Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 570 (Substitute S-1)
Senate Bills 571 and 573 (as introduced 10-10-19)
Senate Bill 572 (Substitute S-1)
Sponsor: Senator Lana Theis (S.B. 570 & 571)
Senator Curtis Hertel, Jr. (S.B. 572 & 573)
Committee: Insurance and Banking

Date Completed: 10-29-19

CONTENT

Senate Bill 570 (S-1) would add Article 18 (Surprise Billing Protections) to the Public Health Code to specify that a nonparticipating provider would have to accept as payment for certain health care services either the average amount negotiated by a health benefit plan with participating providers for the service provided or 150% of the amount that would be covered by Medicare, whichever were greater.

Senate Bill 572 (S-1) would amend the Code to do the following:

- **Require a nonparticipating provider to complete and provide to a nonemergency patient a disclosure containing certain information, and obtain the patient's, or his or her representative's, signature, acknowledging that the individual had received, had read, and understood the disclosure.**
- **Require a nonparticipating provider to retain a copy of the notice for at least seven years.**
- **Require a nonparticipating provider to provide the nonemergency patient or his or her representative with a good-faith estimate of the cost of the health care services to be provided to the patient.**
- **Require a nonparticipating provider who failed to provide the disclosure to accept as payment in full either the average amount negotiated by a health benefit plan with participating providers for the service provided or 150% of the amount that would be covered by Medicare, whichever were greater.**

Senate Bill 571 would amend Part 161 (General Provisions) of the Code to include a violation of Senate Bill 570 (S-1) and 572 (S-1) as grounds for disciplinary action.

Senate Bill 573 would amend Part 161 of the Code to prescribe a fine as disciplinary action for violating Senate Bill 571.

Senate Bills 570 (S-1) and 572 (S-1) are tie-barred. Senate Bills 571 and 573 are tie-barred, and both bills are tie-barred to House Bills 4459 and 4460. (Those bills would make substantially the same changes as Senate Bills 570 and 572, respectively.)

Definitions

The bill specifies that for purposes of proposed Article 18, the words and phrases defined below would have the meanings ascribed to them in the bill. In addition, Article 1 contains general definitions and principles of construction applicable to all articles in the Code.

The bill would define "emergency patient" as an individual with a physical or mental condition that manifests itself by acute symptoms of severity, including pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in one or all of the following:

-- Placing the health of the individual or, in the case of a pregnant woman, the health of the woman or the unborn child, or both, in serious jeopardy.
-- Serious impairment of bodily function.
-- Serious dysfunction of a body organ or part.

"Group health plan" would mean an employer program of health benefits, including an employee welfare benefit plan, to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or coinsurance.

"Health benefit plan" would mean a group health plan, an individual or group expense-incurred hospital, medical, or surgical policy or certificate, or an individual or group health maintenance organization contract. The term would not include accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

"Health care service" would mean a diagnostic procedure, medical or surgical procedure, examination, or other treatment.

"Health facility" would mean any of the following:

-- A hospital.
-- A freestanding surgical outpatient facility.
-- A skilled nursing facility.
-- A physician's office or other outpatient setting.
-- A laboratory.
-- A radiology or imaging center.

"Nonemergency patient" would mean an individual whose physical or mental condition is such that the individual may reasonably be suspected of not being in imminent danger of loss of life or of significant health impairment.

"Participating health facility" would mean a health facility that, under contract with an insurer that issues or administers health benefits plants, or with the insurer's contractor or subcontractor, has agreed to provide health care services to individuals who are covered by health benefits plans issued or administered by the insurer and to accept payment by the insurer, contractor, or subcontractor for the services covered by the health benefits plans as payment in full, other than coinsurance, copayments, or deductibles.

"Participating provider" would mean a provider who, under contract with an insurer that issues health benefit plans, or with the insurer's contractor or subcontractor, has agreed to provide health care services to individuals who are covered by health benefit plans issued or

administered by the insurer and to accept payment by the insurer, contractor, or subcontractor for services covered by the health benefits plan as payment in full, other than coinsurance, copayments, or deductibles.

"Patient's representative would mean any of the following:

-- A person to whom a nonemergency patient has given express written consent to represent the patient.
-- A person authorized by law to provide consent for a nonemergency patient.
-- A provider who is treating the nonemergency patient, but only if the patient is unable to provide consent.)

