VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 32.1-137.2, 38.2-3438, 38.2-3445, and 54.1-2915 of the Code of Virginia; to amend the Code of Virginia by adding in Article 1 of Chapter 5 of Title 32.1 a section numbered 32.1-137.07 and by adding sections numbered 38.2-3445.01 through 38.2-3445.07; and to repeal § 38.2-3445.1 of the Code of Virginia, relating to health insurance; payment to out-of-network providers.

[H 1251]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-137.2, 38.2-3438, 38.2-3445, and 54.1-2915 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 5 of Title 32.1 a section numbered 32.1-137.07 and by adding sections numbered 38.2-3445.01 through 38.2-3445.07 as follows:

§ 32.1-137.07. Violations of certain provisions; penalty.

If the Commissioner receives a report from the State Corporation Commission that a medical care facility has engaged in a pattern of violations pursuant to § 38.2-3445.01 and the report is substantiated after investigation, the Commissioner may levy a fine upon the medical care facility in an amount not to exceed $1,000 per violation and may take other formal or informal disciplinary action as permitted under this chapter.

§ 32.1-137.2. Certification of quality assurance; application; issuance; denial; renewal.

A. Every managed care health insurance plan licensee shall request a certificate of quality assurance with reference to its managed care health insurance plans simultaneously with filing an initial application to the Bureau of Insurance for licensure. If already licensed by the Bureau of Insurance, every managed care health insurance plan licensee may file an application for quality assurance certification with the Department of Health by December 1, 1998, and shall file an application for quality assurance certification with the Department of Health by December 1, 1999, in order to obtain its certificate of quality assurance by July 1, 2000.

On or before July 1, 2000, the State Health Commissioner shall certify to the Bureau of Insurance that a managed care health insurance plan licensee has been issued a certificate of quality assurance by providing the Bureau of Insurance with a copy of each certificate at the time of issuance.

Application for a certificate of quality assurance shall be made on a form prescribed by the Board and shall be accompanied by a fee based upon a percentage, not to exceed one-tenth of one percent, of the proportion of direct gross premium income on business done in this Commonwealth attributable to the operation of managed care health insurance plans in the preceding biennium, sufficient to cover reasonable costs for the administration of the quality assurance program. Such fee shall not exceed $10,000 per licensee. Whenever the account of the program shows expenses for the past biennium to be more than ~~ten~~ *10* percent greater or lesser than the funds collected, the Board shall revise the fees levied by it for certification so that the fees are sufficient, but not excessive, to cover expenses; provided that such fees shall not exceed the limits set forth in this section. Until July 1, 2014, the Department may utilize such certification funds as are needed in fulfilling its responsibilities pursuant to subsection B of § 32.1-16.

All applications, including those for renewal, shall require (i) a description of the geographic area to be served, with a map clearly delineating the boundaries of the service area or areas, (ii) a description of the complaint system required under § 32.1-137.6, (iii) a description of the procedures and programs established by the licensee to assure both availability and accessibility of adequate personnel and facilities and to assess the quality of health care services provided, and (iv) a list of the licensee's managed care health insurance plans.

B. Every managed care health insurance plan licensee certified under this article shall renew its certificate of quality assurance with the Commissioner biennially by July 1, subject to payment of the fee.

C. The Commissioner shall periodically examine or review each applicant for certificate of quality assurance or for renewal thereof.

No certificate of quality assurance may be issued or renewed unless a managed care health insurance plan licensee has filed a completed application and made payment of a fee pursuant to subsection A ~~of this section~~ and the Commissioner is satisfied, based upon his examination, that, to the extent appropriate for the type of managed care health insurance plan under examination, the managed care

health insurance plan licensee has in place and complies with: (i) a complaint system for reasonable and adequate procedures for the timely resolution of written complaints pursuant to § 32.1-137.6; (ii) a reasonable and adequate system for assessing the satisfaction of its covered persons; (iii) a system to provide for reasonable and adequate availability of and accessibility to health care services for its covered persons; (iv) reasonable and adequate policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons; (v) reasonable and adequate standards and procedures for credentialing and recredentialing the providers with whom it contracts; (vi) reasonable and adequate procedures to inform its covered persons and providers of the managed care health insurance plan licensee's policies and procedures; (vii) reasonable and adequate systems to assess, measure, and improve the health status of covered persons, including outcome measures, (viii) reasonable and adequate policies and procedures to ensure confidentiality of medical records and patient information to permit effective and confidential patient care and quality review; (ix) reasonable, timely and adequate requirements and standards pursuant to § 32.1-137.9; and (x) such other requirements as the Board may establish by regulation consistent with this article.

