Legislative Analysis

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SURPRISE BILLING PROTECTIONS

House Bill 4459 (proposed substitute H-6)
House Bill 4990 (proposed substitute H-1)
Sponsor: Rep. Roger Hauck

House Bill 4460 (proposed substitute H-6)
House Bill 4991 as referred to second committee
Sponsor: Rep. Frank Liberati

1st Committee: Health Policy
2nd Committee: Ways and Means
Complete to 6-24-20

BRIEF SUMMARY: House Bill 4459 would add an Article 18 (Surprise Medical Billing) to the Public Health Code to limit the possibility of high charges when patients engage a doctor or hospital outside of their insurance network. HB 4460 would require that a disclosure form on potential costs be given to certain patients by out-of-network providers. HBs 4990 and 4991 would institute penalties for violations of these requirements.

FISCAL IMPACT: The bills would have an indeterminate fiscal impact on the Department of Insurance and Financial Services (DIFS) and the Department of Licensing and Regulatory Affairs (LARA). See **Fiscal Information**, below, for a detailed analysis.

THE APPARENT PROBLEM:

A person receiving medical care expects to pay for that care, ideally with a large portion covered by the person's insurance. However, in the case of a growing problem known as "surprise medical billing," even a person whose hospital and primary physician are in the person's medical insurance network can be hit with a surprise bill for a portion of the care that occurred outside that network. In examples offered in committee, a person undergoing surgery might find out only upon opening a bill weeks later that the anesthesiologist for the surgery was out-of-network, with charges commensurately higher for that reason—and often borne by the patient alone. In recent years, various parties have been working together to take the patient out of the middle of the situation.

Legislation to forestall surprise medical billing is progressing at the federal level. In the U.S. Senate, the "Lower Health Care Costs Act"[1] was introduced in June of 2019 and reported to the floor by the Health, Education, Labor, and Pensions committee in July.

Additionally, various measures to address the issue are being considered at the state level. New York enacted legislation in 2014 to protect residents from out-of-network charges and is also one of nine states that protect consumers from both emergency and in-network hospital services. California enacted legislation in 2016 to protect patients from surprise bills from out-

[1] S. 1895-Lower Health Care Costs Act, https://www.congress.gov/bill/116th-congress/senate-bill/1895

of-network doctors that they did not choose.[2] Reportedly, at least 25 states have laws protecting patients from surprise out-of-network bills, and at least 20 states were considering legislation in 2019.[3]

Legislation has been proposed to address the issue in Michigan.

THE CONTENT OF THE BILLS:

House Bill 4459 would add an Article 18 (Surprise Medical Billing) to the Public Health Code to limit the possibility of high charges when patients engage a doctor or hospital outside of their insurance network.

Specifically, under certain circumstances, described below, the nonparticipating provider would have to accept from the patient's insurer, as payment in full, the greater of the following:

- The average amount negotiated by the patient's insurer for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. (However, a nonparticipating provider could request a review of this calculation, as described below.)
- 150% of the Medicare fee for service fee schedule for the health care service provided (excluding any in-network coinsurance, copayments, or deductibles).

[However, nothing in the proposed Article 18 would prohibit a nonparticipating provider and an insurer from agreeing, through private negotiations or an internal dispute resolution process, to a payment amount greater than these amounts.]

The nonparticipating provider could not collect or attempt to collect from the patient any amount other than the applicable coinsurance, copayment, or deductible.

Review upon request

If a nonparticipating provider believed that the average amount negotiated by the patient's health benefit plan with participating providers was incorrectly calculated, it could appeal to DIFS for a review of the calculation. DIFS could request data on this average amount negotiated by the patient's insurer with providers or other information DIFS believed was necessary for review. (That information would be protected from disclosure.) If, after review, the director determined that the amount was incorrect, he or she would determine the correct amount. A nonparticipating provider could not file a subsequent request for review involving the same rate calculation for which a nonparticipating provider had already received a determination from DIFS.

The circumstances triggering the limit for the nonparticipating provider would include any of the following:

- The health care service was provided to an ***emergency patient***, was covered by the patient's health benefit plan and was provided to him or her by the nonparticipating provider at a participating or nonparticipating health facility.

[2] Assembly Bill 72 of 2016. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72; https://dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf

[3] https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/04/05/surprise-medical-billing-some-states-ahead-of-feds

- The health care service was provided to a nonemergency patient, was covered by the patient's health benefit plan and was provided to him or her by the nonparticipating provider at a participating health facility and the patient did not have the ability or opportunity to choose a participating provider and had not been provided the disclosure required under HB 4460.
- The health care service was provided by the nonparticipating provider at a hospital that was a participating health facility within 72 hours of the emergency patient receiving health care services in the hospital's emergency room. (If this instance were the trigger, the payment limit would apply to any health care services provided by the nonparticipating provider during the emergency patient's stay.)

