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HOUSE BILL NO. 1445

Offered January 16, 2018

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.14:2, relating to health insurance coverage decisions for medically necessary services.

Patron—Hope

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3407.14:2 as follows:

§ 38.2-3407.14:2. Standard of clinical evidence for decisions on coverage of medically necessary services.

A. As used in this section, unless the context requires a different meaning:

"Emergency medical services" means those health care services that are rendered by health care providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Health carrier" means an entity subject to Title 38.2 that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an entity providing a plan of health insurance, health benefits, or health services; an accident and sickness insurance company; a health maintenance organization; or a nonstock corporation offering or administering a health services plan, a hospital services plan, or a medical or surgical services plan, or operating a plan subject to regulation under Chapter 45 (§ 38.2-4500 et seq.).

"Prior authorization" means the approval process required by a health carrier before certain services may be provided or eligible for coverage.

B. Notwithstanding the provisions of § 38.2-3419, no policy, contract, or plan issued or provided by a health carrier shall include any policies, guidelines, terms, practices, or other provisions that deny services as not medically necessary, or require prior authorization for services to be considered covered services, using any criterion that:

1. Relates to any financial benefit inuring to the health carrier;

2. Is not related to the appropriateness of the evaluation or treatment of a disease, condition, illness, or injury, taking into account the applicable standard of care and the medical needs of the insured; or

3. Is based in whole or in part on whether the services are performed in a particular class or type of setting or whether the allowable costs for the services are greater than the allowable costs that would be paid to another provider in a different class or type of setting for the same services.

C. Notwithstanding the provisions of § 38.2-3419, no policy, contract, or plan issued or provided by a health carrier that provides coverage for emergency medical services shall include any policies, guidelines, terms, practices, or other provisions that deny emergency medical services as not medically necessary on the basis of a retrospective determination by the health carrier using the final diagnosis or any other information not related to whether, on the basis of information in the medical record at the time medical attention was sought, the emergency medical services were sought or provided in response to the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment of the individual's bodily functions, (iii) serious dysfunction of any of the individual's bodily organs, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

D. The requirements of this section shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2019, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

E. This section shall not apply to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.