



**Testimony of Rick Sherlock, President & CEO, Association of Air Medical Services (AAMS)
Hearing on “No More Surprises: Protecting Patients from Surprise Medical Bills.”
United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
June 12, 2019**

The Association of Air Medical Services (AAMS) is the leading international organization representing the air medical industry and over 250 air ambulance services across the United States, offering emergency helicopter and fixed wing air medical services. Our vision is to assure that every person has access to high-quality air medical and critical care transport in their time of crisis. Our members are actively working to address balance billing issues related to their services through patient advocacy programs and dramatic increases in their in-network agreements, which take patients out of the middle and hold them harmless. AAMS supports solutions that take patients out of the middle while preserving access to our critical life-saving services. During the last Congress, AAMS supported the bipartisan, bicameral language in the FAA Reauthorization Act that mandated the Air Ambulance Patient Billing Advisory Committee determine appropriate solutions to address billing and cost issues and recommend best practices and steps that can be taken to protect consumers. We request that Congress do no harm and protect access to the critical, life-saving medical interventions and the access to critical care levels of health care that our services provide. In time-sensitive, life-threatening illnesses and injuries, when seconds matter, we want to continue to keep these patients alive.

In summary, AAMS recommends that Congress take the following steps:

- Support and encourage immediate implementation of the Department Of Transportation’s Advisory Committee On Air Ambulance And Patient Billing (AAPB) which is to identify actions to “protect consumers from balance billing” as directed by Congress in the 2018 FAA Reauthorization Act.
- Enact legislation that would require all air medical providers to submit cost and quality data to the Centers for Medicare and Medicaid Services (CMS) and give CMS the authority to update the reimbursement fee schedule. This allows the Federal government, in addition to other stakeholders and the public, to better understand the true costs of emergency air medical services and how the industry operates to provide these services. Moreover, this will enable CMS to update the outdated Medicare reimbursement rate to accurately reflect true industry costs. Requiring all air medical providers to report this data and CMS to reimburse emergency air medical services based on the actual costs of transport will help reduce cost shifting to the private market and increase the number of in-network agreements, which would eliminate the balance billing issue.
- Encourage the Department of Transportation to use its existing authority to investigate charges of certain non-emergency, on-demand private airplane transports that may exceed standard industry charges for similar services, including investigating how such services are arranged.

AAMS offers the following written testimony in support of these recommendations.

Background on Emergency Air Medical Services

AAMS represents both helicopter and fixed-wing air medical providers and operators who deliver life-saving emergency transports every day. AAMS members transport approximately 360,000 critically ill and injured patients per year via emergency helicopter transport and an additional 100,000 per year via fixed-wing airplanes, some of which are also emergency transports. Emergency air medical services (EAMS) go beyond typical ambulance services, as they are essentially flying emergency rooms and critical care units, capable of a level of care beyond most ground ambulance services. They are highly-effective medical interventions, but they are an expensive service that should only be used according to pre-existing protocols developed by local medical and emergency response authorities.

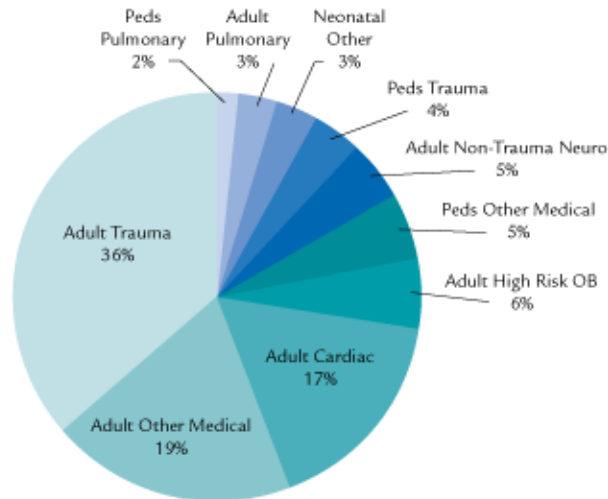
It's important to note that emergency air medical services do not decide which patients are transported by air medical or ground ambulance services. They never self-dispatch; they only respond to requests from medically-trained first-responders or physicians. Medically-trained first responders or physicians determine whether patients need emergency air medical services based on a variety of factors, including but not limited to, the higher level of care offered by an air medical crew (e.g., airway stabilization, blood transfusions, etc.); the need for more rapid transport than a ground transport would allow based on the patient's condition; or the geography in remote or rural areas and the distance to travel to tertiary care. Emergency air medical providers are called to respond to both on-scene requests from first responders and emergency inter-facility requests from physicians.

