



March 2019

# AIR AMBULANCE

## Available Data Show Privately-Insured Patients Are at Financial Risk

Accessible Version

# GAO Highlights

Highlights of [GAO-19-292](#), a report to congressional committees

## Why GAO Did This Study

Air ambulances provide emergency services for critically ill patients. Relatively few patients receive such transports, but those who do typically have no control over the selection of the provider, which means privately-insured patients may be transported by out-of-network providers.

The Joint Explanatory Statement accompanying the 2017 Consolidated Appropriations Act includes a provision for GAO to review air ambulance services. Among other objectives, this report describes (1) the extent of out-of-network transports and balance billing and (2) the approaches selected states have taken to limit potential balance billing.

GAO analyzed a private health insurance data set for air ambulance transports with information on network status and prices charged in 2017 (the most recent data available). Although this was the most complete data identified, the data may not be representative of all private insurers. In addition, GAO interviewed officials in six states (Florida, Maryland, Montana, New Mexico, North Dakota, and Texas) selected in part for variation in approaches to limit balance billing and location. GAO also interviewed air ambulance providers, health insurers, and Centers for Medicare & Medicaid Services and Department of Transportation (DOT) officials.

View [GAO-19-292](#). For more information, contact James Cosgrove at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) or Heather Krause at (202) 512-2834 or [krauseh@gao.gov](mailto:krauseh@gao.gov).

March 2019

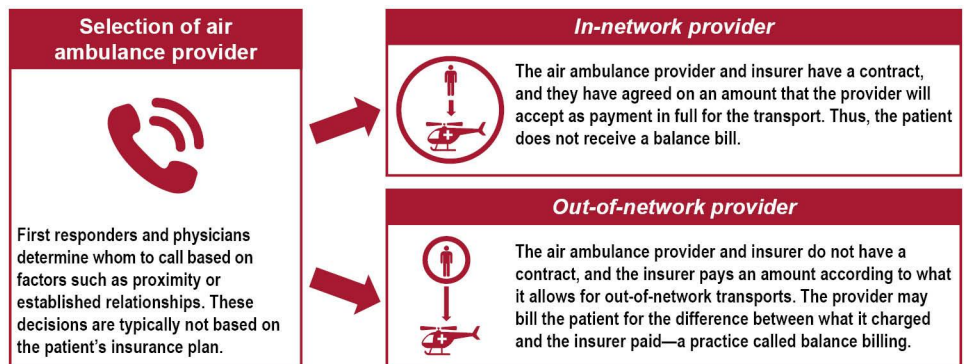
## AIR AMBULANCE

### Available Data Show Privately-Insured Patients Are at Financial Risk

## What GAO Found

Privately-insured patients transported by air ambulance providers outside of their insurers' provider networks are at financial risk for balance bills—which, as the figure shows, are for the difference between prices charged by providers and payments by insurers. Any balance bills are in addition to copayments or other types of cost-sharing typically paid by patients under their insurance coverage.

#### Potential for Balance Billing of Privately-Insured Patients for Air Ambulance Transports



Source: GAO. | GAO-19-292

According to GAO's analysis of the most complete data identified for air ambulance transports of privately-insured patients, 69 percent of about 20,700 transports in the data set were out-of-network in 2017. This is higher than what research shows for ground ambulance transports (51 percent in 2014 according to one study) and other emergency services. Air ambulance providers that GAO spoke with reported entering into more network contracts recently, which could lower the extent of out-of-network transports in areas covered by the contracts.

While out-of-network transports may result in balance billing, the data GAO analyzed do not indicate the extent to which patients received balance bills and, if so, the size of the bills. In addition, as GAO reported in 2017, there is a lack of national data on balance billing, but some states have attempted to collect information from patients. For example, GAO reviewed over 60 consumer complaints received by two of GAO's selected states—the only states able to provide information on the amount of individual balance bills—and all but one complaint was for a balance bill over \$10,000. Patients may not end up paying the full amount if they reach agreements with air ambulance providers, insurers, or both. The amounts of potential balance bills are informed in part by the prices charged. GAO's analysis of the data set with transports for privately-insured patients found the median price charged by air ambulance providers was about \$36,400 for a helicopter transport and \$40,600 for a fixed-wing transport in 2017.

The six states reviewed by GAO and others have attempted to limit balance billing. For example, the six states have taken actions to regulate insurers, generate public attention, or both. As required by recent federal law, the Secretary of Transportation has taken steps to form an advisory committee to, among other things, recommend options to prevent instances of balance billing.

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## Abbreviations

ADA	Airline Deregulation Act of 1978
ADAMS	Atlas & Database of Air Medical Services
DOT	U.S. Department of Transportation
ERISA	Employee Retirement Income Security Act of 1974
FAA	Federal Aviation Administration

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March 20, 2019

The Honorable Roy Blunt  
Chairman  
The Honorable Patty Murray  
Ranking Member  
Subcommittee on Labor, Health and Human Services,  
Education, and Related Agencies  
Committee on Appropriations  
United States Senate

The Honorable Rosa DeLauro  
Chairwoman  
The Honorable Tom Cole  
Ranking Member  
Subcommittee on Labor, Health and Human Services,  
Education, and Related Agencies  
Committee on Appropriations  
House of Representatives

Air ambulances provide emergency services for critically ill patients, primarily in life-threatening situations. First responders call for air ambulances to transport patients from the scene of an injury or an accident to hospitals. Physicians also call for air ambulances to transport patients between hospitals when patients need higher levels of care, such as specialized trauma, cardiac, or stroke care.

The air ambulance industry, particularly as it relates to air ambulance helicopters, has seen numerous changes in recent years. In 2017, we reported that between 2010 and 2014 the median prices charged by air ambulance providers for helicopter transports approximately doubled, and the number of air ambulance helicopters grew by more than 10 percent.<sup>1</sup> We also found that various factors, such as the costs for and volume of transports, may play a role in air ambulance prices, but we concluded that an in-depth analysis of those factors is not possible due to a lack of data, including data on the total number of transports.

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<sup>1</sup>Air ambulance helicopters are nearly three-quarters of all air ambulances. See GAO, *Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight*, [GAO-17-637](#) (Washington, D.C.: July 27, 2017).

A health care billing practice known as balance billing may pose financial risk to patients covered by private health insurance who receive air ambulance services. Balance billing is when privately-insured patients receive a bill from a health care provider for any difference between the amount charged and the payment from the insurer for the service. For privately-insured patients who receive air ambulance services, balance billing can occur when they are transported by air ambulance providers outside of their insurers' provider networks, which means the providers and insurers do not have an agreed-upon payment rate.<sup>2</sup> For example, one consumer in North Dakota reported receiving a balance bill of approximately \$34,700 for an air ambulance transport from Dickinson, North Dakota, to Bismarck, North Dakota, in November 2017. The air ambulance provider had charged \$41,400, and the patient's insurer had paid \$6,700, leaving a balance of approximately \$34,700.<sup>3</sup>

There has been interest among federal and state policymakers and others in the issues of out-of-network air ambulance transports and potential balance billing. For example, the Secretary of Transportation has taken steps to form an advisory committee on air ambulance patient billing, as required by the Federal Aviation Administration (FAA) Reauthorization Act of 2018, which became law in October 2018.<sup>4</sup> Among other things, the committee is directed to recommend steps that states can take to protect consumers.

