Jack Stout

INTERFACE

# Why Subscription Programs?

**Several weeks ago I** was discussing with my philosophical arch-rival, Dennis Murphy, author of *jems'* "Public Forum" column, the legal subtleties of ambulance subscription programs. At the end of our discussion, Dennis suggested that, because this issue is so deceptively complex and poorly understood, I should devote an "Interface" column to subscription programs. Here it is.

*What Are They?* Ambulance subscription programs fall into two major categories: those which involve the actual sale of ambulance services on a prepaid basis (i.e., for purposes of this discussion, Type I programs); and those which allow subscribers to fix-price and prepay the uninsured portions of ambulance bills (i.e., Type II programs). Legally and financially, these two types of programs are profoundly different.

If the subscription agreement (sometimes called a "membership agreement") entitles the subscriber to "free ambulance services" for a defined period of time in exchange for a subscription or membership fee, then the program involves the actual sale of ambulance services on a prepaid basis and is, therefore, a Type I program. But if the subscription agreement merely allows the subscriber to prepay at a fixed price set by the company the uninsured portions of ambulance bills, then the contract is *not* for the sale of ambulance services, but is instead an agreement between the customer and the provider to alter the method of payment of uninsured portions of ambulance bills—i.e., a Type II program.

The most important difference between Type I and Type II subscription programs is that, under a Type II program, the provider may (with certain restrictions) collect and retain third party reimbursements for services rendered to subscribers. Under a Type I program, monies collected from third party payors technically belong to the subscriber, and in some cases, it may be unlawful for third party bills to exceed the amount of annual subscription fee.

In practice, subscription agreements and promotional materials are often so poorly drafted that it is impossible to determine what is actually being sold—ambulance services versus an altered method of paying uninsured costs. That uncertainty carries great financial risk for the provider who bills third party payors, especially Medicare, for services received by subscribers.

*Why Subscription Programs?* For most providers, public and private, a subscription program is primarily a political safety value. If it didn't raise a dollar, the program would still be worth having for some providers.

Since about 1970 the ambulance industry has experienced tremendous clinical and technological progress. In about half of our communities, this progress has been heavily financed by local tax subsidies, with user fees remaining at token levels a fraction of production costs. But in other communities, progress has either been limited or financed through substantial increases in user fees. In addition, many local governments which were able to afford large ambulance subsidies in the easy-money fiscal years of the 1970s must now choose between higher user fees versus allowing a deterioration in quality of ambulance services.

For reasons detailed in depth in previous "Interface" articles, poor EMS at any price is false economy, and there are serious disadvantages to local tax financing of health care services, including EMS. Thus, assuming reasonable levels of efficiency, it is good public policy to finance quality ambulance services by raising ambulance fees to cover full production costs. It's good public policy, but it can also sting.

When ambulance rates go up dramatically, either to finance better service or to offset a subsidy reduction, the wisdom of the action may be less than widely recognized by the public at large. Here's why.

In some insurance policies, the level of maximum reimbursement for ambulance service was established back when teenaged ambulance jockeys roared through the streets in barely modified Cadillac hearses loosely called ambulances. Furthermore, Medicare's method of changing its "allowable charges" for ambulance services incorporates an 18-month delay from the time the rates are raised. And if your community is surrounded by heavily subsidized providers, your neighbor's token rates will, because of Medicare's method, forever depress your own reimbursement levels.

The bottom line: When you raise

---

*Jack Stout has been at the forefront of innovations in the design and implementation of EMS systems for the past dozen years. If you have a question, a problem, or a solution related to the public/private interface in prehospital care, address your letter to "Interface" jems, P.O. Box 1026, Solana Beach, CA 92075.*

ambulance rates, a big gap opens up between the price of service and amount your insured customers will be reimbursed. And while that gap will gradually narrow over time, until it does, folks will howl. A well publicized subscription program affords policymakers a ready and fairly effective defense against these citizen complaints.

Well done, a subscription program can do even more. Through its advertising, it can educate the public on proper use of their prehospital care system, promote CPR training, build a solid base of public support for the EMS program, and explain the reasons behind the increase in rates. It can help allay the (largely unjustified) fear that higher user fees may cause patients to avoid calling for an ambulance when, medically, they should. And contrary to a dying but still widespread belief, subscription programs can raise substantial amounts of money, even in urban areas.

*Is You Is Or Is You Ain't... Insurance.* The answer depends to some extent upon how the subscription program is structured, but mostly upon how "insurance" is defined in state law. Some state statutes define insurance as any arrangement where, in exchange for a fee in advance, the insurer promises to do something good for you if something bad happens to you first. (They say it better in the statutes, but not much better.)

Taken literally, such language would seem to include both Type I and Type II ambulance subscription programs within the legal definition of insurance. In states where the powers that be (e.g., insurance commissioners and attorneys general) insist upon interpreting the statutes so literally, it may be wise to go for additional legislation exempting ambulance subscription programs from insurance regulations.

