

20108079D

SENATE BILL NO. 767

AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Finance and Appropriations
on February 10, 2020)

(Patron Prior to Substitute—Senator Barker)

A BILL to amend and reenact §§ 38.2-3438 and 38.2-3445 of the Code of Virginia, to amend the Code of Virginia by adding sections numbered 38.2-3438.1 and 38.2-3445.01, and to repeal § 38.2-3445.1 of the Code of Virginia, relating to health insurance; payment to out-of-network providers.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3438 and 38.2-3445 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-3438.1 and 38.2-3445.01 as follows:

§ 38.2-3438. Definitions.

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

"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.

"Codes" has the same meaning ascribed to the term in § 65.2-605.

"Cost-sharing requirement" means a 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.

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

64 *"Geographic region" means the Centers for Medicare and Medicaid Services Virginia Geographic*
65 *Rating Areas.*

66 "Grandfathered plan" means coverage provided by a health carrier to (i) a small employer on March
67 23, 2010, or (ii) an individual that was enrolled on March 23, 2010, including any extension of coverage
68 to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long
69 as such plan maintains that status in accordance with federal law.

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

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

76 "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to
77 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health
78 benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a
79 cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan"
80 does not include the "excepted benefits" as defined in § 38.2-3431.

81 "Health care professional" means a physician or other health care practitioner licensed, accredited, or
82 certified to perform specified health care services consistent with state law.

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

84 "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a
85 health condition, illness, injury, or disease.

86 "Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth
87 and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver,
88 arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed
89 to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any
90 other entity providing a plan of health insurance, health benefits, or health care services.

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

93 "Health status-related factor" means any of the following factors: health status; medical condition,
94 including physical and mental illnesses; claims experience; receipt of health care services; medical
95 history; genetic information; evidence of insurability, including conditions arising out of acts of domestic
96 violence; disability; or any other health status-related factor as determined by federal regulation.

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

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

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

107 *"Market-based value" means the rate for health care services determined using the methodology*
108 *established by the Commission pursuant to the provisions of § 38.2-3438.1.*

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

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

114 *"Out-of-network services" means services rendered to a covered person by a health care provider*
115 *that does not have an in-network participation agreement with the health carrier or managed care plan*
116 *that governs reimbursement of such services as a member of the health benefit plan's network.*

117 "Participating health care professional" means a health care professional who, under contract with the
118 health carrier or with its contractor or subcontractor, has agreed to provide health care services to
119 covered persons with an expectation of receiving payments, other than ~~coinsurance, copayments, or~~
120 ~~deductibles~~ *cost-sharing requirements*, directly or indirectly from the health carrier.

121 "PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the

122 Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further
123 amended.

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

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

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

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

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

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

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

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

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

161 **§ 38.2-3438.1. Rate methodology for determining market-based value.**

162 A. *The Commission's Bureau of Insurance (the Bureau) shall develop, and the Commission shall*
163 *promulgate pursuant to the authority granted in § 38.2-223, rules and regulations establishing a rate*
164 *methodology for determining market-based value for a health care service. In establishing the*
165 *methodology, the Bureau shall balance providing fair payments to health care providers against limiting*
166 *the impact on health carrier premiums. In establishing the methodology, the Bureau shall take into*
167 *account:*

168 1. *The most recent weighted average commercial rates available for the same or similar service,*
169 *including the highest and lowest rates;*

170 2. *The geographic region in which the service is provided;*

171 3. *The specialty of the health care provider that provides the service; and*

172 4. *The Medicare payment rate for the same or similar service.*

173 B. *The Bureau may promulgate different methodologies for determining market-based value for*
174 *purposes of emergency services under § 38.2-3445 and for purposes of out-of-network services provided*
175 *at an in-network facility under § 38.2-3445.01, if it deems different methodologies are appropriate.*

176 **§ 38.2-3445. Patient access to emergency services.**

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

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

183 2. Without regard to *the final diagnosis rendered to the covered person or whether the health care*
184 *provider furnishing the emergency services is a participating health care provider with respect to such*
185 *services;*