The Joint Explanatory Statement accompanying the 2017 Consolidated Appropriations Act includes a provision for us to review air ambulance services.<sup>5</sup> In this report, we describe

1. changes in geographic distribution of air ambulance services,

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<sup>2</sup>Insurers have a group of designated providers with whom they have contracts to provide care to patients. Contracted providers accept negotiated payment rates with the insurer as full payment. Providers outside of that network—called out-of-network providers—do not have such contracts and have not agreed to a payment rate with the insurer. Instead, the insurer pays an amount according to what it allows for out-of-network services. Other types of health care providers may also send balance bills to patients.

<sup>3</sup>Source: North Dakota Insurance Department file number 105026. We do not have information on the extent to which the patient paid this balance. It is possible that the provider later discounted the bill.

<sup>4</sup>Pub. L. No. 115-254, § 418, 132 Stat. 3186, 3562.

<sup>5</sup>See Pub. L. No. 115-31, § 4, 131 Stat. 135, 137; 163 Cong. Rec. H3949, H3954 (Daily ed. May 3, 2017).

2. the extent of out-of-network air ambulance transports and balance billing for these services, and
3. what is known about the approaches selected states have taken to limit potential balance billing for out-of-network air ambulance transports.

For all three objectives, we interviewed officials in six states—Florida, Maryland, Montana, North Dakota, New Mexico, and Texas—that were selected to achieve variation among states in the growth in the number of air ambulance bases, the types of those bases (that is, helicopter or fixed-wing, which are the two types of air ambulances), the approaches taken in the state to limit balance billing, and geographic location.<sup>6</sup> We also interviewed officials from the three largest independent air ambulance providers, five national health insurers dominant in our selected states, and officials from the Centers for Medicare & Medicaid Services and the U.S. Department of Transportation (DOT).<sup>7</sup> To gain additional context, we also interviewed academic researchers and a consumer group who have examined the issue of balance billing, and we interviewed officials from local air ambulance providers and hospitals in three states (Maryland, Montana, and Texas) where we conducted site visits.<sup>8</sup>

To describe changes in the geographic distribution of air ambulance services, in addition to the interviews, we analyzed data in the *Atlas & Database of Air Medical Services* (ADAMS) on the locations of air ambulance providers' bases for 2012 and 2017, the most recent year for which data were available.<sup>9</sup> We consulted with officials from the

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<sup>6</sup>Some state approaches have faced legal challenges alleging preemption of federal law. We did not independently attempt to determine whether the states' approaches to balance billing were permissible under federal law, nor did we attempt to identify and report on challenges to these approaches in applicable state courts.

<sup>7</sup>As we have previously reported, there are three large independent air ambulance providers that dominated the industry and that reported operating 73 percent of the air ambulance helicopters in 2016. These are for-profit companies that handle both medical and aviation aspects of air ambulance transports and make business decisions, such as setting prices and determining contracts with private health insurers. Other air ambulance providers may be affiliated with hospitals. See [GAO-17-637](#).

<sup>8</sup>Similar to our overall selection of states, we selected the three states we visited to achieve variation in the growth in the number of air ambulance bases, the types of those bases, the approaches taken in the state to limit balance billing, and geographic location.

<sup>9</sup>The ADAMS data show, among other things, the number and location of fixed-wing and helicopter bases in each state. The data are published as a partnership effort between the Association of Air Medical Services and CUBRC.

Association of Air Medical Services about limitations of the data, including that (1) these data are voluntarily reported by air ambulance providers with, according to officials, an estimated 95 percent of helicopter air ambulance providers and 90 percent of fixed-wing air ambulance providers in each year; and (2) the data include some air ambulance providers that do not offer air ambulance services on a full-time basis or that have a primary mission other than air medical services. We assessed the reliability of the ADAMS data by reviewing related documentation, interviewing relevant officials, checking for internal consistency, and comparing our results across data sets and to published sources. We determined the data were sufficiently reliable for the purposes of our reporting objectives.

To describe the extent of out-of-network air ambulance transports and balance billing for these services, in addition to the interviews, we analyzed private health insurance claims from FAIR Health for 2012 and 2017, the most recent year for which data were available, regarding the status of air ambulance transports as in- or out-of-network and the prices charged for those transports. FAIR Health is an independent, nonprofit organization that collects data for and manages a database of private health insurance claims data. The FAIR Health data set contains claims for around 24,100 transports in 2012 and 33,800 transports in 2017 from all 50 states and the District of Columbia, including claims from over 50 insurers in each year (including both fully-insured and self-insured plans). The data set accounted for 110.1 million covered lives in 2012 and 145.0 million covered lives in 2017.<sup>10</sup> This was the most complete data source we identified with data on prices charged for and the network status of air ambulance transports for privately-insured patients. However, the FAIR Health data may not be representative of all private insurers and therefore cannot be generalized. Our results on prices charged are based on all transports in the FAIR Health data. Our results on the extent of out-of-network transports are based on a subset of about 13,100 transports (accounting for about 58.6 million covered lives) in 2012 and about 20,700 transports (accounting for about 87.3 million covered lives) in 2017 with information on network status.<sup>11</sup> We assessed the reliability of the FAIR Health data by reviewing related documentation, interviewing

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<sup>10</sup>This was 55 percent of the privately insured U.S. population in 2012 and 67 percent in 2017.

<sup>11</sup>According to FAIR Health, two insurers did not report information on network status. This subset of transports represented 29 percent of the privately insured U.S. population in 2012 and 40 percent in 2017.



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relevant officials, checking for internal consistency, and comparing our results across data sets and to published sources. We determined the FAIR Health data were sufficiently reliable for the purposes of our reporting objectives.

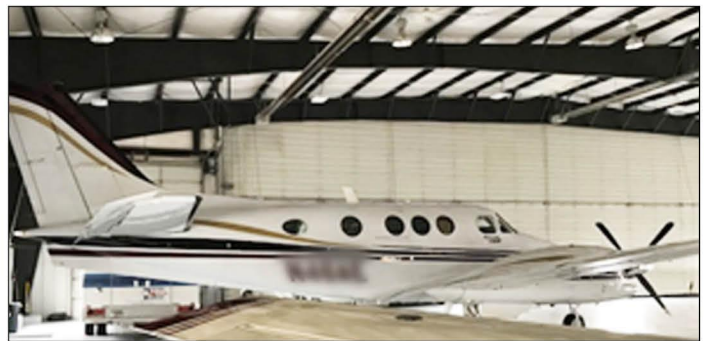
We conducted this performance audit from October 2017 to March 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Air ambulance providers use either helicopters or fixed-wing aircraft, as shown in Figure 1, depending on where and how far they are transporting patients.

- Helicopters are generally used for transports from the scene of the accident or injury to the hospital or for shorter-distance transports between hospitals. Helicopter bases may be at hospitals, airports, or other types of helipads, and a provider may need to fly from its base to the scene or a hospital to pick up the patient being transported. Air ambulance providers typically respond to calls for helicopter transports within a certain area around their bases in part to ensure appropriate response times.
- Fixed-wing aircraft are generally used for longer-distance transports between hospitals. Fixed-wing bases are at airports, and the patient is transported by ground ambulance to and from the airports.