Emergency air medical crews respond to those requests within minutes, day or night; they are ready to respond to the most seriously ill or injured patients on a 24 hours-per-day 7 days-per-week basis. Air medical crews are dedicated critical care providers, with higher levels of training, equipment, and experience than most ground ambulance providers. Air medical pilots are some of the most experienced in aviation. Through both voluntary industry commitments and industry-supported regulations, air medical helicopters operate at a higher level of aviation safety than the rest of the on-demand aviation segments, with several regulations designed solely to address the unique risks associated with the emergency air medical environment. AAMS would ask the Committee to recognize the tremendous commitment that these individuals make to ensure critical emergency medical response is always available to the communities they serve.

Approximately 90% of the patients transported by emergency air medical helicopters are for stroke, cardiac, and trauma conditions; the remaining 10% encompass specialty pediatric care, burns, neonatal, high-risk obstetrics, neurological, and other conditions. Because these age-related conditions are more prevalent in Medicare and Medicaid populations, our members' transport volume directly impacts that patient mix.¹

¹ <https://www.healthsystemtracker.org/chart-collection/know-cardiovascular-disease-spending-outcomes-united-states/#item-mortality-rates-within-30-days-hospital-admission-heart-attack-stroke-decreased-version-2>

Transports by Nature



The Increasing Need for Emergency Air Medical Services

EAMS is a critical component of the health care delivery system in the United States, ensuring that critically injured patients are able to quickly and safely access trauma care and other critical tertiary care. Nearly 85 million Americans can only access a Level I or Level II trauma center within 60 minutes via helicopter. Another 30 million Americans do not have access to these centers within this time sensitive window - sometimes called the “golden hour - even by air. Nonetheless, EAMS serves as a critical lifeline to these individuals who often live in rural areas.

On March 20, 2019, the Government Accountability Office (GAO) published its report, “Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk.” Congress required the GAO to produce the report in the “Explanatory Statement” for Division H of the “Consolidated Appropriations Act, 2017” (H.R. 244). That language directed the GAO “to submit a report to the Committees on Appropriations of the House of Representatives and the Senate on fixed-wing and helicopter air ambulance services, operational costs, and, as available, payment structures no later than 18 months after the enactment of this Act.” GAO reported that “there were 752 bases in the 2012 data and 868 bases in the 2017 data.” The report also notes that the added bases:

- “increased the total area served by helicopter bases by 23 percent.” “About 60 percent of the new helicopter bases and about half of the new fixed-wing bases...were in rural areas.”
- “For just under half of the new helicopter bases...the area served overlapped with existing air ambulance coverage by more than 50 percent.” Added bases “increased the total area served by helicopter bases by 23 percent.”

EAMS expansion in rural areas helped fill the gap in rural health care created by closing rural hospitals. As recent media reports from Fort Scott, KS²; Fairfax, OK³; and Port Arthur, TX⁴ show, rural communities are devastated by the loss of their hospital facilities and the anxiety over who will provide access for emergency health care needs. Those closures follow the closing of 64 rural hospitals in 2013-2017, according to the GAO. Most closures were in southern states, with Texas experiencing 14 closures, but the Midwest, West and Northeast regions also lost hospitals. Furthermore, Navigant recently published an analysis that indicates as many as 21 percent of rural hospitals could be at risk for closing due to changes in payer reimbursements⁵.

