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Sky-High Air Ambulance Prices

by MAURA KELLY

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"Surprise billing by air ambulances is a national public emergency that must be remedied through comprehensive Congressional action," according to Consumer Reports. Nearly 3 in 4 airlifted patients get stuck with hefty bills, according to a new study. The charges are commonly close to $40,000. Will Congress act or keep submitting to lobbyists?

After a baby with croup was airlifted to a hospital in Arizona, his insured parents got a $42,000 bill for the 15-minute flight.* After a 9-year-old with a copperhead bite was flown to a hospital in Indiana, her insured parents were charged close to $56,000 for the trip.† And after an insured young woman had a stroke during a family wedding in Wichita, KS—and her insurance company agreed to fly her home to Massachusetts for treatment—she was nonetheless stuck with a *half-million-dollar tab* for the transport.‡ Insurance is supposed to protect against exorbitant out-of-pocket expenses like these. But when air ambulances are involved in an emergency medical response, surprise bills tend to be both more common and more staggering, and the problem is only getting worse.

According to a new study in the May 2020 issue of *Health Affairs,* as many as 72% of airlifted patients are likely to receive an unexpected out-of-network bill. As for what such bills might cost, a 2019 report by the US Government Accountability Office indicated that air ambulance companies charge a median price of $36,400 for a helicopter transport and $40,600 for a plane ride.

Charges are increasing. "The price of air ambulance transport has gone up by leaps and bounds, rising more than 60% between 2012 and 2017," said Chuck Bell, programs director, Advocacy, for Consumer Reports, the nonprofit consumer advocacy organization. "This is a sharp rise, even compared to the steady onslaught of general health price increases."

At the root of the crisis: a legal loophole that many for-profit air ambulance companies have used to their financial advantage. The legal ambiguity is encoded in the Airline Deregulation Act (ADA) of 1978, established to free airlines from government regulation and thereby allow the market to set prices for air travel. Congress passed the law to encourage competition among airlines and reduce the cost to consumers, and indeed, when controlled for inflation, the cost of a plane ticket has come down considerably since the ADA was passed. The 1978 law makes no provision about how air ambulances should be treated, however. This is, perhaps, understandable, given that the first hospital-based helicopter service for civilians wasn't established until 1972; and similar organizations were so slow to emerge that 8 years later, in 1980, a mere 39 emergency medical services helicopters were flying nationwide, as Karan Chhabra, MD, lead author of the 2020 *Health Affairs* study, noted in a comprehensive blog post.

Since the ADA's passage, air ambulances have existed in a gray zone: If they are airline carriers, they shouldn't be regulated, but at the same time, they haven't been subject to much in the way of market forces because their customers are patients who are in no position to shop around for deals. As such, the air ambulance business offered an opportunity to make a lot money, although it wasn't until 2002, when Medicare officials significantly increased the reimbursement rate for helicopter air ambulance transport, that investors started taking notice: private equity firms aggressively elbowed in on the business. A 2017 article prepared by Consumer Reports noted that before 2002, most air ambulances were owned and operated by hospitals, whereas for-profit operators were virtually nonexistent. Since then, for-profit companies have come to dominate the market to the point at which, in 2016, the industry's 3 biggest firms controlled 73% of the total helicopters, according to a 2017 Government Accountability Office report. "It went from a local hospital-based community service to one that is largely owned and operated by a few international private equity firms," said Michael Abernethy, MD, the chief flight physician for University of Wisconsin Health's Med Flight, in Madison, WI, who has closely monitored the air ambulance industry for the last 3 decades. For more

*This story was reported by *Arizona Republic*.
†This story was reported by NPR.
‡This story was reported by Boston Public Radio, WBUR.

perspective on how the industry has changed, consider that although air ambulance transports made up less than 1% of total ambulance claims in 2011, they represented 8% of the total Medicare spending on ambulance services, as the Consumer Reports study found.

"This is business by the element of surprise," said Jeff Frazier, a partner with Sentinel Air Medical Alliance, an alliance of health care payers established in response to the rapid escalation of air medical transport rates. "There is no market here." He added, "It is profane that the ADA—an act created for the benefit of the American consumer—is being used against consumers. Markets work. The problem is, the patient and the health plan are foreclosed from participating in a market transaction. In fact, they are not even told how much the flight will cost. The ADA is reliant on markets for its very success and cannot perform its intended function in the absence of a market."

Some have called it price gouging. State legislators were concerned enough that a number of them tried to fight the practice. But that effort, paradoxically, ultimately helped put the profiteers in a stronger position to cash in: air ambulance companies sued the states and courts ruled that the businesses should be treated like airline carriers, rather than ambulances. "In 2008 we started seeing the legal decisions that really made it easy for air ambulance operators to charge these really high prices," said Dr. Chhabra,[§] a resident in the Department of Surgery at Brigham and Women's Hospital in Boston, MA.

