CASE STUDY

To Balance Bill or Not to Balance Bill: One Agency's Decision to Change

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TO BALANCE BILL OR NOT TO BALANCE BILL: ONE AGENCY'S DECISION TO CHANGE BALANCE BILLING PRACTICES

Amid the fervent chatter around the No Surprises Act and the final meeting of the federal advisory committee on Ground Ambulance and Patient Billing (GAPB), Digitech has completed an analysis on the impact on a municipal agency that voluntarily ceased balance billing practices in cases where insurance companies did not allow the full charges. Digitech found that the financial impact was modest, but would we advise ambulance providers to stop balance billing patients when commercial insurance plans disallow some of the charges? No – there are additional dynamics at play in the industry that must be considered.

EXECUTIVE SUMMARY

A municipal EMS client of Digitech's ("the Agency") voluntarily implemented a policy to cease balance billing patients in cases where insurance companies have short paid accounts by disallowing a portion of the charges.

By analyzing collections data from before and after the implementation of the policy, the revenue impact for commercially insured patients was as follows:

	Before **No Balance Billing Policy** Implementation	After **No Balance Billing Policy** Implementation
Average Collection Per Account	**$1,737**	**$1,609**
% Change		**-7.3%**

While meaningful, the reduction in payments received was not drastic. This policy implementation certainly warrants consideration given the patient- and citizen-friendly benefit of not holding individual patients responsible for the shortfall payments of their insurance companies.

That said, it is likely not possible to extrapolate this impact to balance billing legislation such as the No Suprises Act. For the Agency, this voluntary implementation of no-balance-billing did not result in behavioral change from the insurance companies. Legislation that bans balance billing, unfortunately, is likely to drive substantial changes from insurance companies where they uniformly short pay insurance claims. Under balance billing legislation, insurance companies would likely tie their reimbursements to arbitrary numbers, such as the Medicare allowable amount under the CMS Ambulance Fee Schedule. This would have a substantial, and most likely devastating, financial impact on EMS providers.

This whitepaper by Digitech will explore the **impact** of balance billing policies on a **real-life EMS agency.**

INTRODUCTION

Rarely do opportunities present themselves whereby an EMS agency makes a policy change that precedes and is similar to the impact of potential federal legislation. Fortunately, because Digitech provides EMS revenue cycle services to a diverse range of EMS agencies across the country, we had the opportunity to be involved in this situation playing out with one of our clients.

A **municipal EMS agency** decided to implement a policy to **stop balance billing patients** in situations where their insurance company short pays on the ambulance charges.

Over the past several years, the prevalence of insurance short pays has increased across the country. What is an insurance short pay? An insurance short pay is when an insurance company views the charges of an out-of-network provider (also known as a provider not under contract) as excessive, and the insurance company sets what they believe to be a fair "allowable" amount that they will reimburse.

The problem is that the allowable amount is typically arbitrary, often tied to some multiple of the Medicare ambulance fee schedule or an opaque "usual and customary" amount. Once the insurance company sets their "allowable," the difference between the charge and the "allowable" becomes stranded; this remaining balance ends up becoming the patient's responsibility. To add to the pain, patients are further punished as any stranded amounts are not credited against any deductibles or out-of-pocket maximums associated with their insurance policy. This dilemma is what has led to patient protective legislation such as the No Surprises Act[1] (currently not applicable to ground ambulance, but under review by the GAPB).

Using data from this specific municipal agency lets us gain some insight into how ceasing balance billing might impact a broader set of agencies in the EMS industry, assuming that legislation does not alter the behavior of commercial insurance payers.

ANALYSIS

How might ceasing balance billing impact a broader set of agencies in the EMS industry, assuming that legislation does not alter the behavior of commercial insurance payers?

We will also address the assumption that the behavior of insurance payers *wouldn't* change, and we will look at both the implications of those potential behavioral changes and possible ways to counter such changes.

CASE STUDY

A few years ago, a municipal EMS agency went through a series of changes that were set in motion as a result of their State implementing a cost-based supplemental Medicaid payment program.

Upon the implementation of the State's Medicaid Supplemental Payment program[2], the agency decided to align their fee schedule with the costs associated with ambulance transports. These costs are the same costs submitted to the State as required under the Medicaid Supplemental Payment Program. For the Agency, making a substantial fee increase made sense; otherwise, the State acknowledged cost would be out of sync with what other payers were being charged.

