AMENDMENTS TO INSURANCE COMPANY LAW OF 1921: EMERGENCY SERVICE SYSTEM BILLING

Act 2015-84 December 20, 2015

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding sections to read:

Section 635.7. Billing.

(a) When an EMS agency is dispatched by a public safety answering point as defined in 35 Pa.C.S. § 5302 (relating to definitions) or an EMS agency dispatch center under 35 Pa.C.S. § 8129(i) (relating to emergency medical services agencies) for an emergency and provides medically necessary emergency medical services, a payment made by an insurer for a claim covered under and in accordance with a health insurance policy for an emergency medical service performed by the EMS agency during the call shall be paid directly to the EMS agency.

(b) An insurer must reimburse a non-network EMS agency under the following:

(1) The EMS agency has submitted a completed standardized form to the department requesting non-network direct reimbursement from an insurer an EMS agency has identified. The form must be submitted to the department annually by October 15. The form shall declare the EMS agency's intention to receive direct payment from an insurer identified on the form for the next calendar year. The department shall develop a standardized form, using an EMS agency's assigned license number, to be used by an EMS agency that meets the conditions established under this section. The department shall develop and maintain a publicly accessible electronic registry that indicates which EMS agency has requested non-network direct reimbursement from an insurer identified on the form.

(2) An EMS agency has provided notification to the insurer upon submitting a claim for reimbursement that the EMS agency is registered with the department to receive direct reimbursement as provided for under this section.

(c) An EMS agency may be subject to periodic audits by an insurer to examine claims for direct reimbursement under this section. If, through the audit, the insurer identifies an improper payment, the insurer may deduct the improper payment from future reimbursements.

(d) Where an insurer has reimbursed a non-network EMS agency at the same rate it has established for a network EMS agency, the EMS agency may not bill the insured directly or indirectly or otherwise attempt to collect from the insured for the service provided, except for a billing to recover a copayment, coinsurance or deductible as specified in the health insurance policy.

(e) An EMS agency that submits a form under this section may solicit donations or memberships or conduct fundraising, except that an EMS agency may not promise, suggest or infer to donors that a donation will result in the donor not being billed directly for any payment as provided under this section. Notwithstanding this paragraph, an EMS agency may bill in accordance with subsection (d). A violation of this section shall be considered a violation of the act of December 17, 1968 (P.L.1224, No.387), known as the "Unfair Trade Practices and Consumer Protection Law."

(f) Claims paid under this section shall be subject to section 2166.

(g) This section shall apply only to an EMS agency that is a nonnetwork provider and provides emergency medical services, unless preempted by Federal law.

(h) The following words and phrases when used in this section shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Department." Department of Health of the Commonwealth. "EMS agency." As defined in 35 Pa.C.S. § 8103 (relating to definitions).
"Emergency medical services." As defined in 35 Pa.C.S. § 8103 (relating to definitions).
"Insurer." As follows:

(1) An entity that is responsible for providing or paying for all or part of the cost of emergency medical services covered by
an insurance policy, contract or plan. The term includes an entity subject to:

(i) section 630, Article XXIV or any other provision of this act;

(ii) the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act; or

(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(2) The term does not include an entity that is responsible for providing or paying under an insurance policy, contract or plan which meets any of the following:

(i) Is a homeowner's insurance policy.

(ii) Provides any of the following types of insurance:

(A) Accident only.

(B) Fixed indemnity.

(C) Limited benefit.

(D) Credit.

(E) Dental.

(F) Vision.

(G) Specified disease.

(H) Medicare supplement.

(I) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

(J) Long-term care.

(K) Disability income.

(L) Workers' compensation.

(M) Automobile medical payment insurance.

This act shall take effect as follows:

(1) The addition of section 635.7 of the act shall take effect January 1, 2016, or immediately, whichever is later.

APPROVED -The 20th day of December, A.D. 2015.

TOM WOLF

Act 84 of 2015
"Direct Pay" of EMS Agencies
Summary of Key Provisions by J.R. Henry

Each EMS agency in Pennsylvania should carefully review, research and analyze relevant billing and collection data in order to make an informed decision on the annual option to "opt in" for direct payment with one or more commercial insurers, as authorized in Act 84

BACKGROUND: Act 84 was signed into law on December 20, 2015 by Gov. Thomas Wolf. Although, the primary purpose of this act was to reauthorize the CHIP health care program in Pennsylvania, it also contained language from HB 347 which now authorizes "direct pay" of EMS agencies.