As it stands, for-profit companies don't have much incentive to negotiate contracts with insurance companies; remaining out of network makes it easier to charge high and even exorbitant amounts. Unfortunately, their higher prices don't guarantee better care; in fact, the opposite is often true. "Many corporate for-profit air ambulances will charge $50,000 for a 30-minute ride in a 30-year-old copter with minimally trained staff, compared to a hospital-based not-for-profit that will typically charge a third of that for a ride in a copter more likely to have state-of-the-art equipment and a highly trained staff," said Dr. Abernethy, who is also a clinical professor of emergency medicine at the University of Wisconsin School of Medicine and Public Health.

"[Many] air ambulance providers do not consider the patient or the health plan as their customer," explained Frazier. "Rather, they consider the referral source as their customer, and for about 80% of transport, the referral source is a hospital." Frazier said that some air ambulance providers even put physicians who work in referring facilities on their payroll as "local medical directors" in an effort to increase the number of referrals they get.

If some for-profit air ambulance companies don't prioritize the financial needs of their customers, they do apparently consider them valuable in at least one respect: when they serve as leverage to pressure insurance plans for bigger payouts. "In our report, we found a disturbing trend toward using patients and their families as bargaining chips in billing disputes between air ambulance companies and insurance companies," said Bell. "Patients and their families don't want to be stuck in the middle of billing disputes, which can drag on for months at a time, as each side haggles over how much to pay or accept." Frazier put it this way: "These guys [the big firms] know they don't get money from patients but they can rely on you [the patient] to show up at HR on Monday morning" and demand that something be done.

Nonprofit air ambulance companies, typically affiliated with hospitals or medical centers, take a different approach. "Leaders at some not-for-profits make a point of not balance billing," said Dr. Chhabra. "They also make a point of not showing up [at the site of a so-called emergency] if they think the airlift is unnecessary. They sometimes operate at a loss."

The onus is on Congress to solve this problem, according to many health policy experts. "With 70% of air ambulance transports out of network, surprise billing by air ambulances is a national public emergency that must be remedied through comprehensive Congressional action," said Bell. "Patients need to quickly get care they need, and there is no time to shop around for a more affordable helicopter or airplane. And the way the private equity operators have rigged the system, they might not be able to find one anyway." He pointed out that, for Medicare and Medicaid patients, balance billing for air ambulance bills is prohibited, and said that it should be banned for the privately insured, too, so that patients are responsible only for predictable costs, such as co-payments and deductibles. Sensing that these issues may eventually be addressed in Washington, some for-profit air ambulance companies now employ their own lobbyists.

A number of bills that would address the air ambulance problem have been floated on Capitol Hill. The Association of Air Medical Services, an organization that represents both for-profit and nonprofit air ambulances companies, favors The End Surprise Medical Bills for Air

[§]In 2020, Dr. Chhabra was paid by Blue Cross Blue Shield of Massachusetts to conduct research about surprise billing in the state.

Ambulances Act of 2020, introduced in July by Senator Roger Wicker (R-Mississippi). But that legislation, which would rely on arbitration to resolve disputed bills, doesn't have much support among policy experts. "The arbitration process can be opaque, time consuming, and susceptible to political and industry influence," said Ge Bai, PhD, CPA, associate professor of accounting and health policy at Johns Hopkins Carey Business School and Bloomberg School of Public Health in Baltimore, MD, and the lead author of a 2019 *Health Affairs* study, "Air Ambulances With Sky-High Charges." Dr. Bai and others who have studied the issue think the most promising piece of legislation is the Senate's Lower Health Care Costs Act, sponsored by Senator Lamar Alexander (R-Tennessee). "It directly bans balance billing and creates a process for resolving the bill without the consumer in the middle," said Bell of Consumer Reports. The Lower Health Care Costs Act has strong bipartisan support, as well as the backing of some powerful congressional leaders. Nonetheless, it's in jeopardy of never being passed. The bill's future is especially uncertain, given that Senator Alexander's term ends this year and he is not seeking reelection.

Although surprise billing, including air ambulance bills, was a hot topic for Congress as recently as this year, possibly because of extensive coverage of the issue by media outlets such as the *New York Times, Kaiser Health News,* Vox, and others, "the virus has put it on the back burner," said Dr. Chhabra. (Lawmakers on Capitol Hill considered folding a surprise billing element into a coronavirus relief package, but that legislation never passed and wouldn't have addressed the air ambulance problem anyway.) Nonetheless, the press may have already pushed one of the largest air ambulance outfits, Air Methods, to revamp itself. The number of privately insured in-network patients whom the company serves increased from just 5% in 2015 to nearly 50% this year, and they are engaged in ongoing talks about going in-network with the "Big Three" insurance companies, Aetna, Cigna, and United Healthcare. Air Methods reported that its new approach has grown out of concern for its patients: "In the past, health insurance companies were doing right by their customers and paying for emergency care, regardless of network status," said Doug Flanders, director of communications and government affairs for Air Methods. "However, when they began to deny or underpay for emergency care, we proactively began to work to go in network." Dr. Abernethy would disagree. "Air Methods was one of the companies that was absolutely notorious for balance billing patients," he explained. "They were in the papers every week for going after patients for forty thousand, fifty thousand." It was as a result of all the spilled ink, Dr. Abernethy said, that the company began negotiating with insurance companies. "They see the writing on the wall: the public will not tolerate [balance billing]," he noted. "They have changed their tune 180 degrees."