Upon the issuance or reissuance of a certificate, the Commissioner shall provide a copy of such certificate to the Bureau of Insurance.

D. Upon determining to deny a certificate, the Commissioner shall notify such applicant in writing stating the reasons for the denial of a certificate. A copy of such notification of denial shall be provided to the Bureau of Insurance. Appeals from a notification of denial shall be brought by a certificate applicant pursuant to the process set forth in § 32.1-137.5.

E. The State Corporation Commission shall give notice to the Commissioner of its intention to issue an order based upon a finding of insolvency, hazardous financial condition, or impairment of net worth or surplus to policyholders or an order suspending or revoking the license of a managed care health insurance plan licensee; and the Commissioner shall notify the Bureau of Insurance when he has reasonable cause to believe that a recommendation for the suspension or revocation of a certificate of quality assurance or the denial or nonrenewal of such a certificate may be made pursuant to this article. Such notifications shall be privileged and confidential and shall not be subject to subpoena.

F. No certificate of quality assurance issued pursuant to this article may be transferred or assigned without approval of the Commissioner.

G. When determining the adequacy of a managed care health insurance plan proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner shall consider whether the managed care health insurance plan proposed provider network or in-force provider network includes a sufficient number of contracted providers of emergency services and surgical or ancillary services, as those terms are defined in § 38.2-3438, at or for the managed care health insurance plan's contracted in-network hospitals to reasonably ensure that enrollees have in-network access to covered benefits delivered at that facility.

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child or any other child eligible for coverage under the health benefit plan.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

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

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means, *regardless of the final diagnosis rendered to a covered person,* a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening

examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd (e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"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.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"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" or "provider" means a health care professional or facility.

"Health care services" means services 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.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic

violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. Student health insurance coverage shall be considered a type of individual health insurance coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by data suppliers pursuant to § 32.1-276.4.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in

administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Surgical or ancillary services" means professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 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 *the final diagnosis rendered to the covered person or* 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, *the health carrier shall pay the out-of-network provider in accordance with § 38.2-3445.01 less* any cost-sharing requirement ~~expressed as copayment amount or coinsurance rate cannot~~. *Any such cost-sharing requirement shall not* exceed the cost-sharing requirement that would apply if such services were provided in-network~~. However, an individual may 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. 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; (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~~ *as provided in § 38.2-3445.01*; 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.

§ 38.2-3445.01. Balance billing for certain services; prohibited.

A. 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.

B. An enrollee that receives services described in subsection A satisfies his obligation to pay for the services if he pays the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract. The enrollee's obligation shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier shall provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing requirement determined under this subsection. The obligation of an enrollee in a health benefit plan that uses no median in-network contracted rate for the services provided shall be determined as provided in § 38.2-3407.3.

C. The health carrier and the out-of-network provider shall ensure that the enrollee incurs no greater cost than the amount determined under subsection B 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)(2) or any other federal or state law. Nothing in this subsection shall preclude a provider from collecting a past due balance on a cost-sharing requirement with interest.

D. The health carrier shall treat any cost-sharing requirement determined under subsection B in the same manner as the cost-sharing requirement for health care services provided by an in-network provider and shall apply any cost-sharing amount paid by the enrollee for such services toward the in-network maximum out-of-pocket payment obligation.

E. If the enrollee pays the out-of-network provider an amount that exceeds the amount determined under subsection B, the provider shall refund the excess amount to the enrollee within 30 business days of receipt. The provider shall pay the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 beginning on the first calendar day after the 30 business days for any unrefunded payments.

F. The amount paid to an out-of-network provider for health care services described in subsection A shall be a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area. Within 30 calendar days of receipt of a clean claim from an out-of-network provider, the carrier shall offer to pay the provider a commercially reasonable amount. If the out-of-network provider disputes the carrier's payment, the provider shall notify the carrier no later than 30 calendar days after receipt of payment or payment notification from the carrier. If the out-of-network provider disputes the carrier's initial offer, the carrier and provider shall 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 as provided in § 38.2-3445.02.

