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Health Care Law Section Publication Notice

The Publication Committee of the Health Care Law Section (HCLS) announces the publication of:

Michigan and Federal Surprise Billing Legislation: Protection for Consumers, Increased Burdens for Providers, and Boon for Payors

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“Surprise billing” (also referred to as “balance billing”) is the term aptly used when an out-of-network provider (either a professional or a facility) bills a patient for emergency or non-emergency services who is unaware that the provider is out-of-network. During 2020, Michigan and federal legislation was enacted limiting the patient’s liability for payment to an out-of-network provider.
This white paper discusses the surprise billing problem, summarizes Michigan and federal legislation, and offers the authors’ commentary.

Michigan and Federal Surprise Billing Legislation:
Protection for Consumers, Increased Burdens for Providers, and Boon for Payors

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Published March 7, 2022

Edited by: Patricia A. Stamler, Esq.

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I. INTRODUCTION

Meriam-Webster defines "surprise" as "an attack made without warning" or "a taking unawares."[2] "Surprise billing" (also referred to as "balance billing") is the term aptly used when an out-of-network provider (either a professional or a facility) bills a patient for emergency or non-emergency services who is unaware that the provider is out-of-network. During 2020, Michigan and federal legislation was enacted limiting the patient's liability for payment to an out-of-network provider. First, effective October 22, 2020, the Michigan Public Health Code was amended to add Article 18, Surprise Medical Billing, which served to impose limits on a patient's liability for "surprise billing."[3] Then, on December 27, 2020, the federal No Surprises Act was signed into law as part of the year-end spending bill.[4] Both statutes focus on consumer protection. The effect of these laws, however, is to impose new regulatory requirements on providers and to some extent to benefit payors by requiring nonparticipating providers to accept participating provider payment rates. This white paper discusses the surprise billing problem, summarizes Michigan and federal legislation, and offers the authors' commentary.

A. Surprise Billing: The Problem

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[2] Merriam-Webster, *Merriam-Webster Dictionary,* https://www.merriam-webster.com/dictionary/surprise (last accessed September 22, 2021).

[3] MCL 333.24509. The Department of Insurance and Financial Services ("DFIS") promulgated regulations effective June 24, 2021. *See* Mich. Admin. Code §§ R 500.241 - 245. The regulations establish procedures for DFIS to review and resolve requests for calculation pursuant to MCL 333.24510 and for approving arbitrators for binding arbitration pursuant to MCL 333.24511.

[4] Consolidated Appropriations Act, 2021, Pub. L. No. 116–260 (2020) Division BB, Title I.

Approximately 94 percent of Michigan residents are covered by some form of health insurance.[5] These individuals reasonably expect that health care services they receive will be covered. "Surprise billing" may occur, for example, when a patient is admitted to a hospital for treatment and receives health care services from multiple providers that the patient did not expect would be billed separately. Although the hospital treating the patient may be in-network, a radiology practice, by way of example, which may have an exclusive contract with the hospital, may be out-of-network for purposes of the patient's health insurance coverage. After receiving radiology services at the in-network hospital, the patient is then "surprised" to receive an unexpected bill from the radiology practice seeking payment for the radiologist's full charges (or the amount of charges that the patient's insurance carrier denies or otherwise permits for out of network providers).

The media has illuminated surprise billing "horror stories" where a patient is responsible for crippling bills of tens of thousands of dollars.[6] Surprise billing frequently arises from services provided by certain specialists like emergency department physicians, radiologists, and anesthesiologists. It has been suggested that these specialists make a conscious decision to be outside of insurance companies' networks to maximize their

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[5] *See* Yang, Jenny, *Health insurance* status *of the population of Michigan 2019, available at* https://www.statista.com/statistics/238768/health-insurance-status-of-the-total-population-of-michigan/ (last accessed 10-18-21)

[6] *See e.g., Study: 1 in 5 Patients Gets a Surprise Medical Bill After Surgery*, Renken, Elena, https://www.npr.org/sections/health-shots/2020/02/11/804906330/study-1-in-5-patients-gets-a-surprise-medical-bill-after-surgery, February 11, 2020 (last accessed 10-18-21); *What is surprise billing for medical care?* Linke Young, Christen; Fiedler, Matthew; Adler, Loren and Lee, Sobin, https://www.brookings.edu/policy2020/votervital/what-is-surprise-billing-for-medical-care/, October 15, 2019 (last accessed 10-18-21); *CBS News investigates confusing and high-priced medical bills*, Werner, Anna https://www.cbsnews.com/video/cbs-news-investigates-confusing-and-high-priced-medical-bills/, September 23, 2019 (last accessed on 10-18-21) *Surprise medical bills lead to liens on homes and crippling debt*, Bomnin, Lindsey and Gosk, Stephanie *t* https://www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371, March 19, 2019 (last accessed 10-18-21).

reimbursement.[7] These providers often have exclusive hospital contracts, thus limiting if not eliminating competition to provide their services to the hospitals' patients, which enables this strategy to succeed.

The increasingly significant financial impact of surprise billing was recently documented in a statistical analysis conducted by researchers at Stanford University who made the following finding:

> 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. [8]

These researchers found that balance billing can have a substantial financial impact on the patient:

> Even modest unexpected bills can create financial stress for patients. A recent survey found that 4 in 10 Americans would be unable to pay an unexpected expense of $400 without selling something or borrowing money. [7]The median amounts for which patients in our study were sent balance bills ($984 for inpatient admissions and $482 for emergency visits in 2016) exceed that level. Further, the top decile of patients with out-of-network bills faced substantial potential financial responsibility: $4112 for inpatient admissions and $1364 for ED visits.[9]

Underscoring the surprise element, these researchers observed that "out-of-network billing was common among medical transport services and hospital-based physicians (*e.g.*,

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[7] *What is surprise billing for medical care? supra*

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

[9] *Id.*

emergency physicians, radiologists, and anesthesiologists) providing care at in-network hospitals. In such circumstances, patients readily assumed that the entire hospital team was in-network and thus the balance billing came as a surprise. Further, in the context of hospitalization or emergency transports, patients may have had a limited ability to choose an in-network physician or ambulance."[10]

B. Prior Legislation

1. Nonemergency Services

Prior to enactment of surprise billing legislation, Michigan law did not contain an explicit statutory prohibition on balance billing by an out-of-network provider for nonemergency services. However, as a matter of contract and state law, providers were subject to some restrictions against surprise billing. In their contracts with hospital-based physicians, many hospitals have eliminated if not reduced the surprise billing problem by requiring the physicians to agree to participate in all health plans in which the hospital participates. Such contractual provisions serve to limit the patient's financial liability, and to reduce the hospital's administrative burden of responding to patient complaints. Moreover, as a matter of statutory law, providers in contract with a Michigan-licensed HMO are prohibited from balance billing.[11] Similar restrictions apply to providers serving Medicare fee for service and managed

[10] *Id.*

[11] MCL 500.3529(3).

care patients[12] as well as Michigan Medicaid patients.[13] The Michigan Court of Appeals has interpreted Michigan no fault insurance[14] provider requirements to contain a similar prohibition,[15] as does the Michigan workers compensation law.[16]

2. Emergency Services

At the federal level, Section 10101 of the Patient Protection and Affordable Care Act[17] requires group health plans that cover emergency services pay providers for those services at the in-network cost-sharing level without requiring prior authorization, regardless of the participation status of the provider. In compliance with this federal law, Michigan law provides that patients who are enrollees of a group health plan, (a) if the service is an emergency episode of illness or injury that requires immediate treatment before such treatment can be secured through the HMO or (b) 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, even if the provider is not normally engaged by the HMO to render services to the HMO's enrollees.[18] In addition, a plan may not deny payment for hospitalization required

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[12] *Medicare Claims Processing Manual*, Chapter 1, Section 30.3, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf (last accessed 10-18-21); Medicare Managed Care Model, Chapter 4, Benefits and Beneficiary Protections, Section 170, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf (last accessed 10-18-21).

[13] *Michigan Medicaid Manual*, General Information for Providers, Section 11, https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html (last accessed on 10-18-21) MCL 400.111b(14), 42 CFR 447.20; and 42 USC 1396a(a)(25)(c).

[14] *McGill v Automobile Ass'n of Mich*, 207 Mich App 402 (1994)

[15] MCL 500.3107.

[16] Michigan Administrative Code, R 418.10105.

[17] 42 USC 18001.