"Provider" would mean an individual who is licensed, registered, or otherwise authorized to engage in a health profession.

Nonparticipating Provider, Payment in Full

Under the bill, the provision described below would apply to a nonparticipating provider who was providing a health care service if any of the following applied:

-- The health care service was covered by an emergency patient's health benefit plan and was provided to the patient by the 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 the patient by the provider at a participating health facility and either of the following applied: a) the patient did not have the ability or opportunity to choose a participating provider and had not been provided the disclosure required in Senate Bill 572; or b) the only provider available to perform the health care service at the facility was a nonparticipating provider.
-- The health care service was provided by the nonparticipating provider at a hospital who was admitted to the hospital with 72 hours after receiving a health care service in the hospital's emergency room.

If any of the circumstances described above applied, a nonparticipating provider would have to accept, as payment in full, the greater of the following, and could not collect or attempt to collect from the patient any amount other than applicable coinsurance, copayment, or deductible:

-- 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.
-- 150% of the amount that would be covered by Medicare for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.

If the health care service were provided by the nonparticipating provider at a hospital that was a participating health facility to an emergency patient who was admitted to the hospital with 72 hours after receiving a health care service in the hospital's emergency room, the bill would apply to any health care service provided by a nonparticipating provider to the emergency patient during his or her hospital stay.

Senate Bill 572 (S-1)

Under the bill, a nonparticipating provider who was providing a health care service to a nonemergency patient would have to provide to the patient at the earliest of the following a disclosure specifying that the patient's health benefit plan could or could not provide coverage for the health care services, that the patient could be responsible for the costs of services not

covered by the health benefit plan, that the provider would have to provide a good-faith estimate of the costs of the services to be provided, and that the patient could contact his or her insurer to arrange for the services to be provided at a lower cost:

-- At least 14 days before providing the health care service.
-- During one of the following: a) a presurgical consultation for the service, b) a scheduling or intake call for the service, c) a preoperative review for the service, or d) any other contract occurring before a service that was similar to a contact described above.

A nonparticipating provider could not provide the disclosure to a nonemergency patient when the patient was being admitted to the health facility or when the patient was being prepared for a surgery or another medical procedure.

The disclosure would have to be at least 12-point type and be in a form substantially similar to that prescribed in the bill.

A nonparticipating provider would have to do all of the following:

-- Complete the disclosure and, after completing it, obtain on the disclosure the nonemergency patient's, or his or her representative's, signature, acknowledging that the nonemergency patient, or his or her representative, had received, had read, and understood the disclosure.
-- Retain a copy of the disclosure for at least seven years.
-- Provide the patient or his or her representative with a good-faith estimate of the cost of the health care services to be provided to the patient.

A nonparticipating provider who failed to provide the disclosure described above 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.
-- 150% of the amount that would be covered by Medicare for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.

Senate Bill 571

The Code requires the Department of Licensing and Regulatory Affairs to investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The Department may hold hearings, administer oaths, and order the taking of relevant testimony. After its investigation, the Department must provide a copy of the administrative complaint to the appropriate disciplinary subcommittee. If one or more grounds for disciplinary subcommittee action exist, the disciplinary subcommittee must impose sanctions.

Under the bill, grounds for disciplinary action would include violations of Senate Bill 570 and 572.

MCL 333.16221 (S.B. 571)
Proposed MCL 333.24509 (S.B. 572)
MCL 333.16226 (S.B. 573)

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

Senate Bill 570 (S-1)

The bill could have a marginal negative fiscal impact on public hospital revenue by effectively imposing a cap on billing and reimbursements under certain circumstances.

The bill would have no general fiscal impact on State or local government.

Senate Bills 571 and 573

The bills would have an indeterminate but likely minimal fiscal impact on State government and no fiscal impact on local units of government. The amount of revenue generated by violations of the provisions of Senate Bill 571 would depend on the magnitude of the fine and number of individuals who committed violations. Statute authorizes fines of up to $250,000. Revenues from fines would be deposited in the Health Professions Regulatory Fund.

Administrative costs would be funded by existing appropriations to the Department of Licensing and Regulatory Affairs.

Senate Bill 572 (S-1)

The bill would have no fiscal impact on State or local government.

Fiscal Analyst: Steve Angelotti
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