G. The carrier shall make payments for services described in subsection A directly to the provider.

H. Carriers shall make available through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this section.

§ 38.2-3445.02. Arbitration.

A. If good faith negotiation, as described in § 38.2-3445.01, does not result in 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 payment amount. To initiate arbitration, the carrier or provider shall provide written notification to the Commission and the noninitiating party no later than 10 calendar days following completion of the period of good faith negotiation provided in § 38.2-3445.01. Such notification shall state the initiating party's final offer. No later than 30 calendar days following receipt of the notification, the noninitiating party shall provide its final offer to the initiating party. The parties may reach an agreement on reimbursement during this time and before the arbitration proceeding.

B. The parties shall be permitted to bundle claims for arbitration. Multiple claims may be addressed in a single arbitration proceeding if the claims at issue (i) involve identical carrier and provider parties, (ii) involve claims with the same or related current procedural terminology codes relevant to a particular procedure, and (iii) occur within a period of two months of one another.

C. Within seven calendar days of receipt of notification from the initiating party, the Commission shall provide the parties with a list of approved arbitrators or entities that provide arbitrations. The arbitrators on the list shall not have a conflict of interest with the parties and shall be trained and have experience and be selected by the Commission as set out in the standards established by the Commission through regulation. The parties may agree on an arbitrator from the list provided by the Commission. If the parties do not agree on an arbitrator, they shall notify the Commission, and the Commission shall provide the parties with the names of five arbitrators from the list. Each party may veto up to two of the five named arbitrators. If one arbitrator remains, that arbitrator shall be the chosen arbitrator. If more than one arbitrator remains, the Commission shall choose the arbitrator from the remaining arbitrators. The parties and the Commission shall complete this process within 20 calendar days of receipt of the original list from the Commission.

D. No later than 30 days after final selection of the arbitrator pursuant to subsection C, each party shall provide written submissions in support of its position to the arbitrator. The initiating party shall include in its written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. A party that fails to make timely written submissions under this subsection without good cause shown shall be considered to be in default, and the arbitrator shall require the defaulting party to pay the final offer of the nondefaulting party and may require the defaulting party to pay the arbitrator's fixed fee. Written submissions required by this subsection may be

submitted electronically.

E. 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 the information described in subsection I to the Commission.

F. In reviewing the submissions of the parties and making a decision requiring payment of the final offer amount of either the initiating or noninitiating party, the arbitrator shall consider the following factors:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable; and

2. Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the service.

The arbitrator may also consider other information that a party believes is relevant to the required factors included in this subsection or other information requested by the arbitrator and information provided by the parties that is relevant to such request, including data sets developed pursuant to § 38.2-3445.03. The arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

G. The Commission shall establish a schedule of fixed fees for the costs of arbitration. Except as provided in subsection D, such fees shall be divided equally among the parties to the arbitration. The enrollee shall not be liable for any of the costs of arbitration and shall not be required to participate in the arbitration process as a witness or otherwise.

H. Within 10 business days of a party notifying the Commission and the noninitiating party of intent to initiate arbitrations, both parties shall agree to and execute a nondisclosure agreement. The nondisclosure agreement shall not preclude the arbitrator from submitting the arbitrator's decision to the Commission or impede the Commission's duty to prepare the annual report required by subsection I.

I. The Commission 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 Commission shall post the report on the Bureau's website and submit it to the Chairs of the House Committee on Labor and Commerce and Committee on Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and Appropriations annually by July 1. The provisions of this subsection shall expire on July 1, 2025.

J. The Commission shall establish an appeals process for a party to appeal to the Commission an arbitrator's decision on the grounds that (i) the decision was substantially influenced by corruption, fraud, or other undue means; (ii) there was evident partiality, corruption, or misconduct prejudicing the rights of any party; (iii) the arbitrator exceeded his powers; or (iv) the arbitrator conducted the proceeding contrary to the provisions of this section and Commission regulations, in such a way as to materially prejudice the rights of the party.

K. The provisions of the Uniform Arbitration Act, Article 2 (§ 8.01-581.01 et seq.) of Chapter 21 of Title 8.01 shall not apply to arbitration proceedings initiated pursuant to this section.

