Senate Fiscal Agency
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BILL ANALYSIS

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House Bill 4459 (Substitute S-4 as reported)
House Bill 4460 (Substitute S-4 as reported)
House Bill 4990 (Substitute S-1 as reported)
House Bill 4991 (Substitute S-1 as reported)
Sponsor: Representative Roger Hauck (H.B. 4459 & 4990)
Representative Frank Liberati (H.B. 4460 & 4991)
House Committee: Health Policy
Ways and Means
Senate Committee: Insurance and Banking

CONTENT

House Bill 4459 (S-4) would add Article 18 (Surprise Billing Protections) to the Public Health Code to do the following:

-- Specify that, except as otherwise provided, a nonparticipating provider would have to accept, and a patient's insurer would have to pay either 150% of the Medicare fee for services fee schedule or the median amount negotiated by the patient's insurer for the region and provider specialty, whichever was greater.
-- Require a patient's insurer to pay the amount determined above to the patient or to the nonparticipating provider.
-- Beginning July 1, 2021, allow a nonparticipating provider that believed the amount negotiated by the patient's insurer was calculated incorrectly to request that the Department of Insurance and Financial Services review the calculation.
-- Allow the Department to request data on the median amount negotiated by the patient's insurer with participating providers or any documents, materials, or other information that it believed was necessary to assist it in reviewing the calculation.
-- Require the Department to determine the correct amount if, after conducting its review, it determined that the amount negotiated by the patient's insurer was calculated incorrectly.
-- Prohibit a nonparticipating provider from filing a subsequent request for review if the request involved the same rate calculation for a health care service for which the nonparticipating provider had previously received a determination from the Department.
-- Specify that any data, documents, materials, or other information would be considered proprietary and to contain trade secrets; would be confidential and privileged and not subject to disclosure under the Freedom of Information Act; and would not be subject to subpoena and would not be subject to discovery or admissible in evidence in any civil action concerning the data.
-- Allow a nonparticipating provider who provided a health care service involving a complicating factor to an emergency patient to file a claim with an insurer for a reimbursement amount greater than the amount it received as payment in full if the insurer did not meet certain network adequacy requirements, and require a claim to be accompanied by certain documentation.
-- Require an insurer to make an additional payment, if it determined that the documentation submitted with the claim demonstrated a complicating factor, or issue a letter to the

-- nonparticipating provider, if it determined that the documentation submitted with the claim did not demonstrate a complicating factor, within 30 days after receiving the claim.
-- Beginning July 1, 2021, allow a nonparticipating provider to file a written request for binding arbitration with the Department, if an insurer denied a claim.
-- Require the Department to notify the insurer if it received a request for binding arbitration from a nonparticipating provider.
-- Require the Department to create a list of approved arbitrators, and require the parties to an arbitration to agree to an arbitrator on the list.
-- Require an arbitrator to make a decision within 45 days after receiving the documentation submitted by the parties.
-- Prohibit a nonparticipating provider participating in arbitration from collecting or attempting to collect from the patient any amount other than the applicable in-network coinsurance, copayment, or deductible.
-- Specify that Article 18 would not prohibit a nonparticipating provider and an insurer from agreeing, through private negotiations or an internal dispute resolution process, to a payment amount that was greater than the amount received as full.
-- Require the Department to prepare an annual report that included certain information, including the number of out-of-network billing complaints the Department received, the number of requests made to the Department to review a calculation, and the number of requests made to the Department for binding arbitration.
-- Require the Department to prepare the report and submit it to the Legislature by July 1 each year.

House Bill 4460 (S-4) would add a section to proposed Article 18 of 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 (not taking into account unforeseen circumstances that could affect the cost of the services to be provided), and provide the estimate at the same time the patient was provided with the disclosure.
-- Require a nonparticipating provider who failed to provide the disclosure to accept, and the nonemergency patient's insurer to pay either 150% of the Medicare fee for services fee schedule or the median amount negotiated by the patient's insurer for the region and provider specialty, whichever was greater.
-- Require a patient's insurer to pay the amount determined above to the patient or to the nonparticipating provider.

House Bill 4990 (S-1) would amend Part 161 (General Provisions) of the Code to include a violation of House Bills 4459 (S-4) and 4460 (S-4) as grounds for disciplinary action, beginning January 1, 2021.

House Bill 4991 (S-1) would amend Part 161 of the Code to prescribe a fine as disciplinary action for violating House Bill 4990 (S-1).

The bills are tie-barred to each other.

Proposed MCL 333.24501 et al. (H.B. 4459)
Proposed MCL 333.24509 (H.B. 4460)
MCL 333.16221 (H.B. 4990)

Legislative Analyst: Stephen Jackson

MCL 333.16226 (H.B. 4991)

FISCAL IMPACT

House Bills 4459 (S-4) and 4460 (S-4) would cap reimbursement in certain situations, but these provisions would not apply to the State's Medicaid program as individual cost-sharing in Medicaid is strictly limited. In terms of impact on State and local governments, there would be a marginal negative fiscal impact on publicly owned hospitals and publicly affiliated clinics to the extent that those entities currently, in the set of circumstances described in the bills, bill for amounts greater than the proposed limits in the bills.

House Bill 4460 (S-4) would have a negative fiscal impact on the Department of Insurance and Financial Services and no fiscal impact on local units of government. The Department likely could use existing appropriations to fund overviews and arbitration activities. However, it is possible that a substantial caseload could result in higher expenses and additional staffing needs. The Department also would incur unknown costs related to the required study.

House Bills 4490 (S-1) and 4491 (S-1) likely would have a minor negative fiscal impact on the Department of Licensing and Regulatory Affairs. They would have no fiscal impact on local units of government.

The Department would be required to investigate violations of the provisions in House Bills 4459 (S-4) and 4460 (S-4) and collect fine revenue if fines were levied. The cost of the investigatory activities likely would be absorbed by existing appropriations; however, it would depend on the number of investigations required. An estimate for the number of likely cases is not available at this time. Fine revenue would be used for administrative and regulatory purposes pertaining to health professions.

Date Completed: 9-9-20

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