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Testimony Before the Senate Insurance Committee  
HB 4933-4935  
April 20, 2016

Good afternoon, Mr. Chair, and members of the Insurance Committee. Thank you for this opportunity to come before you and testify today.

My name is Dr. Dan Spencer. I am a chiropractor with practices in Hudson and Reading. I am a former President and Chairman of the Board of the Michigan Association of Chiropractors (MAC). I am currently a member of the MAC's Government Relations Committee.

The MAC is generally supportive of House Bills 4933, 4934, and 4935, with a few key amendments. These amendments are to prevent unintended consequences and do not change the purpose or spirit of the package of bills at all.

The first three areas that need to be addressed are in HB 4933 and have to do with what happens when there is a coverage dispute between the insurance company on one side, and the patient and health provider on the other. The concern arises when these disputes reach the level of the Michigan Department of Insurance and Financial Services (DIFS). Our suggested amendments are designed to address these concerns.

Our first proposed amendment to HB 4933 deals with "evidence-based standards." The MAC supports evidence-based standards and believes that when there is clear scientific evidence to guide a health care practitioner, these standards should be followed. Unfortunately, all too often, scientific studies on a particular treatment to support a clear, evidence-based standard, do not exist.

It is important to understand that a lack of relevant studies of a particular treatment does not mean the treatment is not efficacious. It just means that there is a lack of relevant studies.

So what should the standard be when there is no clear scientific evidence to guide a provider? We recommend adding "**or applicable standard of care.**" This standard reflects what similar providers would do in a similar situation, and is a standard that is based on results in clinical practice.

Our next two amendments deal with which health care providers the Director of the Michigan Department of Insurance and Financial Services (DIFS) looks to for evidence of the patients' needs. As written, HB 4933 assumes that the health care providers are MDs or DOs. That is not always the case. It is not at all uncommon that a non-MD or a non-DO, such as a chiropractic physician, a psychologist, or an optometrist, is the patient's provider. There may not be an MD or DO even aware of the patient's condition. **We suggest that HB 4933 be amended by removing "TREATING PHYSICIAN" or "PHYSICIAN" and add "TREATING PROVIDER" or "PROVIDER."**

Our third suggested amendment to HB 4933 clarifies who the Director of DIFS looks to for outside expert opinions from reviewers. Problems can arise when reviewers have a different license than those they are reviewing. The differently licensed reviewer will most likely not have the formal training and experience necessary to perform the review. **Our suggested amendment to 4933 would require that if an outside reviewer is utilized, they must hold the same license as the treating provider.** Utilizing outside reviewers that are similarly licensed will not increase the cost of needed reviews.

Our final amendment is to **HB 4935** and relates to the Affordable Care Act (ACA). The ACA currently allows some individual buyers of insurance on the health exchange to qualify for cost subsidies. After the first monthly insurance premium, the insurance company may not cancel a policy for non-payment of premiums in month two and three, though they can send notices of overdue premiums. However, during months two and three of the policy, if premiums are not paid on a timely basis, the insurance companies may pend claims.

This means that a patient can walk into a provider's office, show a health insurance card, and receive services under the policy. Based on the patient's benefits (which the provider has confirmed with the insurer), providers bill for services. However, if the insurance company has decided to pend a claim, payment will not be made on a timely basis, and possibly not at all. The provider has incurred the expenses of seeing and treating the patient, and billing and tracking the claim, but unbeknownst to him or her, they also bear the risk of not being paid.

When claims are pended because the insurance company has determined that the patient may be a financial risk, the providers have no way to protect themselves from having to provide free services and products. No business can survive and thrive with that level of uncertainty.

We believe a sensible solution to this problem is our amendment, which requires the insurer to:

1. Notify the provider when they check the patient's benefits that the claims will be pended.  
The notification that a patient's claims are being pended could easily, and cheaply, be added to the information on the patient that is already online and available to the provider.
2. Within a reasonable time of a provider billing a claim, provide notification that the claim is pended and how long that pending will last.
3. Allow the provider treating the pended patient to charge the patient at the time of service.  
This will allow the provider to discuss financial responsibilities and the provider and patient can both make decisions with a full understanding of costs and risks. Of course, if the insurer pays the claim, the patient would receive a prompt refund.
4. Make unenforceable any requirement in a provider agreement that would force a provider to treat a pended patient who refuses to pay for non-emergency services.

We believe these amendments are sensible, will not unnecessarily raise costs, and will keep the spirit of the legislation as proposed alive.

I am now going to turn the microphone over to Carl Alden, who will speak about the details of the amendments.

# HB 4933 & 4935

## Amendments

### HB 4933

1. Page 3 Line 26 insert "OR APPLICABLE STANDARD OF CARE" after "RESEARCH"
2. Page 14 Line 24, and page 15 Line 8 and 15 replace "Physician" with "Provider"
3. Page 30, line 11 insert "AND HOLDS THE SAME LICENSE AS THE TREATING PROVIDER" after "REVIEW."

### HB 4935

1. Page 41, beginning on line 10 insert new subsection (I)

**(I) NOT WITHSTANDING ANY POLICY OF A HEALTH PLAN OR EFFECTIVE PROVIDER AGREEMENT PROVISION TO THE CONTRARY BETWEEN A PROVIDER AND A HEALTH PLAN, IF A HEALTH PLAN PENDS CLAIMS FOR SERVICES RENDERED BY THE PROVIDER TO THE ENROLLEE IN THE SECOND AND THIRD MONTHS OF THE GRACE PERIOD, THE HEALTH PLAN MUST DO THE FOLLOWING:**

1. **WITHIN 24 HOURS OF RECEIVING AN ELECTRONICALLY BILLED CLAIM, WITHIN 5 DAYS OF RECEIVING A MAILED CLAIM, NOTIFY ANY BILLING PROVIDER THAT THE CLAIM IS BEING PENDED AND HOW LONG THE PENDING PERIOD WILL LAST,**
2. **INFORM THE PROVIDER WHO WILL BE PERFORMING THE SERVICE WHEN BENEFITS ARE CHECKED, THAT THE CLAIMS DURING THE SECOND AND THIRD MONTHS ARE OR WILL BE PENDED,**
3. **(a) ALLOW THE PROVIDER TO COLLECT FROM PATIENT, WHOSE SERVICES WILL BE PENDED, THE ALLOWED CHARGE AT THE TIME OF SERVICE.**  
**(b) IF AND WHEN THE HEALTH PLAN PAYS FOR THE PENDED SERVICE(S), THE PROVIDER WILL PROMPTLY REFUND THE PATIENT THE MONIES COLLECTED FOR THOSE SERVICES,**
4. **NOT ENFORCE ANY REQUIREMENT THAT THE PROVIDER TREAT A PATIENT WHO REFUSES TO PAY FOR THE PROVIDER'S SERVICE DURING THE TIME A CLAIM IS TO BE PENDED.**