*Better Make It Clear.* If you intend to collect from third party payors for services rendered to subscribers, first be certain that your subscription agreement and promotional materials make it very clear that your subscription program is a Type II program. Otherwise, you may find yourself successfully sued and required to pay back, to subscribers or third party payors or both, all the money you have ever collected from third party payors for services rendered to subscribers.

How come? Because if your subscription literature says things like, "A whole year of unlimited ambulance service free!" then what you're selling is prepaid ambulance service—not prepayment of uninsured amounts. Thus, if I as a Type I subscriber have already paid in advance for my ambulance services, and if you as the provider collect from third party sources for that very same service, then the money you have collected is mine—not yours.

To make matters worse, under Medicare law you cannot bill Medicare more than the amount you would charge a private paying patient for the same services. Thus, since your charges to an uninsured Type I subscriber would be limited to the amount of the annual subscription fee, then technically your total annual Medicare billings for services rendered to any given Medicare-eligible subscriber should not exceed the amount of your annual subscription fee. And even that money should be refunded to the

subscriber because, under a Type I subscription plan, he has already paid you for services in advance.

The solution to this problem is simple: If you intend to collect money from third party payors for services rendered to subscribers, just be sure your subscription contract and promotional materials make it very clear that yours is a Type II subscription program.

*Deductibles and Coinsurance.* Even for Type II subscription programs, there have remained questions regarding whether the subscription fees can count toward the subscriber's deductible, and whether the provider is at risk for failing to attempt to collect "coinsurance" amounts as required by Medicare law.

Attorney David Werfel, consultant to the American Ambulance Association, recently succeeded in obtaining from the Health Care Financing Administration (HCFA) clarification of policy regarding these issues. Quoting from HCFA's June 3, 1986 response to Mr. Werfel's letter:

> "Services furnished by an ambulance company under a subscription agreement calling for payment of an annual membership fee may be covered under Medicare only if the agreement explicitly or by clear implication authorizes the company to charge, except for applicable deductible and coinsurance, to the extent of the available Medicare or other coverages of the services. Under this type of agreement, the subscription fees for subscribers who have Medicare or other coverage become, in effect, premiums for coverage by the ambulance company of deductible and coinsurance amounts. Thus, the actual charge and customary charge reductions imposed under *Medicare Carriers Manual* section 5220 for routine waiver of deductible and coinsurance do not apply. There is no requirement, moreover, that subscription fees be uniform for all subscribers nor is there any requirement that fees be different for those subscribers who have Medicare or other insurance than for those subscribers who have no insurance."

That's about as clear-cut a statement of policy as you'll ever get out of HCFA, and what's more, it's a policy our industry and our customers can live with. This happy outcome is, I believe, partly the result of Mr. Werfel's careful drafting of the letter requesting the opinion. (How you ask a question can greatly affect the answer you get.) Mr. Werfel is clearly earning his fee.

*The Plot Thickens.* Mr. Werfel's letter also asked for an opinion on whether subscription programs might violate the anti-kickback provisions of the Social Security Act—i.e., Section 1877(b). He didn't get it.

HCFA's response: "The question of whether these (subscription) agreements involve any criminal conduct under section 1877(b) of the Social Security Act is in the jurisdiction of the Department's Office of Inspector General (OIG). . . . We understand that the OIG does not give advisory opinions on the effect of criminal statutes." Thus, we seem to be left, for the moment, in a sort of awkward situation.

*Pricing Subscription Fees.* Most subscription programs employ a uniform price per "household." However, you may wish to consider setting the subscription fee for Medicare subscribers separately. Here's why.

When you accept assignment, as you will do for all Medicare-eligible subscribers, you agree to accept Medicare's reimbursement as payment in full for the balance which would otherwise be owed by the customer. The subscription fee already paid by the subscriber satisfies the customer's obligation to pay any deductible and coinsurance which would otherwise be owed. Okay so far.

But what if, at the end of a fiscal year, it turns out that your revenues from subscription fees paid by Medicare-eligible subscribers, when added to the Medicare payments received for services rendered to those same patients, exceeds the combined "allowable charges" for all of those services? You *could* be found guilty of overcharging for services to Medicare patients on whom you have accepted assignment.

Readers already familiar with how Medicare works will immediately see the problem. For the rest of you (whose lives are obviously filled with more interesting stuff to think about), just understand that when you "accept assignment" on a Medicare patient, you are agreeing to charge Medicare no more than 80% of its "allowable charge" for that service (which may be far less than your standard rate), and you are agreeing to collect from the patient the remaining 20% and not one cent more. That's the law.

