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BILL ANALYSIS

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House Bill 4459 (Substitute H-6 as passed by the House)
House Bill 4460 (Substitute H-6 as passed by the House)
House Bill 4990 (Substitute H-1 as passed by the House)
House Bill 4991 (as passed by the House)
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

Date Completed: 7-29-20

CONTENT

House Bill 4459 (H-6) 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 to the patient or the nonparticipating provider, as payment in full for certain health care services, either the average amount negotiated by the patient's insurer for the region and provider specialty or 150% of the Medicare fee for services fee schedule, whichever was greater.**
- **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 average 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 determined 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 (FOIA); 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.

-- 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 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.

-- 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 conduct, beginning January 1, 2022, an annual study 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 submit a written report on the study to the Legislature by July 1 each year.

<u>House Bill 4460 (H-6)</u> 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 (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 as payment in full either the average amount negotiated by the nonemergency patient's insurer for the region and provided specialty or 150% of the Medicare fee for service fee schedule for the health care service provided.

<u>House Bill 4990 (H-1)</u> would amend Part 161 (General Provisions) of the Code to include a violation of House Bills 4459 (H-6) and 4460 (H-6) as grounds for disciplinary action, beginning January 1, 2021.

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

The bills are tie-barred to each other. The bills, except House Bill 4991, are described in greater detail below.

House Bill 4459 (H-6)

Definitions

The bill specifies that for purposes of 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 more 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, that is not otherwise described in the bill.
- 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, agrees 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. The term would not include a dentist.

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 service was provided to an emergency patient, was covered by the patient's health benefit plan, and was provided to the patient by the provider at a participating or nonparticipating health facility.
-- The service was provided to a nonemergency patient, was covered by the patient's health benefit plan, and was provided to the patient by the nonparticipating provider at a participating health facility and the nonemergency patient did not have the ability or opportunity to choose a participating provider and had not been provided the disclosure required in House Bill 4460 (H-6).
-- The service was provided by the nonparticipating provider at a hospital who was admitted to the hospital within 72 hours after receiving a health care service in the hospital's emergency room.

Except as otherwise provided, if any of the circumstances described above applied, a nonparticipating provider would have to accept, and the patient's insurer would have to pay to the patient or the nonparticipating provider, as payment in full, the greater of the following, and the nonparticipating provider could not collect or attempt to collect from the patient any amount greater than the applicable in-network coinsurance, copayment, or deductible:

-- The average amount negotiated by the patient's insurer for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles.
-- 150% of the Medicare fee for service fee schedule 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.

Review of Payment Amount

Under the bill, if a nonparticipating provider believed that the amount negotiated by the patient's insurer was calculated incorrectly, it could make a request to the Department for a review of the calculation.

The Department could request data on the average 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 of the amount negotiated by the patient's insurer and could consult an external database that contained the negotiated rates under the patient's health benefit plan for the applicable health care service. For purposes of conducting a review, any data, documents, materials, or other information requested by the Department would have to be submitted only to the Department.

If, after conducting its review, the Department determined that the amount negotiated by the patient's insurer was calculated incorrectly, it would have to determine the correct amount. A nonparticipating provider could not file 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.

All of the following would apply to any data, documents, materials, or other information that were in the possession or control of the Department and that were obtained by, created by, or disclosed to the Director or a Department employee for the purposes of a review:

-- The data, documents, materials, or other information would be considered proprietary and to contain trade secrets.
-- The data, documents, materials, or other information would be confidential and privileged and would not be subject to disclosure under FOIA.
-- The data, documents, materials, or other information would not be subject to subpoena and would not be subject to discovery or admissible in evidence in any civil action concerning the data.

The Director or a Department employee who received data, documents, materials, or other information could not testify in any private civil action concerning the data, documents, materials, or information.

Complicating Factors

The bill would 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 the network adequacy requirements established under Section 3428 of the Insurance Code or applicable Federal law, for the type of provider that was the nonparticipating provider. The 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 portions of the record supporting the complicating factor highlighted.

(Under Section 3428, an insurer that delivers, issues for delivery, or renews in Michigan a health insurance policy must establish and maintain a provider network that, at minimum, satisfies any network adequacy requirements imposed by the Director under Federal law.)

