Montana Legislature

Economic Affairs Interim Committee

Air Ambulance Issues & Solutions

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Outline

- Membership Programs
- Medicare changes
- Why do air ambulance charges vary so much?
  - Cost Drivers
  - Price Drivers
- The real reason for the Balance Billing Problem
- Legislative Solutions

Membership Programs

- Supplemental information provided to Committee:
  - Regulation and reciprocity probably preempted by ADA and Federal Anti-kickback statutes
  - Neither the cause nor solution to balance billing problem
  - Small role in air ambulance economics
  - Small if any role in MT ownership changes

Medicare

- More than anything else, has driven changes in air ambulance ownership across the country.
- Balanced budget act of 1997 abolished cost-based reimbursement for hospital-based ambulances. Fully phased in by 2006.
- In 1997, ±85% of RW operated by hospitals, now <30%
- BBA 1997 established National Air/Ground Ambulance Fee Schedule – mandated *budget neutrality*
  - Consequently Medicare rates were NEVER based on costs
  - Costs have outpaced annual Medicare adjustment of 2%/yr
- All emergency ambulance providers must accept Medicare assignment

Emergency vs Non-Emergency Air Ambulance Providers

- Night and day cost differences
- RW almost always Emergency Only
- FW usually only non-emergency, except in Montana and other large rural states

What Drives Costs for Emergency Air Ambulance Providers?
Cost of Readiness

- Fixed Costs
  - Dedicated Aircraft
    - RW, FW or Both!
  - Permanent RW modifications to aircraft including
    - Safety Enhancements (NVG's, IFR)
    - Oxygen systems
    - Communications systems
  - ICU Level Medical Equipment
  - 4 Full time Pilots per aircraft, 1-2 dedicated mechanics, 4 Flight Nurses, 4 Flight Paramedics plus benefits
  - Physician Medical Direction
  - Crew Housing near aircraft
  - Initial and ongoing training for pilots (simulator) and medical crew (100 hours/hr)
  - Insurance
  - Dispatch center / Flight Following
  - CAMTS Accreditation

- Variable Costs
  - FAA Mandated maintenance Parts replacement
  - Fuel
  - Medical Supplies

- Bad Debt – Many emergency transports pay little or nothing

What Drives Costs for NON-Emergency FW Air Ambulance Providers?