The resulting new fee structure to match costs resulted in the average charge increasing by over 140%. As the Agency implemented the significant fee increase, a decision was made to update some policies so that patients were not unduly burdened by the substantial increase in charges.

One change was to update the Agency's charity and hardship process to make it easier for patients to apply for a full or partial waiver of their bill. A second change that was ultimately implemented was to not hold patients responsible for short pays made by insurance companies.

The traditional thinking has been not to accept a short pay from an insurance company for fear that, over time, all commercially insured accounts would be short paid.

The Agency's new policy to cease balance billing patients for insurance short pays was not made, however, until ten months after the new fee schedule was put in place.

This unique situation allows us to do analysis on the recovery from commercial insurance companies **before and after** the balance billing policy was implemented.

SUMMARY OF ANALYSIS

For the analysis of the impact of the balance billing policy change, two data samples were gathered.

CONTROLLED DATA

In both data samples, only insurance payers classified as **Commercial** were included.

Each data set had a similar number of **records**.
(and statistically significant at multiple thousands per each time period)

<1%

The average charge of the claims submitted to the insurance companies during these time periods had **less than 1% variance**.

While there are market variables that cannot be fully accounted for, there is **no gap** between the time periods, and we found no major marketplace or other external changes that are known to have existed between the two time periods.

1ST DATA SET

Pulled records from the six months **prior** to the implementation of the policy change.

2ND DATA SET

Pulled records from the six months **after** the implementation of the policy change.

The time periods under consideration are over 24 months in the past, so the payments on these accounts in this analysis are fully mature.

PAYMENT RECOVERY PRIOR TO BALANCE BILLING POLICY CHANGE

In the period after higher fees were implemented but before the balance billing policy change, when the Agency did balance bill patients for insurance short pays:

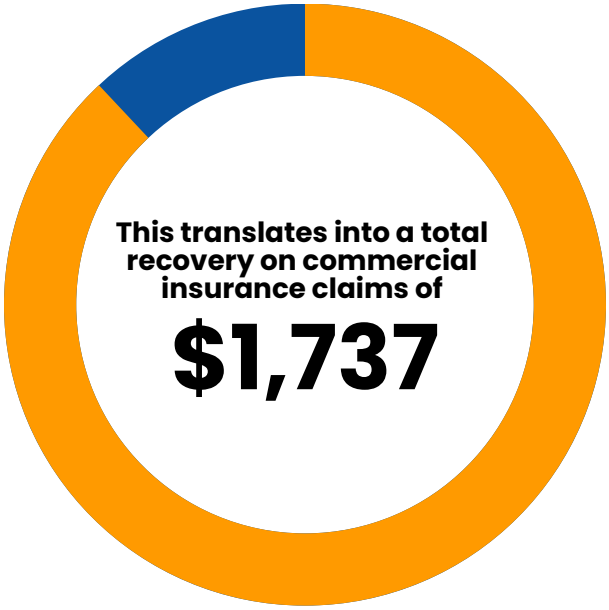
The average payment from insurance companies was

$1,528

Additionally, on average:

$209

was collected from the patient.



PAYMENT RECOVERY POST BALANCE BILLING POLICY CHANGE

After the balance billing policy was put into place, and the Agency had the higher fee structure but no longer balance billed on insurance short pays:

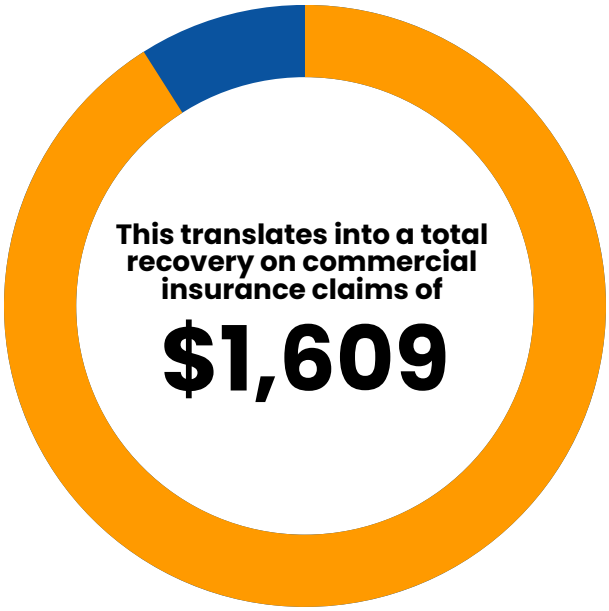
The average payment from insurance companies was

$1,468

Additionally, on average:

$141

was collected from the patient.



