

VIRGINIA ACTS OF ASSEMBLY -- 2018 SESSION

CHAPTER 788

An Act to amend and reenact § 8.01-27.5 of the Code of Virginia, relating to Medicare, Medicaid, and CHIP; duty of in-network providers to submit claims.

[S 536]

Approved April 6, 2018

Be it enacted by the General Assembly of Virginia:

1. That § 8.01-27.5 of the Code of Virginia is amended and reenacted as follows:

§ 8.01-27.5. Duty of in-network providers to submit claims to health insurers; liability of covered patients for unbilled health care services.

A. As used in this section:

"Covered patient" means a patient whose health care services are covered under terms of a health care policy.

"Health care policy" means any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, offered, arranged, issued, or administered by a health insurer to an individual or a group contract holder to cover all or a portion of the cost of individuals, or their eligible dependents, receiving covered health care services. "Health care policy" includes coverages issued pursuant to (i) Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (ii) § 2.2-1204 (local choice); (iii) 5 U.S.C. § 8901 et seq. (federal employees); and (iv) an employee welfare benefit plan as defined in 29 U.S.C. § 1002 (1) of the Employee Retirement Income Security Act of 1974 (ERISA) that is self-insured or self-funded; and (v) Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP). "Health care policy" does not include (a) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP); or Chapter 55 of Title 10 of the United States Code, 10 U.S.C. § 1071 et seq. (TRICARE); (b) subscription contracts for one or more dental or optometric services plans that are subject to Chapter 45 (§ 38.2-4500 et seq.) of Title 38.2; (c) insurance policies that provide coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accidents, including student accident, sports accident, blanket accident, specific accident, and accidental death and dismemberment policies; (d) credit life insurance and credit accident and sickness insurance issued pursuant to Chapter 37.1 (§ 38.2-3717 et seq.) of Title 38.2; (e) insurance policies that provide payments when an insured is disabled or unable to work because of illness, disease, or injury, including incidental benefits; (f) long-term care insurance as defined in § 38.2-5200; (g) plans providing only limited health care services under § 38.2-4300 unless offered by endorsement or rider to a group health benefit plan; (h) TRICARE supplement, Medicare supplement, or workers' compensation coverages; or (i) medical expense coverage issued pursuant to § 38.2-2201.

"Health care provider" has the same meaning ascribed to the term in § 8.01-581.1.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health insurer" means any entity that is the issuer or sponsor of a health care policy.

"In-network provider" means a health care provider that is employed by or has entered into a provider agreement with the health insurer that has issued the health care policy or is a participating provider with such health insurer, under which agreement or conditions of participation the health care provider has agreed to provide health care services to covered patients.

"Patient" means an individual who receives health care services from a health care provider, or any person authorized by law to consent on behalf of the individual incapable of making an informed decision, or, in the case of a minor child, the parent or parents having custody of the child or the child's legal guardian, or as otherwise provided by law.

"Provider agreement" means a contract, agreement, or arrangement between a health care provider and a health insurer, or a health insurer's network, provider panel, intermediary, or representative, under which the health care provider has agreed to provide health care services to patients with coverage under a health care policy issued by the health insurer and to accept payment from the health insurer for the health care services provided.

B. An in-network provider that provides health care services to a covered patient shall submit its claim to the health insurer for the health care services in accordance with the terms of the applicable

provider agreement *or as permitted under applicable federal or state laws or regulations*, provided that the covered patient provides the in-network provider with information required by the terms of the covered patient's health care policy's plan documents, including the information that is required to verify the individual's coverage under the health care policy, within not fewer than 21 business days before the deadline for the in-network provider to submit its claim to the health insurer as required by the terms of the provider agreement. If an in-network provider does not submit its claim to the health insurer in accordance with the requirements of this subsection, then (i) the covered patient shall have no obligation to pay for health care services for which the in-network provider was required to submit its claim, (ii) the in-network provider shall not have the benefit of the liens provided by §§ 8.01-66.2 and 8.01-66.9 with regard to health care services for which the in-network provider was required to submit its claim, and (iii) the in-network provider shall be prohibited from recovering payment for any of the health care services for which it was required to submit its claim from an insurer providing medical expense benefits to the covered patient under a policy of motor vehicle liability insurance pursuant to § 38.2-2201, by exercising an assignment of the covered patient's rights to the medical expense benefits or by other means. If the in-network provider submits its claim to the health insurer in accordance with the requirements of this subsection, the covered patient or the health insurer shall be obligated to pay for the health care services in accordance with the terms of the provider agreement or health care policy's plan documents. To the extent that self-insured or self-funded plans governed by ERISA *or Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP)* provide otherwise, health care providers shall be permitted to submit claims and coordinate benefits as provided for in the provider agreements or plan documents *or as required under applicable federal and state laws and regulations*.