SURPRISE MEDICAL BILLING ANNUAL REPORT
PA 234 of 2020

I. Introduction

On October 22, 2020, Governor Whitmer signed the Surprise Medical Billing Act, Act 234 of 2020, MCL 333.24501, *et seq*., (the Act). The Act protects patients from surprise medical bills. "Surprise billing" occurs when a person receives health care in a facility or from a provider that is covered by the person's health plan, but a portion of their care is rendered by an out-of-network provider. In some instances, the person receives an unexpected bill from the out-of-network provider for these services. Prior to the enactment of the Act, because the out-of-network provider was not required to accept the amount paid by the insurer as payment in full, the out-of-network provider was permitted to bill the patient for the difference between the amount billed by the out-of-network provider and the amount that the insurer paid to the provider for the service(s).

This Surprise Medical Billing Annual Report provides the state Senate and House of Representatives standing committees on health policy and insurance with data on surprise billing complaints, carrier network adequacy, requests for calculation review, and requests for arbitration. The annual report requirement is set forth in MCL 333.24515 as well as Section 304 of Article 7 of 2020 PA 166 (Omnibus Budget Appropriation Bill for fiscal year ending September 30, 2021).

This report contains data from October 1, 2020 through December 31, 2020. Additionally, because the sections of the Act that provide for requests for recalculation and requests for arbitration, MCL 333.24515(1)(e) and (f), are not effective until July 1, 2021, this report does not contain data regarding those requests. Data for the full 2021 calendar year will be included in the DIFS Surprise Medical Billing Annual Report for 2022.

II. Out-of-Network Billing Complaints

MCL 333.24515(1)(a) requires the report to include the number of out-of-network billing complaints received by DIFS from enrollees or their authorized representatives. It should be noted that an out-of-network billing complaint is not necessarily a "surprise billing" complaint. Surprise billing, as noted in Section I above, occurs when a person receives health care in a facility or from a provider that is covered by the person's health plan, but a portion of their care is rendered by an out-of-network provider. In some instances, the person receives an unexpected bill from the out-of-network provider for these services. Complaints involving out-of-network billing can arise in circumstances other than true "surprise billing" situations, such as when a person intentionally receives care out-of-network but mistakenly believes that they should have been covered at an in-network rate. As MCL 333.24515 requires, the complaint statistics in this Surprise Medical Billing Annual Report include all complaints that include any issue related to out-of-network billing, not only true "surprise billing" complaints. In future annual reports, DIFS will identify which of these complaints are true "surprise billing" complaints.

From October 1, 2020 through December 31, 2020, DIFS received 31 complaints from an insured or an insured's authorized representative regarding out-of-network billing.

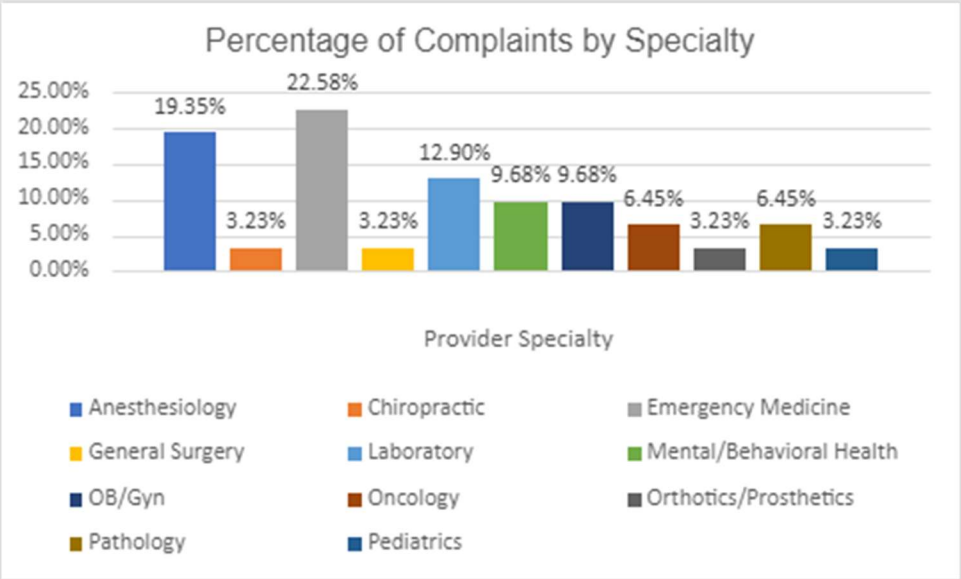
III. Complaints by Provider Specialty

MCL 333.24515(1)(b) requires the report to separate the number of out-of-network billing complaints received by DIFS by provider specialty.

