SURPRISE MEDICAL BILLING ANNUAL REPORT
PA 234 of 2020

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, prepared by the Department of Insurance and Financial Services (the Department), 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 by provider specialty, requests for calculation review, and requests for binding arbitration. The annual report requirement is set forth in MCL 333.24515.

This report contains data from January 1, 2022 through December 31, 2022.

II. Out-of-Network Billing Complaints

MCL 333.24515(1)(a) requires this report to include the number of "out-of-network billing complaints" received by the Department 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 2022, the Department received 70 complaints regarding out-of-network billing.

III. Complaints by Provider Specialty

MCL 333.24515(1)(b) requires this 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 the Department 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 OUT-OF-NETWORK COMPLAINTS	COMPLAINTS BY PERCENTAGE
Ambulance	9	12.9%
Anesthesiology	2	2.9%
Audiology	1	1.4%
Chiropractic Medicine	1	1.4%
Colon/Rectal	4	5.7%
Dermatology	1	1.4%
DME	1	1.4%
Emergency Medicine	7	10.0%
Endodontics	1	1.4%
Gastroenterology	1	1.4%
General Dentistry	3	4.3%
General Pediatrics	1	1.4%
General Surgery	6	8.6%
Laboratory	8	11.4%
Mental/Behavioral Health	3	4.3%
Midwife	1	1.4%
Neurology	1	1.4%
Oncology	6	8.6%
Ophthalmology	1	1.4%
Optometry	1	1.4%
Orthopedic Surgery	3	4.3%
Physical Therapy	1	1.4%
Physician Assistant	1	1.4%
Psychiatry	1	1.4%
Psychology	1	1.4%
Radiology	2	2.9%
Urology	2	2.9%
TOTAL	**70**	

[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.

IV. Ratios of Complaints to Enrollees by Plan

MCL 333.24515(1)(c) requires this 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 was submitted by each plan on its Michigan Health Insurance Enrollment, Premiums, and Losses (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 Better Health of Michigan, Inc.	1	62,946	1:62,946
Blue Care Network of Michigan	4	831,524	1:207,881
Blue Cross Blue Shield of Michigan	31	6,891,840	1:202,701
Cigna	2	201,560	1:100,780
HAP	2	223,108	1:111,554
Meridian	7	643,332	1:91,904
Molina Healthcare of Michigan, Inc.	1	442,702	1:442,702
Physicians Health Plan	1	28,620	1:28,620
Priority Health	14	1,034,500	1:73,892
UnitedHealthcare Insurance Company	6	529,012	1:88,169
Upper Peninsula Health Plan, LLC	1	59,308	1:59,308
TOTAL	**70**	**10,948,452**	**1:156,406**

V. Carrier Network Adequacy by Specialty

MCL 333.24515(1)(d) requires this report to include information regarding carrier network adequacy by provider specialty. The Department 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 (ACA), 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 ACA and federal regulations, specifically, 45 CFR 156.230, which provides:

(a) *General requirement.*

(1) 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:

(i) Includes essential community providers…

(ii) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay; and

(iii) Is consistent with the rules for network plans of section 2702(c) of the [Public Health Service] Act.

All carriers submitted network provider detail on the Michigan Network Data Template (FIS 2273) to the Department for approval. The template included information on each carrier's network(s) according to provider type and specialty, location, service area, hospital admitting privileges for physicians, whether physician providers accept new patients, three-year enrollment projections by county, network product type, and included link to online network provider directory. All networks were subject to a maximum 30-minute travel time standard.

VI. Calculation Reviews

MCL 333.24515(1)(e) requires this report to include the number of requests made to the Department 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 2022, the Department received 25 requests to review a payment calculation.

VII. Requests for Arbitration

MCL 333.24515(1)(f) requires this report to include the number of requests for binding arbitration filed with the Department under section 24511(3) of the Act.

In 2022, the Department received 1 request for binding arbitration.