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

189 4. If such services are provided out-of-network, *a covered person shall not be required to pay an*
190 *out-of-network provider any amount other than the cost-sharing requirement, and any cost-sharing*
191 *requirement expressed as copayment amount or coinsurance rate cannot exceed the cost-sharing*
192 *requirement that would apply if such services were provided in-network. However, an individual may be*
193 *required to pay the excess of the amount the out-of-network provider charges over the amount the health*
194 *carrier is required to pay under this section. The health carrier complies with this requirement if the*
195 *health carrier provides benefits with respect to an emergency service in an amount equal to the greatest*
196 *lower of (i) the amount negotiated with in-network providers for the emergency service, or if more than*
197 *one amount is negotiated, the median of these amounts; (ii) the amount for the emergency service*
198 *calculated using the same method the health carrier generally uses to determine payments for*
199 *out-of-network services, such as the usual, customary, and reasonable amount; and (iii) the market-based*
200 *value for such services or 125 percent of the amount that would be paid under Medicare for the*
201 *emergency service. The health carrier shall pay any amount due the health care provider pursuant to*
202 *this subdivision directly, less any cost-sharing requirement. The health care provider shall not bill or*
203 *otherwise seek payment from the covered person for any amount other than the amount of any such*
204 *cost-sharing requirement.*

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

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

211 B. *If, after the out-of-network provider receives payment from a health carrier, the out-of-network*
212 *provider determines that the amount determined by the health carrier as the appropriate reimbursement*
213 *for emergency services does not comply with the requirements of subdivision A 4, the health care*
214 *provider shall notify the health carrier within 90 days of such determination. The out-of-network*
215 *provider and the health carrier shall make a good faith effort to reach a resolution on the appropriate*
216 *amount of reimbursement, pursuant to subdivision A 4, for the emergency services provided.*

217 C. *If a resolution is not reached between the out-of-network provider and the health carrier within*
218 *30 days of notification under subsection B, either party may request the Commission to review the*
219 *disputed reimbursement amount and make a determination as to whether such amount complies with*
220 *subdivision A 4.*

221 D. *Claims presenting common codes for the health carrier may be reviewed together by the*
222 *Commission.*

223 E. *Except as provided in subsections B, C, and D, the Commission shall have no jurisdiction to*
224 *adjudicate disputes arising out of this section.*

225 F. *This section shall apply to health coverage insurance offered to state employees pursuant to*
226 *§ 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers,*
227 *teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to*
228 *§ 2.2-1204.*

229 G. *Except as provided in this subsection, the provisions of this section shall not apply to an entity*
230 *providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee*
231 *Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded with*
232 *respect to such plan. Such an entity may elect to be subject to the provisions of this section by*
233 *providing notice to the Commission annually, in a form and manner prescribed by the Commission,*
234 *attesting to the plan's participation and agreeing to be bound by the provisions of this section. Such*
235 *entity shall amend the plan, policies, contracts, and other documents to reflect such election.*

236 **§ 38.2-3445.01. Services provided at an in-network facility.**

237 A. *As used in this section, "in-network facility" means a facility having a contract with a carrier to*
238 *provide health care services to a covered person under a health benefit plan as a member of the health*
239 *benefit plan's network.*

240 B. *If a covered person receives out-of-network services at an in-network facility, including any*
241 *referrals for diagnostic services, and such services would be covered if the services were received from*
242 *an in-network provider, the covered person shall not be required to pay any amount other than the*
243 *cost-sharing requirement for such services, and no cost-sharing requirement shall exceed the*
244 *cost-sharing requirement that would apply if such services were provided in-network. The health carrier*

245 *complies with this requirement if the health carrier provides benefits with respect to such services in an*
 246 *amount equal to the lower of the market-based value for such services or 125 percent of the amount*
 247 *that would be paid under Medicare for the service. The health carrier shall pay any amount due the*
 248 *health care provider pursuant to this subsection directly, less any cost-sharing requirement. The health*
 249 *care provider shall not bill or otherwise seek payment from the covered person for any amount other*
 250 *than the amount of any such cost-sharing requirement.*

251 *C. If, after the out-of-network provider receives payment from a health carrier, the out-of-network*
 252 *provider determines that the amount determined by the health carrier as the appropriate reimbursement*
 253 *for services does not comply with the requirements of subsection B, the health care provider shall notify*
 254 *the health carrier within 90 days of such determination. The out-of-network provider and the health*
 255 *carrier shall make a good faith effort to reach a resolution on the appropriate amount of*
 256 *reimbursement, pursuant to subsection B, for the services provided.*

257 *D. If a resolution is not reached between the out-of-network provider and the health carrier within*
 258 *30 days of notification under subsection C, either party may request the Commission to review the*
 259 *disputed reimbursement amount and make a determination as to whether such amount complies with*
 260 *subsection B.*

261 *E. Claims presenting common codes for the health carrier may be reviewed together by the*
 262 *Commission.*

263 *F. Except as provided in subsections C, D, and E the Commission shall have no jurisdiction to*
 264 *adjudicate disputes arising out of this section.*

265 *G. This section shall apply to health insurance coverage offered to state employees pursuant to*
 266 *§ 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers,*
 267 *teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to*
 268 *§ 2.2-1204.*