> ***Emergency patient*** would mean an individual with a physical or mental condition that manifests itself by acute systems of sufficient severity, including pain such that a prudent layperson, possessing average knowledge of health and medicine, could expect any or all of the following: placing the health of the person (or her child, in the case of an pregnant woman, or both) in serious jeopardy, serious impairment of bodily function, or serious dysfunction of a body organ or part.

Potential departure from reimbursement rate

A nonparticipating provider falling under the first or third bullet point, above, could file a claim with an insurer for more than 150% of the Medicaid fee if the insurer did not meet the network adequacy requirements for the type of provider that was a nonparticipating provider, under the Insurance Code or applicable federal law. This claim would have to be accompanied by clinical documentation demonstrating the ***complicating factor*** and the emergency patient's medical record for the health care service, with applicable portions highlighted.

> ***Complicating factor*** would mean a factor that is not normally incident to health care service, including the following:
> - Increased intensity, time, or technical difficulty of the health care service.
> - The severity of the patient's condition.
> - The physical or mental effort required in providing the health care service.

Reimbursement, Denial of Claims, and Arbitration

Within 30 days of receiving this claim, an insurer would have to determine that there was a complicating factor (and make an additional specified payment) or deny the claim. If the insurer denied the claim, the nonparticipating provider could request binding arbitration through DIFS, and DIFS would have to grant the request upon receipt of specified documentation.

If DIFS granted the request for binding arbitration, it would have to notify the insurer, and the insurer would have 30 days to either confirm its denial or offer an additional payment to be considered in the arbitration process

Under the bill, DIFs would have to create and maintain a list of DIFS-approved arbitrators. The parties to an arbitration proceeding would agree on an arbitrator from the list, the arbitration would include a review of written submissions, and the arbitrator would issue a written decisions within 45 days after receiving the documentation. The arbitrator would have to

consider mitigating factors such as the technical difficulty of the medical procedure and the severity of the patient's condition.

The nonparticipating provider and insurer would each pay 1/2 of the total costs of the arbitration proceeding.

Annual study and report

Beginning January 1, 2022, DIFS would have to conduct and complete an annual study that included the following information for the preceding year:

- The number of out-of-network billing complaints received by DIFS from enrollees or their authorized representatives.
- The number of complaints received by DIFS.
- For each health plan, the ratio of out-of-network billing complaints to the total number of enrollees in the health plan.
- Insurer network adequacy by provider specialty.
- The number of claims requested to be reviewed by DIFS.
- The number of requests for binding arbitration filed.

When conducting the study, DIFS could not consider insurance rates. DIFS could convene a workgroup to conduct the study or to compile and review the amounts paid to nonparticipating providers.

By July 1, 2022, and annually thereafter, DIFS would have to prepare a report on the findings of the study and provide it to the Senate and House health policy and insurance committees. DIFS would also have to post the report on its website.

Proposed MCL 333.24501 et seq.

House Bill 4460 would add a section to the proposed Article 18 to require that a disclosure form stating that the patient's health benefit plan may not provide coverage for all services, and that the patient has the right to request that the service be provided by a participating provider, be provided by a nonparticipating provider to a nonemergency patient.

The nonparticipating provider could not provide the disclosure when the nonemergency patient was being admitted (to most health care facilities) or prepared for surgery or another medical procedure, but would have to provide it at the earliest of the following:

- If it was scheduled and being provided at most health care facilities, at least 14 days before providing the health care service (or, if the service is being provided within 14 days, within those 14 days).
- If it was being provided at a physician's office or other outpatient setting not falling under the other categories for a health care facility, at the time of the nonparticipating provider's first contact with the nonemergency patient regarding the service.
- During a surgical consultation, scheduling or intake call, preoperative review, or similar contact regarding the health care service.

The bill would require the disclosure to be provided to and signed off on by the patient or patient's representative and retained by the nonparticipating provider for at least seven years.

The provider would also have to provide the patient or representative with a good-faith estimate of the services to be provided.

A nonparticipating provider who did not supply the disclosure would have to accept from the patient's insurer, as payment in full, the greater of the following:

- The average amount negotiated by the patient's insurer for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. (However, a nonparticipating provider could request a review of this calculation, as described above.)
- 150% of the Medicare fee for service fee schedule for the health care service provided (excluding any in-network coinsurance, copayments, or deductibles).

