# Legislative Analysis

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**SURPRISE BILLING PROTECTIONS**

**House Bills 4459 (proposed substitute H-3) and 4990 as introduced**
**Sponsor: Rep. Roger Hauck**

**House Bills 4460 (proposed substitute H-3) and 4991 as introduced**
**Sponsor: Rep. Frank Liberati**

**Committee: Health Policy**
**Revised 11-8-19**

**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.

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

- The average amount negotiated by the patient's health benefit plan with participating providers for the health care service provided, 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 amount that would be covered by Medicare for the health care service provided (excluding any in-network coinsurance, copayments, or deductibles).

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 the director of the Department of Insurance and Financial Services (DIFS) for a review of the calculation. The director (or a designee) could request data on this average amount or any documents or other information the director 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.

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

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

- The health care service was covered by a nonemergency patient's health benefit plan and was provided to him or her by the nonparticipating provider at a participating health facility and either (1) 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, or (2) the nonparticipating provider was the only provider available at the facility.
- 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.

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 being provided at most health care facilities, at least 14 days before providing the health care service. 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, as payment in full, the greater of the following:

- The average amount negotiated by the patient's health benefit plan with participating providers for the health care service provided, 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 amount that would be covered by Medicare 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 code under section 16221. The Department of Licensing and Regulatory Affairs (LARA) would investigate allegations of violation as it does for the 24 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 code.

MCL 333.16226

**Tie-bars**

All four bills are tie-barred together, which means that none could effect unless the others were also enacted.

## BACKGROUND:

**Actions in other states and at the federal level**

Legislation to forestall surprise medical billing is progressing at the federal level as well. 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-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 are considering legislation this year.[3]

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

[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

**FISCAL IMPACT:**

House Bill 4459 would have an indeterminate fiscal impact on the Department of Insurance and Financial Services (DIFS). The bill would require DIFS to conduct calculation reviews upon the request of a nonparticipating provider, which would result in additional administrative costs. The magnitude of these costs is unknown, but 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 the Department of Licensing and Regulatory Affairs (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.

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