[18] MCL 500.3517(3).

up to the point of stabilization when out-of-area emergency services are provided.[19] Additionally, the federal Deficit Reduction Act of 2005[20] mandated that effective January 1, 2007, non-participating providers that provide emergency services to all states' Medicaid programs' beneficiaries and providers must accept the state Medicaid rate as payment in full.[21]

II. MICHIGAN SURPRISE MEDICAL BILLING LAW

A. Overview

As summarized above, prior to enactment of the Michigan Surprise Medical Billing Law ("MSMBL"), there was a limited scope of protection for patients against receiving surprise medical bills from out-of-network providers in Michigan (particularly with respect to non-emergency services). The enactment of the MSMBL on October 22, 2020, expanded the scope of protection for patients.[22] As summarized by the office of the Governor:

> House Bills 4459-4460 and 4990-4991[23] together protect consumers against surprise medical billing. Instead of a consumer potentially being stuck with a bill they can't pay when they receive care at an in-network hospital but see an out-of-network doctor, their insurance company will pay the doctor according to a formula specified in the bill. The bills also provide for certain good-faith cost estimate disclosures in nonemergency situations and other consumer protections. Additionally, the bills limit the ability of an out-of-network provider to bill a patient directly for certain emergency costs, rather the provider and the insurer will now settle the disputed charge. These bills put Michigan among the states leading the charge for consumer protection when it comes to surprise medical billing.[24]

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[19] MCL 500.3406K.

[20] 42 USC 1305 *et seq.*

[21] 42 USC 1396u-2(b)(2)(D).

[22] On October 22, 2020, the Michigan Public Health Code was amended to add Article 18, Surprise Medical Billing. *See* MCL 333.24501 *et seq.*

[23] https://www.legislature.mi.gov/(S(0bwtn1ce0cdibih0lhqoryc3))/mileg.aspx?page=getObject&objectName=2019-HB-4459 (last accessed on 10-18-21)

[24] *See* https://www.michigan.gov/whitmer/0,9309,7-387-90499_90640-543323--,00.html.

The effect of the MSMBL is to limit the charges of an out-of-network provider for services furnished to emergency and nonemergency patients in specified scenarios.[25] The MSMBL provides important protections for patients and reduces the financial benefits of nonparticipation for providers by imposing a fee cap on services rendered.

As discussed in the following sections, attorneys and providers need to understand how the MSMBL's requirements answer the following questions in each circumstance where the law may apply:

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

B. The Reimbursement Limitation

Under the MSMBL, a nonparticipating provider is required to submit a claim to the patient's carrier within 60 days from the date of service.[26] In turn, the carrier is required to pay the appropriate amount to the provider within 60 days of receipt of the claim.[27] The nonparticipating provider is required to accept, as payment in full, the greater of the following:

[25] Note that the requirements of the statute specifically apply to nonparticipating providers (rather than health facilities).

[26] MCL 333.24507(c)(2)

[27] MCL 333.24507(c)(4)

- The median amount negotiated by the patient's carrier for the region and provider specialty (as determined by the carrier), excluding the patient's coinsurance, copayment, or deductible obligations;[28] or

- 150 percent of the Medicare fee-for-service reimbursement amount under the fee schedule, excluding the patient's coinsurance, copayment, or deductible obligations.[29]

The law also allows a nonparticipating provider and carrier to agree to a payment amount greater than that set forth above.[30]

If a nonparticipating provider believes that a carrier has miscalculated its median negotiated amount for a given non-emergent health care service provided both in the same region and by a provider of the same specialty as the nonparticipating provider, the provider may request Michigan Department of Insurance and Financial Services ("DIFS") review the carrier's calculation. To request a recalculation the nonparticipating provider submits to DIFS a Request for Review of Calculation of Charges form.[31] In conducting its review, DIFS may request data from the carrier necessary to evaluate the accuracy of the carrier's calculation. Under the MSMBL, any such information provided by the carrier to DIFS will be kept confidential.[32] DFIS has promulgated a regulation related to the review process, which provides as follows:

> (1) A nonparticipating provider must make a request for a review of the calculation described in section 24510(1) of the act, MCL 333.24510, on a form provided by the department.

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[28] This provision is mirrored in the regulation, Mich Admin Code § R 500.241(b).

[29] MCL 333.24507 (2) and MCL 333.24509 (5).

[30] MCL 333.24513.

[31] https://www.michigan.gov/documents/difs/FIS_2369_726553_7.pdf.

[32] MCL 333.24510. Note, however, in recent years, there has been a shift towards greater price transparency. Indeed, effective January 1, 2021, all hospitals in the United States are required to provide patients access to a machine-readable file containing the payer-specific negotiated charges for all items and services provided by the hospital (among other pieces of data). 45 CFR 180.50.

(2) In response to a request from a nonparticipating provider for a calculation review under section 24510 of the act, MCL 333.24510, the department shall do the following within 14 days of the date of the request:

(a) Notify the carrier of the request for a calculation review.

(b) Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510.[33]

(3) A carrier must respond within 14 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department makes 1 or more requests for additional information, the carrier must respond within 14 days of the date of the department's request.

(4) The department shall issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response under subrule (3) of this rule or after the expiration of the time period within which the carrier was required to respond, including any extensions provided following the department's request for additional information under subrule (3) of this rule. [34]

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[33] DFIS regulations further require carriers to maintain a database meeting the following requirements:

(1) Subject to subrule (3) of this rule, a carrier may satisfy the requirement under R 500.243 by providing the department with access to a database that contains all of the carrier's median amounts. The database must meet all of the following requirements:

(a) Be updated no less frequently than quarterly.
(b) Be searchable by region, provider specialty, and health care service.
(c) Include negotiated rates for all health care services covered by the carrier.
(d) Be continuously accessible to the department.

(2) For the purposes of conducting a calculation review under section 24510 of the act, MCL 333.24510, the department may, at its discretion, consult any external database described under section 24510(2) of the act, MCL 333.24510, without regard to whether a carrier made the database accessible to the department or whether the database otherwise meets the requirements under subrule (1) of this rule.

(3) A carrier's provision of access to a database under this rule does not preclude the department from requesting any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510. Mich Admin Code § 500.244.

[34] Mich Admin Code § 500.243.

In addition, in a scenario where a nonparticipating provider renders 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.[35] 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 provider's 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. If the carrier denies the claim for additional reimbursement, the nonparticipating provider may request binding arbitration with DIFS.[36]

C. When do Reimbursement Limitations Apply?

1. Emergency Patients

The MSMBL differentiates between emergency patients and nonemergency patients based on the point-of-view of a "prudent layperson." The statue defines "emergency patient" as follows:

> [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:

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[35] MCL 333.24511.

[36] MCL 333.24511. DFIS has promulgated a regulation regarding the procedure to be followed to become an approved arbitrator. Mich Admin Code § 500.245.

See also Appendix 1, summarizing the MSMBL.

(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.[37]

If an emergency patient presents to a *participating or nonparticipating*[38] health facility[39] and receives a health care service covered by his or her health benefit plan from a nonparticipating provider, then the reimbursement limitation discussed in Section II B above applies.[40]

Further, 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 reimbursement limitation discussed in Section II B above applies to any health care services the patient receives from a nonparticipating provider over the course of his or her hospital stay.[41]

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[37] *Id.*

[38] The statute defines a "Participating provider" as "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*." MCL 333.24504 (2) (emphasis added).

"Nonparticipating provider" is defined as "a provider who is not a participating provider" (i.e., an out-of-network provider). MCL 333.24503 (4).

[39] The statute defines "health facility" as follows:

(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. MCL 333.24502.

[40] MCL 333.24507 (1) (a).

[41] MCL 333.24507 (1) (c).

2. Nonemergency Patients

The MSMBL defines a "nonemergency patient" as "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."[42] If a nonemergency patient presents to a *participating* health facility and receives a health care service that is covered by his or her health benefit plan from a nonparticipating provider and either (a) the nonemergency patient does not have the ability or opportunity to choose a participating provider; or (b) the nonemergency patient did not receive the disclosure required by section 24509 of the law (discussed in Section II C 3 below), then the limit on reimbursement discussed in Section II B above applies.[43]

3. Disclosure and Consent

Prior to rendering a health care service to a nonemergency patient, a nonparticipating provider is required to provide written disclosure that the patient's health benefit plan may not provide coverage for the planned health care service.[44] The disclosure must be provided in 12 point or greater font, and substantially be in the following form:

> 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 costs 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 the 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

[42] MCL 333.24503 (2).

[43] MCL 333.24507 (1) (b).

[44] This disclosure required by the MSMBL is similar to the "notice" required under the NSA, which is discussed in Section III B 1 herein.

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.

I have received, read, and understand this disclosure.

_____ _____

(Patient or patient's representative's signature) (Date)

_____

(Type or print name of patient or patient's representative)[45]

The above-cited language does not have a place to insert the good faith estimate; however, the good faith estimate can be added to the same form.

After providing the disclosure to the nonemergency patient and he or she signs and dates it to reflect his or her receipt and understanding, the nonparticipating provider must retain a copy of the signed disclosure for seven years. In addition, the nonparticipating provider must provide the nonemergency patient or his or her representative of a good faith estimate of the cost of the health care service to be provided.[46]

There are timing requirements for the provision of the disclosure, with which providers may find challenging to comply. The disclosure must be provided at the earliest of the following:

- If the health care service is planned to be provided at a physician's office,[47] 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.[48]

- 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

[45] MCL 333.24509 (3).

