

SENATE SUBSTITUTE FOR
HOUSE BILL NO. 4459

A bill to amend 1978 PA 368, entitled
"Public health code,"
(MCL 333.1101 to 333.25211) by adding article 18.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 ARTICLE 18. SURPRISE MEDICAL BILLING

2 Sec. 24501. (1) For purposes of this article, the words and
3 phrases defined in sections 24502 to 24504 have the meanings
4 ascribed to them in those sections.

5 (2) In addition, article 1 contains general definitions and
6 principles of construction applicable to all articles in this code.

7 Sec. 24502. (1) "Carrier" means any of the following:

8 (a) A person that issues a health benefit plan in this state,
9 including an insurer, health maintenance organization, or any other

1 person providing a plan of health benefits, coverage, or insurance
2 subject to state insurance regulation.

3 (b) An entity that contracts with this state or a local unit
4 of government to provide, deliver, arrange for, pay for, or
5 reimburse any of the costs of health care services provided under a
6 self-funded plan established or maintained by the state or local
7 unit of government for its employees.

8 (2) "Department" means the department of insurance and
9 financial services.

10 (3) "Director" means the director of the department or his or
11 her designee.

12 (4) "Emergency patient" means an individual with a physical or
13 mental condition that manifests itself by acute symptoms of
14 sufficient severity, including, but not limited to, pain such that
15 a prudent layperson, possessing average knowledge of health and
16 medicine, could reasonably expect to result in 1 or more of the
17 following:

18 (a) Placing the health of the individual or, in the case of a
19 pregnant woman, the health of the woman or the unborn child, or
20 both, in serious jeopardy.

21 (b) Serious impairment of bodily function.

22 (c) Serious dysfunction of a body organ or part.

23 (5) "Health benefit plan" means an individual or group
24 expense-incurred hospital, medical, or surgical policy or
25 certificate, an individual or group health maintenance organization
26 contract, or a self-funded plan established or maintained by this
27 state or a local unit of government for its employees. Health
28 benefit plan does not include accident-only, credit, dental, or
29 disability income insurance; long-term care insurance; coverage

1 issued as a supplement to liability insurance; coverage only for a
2 specified disease or illness; worker's compensation or similar
3 insurance; or automobile medical-payment insurance.

4 (6) "Health care service" means a diagnostic procedure,
5 medical or surgical procedure, examination, or other treatment.

6 (7) "Health facility" means any of the following:

7 (a) A hospital.

8 (b) A freestanding surgical outpatient facility as that term
9 is defined in section 20104.

10 (c) A skilled nursing facility as that term is defined in
11 section 20109.

12 (d) A physician's office or other outpatient setting, that is
13 not otherwise described in this subsection.

14 (e) A laboratory.

15 (f) A radiology or imaging center.

16 (8) "Health maintenance organization" means that term as
17 defined in section 3501 of the insurance code of 1956, 1956 PA 218,
18 MCL 500.3501.

19 (9) "Hospital" means that term as defined in section 20106.

20 (10) "Insurer" means that term as defined in section 106 of
21 the insurance code of 1956, 1956 PA 218, MCL 500.106.

22 Sec. 24503. (1) "Local unit of government" means that term as
23 defined in section 1 of 2006 PA 495, MCL 550.1951.

24 (2) "Nonemergency patient" means an individual whose physical
25 or mental condition is such that the individual may reasonably be
26 suspected of not being in imminent danger of loss of life or of
27 significant health impairment.

28 (3) "Nonparticipating health facility" means a health facility
29 that is not a participating health facility.

1 (4) "Nonparticipating provider" means a provider who is not a
2 participating provider.

3 Sec. 24504. (1) "Participating health facility" means a health
4 facility that, under contract with a carrier, or with the carrier's
5 contractor or subcontractor, agrees to provide health care services
6 to individuals who are covered by health benefit plans issued or
7 administered by the carrier and to accept payment by the carrier,
8 contractor, or subcontractor for the services covered by the health
9 benefit plans as payment in full, other than coinsurance,
10 copayments, or deductibles.

11 (2) "Participating provider" means a provider who, under
12 contract with a carrier, or with the carrier's contractor or
13 subcontractor, agrees to provide health care services to
14 individuals who are covered by health benefit plans issued or
15 administered by the carrier and to accept payment by the carrier,
16 contractor, or subcontractor for the services covered by the health
17 benefit plans as payment in full, other than coinsurance,
18 copayments, or deductibles.

19 (3) "Patient's representative" means any of the following:

20 (a) A person to whom a nonemergency patient has given express
21 written consent to represent the patient.

22 (b) A person authorized by law to provide consent for a
23 nonemergency patient.

24 (c) A provider who is treating a nonemergency patient, but
25 only if the patient is unable to provide consent.

26 (4) "Provider" means an individual who is licensed,
27 registered, or otherwise authorized to engage in a health
28 profession under article 15, but does not include a dentist
29 licensed under part 166.

