MSV℠ MEDICAL SOCIETY OF VIRGINIA

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HB 1251 and SB 172

SURPRISE BALANCE BILLING

End Surprise Balance Billing for Emergency Services

Surprise balance billing occurs when a patient receives a bill because an insurance company doesn't cover its full share and the patient is billed the difference. The difference happens because a patient, often unknowingly during an emergency, received care from an out-of-network provider.

- Doctors may be "out of network" for several reasons:
  - Insurance companies limit the number of doctors allowed to join their plan.
  - The plan's reimbursement is significantly lower in comparison to others, which would force a physician to practice out of network.

The Problem: Insurers Putting Profits Before Patients

Emergency physicians are not legally able to discuss insurance information with patients or answer questions about coverage. In an emergency, your physician's priority is your health. It is the insurer's responsibility to handle costs so patients and their physician can focus on healing.

Ending the Coverage Gap for Emergency Care

Today, insurance companies must pay for emergency care using the highest of three reimbursement rates:

1. The in-network rate
2. The health plan's typical out of network payment
3. Medicare rates

Options **1** and **2** are controlled by health plans, Option **3** is based on Medicare rates which is below the cost of providing care.

As of 2019, 25 states have laws offering some balance billing protection for patients.

Physicians Support Adding a Fourth Option – a 'Regional Commercial Average'

Almost all the states who have instituted a payment standard for balance billing are using something similar. This has improved balance billing for patients and not increased insurance premiums.

- California is an exception and uses a Medicare-based fee schedule that has caused significant negative outcomes.
- Medicare fee-based schedules result in negative outcomes for patients.

Establishing a payment standard would prevent individual health plans from driving down reimbursements to unsustainable levels, jeopardizing health care access.

The Solution: End Balance Billing for Emergency Care

Require insurance companies to pay a fair rate for the emergency care provided to patients, which should include an option of the regional average of commercial insurance payments.

Surprise Billing | FAQs

Q: How does this solution protect patients?

Patients will be removed from the billing process and held harmless from any costs above their in-network cost-sharing, any payment disputes, or negotiating processes between health care stakeholders. 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. It also decreases patient satisfaction in the health care system and jeopardizes the chances of patients seeking future care.

Q: Why can't doctors be required to take the same insurance as the hospitals that employ them as a solution to balanced billing?

There are many models of employment- some hospitals employ physicians directly, some contract physicians and their practices, and some physicians work at multiple hospitals. Often when a hospital contracts out physicians, they are doing so because the hospital does not have enough physicians to sustain the coverage that they need.

An additional concern is network adequacy. Insurance companies are required to have a network of adequate physicians—and yet patients are often confused about who and what is in their plan. Virginia's network adequacy laws need to be strengthened in order to ensure that health plans do not mislead the public by saying a particular hospital is in-network when there are only few physicians in-network at that hospital.

When a doctor is out of network it is either because the insurance company purposely accepts less physicians to keep their costs down (narrow networks) OR because the contract in-network rate is dramatically lower than the market average.

Q : Does allowing insurance companies to negotiate their rates impact access to care?

Insurers want to solely dictate their own prices to an out-of-network doctor. This gives insurers more monopoly power and eliminates the freedom of doctors to choose what insurance networks they do business with. Insurance companies are already shifting the responsibility to pay for care to patients; patients pay their premiums and co-pays only to find out their insurance company isn't covering the cost of their necessary care.

Q: What would happen in the event of a dispute between a health plan and a physician?

Physicians would be required to notify and attempt to resolve the issue with the health plan. If an agreement cannot be reached, the SCC's Bureau of Insurance would verify that the insurer complied with the law by paying the appropriate amount. There is no provision for negotiation or arbitration, which is why it is vitally important to have a transparent reimbursement method.

Q: Will this bill raise premiums?

No. Other states are using a similar regional average and it has 1) not impacted premiums 2) reduced surprise billing and 3) maintained access to care (doctors aren't leaving the network).

For more information, please contact Clark Barrineau at cbarrineau@msv.org

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