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SENATE BILL NO. 639

Offered January 10, 2018

Prefiled January 10, 2018

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-134.5, by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3466, and by adding a section numbered 54.1-2962.3, relating to health care shared savings; required disclosures by health care providers; and health insurance incentive programs.

Patrons—Dunnavant, Black, Chase, Sturtevant and Wagner

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-134.5, by adding in Chapter 34 of Title 38.2 an article numbered 8, consisting of sections numbered 38.2-3461 through 38.2-3466, and by adding a section numbered 54.1-2962.3, as follows:

§ 32.1-134.5. Price transparency; estimate of charges prior to admission, procedure, or service.

A. As used in this section, "covered person," "facility," "health care service," "health carrier," "network," "network provider," and "out-of-pocket costs" have the same meanings ascribed thereto in § 38.2-3461.

B. If a patient or prospective patient is a covered person, a facility that is a network provider shall provide a patient or prospective patient, within two working days, based on the information available to the facility at the time, sufficient information regarding the proposed non-emergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from his health carrier to identify out-of-pocket costs, which estimate could be received through an applicable toll-free telephone number or website. Such facility may assist a patient or prospective patient in using a health carrier's toll-free number and website.

C. If a facility is unable to quote a specific amount under subsection B in advance due to the facility's inability to predict the specific treatment or diagnostic code, the facility shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure, or service, including the amount for any facility fees required. A facility shall disclose the incomplete nature of the estimate and inform the patient or prospective patient of his ability to obtain an updated estimate once additional information is determined.

D. Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a facility that is not a network provider shall, within two working days, disclose the price that will be charged for the non-emergency admission, procedure, or service, including the amount for any facility fees required.

E. Each facility shall post in a visible area notification of a covered person's ability, for those with coverage under an individual health benefit plan or a small group health benefit plan, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow a health carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for his care to different facilities for similar services. This notification shall inform patients of their right to obtain services from different facilities regardless of a referral or recommendation by another health care provider and that obtaining health care services from a high-value facility, either their currently referred facility or a different facility, may result in an incentive to the patient if he follows the procedure established by the patient's health carrier. The notification shall give an outline of the parameters of potential incentives approved in Article 8 (§ 38.2-3461 et seq.) of Chapter 34 of Title 38.2 and shall notify the patient that his health carrier is required to provide covered persons an estimate of out-of-pocket costs and contracted amounts paid for their care to different facilities for similar services via a toll-free telephone number and health care price transparency tool. A facility may provide additional information in any format to patients that inform them of a health carrier's specific price transparency tools or toll-free phone numbers.

Article 8.

Health Care Shared Savings.

§ 38.2-3461. Definitions.

As used in this article:

"Allowed amount" means the contractually agreed upon amount paid or payable by a health carrier to a health care provider participating in the health carrier's network and the covered person's out-of-pocket costs.

"Average" means mean, median, or mode.

"Comparable health care service" means any covered non-emergency health care service or bundle of health care services for which a carrier has not demonstrated that the allowed amount variation among participating providers is less than $50.

"Covered person" means a policyholder, subscriber, participant, or other individual covered by a health benefit plan.

"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.

"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" means a health care professional or facility.

"Health care service" means a service 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.

"Network" or "provider network" means the group of participating providers providing services to a health benefit plan under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of health care providers.

"Network provider" means a health care provider that has contracted with the health carrier, or with its contractor or subcontractor, to provide health care services to covered persons as a member of a network.

"Out-of-network provider" means a health care provider who is not a network provider.

"Out-of-pocket costs" means any copayment, deductible, or coinsurance that is the responsibility of the covered person with respect to a covered health care service.

"Program" means the comparable health care service incentive program established by a health carrier pursuant to this article.

§ 38.2-3462. Comparable Health Care Service Incentive Program.

A. Beginning upon approval of the next insurance rate filing that follows January 1, 2019, each health carrier offering a health benefit plan in the Commonwealth shall develop and implement a program that provides incentives for covered persons in its health benefit plan who elect to receive a comparable health care service that is covered by the health benefit plan from health care providers that charge less than the average allowed amount paid or payable by that health carrier to network providers for that comparable health care service.