~~Cost of Readiness~~

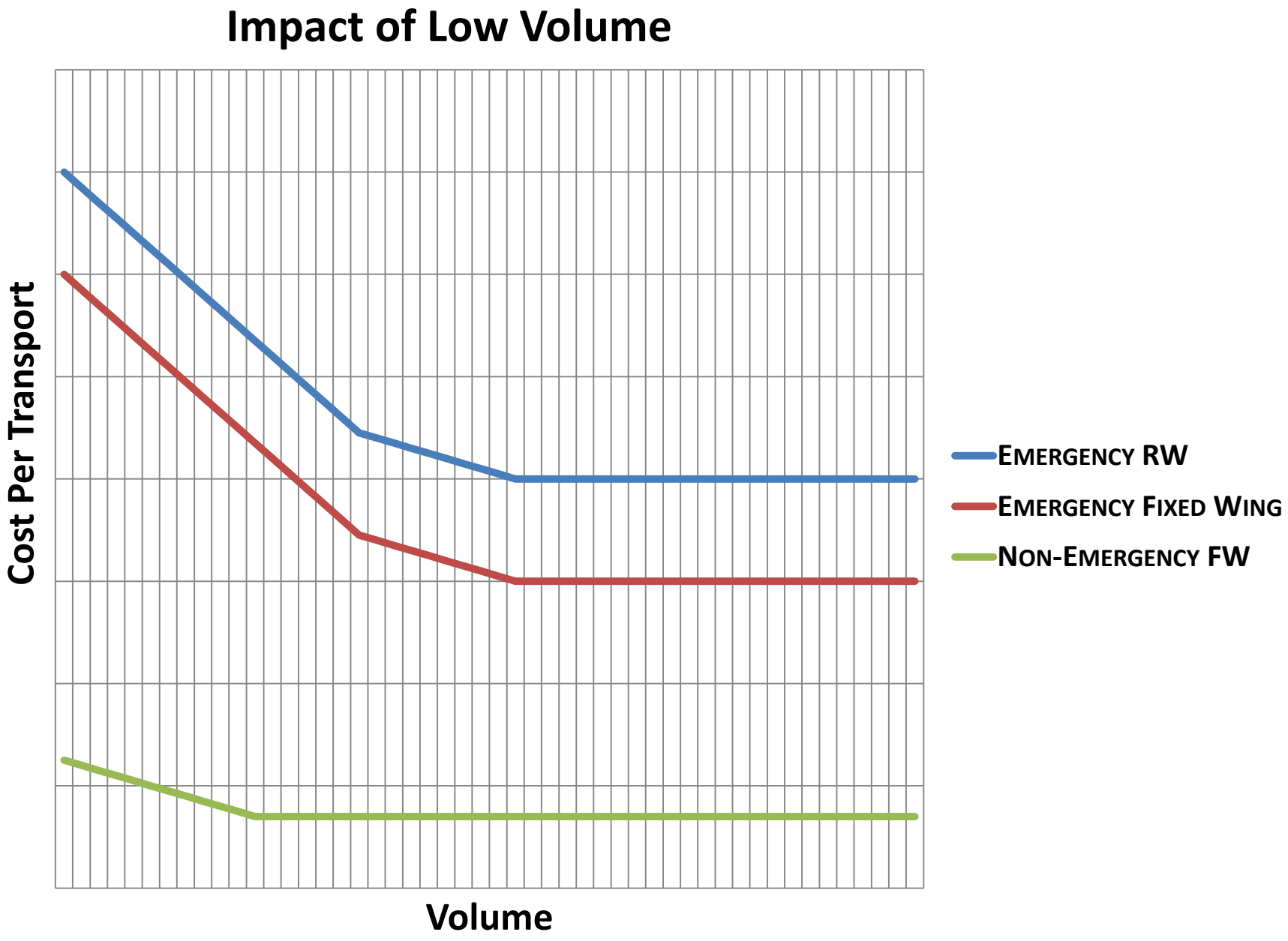
- Fixed Costs
  - ~~Dedicated Aircraft~~ Multi-use as available. Can fly cargo in the morning, and a patient in the afternoon
    - ~~RW~~, FW ~~or Both!~~
  - ~~Permanent RW modifications to aircraft including~~
    - ~~Safety Enhancements (NVG's, IFR)~~
    - ~~Oxygen systems~~
    - ~~Communications systems~~
  - ~~ICU Level Medical Equipment~~ Less critical patients require less sophisticated equipment and training
  - ~~4 Full time Pilots per aircraft, 1-2 dedicated mechanics, 4 Flight Nurses, 4 Flight Paramedics plus benefits~~ On call or as needed. Often only single medical attendant.
  - ~~Physician Medical Direction~~
  - ~~Crew Housing near aircraft~~
  - ~~Initial and ongoing training for pilots and medical crew~~ Less critical patients require less sophisticated equipment and training
  - Insurance
  - ~~Dispatch center / Flight Following~~
  - ~~CAMTS Accreditation~~
  - ~~~~
- Variable Costs
  - Parts replacement
  - Fuel
  - Medical Supplies

- ~~Bad Debt~~ – Payments negotiated and paid in advance. *****In or out of Network is non-issue****

What Drives **Prices** (i.e. Charges) for Emergency Air Ambulances?

- Fixed and Variable Costs
- Profit Margin (reserve)
- Volume
- Payer mix (percentage of transports that pay)
- Amount paid by each payer class

*** Emergency air providers must ***collect*** enough to cover their fixed and variable costs plus a margin or they will go out of business***


Impact of Low Volume
Cost Per Transport
Volume
Emergency RW
Emergency Fixed Wing
Non-Emergency FW

Price Impact of Payer Mix

- Emergency providers respond without knowing if they will get paid
- If you could predict both volume and costs, you could calculate the average cost per transport, and the average collection needed to break even.
- But what if the majority of patients pay less than the average cost?

Price Impact of Payer Mix Cont. Balloon Economics

- Medicare pays far less than cost, so charges to everyone else must increase
- Medicaid* pays less than Medicare, so charges to everyone else must increase even more. *This can be fixed by the MT Legislature!
- Indigents pay nothing, driving charges still higher
- Insurance companies using “allowable scheme” to shift burden to patients drives charges even higher.

The “Allowable” Scheme

- UCR = Usual, Customary, Reasonable (charge)
- Historically, insurance companies reimbursed providers based on the UCR
- In recent years, in States where not prohibited, insurance companies quietly replaced “UCR” with the term “Allowable”, which can mean anything the insurance company says it means.
- Not at all transparent to the consumer, resulting in “sticker shock” and large balance bills.

BRONZE PLANS

Lowest premium costs

Higher out-of-pocket costs when you receive care

60% coverage
You pay 40%

SILVER PLANS

Higher premium costs than Bronze plans

Lower out-of-pocket costs than Bronze plans

70% coverage
You pay 30%

GOLD PLANS

Higher premium costs than Silver plans

Lower out-of-pocket costs than Silver plans

80% coverage
You pay 20%

What are Essential Health Benefits?

The Affordable Care Act requires that all health insurance plans sold on the Marketplace must cover certain basic services that are considered essential to good health. These include:

- Emergency services
- Prescription drugs
- Hospitalization
- Maternity and newborn care
- Rehabilitative services and devices
- Ambulatory services
- Laboratory services
- Mental health/substance use disorder benefits and services
- Preventive/wellness services and chronic disease management