**Figure 1: Helicopter and Fixed-Wing Air Ambulances**

Source: GAO. | GAO-19-292

Air ambulance providers respond to emergencies without knowing patients' health insurance coverage, such as whether the patient has private insurance, Medicare, Medicaid, or no insurance.<sup>12</sup> According to our previous analysis of information from eight selected air ambulance providers, in 2016, Medicare patients received 35 percent of helicopter transports, privately-insured patients received 32 percent, Medicaid patients received 21 percent, uninsured patients received 9 percent, and patients with other types of coverage such as automobile and military-sponsored insurance received a small percentage.<sup>13</sup>

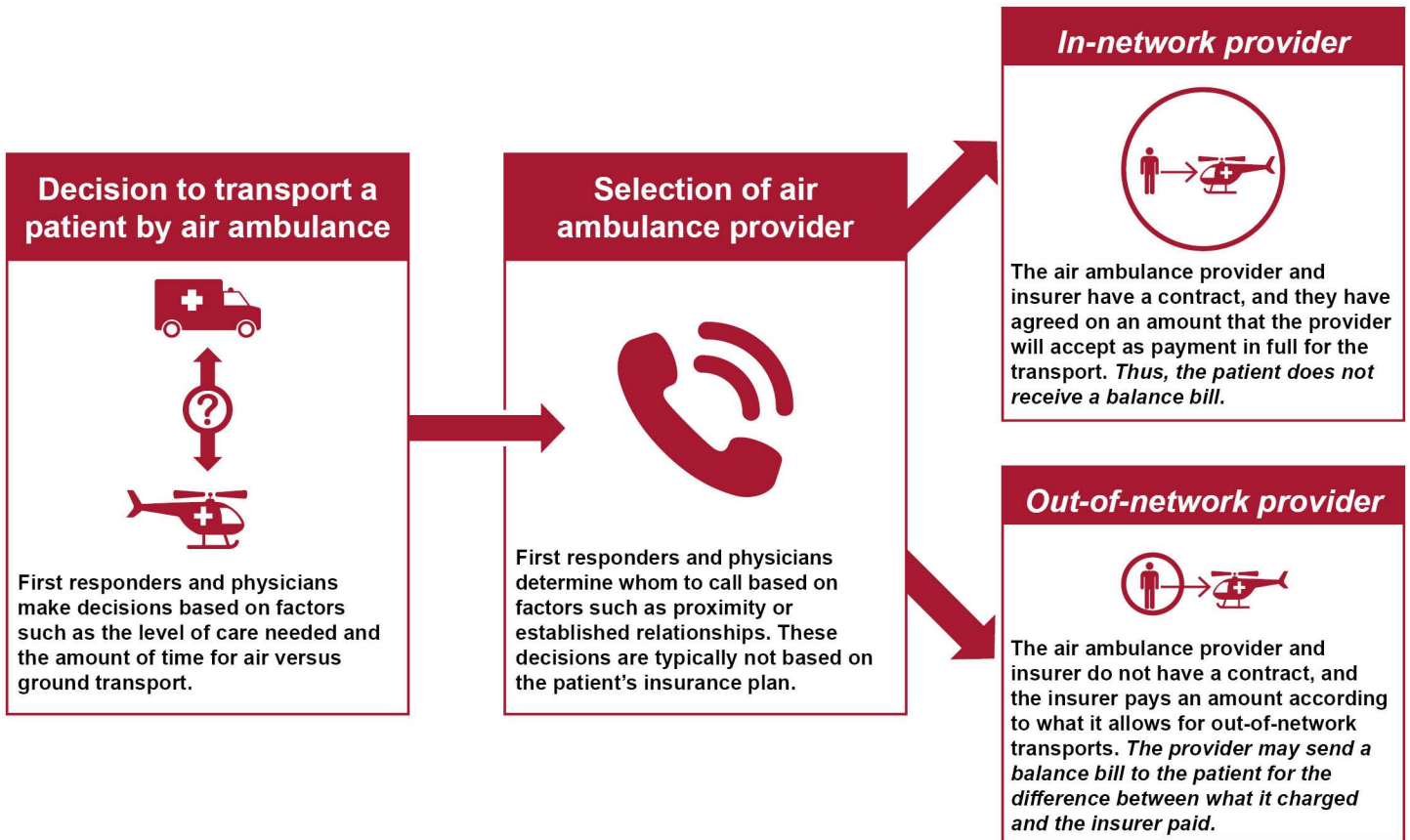
Relatively few patients receive air ambulance transports, but those patients who do generally have no control over the decision to be transported by air ambulance or the selection of the air ambulance provider, as shown in Figure 2. For privately-insured patients, this means they cannot necessarily choose to be transported by air ambulance providers in their insurers' network and can potentially receive a balance bill from the providers for the difference between the price charged by the provider and the amount paid by the insurer. This amount is in addition to copayments, deductibles, or other types of cost-sharing that patients typically pay under their insurance. Air ambulance providers are prohibited from sending balance bills to Medicare and Medicaid patients,

<sup>12</sup>Medicare is the federally-financed health insurance program for people age 65 or older, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state health care financing program for certain low-income and medically needy individuals.

<sup>13</sup>See [GAO-17-637](#). Representatives of the providers we spoke to said that privately-insured patients accounted for the highest percentage of their revenue.

while uninsured patients might be held responsible by the air ambulance provider for the entire price charged.

**Figure 2: Air Ambulance Transports for Privately-Insured Patients and Potential for Balance Bills**



Source: GAO. | GAO-19-292

Note: Patients may have cost-sharing responsibilities, such as copayments or deductibles, when transported by both in-network and out-of-network air ambulance providers. Also, patients may receive bills for the full charged amount if insurers determine transports were not medically necessary.

With many types of health care services, both health care providers and insurers have incentives to negotiate and enter into contracts that specify amounts that providers will accept as payment in full, thereby avoiding the potential for balance bills for those services. Insurers can offer—and health care providers may be willing to accept—payment rates that are much lower than the providers' charged amounts because the providers may receive more patients as an in-network provider. Furthermore, when patients are choosing insurance plans, they may consider how many or

which providers are in-network, particularly for providers such as hospitals or certain physicians.

The emergency nature of most air ambulance transports, as well as their relative rarity and high prices charged, reduces the incentives of both air ambulance providers and insurers to enter into contracts with agreed-upon payment rates, which means air ambulance providers may be more often out-of-network when compared with other types of providers.<sup>14</sup> Decisions by first responders and physicians on which air ambulance provider to call are typically not based on the patient's insurance plan, meaning that being in-network may not increase air ambulance providers' transport volume. As a result, according to stakeholders we spoke to, if insurers offer payment rates that are much lower than the air ambulance providers' charged amounts, the air ambulance providers may be less willing than other health care providers to accept those payment rates. Furthermore, given the relative rarity of air ambulance transports, patients may not anticipate needing air ambulance transports and may not choose insurance plans based on which or how many air ambulance providers are in insurers' networks.

Approaches by states or the federal government to limit balance billing may target providers, insurers, or both. Examples of approaches described in research on balance billing include a cap on the amount that providers can charge or a requirement for insurers to pay the full amount charged by providers.<sup>15</sup> However, according to the research, targeting just providers or insurers can result in undesired outcomes. Capping the amount providers can charge could result in insurers that underpay for services, which could lead some providers to reduce service or exit the market altogether. Conversely, requiring insurers to pay the full amount charged by providers could result in providers that overcharge for services, which could lead to higher premiums charged to patients.

The authority of states to address issues related to air ambulance balance billing is affected by the following federal laws:

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<sup>14</sup>As we have previously reported, costs to provide air ambulance transports are high and relatively fixed, such as costs for the staff required to maintain around-the-clock readiness. See [GAO-17-637](#).

