VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION
An alliance of hospitals and health delivery systems

Balance Billing
Frequently Asked Questions

Last Updated December 1, 2020

Virginia's new balance billing law, effective January 1, 2021, protects patients from getting billed by an out-of-network health care provider for emergency services at a hospital or for certain non-emergency services during a procedure at an in-network hospital or other health care facility. The law covers emergency services, laboratory services, and any professional non-emergency services, including:

- **Surgery**
- **Anesthesia**
- **Pathology**
- **Radiology**
- **Hospitalist**

If a patient is treated by an out-of-network provider or facility for services covered by the new law, the provider or facility will submit the claim to the patient's insurer. The insurer will pay a "commercially reasonable amount" based on payments for the same or similar services in a similar geographic area. If the provider or facility and insurer do not agree to what is a commercially reasonable amount, then an arbitration process is available to resolve disputes.

This document seeks to provide answers to frequently asked questions (FAQs) for Virginia providers and direct them to available resources for further assistance.

Note: For purposes of this FAQ, we use the term "providers" to include health care professionals *and* facilities as those terms are defined in the law.

If you have any questions or require additional information, please contact Brent Rawlings brawlings@vhha.com or Ryan Lodata rlodata@vhha.com.

Law and Regulation

Where can I find the balance billing laws in the Virginia Code and in regulation?

The balance billing legislation can be found at the 2020 Acts of Assembly Chapter 1081 and Chapter 1080.

Provisions of the legislation are found in various sections of the Code of Virginia: §§ 32.1-137.07, 32.1-137.2, 38.2-3438, 38.2-3445, 54.1-2915 as well as §§ 38.2-3445.01 through 38.2-3445.07. The corresponding regulations have been published by the Bureau of Insurance (BOI), but have not yet been published in the Virginia Register of Regulations or in the Virginia Administrative Code available online. It is expected that they will be located at 14VAC5-405-10 *et seq.*

Applicable Services and Health Plans

To what provider types does the balance billing law apply?

The law applies to any "health care provider," which includes "health care professionals" (a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law, *e.g.*, nurse practitioner or physician assistant) and "facilities" (institutions providing health care related services including hospitals, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings).

To what services does the balance billing law apply?

The law covers emergency services, both facility and professional claims. The definition of "emergency services" used in the law includes any medical screening examination, including ancillary services to evaluate an emergency medical condition, and further medical examination and treatment required under EMTALA to stabilize the patient.

The law also covers professional claims for surgical or ancillary services provided at an in-network facility. Surgical or ancillary services include laboratory services and the following professional services:

- Surgery
- Anesthesia
- Pathology
- Radiology
- Hospitalist

Examples:

- Patient goes to an out-of-network emergency department for a serious laceration on her face and emergency surgery is required. The patient is evaluated by an out-of-network emergency physician and has an emergency consult and surgical procedure performed by an out-of-network plastic surgeon, involving anesthesia services by an out-of-network anesthesiologist and CRNA, both who separately bill for anesthesiology services. The law and balance billing prohibition apply to claims by the out-of-network hospital, the out-of-network emergency physician, plastic surgeon, anesthesiologist, and CRNA because the treatments were emergency services.
- Patient goes to an in-network ambulatory surgery center for tendon repair surgery. The orthopedic surgeon and physician assistant are out-of-network. The anesthesiologist and CRNA are out of network. The law and balance billing prohibition apply to claims by the out-of-network orthopedic surgeon, physician assistant, anesthesiologist, and CRNA because the ambulatory surgery center is an in-network facility and the services being provided are surgical or ancillary services.
- Patient goes to an in-network hospital admitted for elective heart bypass surgery. The cardiac surgeon, anesthesiologist, CRNA, are in-network. During the procedure, however, a complication occurs, and a consultation is required by a vascular surgeon. The vascular surgeon is out-of-network. The law and balance billing prohibition apply to claims by the out-of-network vascular surgeon because the hospital is an in-network facility and the services being provided are surgical or ancillary services.
- A patient visits an in-network outpatient clinic for removal of a mass under the skin. A sample of the mass is sent to an out-of-network laboratory and reviewed by an out-of-network pathologist. The law and balance billing prohibition apply to claims by the out-of-network laboratory and pathologist because the outpatient clinic is an in-network facility and the services being provided are surgical or ancillary services.
- A patient goes to an in-network freestanding imaging center for an MRI of shoulder. The radiologist performing the MRI is out-out-of-network. The law and balance billing prohibition apply to claims by the radiologist because the freestanding imaging clinic is an in-network facility and the services being provided are surgical or ancillary services.
- A patient goes to an out-of-network ambulatory surgery center for an elective procedure. The surgeon and anesthesiologist are out-of-network. The law and balance billing prohibition do not apply to claims by the ambulatory surgery center, surgeon, or anesthesiologist because the ambulatory surgery center is an out-of-network network facility.
- A patient goes to an out-of-network freestanding imaging center for an MRI of knee. The radiologist performing the MRI is in-network. The law and balance billing prohibition do not apply to claims by the freestanding imaging center because the freestanding imaging center is an out-of-network facility.