The table below provides a summary of the out-of-network complaints that DIFS received and which specialties were involved. The out-of-network complaints are categorized using the categories of medical specialties listed in Appendix IX of the Michigan Network Adequacy Guidance.

SPECIALTY	NUMBER OF COMPLAINTS
Anesthesiology	6
Chiropractic	1
Emergency Medicine	7
General Surgery	1
Laboratory Services	4
Mental/Behavioral Health	3
Obstetrics/Gynecology	3
Oncology	2
Orthotics/Prosthetics	1
Pathology	2
Pediatrics	1
TOTAL	**31**

The chart below provides the percentage of out-of-network complaints for each specialty:



IV. Ratios of Complaints to Enrollees by Plan

MCL 333.24515(1)(c) requires the report to include the ratio of out-of-network billing complaints to the total number of enrollees in the health plan. The number of enrollees in each health plan was calculated using the number of lives covered that were submitted by each plan on its FIS 322 form. The data reported on the FIS 322 form reflects the data on December 31 of the year preceding the filing.

INSURER - MEDICAL	NUMBER OF OUT-OF-NETWORK COMPLAINTS	NUMBER OF ENROLLEES	RATIO OF COMPLAINT TO ENROLLEES
Aetna Health	2	164,813	1:82,407
Alliance Health & Life Ins Co	0	108,601	N/A
Blue Cross Blue Shield of MI	7	4,515,733	1:645,105
Blue Care Network	1	750,727	1:750,727
CIGNA	1	21,659	1:21,659
Golden Rule	1	15,865	1:15,865
Health Alliance Plan	1	98,090	1:98,090
Humana Ins Co	0	1,377	N/A
McLaren Health Plan Comm	3	18,024	1:6,008
Meridian Health Plan of MI	1	9,322	1:9,322
Molina Healthcare of MI	3	9,587	1:3,196
National Health Ins Co	0	828	N/A
Oscar Insurance Co	0	1,422	N/A
Paramount Care of MI	0	1,092	N/A
Physician's Health Plan	0	37,331	N/A
Priority Health (HMO)	4	452,859	1:113,215
Total Health Care USA	0	34,784	N/A
Trustmark	1	31	1:31
UnitedHealthcare Ins Co	5	67,401	1:13,480
Upper Peninsula Health Plan	1	53,839	1:53,839
TOTAL	**31**	**6,363,385**	**1:205,270**

V. Carrier Network Adequacy by Specialty

MCL 333.24515(1)(d) requires the report to include information regarding carrier network adequacy by provider specialty. DIFS reviews network adequacy for commercial insurers, health maintenance organizations, and any issuer issuing Qualified Health Plans (QHPs) on the Marketplace pursuant to the Patient Protection and Affordable Care Act, Public Law 111-148 under the authority of MCL 500.3428, which provides:

> An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the Director under federal law.

Additionally, QHPs must comply with the Patient Protection and Affordable Care Act and federal regulations: specifically, 45 CFR 156.230, which provides:

> (a) *General requirement.* Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:
>
> (1) Includes essential community providers…
>
> (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,
>
> (3) Is consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act.

All carriers described above are required to submit the Michigan Network Data Template to DIFS for approval. The template includes information on each carrier's network according to provider type, provider specialty, and provider sub-specialty. All networks are subject to a 30-minute travel time standard. DIFS calculates travel time to hospitals and acute care facilities using computer software containing a statewide road network with speed limits and geocoded hospitals to calculate each township, city, and village within 30 minutes of a hospital. Travel time to non-hospital providers is calculated manually.

VI. Calculation Reviews

Because MCL 333.24515(e) is not effective until July 1, 2021, this data could not be collected for the time period that this report encompasses. Data on requests for calculation review for calendar year 2021 will be included in the 2022 DIFS Surprise Medical Billing Annual Report.

VII. Requests for Arbitration

Because MCL 333.24515(f) is not effective until July 1, 2021, this data could not be collected for the time period that this report encompasses. Data on requests for arbitration for calendar year 2021 will be included in the 2022 DIFS Surprise Medical Billing Annual Report.