Proposed MCL 333.24509

House Bill 4990 would include failure to comply with the requirements of HB 4459 or 4460 among violations of the Public Health Code under section 16221, beginning January 1, 2021. LARA would investigate allegations of violation as it does for the offenses currently listed in that section.

MCL 333.16221

House Bill 4991 would incorporate the provisions included in HBs 4459 and 4460 so that violation of the requirements in those bills would subject the provider to a fine under section 16226 of the Public Health Code.

MCL 333.16226

Tie-bars

All four bills are tie-barred together, which means that none of them could take effect unless all of them were enacted.

FISCAL INFORMATION:

House Bill 4459 would have an indeterminate net fiscal impact on DIFS. Under the bill, DIFS would be responsible for conducting calculation reviews upon the request of nonparticipating providers and for overseeing binding arbitration if requested by a nonparticipating provider. The bill stipulates that the nonparticipating provider and the applicable insurer would each be responsible for 1/2 of the total cost of an arbitration proceeding. The bill would also require the department to complete an annual study beginning January 1, 2022, on out-of-network billing complaints. It is unclear what magnitude of costs may arise from this bill, but the cost would largely depend on the volume of requested reviews.

House Bill 4460 would not have a fiscal impact on any unit of state or local government.

House Bills 4990 and 4991 would have an indeterminate fiscal impact on LARA. House Bill 4990 would require the department to investigate allegations that grounds for disciplinary action exist due to nonparticipating providers not following requirements established in House Bill 4459 and 4460. The cost of these investigations would depend on the number of allegations requiring investigation and the complexity of those investigations. House Bill 4991 would

allow the department to assess a fine for violations where grounds for disciplinary action exist. Revenues from any fines would depend on the volume of violations.

ARGUMENTS:

For:

Proponents argued that the bills would remove patients from the middle of a difficult situation by providing them the necessary information. The bills address the instance of nonemergency patients, when there is time to ensure that providers are in-network. Under the bills, providers would have to provide patients with a disclosure stating that some services may not be in the patient's insurance plan and that patients have the right to request that they be provided by in-network professionals. According to supporters, these are common sense protections to even the playing field for patients

Against:

When the bills were first introduced, opponents argued that setting one of the options for a cost limit at 125% of the Medicare reimbursable amount was problematic. Medicare reimbursable rates have not been raised in many years, and someone would have to bear the difference between the actual cost of the service and the amount that the bill would consider to be satisfaction of the charge (i.e., 125% of the Medicare reimbursable amount).

Response:

As referred from the Health Policy committee, the rate was raised to 150%.

Against:

Opponents of the bills testified that they supported the general idea of holding patients harmless in situations where a coverage gap existed. However, they argued that health providers—especially those in private practice with slimmer margins—should not have to bear the brunt of those gaps. Rather, insurance agencies should have to cover those amounts, they argued, especially since reimbursement rates in Michigan are already too low.

POSITIONS:

Representatives of the following entities testified in <u>support</u> of the bills, with H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Michigan Association of Health Plans
Blue Cross Blue Shield of Michigan

Representatives of the following entities testified in <u>support</u> of the H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Economic Alliance for Michigan
Michigan Association of Health Underwriters

The following entities indicated <u>support</u> for the bills, with H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Michigan Manufacturers Association

The following entities indicated <u>support</u> for the H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Michigan Complete Health
America's Health Insurance Plans
Aetna

The following entities indicated support for the H-2 substitute for HB 4459. (10-17-19)

United Healthcare Group
Michigan Radiological Society

The Department of Insurance and Financial Services testified on the H-2 substitutes for HBs 4459 and 4460 and took no position on the bills. (10-17-19)

The following entities indicated a neutral position on the bills, with H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Michigan Health and Hospital Association
Michigan Association of Chiropractors
Michigan Association of Ambulance Services

Mobile Medical Response indicated a neutral position on the H-2 substitute for HB 4459. (10-17-19)

Representatives of the following entities testified in opposition to the H-2 substitutes for HBs 4459 and 4460 (10-17-19):

Michigan State Medical Society
Michigan Society of Anesthesiologists
Michigan Society of Pathologists

The Michigan Osteopathic Association indicated opposition to the H-2 substitutes for HBs 4459 and 4460. (10-17-19)

The following entities indicated opposition to the H-2 substitute for HB 4459 (10-17-19):

Michigan College of Emergency Physicians
American College of Emergency Physicians
Kalamazoo Anesthesiology
Washtenaw County Medical Society
Emergency Department Practice Management Association

Legislative Analyst: Jenny McInerney
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