[46] *Id.*

[47] This requirement also applies to any other outpatient setting not otherwise expressly listed in the statutory definition of health facility. MCL 333.24509 (1) (b).

[48] *Id.*

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.[49]

- 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.[50]

In no event may the disclosure be provided at the time of the nonemergency patient's admittance to a health facility (other than a physician's office) or when preparing the patient for surgery or other procedure.[51]

D. Sanctions for Non-compliance

If a nonparticipating provider is found to violate the MSMBL, sanctions, which include fines and adverse licensure actions, may be imposed pursuant to the statute.[52]

E. Regulations

The statute permits DIFS to promulgate rules implementing sections 24510 (related to review of a carrier's calculation of charges) and 24511 (related to claims involving a complicating factor) of the MSMBL. The statute prohibits DIFS from promulgating administrative rules implementing any other portion of the statute.[53] As discussed in greater detail above, DIFS promulgated regulations that were effective June 24, 2021.[54]

F. Limitations of the Michigan Surprise Medical Billing Law

While the MSMBL serves to provide much-needed protection for patients against receiving

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[49] MCL 333.24509 (1) (a).

[50] MCL 333.24509 (1) (c).

[51] MCL 333.24509 (2)

[52] MCL 333.16221 (z) and MCL 333.16226.

[53] MCL 333.24517.

[54] See Mich Admin Code §§ R 500.241 – 245.

many surprise medical bills, there are noteworthy limitations, which may be addressed, in part, by the federal No Surprises Act. First, and significantly, the MSMBL does not apply to self-funded, or group health plans covered by the Employee Retirement Income Security Act ("ERISA"), as DIFS has no authority over such plans.[55] Therefore, many individuals who work for large employers or government agencies may not enjoy the protections afforded by the statute (as self-funded plans are popular with these types of employers). In addition, the law does not cover ground ambulances, which oftentimes choose to remain out-of-network.[56]

III. FEDERAL NO SURPRISES ACT

Enacted through the Consolidated Appropriates Act, 2021 ("CAA"), the federal No Surprises Act (the "NSA") was signed into law on December 27, 2020, and it became effective January 1, 2022 (or in certain instances, will become effective at the beginning of the plan year following January 1, 2022).[57] The NSA provides protections against balance billing and limits patient's out-of-network cost sharing under the scenarios where surprise bills historically have occurred most frequently. Of significance, the NSA applies to ERISA plans, which state laws, including the MSMBL, do not govern.[58]

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[55] *See* Michigan Department of Insurance and Financial Services https://www.michigan.gov/difs/0,5269,7-303-12902_35510_92612_92613_92614_92730-496728--,00.html#:~:text=DIFS%20does%20not%20have%20authority,Labor's%20Employee%20Benefit%20Security%20Administration (Last accessed 10-18-21)

[56] *See Many Could Face Sky-High Surprise Bills from Air Ambulance Flights*, Gavin, Kara, Gavin May 06, 2020, https://labblog.uofmhealth.org/industry-dx/many-could-face-sky-high-surprise-bills-from-air-ambulance-flights (last accessed 10-18-21).

Note other portions of Michigan law provide certain protections against surprise medical bills of air ambulance providers. *See* MCL 333.20901 *et seq.* As noted in Section III herein, the NSA contains protections for surprise bills from air ambulance providers.

[57] Consolidated Appropriations Act, 2021, Pub. L. No. 116–260 (2020) ("CAA"), Division BB, Title I.

[58] The CAA applies to group health plans and health issuers in the group and individual market in a new Part D of title XXVII of the PHS Act and new provisions added to part 7 of ERISA.

The Departments of Health & Human Services ("HHS"), Labor, and Treasury (together, the "Departments") have issued regulations implementing the NSA in phases. First, on July 13, 2021, the Departments and the Office of Personnel Management ("OPM") published an interim final rule ("Part 1 IFR") in the Federal Register.[59] The IFR focuses on the NSA protections intended to "restrict excessive out of pocket costs to consumers from surprise billing and balance billing."[60] A second interim final rule was issued on September 30, 2021, which provides rules regarding the independent dispute resolution process, transparency requirements, and a patient-provider dispute resolution process ("Part 2 IFR").[61]

A. Emergency Services and Air Ambulance Services[62]

The NSA requires health plans and health insurance issuers offering coverage for (1) services in an emergency department of a hospital, or (2) an independent freestanding emergency department,[63] or (3) air ambulance services, to cover such services without any prior authorization determination, regardless of whether the provider or facility is a participating provider or facility, and regardless of any other term or condition of coverage. If emergency services are provided to a patient by a nonparticipating provider or facility, the NSA further requires the services be

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[59] 86 Fed Reg 36872 (July 13, 2021).

[60] *HHS Announces Rule to Protect Consumers from Surprise Medical Bills*, HHS Press Office, July 21, 2021, https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html, (last accessed on 10-18-21)

[61] 86 Fed Reg 55980 (October 7, 2021). A CMS Fact Sheet is available at https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period (last accessed on 10-18-21).

[62] *See generally,* 45 CFR §149.410 **governing balance billing in cases of emergency services**.

[63] If, under state licensure laws, urgent care centers are permitted to provide emergency services and the urgent care center is geographically separate and distinct from a hospital, the NSA applies to such urgent care centers offering emergency services. In such cases, even if an urgent care center does not operate as an emergency center, it would fall within the definition of an independent freestanding emergency department for purposes of the Part 1 IFR. 86 Fed Reg 36872, 36878.

provided without any more restrictive limitations or requirements on coverage than apply to the same services provided by a participating provider or participating facility.[64] The cost sharing and balance billing restrictions are discussed in Section III C below apply.

The terms "emergency services," "emergency medical condition,"[65] and "to stabilize" generally have the same meanings as provided under the Emergency Medical Treatment and Labor Act ("EMTALA").[66]

"Emergency services" include the following:

> (1) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and
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> (2) Such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.[67]

In the Part 1 IFR, the Departments clarified that the balance billing protections include pre- and post-stabilization services regardless of where the patient receives further medical examination and treatment. The balance billing protections extend to any additional item or service provided

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[64] *Id.*

[65] As in the MSMBL, whether a patient is suffering from an "Emergency medical condition" is determined from a layperson's point of view. For the purposes of the NSA, an "Emergency medical condition" includes "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in EMTALA, including (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part." *Id.* at 36769.

[66] *Id.* at 36768.

[67] *Id.* at 36879.

after the patient is stabilized as part of an outpatient or inpatient stay in which other emergency services are provided. Those additional items or services are considered emergency services.[68]

Post-stabilization services are considered emergency services unless the following four conditions are met:

1) the attending or treating provider determines the patient is able to travel using nonmedical or nonemergency transportation to an available in-network provider or facility located within a reasonable distance;

2) the provider or facility furnishing post-stabilization services must satisfy the notice and consent criteria;[69]

3) the patient or the individual's authorized representative must be in a condition to receive the information in the notice and to provide informed consent; and

4) the provider or facility must satisfy any additional requirements or prohibitions imposed under applicable state law. [70]

The Departments recognize post-stabilization waiver of balance billing protections to be rare. In addition to complying with post-stabilization requirements, the provider must also adhere to ethical guidance published by the American Medical Association.[71]

B. Non-Emergency Services Performed by a Nonparticipating Provider at a Participating Facility[72]

When non-emergency services are provided to a patient by a nonparticipating provider at a participating facility, the group health plan or health insurance issuer cannot impose a cost-

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[68] *Id.*

[69] Notice and consent criteria are discussed in Section III B 1, *supra*, of this paper.

[70] This provision is intended to address those scenarios where a state has imposed stricter standards than imposed by the NSA as implemented by the IFR. 86 Fed Reg at 36881. *See* 45 CFR 149.410(b)(1).

[71] 86 Fed Reg at 36879.

[72] *See generally,* 45 CFR §149.420 governing **Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health facilities.**

sharing requirement that is greater than required of a patient receiving services from a participating provider, unless the notice and consent requirements discussed below are satisfied. Otherwise, the cost sharing and balance billing restrictions limitations discussed in Section III C apply.