§ 38.2-3445.03. Data sets for determining commercially reasonable payments.

A. The Commission 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.

B. Such data set and business protocols shall be (i) developed in collaboration with health carriers and health care providers and (ii) reviewed by the advisory committee established pursuant to § 32.1-276.7:1.

C. The data set shall provide the amounts for the services described in subsection A of § 38.2-3445.01. The data used to calculate the median in-network and out-of-network allowed amounts and the median billed charge amounts by geographic area, for the same or similar services, shall be drawn from commercial health plan claims and shall not include claims paid under Medicare or Medicaid or other claims paid on other than a fee-for-service basis. The 2020 data set shall be based upon the most recently available full calendar year of claims data. The data set for each subsequent year shall be adjusted by applying the Consumer Price Index-Medical Component as published by the Bureau of Labor Statistics of the U.S. Department of Labor to the previous year's data set.

§ 38.2-3445.04. Transparency.

A. The Commission, in consultation with health carriers, health care providers, and consumers, shall

develop standard template language for a notice of consumer rights notifying consumers of the following:

1. The prohibition against balance billing is applicable to health benefit plans issued by health carriers in Virginia and self-funded group health plans issued by entities that elect to participate pursuant to § 38.2-3445.01.

2. Consumers cannot be balance billed for the health care services describe in § 38.2-3445.01 and will receive the protections provided for in § 38.2-3445.01.

3. Consumers may be balance billed for health care services under circumstances other than those described in subsection A of § 38.2-3445.01 or if they are enrolled in a health plan to which the provisions of § 38.2-3445.01 do not apply and steps to take if the consumer is balance billed.

4. Consumers may contact the Commission if they believe they have been balance billed in violation of § 38.2-3445.01.

5. The relevant contact information for the Commission.

B. The Commission shall determine, by regulation, when and in what format health carriers, health care providers, and health care facilities shall provide consumers with the notice required by this section.

C. A health care provider shall post the following information on its website, if one is available, or, if one is not available, provide to a consumer upon written or oral request:

1. The listing of the carrier health plan provider networks with which the provider contracts with or which the facility is an in-network provider; and

2. The notice of consumer rights required by subsection A.

Posting or otherwise providing the information required in this subsection shall not relieve a health care provider of its obligation to comply with the provisions of § 38.2-3445.01.

D. Not less than 30 days prior to executing a contract with a carrier, a health care facility shall provide the carrier with a list of the nonemployed providers or provider groups contracted to provide surgical or ancillary services at the facility. The facility shall notify the carrier within 30 days of a removal from or addition to such list and shall provide an updated list of nonemployed providers and provider groups within 14 calendar days of a request for an updated list by a carrier.

E. An in-network provider shall submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

F. A carrier shall update its website and provider directory no later than 30 days after the addition or termination of a provider.

G. A carrier shall provide an enrollee with (i) a clear description of the health plan's out-of-network health benefits, (ii) the notice of consumer rights required by subsection A, and (iii) notification that if the enrollee receives services from an out-of-network-provider, under circumstances other than those described in subsection A of § 38.2-3445.01, the enrollee shall have the financial responsibility for the applicable services provided outside the health plan's network in excess of applicable cost-sharing amounts and that the enrollee may be responsible for any costs in excess of those allowed by the health plan.

§ 38.2-3445.05. Enforcement.

A. If the Commission has cause to believe that any health care provider has engaged in a pattern of potential violations of § 38.2-3445.01 with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in question were not violations of § 38.2-3445.01.

B. If any health care provider has engaged in a pattern of potential violations of § 38.2-3445.01 with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the health care provider and take other action as permitted under the authority of the Board of Medicine or Commissioner of Health. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or Commissioner of Health shall notify the Commission 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.

C. If a carrier has engaged in a pattern of substantiated violations of any provision of § 38.2-3445.01, the Commission may levy a fine or apply remedies authorized pursuant to Chapter 2 (§ 38.2-200 et seq.).

D. No carrier or provider shall initiate arbitration pursuant to § 38.2-3445.02 with such frequency as to indicate a general business practice.

§ 38.2-3445.06. Applicability of certain sections.