<sup>15</sup>For example, see Kevin Lucia, Jack Hoadley, and Ashley Williams, *Balance Billing by Health Care Providers: Assessing Consumer Protections across States* (Commonwealth Fund, June 2017); and Mark A. Hall et al., *Solving Surprise Medical Bills* (The Schaffer Initiative for Innovation in Health Policy, Oct. 2016).

- **Airline Deregulation Act of 1978 (ADA):** A provision in this law preempts state-level economic regulation—i.e., regulating rates, routes, and services—of air carriers authorized by DOT to provide air transportation.<sup>16</sup> In general, courts have held that air ambulances are considered to be air carriers under the ADA’s preemption provision, and courts, DOT, and state attorneys general have determined specific issues related to the air ambulance industry that can and cannot be regulated at the state level.<sup>17</sup>
- **McCarran-Ferguson Act of 1945:** This act affirmed that states have the authority to regulate the business of insurance.<sup>18</sup> For example, states may review insurers’ health insurance plans and premium rates. In instances of balance billing, states can determine whether the insurer paid a provider in accordance with its policy for paying for out-of-network services.
- **Employee Retirement Income Security Act of 1974 (ERISA):** ERISA provides a federal framework for regulating employer-based pension and welfare benefit plans, including health plans.<sup>19</sup> Although states may regulate health insurers, ERISA preemption generally prevents states from directly regulating self-insured employer-based health plans.<sup>20</sup>

In 2017, as previously mentioned, we reported on the increase in prices charged by helicopter air ambulance providers and on the lack of data on

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<sup>16</sup>Pub. L. No. 95-504, § 4, 92 Stat. 1705, 1707 (codified as revised and amended at 49 U.S.C. §41713(b)).

<sup>17</sup>For example, as we have previously reported, the FAA regulates the aviation components of air ambulances, which includes maintaining and piloting the aircraft. States can regulate the medical component, which includes caring for the patient and, consistent with FAA safety requirements, the medical equipment carried on board. See GAO, *Air Ambulance: Effects of Industry Changes on Services Are Unclear*, [GAO-10-907](#) (Washington, D.C.: Sept. 30, 2010).

<sup>18</sup>Act of Mar. 9, 1945, Ch. 20, § 2, 59 Stat. 33, 34 (codified as amended at 15 U.S.C. § 1012).

<sup>19</sup>See, Pub. L. No. 93-406, 88 Stat. 646 (codified as amended at 29 U.S.C. §§ 1001 et seq.).

<sup>20</sup>Such plans may be referred to as self-insured or self-funded employer sponsored plans. See GAO, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, [GAO/HEHS-95-167](#) (Washington, D.C.: Jul. 25, 1995). Of the workers covered by employer-sponsored insurance in 2018, approximately 61 percent were enrolled in plans that were partially or entirely self-funded. See Kaiser Family Foundation, *Employer Health Benefits: 2018 Annual Survey* (San Francisco, Calif.: Kaiser Family Foundation, 2018).

the factors that may be affecting prices charged.<sup>21</sup> We also found only limited information was available related to several key aspects of the industry, ranging from basic aspects—such as the composition of the industry by type of air ambulance provider, the prices charged by air ambulance providers, and the number of overall transports—to the more complex, such as the extent of contracting between air ambulance providers and insurers or the extent of balance billing to patients.<sup>22</sup>

Given DOT's authority to oversee certain aspects of the industry, we made four recommendations to DOT in 2017 to increase transparency and obtain information to better inform their oversight of the air ambulance industry: (1) communicating a method to receive air ambulance complaints, including those regarding balance billing; (2) taking steps to make complaint information publicly available; (3) assessing available federal and industry data to determine what information could assist in the evaluation of future complaints; and (4) considering consumer disclosure requirements for air ambulance providers, such as established prices charged and the extent of contracting with insurers. DOT has taken steps to respond to the first two recommendations, including adding information to its website describing how air ambulance complaints can be registered and used by DOT. It has also listed the number of air ambulance complaints filed with DOT each month starting in January 2018—23 air ambulance complaints have been filed with DOT through November 2018. DOT has not yet acted on the remaining two recommendations.

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<sup>21</sup>See [GAO-17-637](#).

<sup>22</sup>As we reported in [GAO-17-637](#), there is some limited data on the number of helicopter transports from requirements under the FAA Modernization and Reform Act of 2012, which directed FAA to collect certain specified operation data for the helicopter air ambulance industry and report this information to Congress by 2014 and annually thereafter. Pub. L. No. 112-95, § 306, 126 Stat. 11, 60 (2012). In May 2017, FAA provided its first submission, which contained a summary of data collected from helicopter air ambulance operators from April 1, 2015 through December 31, 2015.

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## Air Ambulance Providers Added Bases from 2012 through 2017

Air ambulance providers added helicopter bases from 2012 through 2017, according to our analysis of the ADAMS data.<sup>23</sup> Specifically, there were 752 bases in the 2012 data and 868 bases in the 2017 data. When we compared the data for each year, there were 554 bases in both years of data (i.e., existing bases), 314 bases in the 2017 data only (i.e., new bases), and 198 bases in the 2012 data only (i.e., closed bases); the new and existing bases are shown in Figure 3.<sup>24</sup> This addition in bases also increased the total area served by helicopter bases by 23 percent.<sup>25</sup> Several air ambulance providers told us about their decisions to open new bases. For example, one air ambulance provider told us that one way it evaluates the need for a new base in an area is to ask hospitals in that area about the number of transports they typically require and the length of time it takes helicopters to arrive to pick up patients.

