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GREAT LAKES HFMA CHAPTER
ANNUAL REIMBURSEMENT UPDATE
SURPRISE BILLING LEGISLATION
MARCH 23, 2021

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Thanks To Maureen Smith and Ed Coyle!

HANDOUTS: Copies of Michigan and Federal no surprise laws. (Some minor variance in slides.)

Disclaimer: This presentation is not intended to provide legal advice. Questions encouraged but *please do not ask questions regarding specific persons or entities.*

Discussion Topics

- Ken:
  - What Is The Surprise Billing Problem?
  - Prior Law
  - Michigan Surprise Billing Law
- Melissa
- Federal Surprise Billing Law

WHAT IS THE SURPRISE BILLING PROBLEM?

"Surprise billing" (also referred to as "balance billing") is the term frequently used when an out-of-network provider (either a professional or a facility) bills a patient for non-emergency services who is unaware that the provider is out of network

Example: Hospital treating the patient may be in network, the radiology practice may be out of network. The patient is then "surprised" to receive an unexpected bill and the requirement to pay either the provider's full charges or the amount of charges that the patient's health coverage denies.

WHAT IS THE SURPRISE BILLING PROBLEM?

Surprise billing has been reported frequently in the media, with “horror stories” where the patient is responsible for crippling bills of tens of thousands of dollars.

Surprise billing frequently arises from services provided by anesthesiologists, emergency department physicians, and radiologists.

Some believe that these specialists make a conscious decision to be out of network in order to maximize their reimbursement. Because they typically have an exclusive hospital contract, thus limiting if not eliminating competition enables this strategy.

WHAT IS THE SURPRISE BILLING PROBLEM?

SURPRISE BILLING POLL

The Washington, D.C.-based advocacy group Families USA last fall surveyed 1,000 registered voters to gauge opinions about surprise medical billings. The results found:

11% said they couldn't pay the bill

44% of people said they had received a surprise out-of-network medical bill

>2/3 said the surprise medical bill was difficult to pay

BILL

BILL

Nearly nine out of 10 people supported legislation to protect patients from surprise medical billing and said it was important for Congress to address. By political affiliation, the support came from:

97% OF DEMOCRATS

74% OF REPUBLICANS

88% OF INDEPENDENTS

POLLING QUESTION

What's the biggest surprise you ever experienced?

1. **Surprise birthday party?**
2. **Surprise pregnancy?**
3. **Surprise raise at work?**
4. **Surprise winning lottery ticket?**

WHAT IS THE SURPRISE BILLING PROBLEM?

The Financial Impact of Surprise Billing:

Researchers studying the impact of surprise billing have found:

"In this analysis of 5 457 981 inpatient admissions and 13 579 006 emergency department admissions between 2010 and 2016 in a large national sample of privately insured patients, the incidence of out-of-network billing increased from 32.3% to 42.8% of emergency department visits, and **the mean potential liability to patients increased from $220 to $628.** For inpatient admissions, the incidence of **out-of-network billing increased from 26.3% to 42.0%, and the mean potential liability to patients increased from $804 to $2040."**

Source: Assessment of Out-Of-Network Billing for Privately Insured Patients Receiving Care In In-Network Hospitals, Eric C. Sun, MD, PhD; Michelle M. Mello, JD, PhD; Jasmin Moshfegh, MA, MSc; Laurence C. Baker, PhD; JAMA Internal Medicine, 11/1/2019; https://jamanetwork.com/searchresults?author=Jasmin+Moshfegh&q=Jasmin+Moshfegh

Surprise Billing Frequently Relates To Transport and Hospital-Based Physicians:

" out-of-network billing was common among medical transport services and hospital-based physicians (e.g., emergency physicians, radiologists, and anesthesiologists) providing care at in-network hospitals. In such circumstances, patients could easily assume that the entire hospital team is in network and thus the balance billing may come as a surprise. Further, in these contexts, patients may have limited ability to choose an in-network physician or ambulance.”

