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HOUSE BILL NO. 1251

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on February 24, 2020)

(Patrons Prior to Substitute—Delegates Torian, Adams [HB 1546], Bagby [HB 1494], Levine [HB189], Sickles [HB 901], and Ware [HB 58])

A BILL to amend and reenact §§ 38.2-3438 and 38.2-3445 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 38.2-3445.01 and 38.2-3445.02, and to repeal § 38.2-3445.1 of the Code of Virginia relating to health insurance; payment to out-of-network providers.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3438 and 38.2-3445 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-3445.01 and 38.2-3445.02 as follows:

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health benefit plan.

"Codes" has the same meaning ascribed to the term in § 65.2-605.

"Cost-sharing requirement" means a deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means, *regardless of the final diagnosis rendered to a covered person,* a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd (e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Fair market value" means the price that is determined on the basis of the amounts billed to and the amounts accepted from health carriers or managed care plans by similar providers for comparable out-of-network emergency services in the community where the services are rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services,

or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission 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 insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student health insurance coverage shall be considered a type of individual health insurance coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Market-based value" means the health-carrier-specific median in-network rate as of January 1, 2019 with respect to health care services covered by a group health plan or group or individual health insurance coverage that is the median negotiated rate under the applicable plan or coverage recognized under the plan or coverage as the total maximum payment for the service under the plan or coverage, for the same or a similar service that is provided by a provider in the same or similar specialty, and in the geographic region in which the service is furnished.

"Network" means the group of participating providers providing services to a managed care plan.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to § 32.1-276.4.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time

during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Out-of-network services" means services rendered to a covered person by a health care provider that does not have an in-network participation agreement with the health carrier or managed care plan that governs reimbursement of such services as a member of the health benefit plan's network.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than ~~coinsurance, copayments, or deductibles~~ *cost-sharing requirements*, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Regional average for commercial payments" means the fixed price, based on data submitted by data suppliers in 2018 pursuant to subdivisions C 1 and 2 of § 32.1-276.7:1 and reported to the Commission's Bureau of Insurance by the nonprofit data services organization, that is determined on the basis of the amounts paid to and the amounts accepted by health care providers from health carriers by category of providers for comparable out-of-network emergency services, identified by codes, in the health planning region where the services were rendered, including amounts accepted under single case agreements, emergency-only participation agreements, and rental network agreements.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 38.2-3445. Patient access to emergency services.

A. Notwithstanding any provision of § 38.2-3407.11~~,~~ *or* 38.2-4312.3~~,~~ or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall

provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to *the final diagnosis rendered to the covered person or* whether the health care provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, *a covered person shall not be required to pay an out-of-network provider any amount other than the cost-sharing requirement, and* any cost-sharing requirement ~~expressed as copayment amount or coinsurance rate~~ cannot exceed the cost-sharing requirement that would apply if such services were provided in-network. ~~However, an individual may be required to pay the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section.~~ The health carrier complies with this requirement if the health carrier provides benefits with respect to an emergency service in an amount equal to the ~~greatest of (i) the amount negotiated with in-network providers for the emergency service, or if more than one amount is negotiated, the median of these amounts; (ii) the amount for the emergency service calculated using the same method the health carrier generally uses to determine payments for out-of-network services, such as the usual, customary, and reasonable amount; and (iii) the amount that would be paid under Medicare for the emergency service~~ *usual and customary commercial payment for such services in the applicable health planning region as of January 1, 2019, as the initial payment. The health carrier shall pay any amount due the health care provider pursuant to this subdivision directly, less any cost-sharing requirement. Such payment shall be made within 40 days for a clean claim. The health care provider shall not bill or otherwise seek payment from the covered person for any amount other than the amount of any such cost-sharing requirement*.

~~A deductible may be imposed with respect to out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits.~~ If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum shall apply to out-of-network emergency services; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

B. If, after the out-of-network provider receives payment from a health carrier, the out-of-network provider determines that the amount determined by the health carrier as the usual and customary payment for emergency services is not reasonable, the health care provider shall notify the health carrier within 90 days of such determination. The out-of-network provider and the health carrier shall make a good faith effort to reach a resolution on the reasonable amount of reimbursement for the emergency services provided.

