be delivered to the party purchasing the same.

61-12-310. Form of contract. A motor club service contract may not be executed, issued, or delivered in this state unless it contains the following:
(1) the name of the motor club service company;
(2) the location of its home office, giving street number, city, and state;
(3) a provision that the contract may be canceled at any time by either the company or the holder and that the holder is, if the holder has actually paid the consideration, entitled to the unused portion of the consideration paid for the contract, calculated on a pro rata basis without any deductions;
(4) a provision plainly specifying the services promised and that the holder is not required to pay any sum for any services specified in the contract in addition to the amount specified in the contract and further specifying the territory where the services are to be rendered and the date when the service commences.

61-12-311. Companies to be licensed. No person shall solicit or aid in the solicitation of another person to purchase a service contract issued by a company not duly licensed under this part.

61-12-312. Contract not to be misrepresented. No company and no officer or agent thereof shall orally or in writing misrepresent the terms, benefits, or privileges of any service contract issued or to be issued by it.

61-12-313. Contracts binding on company although not complying with part. Any service contract made, issued, or delivered contrary to any provision of this part shall nevertheless be valid and binding on the company.

61-12-314. Applicability. This part does not apply to:
(1) a duly authorized attorney at law acting in the usual course of the profession;
(2) an insurance company, bonding company, or surety company licensed and doing business as the licensed company under the laws of the state; or
(3) a company or agent that contracts with a motor club service company licensed under this part to provide emergency road service or towing service to the company's or agent's customers.

61-12-315. Penalty for violation. A person violating the provisions of this part is liable pursuant to 33-1-317.

Cl0106 6022pmxa.

Murdo, Patricia

Subject: FW: Air Ambulance Membership Observations
Attachments: OIG 03-11 Subscriptions.pdf; ATT00001.htm

From: William Bryant
Sent: Tuesday, January 19, 2016 9:04 AM
To: Murdo, Patricia
Subject: Air Ambulance Membership Observations

Hi Pat,
There is another piece of the air ambulance membership puzzle you may not be aware of, and that is the need for providers to be compliant with Medicare rules of participation, and to stay clear of Federal anti-kickback statutes. Air and ground ambulance providers typically sell memberships to the public in exchange for waiving any out of pocket expenses (copays and deductibles) after their primary insurance company (including Medicare) pays. Federal anti-kickback statutes prohibit simply waiving these deductibles and copayments, so the providers are obligated to charge enough for the membership program to at least break even on the program. If they charged less than this amount, they may be subject to fines and penalties from the federal government. In 2003, The HHS Office of the Inspector General (OIG) issued an advisory opinion on this very issue related to ambulance membership programs (OIG Advisory Opinion No. 03-11). I have attached it for your convenience.

As a result of this guidance, most ambulance providers conduct an internal compliance audit from time to time, to make sure they are in compliance. As a consultant, I have conducted more than a dozen of these compliance audits for hospital and non-hospital air and ground providers around the country, although I have not done any in Montana.

What I find very interesting, is the inordinate amount of attention your Committee is paying to membership programs. From the 5,000 foot level, air ambulance membership programs play a minimal role in air ambulance economic issues, and there seems to be a lot of misunderstanding about that amongst those testifying to the committee. I listened to the tape from the June meeting, and I believe it was one of your members stated that he did not understand the business model, or how a $69 membership fee could offset the high cost of providing the service. The answer is that it cannot, and it was never designed to do so. Virtually all of Membership programs I have reviewed or audited are not intended to replace underlying health insurance, but only to replace the out of pocket expenses for those patients who already have some form of health insurance and protect the patient's finances. For the most part, the membership programs tended to break even, or generate a relatively small amount of excess revenue. It is only a small minority of patients who buy ambulance memberships who have no other form of health insurance. As your committee member appears to have surmised, a provider would have to sell many hundreds of memberships just to cover the full cost of providing a single transport. I think it is safe to say that no emergency helicopter air ambulance service could survive only on membership payments, particularly if sold at the $50-$100 level.
There also seems to be some confusion about what may have "changed" in Montana around the 2007 timeframe, resulting in the change from hospital ownership to private ownership. I sincerely doubt if this had anything to do with membership programs. However, hospitals getting out of the air ambulance business is not unique to Montana, but has occurred all over the country. I represented the air ambulance providers during the negotiated rulemaking process that established the Medicare fee schedule back in 1999/2000. At that time, more than 80% of air ambulances across the country were owned/operated by hospitals. Today, those numbers have almost flipped 180 degrees. Only about 30% of the air ambulance fleet across the country are currently owned/operated by hospitals. The primary driving force for this change was the very same federal legislation

that required the development of the Medicare fee schedule. In the Balanced Budget Act (BBA) of 1997, Congress called for the development of a national ambulance fee schedule, and the elimination of cost based reimbursement for hospital based ambulance services. Prior to the 1997 BBA, hospitals were paid by Medicare on the basis of their costs, not their charges, and not on a fee schedule. The more expensively they operated, and the more inefficient they were, the more money Medicare payed them via their year end cost reports. Once the new Medicare ambulance fee schedule was fully phased in by 2006, and cost based payments were completely eliminated, most hospitals experienced a significant drop in net reimbursement from Medicare, and dozens of them left the ambulance market, as they were often unable to increase their private charges fast enough to compensate for the loss. I consulted with many of these hospitals across the country as they evaluated their positions in a post cost reimbursed market. I can provide you much more insight if you are interested.

Finally, I also reviewed your regulation 50-6-320 that seems to both exempt air ambulances from the insurance code, and place additional requirements on them. I presume this has never been challenged, as based on what I sent you last week, if your Attorney General interprets the law and the DOT guidance the same way that the Texas Attorney General has interpreted it, it would likely be unwound entirely. I am particularly confused about the intent of Section 3 of 50-6-320 that seems to suggest that air ambulances develop some type of reciprocity with other air ambulance providers. What does that mean? If provider B transports a patient who had purchased a membership from provider A, would this obligate provider A to compensate provider B for the amount they wrote off and did not collect from the patient? Alternatively, do they both simply agree to honor the competitor's membership without having collected any fees to cover that cost? Not only could this result in a financial disaster for the less dominant provider, but it could result in a major compliance problem for the reasons outlined in the attached OIG guidance.

I hope you find this information helpful.

Regards,

Bill Bryant
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