Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 629 (Substitute S-1 as reported)
Senate Bill 630 (Substitute S-1 as reported)
Sponsor: Senator Bill Bullard, Jr.
Committee: Health Policy

Date Completed: 11-26-02

RATIONALE

Medical transportation services, including both emergency and nonemergency transport of patients to, from, or between health care facilities, is performed by community, hospital, and privately owned ambulance operations. While Medicare and Medicaid send payments directly to ambulance operations (providers) for their services, apparently many private insurers and Blue Cross and Blue Shield of Michigan (BCBSM) send payment directly to patients who have coverage for ambulance services, absent specific insurance contract provisions to the contrary. According to the Michigan Association of Ambulance Services, over half the time insured patients are sent payments for ambulance services, the patients do not reimburse the provider for the service. To get paid, the provider then must attempt to collect from the patient. It has been suggested that health insurers that provide benefits for ambulance services be required to provide direct reimbursement to ambulance service providers under certain conditions.

CONTENT

Senate Bill 629 (S-1) would amend the Nonprofit Health Care Corporation Reform Act (which governs BCBSM), and Senate Bill 630 (S-1) would amend the Insurance Code, to require BCBSM, a health maintenance organization (HMO), and a health insurer providing benefits for emergency services, to provide for direct reimbursement to any provider of covered medical transportation services if that provider had not received payment for those services from any other source. (In the case of BCBSM, payment could be made to the provider or jointly to the covered individual and the provider.) The bills' requirement for direct reimbursement would not apply to a transaction between BCBSM, or an insurer or HMO, and a medical transportation service provider if the parties had entered into a contract providing for direct payment.

Under Senate Bill 629 (S-1), BCBSM would not have to provide for direct reimbursement or joint payment to any nonparticipating provider for medical transportation services that were not emergency health services as defined in the Nonprofit Health Care Corporation Reform Act. Under Senate Bill 630 (S-1), an insurer or HMO, for a policy or certificate issued under Section 3405 or 3631 of the Insurance Code, would not have to provide for direct reimbursement to any nonaffiliated or nonparticipating provider for medical transportation services that were not emergency health services as defined in the Code. (Those sections allow insurers and HMOs authorized to write disability insurance to enter into prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services.)

The bills would apply to a policy or certificate providing benefits for emergency services that was delivered, issued, or renewed in Michigan on or after April 1, 2003.

Proposed MCL 550.1418a (S.B. 629)
Proposed MCL 500.3406l (S.B. 630)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills would help an industry that is

suffering. Currently, ambulance service providers are saddled with substantial amounts of bad debt because reimbursement procedures do not meet their needs. Absent a participating provider contract with a health insurer for ambulance services, health insurers send payment for those services directly to patients. If a patient does not forward the payment to the provider, or only forwards part of it, the provider must attempt to collect from the patient the charge for the service. It has been reported that a majority of the time patients who are directly reimbursed fail to pay the provider. This loss of revenue, combined with provider expenditures made in attempts to collect charges due, has put great financial strain on ambulance services. According to the Office of Financial and Insurance Services (OFIS), about 70% of all emergency ambulance services are provided by private companies. This means that, unlike municipal ambulance services, which may be supported by government funds, these private ambulance services have little choice but to incur bad debt. By requiring health insurers to make direct reimbursement to providers for emergency health services, the bills would alleviate the financial strain on ambulance service providers. Further, it appears that the bills would not cost health insurers any money, since payment for services would not be affected but simply would be redirected to the providers from the patients.

Opposing Argument

The bills would mandate direct payment to providers, thus interfering with contracts that health insurers may have with insured members, and interfering with the parties' ability to negotiate this portion of a contract in the future. According to OFIS, members of a health plan routinely alter their contract with the plan by voluntarily agreeing to assign their benefits to a provider. The bills would supercede the voluntary nature of this assignment. Legislation should not disrupt the content and management of private contracts. Further, by requiring BCBSM to provide direct reimbursement to *any* provider of covered medical transportation services (if that provider had not received payment for those services), or jointly to a provider and a patient, Senate Bill 629 (S-1) would appear to be in conflict with the statute that governs BCBSM. Section 401 of the Nonprofit Health Care Corporation Reform Act prohibits BCBSM from directly reimbursing a provider who has not entered into a participating contract with BCBSM.

Opposing Argument

If ambulance service providers are unable to collect charges from patients or their insurers, the providers should simply refuse to provide services unless a patient demonstrates an ability to pay.

Response: Aside from the moral and ethical dilemma raised by that strategy, Part 209 of the Public Health Code, which prescribes regulations for emergency medical services, requires an ambulance service to provide service to each emergency patient without prior inquiry into ability to pay.

Legislative Analyst: George Towne

FISCAL IMPACT

The bills would have an indeterminate fiscal impact on State and local government. According to providers of ambulance services, they often end up writing off unpaid claims as bad debt, even though the individual who used the ambulance had insurance coverage for that service. The problem, they suggest, is that in many cases the insurer pays the insured for the claim and the ambulance provider then tries to collect from the insured individual. The providers suggest that if they were paid directly by the insurer (or, as suggested in the past, if the insurer paid the insured directly with the check made out to both the insured and the ambulance provider), it would be easier to collect the copayment or uncovered portion of the claim from the individual insured, thereby reducing both the amount of bad debt and the subsequent need of the ambulance provider to raise prices to make up for that bad debt. Under these bills, if an insurer provided coverage for ambulance services, then the insurer would be required to pay an ambulance provider directly (or to pay the provider and the insured jointly, in the case of BCBSM) if one of its insured individuals incurred a claim for that service. The bills do not appear to mandate that an insurer provide coverage for ambulance services, or set the amount of payment for these services.

The provider community claims that bad debt is equivalent to 10% of its revenue. While the Senate Fiscal Agency (SFA) cannot independently verify that, there is no evidence

to the contrary. Although not all of the bad debt results from the claims of people with coverage, the SFA tested the cost savings hypothesis based on that parameter.

Using a simple recursive model that generated successive changes in the average cost of services, where the only cost driver was the need to cover the bad debt, the SFA found that the average charge over three years would have to increase by 21% and all of the bad debt still would not be covered. As noted above, this result is based on an assumed level of bad debt of 10% and is compared with a pricing structure that holds all other factors constant. However, even if the related bad debt were only 5% of revenue, the increased cost over the same period still would be 10%. It is impossible to give a "dollar" savings if the bills were enacted, though they almost certainly would generate "system-wide" savings.

Fiscal Analyst: John Walker

A0102\s629a