The ability of EAMS to fill the gap in access to health care in rural America, is diminishing. Due to mounting financial pressure, since January 1, 2019, 31 helicopter air ambulance bases have closed and the third largest helicopter air ambulance provider in the United States is only now on the path for emergence from voluntary bankruptcy protection filing in March, 2019. Many of the closed bases were located in rural areas where they did not suffer from lack of transport demand but suffered economically due to a larger portion of Medicare, Medicaid, and uninsured patients.

The combination of fewer air medical bases and fewer rural hospitals should be of great concern to Congress. At a time when rural hospitals are closing, it is critical to maintain, or even to increase access to emergency transportation for rural and underserved Americans. An increase in the time required to transport a critically ill or injured patient from an incident scene to the appropriate facility brings with it the risks of life-altering complications or even death. Unfortunately, with the closure of air medical bases and the continued closure of rural hospitals, it seems inevitable that transportation times will increase.

AAMS' members also serve a vital role in our homeland security infrastructure. Notably, our members respond to disasters working in partnership with FEMA and other Federal and State agencies. If federal policy to remedy economic issues effecting emergency air medical services are not implemented, the current capacity of EAMS to surge to support robust participation in disaster response may also be at risk.

The Economics of Air Medical Transport

As of 2017, over 70% of air medical flights are under-reimbursed as they transport Medicare, Medicaid or uninsured patients. EAMS are rarely publicly funded; less than 10% of EAMS nationwide are through a publicly funded agency. This results in an ongoing imbalance between actual costs and government reimbursement and is a significant change from just 10 years ago, when the Medicare and Medicaid populations were significantly smaller. As those populations increased as a percentage of the overall number of transports conducted, the uncompensated cost of those transports multiplied,

² <https://www.npr.org/sections/health-shots/2019/05/14/722199393/no-mercy-how-a-kansas-town-is-grappling-with-its-hospitals-closure>.

³ https://www.washingtonpost.com/news/national/wp/2019/05/11/feature/whos-going-to-take-care-of-these-people/?noredirect=on&utm_term=.504dc41b782d).

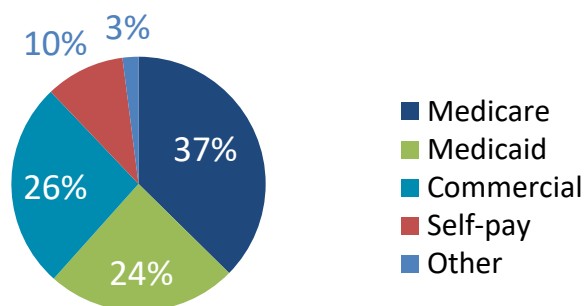
⁴ <https://www.beaumontenterprise.com/opinions/editorials/article/ENTERPRISE-EDITORIAL-St-Mary-closing-is-part-of-13937084.php>.

⁵ <https://www.modernhealthcare.com/article/20190220/NEWS/190229999/nearly-a-quarter-of-rural-hospitals-are-on-the-brink-of-closure>.

increasing the cost for all transports. Today, the single biggest factor increasing cost is the Medicare reimbursement gap. According to a study conducted by Xcenda in 2017⁶:

- **\$10,199.00: Median cost of providing one helicopter transport**
 - \$5,998.00: Median Medicare reimbursement (base rate plus mileage) per transport
 - \$3,463.00: Median Medicaid reimbursement per transport
 - \$354.00 Median self-pay (uninsured) reimbursement

Seven out of ten of patients transported by EAMS are either Medicare, Medicaid, or uninsured; the remaining three out of ten patients must subsidize the remaining cost. This is unsustainable, and drives a significant cost-shift to private insurance-compensated transports.



Of the approximately 360,000 patients transported by EAMS per year:

- ~133,200 are Medicare patients (37%);
- ~86,400 are Medicaid patients (24%);
- ~36,000 are uninsured patients (10%);
- ~93,600 are commercially insured (26%) (approximately 40% of those patients would be in-network);
- ~10,800 are covered by “other” insurance (3%).

