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# HOUSE BILL NO. 1546

Offered January 10, 2020

*A BILL to amend and reenact § 38.2-3445 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 9, consisting of sections numbered 38.2-3465 through 38.2-3472, relating to health insurance; billing by non-participating providers.*

Patrons—Adams, D.M., Bagby, Jenkins, Rasoul and Ware

Referred to Committee on Labor and Commerce

**Be it enacted by the General Assembly of Virginia:**

**1. That § 38.2-3445 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 9, consisting of sections numbered 38.2-3465 through 38.2-3472, as follows:**

**§ 38.2-3445. Patient access to emergency services.**

*A.* Notwithstanding any provision of § 38.2-3407.11, 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 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, 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~~ *Subject to the conditions set out in § 38.2-3469, an insured* individual ~~may be required to pay~~ *shall not be liable for* the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section *or Article 9 (§ 38.2-3465 et seq.)*. ~~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.~~

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. The provisions of Article 9 (§ 38.2-3465 et seq.) shall govern matters related to the determination of the amount a health carrier is required to pay an out-of-network provider for emergency services.*

*Article 9.*

*Billing Disputes with Non-Participating Providers of Health Care Services.*

***§ 38.2-3465. Definitions.***

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

*"Bureau" means the Commission's Bureau of Insurance.*

*"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or (v) a condition described in clause (i), (ii), or (iii) of § 1867(e)(1)(A) of the federal Social Security Act, 42 U.S.C.*

*§ 1395dd.*

*"Emergency services" means, with respect to an emergency condition, (i) a medical screening examination of a patient as is required under § 1867 of the federal 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 stabilize a patient, as required under § 1867 of the federal Social Security Act, that are within the capabilities of the staff and facilities available at the hospital.*

*"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 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, pursuant to the terms of a health benefit plan.*

*"Insured" means a patient covered under a health benefit plan.*

*"Non-participating" means not having a contract with a health carrier to provide health care services to an insured.*

*"Participating" means having a contract with a health carrier to provide health care services to an insured.*

*"Patient" means a person who receives health care services, including emergency services, in the Commonwealth.*

*"Surprise bill" means a bill for health care services, other than emergency services, received by:*

*1. An insured for services rendered by a non-participating physician at a participating hospital or ambulatory surgical center when a participating physician is unavailable or a non-participating physician renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; however, a surprise bill does not include a bill received for health care services when a participating physician is available and the insured has elected to obtain services from a non-participating physician;*

*2. An insured for services rendered by a non-participating provider when the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health benefit plan; or*

*3. A patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center when the patient has not received in a timely manner all required disclosures.*

*"Usual and customary cost" means the eightieth percentile of all charges for a particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization that is not affiliated with a health carrier and is selected by the Commissioner.*

***§ 38.2-3466. Dispute resolution process established.***

*A. The Commissioner shall establish a dispute resolution process by which a dispute over a bill for emergency services or a surprise bill may be resolved by or through a certified independent dispute resolution entity. The Commissioner is authorized to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process.*

*B. The Commission shall adopt regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the health care service that is the subject of the billing dispute. To the extent practicable, the physician shall be licensed in the Commonwealth.*

***§ 38.2-3467. Applicability of article.***

*A. This article shall not apply to health care services, including emergency services, when the physician's fees are subject to schedules or other monetary limitations under any other law, including the Virginia Workers' Compensation Act, and this article shall not preempt any such law.*

*B. With regard to emergency services billed under American Medical Association current procedural terminology (CPT) codes 99281 through 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through 99226, and 99234 through 99236, the dispute resolution process established in this article shall not apply when (i) the amount billed for any such CPT code meets the requirements set forth in subsection C, after any applicable coinsurance, copayment, and deductible, and (ii) the amount billed for any such CPT code does not exceed 120 percent of the usual and customary cost for such CPT code. Each health carrier shall ensure that an insured shall not incur any greater out-of-pocket costs for emergency services billed under a CPT code as set forth in this subsection than the insured*

*would have incurred if such emergency services were provided by a participating physician.*

*C. Beginning January 1, 2021, and each January 1 thereafter, the Commissioner shall publish on a website maintained by the Bureau, and provide in writing to each health carrier, a dollar amount for which bills for the procedure codes identified in subsection B shall be exempt from the dispute resolution process established in this article. Such amount shall equal the amount from the prior year and adjusted by the average of the annual average inflation rates for the medical care commodities and the medical care services components of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor. In no event shall an amount exceeding double the baseline of 2020 for a specific CPT code billed be exempt from the dispute resolution process established in this article.*

***§ 38.2-3468. Criteria for determining a reasonable fee.***

*A. In determining the appropriate amount that a health carrier is required to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:*

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

*a. Fees paid to the involved physician for the same services rendered by the physician to other patients in health benefit plans in which the physician is not participating; and*

*b. In the case of a dispute involving a health carrier, fees paid by the health carrier to reimburse similarly qualified physicians for the same services in the same region who are not participating in a health benefit plan of the health carrier;*

*2. The level of training, education, and experience of the physician;*

*3. The physician's usual charge for comparable services with regard to patients in health benefit plans in which the physician is not participating;*

