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SENATE BILL NO. 522

Offered January 8, 2020

Prefiled January 7, 2020

A BILL to amend and reenact §§ 38.2-3438 and 38.2-3445 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3445.2, relating to health insurance; payment of out-of-network providers.

Patron—McDougle

Referred to Committee on Commerce and Labor

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 a section numbered 38.2-3445.2 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.

"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.

"Elective services" means health care services rendered to a covered person that are not emergency services or post-stabilization services.

"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 by providers from, health carriers for managed care plans, by category of 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. "Fair market value" determinations do not include amounts accepted by providers for patients covered by Medicare or Medicaid.

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"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.

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

"Office-based setting" means care delivered to a covered person in the office of a doctor of medicine, doctor of osteopathic medicine, physician assistant, or nurse practitioner. "Office-based setting" does not include care delivered to a covered person in a facility for outpatient services.

"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.

"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.

"Post-stabilization services" means services rendered to a covered person, related to an emergency medical condition, that are not emergency services or elective services and that are provided after a covered person is stabilized in order to maintain the stabilized condition or improve the covered person's condition until the covered person is discharged following an emergency department encounter.

"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.

"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 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 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.~~

~~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. Post-stabilization services shall be treated as emergency services pursuant to this section if (i) the post-stabilization services are preapproved or related to preapproved services; (ii) for an out-of-network facility, the health carrier does not effectuate transfer of the covered person within a reasonable amount of time after being notified by the facility of the covered person's need for post-stabilization services; (iii) for an out-of-network health care professional, the facility is in-network; or (iv) the out-of-network facility is unable to reasonably obtain health carrier information from the covered person prior to the furnishing of such services.

C. The health carrier shall pay an out-of-network health care provider the fair market value for the emergency services, less applicable cost-sharing requirements, and such payments shall be paid directly to the health care provider. The direct receipt of payment from the health carrier to the out-of-network health care provider for emergency services pursuant to this section shall preclude and prevent the out-of-network health care provider from billing or seeking payment from the covered person for any amounts other than applicable cost-sharing requirements.

D. The final diagnosis rendered to a covered person that a medical condition did not pose a risk of resulting 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 shall not disqualify a covered person's condition from being an emergency medical condition.

§ 38.2-3445.2. Patient access to elective services; out-of-network services.

A. In a facility where a covered person receives elective services, an authorized representative of the facility shall determine if the providers scheduled to deliver elective services to the covered person are in the network of the covered person's managed care plan. If the providers of such services are out-of-network, the authorized representative of the facility shall (i) inform the covered person or his legal representative of the out-of-network status of the provider, (ii) provide the covered person or his legal representative with the opportunity to be referred to an in-network provider, and (iii) prepare a document for signature by the covered person or his legal representative in which the covered person or his legal representative acknowledges liability for the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay. A covered person shall not be required to pay such excess out-of-network provider charges, except applicable deductibles, copayment amounts, coinsurance rates, and amounts charged for services deemed by the health carrier to be noncovered services, unless a provider satisfies clauses (i), (ii), and (iii) and the covered person signs the document described in clause (iii).

B. In an office-based setting, a health care provider making a referral for elective radiology or pathology services shall determine if the providers of such services are in the network of the covered person's managed care plan. If the providers of such services are out-of-network, the health care provider shall (i) inform the covered person or his legal representative of the out-of-network status of the elective services, (ii) provide the covered person or his legal representative with the opportunity to be referred to an in-network provider, and (iii) prepare a document for signature by the covered person or his legal representative in which the covered person or his legal representative acknowledges liability for the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay. A covered person shall not be required to pay such excess out-of-network provider charges, except applicable deductibles, copayment amounts, coinsurance rates, and amounts charged for services deemed by the health carrier to be noncovered services, unless a provider satisfies clauses (i), (ii), and (iii) and the covered person signs the document described in clause (iii).