Out-of-Network Bills from Ground and Air Ambulances

71%
of all ambulance rides involved potential surprise bills

$450
median potential surprise bill (ground)

$21,698
median potential surprise bill (air)

15%
annual increase in air ambulance potential surprise bills (2013 – 2017)

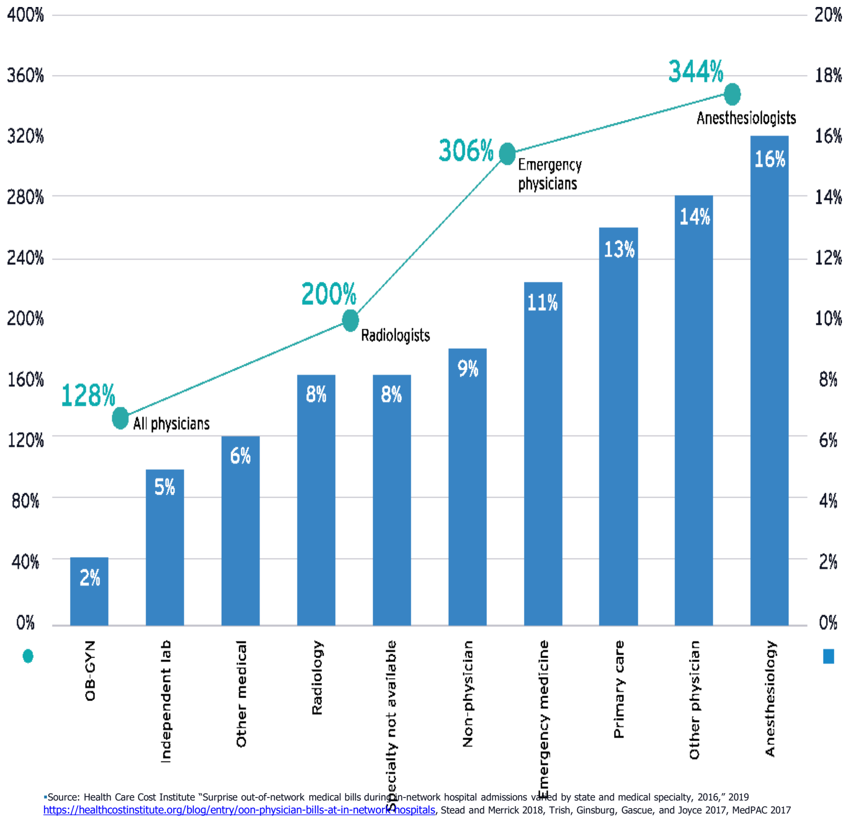
Chhabra KR, et al. Health Affairs 2020. 10.1377/hlthaff.2019.01484

CENTER FOR EVALUATING HEALTH REFORM

▪Out-of-network claims and in-network rates, by specialty

▪Share of out-of-network professional claims by specialty
▪Percent of all OON claims associated with in-network admissions by specialty, 2016

▪Average contracted payment relative to Medicare rates



▪Source: Health Care Cost Institute "Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016," 2019 https://healthcostinstitute.org/blog/entry/oon-physician-bills-at-in-network-hospitals, Stead and Merrick 2018, Trish, Ginsburg, Gascue, and Joyce 2017, MedPAC 2017

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PRIOR LEGISLATION

Prior to recent enactment of surprise billing legislation, Michigan law did not contain an explicit statutory prohibition on balance billing by an out of network provider for non-emergency services. But:

- Hospital contracts with hospital-based physicians frequently require participation with health plans in which the hospital participates.
- Providers in contract with a Michigan licensed HMO are prohibited from balancing billing. (See MCL 500.3529(3)).
- Michigan no fault insurance MCL 500.3107, as interpreted in the case of *McGill v. Automobile Association of Michigan*, 207 Mich. App. 402 (1994), contains a similar prohibition, as does Michigan workers compensation law (Michigan Administrative Rule 418.10105).