A. Except as provided in this section, the provisions of §§ 38.2-3445 through 38.2-3445.05 shall not

apply to an entity providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded with respect to such plan. Such an entity may elect to be subject to the provisions of §§ 38.2-3445 through 38.2-3445.06 in the same manner as applied to a health carrier by providing notice to the Commission annually, in a form and manner prescribed by the Commission, attesting to the plan's participation and agreeing to be bound by the provisions of §§ 38.2-3445 through 38.2-3445.06. Such entity shall amend the plan, policies, contracts, and other documents to reflect such election. In addition, the entity that elects to opt in pursuant to this section shall file current plan documentation confirming that the plan accepts the obligations of §§ 38.2-3445 through 38.2-3445.06 and attests that any amended plan documents will be filed with the Commission before the effective date of such amendments. The Commission shall post on its website a list of entities, including relevant plan information, that have elected to be subject to the provisions of §§ 38.2-3445 through 38.2-3445.06. The Commission shall update such list at least once per quarter.

B. The provisions of §§ 38.2-3445.01 and 38.2-3445.02 shall not apply to services when the provider's fees are subject to schedules or other monetary limitations under any other law, including the Virginia Workers' Compensation Act, and such sections shall not preempt any such law.

C. The provisions of §§ 38.2-3445 through 38.2-3445.05 shall apply to health coverage insurance offered to state employees pursuant to § 2.2-2818 and may apply to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees pursuant to § 2.2-1204.

D. Except for its facilitation of arbitration pursuant to § 38.2-3445.02 and its role in any appeals process established pursuant to subsection J of § 38.2-3445.02, the Commission shall have no jurisdiction to resolve disputes arising out of § 38.2-3445.01.

E. Except for in a provider contract between a carrier and an in-network provider, no person shall waive, be required to waive, or require another person to waive the provisions of §§ 38.2-3445 through 38.2-3445.05.

§ 38.2-3445.07. Rules and regulations.

Pursuant to § 38.2-223, the Commission may adopt rules and regulations to implement and administer the provisions of §§ 38.2-3445 through 38.2-3445.06, including rules and regulations governing the arbitration process established in § 38.2-3445.02.

§ 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action.

A. The Board may refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct:

1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts;

2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

3. Intentional or negligent conduct in the practice of any branch of the healing arts that causes or is likely to cause injury to a patient or patients;

4. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

5. Restriction of a license to practice a branch of the healing arts in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, or for an entity of the federal government;

6. Undertaking in any manner or by any means whatsoever to procure or perform or aid or abet in procuring or performing a criminal abortion;

7. Engaging in the practice of any of the healing arts under a false or assumed name, or impersonating another practitioner of a like, similar, or different name;

8. Prescribing or dispensing any controlled substance with intent or knowledge that it will be used otherwise than medicinally, or for accepted therapeutic purposes, or with intent to evade any law with respect to the sale, use, or disposition of such drug;

9. Violating provisions of this chapter on division of fees or practicing any branch of the healing arts in violation of the provisions of this chapter;

10. Knowingly and willfully committing an act that is a felony under the laws of the Commonwealth or the United States, or any act that is a misdemeanor under such laws and involves moral turpitude;

11. Aiding or abetting, having professional connection with, or lending his name to any person known to him to be practicing illegally any of the healing arts;

12. Conducting his practice in a manner contrary to the standards of ethics of his branch of the healing arts;

13. Conducting his practice in such a manner as to be a danger to the health and welfare of his

patients or to the public;

14. Inability to practice with reasonable skill or safety because of illness or substance abuse;

15. Publishing in any manner an advertisement relating to his professional practice that contains a claim of superiority or violates Board regulations governing advertising;

16. Performing any act likely to deceive, defraud, or harm the public;

17. Violating any provision of statute or regulation, state or federal, relating to the manufacture, distribution, dispensing, or administration of drugs;

18. Violating or cooperating with others in violating any of the provisions of Chapters 1 (§ 54.1-100 et seq.), 24 (§ 54.1-2400 et seq.) and this chapter or regulations of the Board;

19. Engaging in sexual contact with a patient concurrent with and by virtue of the practitioner and patient relationship or otherwise engaging at any time during the course of the practitioner and patient relationship in conduct of a sexual nature that a reasonable patient would consider lewd and offensive;