The study further found that uncompensated care incurred by serving Medicare, Medicaid, and uninsured patients creates cost deficits that require private payers to cover more than \$26,000 per transport to allow providers to just break even. Resolving the Medicare cost gap would reduce the pressures that drive higher pricing, as well as to limit a patient’s potential exposure to a balance bill.

These numbers- both the high fixed cost of providing the service and the mix of patients transported- become significantly worse in rural areas. Rural areas carry the highest demand (mostly due to hospital closures), as well as a significantly higher ratio of Medicare, Medicaid, and uninsured patients. As the recent EAMS base closures show, we are less likely to have the ability to serve the areas where emergency air ambulance transports are needed most.

AAMS strongly supports legislation that would reform the broken Medicare reimbursement system for EAMS, which is a primary driver of balance billing. Legislation introduced in the 115th Congress, the “Ensuring Access to Air Ambulance Services Act” (H.R. 3378), would rebase the Medicare fees for

⁶ <https://aams.org/aams-publishes-findings-air-medical-cost-study/>.

emergency air medical transports utilizing comprehensive cost data collected from providers. This rebasing would address the growing gap between Medicare reimbursements and the actual costs of providing the service.

Air Medical Services and the Airline Deregulation Act

EAMS are unique in the health care system. Air ambulance medical services provided in flight are done so in a unique environment and with concerns for aviation and patient safety that only exist in the air. The service is heavily regulated by the states for the purposes of health care (as ambulances) and the federal government for aviation safety and services (as air carriers). Emergency air medical services are ambulances in that they transport critically ill and injured patients, but it is their status as air carriers that allows rapid transport of those patients over longer distances; over 33% of EAMS flights cross state lines every day and nearly all of them will cross a county or municipal boundary.

The Airline Deregulation Act's (ADA) uniform authority over the national airspace is essential to the provision of this life-saving service. Air medical services were always meant to be included as air carriers under the ADA; a Senate floor colloquy directly discussed "the need for air ambulance services" during debate on the ADA on April 19, 1978.⁷

Exempting air medical services from the ADA would allow states to regulate a wide range of issues in relationship to the aviation aspects of a licensed air-carrier, including where and when they are able to fly, creating borders in the sky and limiting access to critical care. Rate regulation is only the latest argument in a long history of attempts by some states to regulate the following issues:

- Competition in air medical transport;
- Aviation safety regulations;
- The size of the aircraft;
- The areas in which the aircraft can operate;
- The distances an aircraft can travel; and
- The relationship to hospitals or existing medical services.

Emergency air medical services are already heavily regulated by states; they are licensed ambulance providers overseen by state-licensed medical directors. States have full and unfettered authority to regulate every aspect of the provision of medical care within the aircraft. Further, states and local communities often regulate the triage protocols for requesting an emergency air medical service, and whether that patient should be taken by air or ground.

Should there be a change to the 40-year-old federal primacy over aviation and air carrier regulation, there would be enormous consequences for air medical operations, including:

- **Negative Impact on Safety:** Allowing states to regulate prices or billing would reduce financial compensation needed to invest in both required and voluntary safety enhancements. EAMS operators support enhanced safety regulation and stand fully committed to additional safety enhancements beyond regulation (night vision goggles, Crash Resistance Fuel Systems, and

⁷ <https://aams.org/wp-content/uploads/2018/06/ADA-Leg-Hx-involving-Air-Ambulances-1978.pdf>

robust flight operational quality assurance systems). All of those safety enhancements would be severely hampered by state rate regulation that reduces the ability to make these investments.

