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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

A Model Act Regarding Air Ambulance Insurance Claims

**Adopted by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on October 13, 2017*

Sponsor's Technical Amendments adopted by the NCOIL Health, Long Term Care & Health Retirement Issues Committee on November 18, 2017. Adopted by the NCOIL Executive Committee on November 19, 2017. Re-adopted on March 6, 2022.

**Sponsored by Assemblyman Will Barclay (NY)*

Section 1. Legislative findings, purpose and scope.

(A) The legislature finds that:

- (1) Air ambulance services provide a necessary, and sometimes lifesaving, means of transporting medical patients in both emergency and non-emergency situations;
- (2) Adequate access to air ambulance services is essential;
- (3) In some cases, the difference between charges assessed by out-of-network air ambulance service providers and reimbursements by consumers' health plans have resulted in high balance bills to consumers; and
- (4) The Federal Airline Deregulation Act ("ADA") preempts states from enacting any law related to a price, route, or service of an air carrier, which has been interpreted by some courts as applying to air ambulance service provider charges.

(B) The purpose of this legislation is to protect consumers who are covered by commercial insurance from overall disproportionate financial responsibility and liability for using out-of-network air ambulance services instead of in-network air ambulance services in an emergency situation, including balance bills from out-of-network air ambulance service providers in a manner that is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA") or the ADA.

(C) This legislation applies to all health plans licensed, operating or otherwise doing business in this state, and registered air ambulance service providers.

Section 2. Definitions.

(A) A “registered air ambulance service provider” is an air ambulance service provider licensed by the [insert appropriate state EMS agency] that has registered with the Department of Insurance to participate in the voluntary dispute resolution process established hereunder, as provided in Section 5(B).

(B) A “covered person” is an individual covered by a health plan licensed, operating or otherwise authorized to do business in this state.

(C) A “health plan” provides coverage for health benefits to residents of this state and is licensed, operating or otherwise authorized to do business in this state. “Health plan” includes health insurers as well as self-funded health benefit plans. “Health plan” does not include:

- (1) Medicaid managed care programs operated under [Insert Applicable State Statute];
- (2) Medicaid programs operated under [Insert Applicable State Statute];
- (3) the state child health plan operated under [Insert Applicable State Statute];
- (4) Medicare; or
- (5) “excepted benefit” products as defined under 42 U.S.C. 300gg-91(c).

(D) “Balance bill” or “balance billing” refers to the difference between (i) the amount charged by an air ambulance service provider and (ii) any amount paid by a health plan plus the covered person’s copayment, deductible or coinsurance amount applicable to a specific air ambulance transport.

(E) “Disputed air ambulance service provider charge” means the amount remaining after payment by a health plan of the amount set forth in Section 4.

Section 3. Network Adequacy; Medical Necessity.

(A) A health plan that does not have an adequate network of air ambulance service providers in this state may not use an allowed amount for air ambulance reimbursement that is less than the applicable average rates published by registered air ambulance service providers. The Department of Insurance will determine such average rates on an annual basis.

(B) For purposes of this [chapter], a patient transport shall be deemed to be medically

necessary by health plans if (i) requested by a neutral third party licensed or certified medical professional or first responder and (ii) determined by that neutral third party licensed or certified medical professional or first responder to be conducted by an air ambulance service provider without regard to the patient's ability to pay.

Section 4. Hold harmless.

(A) If a covered person, after being picked up in the state, receives services from a registered air ambulance service provider that is not part of the covered person's health plan's network, the health plan shall assume the covered person's responsibility for amounts charged by such registered air ambulance service provider other than any applicable copayments, coinsurance, and deductibles.

(B) A health plan that has assumed a covered person's responsibility as required pursuant to Section 4(A) shall notify the air ambulance service of that assumption no later than the date the health plan issues payment under Section 4(D).

(C) If a registered air ambulance service provider receives notice pursuant to Section 4(B), with the exception of amounts owed for applicable copayments, coinsurance, and deductibles, the registered air ambulance service may not:

- (1) bill, collect, or attempt to collect from the covered person for the responsibility assumed under Section 4(A); or
- (2) report to a consumer reporting agency that the covered person is delinquent for the amount assumed by the health plan under Section 4(A); or
- (3) obtain a lien on the covered person's property in connection with the amount assumed by the health plan under Section 4(A); or
- (4) take any other action adverse to the covered person with regard to the amount covered by the health plan pursuant to Section 4(A).

(D) (1) Subject to the provisions of the covered person's health plan contract, a health plan is responsible for payment directly to the air ambulance service provider or denial of a claim for air ambulance services within 30 days after receipt of a proof of loss. Within such timeframe, the health plan shall notify the covered person and the registered air ambulance service provider of the amount of deductible, coinsurance, or copayment that is the covered person's responsibility to pay.

(2) The health plan responsible under Section 4(A) shall make payment based on:

- (a) the billed charges of the registered air ambulance service;
 - (b) another amount negotiated with the registered air ambulance service;
- or

(c) the maximum amount the health plan would pay to an in-network air ambulance service provider for the services performed, unless Section 3(A) is applicable, in which case the average amount as determined by the Department of Insurance.