PRIOR LEGISLATION

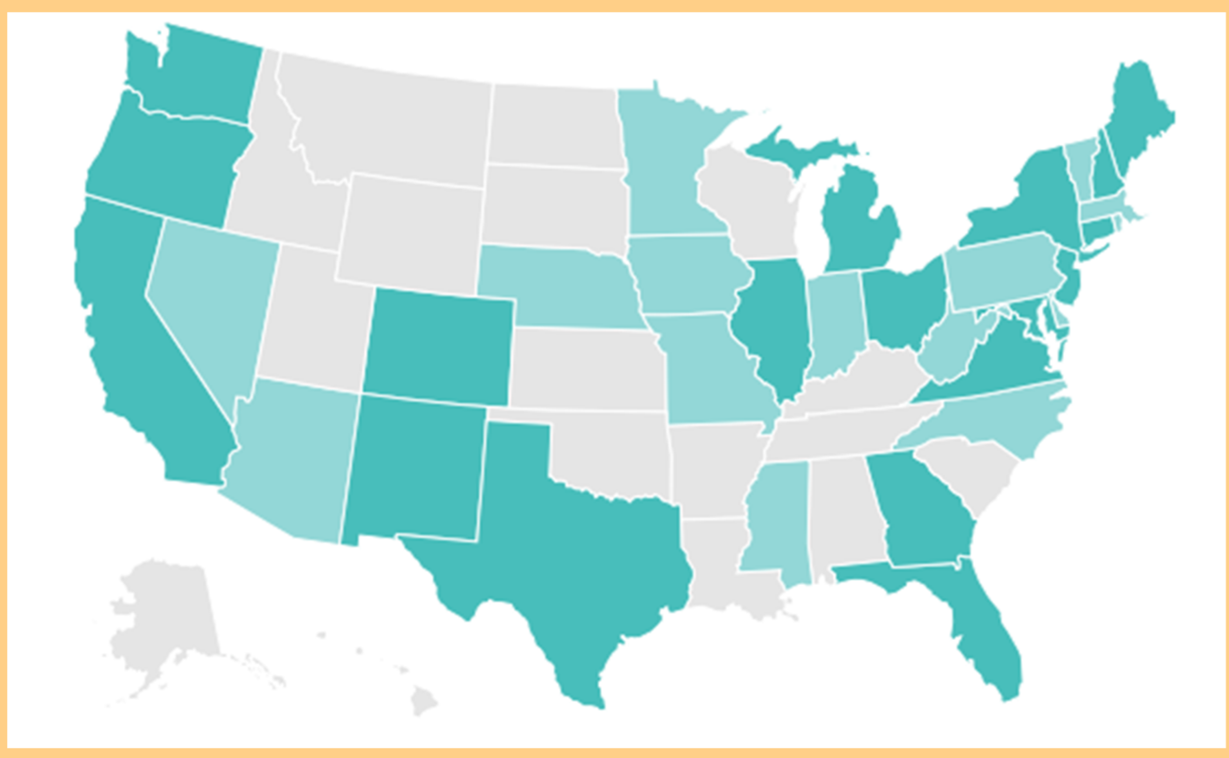
- Restrictions apply to providers serving Medicare fee for service and managed care patients as well as to Medicaid patients. The Deficit Reduction Act of 2005 mandated that effective January 1, 2007, non-participating providers that provide emergency services to Medicaid beneficiaries are entitled to receive the state Medicaid rate. See 42 U.S.C. § 1396u-2(b)(2).

- Section 10101 of the Patient Protection and Affordable Care Act requires group health plans that cover emergency services to make payment without the need for prior authorization, regardless of the participating status of the provider and at the in-network cost-sharing level.

- In compliance with this federal law, Michigan law, MCL 500.3517(3), provides that if the service is an emergency episode of illness or injury that requires immediate treatment before it can be secured through the HMO or for an out-of-area service specifically authorized by the HMO, the HMO must pay reasonable expenses or fees to the provider or enrollee, as appropriate in an individual case.
- Michigan law provides that a plan may not deny payment for hospitalization required up to the point of stabilization in out-of-area emergency services.

STATE SURPRISE BILLING LEGISLATION NATIONALLY

Source: The Commonwealth Fund, *State Balance-Billing Protections*, retrieved on Feb. 24, 2021 from: https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-balance-billing-protections



- No Balance Billing Protections
- Partial Balance Billing Protections
- Comprehensive Balance Billing Protections

POLLING QUESTION

What is your least favorite surprise?

1. **Parking ticket on windshield?**
2. **Letter from IRS?**
3. **Awakening from a dream?**
4. **Letter dismissing your Medicare appeal?**

MICHIGAN SURPRISE BILLING LEGISLATION: INTRODUCTION

Effective 10/22/2020, Adds Article 18 to Michigan Public Health Code

The law limits the charges a nonparticipating provider may charge emergency patients and nonemergency patients in certain specified scenarios.