C. If a resolution is not reached between the out-of-network provider and the health carrier within 30 days of notification under subsection B, either party may request to enter into arbitration pursuant to § 38.2-3445.02.

D. Except for its facilitation of arbitration pursuant to § 38.2-3445.02, the Commission shall have no jurisdiction to adjudicate disputes arising out of this section.

E. This section shall apply to health coverage insurance offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees pursuant to § 2.2-1204.

F. Except as provided in this subsection, the provisions of this section shall not apply to an entity providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded with respect to such plan. Such an entity may elect to be subject to the provisions of this section by providing notice to the Commission annually, in a form and manner prescribed by the Commission, attesting to the plan's participation and agreeing to be bound by the provisions of this section. Such entity shall amend the plan, policies, contracts, and other documents to reflect such election. In addition, the entity that elects to opt in pursuant to this section shall file current plan documentation confirming the plan accepts the obligations pursuant to this section and attests that any amended plan documents will be filed with the Commission before the effective date of such amendments. The Commission shall post on its website a list of entities, including relevant plan information, that have elected to be subject to the provisions of this section. The Commission shall update such list at least once per quarter.

§ 38.2-3445.01. Services provided at an in-network facility.

A. As used in this section, "in-network facility" means a facility 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.

B. If a covered person receives out-of-network services at an in-network facility and such services would be covered if the services were received from an in-network provider, the covered person shall not be required to pay any amount other than the cost-sharing requirement for such services, and no cost-sharing requirement shall exceed the cost-sharing requirement that would apply if such services were provided in-network. The health carrier complies with this requirement if the health carrier provides benefits with respect to such services in an amount equal to the usual and customary commercial payment for such services in the applicable health planning region as of January 1, 2019 as the initial payment. The health carrier shall pay any amount due the health care provider pursuant to this subsection directly, less any cost-sharing requirement. Such payment shall be made within 40 days for a clean claim. The health care provider shall not bill or otherwise seek payment from the covered person for any amount other than the amount of any such cost-sharing requirement.

C. If, after the out-of-network provider receives payment from a health carrier, the out-of-network provider determines that the amount determined by the health carrier as the usual and customary payment for services is not reasonable, the health care provider shall notify the health carrier within 90 days of such determination. The out-of-network provider and the health carrier shall make a good faith effort to reach a resolution on the reasonable amount of reimbursement for the services provided.

D. If a resolution is not reached between the out-of-network provider and the health carrier within 30 days of notification under subsection C, either party may request to enter into arbitration pursuant to § 38.2-3445.02.

E. This section shall apply to health insurance coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees pursuant to § 2.2-1204.

F. Except as provided in this subsection, the provisions of this section shall not apply to an entity providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded with respect to such plan. Such an entity may elect to be subject to the provisions of this section by providing notice to the Commission annually, in a form and manner prescribed by the Commission, attesting to the plan's participation and agreeing to be bound by the provisions of this section. Such entity shall amend the plan, policies, contracts, and other documents to reflect such election. In addition, the entity that elects to opt in pursuant to this section shall file current plan documentation confirming the plan accepts the obligations pursuant to this section and attests that any amended plan documents will be filed with the Commission before the effective date of such amendments. The Commission shall post on its website a list of entities, including relevant plan information, that have elected to be subject to the provisions of this section. The Commission shall update such list at least once per quarter.

§ 38.2-3445.02. Arbitration.

A. The Commission shall establish rules for an expedited arbitration process to settle disputes between providers and health carriers arising out of §§ 38.2-3445 and 38.2-3445.01. Such rules shall require that any claim submitted to arbitration be resolved by the arbitrator within 60 days of submission of the claim.

B. The Commission shall (i) establish a portal on its website for the submission of arbitration claims, (ii) contract with independent arbitrators to settle such disputes, (iii) ensure the arbitrators do not have a conflict of interest with the parties and have experience in health care billing, and (iv) maintain a list of such arbitrators on its website.

