

**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) "Department" means the department of insurance
8 and financial services.

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



1 her designee.

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

8 (a) Placing the health of the individual or, in the case of a
9 pregnant woman, the health of the woman or the unborn child, or
10 both, in serious jeopardy.

11 (b) Serious impairment of bodily function.

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

13 (4) "Group health plan" means an employer program of health
14 benefits, including an employee welfare benefit plan as defined in
15 section 3(1) of subtitle A of title I of the employee retirement
16 income security act of 1974, Public Law 93-406, 29 USC 1002, to the
17 extent that the plan provides medical care, including items and
18 services paid for as medical care to employees or their dependents
19 as defined under the terms of the plan directly or through
20 insurance, reimbursement, or otherwise.

21 (5) "Health benefit plan" means a group health plan, an
22 individual or group expense-incurred hospital, medical, or surgical
23 policy or certificate, or an individual or group health maintenance
24 organization contract. Health benefit plan does not include
25 accident-only, credit, dental, or disability income insurance;
26 long-term care insurance; coverage issued as a supplement to
27 liability insurance; coverage only for a specified disease or
28 illness; worker's compensation or similar insurance; or automobile
29 medical-payment insurance.



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

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

4 (a) A hospital.

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

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

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

11 (e) A laboratory.

12 (f) A radiology or imaging center.

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

14 Sec. 24503. (1) "Nonemergency patient" means an individual
15 whose physical or mental condition is such that the individual may
16 reasonably be suspected of not being in imminent danger of loss of
17 life or of significant health impairment.

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

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

22 Sec. 24504. (1) "Participating health facility" means a health
23 facility that, under contract with an insurer that issues or
24 administers health benefit plans, or with the insurer's contractor
25 or subcontractor, agrees to provide health care services to
26 individuals who are covered by health benefit plans issued or
27 administered by the insurer and to accept payment by the insurer,
28 contractor, or subcontractor for the services covered by the health
29 benefit plans as payment in full, other than coinsurance,



1 copayments, or deductibles.

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

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

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

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

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

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

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

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

29 (b) The health care service is provided to a nonemergency



1 patient, is covered by the nonemergency patient's health benefit
2 plan, and is provided to the nonemergency patient by the
3 nonparticipating provider at a participating health facility and
4 the nonemergency patient does not have the ability or opportunity
5 to choose a participating provider and has not been provided the
6 disclosure required under section 24509.

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

12 (2) Except as otherwise provided in section 24511 or 24513, if
13 any of the circumstances described in subsection (1) apply, the
14 nonparticipating provider shall accept, and the patient's insurer
15 shall pay to the patient or the nonparticipating provider, as
16 payment in full, the greater of the following, and the
17 nonparticipating provider shall not collect or attempt to collect
18 from the patient any amount greater than the applicable in-network
19 coinsurance, copayment, or deductible:

20 (a) Subject to section 24510, the average amount negotiated by
21 the patient's insurer for the region and provider specialty,
22 excluding any in-network coinsurance, copayments, or deductibles.

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

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



1 Sec. 24510. (1) If a nonparticipating provider believes that
2 the amount described in section 24507(2) (a) or 24509(5) (a) was
3 incorrectly calculated, the nonparticipating provider may make a
4 request to the department for a review of the calculation.

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

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

24 (4) All of the following apply to any data, documents,
25 materials, or other information described in subsection (2) that
26 are in the possession or control of the department and that are
27 obtained by, created by, or disclosed to the director or a
28 department employee for purposes of this section:

29 (a) The data, documents, materials, or other information is



1 considered proprietary and to contain trade secrets.

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

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

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

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

21 (a) Clinical documentation demonstrating the complicating
22 factor.

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

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

28 (a) If the insurer determines that the documentation submitted
29 with the claim demonstrates a complicating factor, make 1



1 additional payment that is 25% of the amount provided under section
2 24507(2) (a) .

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

6 (3) If an insurer denies a claim under subsection (2), the
7 nonparticipating provider may file a written request for binding
8 arbitration with the department on a form and in a manner required
9 by the department. The department shall accept the request for
10 binding arbitration if it receives all of the following from the
11 nonparticipating provider:

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

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

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

17 (4) If the request for binding arbitration under subsection
18 (3) is accepted by the department, the department shall notify the
19 insurer. Within 30 days after receiving the department's
20 notification under this subsection, the insurer shall submit
21 written documentation to the department either confirming the
22 insurer's denial or providing an alternative payment offer to be
23 considered in the arbitration process.

24 (5) The department shall create and maintain a list of
25 arbitrators approved by the department who are trained by the
26 American Arbitration Association or American Health Lawyers
27 Association for purposes of providing binding arbitration under
28 this section. The parties to the arbitration shall agree on an
29 arbitrator from the department's list. The arbitration must include



1 a review of written submissions by both parties, including
2 alternative payment offers, and the arbitrator shall provide a
3 written decision within 45 days after receiving the documentation
4 submitted by the parties. In making a determination, the
5 arbitration shall consider documentation supporting the use of a
6 procedure code or modifier for care provided beyond the usual
7 health care service and any of the following:

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

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

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

13 (6) The nonparticipating provider and the insurer shall each
14 pay 1/2 of the total costs of the arbitration proceeding.

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

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

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

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

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

25 Sec. 24513. This article does not prohibit a nonparticipating
26 provider and an insurer from agreeing, through private negotiations
27 or an internal dispute resolution process, to a payment amount that
28 is greater than the amounts described in section 24507(2) or
29 24509(5).



1 Sec. 24515. (1) Beginning January 1, 2022, the department
2 shall conduct and complete an annual study that, except as
3 otherwise provided in subsection (2), includes, but is not limited
4 to, the following information for the immediately preceding
5 calendar year:

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

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

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

14 (d) Insurer network adequacy by provider specialty.

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

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

19 (2) The department shall not consider insurance rates when
20 conducting the study required under this section.

21 (3) The department may convene a workgroup for purposes of
22 conducting the study required under this section or to compile and
23 review the amounts paid to nonparticipating providers under this
24 article.

25 (4) By July 1, 2022, and annually thereafter, the department
26 shall prepare a written report on the findings of the department's
27 study under this section and provide it to the senate and house of
28 representatives standing committees on health policy and insurance.
29 The department shall also post the report on the department's



1 **website.**

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

5 (a) House Bill No. 4460.

6 (b) House Bill No. 4990.

7 (c) House Bill No. 4991.

