Legislative Analysis

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MEDICAL TRANSPORTATION SERVICES

Senate Bill 296 (Substitute H-1)
Sponsor: Sen. Jud Gilbert
House Committee: Health Policy
Senate Committee: Health Policy

First Analysis (5-28-04)

BRIEF SUMMARY: The bill would require health insurers who provide benefits for emergency services either 1) to directly pay ambulance operations that transport a patient in an emergency or 2) to make payment jointly to the patient and the ambulance operation. (In other words, payment could not be made directly to the patient alone.)

FISCAL IMPACT: The bill would have an indeterminate fiscal impact on state and local governmental units.

THE APPARENT PROBLEM:

According to private ambulance operations, it can be difficult at times to be reimbursed for transporting emergency patients, even if the patient has health insurance that covers, in whole or in part, emergency ambulance services. This is because many contracts between health insurers and the purchasers of health care plans (i.e., employers) require the payment to be made directly to the patient instead of to the ambulance operation. However, instead of using the insurance payment to pay the bill for the transport service provided by the ambulance operation, many people (as many as 50 percent) cash the check and keep the money.

Reportedly, when this happens to municipally-operated ambulance operations, the ambulance operation does have some means not available to the private operations to collect on the debt. The private ambulance operation must either "eat" the amounts that are not reimbursed or expend a great deal of time and money suing the patient or hiring a collection agency to try to collect on the debts. Either way, prices for emergency transport must be adjusted to help cover the amount of unpaid claims. Some people believe that the situation could be alleviated if insurers either reimbursed the ambulance operation directly or at least issued a check that was made out to both the patient and the ambulance operation.

THE CONTENT OF THE BILL:

The bill would add a new section to the Insurance Code to require an expense-incurred hospital, medical, or surgical policy or certificate (commercial insurer or HMO) that provides benefits for emergency services to reimburse directly any provider of covered medical transportation services <u>or</u> to make the payment jointly to the insured and the

provider of the transportation service (as long as the provider had not received payment for those services from any other source). This would apply to policies and certificates that provided benefits for emergency health services that were delivered, issued for delivery, or renewed in this state on or after September 1, 2004.

The bill would not apply to a transaction between an insurer and a medical transportation service provider (i.e., ambulance operation) if the parties had entered into a contract that provided for direct payment. Also, a health insurer would not have to directly reimburse a nonaffiliated or nonparticipating provider for nonemergency medical transportation services if the policy or certificate had been issued for disability insurance for the provision of health care services under a prudent purchaser agreement.

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HOUSE COMMITTEE ACTION:

The committee substitute changed the effective date of the bill from April 1, 2004 to September 1, 2004.

FISCAL INFORMATION:

The fiscal impact on state or local units of government is indeterminate as it is not clear whether the bill would decrease or increase health care costs. If health care costs decrease as a result of the bill, there could be savings, though probably minimal, to the state and local units of governments in providing health care coverage for their employees.

ARGUMENTS:

For:

Ambulance operations are required to provide services in an emergency regardless of a person's ability to pay. However, many patients have private insurance that cover emergency services, including transport to a hospital. Where some insurance contracts require direct payment to the ambulance service providing the emergency transport, others send the payment to the patient; it is then the responsibility of the patient to use that insurance payment to reimburse the ambulance operation. Reportedly, though, about 50 percent of the patients keep the payment instead of paying the ambulance operation.

Regardless of the reason that a person may use to justify not paying for emergency transport services, the effect is financially devastating to the ambulance operation, especially those operating in rural communities where there may not be sufficient ambulance transports to cover a few unpaid ones. Similar to retailers who must raise prices to cover merchandise revenue lost through shoplifting, ambulance operations may have to charge more to cover the unpaid services. This raises health care costs for everyone.

The bill would remedy the situation by requiring an insurer to either pay the emergency transport provider directly or to issue a check that requires the endorsement of both the patient and the provider. The bill only applies to insurance policies that provide emergency medical services and only for transport by ambulance in emergency situations. Nonemergency transports would be reimbursed according to the contract language of the health plan. Also, since the bill would only apply to contracts that are issued, delivered, or renewed after September 1 of this year, it would not interfere with existing health plan contracts, nor, after that date, would it apply to any contract in which the parties have already negotiated direct payment.

The bill would not increase costs to insurers or to purchasers of health plans. It only changes who the check is made out to. In fact, some believe that by ensuring that ambulance operations receive the intended insurance reimbursements, the bill may result in system-wide savings because ambulance operations would not have to set prices to cover bad debts.

Against:

As written, the bill would apply to both commercial insurance contracts and HMOs. Reportedly, the original intent was not to include HMOs as they operate differently from commercial insurers; for example, the contract issue regarding how to pay providers of emergency transport services is already handled through the existing contract process. Therefore, it is not necessary to include HMOs in this provision. However, under Section 3503 of the Insurance Code, the bill would have to specifically exclude HMOs.

Against:

Insurers use direct reimbursement as a tool to encourage health care providers to become a participating or affiliated provider. However, the bill would require insurers to directly pay (or issue a joint check) even to nonparticipating or nonaffiliated providers of emergency transportation services. This could act as a disincentive for these providers to negotiate with an insurer to become a participating provider.

The situation is compounded by the ability of nonparticipating or nonaffiliated providers to “balance bill”. A participating or affiliated provider is required by contract with the insurer to accept as payment in full whatever the insurer approves as a price for a particular service; the insurer pays its share according to the plan benefits negotiated with the health plan purchaser, and the insured pays the rest according to his or her deductible and/or copay amounts. However, if a provider does not participate or is not affiliated with the health plan, the provider can charge the patient for the amount not covered by the insurance and copay amounts. For example, if an ambulance operation charges $500 for transport to a hospital in an emergency, but the health plan only approves $400 (the payment of which consists of the insurer’s share plus the patient’s copay and/or deductible), a nonparticipating or nonaffiliated ambulance operation can charge the patient the extra $100, whereas a participating or affiliated provider cannot. The bill would not prevent “balance billing”, and could increase the likelihood of occurrence by reducing the incentive to become a participating or affiliated provider.

Response:

Reportedly, similar legislation in other states has had no significant impact on participation rates, perhaps because there are benefits of participation regarding nonemergency transportation such as when a person is transported from home or a hospital to a nursing home. Apparently, nonemergency transports may account for as much as 60 percent of the transportation services provided by an ambulance operation; therefore, a strong incentive will still exist to encourage participation.

Against:

A joint check could delay payment to the ambulance provider; the bill should require direct payments, instead.

Response:

Some insurers may feel more comfortable issuing a joint check to a nonparticipating or nonaffiliated provider than making a direct payment. Besides, since a patient cannot legally cash a joint check, there is less likelihood of the money being pocketed and the emergency transport provider going unpaid. Even a delayed payment is better than no payment.

POSITIONS:

The Office of Financial and Insurance Services supports the bill. (5-19-04)

The Michigan Association of Ambulance Services supports the bill. (5-28-04)

A representative of Lifecare EMS testified in support of the bill. (5-25-04)

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■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.