C. The cost of arbitration shall be split between the parties.

D. In determining the reasonable amount that a health carrier is required to pay for a service, an arbitrator shall consider all relevant factors, including:

1. Whether there is a gross disparity between the fees charged by the provider for services rendered as compared with:

a. Fees paid to the involved provider for the same services rendered by the provider to other enrollees; and

b. In the case of a dispute involving a health carrier, fees paid by the health carrier to reimburse a similarly qualified provider for the same services in the same region and fees paid to the provider by other health carriers in the same region;

2. The level of training, education, and experience of the provider or for a facility, the availability of specialized equipment, personnel, or services or training and expertise required to maintain such specialized equipment, personnel, or services;

3. The provider's usual charge for comparable services with regard to patients in health benefit

plans in which the provider is not participating;

4. The circumstances and complexity of the particular case, including time and place of the service;

5. Individual patient characteristics;

6. The history of network contracting between the parties;

7. The market-based value, the regional average for commercial payments, and the fair market value; and

8. The impact on the cost of insurance premiums.

E. A party shall be permitted to bundle claims involving a single health carrier for arbitration.

F. The provisions of this section shall not affect any existing right to appeal or other legal remedies.

G. This section shall not apply to services when the provider's fees are subject to schedules or other monetary limitations under any other law, including the Virginia Workers' Compensation Act, and this section shall not preempt any such law.

H. The Commission shall require in any contract with an independent arbitrator entered into pursuant to this section provisions requiring the arbitrator to report to the Commission information regarding the frequency, nature, and disposition of disputes submitted for arbitration and any other such figures and information as the Commission determines to be necessary to fulfill its obligations to report information to the public or the General Assembly regarding arbitration between health carriers and providers under this section.

2. That § 38.2-3445.1 of the Code of Virginia is repealed.

3. That the nonprofit data services organization (the nonprofit organization) with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to § 32.1-276.4 of the Code of Virginia shall submit a report (the report) by July 1, 2020, to the State Corporation Commission's Bureau of Insurance (the Bureau) establishing the regional average for commercial payments, as defined in § 38.2-3438 of the Code of Virginia, as amended by this act, for emergency services. The report shall not identify individual health plans or health-care-provider-specific reimbursement amounts. Prior to submission of the report to the Bureau, the nonprofit organization shall submit the report to the Virginia All-Payer Claims Database Data Review Committee for review and approval.

4. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance (the Bureau) no later than September 1, 2020, the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia, as amended by this act, in fiscal years 2017, 2018, and 2019. Thereafter, any health carrier providing individual or group health insurance coverage shall report to the Bureau, no later than November 1 of each year, the number of (i) out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia, as amended by this act, and (ii) out-of-network claims for services provided at in-network facilities paid pursuant to § 38.2-3445.01 of the Code of Virginia, as created by this act, for the previous fiscal year.

5. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance no later than September 1 of each year the number and identity of health care providers in the health carrier's network of emergency services providers whose participation in the network was terminated by either the health carrier or the health care provider in the previous year and, if applicable, whether participation was subsequently reinstated in the same year. For any terminated health care providers identified by the health carrier in such report, the health carrier shall include (i) a description of the health care provider's or health carrier's stated reason for terminating participation and (ii) a description of the nature and extent of differences in payment levels for emergency services prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination.

6. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall notify the Chairmen of the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor of the information reported to the Bureau pursuant to the third, fourth, and fifth enactments of this act and other information specified in this enactment no later than December 1 of each year. Such notice shall include (i) the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia, as amended by this act, for the previous fiscal year; (ii) the number of out-of-network claims for services provided at in-network facilities paid pursuant to § 38.2-3445.01 of the Code of Virginia, as created by this act; (iii) the number and identity of health care providers in the health carrier's network of emergency services providers whose participation in the network was terminated by the health carrier or the health care provider in the previous year and whether participation was subsequently reinstated in the same year; (iv) a summary of the stated reasons for terminating

participation; (v) a summary of the nature and extent of differences in payment levels prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination; (vi) an assessment by the Bureau of the potential impact of any changes in network participation or payment levels for emergency services on health insurance premiums in the time period to which the report applies; and (vii) the number and type of claims resolved by arbitration and figures on the disposition of those arbitrations, including in which party's favor the dispute was resolved, and information on the variation between the initial payment and final settlement amounts.