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303---642---0396

Interim Montana Report

5---1---16

The $1.70 solution

There is some interesting new data coming out of the legislatively mandated Joint Economic Affairs Committee and Workgroup in Montana, that may be a small but helpful data point in the ongoing national discussion about air ambulance charges, insurance payments, and balance billing.

Summary:

One of the underlying questions raised in the Committee, was what if the Montana insurance carriers simply paid air ambulances full billed charges (setting aside normal deductibles and copayments established by the plan terms), which would eliminate large balance billing, and passed their increased costs onto their beneficiaries through higher insurance premiums. How much would they need to increase their premiums? The answer is in the ballpark of $1.70 per month or less, which represents less than a 1% increase in premiums.

Detail:

In Montana, Blue Cross has more than 70% of the private insurance market. They testified that they unilaterally determined that the amount they were going to pay for air ambulance transport was 200% of Medicare as their “maximum allowed amount", regardless of whether the air transport was an emergency or not emergency. They do not base their “maximum allowed amount” on the Usual, Customary, and Reasonable (UCR) charges in the area, which is required in many states. Blue Cross stated they pay the same rate (200% of Medicare) regardless of whether the provider is in-network or out of network.

Historically, most of the air transports in Montana have been by traditional hospital-based providers who are typically leveraged to be in-network for their entire hospital, so they accepted the 200% of Medicare as payment in full and do not balance bill the patient. Non-hospital providers are typically out of network and get paid the 200% of Medicare and balance bill the patient, often in excess of $10-20K. Blue Cross also testified that 75% of their claims last year were by in-network providers where the patient received no balance bill, and 25% were provided by out of network providers who balance billed the patient. Fortunately, Blue Cross provided lots of data to the Committee that showed the amount billed on every claim and the amount paid on each claim. They also calculated how much money was “saved” by their in-network providers who did not balance bill the patient, and calculated how much the out of network providers balance billed their patients (the difference between the billed amount and the 200% of Medicare they paid on the claim).

A quick visit to the Blue Cross website provided their total number of insured patients in MT, so it was easy to calculate what the difference in insurance premiums would be if ALL air transports (both in- network and out of network) were paid at 100% of their billed charges instead of the 200% of Medicare. The answer was $1.58 per month. At first they dismissed this calculation, but later came back and said that the actual number was $1.70 per month. We do not yet know what their current average premium is but my personal current monthly premium (Blue Cross of Colorado Silver Plan) is $650/month. Thus a $1.70 increase would represent a 0.26% increase in my insurance premium.

While this Montana data represents a fairly large sample size (roughly 250,000 insured members), it is difficult to conclude how this would extrapolate to the rest of the country. Montana is an expensive place to provide air ambulance service, as the population density is low, and there are long distances between tertiary care facilities. Most of the emergency air ambulance providers in MT staff both a RW and FW to be able to provide emergency responses regardless of the distance involved. This drives up their costs considerably. While the actual base rate and mileage charges are comparable to the rest of the country, the average total charge could be higher than the rest of the country, simple because of the distances involved.

Paying only 200% of Medicare places Blue Cross and Blue Shield of Montana is on the lower end of what private insurance companies pay across the country. We know from other documents provided to the Committee that in other NW states of WA and AK, Blue Cross and at least some other insurance carriers pay an innetwork contract rate in excess of 90% of billed charges, which works out to be as much as 700% to 1,000% of the Medicare rate, so there are probably few if any large balance bills sent to patients. A preliminary review of insurance premiums from company websites suggests that insurance premiums in the state of Washington are less than Montana. Of course air ambulances represent only a tiny fraction of the factors that drive overall health insurance premiums. In states where private insurance pays less than the UCR, but more than the Montana 200% of Medicare, the “$1.70 solution” could be less than $1.

Looking at it from the other perspective, air ambulance providers have testified that low insurance payments in Montana have driven prices higher as their ability to collect from individuals who are balance billed is limited. Should insurance carriers be forced to pay out of network providers based on UCR as they are in other states, or fully stand in the shoes of the patient as they are in others, it would not only resolve most of the balance billing issues, but could result in actual price decreases, or at least limit future price increases as costs continue to rise. This may reduce the “$1.70 solution” to a much smaller amount.

The Committee and Workgroup have both recognized that the Medicaid rates paid in the State of Montana are inadequate to cover air ambulance costs, and have been one of the factors driving prices higher. Should the work of the Committee result in higher Medicaid rates, this too would put downward pressure on pricing.

It is worth noting that using Medicare as a reference point is not ideal. It is being used here simply because the insurance companies have been providing most of their data to the Committee and Workgroup using Medicare as the reference point. The Medicare fee schedule was not based on cost when it was developed in 1999/2000 and is somewhat arbitrary. The Medicare Fee Schedule arguably has become less relevant each year as the annual increases have only averaged 2% per year, while actual costs have increased at a far more rapid pace.

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