What You Need To Know:

- What is the magnitude of the *fee restriction* if applicable? Can it be modified?
- Was the service furnished by:
  - *Participating* Provider?
  - *Nonparticipating* Provider?
- Was the service furnished to:
  - *Emergency* Patient?
  - *Nonemergency* Patient?
- What *required notice* must be furnished to the patient?
- What is the penalty for noncompliance?
- Is *arbitration* available?

MICHIGAN SURPRISE BILLING LEGISLATION: WHAT IS THE FEE RESTRICTION?

If the fee restriction applies: The nonparticipating provider shall submit a claim to the patient's carrier within 60 days after the date of the health care service and shall accept from the patient's carrier, as payment in full, **the greater of the following**:

(a) Subject to section 24510 (which permits a provider to request review), **the median amount negotiated by the patient's carrier for the region and provider specialty**, excluding any in-network coinsurance, copayments, or deductibles. The patient's carrier 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.

MICHIGAN SURPRISE BILLING LEGISLATION: FEE MODIFICATIONS

Section 24510 establishes a procedure for a nonparticipating provider to ***request review of the fee computation*** and requires that the nonparticipating provider furnish specific data and documentation.

Section 24511 gives a nonparticipating provider the right to ***claim greater payment*** for furnishing "a health care service involving a ***complicating factor*** to an emergency patient." The term "complicating factor" is not defined. This provision specifies the support necessary for this type of claim.

Section 24513 provides that this legislation ***does not prohibit a nonparticipating provider and a carrier from agreeing to a greater payment amount***, although a nonparticipating provider entering into this type of agreement is prohibited from seeking to collect from the patient other than for in-network coinsurance, copayment or deductible.

MICHIGAN SURPRISE BILLING LEGISLATION: PARTICIPATING PROVIDER

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

MICHIGAN SURPRISE BILLING LEGISLATION: NONPARTICIPATING PROVIDER

"Nonparticipating health facility" means a health facility that is not a participating health facility.

"Nonparticipating provider" means a provider who is not a participating provider.

Note Two Limitations:

The law does not apply to ***self funded plans*** or to services of a ***ground ambulance***.

MICHIGAN SURPRISE BILLING LEGISLATION: EMERGENCY PATIENT

- "Emergency patient" is defined as follows (MCL 333.24503 (4):

  [A]n 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***:

    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.

MICHIGAN SURPRISE BILLING LEGISLATION: NONEMERGENCY PATIENT

- Nonemergency patient
  - "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 significant health impairment***" (MCL 333.24503 (2)).

MICHIGAN SURPRISE BILLING LEGISLATION: APPLICATION OF THE FEE RESTRICTION

The fee restriction ***applies to a nonparticipating provider*** who is providing a health care service if any of the following apply:

Emergency Patient: 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.***

Nonemergency Patient: *All* of the following apply:

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

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

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

Either of the following:

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

The nonemergency patient ***has not been provided the disclosure*** required under section 24509.

MICHIGAN SURPRISE BILLING LEGISLATION: APPLICATION OF THE FEE RESTRICTION

- If an emergency patient presents to a *participating or nonparticipating* health facility and receives a health care service covered by the patient's benefit plan from a nonparticipating provider, then the limitations on charges apply.

- If an emergency patient presents to the emergency department of a hospital that is a **participating health facility** and receives a health care service from a *nonparticipating* provider in the emergency department and is ***thereafter admitted to the hospital within the subsequent 72 hours,*** the limitations on charges apply to any health care services the patient receives from a nonparticipating provider ***over the course of his or her hospital stay.***

- The statute defines "health facility" as follows:
- A hospital.
- A freestanding surgical outpatient facility as that term is defined in section 20104.
- A skilled nursing facility as that term is defined in section 20109.
- A physician's office or other outpatient setting that is not otherwise described in this subsection.
- A laboratory.
- A radiology or imaging center.

MCL333.24502. MCL 333.24507 (1) (a).

MICHIGAN SURPRISE BILLING LEGISLATION: THE FEE RESTRICTION IMPOSED ON THE NONPARTICIPATING PROVIDER; SERVICES TO EMERGENCY PATIENT WITH "COMPLICATING FACTOR" (MCL 333.24511)

- If a nonparticipating provider furnishes care to an *emergency patient* who presents with ***a "complicating factor,"*** (i.e., "***factor not normally incident to a health care service***"), ***the nonparticipating provider may submit a claim for increased reimbursement.***

- Complicating factors include, but are not limited to, a patient presenting with ***particularly severe condition***; the health care service provided requiring ***increased physical or mental effort by the physician***; and the delivery of a health care service requiring ***increased intensity, time, or technical difficulty***

- The nonparticipating providers' claim must be accompanied by ***clinical documentation supporting the complicating factor*** as well as the ***patient's medical record*** for the health care service (highlighted to emphasize the complicating factor).