B. Incentives may be calculated as a percentage of the difference in allowed amounts to the average, as a flat dollar amount, or by some other reasonable methodology approved by the Commissioner. The health carrier shall provide the incentive as a cash payment to the covered person or credit toward the covered person's annual in-network deductible and out-of-pocket limit. Health carriers may let covered persons decide which method they prefer to receive the incentive.

C. The incentive program shall provide covered persons with at least 50 percent of the health carrier's saved costs for each service or category of comparable health care service resulting from comparison shopping by covered persons. A health carrier is not required to provide a payment or credit to a covered person when the health carrier's saved cost is $25 or less.

D. A health carrier shall determine the allowed amount paid or payable by that health carrier to network providers for that comparable health care service on the basis of the average allowed amount for the procedure or service under the covered person's health benefit plan. Such determination shall be made on the basis of the average of the allowed amounts using data collected over a reasonable period not to exceed one year. A health carrier may determine an alternate methodology for calculating the average allowed amount if approved by the Commissioner. A health carrier shall, at minimum, inform covered persons of their eligibility for an incentive payment and the process to request the average

allowed amount for a procedure or service on the health carrier's website and in health benefit plan materials.

E. Eligibility for an incentive payment may require a covered person to demonstrate, through reasonable documentation such as a quote from the health care provider, that the covered person shopped prior to receiving care from the health care provider who charges less for the comparable health care service than the average allowed amount paid or payable by that health carrier. Health carriers shall provide additional mechanisms for the covered person to satisfy this requirement by utilizing the health carrier's cost transparency website or toll-free number, established under this article.

F. Each health carrier shall make the program available as a component of all health benefit plans offered by the health carrier in the Commonwealth. Annually at enrollment or renewal, each health carrier shall provide notice about the availability of the program, a description of the incentives available to a covered person, and instructions on how to earn such incentives, to any covered person who is enrolled in a health benefit plan eligible for the program.

G. A comparable health care service incentive payment made by a health carrier in accordance with this section shall not constitute an administrative expense of the health carrier for rate development or rate filing purposes.

H. Prior to offering the program to any covered person, a health carrier shall file a description of the program with the Commission in the manner determined by the Commissioner. The Commissioner may review the filing made by the health carrier to determine if the health carrier's program complies with the requirements of this article. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been approved or denied by the Commissioner.

I. Annually each health carrier shall file with the Commissioner, for the most recent calendar year, the total number of comparable health care service incentive payments made pursuant to this article, the use of comparable health care services by category of service for which comparable health care service incentives are made, the total payments made to covered persons, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of a health carrier's covered persons that participated in such transactions.

J. Beginning no later than 18 months after implementation of comparable health care service incentive programs under this section and annually by April 1 of each year thereafter, the Commissioner shall submit an aggregate report for all health carriers filing the information required by this section to the chairs of the House and Senate Committees on Commerce and Labor.

§ 38.2-3463. Health care price transparency tools.

Beginning upon approval of the next health insurance rate filing that follows January 1, 2019, each health carrier offering a health benefit plan in the Commonwealth shall comply with the following requirements:

1. A health carrier shall establish an interactive mechanism on its publicly accessible website that enables a covered person to request and obtain from the health carrier information on the payments made by the health carrier to network providers for comparable health care services, as well as quality data for those providers, to the extent available. The interactive mechanism shall allow a covered person seeking information about the cost of a particular health care service to compare allowed amounts among network providers, estimate out-of-pocket costs applicable to that covered person's health benefit plan, and determine the average paid to a network provider for the procedure or service under the covered person's health benefit plan. Such determination shall be made on the basis of the average of the allowed amounts using data collected over a reasonable period not to exceed one year. The out-of-pocket estimate shall provide a good faith estimate of the amount the covered person will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a health carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the health carrier at the time the request is made. A health carrier may contract with a third-party vendor to satisfy the requirements of this subdivision.

2. Nothing in this section shall prohibit a health carrier from imposing cost-sharing requirements disclosed in the covered person's certificate of coverage for unforeseen health care services that arise out of the non-emergency procedure or service or for a procedure or service provided to a covered person that was not included in an original estimate provided under subdivision 1.

3. A health carrier shall notify a covered person that an estimate provided under subdivision 1 is an estimate of costs and that the actual amount the covered person will be responsible to pay may vary due to the need for unforeseen services that arise out of the proposed non-emergency procedure or service.

§ 38.2-3464. Patient choice.