The net difference after the policy change was a **drop** in the yield from commercial insurance accounts of **7.3%**. The amount recovered from patients decreased by **32%**, and the amount recovered directly from insurance companies decreased by **4%**.

CONCLUSIONS

As expected, implementing a policy ending balance billing did result in a decrease in the dollars recovered. The policy also removed a financial burden from patients as intended, and it removed the pressure that patients put on their insurance company to reconsider charges, although relatively small amounts were reconsidered and paid directly by the insurance company to the Agency.

It is worth noting that when some insurance companies reconsider "allowable" amounts, they issue those additional funds directly to the patient, and place the burden on the agency (in this case, Digitech as the Agency's EMS billing vendor) to collect those dollars from the patient. So, this approach to measurement may understate the amount of money that insurance companies paid out but ultimately ended up stranded with the patient.

Whether making a policy change is worth the lost revenue is up to each EMS provider to consider. Let's say an entity is collecting $1 million annually related to commercially insured transports prior to implementing a no-balance-billing policy. The question becomes whether the loss of $73,000 in revenue is worth the benefit of the more compassionate approach of not holding patients responsible for their insurance companies' unwillingness to acknowledge full charges.

IMPLICATIONS

On the surface, this case study is fairly straightforward. Implementing a policy to stop balance billing does result in a loss of revenue. It is safe to assume that an EMS agency could expect to lose 5-10% of the revenue from commercially insured patients after implementing a similar policy depending on the charge levels and the insurance companies in that geography.

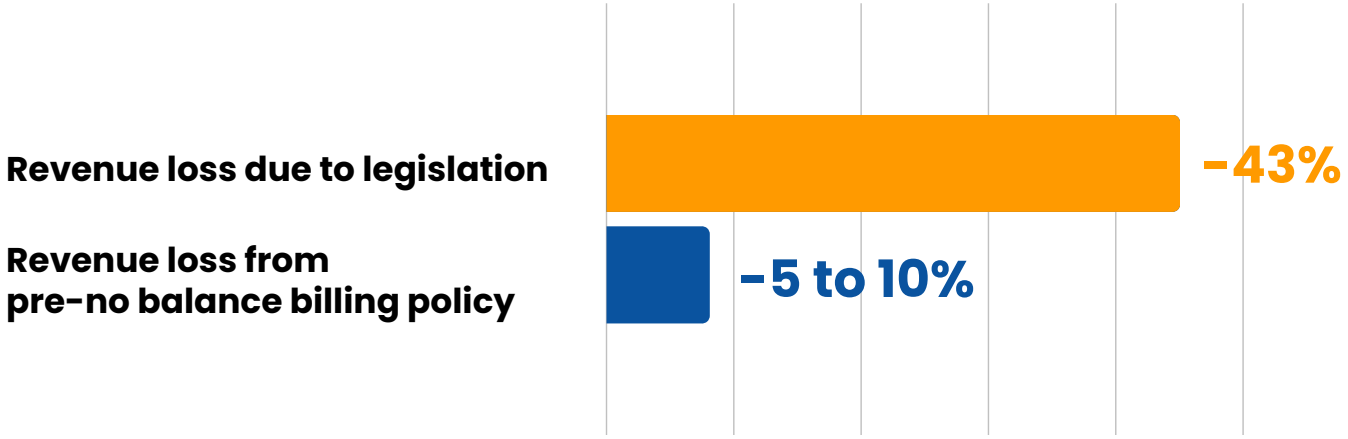
Given the relatively modest impact from ceasing balance billing, does that mean that the ambulance industry is overreacting to the threat from the No Surprises Act[1] being applied to ground ambulance providers, as well as other billing legislation that is continuously being proposed at State levels?

The answer to this is a resounding no and here's why.

IMPLICATIONS (CONT.)

In our case study, the Agency's policy change was proactive. It was not publicized to payers – or substantially to patients for that matter. In instances of current balance billing legislation such as the No Surprises Act, much of the push to change ambulance ground transport billing policies is backed by the insurance industry. Legislation is specifically tailored to allow insurance companies to systematically impose usual and customary amounts on "out-of-network" providers that are well below charges and in many cases below the providers' costs.