In the context of non-emergency services, participating health care facilities include those that have a contractual relationship directly or indirectly with a group health plan or issuer offering group or individual coverage. The Part 1 IFR extends protections where a single case agreement is entered into between a health care facility and a plan or issuer. Under such agreements, a contractual relationship is established, and the reimbursement limitations discussed in Section III C apply. In the context of non-emergency services, a health care facility, includes the following: hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers. Urgent care centers are not included as a non-emergency facility due to the variation in state law definitions. The statutory definition of a visit includes furnishing equipment and devices, telemedicine, imaging, and preoperative and postoperative services, regardless of where the item or service is furnished. The Departments have the authority to specify other items and services. In the Part 1 IFR, the Departments solicited comments regarding other items and services that would be appropriate inclusions in the scope of a "visit."[73]

1. Notice and Consent

a. When Notice is Required

When a non-participating provider provides a non-emergency item or service and issues a proper notice and consent, it may balance bill the beneficiary. The notice and consent exception does not apply to emergency services (other than post-stabilization services) or air ambulance

[73] *Id.* at 36882-36883.

services (under most circumstances).[74] Additionally, a non-participating provider or facility cannot issue a notice and consent for items or services related to: emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory services, regardless whether such items or services are provided by a physician or non-physician practitioner, assistant surgeons, hospitalists or intensivists.[75] Furthermore, notice and consent cannot be issued if there is a lack of a participating provider who can provide such item or service at a facility.[76] The main threshold criteria for a valid notice and consent are timing, specific terms, available in common languages, and must be signed.[77]

b. Timing of Notice

When an item or service is scheduled at least 72 hours before the date of service, a notice must be issued to the patient no later than 72 hours prior to the date of service. If an item or service is scheduled within 72 hours of the date of service, the notice must be issued on the date the appointment is made.[78] The IFR requires a notice be provided to the patient at least three hours prior to a nonparticipating provider furnishing an item or service. It is the Departments' view this allows time to provide a voluntary informed consent. The Departments sought comment as to whether the three-hour requirement is appropriate.[79]

c. Form of Notice

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[74] *Id*. at 36905.

[75] *Id*. at 36911.

[76] *Id*.

[77] *Id.*

[78] 86 Fed Reg at 36907.

[79] *Id.*

The notice must be made using the form specified by HHS.[80] The notice must be made in writing and provided either electronically or in paper form (but must be provided to the patient in one of the two methods he or she selected).[81]

The notice and consent must:

- Clearly state that consent by the individual to receive an item or service from a non-participating provider or facility is optional;
- State the patient may instead seek care from a participating provider or facility, in which the cost-sharing would not exceed the responsibility that would apply is provided from a participating provider or facility;
- Be available in the 15 most common languages in the geographic region of the applicable facility;
- Include consent by the individual to be treated by a non-participating provider or non-participating facility; and
- Provide a signed copy of the consent to the patient through mail or email as selected by the individual.[82]

The notice must clearly inform the patient that the health care provider or the facility is out-of-network with the health plan. The notice must include a good faith estimate of the items or services that the provider or facility reasonably expects to provide, along with a statement that the consent does not constitute a contract with respect to the charges estimated for the item and services.[83] Additionally, when an item or service is provided at a participating facility by a nonparticipating provider, the individual must be provided with a list of participating providers at

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[80] Standard Notice and Consent Documents are *available at* https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf.

[81] 86 Fed Reg at 36907.

[82] *Id.*

[83] *Id.*

the facility who can furnish the item or service.[84] The notice also must include information regarding whether an item or service requires a prior authorization or if there are other care management limitations related to the item or service.[85]

d. Consent

As with the notice document, providers and facilities must use the consent document specified by HHS to document a patient's consent to balance billing.[86] The consent must be signed by the participant, beneficiary or enrollee before the item or service is furnished within the timeframes discussed above. The consent serves as an acknowledgement that the participant, beneficiary, or enrollee has been provided the written notice and is informed of the anticipated charges. The consent also must include an acknowledgement that the participant, beneficiary, or enrollee was provided the opportunity to receive the notice and consent either electronically or in paper form. The notice and consent must include two dates: (1) the date when the notice was received and (2) the date on which the notice and consent was signed.[87]

e. Retention of Notice and Consent Forms

The notice and consent forms must be retained by the facility for a period of seven years from the date on which the item or service is furnished.[88] Because the date of the signed notice and consent may not be the date an item or service is provided (*i.e.*, oftentimes the signed notice and consent will be obtained on a date prior to the date the item or service is provided), using the

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[84] *Id.*

[85] *Id.* at 36907–36908.

[86] Standard Notice and Consent Documents are *available at* https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf.

[87] *Id.* at 36908–36909.

[88] *See* NSA, Section 104.

date the notice was signed by the patient may not always be the threshold date to use to base destruction of the document.

C. Cost Sharing and Balance Billing Limitations

1. The Patient's Payment Obligation: The Cost-Sharing Amount

With respect to *emergency services,* if a health plan or issuer provides or covers any benefits with respect to (1) services in an emergency department of a hospital or (2) in a freestanding emergency department or (3) air ambulance services, the cost-sharing requirement for any such services performed by a nonparticipating provider or nonparticipating emergency facility must not be greater than the cost-sharing requirement that would apply if such services were provided by a participating provider or participating emergency facility. With respect to *non-emergency services,* if a plan or issuer provides or covers any benefits for non-emergency items and services furnished by a nonparticipating provider that renders care at a participating facility, unless the provider satisfies the notice and consent criteria discussed in Section III B 1 herein, the plan or issuer may not impose a cost-sharing requirement for such items and services that is greater than the cost sharing requirement that would apply if the items or services had been furnished by a participating provider. Under the Part 1 IFR, any such cost-sharing payments must be counted toward any in-network deductible or out-of-pocket maximums in the same manner as if such cost-sharing payments were made with respect to services furnished by a participating provider or facility.[89]

A patient's cost sharing amount under the IFR for emergency services received from a nonparticipating provider or facility, and for non-emergency services received from a nonparticipating provider at a participating facility, is calculated as if the total amount that would

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[89] *Id.* at 36883.

have been charged for the services by a participating facility or participating provider were the "recognized amount" for such services.[90]

The "recognized amount" is (i) the amount determined by an applicable All-Payer Model Agreement,[91] or (ii) if there is not applicable All-Payor Model Agreement, then the amount determined by a specified state law or, (iii) if there is no applicable All-Payor Model agreement or not specified by state law, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount ("QPA") for such item or service.[92] Generally, the QPA is based on the median contracted rates by the plan or issuer for the same or similar item or service in the same or similar specialty provided in the same geographic region.[93]

For patients that receive services from a nonparticipating air ambulance provider, the "recognized amount" is not used to determine a patient's cost sharing obligation. Instead, the cost sharing requirement is that which would apply if the services were rendered by a participating provider, and any coinsurance or deductible must be based on rates that would apply for such services if they were provided by a participating provider.[94]

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[90] *Id.*

[91] *See* 42 USC 1315] (a) *et seq.* Very few states currently have an All-Payer Model Agreement with CMS; Michigan does not have an All-Payer Model Agreement with CMS. *See* https://innovation.cms.gov/innovation-models/maryland-all-payer-model (last accessed 10-19-21).

[92] 86 Fed Reg at 36883.

[93] The calculation of the QPA is complex. *See* 86 Fed Reg at 36883 *et seq.* for an in-depth discussion of the calculation. Generally, the QPA is based on the median contracted rates by the plan or issuer on January 31, 2019, for the same or similar item or service in the same or similar specialty provided in a geographic region which the item or service was furnished. The median contract rate is to be determined with respect to all group health plans of the plan sponsor or all group or individual health insurance that is offered in the same insurance market. The Departments require a minimum of three contracted rates to calculate a median rate. In cases where there is insufficient information the Act allows for an alternative method by use of a third-party database. The use of the alternative method is limited to use when the plan or issuer cannot rely on contracted rates as a reflection of the market dynamics in a geographic region.

[94] 86 Fed Reg at 86883.

NSA requires that the Departments and the Internal Revenue Service ("IRS") audit group health plans and health insurance issuers to ensure that plans and coverages comply with the requirement of applying a QPA.[95]

2. The Plan's Payment Obligation: The Out-of-Network Rate

The NSA and Part 1 IFR also establish requirements related to the total amount a plan or issuer must pay for items and services subject to the NSA, referred to as the "out of network rate." The "out of network rate" for an item or service provided by a nonparticipating provider or facility is determined in a manner similar to the "recognized amount." The "out of network rate" is (i) the amount that a state has approved under an All-Payer Model Agreement,[96] or (ii) if clause (i) does not apply to the item or service, the amount determined under a "specified state law" for such item or service, but (iii) if neither clause (i) nor clause (ii) applies to the item or service, then the amount that is the "out of network rate" for such item or service is (A) the amount agreed on between the provider or facility and the plan or coverage, or (B) the amount determined by the certified Independent Dispute Resolution ("IDR") entity.[97]

(1) Is the MSMBL a "Specified State Law" for Purposes of the NSA?

A "specified state law" is a state law that provides a method for determining the total amount payable under a plan, coverage, or issuer with respect to an item or service provided by nonparticipating provider or facility, but only to the extent such state law applies to the plan, coverage, or issuer and is not preempted by ERISA. The MSMBL is a state law that provides a

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95 *Id.* at 86889.

96 *See* 42 USC 1315 (a) *et seq*. *See also,* n. 73 *supra*.