A. If a covered person elects to receive a covered health care service from an out-of-network provider at a price that is the same or less than the average that a covered person's health carrier pays

for that service to health care providers in its provider network, or the statewide average for the same covered health care service based on data reported on a publicly accessible health care cost website of the Virginia All-Payer Claims Database, within a period not to exceed one year, the health carrier shall allow the covered person to obtain the service from the out-of-network provider at the provider's price and, upon request by the covered person, shall apply the payments made by the covered person for that health care service toward the covered person's deductible and out-of-pocket maximum as specified in the covered person's health benefit plan as if the health care services had been provided by a network provider. The health carrier shall provide a downloadable or interactive online form to the covered person for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section.

B. A health carrier may base the average paid to a network provider on what that health carrier pays to providers in the network applicable to the covered person's specific health benefit plan, or across all of their plans offered in the Commonwealth. A health carrier shall, at minimum, inform covered persons annually within 60 days following the anniversary of the commencement of coverage under the health benefit plan of their ability to obtain the service from the out-of-network provider as set forth in subsection A and of the process to request the average allowed amount paid or payable for a procedure or service on the health carrier's website and in benefit plan material.

§ 38.2-3465. Use of All-Payer Claims Database.

The use by a health carrier of data reported on a publicly accessible health care cost website of the Virginia All-Payer Claims Database in determining the statewide average for a health care service based on data reported on a publicly accessible health care cost website of the Virginia All-Payer Claims Database shall be voluntary. The provisions of this section shall not be deemed to require health carriers of health care providers to report data to the Virginia All-Payer Claims Database or to require the Virginia All-Payer Claims Database to release data to health carriers to the extent such release of data is not required or permitted under § 32.1-276.7:1.

§ 38.2-3466. Rules and regulations; orders.

The Commission, after notice and opportunity for all interested parties to be heard, may issue any rules and regulations necessary or appropriate for the administration and enforcement of this article.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, *Article 8 (§ 38.2-3461 et seq.) of Chapter 34*, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.19, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, *Article 8 (§ 38.2-3461 et seq.) of Chapter 34*, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance

organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 54.1-2962.3. Price transparency; estimate of charges prior to admission, procedure, or service.

A. In this section, "covered person," "health care professional," "health care service," "health carrier," "network," "network provider," and "out-of-pocket costs" have the same meanings ascribed thereto in § 38.2-3461.

B. If a patient or prospective patient is a covered person, a health care professional that is a network provider shall provide a patient or prospective patient, within two working days, based on the information available to the health care professional at the time, sufficient information regarding the proposed non-emergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from his health carrier to identify out-of-pocket costs, which could be received through an applicable toll-free telephone number or website. A health care professional may assist a patient or prospective patient in using a health carrier's toll-free number and website.

C. If a health care professional is unable to quote a specific amount under subsection B in advance due to the health care professional's inability to predict the specific treatment or diagnostic code, the health care professional shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure, or service, including the amount for any facility fees required. A health care professional shall disclose the incomplete nature of the estimate and inform the patient or prospective patient of his ability to obtain an updated estimate once additional information is determined.

D. Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a health care professional that is not a network provider shall, within two working days, disclose the price that will be charged for the non-emergency admission, procedure, or service, including the amount for any facility fees required.

E. Each health care professional shall post in a visible area notification of a covered person's ability, for those with coverage under an individual health benefit plan or a small group health benefit plan, to obtain a description of the service or the applicable standard medical codes or current

procedural terminology codes used by the American Medical Association sufficient to allow a health carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for his care to different facilities for similar services. This notification shall inform patients of their right to obtain services from different health care professionals, regardless of a referral or recommendation by another health care provider and that obtaining health care services from a high-value health care professional, either their currently referred health care professional or a different health care professional, may result in an incentive to the patient if he follows the procedure established by the patient's health carrier. The notification shall give an outline of the parameters of potential incentives approved in Article 8 (§ 38.2-3461 et seq.) of Chapter 34 of Title 38.2 and shall notify the patient that his health carrier is required to provide covered persons an estimate of out-of-pocket costs and contracted amounts paid for their care to different health care professionals for similar services via a toll-free telephone number and health care price transparency tool. A health care professional may provide additional information in any format to patients that inform them of a health carrier's specific price transparency tools or toll-free phone numbers.