1 Sec. 24507. (1) Subsection (2) applies to a nonparticipating
2 provider who is providing a health care service if any of the
3 following apply:

4 (a) The health care service is provided to an emergency
5 patient, is covered by the emergency patient's health benefit plan,
6 and is provided to the emergency patient by the nonparticipating
7 provider at a participating health facility or nonparticipating
8 health facility.

9 (b) All of the following apply:

10 (i) The health care service is provided to a nonemergency
11 patient.

12 (ii) The health care service is covered by the nonemergency
13 patient's health benefit plan.

14 (iii) The health care service is provided to the nonemergency
15 patient by the nonparticipating provider at a participating health
16 facility.

17 (iv) Either of the following:

18 (A) The nonemergency patient does not have the ability or
19 opportunity to choose a participating provider.

20 (B) The nonemergency patient has not been provided the
21 disclosure required under section 24509.

22 (c) The health care service is provided by the
23 nonparticipating provider at a hospital that is a participating
24 health facility to an emergency patient who was admitted to the
25 hospital within 72 hours after receiving a health care service in
26 the hospital's emergency room.

27 (2) Except as otherwise provided in section 24511 or 24513 and
28 subject to subsection (4), if any of the circumstances described in
29 subsection (1) apply, the nonparticipating provider shall submit a

1 claim to the patient's carrier within 60 days after the date of the
2 health care service and shall accept from the patient's carrier, as
3 payment in full, the greater of the following:

4 (a) Subject to section 24510, the median amount negotiated by
5 the patient's carrier for the region and provider specialty,
6 excluding any in-network coinsurance, copayments, or deductibles.
7 The patient's carrier shall determine the region and provider
8 specialty for purposes of this subdivision.

9 (b) One hundred and fifty percent of the Medicare fee for
10 service fee schedule for the health care service provided,
11 excluding any in-network coinsurance, copayments, or deductibles.

12 (3) If the circumstance described in subsection (1)(c)
13 applies, this section applies to any health care service provided
14 by a nonparticipating provider to the emergency patient during his
15 or her hospital stay.

16 (4) A patient's carrier shall pay the amount described in
17 subsection (2) to the nonparticipating provider within 60 days
18 after receiving the claim from the nonparticipating provider under
19 subsection (2). The nonparticipating provider shall not collect or
20 attempt to collect from the patient any amount other than the
21 applicable in-network coinsurance, copayment, or deductible.

22 Sec. 24510. (1) Beginning July 1, 2021, if a nonparticipating
23 provider believes that the amount described in section 24507(2)(a)
24 or 24509(5)(a) was incorrectly calculated, the nonparticipating
25 provider may make a request to the department for a review of the
26 calculation. The request must be made on a form and in a manner
27 required by the department.

28 (2) The department may request data on the median amount
29 negotiated by the patient's carrier with participating providers or

1 any documents, materials, or other information that the department
2 believes is necessary to assist the department in reviewing the
3 calculation described in subsection (1) and may consult an external
4 database that contains the negotiated rates under the patient's
5 health benefit plan for the applicable health care service. For
6 purposes of conducting a review under this section, any data,
7 documents, materials, or other information requested by the
8 department must only be submitted to the department.

9 (3) If, after conducting its review under this section, the
10 department determines that the amount described in section
11 24507(2) (a) or 24509(5) (a) was incorrectly calculated, the
12 department shall determine the correct amount. A nonparticipating
13 provider shall not file a subsequent request for a review under
14 subsection (1) if the request involves the same rate calculation
15 for a health care service for which the nonparticipating provider
16 has previously received a determination from the department under
17 this section.

18 (4) All of the following apply to any data, documents,
19 materials, or other information described in subsection (2) that
20 are in the possession or control of the department and that are
21 obtained by, created by, or disclosed to the director or a
22 department employee for purposes of this section:

23 (a) The data, documents, materials, or other information is
24 considered proprietary and to contain trade secrets.

25 (b) The data, documents, materials, or other information are
26 confidential and privileged and are not subject to disclosure under
27 the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

28 (c) The data, documents, materials, or other information are
29 not subject to subpoena and are not subject to discovery or

1 admissible in evidence in any private civil action.

2 (5) The director or a department employee who receives data,
3 documents, materials, or other information under this section shall
4 not testify in any private civil action concerning the data,
5 documents, materials, or information.

6 Sec. 24511. (1) A nonparticipating provider who provides a
7 health care service involving a complicating factor to an emergency
8 patient described in section 24507(1)(a) or (c) may file a claim
9 with a carrier for a reimbursement amount that is greater than the
10 amount described in section 24507(2). The claim must be accompanied
11 by both of the following:

12 (a) Clinical documentation demonstrating the complicating
13 factor.

14 (b) The emergency patient's medical record for the health care
15 service, with the portions of the record supporting the
16 complicating factor highlighted.