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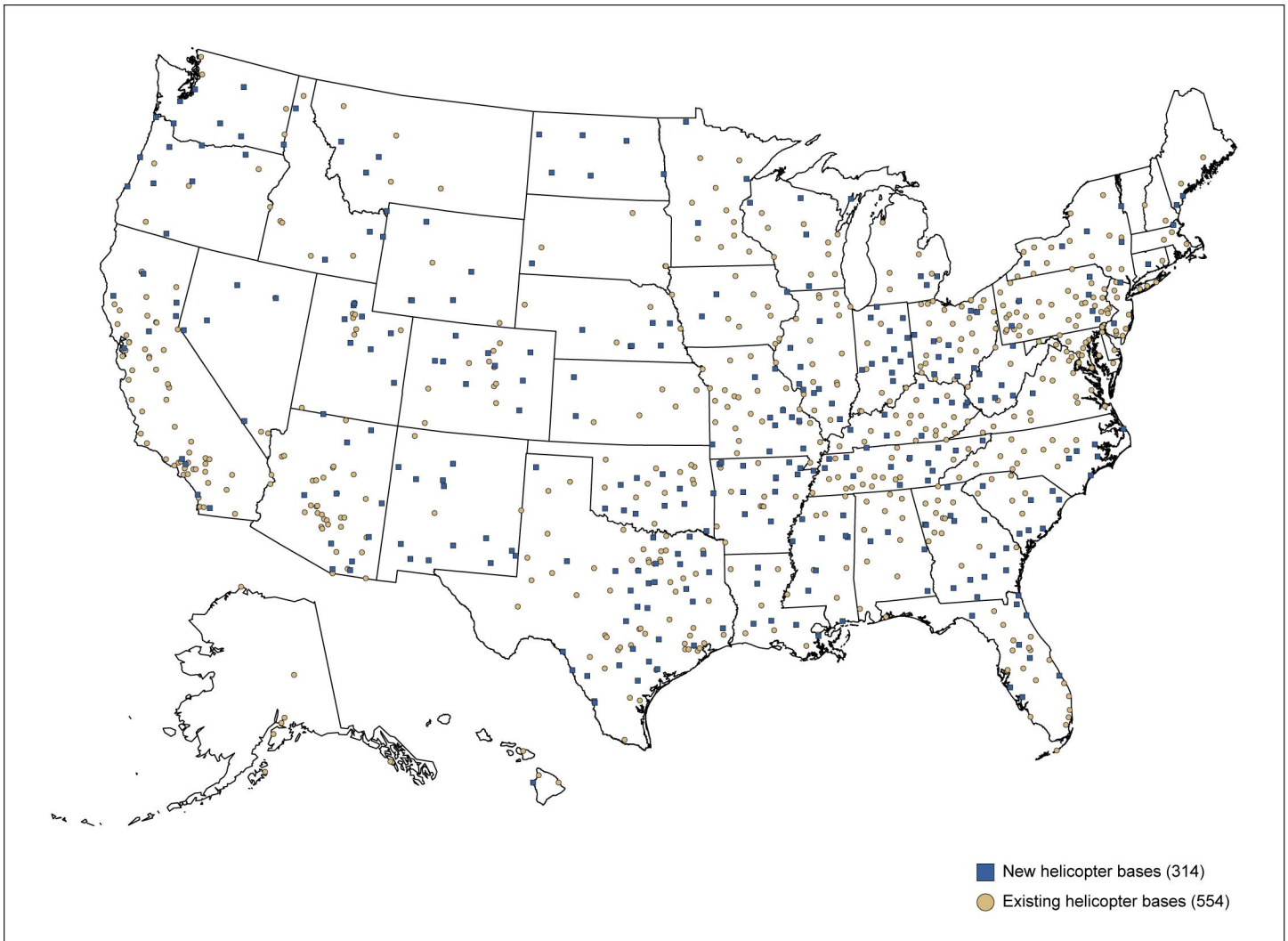
<sup>23</sup>We identified bases by the geographic coordinates in the ADAMS data, and some bases, such as certain airports, had more than one provider.

<sup>24</sup>The ADAMS data are voluntarily reported by air ambulance providers, and some of the changes in bases may be related to changes in which air ambulance providers reported data in each year. For example, after we completed our analyses, the Association of Air Medical Services identified 21 helicopter bases that were operational in 2012 but were not in the 2012 data due to provider underreporting. From 2012 through 2017, the average number of helicopters per base slightly decreased from 1.24 to 1.21.

<sup>25</sup>We calculated the potential area served by each helicopter base, in square miles, according to a 10-minute fly circle around the midpoint.



**Figure 3: Helicopter Air Ambulance Bases, September 2017**



Source: GAO analysis of data from the Atlas & Database of Air Medical Services (ADAMS). | GAO-19-292

Note: Some bases, such as certain airports, had more than one provider. We identified 752 bases in the 2012 ADAMS data and 868 bases in the 2017 ADAMS data. Of those bases, 554 are in both years of data (i.e., existing bases), 314 are in the 2017 data only (i.e., new bases), and 198 are in the 2012 data only (i.e., closed bases, which are not shown in the map). The ADAMS data are voluntarily reported by air ambulance providers, and some of the changes in bases may be related to changes in which providers reported data in each year.

Along with adding helicopter bases, air ambulance providers also added fixed-wing bases from 2012 through 2017, according to our analysis of the ADAMS data. Specifically, there were 146 bases in the 2012 data and 182 bases in the 2017 data. When we compared the data for each year, there were 114 bases in both years of data (i.e., existing bases), 68



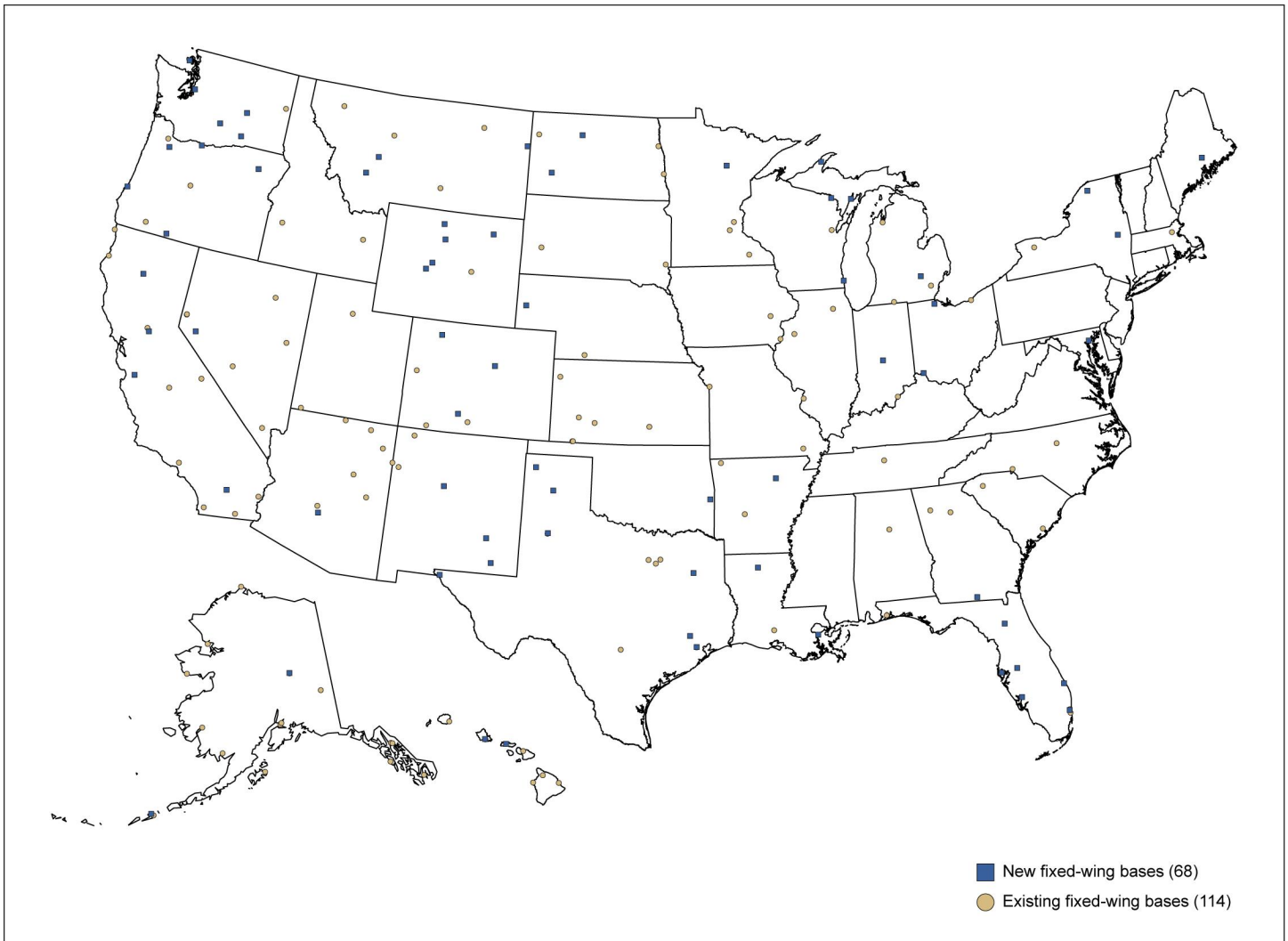
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bases in the 2017 data only (i.e., new bases), and 32 bases in the 2012 data only (i.e., closed bases); the new and existing bases are shown in Figure 4.<sup>26</sup> Both the existing and new bases are more prevalent in the Western and Southern parts of the United States. Given that fixed-wing aircraft are used for longer-distance transports and that patients are brought to the base rather than picked up by fixed-wing aircraft, we did not measure the area or any changes in the area served by fixed-wing bases, which are usually airports.