- Within 30 days of receipt of the claim, the carrier will either: (1) authorize an additional payment ***of 25 percent*** of the median amount negotiated for the health care service based on the region and provider specialty (as determined by the carrier), excluding the patient's coinsurance, copayment, or deductible obligations; or (2) deny the claim. ***Beginning July 1, 2021, if the carrier denies the claim for additional reimbursement, the nonparticipating provider may request binding arbitration with the Michigan Department of Insurance and Financial Services (DIFS).***

MICHIGAN SURPRISE BILLING LEGISLATION: PROMPT PAYMENT REQUIREMENT

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

MICHIGAN SURPRISE BILLING LEGISLATION: REQUIRED DISCLOSURE

Required Patient Disclosure (MCL 333.24509 (3).

- Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.
- The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.
- You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

MICHIGAN SURPRISE BILLING LEGISLATION: REQUIRED DISCLOSURE

Provider Requirements

- Complete the disclosure and, after completing the disclosure, ***obtain on the disclosure the signature of the nonemergency patient, or that patient's representative***, acknowledging that the nonemergency patient, or that patient's representative, has received, has read, and understands the disclosure.
- Retain a copy of the disclosure for ***not less than 7 years***.
- Provide the nonemergency patient or that patient's representative with a ***good-faith estimate of the cost of the health care services to be provided to the nonemergency patient.***

MICHIGAN SURPRISE BILLING LEGISLATION: REQUIRED DISCLOSURE

Provider Requirements

The disclosure must be provided at the earliest of the following (MCL 333.24509)

- If the health care service is planned to be provided at a ***physician's office***, then the notice must be provided at the time of the nonparticipating ***provider's first contact with the patient regarding the planned health care service***.
- If the health care service is to be provided at ***any other health facility (other than a physician's office),*** then the notice must be provided ***at least 14 days before the health care service is provided***. If the health care service is not scheduled at least 14 days before its planned provision, then the notice must be provided ***as soon as possible within the 14 days*** prior to the health care service being rendered.
- During (a) a presurgical consultation; (b) scheduling or intake call; (c) preoperative review for the health care service; or (d) any other contact similar in nature (this requirement applies also to any other outpatient setting not otherwise expressly listed in the statutory definition of health facility).

MICHIGAN SURPRISE BILLING LEGISLATION: REQUIRED DISCLOSURE

Nonparticipating Provider Penalty For Failure To Provide Required Disclosure

- Except as otherwise provided in section 24513 [agreement between provider and carrier] and subject to subsection (6)*, ***a nonparticipating provider who fails to provide the disclosure*** as required under this section shall submit a claim to the nonemergency patient's carrier within 60 days after the date of the health care service and ***shall accept from the nonemergency patient's carrier, as payment in full, the greater of the following:***
- Subject to section 24510, [the right of the nonparticipating provider to request review of calculation]the median amount negotiated by the nonemergency patient's carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. The nonemergency patient's carrier shall determine the region and provider specialty for purposes of this subdivision.
- 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.
- ***This amount must be paid within 60 days. Nonparticipating provider must accept as payment in full except for the in-network coinsurance, copayment / deductible**.

MICHIGAN SURPRISE BILLING LEGISLATION: PENALTIES FOR NONCOMPLIANCE

The penalties for failure to comply with the surprise billing legislation range from probation to permanent revocation of licensure. (MCL 333.16226; MCL 333.16221(z))

ARBITRATION

Available to nonparticipating provider requesting additional payment for complicating factors for emergent patients

Must submit written request to DIFS that includes:

- Documentation submitted to the carrier
- Contact information for the emergency patient’s health benefit plan
- Denial letter from the carrier

DIFS sends notice to the carrier

Carrier has 30 days to submit written documentation

Confirming denial, or

Provide an alternative payment offer to be considered by the arbitrator

Federal "No Surprises Act"

- Enacted at the end of 2020
- Part of Consolidated Appropriations Act, 2021
- Big impact on employer-sponsored group health plans, health plan issuers, providers and patients
- Largely effective January 1, 2022

Polling Question:
Was the "No Surprises Act" appropriately titled?