17 (2) A carrier shall do 1 of the following within 30 days after
18 receiving the claim described in subsection (1):

19 (a) If the carrier determines that the documentation submitted
20 with the claim demonstrates a complicating factor, make 1
21 additional payment that is 25% of the amount provided under section
22 24507(2)(a).

23 (b) If the carrier determines that the documentation submitted
24 with the claim does not demonstrate a complicating factor, issue a
25 letter to the nonparticipating provider denying the claim.

26 (3) If a carrier denies a claim under subsection (2),
27 beginning July 1, 2021, the nonparticipating provider may file a
28 written request for binding arbitration with the department on a
29 form and in a manner required by the department. The department

1 shall accept the request for binding arbitration if the department
2 receives all of the following from the nonparticipating provider:

3 (a) The documentation that the nonparticipating provider
4 submitted to the carrier under subsection (1).

5 (b) The contact information for the emergency patient's health
6 benefit plan.

7 (c) The denial letter described in subsection (2).

8 (4) If the request for binding arbitration under subsection
9 (3) is accepted by the department, the department shall notify the
10 carrier. Within 30 days after receiving the department's
11 notification under this subsection, the carrier shall submit
12 written documentation to the department either confirming the
13 carrier's denial or providing an alternative payment offer to be
14 considered in the arbitration process.

15 (5) The department shall create and maintain a list of
16 arbitrators approved by the department who are trained by the
17 American Arbitration Association or American Health Lawyers
18 Association for purposes of providing binding arbitration under
19 this section. The parties to the arbitration shall agree on an
20 arbitrator from the department's list. The arbitration must include
21 a review of written submissions by both parties, including
22 alternative payment offers, and the arbitrator shall provide a
23 written decision within 45 days after receiving the documentation
24 submitted by the parties. In making a determination, the arbitrator
25 shall consider documentation supporting the use of a procedure code
26 or modifier for care provided beyond the usual health care service
27 and any of the following:

28 (a) Increased intensity, time, or technical difficulty of the
29 health care service.

1 (b) The severity of the patient's condition.

2 (c) The physical or mental effort required in providing the
3 health care service.

4 (6) The nonparticipating provider and the carrier shall each
5 pay 1/2 of the total costs of the arbitration proceeding. A
6 nonparticipating provider participating in arbitration under this
7 section shall not collect or attempt to collect from the patient
8 any amount other than the applicable in-network coinsurance,
9 copayment, or deductible.

10 (7) This section does not limit any other review process
11 provided under this article.

12 (8) As used in this section, "complicating factor" means a
13 factor that is not normally incident to a health care service,
14 including, but not limited to, the following:

15 (a) Increased intensity, time, or technical difficulty of the
16 health care service.

17 (b) The severity of the patient's condition.

18 (c) The physical or mental effort required in providing the
19 health care service.

20 Sec. 24513. This article does not prohibit a nonparticipating
21 provider and a carrier from agreeing, through private negotiations
22 or an internal dispute resolution process, to a payment amount that
23 is greater than the amounts described in section 24507(2) or
24 24509(5). A nonparticipating provider entering into an agreement
25 authorized under this section shall not collect or attempt to
26 collect from the patient any amount other than the applicable in-
27 network coinsurance, copayment, or deductible.

28 Sec. 24515. (1) Subject to subsection (3), the department
29 shall prepare an annual report that, except as otherwise provided

1 in subsection (2), includes, but is not limited to, the following
2 information for the immediately preceding calendar year:

3 (a) The number of out-of-network billing complaints received
4 by the department from enrollees or their authorized
5 representatives.

6 (b) The number of complaints received by the department from
7 enrollees or their authorized representatives, separated by
8 provider specialty.

9 (c) For each health plan, the ratio of out-of-network billing
10 complaints to the total number of enrollees in the health plan.

11 (d) Carrier network adequacy by provider specialty.

12 (e) The number of requests made to the department under
13 section 24510(1).

14 (f) The number of requests for binding arbitration filed under
15 section 24511(3).

16 (2) The department shall not consider insurance rates when
17 preparing the report required under this section.

18 (3) By July 1 of the year following the year of the effective
19 date of the amendatory act that added this article, and by every
20 July 1 thereafter, the department shall prepare the report required
21 under this section and provide the report to the senate and house
22 of representatives standing committees on health policy and
23 insurance. The department shall also post the report on the
24 department's website.

25 Sec. 24517. The department may promulgate rules to implement
26 sections 24510 and 24511. However, the department or another
27 department of this state shall not promulgate rules to implement
28 any other section in this article.

29 Enacting section 1. This amendatory act does not take effect

1 unless all of the following bills of the 100th Legislature are
2 enacted into law:

3 (a) House Bill No. 4460.

4 (b) House Bill No. 4990.

5 (c) House Bill No. 4991.