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<sup>26</sup>The ADAMS data are voluntarily reported by air ambulance providers, and some of the changes in bases may be related to changes in which air ambulance providers reported data in each year. For example, after we completed our analyses, the Association of Air Medical Services identified 10 fixed-wing bases that were operational in 2012 but were not in the 2012 data due to provider underreporting. From 2012 through 2017, the average number of fixed-wing aircraft per base slightly decreased from 2.14 to 1.99.

**Figure 4: Fixed-Wing Air Ambulance Bases, September 2017**



Source: GAO analysis of data from the Atlas & Database of Air Medical Services (ADAMS). | GAO-19-292

Note: Some bases, such as certain airports, had more than one provider. We identified 146 bases in the 2012 ADAMS data and 182 bases in the 2017 ADAMS data. Of those bases, 114 are in both years of data (i.e., existing bases), 68 are in the 2017 data only (i.e., new bases), and 32 are in the 2012 data only (i.e., closed bases, which are not shown in the map). The ADAMS data are voluntarily reported by air ambulance providers, and some of the changes in bases may be related to changes in which providers reported data in each year.

Based on our previous work, we further analyzed two trends related to where air ambulance providers have chosen to locate their new bases.

- **New bases in rural areas:** About 60 percent of the new helicopter bases and about half of the new fixed-wing bases in the ADAMS data

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were in rural areas. We previously reported that some helicopter air ambulance providers told us that the lower population density in rural areas leads to fewer transports per helicopter at rural bases.<sup>27</sup> They also said that, despite the lower population density, rural areas may have greater need for air ambulance transports. This may be due to, for example, the closure of some rural hospitals and the establishment of regional medical facilities, such as cardiac and stroke centers that provide highly specialized care.<sup>28</sup>

- **New bases in areas with existing coverage:** For just under half of the new helicopter bases in the ADAMS data, the area served overlapped with existing air ambulance coverage by more than 50 percent.<sup>29</sup> On one hand, according to some stakeholders we spoke to, the new helicopters may help enhance available services by, for example, being able to respond to a call if the existing ambulance resources are in use or otherwise unavailable.<sup>30</sup> On the other hand, as we have previously reported, some air ambulance providers told us that when helicopters are added to bases in areas with existing coverage, those helicopters are not serving additional demand.<sup>31</sup> As a result, the same number of transports is spread out over more helicopters, reducing the average number of transports per helicopter.

The FAA Reauthorization Act of 2018, which became law in October 2018, requires the FAA to assess the availability of information to the general public related to the location of heliports and helipads used by helicopters providing air ambulance services and to update current

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<sup>27</sup>See [GAO-17-637](#). This report focused on air ambulance helicopters.

<sup>28</sup>As we have previously reported, out of 2,400 rural hospitals open in 2013, approximately 3 percent closed in the subsequent 4 years. See GAO, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, [GAO-18-634](#) (Washington, D.C.: Aug. 29, 2018).

<sup>29</sup>For helicopter bases, we calculated the potential area served by each base, in square miles, according to a 10-minute fly circle around the midpoint, and we determined the extent of overlap between the area served by each new base and the area served by all bases as of 2012. As previously mentioned, we did not measure the area served by fixed-wing bases, because fixed-wing aircraft are used for longer-distance transports and patients are brought to the base rather than picked up by fixed-wing aircraft.

<sup>30</sup>In addition, the ADAMS data includes some air ambulance providers that may not offer air ambulance services on a full-time basis or that have a primary mission other than air medical services. In some cases, a new base in an area with existing coverage may increase the number of hours that an air ambulance is available to respond to a call for a transport.

<sup>31</sup>See [GAO-17-637](#).

databases or, if appropriate, develop a new database containing such information.<sup>32</sup> This could provide additional information about base locations going forward.

## Available Data Indicate About Two-Thirds of Air Ambulance Transports for Privately-Insured Patients Were Out-of-Network but Not Extent of Balance Billing for these Services

In the FAIR Health data on air ambulance transports for privately-insured patients, about two-thirds of the approximately 13,100 and 20,700 transports with information on network status were out-of-network in 2012 and 2017, respectively. (See Table 1.) The proportions were similar for both helicopter and fixed-wing transports in each year.

**Table 1: Out-of-Network Air Ambulance Transports for Privately-Insured Patients Analyzed**

Year	All transports	Out-of-network transports	Proportion of out-of-network transports
2012	13,087	9,762	75%
2017	20,726	14,316	69%

Source: GAO analysis of data from FAIR Health. | GAO-19-292

Note: Our results reflect the subset of transports in the FAIR Health data set with information on network status. The FAIR Health data set may not be representative of all private insurers.

The proportion of out-of-network air ambulance transports in the FAIR Health data set is higher than what research shows for ground ambulance transports and other types of emergency services. For example, one study found that 51 percent of ground ambulance transports in 2014 were out-of-network, and the same study and another one found that 14 and 22 percent of emergency department visits in 2014 and 2015 involved out-of-network physicians, even at in-network hospitals.<sup>33</sup>

<sup>32</sup>Pub. L. No. 115-254, § 314, 132 Stat. 3266.

<sup>33</sup>C. Garmon and B. Chartock, “One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills,” *Health Affairs*, vol. 36, no. 1 (2017); and Z. Cooper and F. S. Morton, “Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise,” *New England Journal of Medicine*, vol. 375, no. 20 (2016). Some ground ambulance transports are from municipal providers, which may not enter into contractual agreements with private insurance companies.

Air ambulance providers and insurers we spoke to confirmed that their proportion of out-of-network transports was high in 2017, but some also reported they have recently been entering into more network contracts.<sup>34</sup> For example, one of the large independent air ambulance providers and a national insurer entered into a contract that covered patients in five states as of August 2018. These contracts could decrease the extent of out-of-network transports and balance billing in the future for these states.

Increases in the prices charged for air ambulance transports may exacerbate the financial risks related to balance billing for those with private insurance. In 2017, the median price charged by air ambulance providers for a transport was approximately \$36,400 for a helicopter transport and \$40,600 for a fixed-wing transport, according to our analysis of FAIR Health data.<sup>35</sup> The prices charged in 2017 were an increase of over 60 percent from 2012, when the median price charged was approximately \$22,100 for a helicopter transport and \$24,900 for a fixed-wing transport. There is limited information on what insurers pay for out-of-network services.<sup>36</sup>

While out-of-network transports may result in balance billing, the FAIR Health data we analyzed do not indicate the extent to which patients received balance bills and, if so, the size of the bills. In addition, as we previously reported, there is a lack of comprehensive national data about

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<sup>34</sup>Some air ambulance providers and insurers provided data to GAO about the network status of transports by state across some or all of our six selected states. Nearly all state-level data from both providers and insurers showed that at least two-thirds of transports were out-of-network in 2017.