- Pediatric services

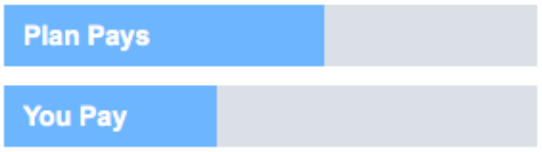
Plan Levels

We have four levels of health care plans available — bronze, silver, gold and platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. All plans have similar benefits, and all include essential health benefits. Where they differ is on how the costs of the benefits are applied.

Bronze Plans

Lowest monthly costs.

Higher out-of-pocket costs when you receive care.



60% coverage
you pay **40**%

Compare Marketplace Bronze Plans

Compare Individual Bronze Plans

Silver Plans

Higher monthly costs than Bronze plans.

Lower out-of-pocket costs than Bronze plans.

70% coverage
you pay **30**%

Compare Marketplace Silver Plans

Compare Individual Silver Plans

Gold Plans

Higher monthly costs than Silver plans.

Lower out-of-pocket costs than Silver plans.

80% coverage
you pay **20**%

Compare Marketplace Gold Plans

Compare Individual Gold Plans

Air Ambulance Costs and therefore Charges Vary Widely

- Emergency vs Non Emergency
- FW vs RW vs Both
- High Volume vs Low Volume
- Favorable vs Unfavorable Payer mix

Yet some Insurance Companies want to pay them all the same

Network negotiations are not real negotiations. They are typically take it or leave it propositions.

Paul Pedersen, Blue Cross Blue Shield of Montana, Senior Director, Provider Networks
September 1, 2015 Video Timestamp 2:23:45

"Our Allowed amount for Blue Cross and Blue Shield of Montana was determined by our team, and that was the amount negotiated with the providers. So those providers that are contracted with us then have agreed to accept that allowed amount and to not balance bill our members. So any charges in excess of the allowed amount are a provider discount.

And so when we went to the hospitals and the Montana medical transport operators, we negotiated that rate, and we negotiated the same rate for all of them. And so we had organizations agree to that rate, and in some instances some organizations not agree to that rate. So then we had participating providers and non-participating providers. Again, the key point is that our contracted providers have agreed not to balance bill our members."

Balance Billing Solutions

Consumer Protection

Alternative #1. Hold Patient Harmless.

Pass legislation requiring insurance carriers to stand in the shoes of the patient, and accept full financial responsibility for emergency air ambulance services for everything beyond the patient's normal deductibles and copayments.

This would encourage real in network negotiations, and shift all disputes and resulting litigation over Fair Market Value (UCR) away from the patients and make it between the Insurance Carrier and the Provider.

Balance Billing Solutions

Consumer Protection

Alternative #2. Require “allowable” to be based on UCR, not arbitrarily and unilaterally set by the Insurance Carrier.

Other patient protections to legislate:

- Require Prompt payment
- Require direct payment to providers
- Prohibit non-assignment clauses to policies
- Follow Medicare rules on Deemed Medical Necessity. *Thanks to Senator Max Baucus*

Texas Consumer Protection

http://www.tdi.texas.gov/pubs/consumer/cb005.html

"For care you receive out-of-network due to an emergency, or if an in-network provider isn't available, plans must pay out-of-network providers at the usual or customary charge. Usual and customary charges are based on the customary charge for a service billed by other doctors and hospitals in your area."

Is Paying UCR Cost Prohibitive?

- Assuming Insurance Companies do not have sufficient profit margins to absorb the cost…*

