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HOUSE BILL NO. 1584

Offered January 19, 2018

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3407.13:3, relating to health insurance; balance billing by out-of-network providers of ancillary services; liability of covered person.

Patron—Byron

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3407.13:3 as follows:

§ 38.2-3407.13:3. Balance billing by out-of-network provider of ancillary services; liability of covered person.

A. As used in this section, unless the context requires otherwise:

"Allowed amount" means the amount that a carrier is obligated to pay, pursuant to the terms of the covered person's health benefit plan, to a covered person for ancillary services provided to the covered person by an out-of-network provider. The allowed amount shall be net of any cost-sharing.

"Ancillary services" means screening, diagnostic, or laboratory services, including radiology and pathology services and diagnostic interpretations, that are covered services provided (i) to a covered person and (ii) in connection with or arising out of other health care services that the covered person receives from an in-network provider.

"Balance billing" means charging a covered person who is insured through a health benefit plan that uses a provider network to recover from the covered person the portion of an out-of-network health care provider's fees or charges for ancillary services provided to the covered person by such out-of-network health care provider that is in excess of the allowed amount.

"Carrier" means any entity that is authorized to sell, offer, or provide a health benefit plan, including an entity providing a plan of health insurance, an accident and sickness insurance company, a health maintenance organization, a corporation offering a health benefit plan, a fraternal benefit society, or other entity that provides health benefit plans subject to state insurance regulation. "Carrier" does not include a multiple employer welfare arrangement.

"Cost-sharing" means a copayment, coinsurance, or deductible, or any other form of financial obligation of the covered person other than a premium or share of premium, or any combination of any of these financial obligations.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual who is entitled to health care services provided, arranged for, paid for, or reimbursed pursuant to a health benefit plan.

"Covered service" means a health care service that is covered under a covered person's health benefit plan.

"Health benefit plan" means an arrangement for the delivery of health care, on an individual or group basis, in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person and that is offered in accordance with the laws of any state. "Health benefit plan" does not include short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

"Health care facility" means a facility providing a health care service, including a general, special, psychiatric, or rehabilitation hospital; an ambulatory surgical facility; a laboratory, diagnostic, or outpatient medical service facility; and a physician office or clinic.

"Health care practitioner" or "practitioner" means any individual certified or licensed by any of the health regulatory boards within the Department of Health Professions, except individuals regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health care services" has the same meaning ascribed thereto in § 38.2-3438.

"In-network provider" means a health care provider 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.

"Network" or "provider network" means the health care providers designated by a carrier to provide health care services to covered persons.

"Out-of-network provider" means any health care provider other than an in-network provider.

"Provider" or "health care provider" means any health care practitioner or health care facility.

B. If a covered person receives from an out-of-network provider one or more ancillary services:

1. The covered person shall not owe or be liable to the out-of-network provider for the ancillary services any more than the allowed amount; and

2. The out-of-network provider shall not balance bill or collect any amount from the covered person for the ancillary services except for the allowed amount.

C. A carrier shall pay the allowed amount directly to the covered person, and the covered person shall be advised of his responsibility to apply such payment to the claim of the out-of-network provider as provided in § 38.2-3407.13:2.

D. Any communication from an out-of-network provider of ancillary services to the covered person prior to the receipt of information regarding the allowed amount shall include a notice in 12-point bold type stating that:

1. The covered person is not obligated to pay any amount until the covered person is informed by his carrier of the allowed amount; and

2. A covered person shall only be responsible for payment of the allowed amount.

E. The Commission shall provide a notice on its website containing information for consumers relating to the protections provided by this section and information on how consumers may report and file complaints with the Commission.

F. Any health care provider that provides ancillary services to individuals who may be covered by a health benefit plan of which the provider is not an in-network provider shall post a prominent notice in its offices that (i) states the rights of covered persons under this section, (ii) identifies the Commission as the proper agency to receive complaints relating to balance billing prohibited under this section, and (iii) provides contact information for the Commission. The Commission may by regulation specify the form and content of the notice.

G. Any in-network provider that refers an individual to an out-of-network provider for the provision of ancillary services shall (i) notify the individual in writing that the health care provider to which he is being referred is not an in-network provider under the individual's health benefit plan and (ii) advise the individual of the names and locations of any in-network providers that may provide the ancillary services.

H. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

I. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

2. That the provisions of this act shall become effective on January 1, 2019.