COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 6, 2019

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

CASE NO. INS-2019-00081

Ex Parte: In the matter of Adopting New
Rules Governing Health Insurance Balance Billing

ORDER TO TAKE NOTICE

Section 12.1-13 of the Code of Virginia ("Code") provides that the State Corporation Commission ("Commission") shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code.

The rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code are set forth in Title 14 of the Virginia Administrative Code. A copy also may be found at the Commission's website: http://www.scc.virginia.gov/case.

The Bureau of Insurance ("Bureau") has submitted to the Commission a proposal to promulgate new rules at Chapter 235 of Title 14 of the Virginia Administrative Code entitled "Rules Governing Health Insurance Balance Billing," which are recommended to be set out at 14 VAC 5-235-10 through 14 VAC 5-235-30.

The proposed new rules are necessary in light of the enactment of § 38.2-3445.1 of the Code, which takes effect on July 1, 2019, by the 2019 General Assembly and based on the complaints the Bureau has received related to surprise balance billing. The provisions of the new chapter are intended to remove the burden from the covered person and allow them to actively

choose whether they receive health care services from an in-network or out-of-network provider at an in-network facility for non-emergency services.

NOW THE COMMISSION is of the opinion that the proposal to adopt new rules recommended to be set out at Chapter 235 in the Virginia Administrative Code as submitted by the Bureau should be considered for adoption with a proposed effective date of October 1, 2019.

Accordingly, IT IS ORDERED THAT:

(1) The proposed new rules entitled "Rules Governing Health Insurance Balance Billing," recommended to be set out at 14 VAC 5-235-10 through 14 VAC 5-235-30, are attached hereto and made a part hereof.

(2) All interested persons who desire to comment in support of or in opposition to, or request a hearing to consider the adoption of, proposed Chapter 235 shall file such comments or hearing request on or before August 9, 2019, with Joel H. Peck, Clerk, State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218. Interested persons desiring to submit comments electronically may do so by following the instructions at the Commission's website: http://www.scc.virginia.gov/case. All comments shall refer to Case No. INS-2019-00081.

(3) If no written request for a hearing on the adoption of the proposed new rules as outlined in this Order is received on or before August 9, 2019, the Commission, upon consideration of any comments submitted in support of or in opposition to the proposal, may adopt the rules as submitted by the Bureau.

(4) The Bureau forthwith shall provide notice of the proposal to all health carriers licensed in Virginia to offer a managed care health insurance plan and to all interested persons.

(5) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the proposed rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the *Virginia Register of Regulations*.

(6) The Commission's Division of Information Resources shall make available this Order and the attached proposal on the Commission's website: http://www.scc.virginia.gov/case.

(7) The Bureau shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of Ordering Paragraph (4) above.

(8) This matter is continued.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Office of the Attorney General, Division of Consumer Counsel, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and a copy hereof shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

Project 6030 - none

STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

Rules Governing Health Insurance Balance Billing

CHAPTER 235

RULES GOVERNING HEALTH INSURANCE BALANCE BILLING

14VAC5-235-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Cost-sharing requirement," "in-network provider," and "provider group" shall have the meanings set forth in § 38.2-3445.1 of the Code of Virginia.

"Covered benefits," "covered person," "emergency services," "facility," "health benefit plan," "health care provider," "health carrier," "managed care plan," and "network" shall have the meanings set forth in § 38.2-3438 of the Code of Virginia.

"Elective health care services" means covered benefits rendered to a covered person that are not emergency services.

"Out-of-network provider" means a health care provider or provider group that is not contracted with a health carrier to provide health care services to a covered person under a health benefit plan as a member of the health benefit plan's network.

14VAC5-235-20. Balance billing of provider services.

A. Any provider contract entered into by and between a facility and a health carrier offering a managed care plan shall contain a provision that requires the facility to notify a covered person no later than at the time of pre-admission or pre-registration if the covered person will or is likely to receive elective health care services from an out-of-network provider and document in writing

that this notice was provided to the covered person. Prior to the covered person's receipt of elective health care services, the facility shall obtain written consent from the covered person to either: (i) accept any necessary health care services from in-network providers only; or (ii) accept any necessary health care services from out-of-network providers. The notice provided to the covered person shall state that elective health care services received from an out-of-network provider may result in amounts owed in addition to any cost-sharing requirements.

B. Any provider contract entered into by and between a facility and a health carrier offering a managed care plan shall also contain a provision that notifies a facility that failure to comply with requirements of subsection A of this section shall result in the facility being financially responsible for any elective health care services rendered by the out-of-network provider to the extent that the cost of these services exceeds the covered person's in-network cost-sharing requirements.

C. A health carrier offering a managed care plan shall seek to amend its provider contracts to comply with the provisions of subsections A and B of this section as soon as practicable but no later than 90 days after the effective date of this regulation.

D. The notice requirement contained in subsection A of this section applies notwithstanding the provisions of § 38.2-3445.1 of the Code of Virginia.

14VAC5-235-30. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.