How do I know if a health plan is subject to the balance billing law?

The balance billing law applies to all Virginia-regulated managed care plans and state employee health benefit plans. Self-funded group health plans not regulated by Virginia and certain other self-funded group health plans mentioned in the balance billing law may opt-in to offer the balance billing protections to their enrollees. A listing of the elective group health plans that have opted in can be viewed here.

Additionally, insurers are required to make information regarding the applicability of the balance billing law available to providers through electronic or other communications generally used by a provider to verify enrollee eligibility and benefits information. The means of access and format of this information will likely vary by insurer. If you experience difficulty accessing this information from any insurer licensed in Virginia, please feel free to contact VHHA for assistance so that we may track these deficiencies and work with the BOI to resolve them.

Required Notice to Patients

What notice must be given by providers to patients?

The SCC has developed a form notice of consumer rights that must be used. The BOI interprets the law and regulations to require providers to provide patients with the *entire* notice of consumer rights each and every time any nonemergency service is scheduled, with the bill sent to the patient, and upon request. A health care facility is also required to provide the notice of consumer rights with any bill for an emergency service. The BOI further interprets the law and regulations to regard the provision of a hyperlink to the notice of consumer rights in a written communication or the sending of a text message containing a hyperlink to the notice of consumer rights as insufficient; however, the provider is permitted to provide the entire notice of consumer rights in electronic format.

Additionally, providers must post the notice on their website along with a list of carrier provider networks with which it contracts. The list of carrier provider networks must be updated on a regular basis.

Patient Out-of-Pocket Costs

What amount will a patient be responsible for if they receive a balance bill from an out-of-network provider?

In short, the balance billing law requires patients to pay balance bills as if the bill had been sent by an in-network provider or facility. If the balance billing law applies to the services received by the patient, the patient is obligated to pay the in-network cost-sharing requirements of their health plan based on the median in-network contracted rate for the same or similar service in the same or similar geographic area. When there is no median in-network contracted rate for the specific services provided, the enrollee's cost-sharing requirement will be determined by a pre-established amount required by insurance laws at § 38.2-3407.3.

If there is an arbitration decided in favor of the provider, the insurer, not the patient, is required to pay the difference between initial amount and the good faith negotiated amount or final offer amount approved by the arbitrator, unless the patient is enrolled in a high-deductible health plan with a health savings account or other plan that prohibits payment for first-dollar coverage prior to the enrollee meeting the deductible. For these plans, the patient will be required to pay any additional amounts that may be owed to the provider resulting from arbitration until the deductible is met.

Patient Overpayment

What happens if a patient overpays a provider?

If a patient pays more than the cost-sharing requirement for an in-network provider or facility, the provider or facility must:

- Refund the patient the excess amount within 30 business days of receipt of payment or notice that the patient's plan is subject to the balance billing law, whichever occurs later; and
- Pay the enrollee computed daily interest based on an annual rate of 6% for every day after the 30-day grace period.

Clean Claims

What is a clean claim?

A "clean claim" is defined in the balancing billing law similar to how "clean claim" is defined in the Fair Business Practices Act. A clean claim is a claim that (i) has no material defect or impropriety, including any lack of any reasonably require substantiation documentation, that substantially prevents timely payment from being made on the claim; and (ii) that includes Internal Revenue Service (IRS) documentation required for the insurer to process payment.

What IRS Documents are required to be submitted with a claim to make it a clean claim?

Typically, the only IRS documentation that is required for an insurer to process claims is IRS Form W-9. We are currently seeking clarification on whether any additional information may be required, what format the documentation should be provided in, and whether documentation is required to be submitted with each claim where a provider already has a IRS Form W-9 on file with the insurer. We will update this FAQ as more information becomes available.

Payment to Out-of-Network Providers

How is the allowed amount determined?

The amount a provider or facility is paid under the balance billing law must be a commercially reasonable amount and based on payments for the same or similar services in a similar geographic area. The law does not specify an amount or include any minimum or maximum amount or reference-based amount for what constitutes a commercially reasonable amount. We expect that in most instances, this will be the insurer's in-network amount.

If the health plan and provider or facility cannot agree on what is a commercially reasonable amount to be paid for the service after 30 days, either party will have 10 days to elect to have the dispute settled by arbitration.