Steve Williamson, Executive Director of the Tulsa system, and manager of an unusually successful urban subscription program, has a solution to this problem that should satisfy the law. Every year, before setting the following year's subscription fees, Steve compiles

complete financial statistics related to services rendered during the past fiscal year to his Medicare-eligible subscribers. He is going after two critical pieces of financial information: first, how much money has he received both in subscription fees from Medicare-eligible subscribers *and* in Medicare payments for services rendered to those same people; and second, what is the combined total of 100% of the "allowable charges" for services rendered to those same people, plus the standard fees that would have been charged subscribers for services rendered but for which payment was denied by Medicare. The idea is to be certain that the first number (i.e., actual revenues from Medicare-eligible subscribers) does not exceed the second number (i.e., justifiable revenues from the same folks), and to set subscription fees so that revenue limits aren't exceeded next year either.

If the money you're getting from the combination of subscription fees and Medicare payments does not exceed what you could legally have received without the subscription program, then you can at least argue that your subscription program is not being used to circumvent the legal limitations on coinsurance and deductible billings. (Remember, subscription fees need not be uniform.) Oh, what tangled webs we humans weave.

*Regarding Token User Fees.* Most subscription programs today charge subscribers no user fees for "medically necessary" ambulance service. Perhaps that should change. Part of the legislative intent behind the deductibles and coinsurance provisions of the Medicare program is to provide a financial incentive for limiting unnecessary utilization of services. By eliminating that incentive, subscription programs may, to some extent, work to defeat legislative intent.

A sound and well-documented program for controlling abuse by subscribers (e.g., routine analyses of utilization patterns, objective rules for cancelling abusers' subscriptions, etc.) will help. But except in systems where the provider has no direct financial interest in fee-for-service revenues (e.g., public utility model systems), an argument can be made that, in certain cases, the provider can benefit financially from successful abuse by subscribers. The obvious solution: small user fees for subscription program members. If I were the Feds, I would require them.

*Annual Enrollment Period.* Nearly every successful subscription program allows a limited annual enrollment opportunity—usually a 30- to 60-day period. If folks think they can buy in anytime they wish, many put it off forever, or until they need it. What you don't want to wind up with is a small number of high risk subscribers—they can break you.

By concentrating your marketing efforts within a short term annual blitz, and limiting enrollment opportunity to one or two months a year, public relations benefits are maximized and a larger percentage of low risk subscribers will be attracted.

*Mutual Aid.* Most subscription programs cover intra-jurisdictional services. Even so, most emergency service providers occasionally find it necessary to respond a mutual aid provider to a call from a subscriber. In such a situation, the mutual aid provider becomes, in effect, the primary provider's subcontractor, creating several potential legal and financial complications.

I recommend specifically reserving the right in subscription agreements to employ mutual aid providers when necessary and appropriate, and incorporating into mutual aid agreements provisions to ensure that when subscribers are served by a mutual aid provider, you—not your subscriber—will pay the bill or otherwise arrange for the service to be rendered without charge to the subscriber.

*Emergency-Only Subscription Programs.* I don't recommend them. Subscription programs work best in single-provider, full service systems. When an "emergency-only" provider sells subscriptions, a powerful incentive for abuse is automatically created. (Why pay for a non-emergency transfer if you can fake the symptoms and ride free on your emergency-only subscription?)

If you're an emergency-only government provider and insist upon selling subscriptions, consider offering a full-service subscription program and subcontracting your non-emergency work to a competitively selected non-emergency firm.

*Multiple Provider Systems.* Unless you are the primary emergency services provider in a multiple provider system, offering a subscrip-

tion program may be risky. Two reasons: first, if you sell subscriptions limited to non-emergency services only, you may be inadvertently encouraging patients who should call 911 to call your number instead, and you may end up embroiled in a messy and expensive negligence suit.

Second, if you run a full service subscription program that places you in direct competition with the 911 provider for emergency calls, the day will surely come when the ambulance you sent was not the "nearest ambulance" to a subscriber's emergency, the subscriber will die, and you will be trying to convince the court that there's nothing wrong with making a buck by luring customers away from the 911 system. (Don't call me as your expert witness on that one.)

*Ingredients for Success.* Today's most successful, big-system subscription programs generally have several features in common. All are full-service programs offered by the area's primary (and often exclusive) provider. Many are offered by all-ALS, full-service, single provider systems. In nearly every case, quality of service is well above average, the local reputation of the provider is good, fee-for-service rates are set at or near full production costs, efforts to collect from non-subscribers are professional and aggressive. (Why buy a subscription when the provider always accepts assignment anyway, or when the user fees are heavily subsidized, or when nothing much happens when you don't pay your bill?)

Nearly every successful subscription program includes a serious marketing and advertising budget, a limited annual enrollment period, and employs easy access for signing up (e.g., area banks, senior citizen centers, pharmacies, etc.). In later years, most programs enjoy high rates of renewal by existing subscribers, and make active use of their billing/collection process to stimulate renewals and to market new subscribers.

*Conclusions.* Ambulance subscription programs are a natural and useful result of our industry's rapid upgrade in clinical capabilities and the unequal evolution of third party reimbursement practices. They are, however, quite complex and may not be appropriate in many situations. I suspect it is no accident that our industry's most successful subscription programs are sponsored by some of our industry's best-managed providers. □