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BILL ANALYSIS

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Senate Bill 296 (Substitute S-3 as reported)
Senate Bill 297 (Substitute S-2 as reported)
Sponsor: Senator Jud Gilbert, II
Committee: Health Policy

Date Completed: 11-24-03

RATIONALE

Bills for ambulance services evidently are difficult to collect at times. The challenge of providing service regardless of a patient's ability to pay can be compounded when a health insurance plan, with which an ambulance services provider does not participate, does not reimburse the provider directly. Sometimes, an insurance company will send the patient a check, with which the patient is expected to pay the provider. Reportedly, however, in 50% of the cases in which the insurer does not directly reimburse the provider, the patient keeps the money and the ambulance company never receives any payment for providing emergency medical transportation. In order to ensure that ambulance providers are compensated for their services, it has been suggested that insurance companies should be required either to reimburse providers directly or to issue a joint check to the patient and the provider.

CONTENT

Senate Bills 296 (S-3) and 297 (S-2) would amend the Insurance Code and the Nonprofit Health Care Corporation Reform Act, respectively, to require a policy or certificate to provide for direct reimbursement to any provider of covered medical transportation services, or provide for joint payments to the insured and the provider, if the provider had not received payment from any other source. Senate Bill 296 (S-3) would apply to an expense-incurred hospital, medical, or surgical policy or certificate providing benefits for emergency health services delivered, issued for delivery, or renewed in this State on or after April 1, 2004. Senate Bill 297 (S-2) would apply to a Blue Cross and Blue Shield of Michigan (BCBSM) certificate delivered, issued for delivery, or renewed in this State on or after April 1, 2004.

The proposed requirements would not apply to a transaction between an insurer or BCBSM and a medical transportation services provider, if the parties had entered into a contract providing for direct payment.

An insurer for an individual or group disability or family expense policy and BCBSM would not have to provide for direct reimbursement or joint payment to any nonaffiliated or nonparticipating provider for medical transportation services that were not emergency health services.

Senate Bill 297 (S-2) also would require the Commissioner of the Office of Financial and Insurance Services to report, by January 1, 2007, to the Governor, the Clerk of the House of Representatives, the Secretary of the Senate, and all members of the House and Senate standing committees on insurance and health issues, on the number of BCBSM-participating emergency medical transportation service providers. If the report stated that 40% or less or 90% or more of the providers in Michigan were participating providers, effective March 1, 2007, providers receiving direct reimbursement would have to accept payment from BCBSM as payment in full and could not seek additional payment from the patient except for any required deductible, copayment, or coinsurance amount.

MCL 500.3406l (S.B. 269)
550.1418a (S.B. 297)

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

Patients who pocket the money intended for the ambulance company contribute to the hardship providers face in continuing to provide emergency medical services. The temptation to keep a check for several hundred dollars can be very strong, especially for someone facing other medical bills connected to his or her need for emergency transport to a hospital. When this happens, ambulance companies must employ a collection agency to attempt to recover the money they should rightfully have received and could have used to continue keeping rates low. Particularly in rural areas of the State, where an ambulance company might not engage in patient transportation very often, a patient's failure to reimburse can result in significant financial hardship for the provider. Many insurance companies have provided direct reimbursement to ambulance services providers for years without any problems. By requiring direct reimbursement or a joint check, the bills would help ensure that providers are able to continue adequately serving their communities for a reasonable price.

Response: The bills would unfairly shift the burden of loss from ambulance companies to individual patients and their families, who do not have the option of shopping for the best or the least expensive transportation during a medical emergency.

Opposing Argument

Direct reimbursement is a tool insurers can use as an incentive for providers to participate with them, thereby ensuring that providers meet certain standards and do not jeopardize the health of patients. The bills, however, would require insurers and BCBSM to make direct reimbursement to providers with which they have no contractual relationship. This could raise significant quality of care questions about the providers' qualifications and credentialing, as well as lead to a serious drop in participation rates. As a result, individuals and employers would experience higher health care costs over time as premiums increased. This problem then would be compounded if other types of health service providers demanded and received similar treatment.

Response: The bills would help keep costs down by ensuring that health care dollars remained within Michigan's health care system. Ambulance providers then would feel less pressure to increase their rates in order to offset the losses they experience under the current system. Furthermore, similar legislation in other states reportedly has had no significant impact on participation rates.

Opposing Argument

Although many insurers prohibit participating providers from engaging in "balance billing", the bills would not prohibit ambulance companies from billing patients for any unreimbursed portion of the companies' fees not reimbursed by an insurer. On the contrary, the bills would remove an incentive for ambulance companies to be participating providers with insurers and BCBSM, which could lead to an increase in balance billing. For example, if an ambulance company thinks it costs $500 to make a run, but the insurer will pay only $400, the company could bill the patient for the difference. The sole limitation under the bills would apply to participating providers' accepting payment from BCBSM, but only if participation rates reached a specific floor or ceiling and not until March 2007. If ambulance companies believe that they are being inadequately reimbursed, they should negotiate an acceptable schedule of fees with insurers and BCBSM. This would enable the insurers and BCBSM to make sure that the transportation providers met safety criteria and billed only for true emergencies.

Response: When an insurance company does not cover completely the cost of ambulance service, the provider must bill the patient for the remainder. If providers were not able to do so, they could not recover the cost of providing service and would go out of business. Furthermore, because 86% of ambulance companies reportedly participate with BCBSM, balance billing occurs only in a small percentage of cases. A joint check would not be a disincentive to participate because providers would not want to risk losing the 60% of their business that comes from nonemergency runs.

Opposing Argument

A joint check could delay payment to the ambulance provider and would not protect against balance billing.

Response: A provider would be more

likely to get payment through a joint check than if the patient were reimbursed and trusted to pass that payment on to the provider. Once a check is issued, the insurance company is no longer involved and the provider and patient are left to determine payment arrangements. With a joint check, a patient could not legally pocket money that was intended for an ambulance service provider.

Legislative Analyst: Julie Koval

FISCAL IMPACT

The bills would have an indeterminate fiscal impact on State and local government. Providers of ambulance services complain that 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 is left with having to try to collect from the insured individual. The providers suggest that if they were paid directly by the insurer, or 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 if one of its insured 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. To the extent that these bills would reduce the need of ambulance providers to raise prices to make up for bad debt, the bills would likely generate system-wide savings.

In addition, Senate Bill 297 (S-2) would result in costs to the State associated with the issuance of the required report.

Fiscal Analyst: Dana Patterson

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