97 45 CFR §149.510(b)

method for determining the total amount payable under a group health plan or group or individual health insurance coverage, and as such, is a "specified state law." However, as discussed elsewhere herein, the scope of the MSMBL is limited. ERISA plans in Michigan are not covered by the MSMBL, and as such the NSA applies to these plans.[98]

(2) Open Negotiation and Independent Dispute Resolution ("IDR") to Determine the Plan or Issuer's Payment Obligation[99]

(a) Open Negotiation

The NSA requires plans and issuers to send "an initial payment or notice of denial of payment" no more than 30 days after a nonparticipating provider or facility submits a bill related to items and services falling within the purview of the statute.[100] With its payment or denial of payment, the plan or issuer must notify the provider or facility of the opportunity to enter into open negotiation for the purpose of determining the out of network rate.[101] Either party may initiate the open negotiation process.[102] The party initiating the open negotiation must provide written notice of its desire to enter into open negotiation to the other party within 30 business days of the receipt of the initial payment or notice of denial of payment.[103] The Departments have issued a standard

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[98] However, the MSMBL does not prohibit an ERISA plan from opting into its coverages. If the ERISA plan opt into the MSMBL, then the MSMBL applies. 86 Fed Reg at 36886.

[99] *See generally*, Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, *available at* https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf.

[100] 86 Fed Reg at 36900.

[101] 86 Fed Reg at 55990.

[102] 45 CFR §149.510(b)(1).

[103] *Id.* at 149.510(b)(1)(ii)(B) Notice may be sent electronically (by email) provided that (1) the initiating party has a good faith belief that the electronic method is readily accessible to by the other party; and (2) the notice is provided free of charge in paper form upon request. *Id.*

Open Negotiation Notice that a party is required to use to provide notice to the other of the party's desire to enter into open negotiation.[104] During this 30-business day open negotiation period, the Departments encourage (but do not require) the parties to come to an agreement regarding out of network rate.[105]

(b) IDR Initiation

If the parties do not reach an agreement, the IDR process may be used to determine the out-of-network rate for the services. Either the out-of-network provider or facility, or the plan or issuer, may initiate the IDR process during the four-business day period starting on the day after the open negotiation period ends (i.e., on the 31st business day following the start of the open negotiation period).[106] However, note that the parties are permitted to continue negotiations following the completion of the open negotiation period.[107]

To initiate the IDR process, the initiating party must submit a notice to the other party and to the Departments through a Federal IDR portal.[108] The Departments have issued a standard Notice of IDR Initiation that the parties are required to use.[109]

(c) Selection of IDR entity

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[104] https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf.

[105] 86 Fed Reg at 55991.

[106] 45 CFR §149.510(b)(2)(i).

[107] *Id.* at 55993. If the parties are successful in agreeing upon the out-of-network rate, the initiating party must notify the Departments. The Notice of Agreement must include the data elements published by the Departments, which are *available at* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-5.pdf.

[108] https://www.nsa-idr.cms.gov.

[109] https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-3.pdf.

No later than three business days following IDR initiation, the parties must jointly select an IDR entity.[110] The initiating party must notify the Departments of the IDR entity selection (or failure to select an IDR entity) by submitting notice to the Departments.[111] If the parties are unable to jointly select a certified IDR entity, then the Departments will select the IDR entity.[112] The IDR entity cannot have a conflict of interest with either party: The IDR entity may not be an employee or agent of either party and cannot have any material familial, financial, or professional relationship with either party.[113] Within three business days of selection as the IDR entity, the IDR entity must review the Notice of IDR Initiation and: (1) attest that it meets the regulatory criteria to serve as the IDR entity (and has no conflict of interest); and (2) determine whether the federal IDR process applies.[114] If the IDR entity is unable to provide the attestation, the parties must select another IDR entity.[115]

(d) Offers

Within 10 days after the IDR entity is selected, both parties must provide an offer for a payment amount for the item or service.[116] Along with the offer, the parties are required to supply additional information including: (1) QPA; (2) the size of the facility or provider practice; (3) the

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[110] 86 Fed Reg at 55991-2. A list of certified IDR entities is *available at* https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list.

[111] Selection of Certified IDR Entity Data Elements are *available at* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-4.pdf.

[112] 45 CFR §149.510(c)(1)(iv).

[113] NSA, Section 103. *See also* 86 Fed Reg at 55992.

[114] 45 CFR §149.510(c)(1)(v).

[115] *Id.*

[116] *Id.* at 149.510(c)(4)(i)

specialty of the facility or provider practice; (4) the coverage area of the plan or issuer; (5) and any additional information requested by the IDR entity.[117]

Unlike the MSMBL, the NSA allows the batching of claims for IDR.[118] The benefit to batching claims is to take like-type claims and bring them forward as part of a single determination. The batching option is to encourage efficiency where possible. To be eligible to batch claims, the claims subject to the IDR must meet the following requirements: the services and items must be furnished by the same provider or facility; payment for the item or services is required by the same group health plan or issuer; the items and services must be related to the treatment of similar conditions; and all of the services must have been furnished during the 30-day period following the date of the first claim determination. The bundled payment will be handled as part of a single determination.[119]

(e) IDR Determination

Within 30 business days of the selection of the IDR entity, the IDR entity must select one of the offers as the final payment determination (without modification) and provide notice to the parties of the determination.[120] The IDR entity's determination will be binding on the parties absent evidence of fraud or material misrepresentation of material facts to the IDR entity.[121]

In making its determination, the IDR entity may consider the following:

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[117] *Id.* at 149.510(c)(4)(A)(3). The Departments have published guidance regarding the data elements to be supplied along with the offer, which are *available at* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-6.pdf.

[118] *Id.* at 149.510(c)(3).

[119] *Id.*

[120] *Id.* at 149.510(4)(ii). The Departments have published guidance outlining the data elements that will be included in an IDR entity's written decision, which is *available at* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-11.pdf.

[121] *Id.* at 149.510(c)(4)(vii)(A)(1).

- The QPAs for items or services that are comparable to the item or service being reviewed and that are furnished in the same geographic region;

- The level of training, experience, and quality outcomes measurement of the provider or facility providing the item or service under review;

- The market share held by the nonparticipating provider or facility or of the plan or issuer in the geographic region in which the item or service under review was provided;

- The acuity of the individual receiving the item or service or the complexity of providing the item or service;

- The teaching status, case mix, scope of service furnished by the nonparticipating facility; and

- The demonstration of good faith efforts (or lack thereof) made by the nonparticipating provider or facility or the plan or issuer to enter into network agreements.[122]

The IDR is prohibited from considering the usual and customary charges, the amount which would have been billed by the provider or facility in respect to the item or service, the payment or reimbursement rate payable by a public payor, including Medicare, Medicaid, Children's Health Insurance Program, and Tricare.[123]

In the Part 2 IFR, the Departments interpreted the NSA to require the IDR entity to presume the QPA to be the appropriate out-of-network rate.[124] In considering the additional information supplied, the IDR entity will evaluate whether credible information has demonstrated that the QPA

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[122] *Id.* at 149.510(c)(4)(iii)(C).

For air ambulance, in addition to the considerations outlined in 45 CFR §149.510(c)(4)(iii), in evaluating which offer to select, the IDR entity also may consider the ambulance vehicle type (aircraft) and the clinical capability level of the vehicle (aircraft). Additionally, the population density of the pick-up location can also be a consideration in determining the acceptance of payment, such as urban, rural, suburban, or frontier. These are the only additions regarding the IDR process for air ambulance under the NSA. 86 Fed Reg at 56998-56999 and 45 CFR §149.520(b)(2).

[123] *Id.* at 149.510(c)(4)(v).

[124] *Id.* at 55996.

is materially different from the appropriate out-of-network rate.[125] The Departments' interpretation has proved highly controversial and is the basis of legal challenges to the NSA in multiple jurisdictions.[126]

(f) Cost of IDR

The cost of IDR is comprised of the IDR entity fee as well as an administrative fee:

- *IDR Entity Fees.* Each party must pay the entire IDR entity fee when the offers are submitted to certified IDR entity.[127] The IDR entity will hold the funds in trust until the IDR entity makes a written determination, at which time the IDR entity will refund the IDR entity fee to the prevailing party.[128] If the parties reach a settlement prior to an IDR determination, however, each party then pays half of all fees charged by the IDR, unless otherwise agreed between the parties.[129]

- *Administrative Fees.* Each party to an IDR determination must pay a non-refundable administrative fee to the Departments when the IDR entity is selected.[130]

(g) Timing of Payment.

Once an IDR has issued a written determination of the OON rate, payment must be made to the nonparticipating provider or facility within 30-calendar days of the final determination.[131]

(h) 90-Calendar Day Suspension Period

Once there is a determination by the IDR entity, the initiating party is prohibited from

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[125] 45 CFR §149.510(c)(4)(ii)(A).

[126] *See e.g., American Medical Association et al. v. United States Department of Health and Human Services et al.,* 1:21-cv-03231 (D.D.C. December 8, 2021), *available at* https://www.aha.org/litigation and *Texas Medical Association et al. vs. United States Department of Health and Human Services et al.,* 6:21-cv-00425 (D.D.C. October 28, 2021), *available at* https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/Surprise_Billing_Lawsuit_102821.pdf.

[127] 45 CFR §149.510(d)(1)(ii).