- In order to have completely avoided balanced billing to patients by paying air ambulances their normal billed charges (UCR) for in-state transports instead of the arbitrary “Allowed” amount, for BOTH in network and out of network providers, the average monthly insurance premium would need to increase by approximately **$1.58 per month**.

Cost Prohibitive?

Calculations and sources

- **https://www.bcbsmt.com/member/advantages-of-membership**
- Blue Cross and Blue Shield of Montana is the largest and most experienced health care insurance company in the state. We provide coverage to more than 240,000 members.

- Paul Pedersen, Blue Cross Blue Shield of Montana Testimony:

  Last year 85% of in-state air transports done by in-network contracted providers. They did not balance bill $3.5 million. This was the "value" of in-network providers.

- 70 in state transports (32 FW 38 RW) were done by non-contracted providers. The average balance bill was $10-15K each.

- Worst case is $15,000 * 70 in state non-contracted transports = $1,050,000

- With 240,000 members, it would require an average premium increase of $4.37 per year **($0.37 per month)** to pay the UCR, and avoid the balance billing. ($1.05M/240,000)

- Even if you added in the $3.5 million of balance billing "avoided" by the in–network providers, and paid the UCR to all providers, it would require an average premium increase of $18.96 per year ($4.55M/240,000 = $18.96) **or $1.58 per month**

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Blue Cross of Montana execs' pay dwarfed by compensation at potential buyer

Mike Dennison Apr 17, 2013 2

Blue Cross of Montana executive salaries

HCSC salary information

Montana officials not yet convinced on Blue Cross merger

HELENA – State insurance officials said this week they're not yet convinced the proposed mer...

HELENA – Blue Cross and Blue Shield of Montana's top executives received big bonuses in 2012 – but their payments are chicken feed compared to bonuses paid to executives that run the health care giant planning to buy Blue Cross.

And, if the merger goes forward, 2012 could be the last year that Montana Blue Cross policyholders get to know how much Blue Cross of Montana pays its top executives.

Mike Frank, the CEO and president of Blue Cross of Montana, had $635,000 in total compensation for 2012, according to records filed with the state, including a $213,000 bonus.

Blue Cross of Montana reported $10 million in underwriting losses last year – a year after having $5.4 million in losses.

Chicago-based Health Care Services Corp., which is proposing to buy Blue Cross of Montana, paid its CEO Patricia Hemingway Hall a total of $16 million in 2012, including a whopping $14.9 million bonus. HCSC is the fourth-largest private health insurer in the nation.

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Print Story

Printed from ChicagoBusiness.com

Blue Cross parent CEO's compensation rockets past $16 million

By Andrew L. Wang April 11, 2013

The CEO of the parent of Blue Cross & Blue Shield of Illinois received a 24 percent pay increase in 2012, to $16 million, even as the company's net income declined, according to a filing with state insurance regulators.

Patricia Hemingway Hall's 2012 base salary was just $1.1 million, but the nurse-turned-executive garnered a $14.9 million bonus. The CEO of Chicago-based Health Care Service Corp. received **$12.9 million in 2011.**

Her 2012 compensation is about 70 percent of the $23 million that the company has agreed to pay to acquire Blue Cross & Blue Shield of Montana.