269 *H. Except as provided in this subsection, the provisions of this section shall not apply to an entity*
 270 *providing or administering an employee welfare benefit plan, as defined in § 3(1) of the Employee*
 271 *Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1), that is self-insured or self-funded with*
 272 *respect to such plan. Such an entity may elect to be subject to the provisions of this section by*
 273 *providing notice to the Commission annually, in a form and manner prescribed by the Commission,*
 274 *attesting to the plan's participation and agreeing to be bound by the provisions of this section. Such*
 275 *entity shall amend the plan, policies, contracts, and other documents to reflect such election.*

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

277 **3. That no later than January 1, 2021, the State Corporation Commission's Bureau of Insurance**
 278 **(the Bureau) shall develop, and the Commission shall promulgate pursuant to the provisions of**
 279 **§ 38.2-3438.1 of the Code of Virginia, as created by this act, regulations establishing a rate**
 280 **methodology for determining market-based value for health care services for the purposes of**
 281 **§ 38.2-3445 of the Code of Virginia, as amended by the act, and § 38.2-3445.01 of the Code of**
 282 **Virginia, as created by this act. In developing such regulations, the Bureau shall consult with**
 283 **stakeholders, including representatives of health plans, the Virginia Association of Health Plans,**
 284 **health care providers, the Virginia Hospital and Healthcare Association, representatives of**
 285 **hospitals, consumer advocates, and any other interested stakeholders as it deems appropriate. The**
 286 **Bureau shall allow for a public comment period and hold at least one public hearing. The**
 287 **Commission shall promulgate regulations pursuant to this enactment to be effective no later than**
 288 **January 1, 2021.**

289 **4. That any health carrier providing individual or group health insurance coverage shall report to**
 290 **the State Corporation Commission's Bureau of Insurance (the Bureau) no later than August 15,**
 291 **2020, data identifying its average commercial in-network rates for services typically provided**
 292 **pursuant to § 38.2-3445 of the Code of Virginia, as amended by this act, and § 38.2-3445.01 of the**
 293 **Code of Virginia, as created by this act, including the highest and lowest rates for calendar year**
 294 **2019. The data provided to the Bureau pursuant to this enactment shall be confidential and shall**
 295 **exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the**
 296 **Code of Virginia).**

297 **5. That any health carrier providing individual or group health insurance coverage shall report to**
 298 **the State Corporation Commission's Bureau of Insurance (the Bureau) no later than September 1,**
 299 **2020, the number of out-of-network claims for emergency services paid pursuant to subdivision A**
 300 **4 of § 38.2-3445 of the Code of Virginia, as amended by this act, in fiscal years 2017, 2018, and**
 301 **2019. Thereafter, any health carrier providing individual or group health insurance coverage shall**
 302 **report to the Bureau, no later than November 1 of each year, the number of (i) out-of-network**
 303 **claims for emergency services paid pursuant to subdivision A 4 of § 38.2-3445 of the Code of**
 304 **Virginia, as amended by this act, and (ii) out-of-network claims for services provided at**
 305 **in-network facilities paid pursuant to § 38.2-3445.01 of the Code of Virginia, as created by this act,**

306 for the previous fiscal year.

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

318 7. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall notify the
319 Chairmen of the House Committee on Labor and Commerce and Senate Committee on Commerce
320 and Labor of the information reported to the Bureau pursuant to the fourth, fifth, and sixth
321 enactments of this act no later than December 1 of each year. Such notice shall include (i) the
322 number of out-of-network claims for emergency services paid pursuant to subdivision A 4 of
323 § 38.2-3445 of the Code of Virginia, as amended by this act, for the previous fiscal year; (ii) the
324 number of out-of-network claims for services provided at in-network facilities paid pursuant to
325 § 38.2-3445.01 of the Code of Virginia, as created by this act, (iii) the number and identity of
326 health care providers in the health carrier's network of emergency services providers whose
327 participation in the network was terminated by the health carrier or the health care provider in
328 the previous year and whether participation was subsequently reinstated in the same year; (iv) a
329 summary of the stated reasons for terminating participation; (v) a summary of the nature and
330 extent of differences in payment levels prior to termination and after reinstatement, if applicable,
331 including a determination of whether such payment levels after reinstatement were higher or lower
332 than those applied prior to termination; and (vi) an assessment by the Bureau of the potential
333 impact of any changes in network participation or payment levels for emergency services on health
334 insurance premiums in the time period to which the report applies.

335 8. That the provisions of the first and second enactments of this act shall become effective on
336 January 1, 2021, and that the provisions of the third, fourth, fifth, sixth, and seventh enactments
337 of this act shall become effective on July 1, 2021.