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SENATE BILL NO. 593

Offered January 14, 2026

Prefiled January 14, 2026

A BILL to amend and reenact §§ 38.2-3438 and 38.2-3445.01 of the Code of Virginia, relating to health insurance; balance billing protection; emergency medical services vehicle transportation.

Patron—Perry

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3438 and 38.2-3445.01 of the Code of Virginia are amended and reenacted as follows:

§ 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.

"Behavioral health crisis service provider" means a provider licensed by the Department of Behavioral Health and Developmental Services to provide mental health or substance abuse services as a provider of mobile crisis response, residential crisis stabilization, or a crisis receiving center.

"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 medical services vehicle" means any vehicle, vessel, or aircraft that holds a valid emergency medical services vehicle permit issued by the Office of Emergency Medical Services and that is equipped, maintained, or operated to provide emergency medical care or transportation of patients who are sick, injured, wounded, or otherwise incapacitated or helpless.

"Emergency services" means with respect to an emergency medical condition (i) (a) 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 (b) 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 and (ii) as it relates to any mental health services or substance abuse services, as those terms are defined in § 38.2-3412.1, rendered at a behavioral health crisis service provider (a) a behavioral health assessment that is within the capability of a behavioral health crisis service provider, including ancillary services routinely available to evaluate such emergency medical condition, and (b) such further examination and treatment, to the extent that they are within the capabilities of the staff and facilities available at the behavioral health crisis service provider, as are required so that the patient's condition does not deteriorate.

"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 as of January 1, 2019: (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 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.

"Preventive services" means (i) evidence-based items or services for which a rating of A or B is in effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual involved; (ii) immunizations for routine use in children, adolescents, and adults for which a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is in effect with respect to the individual involved; (iii) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration with respect to infants, children, and adolescents; and (iv) evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women. For purposes of this definition, a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

"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.

§ 38.2-3445.01. 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, *or (iii) any transportation provided by an emergency medical services vehicle*.

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.