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HOUSE BILL NO. 2544

Offered January 9, 2019
Prefiled January 9, 2019

A BILL to amend and reenact § 38.2-3445 of the Code of Virginia, relating to health benefit plans; balance billing for emergency services.

Patrons—Byron, Kory, Robinson and Webert

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3445 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3445. Patient access to emergency services.

Notwithstanding any provision of § 38.2-3407.11, 38.2-4312.3, or any other section of this title to the contrary, if a health carrier providing individual or group health insurance coverage provides any benefits with respect to services in an emergency department of a hospital, the health carrier shall provide coverage for emergency services:

1. Without the need for any prior authorization determination, regardless of whether the emergency services are provided on an in-network or out-of-network basis;

2. Without regard to whether the health care provider furnishing the emergency services is a participating health care provider with respect to such services;

3. If such services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to such services received from an in-network provider;

4. If such services are provided out-of-network, any cost-sharing requirement expressed as copayment amount or coinsurance rate cannot exceed the cost-sharing requirement that would apply if such services were provided in-network. ~~However,~~ ~~an~~ *An* individual ~~may~~ *shall not* be required to pay the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this section *for covered services except applicable deductibles, copayment, coinsurance, or other cost-sharing amounts deemed by the health carrier to be non-covered services*. The health carrier complies with this requirement if the health carrier provides benefits with respect to an emergency service in an amount equal to the greatest of (i) the ~~amount negotiated with in-network providers for the emergency service, or if more than one amount is negotiated, the median of these amounts~~ *average of the contracted commercial rates paid by the health carrier for the same emergency service in the geographic region, as defined by the Commission, where the emergency service was provided*; (ii) 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; and (iii) the amount that would be paid under Medicare for the emergency service.

A deductible may be imposed with respect to out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum shall apply to out-of-network emergency services; and

5. Without regard to any term or condition of such coverage other than the exclusion of or coordination of benefits or an affiliation or waiting period.

6. An out-of-network provider may request the Commission's Bureau of Insurance to determine whether the benefits that the health carrier has determined satisfy its obligation under subdivision 4 do satisfy the carrier's obligation to provide benefits in the amount equal to the greatest of the amounts described in subdivisions (i), (ii), and (iii) of subdivision 4.