[128] *Id.* at 149.510(e)(2)(viii)

[129] *Id.*

[130] 86 Fed Reg 55998

[131] *Id.* at 56000.

submitting another notice of IDR Initiation involving the same other party and same or similar items or services for 90 calendar days.[132] This suspension period is intended as a "cooling off" timeframe between disputes.[133]

D. Notice Posted on Provider/Facility Website[134]

Under the NSA, beginning January 1, 2022, all health care providers and facilities must make publicly available, and post on their websites, a one-page notice in clear and understandable language information on the requirements and prohibitions under the NSA regarding balance billing in cases of emergency services and balance billing in cases of non-emergency services performed by nonparticipating providers at participating facilities.[135]

Additionally, the notice must include information (i) about any state law requirements on the provider or facility regarding the amounts the provider or facility may charge a participant, beneficiary, or enrollee of a group health plan or health coverage with respect to which the provider or facility does not have a contractual relationship (under the MSMBL, for Michigan, this currently is the median amount negotiated by the carrier or the region for a provider specialty or 150 percent of the Medicare Fee Schedule, whichever is greater), and (ii) on contacting state and federal agencies if an individual believes that the provider or facility has violated any of the requirements stated in the notice.[136]

E. Enforcement

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[132] *Id.*

[133] *Id.*

[134] *See generally,* 45 CFR. §149.430 Provider and facility disclosure requirements regarding patient protections against balance billing.

[135] 86 Fed Reg at 36913.

[136] *Id.*

A complaint process will be established by the Departments.[137] The complaint process must establish a method to receive complaints and provide a response to complaints within 60 days.[138]

The NSA provides for civil monetary penalties up to $10,000 to providers, air ambulance, and facilities.[139] The penalty applies to each violation of the NSA, and therefore can be substantial in the event of numerous violations. There are exceptions under the NSA for which penalties may be waived. The penalty can be waived upon a showing by a provider, facility, or air ambulance that it did not knowingly violate and could not have reasonably known it violated the NSA.[140]

Within 30 days of a violation, the provider, facility, or air ambulance must withdraw the bill that was in violation of the NSA and reimburse the health plan or enrollee as applicable. The reimbursement amount must be equal to the difference between the amount billed and the amount allowed under the provisions including interest.

F. Protections for the Uninsured

1. Good Faith Estimates ("GFE" for Uninsured (or Self-Pay) Individuals

The NSA requires health care providers and facilities, upon scheduling an item or service, or upon the request of the individual, to inquire about the individual's health coverage status and provide notification of a GFE of the expected charges for furnishing the items or services with the expected billing and diagnostic codes.[141] The Part 2 IFR sets forth requirements for the provision

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[137] *See* 45 CFR §149.450 Complaint process for balance billing regarding providers and facilities

[138] 86 Fed Reg at 36915.

[139] *See* NSA, Section 104.

[140] *Id.*

[141] *Id.* at 56013.

of GFEs to individuals that are not enrolled in a plan or coverage and are not seeking to file a claim with the plan or coverage (i.e., uninsured or self-pay individuals).[142] The requirements are codified at 45 CFR §149.610.

Under the Part 2 IFR, a "convening health care provider" or "convening health care facility" (defined as the provider or facility that receives the request for a GFE and who would be responsible to schedule the primary item or service) is required to:

- Inquire whether the individual is enrolled in a plan or coverage or is seeking to have a claim submitted to such plan or coverage for the item or service;
- Inform all uninsured or self-pay individuals of the availability of a GFE of expected charges upon scheduling an item or service or upon request (the convening health care provider or convening health care facility must treat any inquiry regarding potential costs as a request for GFE);
- Timely provide a GFE to the individual.[143]

a. Notice of the availability of a GFE

The convening provider or convening health care facility is required to inform uninsured or self-pay individuals of the availability of a GFE for expected charges.[144] This notice must be provided both orally (when questions surrounding the cost of items or services are raised) and in writing.[145] The written notice be displayed in a clear and understandable manner in multiple locations:

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[142] *Id.* The NSA also requires that providers and facilities furnish GFE to insured individuals' plans or issuers. However, acknowledging that the Departments had received feedback from stakeholders that establishing the technical infrastructure necessary to transmit such information to plans or issuers had proven challenging, the Departments concluded that HHS would defer enforcement of the requirement until such time rulemaking for such requirement had been fully implemented. *Id.* at 55984.

[143] *Id.* at 56016.

[144] *Id.*

[145] *Id.*

- On the convening provider's or convening facility's website, in an easily searchable location from a public search engine;
- In a convening provider's office; and
- At a location where scheduling or questions surrounding the cost of items or services occur.[146]

HHS has developed a model notice; however, use of the model notice is not required.[147]

b. Content of the GFE

The GFE must include the following data elements:

- Patient name and date of birth;
- A description of the primary item or service and the date such item or service is scheduled to be provided;
- An itemized list of items or services grouped by provider or facility that are reasonably expected to be provided (including those items and services to be provided by a co-provider or co-facility, i.e., a provider or facility that is not the convening health care provider or convening health care facility[148]);
- Applicable diagnosis codes, expected service codes, and expected charges;
- The name, NPI, and TIN of each provider or facility represented in the GFE, and the state(s) where the items or services are expected to be provided;
- A list of items or services that are expected to require separate scheduling; and
- Disclaimers related to the limitations of the GFE.[149]

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[146] *Id.*

[147] *Id. See also* Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act, *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

[148] In the Part 2 IFR, HHS notes that, "it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an insured (or self-pay) individual does not include expected charges from co-providers or co-facilities." *Id.* at 56023.

[149] *Id.* at 56018. *See also* Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act, *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

a. Timely Notice of the GFE

The GFE must be provided to an uninsured or self-pay individual within the following timeframes:

- In scenarios where an item or service is planned to be furnished at least 3 business days after scheduling, the GFE must be provided within one business day after the date of scheduling;

- In scenarios where an item or service is planned to be furnished at least 10 business days after scheduling (or if a GFE is requested by an individual for an item or service that is not yet scheduled), the GFE must be provided within 3 business days from the date of scheduling or request.[150]

If the convening health care provider or convening health care facility anticipates that an uninsured or self-pay individual also will require care from a co-provider or co-facility, the convening health care provider or convening health care facility has the responsibility to request a GFE from the co-provider or co-facility no later than one business day following scheduling an item or service or the individual's request.[151] The convening health care provider or convening health care facility will notify the co-provider or co-facility of the date the GFE information must be received.[152]

If the scope of information included in a GFE changes, the convening health care provider or convening health care facility is required to furnish the individual a new GFE no later than one business day before the item or service is scheduled.[153] Furthermore, if the expected providers or facilities represented in a GFE change within one business day before an item or service is

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[150] 86 Fed Reg at 56017.

[151] *Id.*

[152] *Id.*

[153] *Id.*

scheduled, and a replacement provider or replacement facility is to render the item or service, the replacement provider or replacement facility must accept he GFE as the expected charges.[154]

2. Patient-Provider Dispute Resolution ("PPDR")

The NSA requires HHS to establish a PPDR process for an uninsured (or self-pay) individual to use if he or she receives a GFE and is billed in an amount "substantially in excess" of the expected charges contained in the GFE.[155] The Part 2 IFR defines "substantially in excess" to mean at least $400 more than the total amount of expected charges listed on the good faith estimate.[156] The PPDR process is outlined at 45 CFR §149.620.

a. Initiating PPDR

An individual can initiate the PPDR process by submitting a notice to HHS within 120 calendar days of receiving an initial bill from the provider or facility (hereafter, the "PPDR initiation notice").[157] The PPDR initiation notice may be submitted online,[158] by fax, or by mail (and postmarking the submission within 120 days calendar days from receipt of the initial bill).[159] The PPDR initiation notice must satisfy certain content requirements. HHS has developed a standard form that must be used as the PPDR initiation notice.[160] The individual also must include an administrative fee for the selected dispute resolution ("SDR") entity with

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[154] *Id.*

[155] *Id.* at 56024.

[156] 45 CFR §149.620(a)(2)(ii).

[157] 86 Fed Reg at 56031.

[158] https://www.cms.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured.

[159] 86 Fed Reg at 56031.

[160] *See* PPDR Form Notice, *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

the PPDR initiation notice.[161]

b. Selecting the SDR Entity

Once HHS receives the PPDR initiation notice, it will select an SDR entity.[162] If the selected SDR entity has a conflict of interest, the SDR entity must notify HHS no later than 3 business days following selection, and HHS will select a different SDR entity from the remaining pool of SDR entities. Selection will occur in a round-robin format.[163]

Provided that no conflict exists, the SDR entity will provide notice to the individual and the provider or facility that a PPDR initiation notice was received and is under review.[164] While the PPDR process is ongoing, the provider or facility is prohibited from moving bills for the items or services into collection or threatening to do so.[165] The provider or facility also must defer accrual of any late fees on the unpaid bill amounts until the conclusion of PPDR.[166]

The SDR entity shall review the PPDR initiation notice to ensure the disputed items and services meet eligibility criteria and the PPDR initiation notice contains the required information.[167]

- If the SDR entity determines that an item or service is *ineligible* for PPDR or the

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[161] 86 Fed Reg at 56032.