Whatever the reason for Air Methods' remodeling, it's seen by many as a positive development, and change of the kind that some other for-profit air ambulance companies are strenuously resisting. Their lobbyists have long helped stall surprise-billing legislation and may continue to succeed in their efforts, Dr. Chhabra said. Indeed, Dr. Bai pointed out that at least one company with plenty at stake is spending more than ever to influence the folks on Capitol Hill: "A large air ambulance provider [Air Medical Group Holdings] is among the largest spenders on lobbying in Q1 [fiscal quarter 1] 2020, with a 49% increase from Q4 2019,"[1] she said. "It will take substantial political will and strong resistance to industry influence for the passage [of The Lower Health Care Costs Act] to happen," said Dr. Bai. "It is unclear at this moment whether these necessary ingredients are in place for the bill to … become law." (*Annals* asked a spokesperson for Global Medical Response, the parent company of Air Medical Group Holdings, to weigh in. "GMR's [Global Medical Response's] goal is always to keep the patient out of the middle and to work with private insurers to achieve tangible solutions that provide patients the emergency air medical services they need, without putting them in financial hardship," said public relations manager Nicole Lee.)

In the meantime, emergency physicians are in a position to help ameliorate the crisis, according to Dr. Chhabra. "Emergency doctors often have a role in calling an ambulance to transport someone from their facility to another," he said. "And they need to ask themselves, 'Are we calling for air ambulance in the right situations? And who are we calling? Good actors who will do right by patients or an outfit that will send a balance bill?' I think most doctors don't know the answers to those questions, and that is something they should look into at their own facilities."

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REFERENCES

1. Olson A, Barrick J, Tayer WB, et al. Lobbying expenditures of the health sector during the COVID-19 pandemic. *J Gen Intern Med*; 2020;. https://doi.org/10.1007/s11606-020-06085-6.

Annals Q & A With Dr. Michele Harper

by MAURA KELLY

Special Contributor to Annals News & Perspective

Only 2% of US physicians are Black women—and the writer of a new hit memoir, *The Beauty in Breaking,* tells *Annals* about her life as one of them.

Michele Harper, MD, had just learned to drive when she decided she wanted to be an emergency physician on the night she took her brother to the emergency department (ED). He'd been wounded by their abusive father, bitten so viciously that he needed antibiotics and stitches. Despite the traumatic circumstances, Dr. Harper left the ED marveling, not least because of the sense of commonality she'd felt with the other people in the waiting room. "All of us had converged…to reveal our wounds, to offer up our hurt and [for] our pain to be eased," she observed in her new memoir, *The Beauty in Breaking*. She added,

"Unlike in the war zone that was my childhood, I would be in control of that space, providing relief or at least a reprieve to those who called out for help." After getting her undergraduate degree from Harvard University, she went on to the Renaissance School of Medicine at Stony Brook University. Her book, a *New York Times* bestseller, relates the experiences she's had practicing emergency medicine in the South Bronx and Philadelphia as one of only about 2% of US physicians who are Black women,[1] including a time when a drunk patient punched her in the face and a shift when police officers pressured her to search the stomach of a man they brought in, although they had no court order. Dr. Harper also described many moments of renewal and hope, however. "I wrote the book to demonstrate that we're interconnected as humans, and in making the choice to heal ourselves we can heal each other and uplift society," she told *Annals*. It's a "riveting, heartbreaking, sometimes difficult, always inspiring story," according to *The New York Times Book Review*, and "a profoundly humane memoir from a thoughtful doctor," according to *Kirkus Reviews*. Dr. Harper spoke with *Annals* recently about her life, her work, and her writing.

Annals: Why did that trip to the ED, in your youth, have such a profound effect on you?

MH: I grew up in a chaotic abusive household that always felt unsafe. I didn't know at any point in time how I would navigate what might happen. In that sense, I was groomed to be an emergency room [ED] doctor from when I was young. I often had to make quick decisions: Is there something we have to do right now to be safe? The skills I developed in that house are skills I use in the ED. I also learned early on that I would have to save myself and my family; no cavalry was coming for me. And when I went into the ED with my brother that night, all kinds of people were there looking for their own kind of salvation, whether for a soft tissue injury, an infection, or because they were coding. All of them were looking for healing and as I waited in the ED, I saw many of them found it and left somehow better, feeling better and fixed. For me that was a powerful thing to see: that the world in which I was living was not the only one.

Annals: In your book you talk about a man who was brought into the ED by police officers who said the man was under arrest. They told you he'd swallowed a bag of drugs. They asked you to examine him and get the drugs out of him. You refused. Why?

MH: Let me be clear that this was just an allegation, that he'd swallowed those drugs. We had no way of knowing it was accurate. But aside from that, as long as a patient is competent and sober, which goes into competency, that patient has rights. If there is not some kind of overriding legal reason that I should examine