20. Conviction in any state, territory, or country of any felony or of any crime involving moral turpitude;

21. Adjudication of legal incompetence or incapacity in any state if such adjudication is in effect and the person has not been declared restored to competence or capacity;

22. Performing the services of a medical examiner as defined in 49 C.F.R. § 390.5 if, at the time such services are performed, the person performing such services is not listed on the National Registry of Certified Medical Examiners as provided in 49 C.F.R. § 390.109 or fails to meet the requirements for continuing to be listed on the National Registry of Certified Medical Examiners as provided in 49 C.F.R. § 390.111; ~~or~~

23. Failing or refusing to complete and file electronically using the Electronic Death Registration System any medical certification in accordance with the requirements of subsection C of § 32.1-263. However, failure to complete and file a medical certification electronically using the Electronic Death Registration System in accordance with the requirements of subsection C of § 32.1-263 shall not constitute unprofessional conduct if such failure was the result of a temporary technological or electrical failure or other temporary extenuating circumstance that prevented the electronic completion and filing of the medical certification using the Electronic Death Registration System*; or*

24. Engaging in a pattern of violations of § 38.2-3445.01.

B. The commission or conviction of an offense in another state, territory, or country, which if committed in Virginia would be a felony, shall be treated as a felony conviction or commission under this section regardless of its designation in the other state, territory, or country.

C. The Board shall refuse to issue a certificate or license to any applicant if the candidate or applicant has had his certificate or license to practice a branch of the healing arts revoked or suspended, and has not had his certificate or license to so practice reinstated, in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction.

2. That § 38.2-3445.1 of the Code of Virginia is repealed.

3. That the provisions of the first and second enactments of this act shall become effective January 1, 2021.

4. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance (the Bureau) no later than September 1, 2020, the number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of Virginia, as amended by this act, in fiscal years 2017, 2018, and 2019. Thereafter, any health carrier providing individual or group health insurance coverage shall report to the Bureau, no later than November 1 of each year, the number of out-of-network claims for services described in subsection A of § 38.2-3445.01 of the Code of Virginia, as created by this act, for the previous fiscal year.

5. That any health carrier providing individual or group health insurance coverage shall report to the State Corporation Commission's Bureau of Insurance no later than September 1 of each year the number and identity of health care providers in the health carrier's network of emergency services providers and surgical or ancillary providers whose participation in the network was terminated by either the health carrier or the health care provider in the previous year and, if applicable, whether participation was subsequently reinstated in the same year. For any terminated health care providers identified by the health carrier in such report, the health carrier shall include (i) a description of the health care provider's or health carrier's stated reason for terminating participation and (ii) a description of the nature and extent of differences in payment levels for emergency services and surgical or ancillary services prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination.

6. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall notify the Chairmen of the House Committee on Labor and Commerce and the Senate Committee on

Commerce and Labor of the information reported to the Bureau pursuant to the fourth and fifth enactments of this act and other information specified in this enactment no later than December 1, 2021, and annually thereafter. Such notice shall include (i) the number of out-of-network claims for services described in subsection A of § 38.2-3445.01 of the Code of Virginia, as created by this act, for the previous fiscal year; (iii) the number and identity of health care providers in the health carrier's network of emergency services providers and surgical or ancillary services providers whose participation in the network was terminated by the health carrier or the health care provider in the previous year and whether participation was subsequently reinstated in the same year; (iv) a summary of the stated reasons for terminating participation; (v) a summary of the nature and extent of differences in payment levels prior to termination and after reinstatement, if applicable, including a determination of whether such payment levels after reinstatement were higher or lower than those applied prior to termination; (vi) an assessment by the Bureau of the potential impact of any changes in network participation or payment levels for emergency services on health insurance premiums in the time period to which the report applies; and (vii) the number and type of claims resolved by arbitration and aggregate information on the disposition of those arbitrations, including in which category group's favor the dispute was resolved, and aggregate information on the variation between the initial payment and final settlement amounts.

7. That the State Corporation Commission shall contract with the nonprofit data services organization to establish a data set and business process in accordance with § 38.2-3445.03 of the Code of Virginia, as created by this act. Such data set and business protocols shall be (i) developed in collaboration with health carriers and health care providers, (ii) reviewed by the advisory committee established pursuant to § 32.1-276.7:1 of the Code of Virginia, and (iii) available beginning November 1, 2020.