Department of Planning and Budget
2020 Fiscal Impact Statement

1. **Bill Number:** HB1251

House of Origin	☒	Introduced	☐	Substitute	☐	Engrossed
Second House	☐	In Committee	☐	Substitute	☐	Enrolled

2. **Patron:** Torian

3. **Committee:** General Laws

4. **Title:** Balance billing; emergency services.

5. **Summary:** Provides that when a covered person receives covered emergency services from an out-of-network health care provider, the covered person is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement. The measure deletes a provision that allows an out-of-network provider to charge an individual for the balance of the provider's billed amount after applying the amount the health carrier is required to pay for such services. The measure also establishes a fourth standard for calculating the health carrier's required payment to the out-of-network provider of the emergency services, which standard is (i) the regional average for commercial payments for such service if the provider is a health care professional or (ii) the fair market value for such services if the provider is a facility. This fourth standard is the amount the health carrier is obligated to pay to the out-of-network provider if the amount is greater than any of the other three standards, which are (a) the amount negotiated with in-network providers for the emergency service or, if more than one amount is negotiated, the median of these amounts; (b) 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; or (c) the amount that would be paid under Medicare for the emergency service. The measure requires the health carrier to pay the required amount, less applicable cost-sharing requirements, directly to the out-of-network health care provider of the emergency services. If such provider determines that the amount to be paid by the health carrier does not comply with the applicable requirements, the measure requires the provider and the health carrier to make a good faith effort to reach a resolution on the appropriate amount of the reimbursement and, if a resolution is not reached, authorizes either party to request the State Corporation Commission to review the disputed reimbursement amount and determine if the amount complies with applicable requirements. The measure also provides that final diagnosis rendered to a covered person who receives emergency services for a medical condition shall not be considered in the health carrier's determination of whether the medical condition was an emergency medical condition. The measure establishes the procedure by which the regional average for commercial payments for emergency services will be calculated by the nonprofit data services organization that compiles the Virginia All-Payer Claims Database. The measure also requires health carriers to makes reports to the Bureau of Insurance and directs the Bureau to provide reports to certain committees of the General Assembly.

6. **Budget Amendment Necessary**: Indeterminate – see Item 8.

7. **Fiscal Impact Estimates:** Indeterminate – see Item 8.

8. **Fiscal Implications:** The fiscal impact the proposed legislation may have to the state health insurance plans is indeterminate at this time. According to the Department of Human Resource Management's actuary, Aon, the percentage of emergency services provided by out-of-network providers is relatively low and the percentage of emergency services provided by out-of-network providers in the previous fiscal year was less than one percent of all state health insurance claims. The number of emergency services provided by out-of-network providers varies each year; however, the number of emergency services provided by out-of-network providers is expected to remain low compared to the total number of state health insurance claims. The state health insurance plans are administered by carriers that generally have favorable network contract rates; however, under this bill, out-of-network providers could be paid more than in-network providers for emergency services. This may generate an incremental fiscal impact to the state health insurance plans. Any potential impact for out-of-network providers to begin receiving higher fees than in-network providers is indeterminate at this time; in such case, in-network providers could potentially choose to leave the network or request higher fees.

   The proposed legislation is not expected to have a fiscal impact for the Department of Medical Assistance Services or Medicaid.

   The proposed legislation may have a minimal fiscal impact for the Virginia Department of Health; however, the agency expects to absorb any costs needed to implement the proposed legislation within its current operating budget.

   The State Corporation Commission expects to absorb any additional costs needed to implement the proposed legislation within its current operating budget.

9. **Specific Agency or Political Subdivisions Affected:** State Corporation Commission, Department of Human Resource Management, Department of Medical Assistance Services, and Virginia Department of Health.

10. **Technical Amendment Necessary:** No.

11. **Other Comments:** This bill is identical to House Bill 58 (Ware) and Senate Bill 172 (Favola). This bill is also identical to Senate Bill 243 (Chase), except Senate Bill 243 requires the nonprofit organization which operates the All-Payer Claims Database to submit a report establishing the regional average for commercial payments for emergency services to the SCC by August 1, 2020. Senate Bill 172, House Bill 58, and House Bill 1251 require the nonprofit organization to submit a report establishing the regional average for commercial payments for emergency services to the SCC by July 1, 2020.