DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

SURPRISE MEDICAL BILLING ANNUAL REPORT: 2021

I. Introduction

On October 22, 2020, Governor Whitmer signed Public Acts 234 and 235 of 2020, MCL 333.24501, *et seq*., (the Act). The Act protects patients from surprise medical bills. “Surprise billing” generally occurs when a person receives health care 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 Michigan Senate and House of Representatives standing committees on health policy and insurance with data on out-of-network billing complaints, carrier network adequacy, requests for calculation review, and requests for arbitration. The annual report requirement is set forth in MCL 333.24515.

This report contains data from January 1, 2021 through December 31, 2021.

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, generally occurs when a person receives health care 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 under the health plan. As MCL 333.24515 requires, the complaint statistics in this report include all complaints regarding any issue related to out-of-network billing, not only true “surprise billing” complaints.

In 2021, DIFS received 86 complaints regarding out-of-network billing.

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III. Complaints by Provider Specialty

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

The table below provides a summary of the out-of-network billing complaints that DIFS received and which medical specialties were involved. The out-of-network billing complaints are categorized using the medical specialties listed in the Michigan Network Adequacy Guidance.[1]

SPECIALTY	NUMBER OF COMPLAINTS	COMPLAINTS BY PERCENTAGE
Ambulance	4	4.6
Anesthesiology	6	7.0
Cardiovascular medicine	3	3.5
Colon/rectal	4	4.6
DME	4	4.6
Emergency Medicine	14	16.3
Family Practice	1	1.0
General Dentistry	1	1.0
General Practice	6	7.0
General Surgery	7	8.1
Laboratory Services	6	7.0
Mental/Behavioral Health	5	5.8
Nurse Practitioner	1	1.0
Obstetrics/Gynecology	4	4.6
Oncology	3	3.5
Optometry	1	1.0
Oral & Maxillofacial Surgery	1	1.0
Orthopedic Surgery	2	2.3
Pain Management	2	2.3
Pediatrics	3	3.5
Physical Therapy	2	2.3
Psychology	3	3.5
Radiology	1	1.0
Urgent Care	1	1.0
Urology	1	1.0
TOTAL	**86**	**100.0**

[1] Ambulance providers are not listed as a "medical specialty" in DIFS' Michigan Network Adequacy Guidance; however, because DIFS received complaints regarding out-of-network billing related to ambulance services, they are included in this chart.

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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	3	407,839	1:135,946
Blue Care Network	1	840,212	1:840,212
Blue Cross Blue Shield of MI	36	3,432,356	1:95,343
Blue Cross Complete of MI	1	324,160	1:324,160
CIGNA	2	52,464	1:26,232
McLaren Health Plan Comm	3	273,029	1:91,010
Meridian Health Plan of MI	8	619,534	1:77,442
Molina Healthcare of MI	3	428,377	1:142,792
Oscar Insurance Co	4	1,522	1:381
Priority Health	16	897,810	1:56,113
Total Health Care USA	1	25,181	1:25,181
UnitedHealthcare Ins Co	6	205,854	1:34,309
Upper Peninsula Health Plan	1	56,983	1:56,983
Nippon Life	1	4,537	1:4,537
TOTAL	**86**	7,569,858	1:88,021

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 [D]irector 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

MCL 333.24515(1)(e) requires the report to include the number of requests made to DIFS under section 24510(1) of the Act for a review of an insurer's calculation of a payment to a nonparticipating provider for a health care service. In 2021, the Department received 37 requests to review a payment calculation.

VII. Requests for Arbitration

MCL 333.24515(1)(f) requires the report to include the number of requests for binding arbitration filed with DIFS under section 24511(3) of the Act. DIFS received no requests for binding arbitration in 2021.