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SENATE BILL NO. 1362

Offered January 9, 2019

Prefiled January 8, 2019

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.13:3, relating to health insurance; balance billing by out-of-network providers of ancillary services; liability of covered person.

Patron—Wagner

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 38.2-3407.13:3 as follows:

§ 38.2-3407.13:3. Balance billing by out-of-network provider of ancillary services; liability of covered person.

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

"Allowed amount" means the amount that a carrier is obligated to pay, pursuant to the terms of the covered person's health benefit plan, to a covered person for ancillary services provided to the covered person by an out-of-network provider. The allowed amount shall be net of any cost-sharing amount.

"Ancillary services" means screening, diagnostic, or laboratory services, including radiology and pathology services and diagnostic interpretations, that are covered services provided (i) to a covered person and (ii) in connection with or arising out of other health care services that the covered person receives from an in-network provider.

"Balance billing" means charging a covered person who is insured through a health benefit plan that uses a provider network to recover from the covered person the portion of an out-of-network health care provider's fees or charges for ancillary services provided to the covered person by such out-of-network health care provider that is in excess of the allowed amount.

"Carrier" means any entity that is authorized to sell, offer, or provide a health benefit plan, including an entity providing a plan of health insurance, an accident and sickness insurance company, a health maintenance organization, a corporation offering a health benefit plan, a fraternal benefit society, or other entity that provides health benefit plans subject to state insurance regulation. "Carrier" does not include a multiple employer welfare arrangement.

"Cost-sharing" means a copayment, coinsurance, or deductible, or any other form of financial obligation of the covered person other than a premium or share of premium, or any combination of any of these financial obligations.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual who is entitled to health care services provided, arranged for, paid for, or reimbursed pursuant to a health benefit plan.

"Covered service" means a health care service that is covered under a covered person's health benefit plan.

"Health benefit plan" means an arrangement for the delivery of health care, on an individual or group basis, in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person and that is offered in accordance with the laws of any state. "Health benefit plan" does not include short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor 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.

"Health care facility" means a facility providing a health care service, including a general, special, psychiatric, or rehabilitation hospital; an ambulatory surgical facility; a laboratory, diagnostic, or outpatient medical service facility; and a physician office or clinic.

"Health care practitioner" or "practitioner" means any individual certified or licensed by any of the health regulatory boards within the Department of Health Professions, except individuals regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health care services" has the same meaning ascribed thereto in § 38.2-3438.

"In-network provider" means a health care provider having a contract with a 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.

"In-network provider's notice of liability for balance" means a written notice prepared by an in-network provider for delivery to a covered person that:

1. Informs the covered person that they are being referred to an out-of-network provider;

2. Provides the name and contact information for the out-of-network provider;

3. Informs the covered person that he will be financially responsible for cost-sharing amounts attributable to using an out-of-network provider to provide the ancillary service; and

4. Informs the covered person that any ancillary service provided by the out-of-network provider will not be a covered service and that the covered person may be subject to balance billing with respect to the ancillary service.

"Network" or "provider network" means the health care providers designated by a carrier to provide health care services to covered persons.

"Out-of-network provider" means any health care provider other than an in-network provider.

"Out-of-network provider's notice of liability for balance" means a written notice prepared by an out-of-network provider for delivery to a covered person that:

1. Informs the covered person that he will be financially responsible for cost-sharing amounts attributable to using an out-of-network provider to provide the ancillary service; and

2. Informs the covered person that any ancillary service provided by the out-of-network provider will not be a covered service and that the covered person may be subject to balance billing with respect to the ancillary service.

"Provider" or "health care provider" means any health care practitioner or health care facility.

B. An in-network provider that directs or refers a covered person to an out-of-network provider for an ancillary service shall provide to the covered person an in-network provider's notice of liability for balance.

C. Upon request by a covered person, an out-of-network provider, prior to providing an ancillary service to the covered person, shall provide a good faith estimate of the out-of-network provider's charges for the ancillary service.

D. If a covered person chooses to receive ancillary services from an out-of-network provider, the out-of-network provider, prior to providing an ancillary service to the covered person, shall provide to the covered person an out-of-network provider's notice of liability for balance.

E. If:

1. The in-network provider that directed or referred a covered person to an out-of-network provider for an ancillary service failed to provide to the covered person an in-network provider's notice of liability for balance as required by subsection B;

2. The out-of-network provider, prior to providing an ancillary service to the covered person, failed to provide a good faith estimate of the out-of-network provider's charges for the ancillary service when requested by the covered person as required by subsection C;

3. The out-of-network provider, prior to providing an ancillary service to the covered person, failed to provide to the covered person an out-of-network provider's notice of liability for balance as required by subsection D; or

4. The covered person failed or refused to acknowledge, by signing the out-of-network provider's notice of liability for balance, that the covered person is aware that the use of the out-of-network provider for the ancillary service may result in his being balance billed by the out-of-network provider,

Then (i) the covered person shall not owe or be liable to the out-of-network provider for the ancillary service any more than the allowed amount and (ii) the out-of-network provider shall not balance bill or collect any amount from the covered person for the ancillary service except for the allowed amount.

F. A carrier shall pay the allowed amount directly to the covered person, and the covered person shall be advised of his responsibility to apply such payment to the claim of the out-of-network provider as provided in § 38.2-3407.13:2.

G. Any communication from an out-of-network provider of an ancillary service to the covered person prior to the covered person's receipt of information from his carrier regarding the allowed amount for the ancillary service shall include a notice in at least 12-point boldface type stating that:

1. The covered person is not obligated to pay any amount to the out-of-network provider with respect to the ancillary service until the covered person is informed by his carrier of the allowed amount; and

2. A covered person's obligation to the out-of-network provider with respect to the ancillary service shall not exceed the allowed amount unless the conditions set forth in subdivisions E 1 through 4 have been satisfied.

H. The Commission shall provide a notice on its website containing information for individuals relating to the protections provided by this section and information on how individuals may report and file complaints with the Commission.

I. Any health care provider that provides ancillary services to individuals who may be covered by a health benefit plan of which the health care provider is not an in-network provider shall post a prominent notice in its offices that (i) states the rights of covered persons under this section, (ii) identifies the Commission as the proper agency to receive complaints relating to balance billing

prohibited under this section, and (iii) provides contact information for the Commission. The Commission may by regulation specify the form and content of the notice.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2. That the provisions of this act shall become effective on January 1, 2020.