<sup>35</sup>Air ambulance providers, like other health care providers, charge standard prices regardless of insurance type. Prices charged for air ambulance transports have two parts: a service-level charge for the type of transport provided and a charge per mile that the patient is transported. Fixed-wing transports generally cover longer distances, and the mileage charge is therefore a larger portion of the prices charged. For example, in 2017, the fixed-wing mileage charge was over half of the total median charge based on a median charge per mile of \$110 and a median distance of 204 miles. In contrast, the helicopter mileage charge was about one-third of the total median charge based on a median charge per mile of \$242 and a median distance of 45 miles.

<sup>36</sup>Insurers' payment arrangements for out-of-network services vary and are detailed in individual plan documents, but a report from the Health Care Cost Institute, which included data from three, large national private health insurance insurers, cited the median payment these insurers paid for a helicopter transport was \$15,600 in 2010 and \$26,600 in 2014. We reported that while the data included approximately 40 million individuals with employer-sponsored insurance, patients in rural areas may be underrepresented. See [GAO-17-637](#).

the extent and size of balance bills, and air ambulance providers are generally not required to report such data.

However, some states have attempted to collect information from patients about balance billing for air ambulance services. Therefore, to provide insights into potential balance bill amounts, we reviewed data on consumer complaints that two of our selected states had received about specific incidents of balance billing for 2014 through 2018.<sup>37</sup> Data for Maryland contained about two dozen complaints with information on the specific amount of balance bills, and those amounts ranged from \$12,300 to \$52,000. Data from North Dakota contained three dozen complaints with information on the specific amount of balance bills, and those amounts ranged from \$600 to \$66,600, though all but one amount was over \$10,000.<sup>38</sup>

Given that providers may agree to reduce amounts that patients would otherwise owe or insurers may increase their payments to providers, along with limited national data, the extent to which patients actually pay the full amounts of balance bills received is also unclear.<sup>39</sup> Generally, officials from air ambulance providers we spoke to said that they first encourage patients to appeal to their insurers for increased payment. If these appeals do not fully address the balance bill, the providers may offer various payment options. For example, officials from one air ambulance provider said that it offers a discount of up to 50 percent off the balance bill if the patient pays the remaining 50 percent immediately. Alternatively, the provider requests detailed financial information—such as income, obligations and debts, and medical bills—to determine

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<sup>37</sup>Of our six selected states, Maryland and North Dakota provided us with complaint data that included information on the specific amount of individual balance bills. Other states provided more general information on the complaints they had received. Maryland's Office of the Attorney General, Health Education and Advocacy Unit, which mediates consumer complaints and works in conjunction with the Maryland Insurance Administration for state-regulated plans, provided data for complaints closed from January 2014 through April 2018. The most recent relevant balance billing complaint in the data was from September 2017. The North Dakota Insurance Department provided data for June 2014 through December 2018. The most recent relevant balance billing complaint in the data was from October 2018.

<sup>38</sup>The complaint data for both Maryland and North Dakota did not always include information on how much was ultimately paid. There were also additional complaints in the data for both states that lacked information on the size of the balance bills.

<sup>39</sup>As previously mentioned, air ambulance providers are generally not required to report such data.

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whether to potentially offer other discounts or a payment plan. This process can take multiple months, and officials from another air ambulance provider said patients who do not respond to letters and calls may be more likely to be referred to a collections process. Air ambulance providers we spoke with said that they use discretion on how much assistance to offer, and not all patients receive discounts after providing all relevant documentation. Even with discounts, according to data from some air ambulance providers we spoke with, the amount patients pay can still be in the thousands of dollars.

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## Selected States Have Attempted to Limit Potential Air Ambulance Balance Billing through Insurance Regulation and Public Attention

Four of our selected states attempted to limit balance billing through the regulation of insurers (Montana, New Mexico, North Dakota, and Texas). Additionally, four states have attempted to limit balance billing through education and public pressure on stakeholders (Florida, Maryland, New Mexico, and North Dakota).

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### Insurance Regulation

Four of the six states we selected—Montana, New Mexico, North Dakota, and Texas—have attempted to limit balance billing by air ambulance providers through the regulation of insurers, as shown in Table 2. Three states have faced challenges in federal district court related to whether their attempts to limit balance billing by air ambulance providers are preempted by the federal ADA. As of January 2019, the case in New Mexico was dismissed on procedural grounds, and the cases in North Dakota and Texas have been decided.

**Table 2: Selected States’ Use of Insurance Laws and Regulations that Aim to Limit Balance Billing for Air Ambulance Transports**

State	Description
Montana	A 2017 state law imposes a hold-harmless requirement on insurers or health plans for charges pertaining to out-of-network air ambulance transports. That is, insurers or health plans assume responsibility for amounts charged to a covered person in excess of both allowed amounts and applicable cost-sharing amounts. It also requires the use of a nonbinding dispute resolution process, including a determination of the fair market price of the services provided, before an aggrieved party may pursue any remedy in court. <sup>a</sup>
New Mexico	Managed health care plans are required to make emergency care services available to covered individuals without requiring prior authorization and to ensure the provision of appropriate out-of-network services without additional cost. <sup>b</sup> New Mexico’s Office of Superintendent of Insurance began applying these requirements to air ambulance services in 2017.  A claim was filed in federal district court alleging that the application of this requirement to air ambulance providers was preempted by the Airline Deregulation Act (ADA). In December 2018, the court dismissed the claim for lack of subject matter jurisdiction. <sup>c</sup>
North Dakota	A state law effective in 2018 requires insurers to pay for out-of-network air ambulance transports at the average of the insurer’s in-network rates for air ambulance providers in the state. This payment is deemed to be full and final payment by the covered person for the transport. <sup>d</sup>  In January 2019, a federal district court concluded that this payment provision is preempted by the ADA. <sup>e</sup> The following month, the state Insurance Commissioner announced plans for North Dakota to appeal this ruling to the 8th Circuit of the U.S. Court of Appeals.
Texas	Payments for patients in the state’s workers’ compensation program made pursuant to applicable rate guidelines must be accepted as payment in full. <sup>f</sup> The Texas Department of Insurance Division of Workers’ Compensation began applying this requirement to air ambulance services in 2016.  A federal district court recently decided that the ADA preempts enforcement of workers’ compensation rate restrictions on air ambulance services. <sup>g</sup>

Source: GAO analysis of information from selected states. | GAO-19-292

<sup>a</sup>Mont. Code Ann. §§ 33-2-2302, -2305 (as added by S.B. 44 (2017)).

<sup>b</sup>N.M. Stat. Ann. § 59A-57-4 (1978); N.M. Code R. § 13.10.21.8.

<sup>c</sup>*PHI Air Medical, LLC. v. N.M. Office of Superintendent of Ins.*, No. 2:18-cv-382, slip op. (2018 WL 6478626, D.N.M., Dec. 10, 2018).

<sup>d</sup>N.D. Cent. Code § 26.1-47-09 (as added by S.B. 2231 (2017)).

<sup>e</sup>*Guardian Flight LLC v. Godfread*, No. 1:18-cv-007 (D.N.D. order filed Jan. 14, 2019). In addition, the U.S. District Court for the District of North Dakota previously ruled that the ADA preempted enforcement of a North Dakota statute enacted in 2015 that created a “primary call list” of providers that were in network with health insurers covering a certain proportion of the state’s population. The court found that the call list requirement was “precisely the type of state regulation Congress sought to prevent... in the ADA.” See *Valley Med Flight, Inc. vs. Dwelle*, 171 F. Supp. 3d 930, 941 (D.N.D., 2016).