[162] *Id.*

[163] *Id.* at 56035.

[164] *Id.* at 56032. *See also* Standard Notice: Selected Dispute Resolution (SDR) Entity Notification to Health Care Providers and Facilities and Uninsured (or Self-Pay) Individuals, *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

Following selection of the SDR entity, and even if the SDR entity has not identified a conflict of interest, either party may attest that a conflict of interest exists, which case the SDR entity must notify HHS no later than three business days following receipt of the attestation. HHS will select a different SDR entity. 86 Fed Reg at 56035.

[165] 86 Fed Reg at 56032.

[166] *Id.*

[167] *Id.*

initiation notice is incomplete, the SDR entity will issue an insufficiency notice, and the individual will be provided 21 calendar days to submit missing information or other information to demonstrate the item or service is eligible for PPDR.[168]

- If the SDR entity determines that an item or service is *eligible* for PPDR, the SDR entity must notify both parties and request that the provider or facility provide certain information within 10 business days, including:
  - A copy of the GFE;
  - A copy of the billed charges provided to the individual; and
  - Documentation demonstrating that the difference between the billed charges and the expected charges in the GFE reflects the cost of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the GFE was provided.[169]

c. Payment Determination

(1) Determination of the Payment Amount through Settlement

In the event the parties agree to settle the dispute prior to the date the SDR entity issues a payment determination, the provider or facility must notify the SDR entity through the Federal IDR portal or by mail as soon as possible, but no later than 3 business days after the date of the agreement.[170]

Administrative fee. Any settlement must reflect that the provider or facility applied a reduction to the amount owed that is equal to at least half of the administrative fee.[171]

(2) Determination of the Payment Amount through PPDR

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[168] *Id.* HHS has developed a Standard Notice: Ineligible for Patient-Provider Dispute Resolution or Additional Information Needed, *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

[169] 86 Fed Reg at 56033. A list and description of the Data Elements to be supplied is *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

[170] 86 Fed Reg at 56036. HHS has developed a Standard Notice of Settlement and Standard Notice of Receipt of Dispute Settlement, both of which *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

[171] 86 Fed Reg at 56036.

The SDR entity will use the expected charges as listed in the GFE as the presumed appropriate amount, unless the provider or facility provides credible information justifying the difference between the billed charges and the expected charges in the GFE by demonstrating that the difference reflects: (1) the cost of a medically necessary item or service; and (2) is based on unforeseen circumstances that could not have been reasonably anticipated by the provider or facility when the GFE was provided.[172]

For an item or service where the billed charge is more than the expected charge listed in the GFE, the SDR entity will determine the payment amount as follows:

- If the SDE entity determines the provider or facility *has <u>not</u> provided* such credible information:
  - *For an item or service listed in the GFE,* the amount the individual will be required to pay will be equal to the expected charge for the item or service as listed in the GFE.
  - *For an item or service <u>not</u> listed in the GFE,* the amount the individual will be required to pay will be $0.[173]

- If the SDE entity determines the provider or facility *has provided* such credible information:
  - *For an item or service listed in the GFE,* the amount the individual will be required to pay will be equal to the lesser of: (1) the billed charge; or (2) The median payment amount for the same or similar service in the geographic area that is reflected in an independent database (or if the amount in the independent database is less than the expected charge in the GFE, then the amount listed in the GFE).
  - *For an item or service <u>not</u> listed in the GFE,* the amount the individual will be required to pay will be equal to the lesser of: (1) the billed charge; or (2) The median payment amount for the same or similar service in the geographic area that is reflected in an independent database.[174]

d. Notice of Determination

Once a final payment determination amount has been calculated, the SDR entity must

[172] *Id.* at 56037.

[173] *Id.* at 56038.

[174] *Id.*

inform the parties through the Federal IDR portal or by mail of the final payment determination and the justification for the determination.[175] The determination made by an SDR entity will be binding on the parties absent a fraudulent claim or evidence of misrepresentation of facts presented to the SDR entity.[176]

G. Health Plan Requirements

Health plans will not escape requirements under the Act. The Departments have delayed implementation of some requirements for health plans and issuers, but not all have been delayed. Those requirements not delayed for health plans are left with implementing compliance in good faith; however, enforcement action is delayed.[177]

The CAA has imposed new transparency requirements on plans and issuers, including prescription drug reporting requirements. The new rules significantly differ from the Transparency in Coverage Final Rules (the TiC Final Rules).[178] As a result, the Departments will defer enforcement.[179] The Departments have issued under the FAQ enforcement regarding machine-readable files for in-network rates and out-of-network allowed amounts are set to begin on July 1, 2022.

Additionally, the Departments recognized duplications between the CCA and TiC Final

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[175] *Id.* at 56037. HHS has developed a Standard Notice of payment determination, which is *available at* https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

[176] 86 Fed Reg at 56040.

[177] *FAQ About Affordable care Act and Consolidated Appropriations Act,* 2021 Implementation Part 49, August 20, 2021. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[178] 85 Fed Reg 71258 (Nov. 12, 2020).

[179] *FAQ About Affordable care Act and Consolidated Appropriations Act,* 2021 Implementation Part 49, August 20, 2021. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

Rule for self-service price comparison tools. As a result, the Departments will defer enforcement of the requirements and begin enforcement on or after January 1, 2023.

Adding to the list of deferred requirements includes ID cards. Under the CCA, health plans and issuers were required to design beneficiary and enrollee ID cards to comply with certain requirements including, major medical deductibles, out-of-pocket maximums, and telephone number and website address for customer service assistance. The Departments intend to address implementation through future rulemaking.[180]

The Departments received feedback regarding the challenges of implementing the Advance Explanation of Benefits. Stakeholders have raised compliance concerns regarding the transfer of data between, providers, facilities, plans, and issuers.[181] The Departments have recognized compliance with all the various requirements related to the Advanced Explanation of Benefits was likely not possible by January 1, 2022.

Health plans have some reprieve of provider directory requirements. The Departments will undertake through the rulemaking process any future requirements related to provider directory requirements.[182]

Health plans will need to configure their claims system to accommodate provider and facilities who have continuing care patients. This could be an operational challenge to keep straight and ensure proper adjudication of claims including patient accumulators and patient accounting of deductibles, co-payments, and coinsurance amounts.

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[180] *Id.*

[181] *Id.*

[182] *Id.*

H. Price Comparison Tool

Health plans will be required to provide price comparison guidance either through telephone or website. The price comparison tool must provide pricing information to allow a plan participant to compare the amount of cost sharing that he or she is responsible to meet.[183]

IV. CONCLUSION AND COMMENTS

For providers, facilities and plans serving patients in Michigan and their legal counsel, it will be necessary to understand the MSMBL and NSA and know when each statute controls. It is important to monitor the regulations implementing the NSA, as they may be modified throughout the rulemaking process. These regulations may lead to operational challenges. There was a short window of time from when the interim final rules were issued and the January 1, 2022, effective date of the NSA. This schedule leaves little time for payors, providers, and facilities to implement processes necessary to comply with the law.

The thrust of these laws is to assure that the consumer is made aware of a potential additional payment responsibility before health services are furnished. Consumer protection is a laudable goal. From the discussions of the Michigan and federal legislation addressed in this article, however, it should be clear to the reader that the consumer protection goals impose significant burdens on providers in several respects. First, to avert the risk of being penalized, providers must comply with the patient disclosure requirements. Second, providers must assure compliance with state and federal law, which will require legal guidance regarding the extent to which inconsistent provisions must be reconciled. Third, in certain circumstances nonparticipating providers will be required to accept lower, participating provider payment rates, thus enabling

[183] *FAQ About Affordable care Act and Consolidated Appropriations Act*, 2021 Implementation Part 49, August 20, 2021. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

payors to impose payment rates on providers unwilling to accept such rates, and potentially resulting in efforts by nonparticipating providers to minimize the extent to which they provide services to patients not enrolled in the payors with which the providers participate.

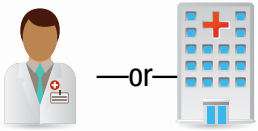
Similarly, and in the interest of consumer protection, the requirements discussed in this article impose administrative burdens on health plans. These requirements add to the cost of operating a health plan, which could result in higher premiums or reduced provider payments, or both.

Finally, due to the "law of unintended consequences," time will tell what legal and operational issues will arise as consumers, providers and health plans are impacted by the federal and state legislation.