A. Yes, of course.

B. No way.

C. It's misleading, but that's ok.

Cost-Sharing for ER and Air Ambulance

- Coverage for emergency services and air ambulance services
  - Same for in-network and out-of-network
  - Without pre-authorization or more restrictive limitations
- Out-of-network cost-sharing cannot be greater than in-network
- Calculate cost-sharing based on the statutorily defined "recognized amount"
- Cost-sharing payments must count for tracking a participant's in-network deductible and out-of-pocket maximum
- Within 30 days of provider bill, plan must provide payment or denial
- Effective January 1, 2022

Cost-Sharing Determination

- Prescribed process for determining patient cost-sharing
  - "Recognized amount"
  - "Qualifying amount"
- Recognized amount = required under state law, all-payer rate setting model, or qualifying amount
- Qualifying amount applies if no state law or policy applies to the situation/service
- Qualifying amount determined based on historic rates between plan and provider (or independent database)
- HHS to issue regulations no later than July 1, 2021 to establish qualifying amount

No Balance Billing

- Out-of-network providers providing services at an in-network facility cannot balance bill
- Notice and consent exception for non-emergency services
  - Participant may consent to out-of-network cost greater than in-network amount
  - Provider must deliver at least 72 hours prior to services:
    1. written notice of out-of-network status;
    2. list of in-network providers; and
    3. good faith estimate of charges.
  - Written consent must be obtained prior to the delivery of services.
- No consent exception for emergency services (including out-of-network air ambulance services)
- No consent exception for "ancillary services"

Independent Dispute Resolution (IDR)

- Reimbursement for out-of-network rates by state law or policy as default
- Applies to out-of-network rates (including out-of-network services performed at in-network facilities)
- Negotiation opportunity during 30 day window after payment or denial from plan
- If failed negotiation, either party may initiate new IDR process (within 4 days)
- Certified IDR entity jointly selected by parties
- Each party proposes offer amount and IDR entity selects one as final payment
- Costs
  - Each party must pay administrative fee to regulators for the IDR process
  - Losing party pays IDR entity's fees, unless settle and then parties split or otherwise allocate
- Regulations to be issued by December 27, 2021

Continuity of Care

- Continuing care patients (CCPs):
  - Undergoing course of treatment for serious and complex condition
  - Scheduled for nonelective surgery
  - Pregnancy
  - Terminally ill
- If contractual relationship with provider or facility is terminated and benefits/coverage terminated
- Plan must provide notice to each CCP of right to elect transitional care
- Plan must provide transitional care if elected by CCP for up to 90 days
- Transitional care = continuation of benefits under same terms and conditions that would have applied if no termination
- Effective January 1, 2022

New Disclosure Requirements

- Plan ID cards must include applicable deductible, out-of-pocket maximum and telephone number and website for information
- Price Comparison Tool
  - Allows plan participants to compare the amount of cost-sharing
  - For each specific item or service
  - By any provider
  - With respect to a plan year and by geographic region
  - Available by phone or website
- Disclosure of no balance billing
  - Publicly available website
  - EOBs
  - Must include contact information for reporting violations to state/federal agencies

Advance Explanation of Benefits and Good Faith Estimates

- Not later than 1 business day after notification from provider of scheduled service
- Whether in-network provider and if so, contracted rate and if not, info about in-network
- Good faith estimates (i) from provider, (ii) amount of plan coverage, (iii) cost-sharing, and (iv) participant's current spend toward deductible/OOP max
- Disclosure of any medical management techniques applicable
- Disclaimer that only an estimate

Polling Question:
Where would you most like to be right now?

A. With your nose in the middle of the 300+ page No Surprises Act
B. On a beach
C. Standing line for your COVID vaccination

What We Don’t Know Yet, But What We Can Expect

- Examples of What We Don’t Know
  - Methodology for determining amounts for cost-sharing requirements
  - Certification of IDR entities, costs and admin fees
  - Cost estimates
- What We Can Expect
  - Regulations and guidance – most by July 1, 2021
  - Increased audit activity – several specific provisions in statute requiring government agency audits
  - Increased participant complaints (and potential litigation/audit actions)