The payment provisions of Act 84 provide an option for non-contracted EMS agencies in regard to billing and payments related to emergency medical services transportation. The new law provides EMS agencies with an annual choice to "opt in" for direct payments from certain commercial insurance companies.

The payment provisions do not apply to EMS claims submitted to insurers such as Medicare, Medicaid or others in which "balance billing" is preempted under federal law. The new law also exempts EMS claims related to insurers who provide coverage related to auto accidents, worker's compensation claims and other types of limited benefit insurance programs.

If an EMS agency elects to "opt in" with a specific commercial insurance company, the EMS agency is then eligible to receive direct payments from the insurer at "in-network" rates. In 2016, many of the large commercial insurers in PA have established "in network" contract amounts which are near or slightly above the current Medicare approved amounts. These "in network" rates range typically anywhere from $400 - $600 less what an average EMS agency would routinely charge for services rendered.

The "in network" rates are also subject to all applicable co-payment, co-insurance and deductible amounts. Direct payments to an EMS agency which chooses to "opt in" will be reduced by any applicable co-payment, co-insurance and deductible amounts. The EMS agency is required to directly bill the patient for any applicable co-payment, co-insurance and deductible amounts.

EMS agencies who elect to "opt in" are prohibited from "balance billing" the patient or the insurer for any amount which exceeds the "in-network" or "contract" rate.

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The Pennsylvania Department of Health (PADOH) is responsible under Act 84 to create a registry and specific details by which EMS agencies may make their choices related to "opting in" each year. The time frame for development and implementation of such a registry by the PA DOH is unknown at this time.

The law also stipulates that an EMS agency must provide notification to the insurer that they have registered with the PADOH to receive direct reimbursement.

The law also states that any fundraising efforts by EMS agencies which "opt in" cannot *"promise, suggest, infer to donors (subscribers, members, etc.) that a donation will result in the donor not being billed directly for any payment as provided under this section".*

This provision will have a dramatic impact on EMS agencies who offer subscription or membership programs. If an EMS agency elects to "opt-in", the subscriber will now be responsible to pay all non-covered co-payments, deductibles and co-insurance amounts. This provision may increase billing revenue. However, EMS agencies who "opt-in" should expect subscriber revenue to decrease dramatically as the promise to forgive or write-off all or a percentage of copayment, deductible and co-insurance amounts is one of the major incentives for a person to subscribe or join an ambulance membership program.

Also, balance billing of non-subscribers who are covered by an "opt-in" insurer will also be prohibited. Although direct payment of the lower "in-network" rates will be received by the EMS agency, losing the ability to "balance bill" could result in decreased billing revenue.

The overall effects of these provisions will potentially result in significant revenue losses for EMS agencies which conduct subscription / membership programs

Act 84 also grants insurer's the right to conduct audits of "opt-in" EMS agencies and further grants insurer's the right to deduct improper payment amounts from future reimbursements. The law is silent about the potential administrative and financial burdens which the EMS agency will face if each insurer elects to conduct its own periodic audit.

The law is also silent on the EMS agencies due process and appeal rights related to any periodic audit mandated by insurers.

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Each EMS agency in Pennsylvania should carefully review, research and analyze their respective billing and collection data in order to make an informed decision on "opting in" for direct payment with one or more commercial insurers.

Data Analysis and Issues:

1) **Overall Payer Mix:** Review and analyze total dollars received, the number of claims and collection percentages for each of the four (4) major payer categories including Medicare, Medicaid, Commercial and Private Pay. (Use annual data for at least 3 years)
2) **Subscription / Membership Revenue and Billing Revenue:** Determine total subscriber write off and compare it with overall subscription revenue;
3) **Commercial Insurers:** Review and analyze data which outlines the number of claims, base rate and mileage charges and dollars billed vs. dollars received from each commercial insurer. Determine the actual dollars received per claim. Research and apply knowledge of each insurer's payment policies. For example, does this specific insurer pay the EMS agency directly or do they forward the check to the patient? What are the co-payment, co-insurance and deductible requirements of this insurer? Estimate potential impact of the loss of balance billing revenue
4) **Network Rates:** Research and determine each insurer's current or future in-network or contracted base rate and mileage fee schedule amounts. Also, determine co-payment, co-insurance and deductible amounts for various plans offered by the insurer
5) **Determination:** Calculate the potential revenue loss or gain of contracting with one or more of the commercial insurers based upon the projected number of claims submitted and overall revenue (in total and per claim)

It is this author's opinion that pursuant to careful analysis of the relevant issues and their respective billing / collection data, many EMS agencies in Pennsylvania will determine that "opting in" for direct reimbursement will result in significant decreases in their overall subscription and billing revenue