- **Borders in the Sky:** The ADA protects airlines from state regulation on air carrier routes. By exempting EAMS from the ADA, state authorities would be allowed to regulate where air medical services fly, usually in attempts to restrict competition. For example, an aircraft in South Carolina transported a critically injured child to a North Carolina hospital. The hospital, acting under the state's then-existing Certificate of Need (CON) law, attempted to bar the aircraft from the helipad, going so far as to threaten the impoundment of the aircraft and the arrest of its crew. A federal court affirmed the ADA's protection of that aircraft's ability to cross borders and ensure that the closest appropriate aircraft can transport a patient to the closest appropriate hospital or trauma facility for their time-sensitive medical condition.
- **Decrease in Access to Critical Air Medical Transport, especially in Rural Areas:** Limiting the number of air medical services in an area (including through CON laws) will cause a significant decrease in access, especially in rural areas, in cases where state-regulated systems arbitrarily determine a lack of sufficient "need."
- **Limit Patient Care Decisions by Referring Physicians:** In the case of inter-facility transports, physicians are currently able to make a transport determination based on their expertise and the condition of the patient. Altering the ADA would limit that decision-making ability.
- **Restrict access to choose:** A state could restrict the ability of a health care entity to choose to possess their own Part 135 certificate, or to freely choose the Part 135 operator that meets their needs. Restrictions on the ability of an air carrier to operate where needed means that a state could choose to not allow an operator to provide services within its boundaries.

Current Efforts to Address Balance Bills: Patient Advocacy and Network Participation

AAMS' members are addressing balance billing in a number of ways, including through patient advocacy programs and increased insurance network participation. AAMS is concerned that recent insurance industry behavior toward emergency air medical transport has only worsened problems of balance billing and air medical program stability, especially in the rural environment.

States possess the ability to regulate insurance plans offered within their borders, with the exception of federally-regulated Employee Retirement Income Security Act (ERISA) plans. Together, either the state or the federal government has the authority to compel insurers to offer insurance products that provide fair compensation for emergency air medical services. Yet, private insurance has responded by increasingly setting rates arbitrarily or denying payments through medical necessity denials, underpayments, and other tactics. For example, nearly half of all claims are initially denied reimbursement by the health plan. Almost 40% of these denials are for medical necessity – a decision made by the attending physician or first responder based on medical protocols and state EMS protocols, not the air medical program. If insurance companies are allowed to disregard decisions made in emergency situations, by a medical professional that are in the best interest of the insured patient, then what is the purpose of health insurance? Health care providers, especially in emergency situations, cannot be concerned with their decisions being second-guessed after-the-fact by insurers, whose intent may be more focused on financial concerns than patient needs.

Our members are actively negotiating with insurance companies to secure in-network contracts where such negotiations are available. Despite that willingness to negotiate in-network rates, some insurers,

citing low volumes and infrequent need for transports, have outright refused to even discuss an in-network agreement with emergency air medical providers. AAMS finds that refusal simply unconscionable; while it may make sense to the insurer, it hurts both the patients they are insuring and the health care providers. Despite this, our members have managed to increase network participation significantly; one member alone has increased their overall network participation from 2% to almost 30% in the last three years. Insurance companies must recognize the need for this service and limit questions of medical necessity, enter into network negotiations with emergency air medical providers, and stop the practice of slow payments or payments directly to the patient (which only places patients in the middle).

It is important to note that emergency air medical transports are not a cost driver for health insurance companies – in fact, this life-saving service is less than one percent of all health care costs. According to testimony before the Montana Legislature Joint Economic Affairs Subcommittee in 2016, and supported by national health insurance data, covering air medical services in full represents about \$1.70 of the average monthly premium. While these services are expensive to operate and expensive per transport due to the nature of the service, the math shows that they can be covered easily by health insurers for a tiny fraction of a monthly insurance premium. Emergency air ambulance transport is an extremely rare service and a very small part of the entire health care delivery system. According to the 2018 Milliman Medical Index Study on health care costs, emergency air ambulance services represent a tiny fraction of the “other” 4% of premium costs (“other” costs also includes ground ambulance, durable medical equipment (DME), home health, and all medical supplies)⁸. To break it down even further, air ambulance transports account for less than 1% of all ambulance transports.