(E) If after payment is made under Section 4(D)(2) the health plan or registered air ambulance service provider disputes the reasonableness of that payment, the health plan or registered air ambulance service provider shall invoke the independent dispute resolution process established hereunder, if good-faith settlement negotiations fail to resolve the dispute.

Section 5. Independent Dispute Resolution.

(A) A program of Independent Dispute Resolution (“IDR”) for disputed air ambulance service charges shall be established and administered by the Department of Insurance (“DOI”).

- (1) The DOI shall promulgate rules, forms and procedures for the implementation and administration of the IDR program.
- (2) The DOI may charge such fees as necessary to cover its costs of implementation and administration.
- (3) The DOI shall maintain a list of qualified reviewers.

(B)Registration, Waiver and Reporting.

- (1)
 - (a) By January 1 of each year, air ambulance service providers wishing to participate in the IDR program established hereunder shall register with the DOI on such forms, in such manner and providing such information as required by the DOI.
 - (b) This registration shall automatically renew quarterly unless the registered air ambulance service provider gives notice to the DOI of its intent to not renew its registration not less than 30 days prior to the end of the quarter.
 - (c) All disputed charges incurred during the quarter of a registered air ambulance service provider’s registration shall be subject to IDR.

(2) By registering, a registered air ambulance service provider acknowledges that, notwithstanding the ADA, it is voluntarily agreeing to participate in the IDR program as established hereunder, and such voluntary agreement constitutes a waiver of the air ambulance service provider’s ability to challenge the IDR program based on the ADA with respect to disputed charges as provided in Section 5(B)(1)(c).

(3) As a further condition of participation in the IDR program, the registered air ambulance provider agrees (a) to publish the air ambulance transport rates charged by it in this state and (b) to provide de-identified, itemized billings for each of its transports in this state.

(4) The DOI shall keep and maintain records of each IDR proceeding.

(5) The DOI shall analyze the results of the IDR proceedings, as well as the information submitted pursuant to Section 5(B)(3) each year, and issue a report annually, the contents of which shall include, but not be limited to:

- (a) the overall aggregate statistics of the IDR program for the year;
- (b) the deidentified results of all disputes decided by each independent reviewer through the IDR program;
- (c) the number of disputes settled between the parties;
- (d) an analysis of financial and market trends of the air ambulance service provider claims; and,
- (e) recommended changes to improve the IDR program

(6) The report shall be made public through, at minimum, posting on the website of the DOI.

(C) The sole issue to be considered and determined in a IDR proceeding is the reasonable charge for the air ambulance service provided. The basis for this determination shall include, but not be limited to, the overall fixed and variable cost for providing the air ambulance services including:

- (1) Costs of maintaining aircraft, hangar and crew facilities;
- (2) Compensation for pilots and flight crew (taking into consideration training and qualifications);
- (3) Overhead;
- (4) Insurance;
- (5) Fuel;
- (6) Costs attributable to any medical services provided in-flight;
- (7) Costs associated with 24/7/365 readiness;

- (8) The cost of uncompensated care and undercompensated care; and
- (9) A reasonable profit.

Section 6. Independent Dispute Resolution Procedures.

(A) Either the registered air ambulance service provider or the health plan may request adjudication of a disputed charge by submitting a request for IDR on such forms or in such manner as prescribed by the DOI, and shall include the amount in dispute and a brief description of the service provided. The requesting party shall copy the other party on its submission to the DOI.

(B) The insurance commissioner shall establish an application process and fee schedule for independent reviewers.

(C) If the parties have not designated an independent reviewer by mutual agreement within 30 days of the request for IDR, the insurance commissioner shall select an independent reviewer from its list of qualified reviewers.

(D) To be eligible to serve as an independent reviewer, an individual must be knowledgeable and experienced in applicable principles of contract and insurance law and the healthcare industry generally.

(1) In approving an individual as an independent reviewer, the insurance commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution procedure. A conflict of interest includes but is not limited to current or recent ownership or employment of either the individual or a close family member in a health plan, a health care provider, or an air ambulance service provider that may be involved in an independent dispute resolution procedure.

(2) The insurance commissioner shall immediately terminate the approval of an independent reviewer who no longer meets the requirements to serve as an independent reviewer.

(E) Either party to a IDR proceeding may request an oral hearing.

(1) If no oral hearing is requested, the independent reviewer shall set a date for the submission of all information to be considered by the independent reviewer.

(2) Each party to the IDR shall submit a "binding award amount"; the independent reviewer must choose one party's or the other's "binding award amount" based on which amount the independent reviewer determines to be closest to the reasonable charge for air ambulance services provided in accordance with Section 5(C), with no deviation.

- (3) If an oral hearing is requested, the independent reviewer may make procedural rulings.
 - (4) There shall be no discovery in IDR proceedings.
 - (5) The independent reviewer shall issue his or her written decision within ten (10) days of submission or hearing.
- (F) Unless otherwise agreed by the parties, each party shall:
- (1) Bear its own attorney fees and costs, and
 - (2) Equally bear all fees and costs of the independent reviewer.
- (G) The decision of the independent reviewer is final and shall be binding on the parties. The prevailing party may seek enforcement of the independent reviewer's decision in any court of competent jurisdiction.