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HOUSE BILL NO. 2538

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor on January 31, 2019)

(Patron Prior to Substitute—Delegate Ware)

A BILL to amend the Code of Virginia by adding a section numbered 38.2-3445.1, relating to health insurance; payment of out-of-network providers.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.2-3445.1 as follows:

§ 38.2-3445.1. Patient access to elective services.

A. As used in this section:

"Cost-sharing requirement" means a deductible, copayment amount, or coinsurance rate.

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

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

"Provider group" means a group of multispecialty or single-specialty health care providers who contract with a facility to exclusively provide multispecialty or single-specialty health care services at such facility.

"Required notice" means notice by a facility to a covered person (i) that health care services provided by a provider group will be billed separately from the facility and (ii) that some health care services may not be provided by an in-network provider.

B. In a facility where a covered person receives scheduled elective services, the facility shall post the required notice or inform the covered person of the required notice at the time of pre-admission or pre-registration.

C. The facility shall inform the covered person or his legal representative (i) of the names of all provider groups providing health care services at the facility, (ii) that consultation with the covered person's managed care plan is recommended to determine if the provider groups providing health care services at the facility are in-network providers, and (iii) that the covered person may be financially responsible for health care services performed by a provider that is not an in-network provider, in addition to any cost-sharing requirements.