As an example, written legislation often begins by stating that the allowable should be equal to the Medicare allowable. Let's assume that insurance companies "generously" agree to pay twice the Medicare allowable in proposed legislation. For the municipal agency analyzed in this case study, their blended ALS/BLS transport allowable at twice Medicare is $986. Assuming this were paid at 100% (a bad or at least aggressive assumption given co-pays and deductibles that remain), it would result in a 43% reduction in revenue for the Agency versus its pre-no balance billing policy.



Using the earlier example of a municipality with $1 million in commercial insurance revenue prior to a change to no balance billing, the revenue would be reduced to $570,000. For many EMS agencies, commercial insurance transports represent close to 50% of the overall revenue. How many EMS agencies can afford to lose 20-25% of their total revenue and remain financially viable?

Although this case study is a very useful assessment of the impact of a voluntary policy of eliminating balance billing practices by a municipal EMS agency, it does not hold up in an environment where the insurance payers take advantage of the policy and systematically reduce the amounts they solely determine should be "allowed."

HOW SHOULD EMS AGENCIES APPROACH BALANCE BILLING LEGISLATION AND RELATED POLICIES?

Insurance companies have deep pockets and spend aggressively to protect their interests. In the face of this, EMS agencies need to pursue public awareness efforts just as aggressively. The public, including legislators and the population at large, needs to become more aware of the true cost of running a 24/7 immediate response service.

Reimbursement cannot be tied to existing governmental payments such as the Medicare or Medicaid CMS Ambulance Fee Schedule. Instead, reimbursement needs to be tied to the true cost of providing an invaluable community service. Unless and until the dialogue shifts to focus on the cost of providing these services, the financial burden will be placed primarily on taxpayers and will result in some providers ceasing operations due to lack of funding sources.

Insurance companies have a reasonable argument that they are subsidizing payments relative to the reimbursement rates of other payers. But acting upon this argument creates a downward spiral whereby all payers are then reimbursing substantially below the cost of providing the service. That race to the bottom leads to unsustainable EMS services.

Public engagement is the best way to counter some of the false messaging that EMS providers are excessively charging for their emergency services. EMS agencies should seek direct engagement with legislators, community leaders, and local constituents to seek fair reimbursement for services rendered to patients with commercial insurance coverage (as well as from governmental payers). It is not acceptable for insurance companies to place an undue burden on their customers, label it surprise billing, and shape the storyline as one of ambulance agencies charging excessively. Most EMS agencies would be willing to work out a solution on balance billing if the true cost of saving patients' lives were recognized and included as a fully allowable charge.

CONCLUSION

EMS agencies should seek direct engagement with legislators, community leaders, and local constituents to seek fair reimbursement for services rendered to patients with commercial insurance coverage.

ENDNOTES

1. The No Surprises Act (NSA) was enacted as part of the Consolidated Appropriations Act, 2021. It prohibits providers from billing patients for emergency medical services when the insurance company does not recognize an out-of-network provider's charges and allows some amount below the charges. Ground Ambulance services were carved out from the NSA to be studied by a Ground Ambulance and Patient Billing Committee (GAPB). The GAPB met in May 2023 for the first time. The committee is tasked with making recommendations for how to treat ground ambulance services since they are different from other parts of healthcare (e.g., there is no competition for 911 services at the time of need) within six months of their first meeting.

2. Many states have implemented Medicaid supplemental payment programs for emergency transports. These programs increase federal match amounts for the Medicaid payments, whereby the state puts in money collected from the transporting agencies to increase their federal draw-down. In some states, the additional funds distributed to providers from federal funds are substantial, but typically still leave net reimbursement for Medicaid transports well below the cost of providing the service.

ABOUT DIGITECH

Digitech is a leading provider of advanced billing and technology services to the EMS transport industry. Since its founding in 1984, Digitech has refined its software platform to create a cloud-based billing and business intelligence solution that monitors and automates the entire EMS revenue lifecycle. Digitech leverages its proprietary technology to offer fully outsourced services that maximize collections, protect compliance, and deliver results for clients.
For more information, visit digitechcomputer.com.

ABOUT THE AUTHOR

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Michael Brook has been in the EMS billing industry for 15 years in a variety of capacities, including both overseeing billing operations and managing client accounts. He currently provides leadership and support to Digitech clients, partnering with them to optimize revenue and navigate a changing marketplace. Michael would love to hear your thoughts and can be reached on LinkedIn.

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