Arbitration

How does the arbitration process work?

If the insurer and out-of-network provider cannot agree on the payment amount for the service within 30 days of the initial offer, one of the parties can request that the dispute be settled through arbitration by sending the Notice of Intent to Arbitrate Form to the SCC and the non-initiating party.

The parties then choose an arbitrator from a list of approved arbitrators that will be provided on the SCC's balance billing website. If the parties cannot agree to an arbitrator within five calendar days, the SCC will provide the parties with the names of five arbitrators from the list of approved arbitrators. Each party will then review the list and notify the SCC if there are any conflicts of interest. Each party can then veto up to two of the arbitrators. If only one name remains, the remaining arbitrator is selected. If more than one arbitrator remains, the SCC will choose the arbitrator.

Who pays for the arbitration?

The cost of arbitration is split evenly between the parties. Neither party may claim or recover from the other party any attorneys' fees resulting from arbitration.

How does the arbitrator determine the commercially reasonable amount?

The arbitration is "baseball style" meaning the arbitrator will determine the final payment amount the insurer or provider must accept by choosing one of the parties' best final offer.

The arbitrators and the parties can access a data set created under the law to help assess whether a payment amount is a commercially reasonable payment amount; however, the data set is only one factor that the arbitrator may consider. In determining which of the two final offer amounts submitted to the parties represents the commercially reasonable amount, the arbitrator is required to consider the following factors:

- The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable;
- Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the services; and
- The arbitrator may also consider other information that party believes is relevant.

What does the arbitration timeline look like?

Day 0: Out-of-network provider submits clean claim to carrier/payer.
Day 30: Carrier/payer pays out-of-network provider.
Day 60: Provider may dispute payment by notifying carrier/payer. Parties are engaged in good faith negotiation.
Day 70: Carrier/payer or provider can request arbitration by sending the SCC's arbitration form to the SCC and to the non-initiating party. Initiating party must include their final offer with request.
Day 80 (business): Nondisclosure agreement signed 10 business days after request to initiate arbitration is made.
Day 90: Arbitrator is chosen. Commission notifies initiating and non-initiating parties of chosen arbitrator and copies chosen arbitrator.
Day 100: Both parties must make written submissions in support of final offer.
Day 100: Parties each pay arbitrator their half of the applicable fee.
Day 115: Arbitrator issues decision.
Day 125: Claim payment is made.

Parties can come to an agreement at any time during this process. Claim must be paid within 10 days of agreement.

Are providers able to bundle claims for arbitration?

Yes. A **single** provider can bundle multiple claims if those claims (i) involve identical health carrier or administrator and provider parties; (ii) involve claims with the same procedure codes; and (iii) occur within a period of two months of one another.

However, the BOI interprets the law to mean that provider groups composed of one or more health care professionals billing under a single Tax Identification Number are not permitted to bundle claims for arbitration if the health care professional providing the service is not the same.

Data Set Used for Claims Payment Information

How is the data set developed and adjusted?

As discussed above, the data set may be used to help arbitrators, providers, or carriers to determine what constitutes a "commercially reasonable amount." The data set, effective January 1, 2021, is based on the most recently available full calendar year of data, so claims are for services provided between January 1, 2019 and December 31, 2019. The calculations are drawn from commercial health plan claims and exclude Medicare, Medicaid, workers' compensation, and claims paid on other than a fee-for-service basis. The data set includes the following amounts:

- The median allowed amount (combined in- and out-of-network) from 2019 and updated for 2021 using a Medical Consumer Price Index (CPI) adjustment.
- The median billed amount (combined in- and out-of-network) from 2019 and updated for 2021 using a Medical Consumer Price Index (CPI) adjustment.

Allowed amount is the sum of the amount paid by the payer and enrollee cost-sharing.

In addition, the data set provides the calculations by geographic rating area, health planning region as commonly used by Virginia Health Information (VHI) in reporting, and statewide, except when suppressed if a field includes less than 30 claims.

Updates to the data set in subsequent years will be based on data collected in 2020 that delineates between paid claims in-network versus out-of-network and adjusted by the Medical CPI for every year thereafter.

Additional information about the data set methodology is found in the data set itself.

Enforcement

How will the balancing billing laws be enforced?

If health care providers have a pattern of violations under the new law without attempting corrective action, they are subject to fines or other remedies by the Virginia Board of Medicine or the Virginia Commissioner of Health. Similarly, insurance companies that are found to engage in a pattern of violations of the new law are subject to fines or other remedies by the SCC. Neither insurance companies nor health care providers may use arbitration as a general business practice for resolving claims payments.

Additional Resources

- SCC BOI Balance Billing Protection Information for Insurers
- SCC BOI Balance Billing Protection Information for Consumers