Market Conduct Considerations Concerning Balance Billing

During an investigation or examination, the Bureau of Insurance may request information to determine compliance with Virginia's balance billing statutes, specifically § 38.2-3445.01 of the Code of Virginia (Code). A health carrier should be prepared to document compliance with all requirements set forth in this statute, to include the carrier's processes and procedures for determining which claims are subject to the Virginia balance billing statutes. Carriers should also be prepared to provide documentation for claims subject to the Federal No Surprises Act (NSA).

We will request information from carriers when evaluating the following amounts in applicable claims:

- The carrier's determination of the enrollee's cost-sharing, and
- The carrier's determination of the amount of the payment/allowance to the provider.

For Enrollee cost-sharing:

Section 38.2-3445.01 B of the Code states:

- An enrollee that receives services subject to Virginia's balance billing statute satisfies his obligation to pay for the services if he pays the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract.
- The enrollee's obligation shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area.
- The obligation of an enrollee in a health benefit plan that uses no median in-network contracted rate for the services provided shall be determined as provided in § 38.2-3407.3 of the Code.

We will require documentation of the carrier's determination of the median in-network contracted rate for the services billed on the claim(s) and will confirm that the:

- Enrollee cost-sharing on the claim was calculated on an amount that does not exceed the median in-network contracted rate.
- Explanation of Benefits (EOB) and the provider remittance advice (PRA) clearly indicate that the enrollee shall not be balanced-billed, as required.
- EOB and PRA information is accurately described to the enrollee and to the provider and that EOBs show cost-sharing amounts paid by the enrollee for such services are applied toward the in-network deductible(s) and maximum out-of-pocket limits.

For the payment/allowance to the Provider:

Section 38.2-3445.01 F of the Code states that the amount paid to an out-of-network provider for health care services described in subsection A shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. If the carrier and provider do not agree to a commercially reasonable payment amount within 30 calendar days and either party chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration as provided in § 38.2-3445.02 of the Code.

In accordance with § 38.2-3445.03 of the Code, the Commission has established a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers.

- We will review the EOB and PRA of sample claims to ensure the proper amount is paid/allowed.
- We will require documentation from the carrier supporting the carrier's determination of the commercially reasonable amounts for the payments/allowances for the services billed on the claim.

Additional Items of Note:

- Carriers should be aware of the requirements for EOBs and PRAs, including (but not limited to) those described in §§ 38.2-3445.01 B, 38.2-3407.4 B and 38.2-514 B of the Code, and be prepared to provide copies for review.
- For services described in § 38.2-3445.01 A, carriers will be required to explain their methodology for determining the:
    - Median in-network contracted rate
    - Commercially reasonable payment amount

  We also require carriers to provide supporting documentation for these calculations, as captured by their claims systems at the time of processing.

- Carriers are required under § 38.2-3445.01 G of the Code to make payments for services described in this section directly to the **provider**.
- Carriers must follow the requirements of § 38.2-3407.3 of the Code and use an amount that does not exceed the amount actually paid or payable to the provider for the services to determine enrollee cost-sharing obligations, as explained in that section.
- Carriers must describe and document their process to identify out-of-network claims defined by § 38.2-3445.01 A of the Code and the NSA, including but not limited to:
    - System processes and guidelines used to determine applicable claims, and

    - If manual intervention is used, guidelines to determine when manual intervention is initiated and processes used for identification.
- Carriers must explain how their process to address out-of-network claims defined by § 38.2-3445.01 A of the Code interacts with the NSA and how the carrier determines when the Virginia requirements versus the NSA requirements are applicable.