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CLIENT ADVISORY

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Submission of Claims to Healthcare Providers and Assignment of Benefits to Obtain Motor Vehicle Expense Coverage

Billing and reimbursement specialists for healthcare providers should be aware of the passage of SB 707 dealing with the submission of claims to health insurance carriers and HB 1655 dealing with the assignment of benefits (AOB) to obtain medical expense coverage under motor vehicle insurance policies. Both pieces of legislation have passed the Virginia General Assembly and are awaiting action by the Governor prior to his March 25 deadline.

Senator Donald McEachin (D-Henrico) introduced SB 707 after encountering a situation involving one of his personal injury clients. Specifically, the client reported to a hospital subsequent to a motor vehicle accident. The client had health insurance coverage with a major carrier. The client underwent significant healthcare treatment and, unfortunately, succumbed to his injuries leaving a hospital bill well into the six figures. The hospital elected not to bill the patient's health insurance carrier but instead sought to recover full charges from the wrongful death settlement from the motor vehicle accident. After extensive communications with Senator McEachin, the hospital decided to write off the outstanding balance as the time period to file the claim with the health insurance carrier had expired.

This experience gave rise to Senator McEachin introducing legislation in the 2012 General Assembly Session and after being approached by the healthcare community, he agreed to allow the stakeholders to work over the summer of 2012 to find a solution. After many stakeholder meetings involving the Medical Society of Virginia, the Virginia Hospital & Healthcare Association, the Virginia Trial Lawyers Association, the health insurance carriers and others, an agreement was reached which was reflected in the introduction of SB 707 in the 2013 General Assembly Session.

Of interest, the new requirements on healthcare providers were not included in the insurance section of the Code but instead were included in Title 8.01 so the Bureau of Insurance would not have to assume responsibility for regulatory oversight.

The foundation of the bill is centered on what is "a health care policy." Since health insurance can be provided under a number of different vehicles, some private and some public, attention was drawn categorizing what constitutes "a health care policy" and what does **not** constitute "a health care policy." Coverage provided under indemnity policies, PPO's, HMO's, the state employee insurance plan, local choice federal employee plans, and ERISA plans are included in the definition. Excluded from the definition of "health care policies" are coverages provided under Medicare, Medicaid, TriCare, subscription contracts for dental or optometric services, certain disability or accident policies, disability policies, long-term care insurance, plans providing limited healthcare insurance, TriCare supplements, Medicare supplements, workers' compensation or medical expense coverage under a motor vehicle policy.

Next attention must be given to which healthcare providers the new statutory requirements apply. The application of the statute is limited to those healthcare providers who are in-network providers, meaning that they are employed by or have entered into a provider agreement with the health insurer which has issued a healthcare policy as defined under the statute. The statute does not apply to out-of-network providers.

Paragraph B of Va. Code § 8.01-27.5 establishes the new requirements for in-network providers providing healthcare services to a covered patient under "a health care policy." Specifically, if the covered patient has provided the in-network provider with information required under the plan documents,

including information required to verify the covered patient's eligibility, and such information is provided more than 21 business days before the deadline of the in-network provider to submit claims to the health insurance carrier under the provider agreement, then the in-network provider is compelled to abide by the obligations of the statute. If the in-network provider complies with the obligations, certain rules of the road are established. If the in-network provider fails to comply, certain consequences will flow.

If an in-network provider fails to submit its claim to the health insurance carrier in accordance with the plan documents and after the patient has provided the necessary documentation to verify eligibility with more than 21 business days before the deadline of the provider to submit claims, then (i) the covered patient shall have **no** obligation to pay for the healthcare services for which the provider was required to submit a claim, (ii) the provider shall not have the benefit of any of the liens that are established under § 8.01-66.2 and 8.01-66:9 regarding the healthcare services that have been provided, and (iii) the in-network provider shall be prohibited from recovering medical expense coverages under the patient's motor vehicle liability insurance policy.

If the in-network provider submits a claim to the health insurance carrier in accordance with the plan documents and after the covered patient has provided the necessary information to verify eligibility with more than 21 days remaining on the timeframe to submit a claim, then the health insurance carrier is obligated to pay for the healthcare services in accordance with the provider agreement and the plan documents.

Since self-insured or self-funded plans under ERISA may provide for alternative means of claim submission, then in-network providers are permitted to submit claims and coordinate benefits in accordance with those provider agreements and plan documents.

It is not uncommon for patients to refuse to provide their health insurance information to a healthcare provider following a motor vehicle accident for fear that the report of the claim will cost their insurance premiums to go up, could cause coverage to be denied, or may somehow impact their litigation. For patients who refuse to provide this information and refuse to respond to subsequent follow-ups, the application of SB 707 will mean that the patient still bears full responsibility for payment of the healthcare services as they do today. Likewise, for providers who choose not to bill health insurance after a patient has timely provided information to verify eligibility and attempt to seek reimbursement from the personal injury or wrongful death action, the effects of this statute will mean that those providers will be barred from recovery from the patient for any amount that the patient would not have owed otherwise and in the event the health insurance carrier fails to process a claim from a healthcare provider that is filed after the timeframe permitted under the provider agreement, the provider will be left with no means of recourse.