"Complicating factor" would mean a factor that is not normally incident to a health care services, 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.

An insurer would have to do one of the following within 30 days after receiving the claim:

- -- Make one additional payment that was 25% of the amount negotiated by the insurer, if it determined that the documentation submitted with the claim demonstrated a complicating factor.
- -- Issue a letter to the nonparticipating provider, if the insurer determined that the documentation submitted with the claim did not demonstrate a complicating factor.

Arbitration

Under the bill, if an insurer denied a claim, the nonparticipating provider could file a written request for binding arbitration with the Department on a form and in a manner required by the Department. The Department would have to accept the request for binding arbitration if it received all of the following from the nonparticipating provider:

- -- The documentation that the nonparticipating provider submitted to the insurer.
- -- The contact information for the emergency patient's health benefit plan.
- -- The denial letter.

If the Department accepted the request for binding arbitration, it would have to notify the insurer. Within 30 days after receiving the Department's notification, the insurer would have to submit written documentation to the Department either confirming the insurer's denial or providing an alternative payment offer to be considered in the arbitration process.

The Department would have to create a list of Department-approved arbitrators who were trained by the American Arbitration Association or American Health Layers Association for purposes of providing binding arbitration. The parties to the arbitration would have to agree on an arbitrator from the list. The arbitration would have to include a review of written submissions by both parties, including alternative payment offers, and the arbitrator would have to provide a written decision within 45 days after receiving the documentation submitted by the parties.

In making a determination, the arbitration would have to consider documentation supporting the use of a procedure code or modifier for care provided beyond the usual health care services and any of 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.

The nonparticipating provider and the insurer each would have to pay one-half of the total costs of the arbitration proceeding.

The bill would not limit any other review process provided under Article 18.

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 payment in full.

Annual Study

The bill would require the Department to conduct and complete, beginning January 1, 2022,

an annual study that, except as otherwise provided, included the following information for the immediately preceding calendar year:

-- The number of out-of-network billing complaints received by the Department from enrollees or their authorized representatives.
-- The number of complaints received by the Department from enrollees or their authorized representatives, separated by provider specialty.
-- 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 requests made to the department for to review a calculation.
-- The number of requests filed for binding arbitration.

The Department could not consider insurance rates when conducting the study. The Department could convene a workgroup for purposes of conducting the study or to compile and review the amounts paid to nonparticipating providers under Article 18.

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

House Bill 4460 (H-6)

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 (not taking into account unforeseen circumstances that could affect the cost 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 and to receive information on in-network providers who could perform the service that the patient needed:

-- At least 14 days before providing the health care service, if the health care service were scheduled and were being provided in a hospital, a freestanding surgical outpatient facility, a skilled nursing facility, a laboratory, or a radiology or imaging center, or within 14 days, if the health care services would be provided within 14 days after scheduling the health care service.
-- At the time of nonparticipating provider's first contact with the nonemergency patient regarding the health care service, if the health care service were being provided in a physician's office or other outpatient setting.
-- 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 at the time of his or her admittance to a hospital, a freestanding surgical outpatient facility, a skilled

nursing facility, a laboratory, or a radiology or imaging center or at the time of preparing the patient 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.

Except as otherwise provided, a nonparticipating provider who failed to provide the disclosure described above would have to accept, and the nonemergency patient's insurer would have to pay to the nonemergency patient or the nonparticipating provider, as payment in full, the greater of the following:

-- The average amount negotiated by the nonemergency patient's insurer for the region and provided specialty, excluding any in-network coinsurance, copayments, or deductibles.
-- 150% of the Medicare fee for service fee schedule for the health care service provided, excluding any in-network coinsurance, copayments, or deductibles.

House Bill 4990 (H-1)

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 House Bills 4459 (H-6) and 4460 (H-6).

Proposed MCL 24501 et al. (H.B. 4459)
Proposed MCL 24509 (H.B. 4460)
MCL 333.16221 (H.B. 4990)
333.16226 (H.B. 4991)

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

House Bills 4459 (H-6) & 4460 (H-6)

House Bills 4459 (H-6) and 4460 (H-6) 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 (H-6) 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 sufficiently 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 (H-1) & 4491

The bills 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 (H-6) and 4460 (H-6) 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.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.