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:

ARTICLE 18. SURPRISE MEDICAL BILLING

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

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

Sec. 24502. (1) "Department" means the department of insurance and financial services.

(2) "Director" means the director of the department or his or

her designee.

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

(a) 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.

(b) Serious impairment of bodily function.

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

(4) "Group health plan" means an employer program of health benefits, including an employee welfare benefit plan as that term is defined in 29 USC 1002 or a governmental plan as that term is defined in 29 USC 1002, 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 otherwise.

(5) "Health benefit plan" means 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. Health benefit plan does 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.

(6) "Health care service" means a diagnostic procedure,

medical or surgical procedure, examination, or other treatment.

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

(a) A hospital.

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

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

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

(e) A laboratory.

(f) A radiology or imaging center.

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

(9) "Insurer" means any of the following:

(a) An insurer or health maintenance organization regulated under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(b) A sponsor of a group health plan.

(c) A self-insured governmental group health plan that is sponsored by this state or a political subdivision of this state and that is exempt under 29 USC 1003(b)(1) from title I of the employee retirement income security act of 1974, Public Law 93-406, and any contractor and subcontractor of the self-insured governmental group health plan.

Sec. 24503. (1) "Nonemergency patient" means 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.

(2) "Nonparticipating health facility" means a health facility that is not a participating health facility.

(3) "Nonparticipating provider" means a provider who is not a participating provider.

Sec. 24504. (1) "Participating health facility" means a health facility that, under contract with an insurer that issues or administers 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 the services covered by the health benefit plans as payment in full, other than coinsurance, copayments, or deductibles.

(2) "Participating provider" means a provider who, under contract with an insurer that issues or administers 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 the services covered by the health benefit plans as payment in full, other than coinsurance, copayments, or deductibles.

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

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

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

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

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

licensed under part 166.

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

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

(b) All of the following apply:

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

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

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

(*iv*) Either of the following:

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

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

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

(2) Except as otherwise provided in section 24511 or 24513 and subject to subsection (4), if any of the circumstances described in

subsection (1) apply, the nonparticipating provider shall accept, and the patient's insurer shall pay, the greater of the following:

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

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

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

(4) A patient's insurer shall pay the amount described in subsection (2) to the patient or to the nonparticipating provider. If an insurer pays the patient the amount described in subsection (2), the insurer shall inform the patient that he or she is responsible for paying the nonparticipating provider directly for the amount billed by the nonparticipating provider. If a nonparticipating provider receives the amount described in subsection (2) from the patient or the patient's insurer, the nonparticipating provider shall accept the amount as payment in full and shall not collect or attempt to collect from the patient any amount other than the applicable in-network coinsurance, copayment, or deductible. If the nonparticipating provider does not receive the amount described in subsection (2) from the patient or the patient's insurer, the nonparticipating provider is limited to collecting the amount described in subsection (2) from the patient

or the patient's insurer as payment in full but may collect the applicable in-network coinsurance, copayment, or deductible from the patient.

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

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

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

(4) All of the following apply to any data, documents,

materials, or other information described in subsection (2) that are in the possession or control of the department and that are obtained by, created by, or disclosed to the director or a department employee for purposes of this section:

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

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

(c) The data, documents, materials, or other information are not subject to subpoena and are not subject to discovery or admissible in evidence in any private civil action.

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

Sec. 24511. (1) A nonparticipating provider who provides a health care service involving a complicating factor to an emergency patient described in section 24507(1)(a) or (c) may file a claim with an insurer for a reimbursement amount greater than the amount described in section 24507(2) if the insurer does not meet the network adequacy requirements established under section 3428 of the insurance code of 1956, 1956 PA 218, MCL 500.3428, or applicable federal law, for the type of provider that is the nonparticipating provider. The claim must be accompanied by both of the following:

(a) Clinical documentation demonstrating the complicating factor.

(b) The emergency patient's medical record for the health care service, with the portions of the record supporting the

complicating factor highlighted.

(2) An insurer shall do 1 of the following within 30 days after receiving the claim described in subsection (1):

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

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

(3) If an insurer denies a claim under subsection (2), beginning July 1, 2021, the nonparticipating provider may file a written request for binding arbitration with the department on a form and in a manner required by the department. The department shall accept the request for binding arbitration if the department determines that the insurer does not meet the network adequacy requirements described in subsection (1) and the department receives all of the following from the nonparticipating provider:

(a) The documentation that the nonparticipating provider submitted to the insurer under subsection (1).

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

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

(4) If the request for binding arbitration under subsection (3) is accepted by the department, the department shall notify the insurer. Within 30 days after receiving the department's notification under this subsection, the insurer shall 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.

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

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

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

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

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

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

(8) As used in this section, "complicating factor" means a factor that is not normally incident to a health care service,

including, but not limited to, the following:

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

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

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

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

Sec. 24515. (1) Subject to subsection (3), the department shall prepare an annual report that, except as otherwise provided in subsection (2), includes, but is not limited to, the following information for the immediately preceding calendar year:

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

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

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

(d) Insurer network adequacy by provider specialty.

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

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

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

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

Sec. 24517. Other than prescribing the manner in which required forms are to be submitted under sections 24510 and 24511, the department or any other department of this state shall not promulgate rules to implement this article.

Enacting section 1. This amendatory act does not take effect unless all of the following bills of the 100th Legislature are enacted into law:

(a) House Bill No. 4460.

(b) House Bill No. 4990.

(c) House Bill No. 4991.