HB 1655: Recovery of Medical Expense Under Motor Vehicle Insurance Policies Through Use of An Assignment of Benefits

Patients presenting to emergency rooms commonly are asked to execute a number of documents including a general AOB. It is common for healthcare providers to use the AOB to seek payment from the patient's motor vehicle insurance carrier if the patient carries medical expense coverage. Typically, medical expense coverage is coverage offered to a patient as a rider on their motor vehicle insurance policy and obligates the motor vehicle insurance carrier to pay the patient usual and customary charges for medical bills incurred from healthcare services relating to a motor vehicle accident. Payment to the patient is obligated regardless of whether the patient has health insurance or other means of payment.

A growing number of disputes have arisen over patients who have been in motor vehicle accidents, who execute an AOB, their healthcare provider seeks reimbursement from the motor vehicle insurance carrier with the AOB, and once the patient hires counsel, counsel attempts to revoke the AOB or litigate with motor vehicle insurance carriers as to whether the patient should be paid the medical expense coverage or whether the payment should be forwarded to the healthcare provider pursuant to the AOB.

Delegate Terry Kilgore (R – Gate City) introduced legislation in the 2012 Session of the Virginia General Assembly regarding the use of AOB's to access medical expense coverage from motor vehicle insurance carriers. The stakeholders from the healthcare community approached Delegate Kilgore and requested an

opportunity to work over the summer of 2012 to find agreeable language and to also address the issue of a number of health insurance policies governed by ERISA plans and others that require healthcare providers to coordinate benefits prior to submitting claims. After many stakeholder meetings with the motor vehicle insurance carriers, the Medical Society of Virginia, the Virginia Hospital & Healthcare Association, the Virginia Trial Lawyers Association, and the Virginia Association of Health Plans, language was agreed upon and HB 1655 was introduced by Delegate Kilgore in the 2013 Session of the General Assembly.

The legislation amends Va. Code § 38.2-2201 which is the medical expense statute that has been law in Virginia for many years. It sets forth the framework to establish which AOB's are valid and appropriate, what requirements must be met by healthcare providers seeking to execute AOB's, and establishes rules of the road for payment of medical expense benefits pursuant to an AOB by motor vehicle insurance carriers.

There are a number of requirements that AOB's must meet in order to be valid. Specifically, a copy of the AOB must be executed by the healthcare provider and the patient must be provided specific notice enumerated in the statute. The form must be in writing, dated and executed by the patient. The form must contain a conspicuous statement that the patient is **not** required to execute the AOB form. The form must include a notice to the patient and the patient must sign, initial, or otherwise mark near the notice provision to acknowledge that the patient has read or had the opportunity to read the notice. The statements and notices required by the section must be provided in a font type no smaller than 8 point type. The notice required by this section is enumerated in the statute and must read as follows:

> *Notice: Automobile Accident Patients. If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving your healthcare provider the right to receive some or all of that payment directly from your automobile insurance company.*
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> *If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any co-payment, co-insurance, or deductible to your automobile insurance and you will be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your provider is not in your health insurance provider network, your healthcare provider may bill their full charges to your automobile insurance.*
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> *You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign or initial this form to receive care.*

Next, the statute gives direction to motor vehicle insurance carriers receiving an AOB that satisfies the administrative requirements previously discussed. Specifically, upon receipt of certain documentation, a motor vehicle insurance carrier is obligated to take action. The documentation required by the motor vehicle insurance carrier will be a copy of the AOB form satisfying the requirements discussed above, and an explanation of benefits or remittance advice or a bill, claim form, or documentation from the healthcare provider advising that it has been represented to the healthcare provider that the patient does not have health insurance or is covered by an ERISA plan which requires medical expense coverage to be primary, then such motor vehicle insurance carrier shall pay directly to the healthcare provider any medical expense benefit available to the patient under the policy.

If the patient is covered under "a health care policy" (same definition as in SB 707) and the healthcare provider is an in-network provider and the provider has submitted its claims to the health insurance carrier for the healthcare services, then the amount of any co-payments, co-insurance, or deductibles owed by the patient to the healthcare provider as evidenced on an EOB, remittance advice or other similar documentation will be paid.

If the patient is **not** covered by "a health care policy" or the patient is covered by a self-insured or self-funded ERISA plan, which requires medical expense coverage to be primary, or the healthcare provider is not an in-network provider, then the amounts of coverage for costs of the services shall be paid to the healthcare provider as the usual and customary fee for the community in which healthcare services are rendered.

Motor vehicle insurance carriers are held harmless under this statute for payments made pursuant to the requirements of the new statutory provision. For those patients entitled to benefits under Medicare, Medicaid or other state or federal assistance programs, nothing in this statute will prohibit the payment of medical expense benefits by motor vehicle insurance carriers directly to such programs.

The practical change that healthcare providers will experience with passage of this legislation largely will center upon making sure the AOB forms comply with the administrative and technical requirements of the statute and also determining whether the patient has health insurance and, if so, what type. The practice of seeking reimbursement for full charges from a patient's medical expense coverage under a motor vehicle insurance policy when the patient also has health insurance coverage will also be prohibited after July 1 to the extent any reimbursement is in excess of co-pays, co-insurance, or deductibles or non-covered services.

In conclusion, SB 707 will operate to require the timely filing of health insurance claims from those patients involved in motor vehicle accidents and coupled with the passage of HB 1655 will limit providers from seeking full recovery from a patient's medical expense coverage under motor vehicle insurance policies to the extent such amounts exceed co-insurance, co-pays or deductibles.

If you have questions about what this recent change means for your organization, please contact Scott Johnson (sjohnson@hdjn.com), Mary Malone (mmalone@hdjn.com) or Emily Towey (etowey@hdjn.com). They can also be reached by phone at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C., is available on the firm's website at www.hdjn.com.