Department of Planning and Budget
2020 Fiscal Impact Statement

1. **Bill Number:** SB172-H2

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

2. **Patron:** Favola

3. **Committee:** -

4. **Title:** Health insurance; payment to out-of-network providers.

5. **Summary:** Provides that when a covered person receives covered emergency services from an out-of-network health care provider, the health carrier shall pay the out-of-network provider less any cost-sharing requirement. Any cost-sharing requirement shall not exceed the cost-sharing requirement that would apply if such services were provided in-network. No out-of-network provider shall balance bill an enrollee for (i) emergency services provided to an enrollee or (ii) nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider. The health carrier and the out-of-network provider shall ensure that the enrollee incurs no greater cost than the amount determined and shall not balance bill or otherwise attempt to collect from the enrollee any amount greater than such amount. Additional amounts owed to health care providers through good faith negotiations or arbitration shall be the sole responsibility of the carrier unless the carrier is prohibited from providing the additional benefits under 26 U.S.C. § 223 (c) or any other federal or state law. If good faith negotiation does not result in a resolution of the dispute, and the carrier or the out-of-network provider chooses to pursue further action to resolve the dispute, the carrier or out-of-network provider shall initiate arbitration to determine a commercially reasonable amount. No later than 30 days after final selection of the arbitrator, each party shall provide written submissions in support of its position to the arbitrator. No later than 30 calendar days after the receipt of the parties' written submissions, the arbitrator shall (i) issue a written decision requiring payment of the final offer amount of either the initiating or noninitiating party, (ii) notify the parties of the decision, and (iii) provide the decision and information to the State Corporation Commission (SCC). These provisions shall become effective on January 1, 2021.

   The SCC shall prepare an annual report summarizing the dispute resolution information provided by arbitrators, including information related to the matters decided through arbitration as well as the following information for each dispute resolved through arbitration: the name of the carrier, the name of the health care provider, the health care provider's employer or the business entity in which the provider has an ownership interest, the health care facility where the services were provided, and the type of health care services at issues. The SCC shall post the report on the Bureau of Insurance’s website and submit the report to the Chairs of the House Committees on Labor and Commerce and Appropriations and the

Senate Committees on Commerce and Labor and Finance and Appropriations annually by July 1. The annual reporting requirements shall expire on July 1, 2025.

The SCC also shall contract with the nonprofit data services organization to establish a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers. Such data set and business protocols shall be (i) developed in collaboration with health carriers and health care providers, (ii) reviewed by the All-Payer Claims Database Advisory Committee, and (iii) available beginning November 1, 2020.

6. **Budget Amendment Necessary**: No – see Item 8.

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

8. **Fiscal Implications:** The legislation is not expected to have a fiscal impact to the state health insurance plan. The bill requires an out-of-network provider to be paid a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area, for emergency services provided to an enrollee and nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider. The bill establishes an arbitration process if the out-of-network provider disputes the carrier's initial offer to pay the commercially reasonable amount. The carrier and provider have 30 calendar days from the initial offer to negotiate in good faith. If the carrier and provider do not agree to a commercially reasonable payment amount within 30 calendar days and either party chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration. The bill also requires the SCC to contract with the nonprofit data services organization to establish a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes.

   The bill authorizes the Board of Medicine or Commissioner of the Virginia Department of Health (VDH) to levy a fine or cost recovery upon a health care provider, and take other action as permitted, if the health care provider has violated § 38.2-3445.01 with no corrective action. Upon completion of its review of any potential violation submitted by the SCC or initiated directly by an enrollee, the Board of Medicine or Commissioner of VDH shall notify the SCC of the results of the review, including whether the violation was substantiated and any enforcement action taken as a result of a finding of a substantiated violation. The fiscal impact for the Department of Health Professions (DHP) to implement the enforcement requirements cannot be determined. According to DHP, the potential cost would depend on the number of complaints received and the extent to which those complaints would have to be investigated and adjudicated. The legislation may have a minimal fiscal impact for VDH; however, the agency expects to absorb any costs needed to implement the legislation within its current operating budget. Any costs for VDH would be associated with the administrative expenses incurred by the nonprofit organization responsible for maintaining the All-Payer Claims Database.

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

The State Corporation Commission expects to absorb any additional costs needed to implement the provisions of the 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, Department of Health Professions, Virginia Health Information, and Virginia Department of Health.

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

11. **Other Comments:** This bill is identical to HB 1251-S2 (Torian).