<sup>f</sup>Tex. Lab. Code § 413.011 (2017); 28 Tex. Admin. Code §§ 134.1(a), 134.203(d) (2017). Workers’ compensation insurance generally pays benefits to an employee injured on the job regardless of fault or negligence, and the employee waives the right to sue for injuries.

<sup>g</sup>*Air Evac EMS, Inc. v. Sullivan*, 331 F. Supp. 3d 650 (W.D. Tex., 2018) (U.S. District Ct. granted injunctive relief, prohibiting state from enforcing rate restrictions).

The hold-harmless requirement and dispute resolution process established by Montana’s law is an example of how states are attempting to limit balance billing by regulating the business of insurance. Under the hold-harmless requirement, the financial risk for potential balance billing



is transferred from patients to the insurer by limiting the patients' out-of-pocket costs to their cost-sharing responsibilities. However, according to state officials, the dispute resolution process established by this law had not yet been used as of December 2018. The requirement and process apply to transports for patients covered by Montana-regulated insurance plans.<sup>40</sup> It does not apply to transports for individuals in most self-insured plans subject to ERISA, nor does it apply to transports for individuals, such as tourists, covered by insurance plans regulated by other states. The stated purpose of the law establishing this process is to prevent state residents from incurring excessive out-of-pocket expenses in air ambulance situations in a manner that is not preempted by the ADA.<sup>41</sup>

Officials in Montana and North Dakota reported receiving fewer consumer complaints about balance billing after implementing their laws to limit balance billing. One reason for this decrease in consumer complaints, according to officials in Montana, was that uncertainty over the possible effects of the law has made most air ambulance providers more willing to enter into contract negotiations with insurers. The officials added that shortly after the law's enactment, a large insurer and a large air ambulance provider entered into a network contract. Additionally, another air ambulance provider in Montana confirmed that although it had provided out-of-network transports, it had not sent balance bills to patients since the law took effect. Officials in both states could not comprehensively report the extent to which instances of balance billing may have decreased in their state.

As required by FAA Reauthorization Act of 2018, the Secretary of Transportation has taken steps to form an advisory committee on air ambulance patient billing.<sup>42</sup> DOT issued a solicitation in December 2018 for applications and nominations for membership on this advisory committee. The committee is to consist of representatives from state insurance regulators, health insurance providers, patient advocacy groups, consumer advocacy groups, and physicians specializing in emergency, trauma, cardiac, or stroke care, among others. The Act directs the advisory committee to issue a report within 180 days of its first

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<sup>40</sup>This includes group health insurance plans for Montana public employees and officers and for employees of the Montana university system.

<sup>41</sup>Mont. Code Ann. §§ 33-2-2301(2) (as added by S.B. 44 (2017)).

<sup>42</sup>Pub. L. No. 115-254, § 418, 132 Stat. 3562.

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meeting and to make recommendations that address the following, among other things:

- The disclosure of charges and fees for air ambulance services;
- Options and best practices for preventing balance billing—such as improving network and contract negotiation, dispute resolutions between health insurers and air medical service providers, and explanations of insurance coverage;
- Steps that states can take to protect consumers consistent with current legal authorities regarding consumer protection; and
- The recommendations from our 2017 report, including any additional data that DOT should collect from air ambulance providers and other sources to improve its understanding of the air ambulance market and oversight of the industry.

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## Education and Public Pressure

Officials in three selected states—Florida, New Mexico, and North Dakota—have provided information to educate consumers and other stakeholders about balance billing for air ambulance transports. The Florida Office of the Insurance Consumer Advocate and the New Mexico Office of Superintendent of Insurance reviewed air ambulance transports in their states and issued public reports with recommendations to improve transparency and education, among other recommendations.<sup>43</sup> Florida's report, issued in June 2018, recommends that insurers and air ambulance providers improve transparency about the availability of in-network air ambulance providers in a given area and provide information about rate justifications and billing practices to help consumers anticipate potential out-of-network costs. New Mexico's report, issued in January 2017, recommends educating emergency room physicians and other health care providers about the impact of air ambulance bills on consumers and on how to select in-network air ambulance providers. Additionally, since 2017, the North Dakota Insurance Department has produced a publicly available guide showing which air ambulance providers are in-network

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<sup>43</sup>Florida Office of the Insurance Consumer Advocate, *Emergency Medical Transportation Costs in Florida* (Tallahassee, Fla.: June 2018); and New Mexico Office of Superintendent of Insurance, *Air Ambulance Memorial Study Report* (Jan. 2017). The Florida Office of the Insurance Consumer Advocate is part of the Department of Financial Services. As of November 2018, officials we spoke with said that neither state has implemented the recommendations listed in their report.

with the three insurers in the state. This guide is part of the state's requirement that, for non-emergency transports, hospitals inform patients about the network status of air ambulance providers.<sup>44</sup> Although the three large independent air ambulance providers we spoke with told us that non-emergency transports comprise only a small percentage of air ambulance transports, officials in North Dakota said some dispatchers and first responders reported using the guide to call in-network air ambulance providers when possible for emergency transports.

Finally, one additional selected state—Maryland—has increased public awareness of air ambulance balance billing, which has generated public pressure on air ambulance providers and insurers to encourage the two sides to negotiate contracts. The Maryland Insurance Administration convened a public meeting in September 2015 with the goal of raising public awareness about air ambulance balance billing in the state. The meeting involved statements from patient, air ambulance, hospital, and insurer stakeholders. One of the large independent air ambulance providers said that public pressure following the meeting, as well as subsequent engagement from the state insurance commissioner, were factors in securing a contract with a large insurer in the state.

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## Agency Comments

We provided a draft of this report to the Department of Health and Human Services and DOT for review and comment. The Department of Health and Human Services told us they had no comments on the draft report, and DOT provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Administrator of the Centers for Medicare & Medicaid Services, the Secretary of the Department of Transportation, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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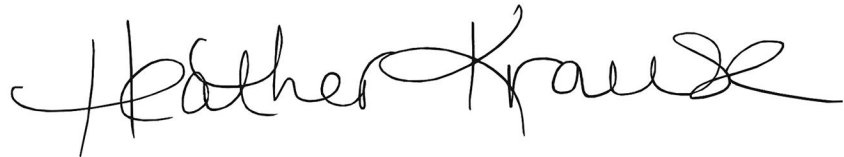
<sup>44</sup>N.D. Cent. Code § 23.16-17 (as added by S.B. 2231 (2017)).

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If you or your staff have any questions about this report, please contact James Cosgrove, Director, Health Care at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) or Heather Krause, Director, Physical Infrastructure at (202) 512-2834 or [krauseh@gao.gov](mailto:krauseh@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix I.



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# Appendix I: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

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## Staff Acknowledgments

In addition to the contacts named above, Lori Achman (Assistant Director), Heather MacLeod (Assistant Director), Corissa Kiyon-Fukumoto (Analyst-in-Charge), William Black, George Bogart, Stephen Brown, Krister Friday, Matthew Green, Barbara Hansen, Giselle Hicks, and Vikki Porter made key contributions to this report.

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## Related GAO Products

*Air Ambulance: Data Collection and Transparency Needed to Enhance DOT Oversight.* [GAO-17-637](#). Washington, D.C.: July 27, 2017.

*Air Ambulance: Effects of Industry Changes on Services Are Unclear.* [GAO-10-907](#). Washington, D.C.: Sept. 30, 2010.

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