AN END TO SURPRISE BILLING: A NEW BALANCE BILLING PROCESS IN VIRGINIA

April 14, 2020

On April 10, 2020, Governor Ralph Northam signed Senate Bill 172 and House Bill 1251 into law, officially ending surprise medical billing in Virginia. Surprise billing, or balance billing, often occurs when a patient receives care at an in-network facility from an out-of-network provider. When patients receive a surprise bill, they face an unforeseen financial penalty right after receiving emergency or necessary medical care. This financial burden creates stress for patients and undermines patient recovery. Balance billing decreases patients' trust in the health care system and jeopardizes patients seeking future care. This new law prohibits out-of-network providers from balance billing patients for emergency services or non-emergency services involving surgical or ancillary services provided at an in-network facility. **The new law will become effective on January 1, 2021.**

BALANCE BILLING PROCESS

Negotiation

When a balance billing event occurs, the patient/enrollee will only be obliged to pay the in-network cost-sharing requirement specified in the enrollee's health plan contract, commonly referred to as the deductible, co-pay, or co-insurance. Any additional amount owed to the health care provider for emergency or non-emergency surgery or ancillary services must be sought from the insurance carrier through good faith negotiations or arbitration. If the enrollee pays the provider any amount above his or her in-network cost-sharing requirement, the provider must refund the excess amount within 30 business days.

The negotiation process begins with the out-of-network provider submitting a "clean claim" for the balance of cost of the services rendered to the carrier.[1] Within 30 days of the submission of a clean claim, the carrier must offer to pay a "commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area." If the provider disputes the carrier's payment, the provider must notify the carrier within 30 days of receipt of payment or payment notification.[2] After that notification of dispute, the carrier and the provider have 30 days to negotiate

[1] A "clean claim" under VA Code § 38.2-3407.15 means a claim that has no material defect or impropriety or a lack of timely notification by the carrier of such defect or impropriety so as to substantially prevent timely payment on the claim.
[2] "Offer to pay" and "payment notification" are both defined to mean a claim that has been paid by a carrier or determined by carrier to be payable by an enrollee for services described in this law.

in good faith to agree on a payment amount. If no agreement is reached within that 30-day period, the dispute must then be resolved by arbitration.

The Virginia Board of Medicine (for physicians), the Commissioner of Health (for hospitals), and the Bureau of Insurance (for carriers) shall have the authority to levy fines or cost recoveries on persons who engage in patterns of potential violations of this new law.

Arbitration

If the good-faith negotiation does not resolve the dispute, the carrier or provider must initiate arbitration to determine the commercially reasonable payment amount. To do so, the initiating party must provide written notification containing the initiating party's final offer to the State Corporation Commission (SCC) and non-initiating party within 10 days following the good faith negotiation. The non-initiating party has 30 days to respond with its final offer. Claims may be bundled in arbitration provided that they involve the same parties, involve the same procedure codes, and occur within two months of one another. The parties may still reach a negotiated agreement during the arbitration proceeding.

Within seven days of receiving notice of arbitration, the SCC must provide the parties with a list of approved arbitrators with no conflicts of interest. If the parties do not agree initially on an arbitrator on the list, the parties have 20 days to agree to an arbitrator on the list through a back and forth veto process with the SCC having the ultimate decision if more than one arbitrator remains.

After an arbitrator is selected, each party must submit written documentation in support of its final offer to the arbitrator within 30 days, providing evidence and methodology as to why it is or is not commercially reasonable. Within 30 days of receiving the parties' written submissions, the arbitrator must notify the parties and issue a decision requiring payment of either the initiating or non-initiating party's final offer. The arbitrator shall have considered the evidence and methodology submitted by the parties as well as patient characteristics and the complexity of the case. The arbitration fees will be divided equally by the parties. The arbitrator's decision may be appealed by a party on the grounds that the decision was unduly influenced by fraud or corruption or if the arbitrator exceeded his or her powers.

COMMERCIALLY REASONABLE AMOUNT

The state insurance commissioner and Virginia Health Information (VHI) will establish a data set and business protocols to assist health plans, providers, and arbitrators in determining commercially reasonable payments resolving disputes. The data set will include:

- Median in-network allowed amount
- Median Out-of-Network allowed amount
- Median billed charges for similar services in the same geographical region

The data set specifically excludes Medicare, Medicaid, and non-fee-for-service rates. The payment rate is set to 2019's data as a baseline and will be adjusted annually by medical Consumer Price Index. VHI is to assemble a stakeholder work group to establish commercially reasonable payment amounts.

TRANSPARENCY

Moving forward, health care providers must provide a listing of health plans in which the provider or facility participates as well as a notice of consumer rights with regard to balance billing, which will be developed by the SCC in consultation with providers and health plans. This listing and notice must be posted on the provider's or facility's website or provided to a consumer upon request if a website is not available.

Furthermore, at least 30 days prior to contracting with a health plan, the facility must provide the carrier with a list of non-employed providers or provider groups contracted to provide surgical or ancillary services at the facility. The facility must continue to notify the carrier of changes to such list within 14 days of a request from the carrier or within 30 days of a removal from or addition to the list. In-network providers must submit timely and accurate information regarding the provider's network status consistent with the provider's contract with the carrier.

For questions, please contact a member of our Government Relations team.