Many of AAMS’ members have patient advocacy programs that allow dedicated patient advocates to work side-by-side with patients to help them and their families navigate the complex world of insurance claims. If, and when, the insurance company underpays or rejects a first responder or physician’s decision, our members’ patient advocacy programs intervene by advocating on the patients’ behalf to appeal these decisions and ensure they are covered fairly by the health plan for which they pay their premiums. Our members are committed to helping our patients from the start of their medical emergency until their claim is resolved. For one of our largest members, through their growing in network relationships, patient advocacy and robust financial assistance program, the average out of pocket for their patients including copays and deductibles is less than \$400.

Emergency Air Medical Services vs. Non-Emergent Medical Transport

EAMS provide emergency medical response 24 hours-per-day, seven days-per-week to ensure that patients have access to, and receive, the best care and transport possible, regardless of when or where an emergency happens. Providers transport a patient only when a physician or medically-trained first responder has deemed air medical transport medically necessary. Whether these transports are from the actual scene of an accident or injury (such as the side of the road or a football field) or inter-facility (from a smaller less-equipped hospital to more advanced care at a tertiary health care center), they are all deemed emergency situations by the requesting physician or first responder. After determining whether the flight conditions allow for a safe flight, EAMS respond to every request within minutes and without knowledge or regard for a patient’s ability to pay.

⁸ <http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf>.

Emergency air medical services include all helicopter transports. In some cases of extreme distances fixed-wing airplanes are used in emergency patient response; while these flights are less frequent, they are by no means less critical.

There are also services that offer non-emergency private fixed-wing airplane medical transport by air. Those services are not always requested by physicians; they can be requested by anyone with an ability to pay, and are most often arranged through hospital case managers or by patients' families using internet directories. Traditionally, and like any pre-arranged private air-taxi service, the fees for private airplane medical transportation would be paid up-front by the person arranging the flight; these flights would rarely be covered by Medicare, Medicaid, or private insurance.

AAMS is aware of several companies currently offering different options to arrange and finance these types of flights; AAMS has also received questions regarding these types of privately arranged airplane transports. It should be noted that these flights are no different in their arrangement than any other on-demand private aircraft transport. These flights should also never be confused with emergency air medical services or the economic issues faced by emergency air medical services or providers.

AAMS refers all questions and concerns regarding billing to the Department of Transportation's Consumer Protection Division (DOT CPD). DOT CPD has full authority to regulate the economic aspect of these services and AAMS strongly recommends that DOT exercise this authority wherever necessary to ensure that patients and their insurers are informed of the full cost estimate of the services before the non-emergent flight and are not excessively charged following the flight.

Legislative Actions Already Taken to Address Air Medical Balance Billing

In order to address possible billing concerns, and because EAMS is both ambulance and air-carrier, Congress took significant action on emergency air medical balance billing in 2018. In the "FAA Reauthorization Act of 2018" (H.R. 302):

- Congress established the "Advisory Committee on Air Ambulance and Patient Billing", which is composed of all stakeholders in air medical services and is directed to identify actions to "protect consumers from balance billing." The Committee includes the Secretary of Health and Human Services and is further required to make recommendations for "consumer protection...and the prevention of balance billing," including "options, best practices, and identified standards to prevent instances of balance billing." The provision requires the Committee to deliver its final report to Congress, and further directs the Secretary of Transportation to issue any necessary regulations or guidance to enhance the transparency and data reporting of emergency air medical providers and establish "consumer protections for customers of air ambulance providers."
- Another provision of the FAA Reauthorization Act requires the Secretary of Transportation to provide a separate report to Congress on plans for additional "oversight of air ambulance providers."
- A third section of the legislation establishes additional requirements for emergency air medical services, including providing contact information for the Department of Transportation's Aviation Consumer Advocate.

We would urge both the Committee and Congress to allow the Advisory Committee to carry out its mandate, which is specifically required to identify solutions to EAMS balance billing issues. Congress structured the Advisory Committee to bring together insurers, insurance regulators, consumer groups, physicians, and air medical providers to perform a comprehensive review and to recommend actions to provide relief for patients while taking into account the unique operational, regulatory, and financial aspects of emergency air medical services.