Michigan Surprise Medical Billing

Non-par

Provider Facility



Transmits Claim to Payor
within 60 Days

Payor Sets Payment
Greater of the following:

- **Median Amount**
  Amt. Negotiated by carrier for region and provider specialty (excluding: in-network co-insurance, copay, or deductibles)
- **150% Of Medicare Fee Schedule**
  (excluding: in-network co-insurance, copay, or deductibles)

EFFECTIVE JULY 1, 2021

Pay
Pays determined payment within 60 days after receiving claim

Provider Disputes Payor Payment Calculation
Request DIFS for review of calculation

DIFS Calculation

- Confirms Payor Set Payment
  —or—
- Determines calculation incorrect issues the correct amount

[1] *A non-par provider cannot submit a request for the same health care services which have been previously submitted and received.*

Michigan Surprise Medical Billing

Complicating Factor to Emergency Patient

Non-par provider may file a claim for greater reimbursement amount greater than payor set median amount or 150% of Medicare Fee Schedule

Non-par Provider

Claim must be accompanied by:

- Documentation demonstrating complicating factor

—and—

- Emergency patient's medical record with portions supporting complication highlighted

Payor

Within 30 days must do one of the following

- **Pay additional amount 25% above:**
  - — Payor Median Amount
  - —or—
  - —150% Medicare Fee Schedule
- **Issue Denial Letter**

Denial Letter

Eff. 7/1/2021 may Request binding arbitration

Arbitration Request

Non-par provider submits written request to DIFS for arbitration[1].

DIFS

Accepts Request DIFS sends notice to payor

Payor

With 30 days of receipt of DIFS notice:

- Confirms Denial

—or—

- Provides alternative payment offer to be considered in arbitration

Arbitrator Selection

Partial Select from DIFS list of trained Arbitrators

- American Arbitration Association
- American Health Lawyers Association

Arbitrator

Reviews written submission by both parties

Arbitrator's Decision

45 days after receiving documentation from both parties

[1] *Request must include documentation submitted to payor, contact information of emergency patient's health benefit plan, and denial letter.*

DIFS = Department of Insurance and Financial Services.

NO SURPRISES ACT[1]

Nonpar

Provider —or— Facility

Transmits Claim to Payor

Payor within 30 Days

Makes initial payment

—or—

Denial

Open Negotiation 30 Days

—and—

Negotiations Fail

4 days to Select Independent Dispute Resolution Party[2]

I.D.R Selected by both Parties

Submission of Offer

Withing 10 days of I.D.R. selection both parties must submit I.D.R offer for payment amount

I.D.R. Determination

No later than 30 days after selection of I.D.R.

Decistion Final and Binding on Parties

[1] *Consolidated Appropriations Act, 2021, Division BB, Title 1*

[2] *If parties do not select I.D.R. within 6 days of the date of initiation, HHS must select I.D.R.*

Michigan and Federal Surprise Billing Law at a Glance

This table is a high-level comparison between state and federal surprise billing law.

	Michigan	Federal No Surprises Act
Effective Date	**October 22, 2020**	**January 1, 2022**
Applicable Payor Types	"Carrier" means any of the following: (a) A person that issues a health benefit plan in this state, including an insurer, health maintenance organization, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation. (b) An entity that contracts with this state or a local unit of government to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services provided under a self-funded plan established or maintained by the state or local unit of government for its employees. MCL 333.24502(1)	• Self-Funded Plans • Federally Funded Plans • Non-federal Government Plans • Group Health Plans • Individual Health Insurance 45 CFR 149.20
Applicable Providers	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. MCL 333.24504(4)	• *Physician or health care provider* means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services. • *Provider of air ambulance services* means an entity that is licensed under applicable State and Federal law to provide air ambulance services. 45 CFR 149.10

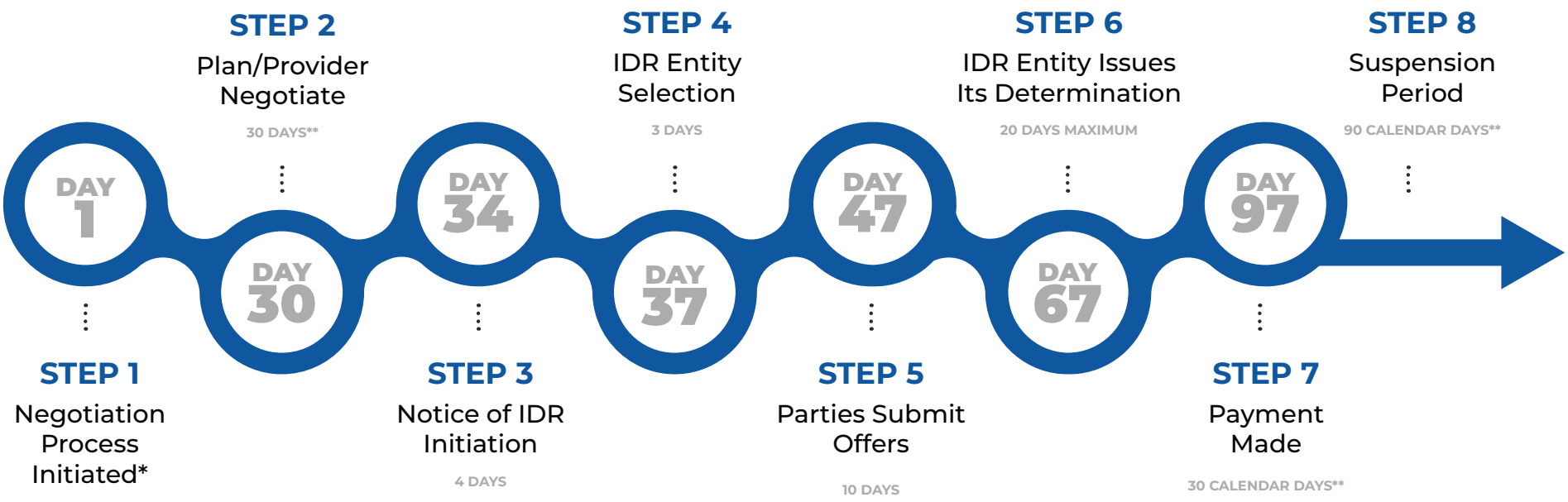
	Michigan	Federal No Surprises Act
Effective Date	**October 22, 2020**	**January 1, 2022**
Protections Do Not Apply To	• Ground / Air Ambulance • Enrollees Consenting to Waive Protections • Self-Funded Plans • Non-federal Government Plans • Out of State Provider	• Enrollees Consenting to Waive Protections • HMO • PPO • Ground Ambulance
Timing of Notice	• 14 days before scheduled procedure; or • Within 14 days if service provide within 14 days MCL 333.24509(1)(a)	• Scheduled appointment at least 72 hours before date of appointment – notice to be given no later than 72 hours before appointment. • Scheduled appointment within 72 hours of date of appointment – notice given on date appointment is made. • Receiving services on the same day of service – notice be given within 3 hours prior to furnishing service. 45 CFR 149.420
Notice and Consent Restrictions	• Cannot be provided at the time of non-emergency admittance to a facility; or • At the time of preparation for surgery or other medical procedure MCL 333.24509(2)	Does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non- physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no participating provider who can furnish such item or service at such facility. The notice and consent exception does not apply to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which a nonparticipating provider satisfied the notice and consent criteria. 45 CFR 149.420(b)

	Michigan	Federal No Surprises Act
Effective Date	**October 22, 2020**	**January 1, 2022**
Retaining Notice/ Consent	No less than 7 years. MCL 333.24509(4)(b)	7-year period after the date on which the item or service is so furnished. 45 CFR 149.420(h)
Language Access	None	Must make the notice available in any of the 15 most common languages in the geographic region in which the applicable facility is located; or Alternatively provide the notice and consent documents in the 15 most common languages in the geographic region, which reasonably reflects the geographic region served by the applicable facility. 45 CFR 149.420(f)
Reimbursement Calculation	The greater of: • Median amount negotiated by carrier for region and provider specialty (excluding in-network coinsurance, copayments, or deductibles); or • 150% of the Medicare Fee Schedule. MCL 333.24507(a), (b)	Qualifying Payment Amount (QPA) is based on: 1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; 2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law 3) if there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility; or 4) if none of those three conditions apply, an amount determined by an IDR entity. 45 CFR 149.140
Independent Dispute Resolution	Only available for claims involving emergency patients with complicating factors for an additional payment of 25%. MCL 333.24511	Available to dispute denial or received payment amount. 45 CFR 149.510

	Michigan	Federal No Surprises Act
Effective Date	**October 22, 2020**	**January 1, 2022**
Penalties	Fines MCL 333.16221(z) and MCL 333.16226	Interim final rules authorize HHS to impose civil money penalties on facilities and providers that violate these requirements Fed Reg 36905 (July 13, 2021)
Timely Filing	60 days after the date of service. MCL 333.24507(2)	
Interaction Between Law	Fines MCL 333.16221(z) and MCL 333.16226	Defers to State payment standard and IDR for state regulated plans 45 CFR 149.30

FEDERAL NO SURPRISES ACT (NSA): Independent Dispute Resolution (IDR) Process

The NSA requires parties to attempt to negotiate an acceptable payment amount before the provider can access the IDR process.



* Negotiation must be initiated within 30 days of initial payment or denial.

** All references to days are "business days" unless otherwise noted.