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

*5. Individual patient characteristics; and*

*6. The usual and customary cost of the service.*

*B. The provisions of this section shall be effective until January 1, 2026.*

***§ 38.2-3469. Dispute resolution for emergency services.***

*A. If emergency services are provided for an insured:*

*1. When a health carrier receives a bill for emergency services from a non-participating physician, the health carrier shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, except for the insured's coinsurance, copayment, or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred if such emergency services were provided by a participating physician;*

*2. A non-participating physician or a health carrier may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity;*

*3. The independent dispute resolution entity shall make a determination within 30 days of receipt of the dispute for review; and*

*4. In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health carrier's payment or the non-participating physician's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in § 38.2-3468. If an independent dispute resolution entity determines, on the basis of the health carrier's payment and the non-participating physician's fee, that a settlement between the health carrier and non-participating physician is reasonably likely, or that both the health carrier's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health carrier and non-participating physician may be granted up to 10 business days for this negotiation, which shall run concurrently with the 30-day period for dispute resolution.*

*B. If emergency services are provided for a patient who is not an insured:*

*1. The patient or the patient's physician may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the Commissioner;*

*2. An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in § 38.2-3468; and*

*3. The patient shall not be required to pay the physician's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.*

*C. A determination of an independent dispute resolution entity shall be binding on the health carrier, physician, and patient and shall be admissible in any court proceeding between the health carrier, physician, or patient, or in any administrative proceeding between the Commonwealth and the physician.*

*D. The provisions of this section shall be effective until January 1, 2026.*

***§ 38.2-3470. Hold harmless and assignment of benefits for surprise bills for insureds.***

*When an insured assigns benefits for a surprise bill or a bill for emergency services in writing to a non-participating physician who knows the insured is covered under a health benefit plan, the non-participating physician shall not bill the insured except for any applicable coinsurance, copayment, or deductible that would be owed if the insured utilized a participating physician.*

***§ 38.2-3471. Dispute resolution for bills for health care services other than emergency services.***

*A. When an insured assigns benefits for non-emergency services under his health benefit plan to a non-participating physician and receives a surprise bill from the non-participating physician:*

*1. The non-participating physician may bill the health carrier for the health care services rendered, and the health carrier shall pay the non-participating physician the billed amount or attempt to negotiate reimbursement with the non-participating physician;*

*2. If the health carrier's attempts to negotiate reimbursement for health care services provided by a non-participating physician do not result in a resolution of the payment dispute between the non-participating physician and the health carrier, the health carrier shall pay the non-participating physician an amount the health carrier determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance, or deductible;*

*3. Either the health carrier or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity; however, the health carrier may not submit the dispute unless it has complied with the requirements of subdivisions 1 and 2;*

*4. The independent dispute resolution entity shall make a determination within 30 days of receipt of the dispute for review; and*

*5. When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health carrier's payment or the non-participating physician's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in § 38.2-3468. If an independent dispute resolution entity determines, based on the health carrier's payment and the non-participating physician's fee, that a settlement between the health carrier and non-participating physician is reasonably likely, or that both the health carrier's payment and the non-participating physician's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health carrier and non-participating physician may be granted up to 10 business days for this negotiation, which shall run concurrently with the 30-day period for dispute resolution.*

*B. When (i) an insured does not assign benefits for non-emergency services under his health benefit plan to a non-participating physician and receives a surprise bill from the non-participating physician or (ii) a patient who is not an insured receives a surprise bill from a non-participating physician:*

*1. The insured or patient may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity;*

*2. The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in § 38.2-3468; and*

*3. The insured or patient shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute entity.*

*C. The determination of an independent dispute resolution entity shall be binding on the patient, physician, and health carrier and shall be admissible in any court proceeding between the patient or insured or between the physician or health carrier or in any administrative proceeding between the Commonwealth and the physician.*

***§ 38.2-3472. Payment for independent dispute resolution entity.***

*A. Until January 1, 2026, for disputes involving an insured, when the independent dispute resolution entity determines that the health carrier's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician. When the independent dispute resolution entity determines the non-participating physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health carrier. When a good faith negotiation directed by the independent dispute resolution entity pursuant to subdivision A 4 of § 38.2-3469 or subdivision A 5 of § 38.2-3471 results in a settlement between the health carrier and non-participating physician, the health carrier and the non-participating physician shall evenly divide and share the prorated cost for dispute resolution.*

*B. On and after January 1, 2026, for disputes involving an insured, when the independent dispute resolution entity determines the health carrier's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician or hospital. When the independent dispute resolution entity determines the non-participating physician's or hospital's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health carrier. When a good faith negotiation directed by the independent dispute resolution entity pursuant to subdivision A 4 of § 38.2-3469 or subdivision A 5 of § 38.2-3471 results in a settlement between the health carrier and non-participating physician or hospital, the health carrier and the non-participating physician or hospital shall evenly divide and share the prorated cost for dispute resolution.*

*C. For disputes involving a patient who is not an insured, when the independent dispute resolution entity determines the physician's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The Commissioner shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the independent dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the physician.*

*D. If the dispute is resolved, neither the physician, hospital, nor the health plan shall hold the patient responsible for fees in excess of the agreed-upon negotiated fee amount.*