Even before enactment of the FAA Reauthorization Act, the Department of Transportation took action, using its existing authority, as described in the 2017 Government Accountability Office (GAO) report on air medical billing and cost issues. The Department's Aviation Consumer Protection Division established a portal for addressing air ambulance consumer complaints, and is responding to those complaints. In 2018, of over 350,000 air medical transports, DOT has received 24 complaints, which represents approximately .007% of all patient transports. To date in 2019, 6 complaints have been reported to DOT.

In Conclusion: Increase Transparency, Preserve the Service, and Do No Harm

AAMS also supports efforts to increase transparency regarding emergency air medical services, costs, and prices. The FAA Reauthorization Act tasks the Advisory Committee with developing recommendations for the federal collection of additional data on costs, charges and payments, operations, and competition.

The "Ensuring Access to Air Ambulance Services Act" would also enhance transparency, not only by collecting comprehensive cost data, but also by directing the GAO to compile this data into a report to Congress. The legislation would also establish a data collection program for reporting of quality metrics for health care provided by emergency air medical services.

As rural hospitals continue to close, air medical transports provide an essential, life-saving service for rural patients. The ongoing and growing shortfall in Medicare and government payments for the service is undermining the ability of providers to continue to serve patients-in-need. It is therefore vital for Congress to both reform Medicare reimbursements and avoid taking any action that would accelerate the closure of bases and further limit access to critical levels of health care for millions of Americans.

We believe that some current ideas to solve for balance billing for patients are misguided, such as a proposal to require air medical providers to separate "aviation" costs from "health care" costs in bills. Emergency medical care provided in flight is done so in a unique environment and with concerns for aviation and patient safety that only exist in the air. Health care and aviation services are inextricably linked and impossible to separate in any meaningful way. For example, many aircraft are fitted with external oxygen tanks to decrease the risk of cabin fire, thus changing the nature of delivering oxygen to patients. The costs for that service are increased by its use in an airborne environment, and should not be compared to similar services on the ground. Most importantly, the separation of bills in this manner would provide no discernable benefit for patients, and does nothing to reduce the costs of emergency air medical services or protect patients from receiving balance bills caused by extraordinarily low payments made by insurers or insurer's refusal to discuss in-network agreements with air medical providers.

Additionally, proposals to limit air ambulance charges by using Medicare as a metric would be devastating to EAMS. As we have shown, and as independent studies have clearly indicated, the current Medicare fee schedule was developed without a study of costs and since its implementation CMS has never collected a single cost data point nor undertaken an analysis of the cost of providing the services. By capping rates at 125% of Medicare as some propose, EAMS would essentially collect the following:

- **\$10,199.00: Median cost of providing one helicopter transport**
 - \$7,497.50 Proposed Median Commercial Insurance reimbursement per transport
 - \$5,998.00: Median Medicare reimbursement (base rate plus mileage) per transport
 - \$3,463.00: Median Medicaid reimbursement per transport
 - \$354.00 Median Self-Pay Reimbursement

This proposal would end emergency air medical transport in the United States, limiting services only to those communities who choose to provide them as a public service or hospitals willing to subsidize the bulk of the cost.

Finally, we believe that the entire discussion of balance and surprise billing, at least as it has applied to emergency air medical services, seems to ignore a simple but important principle: “do no harm.” Do no harm to patients who may receive these bills, but also do no harm to the caregivers who have dedicated their life’s work to serving others, either in the back of helicopter, a ground ambulance, an emergency room, or at a patient’s bedside. AAMS believes in protecting patients; our members protect them every day. AAMS believes in protecting them from the devastating disability of strokes and heart attacks, protecting their lives from horrible injuries caused by accidents, and protecting them from worsening injuries sustained during floods, storms, mass shootings, and other natural disasters.

AAMS thanks the Committee for the opportunity to offer this testimony and welcomes continued dialogue on this important topic. Again, we ask the Committee to recognize the unique and distinct regulatory, economic and operational aspects of this essential service and to take care that any legislation does not inadvertently curtail access to EAMS for patients-in-need.