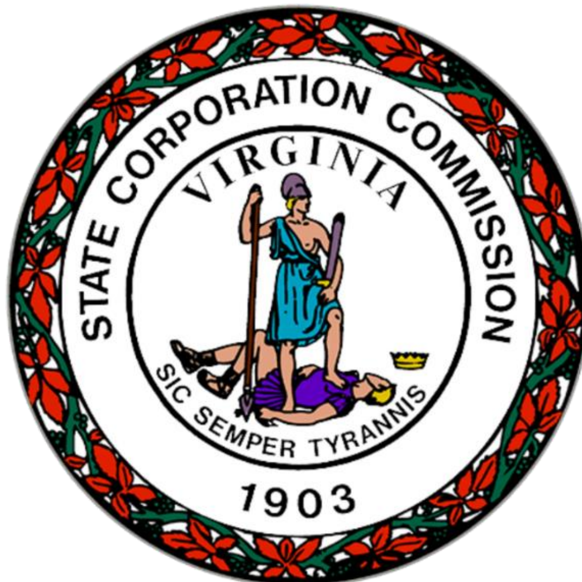
BALANCE BILLING AND ARBITRATION PROCESS

Annual Report



State Corporation Commission
Bureau Of Insurance

December 2022

COMMONWEALTH OF VIRGINIA

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December 1, 2022

The Honorable Richard L. Saslaw
Chair, Senate Committee on Commerce and Labor
Senate of Virginia

The Honorable Kathy J. Byron
Chair, House Committee on Commerce and Energy
Virginia House of Delegates

Dear Senator Saslaw and Delegate Byron,

In accordance with § 38.2-3445.2 C of the Code of Virginia, and on behalf of the State Corporation Commission, the Bureau of Insurance is providing this annual notice of: (i) required reported claims and provider network information collected by the Bureau; (ii) an assessment of the potential impact of changes in network participation or payment levels for emergency services on health insurance premiums during Fiscal Year 2022; and (iii) information related to claims resolved by arbitration.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

In 2020, the Virginia General Assembly passed House Bill 1251 and Senate Bill 172.[1] The legislation prohibited out-of-network health care providers from charging enrollees for any amount other than the enrollee's applicable cost-sharing requirements for emergency services, and for surgical or ancillary services performed at an in-network facility. The prohibition on this matter, referred to as balance billing, became law on January 1, 2021, and is codified at § 38.2-3445.01, Code of Virginia (Code).

Section 38.2-3445.2 C of the Code directs the State Corporation Commission (Commission) to submit an annual report by December 1 of each year. Prepared by the Bureau of Insurance (Bureau), this report:

(i) presents information reported to the Bureau by health insurance carriers (health carriers) on the number of out-of-network claims[2] paid;
(ii) studies changes in provider participation in health carrier networks and variances in payment levels if providers are reinstated following termination;
(iii) assesses the potential impact of these changes in participation or payment levels for emergency services on premiums; and
(iv) presents an update on the number and type of claims resolved by arbitration from November 1, 2021 through October 31, 2022, including any difference between the initial payment and final settled amounts.

The Bureau makes the following observations and comparisons in this report:

- About half (46.3%) of out-of-network emergency services and less than half (40.7%) of out-of-network non-emergency ancillary and surgical services are provided at an in-network facility in Virginia and are fully subject to Virginia's laws;

- Emergency services claim counts for in-state, out-of-network claims (eligible for arbitration) increased 7% from Calendar Year (CY) 2020 to Fiscal Year (FY) 2022 (July 1, 2021 through June 30, 2022);

- A large majority (78%) of providers reinstated in the same year in which their contract terminated were reinstated at the same payment level as their previous contract;

- Nearly every (94%) provider new to a network rejoined at the same payment level as their previous contract;

- Given the minimal number of out-of-network emergency claims compared to total claims, premiums should not be materially impacted by changes to network participation and payment levels for emergency services;

[1] Chapters 1080 and 1081, respectively, Virginia Acts of Assembly – 2020 Session.
[2] A claim is a request for payment submitted to the insurance carrier for services performed by the health care provider.

- There have been 810 decisions since inception of the arbitration process (January 1, 2021 through October 31, 2022):
    - 509 arbitrations (63%) in favor of the health carrier, and
    - 301 arbitrations (37%) in favor of the provider;

- Of the 264 arbitration decisions resolved during this report period (November 1, 2021 through October 31, 2022):
    - 153 arbitrations (58%) were decided in favor of the health carrier, and
    - 111 arbitrations (42%) in favor of the provider; and

- The percentage of bundled arbitrations increased from 24% to 36%, with the most notable increase occurring in emergency medicine arbitrations.

Annual Data Reports

In 2020, the Virginia General Assembly passed House Bill 1251 and Senate Bill 172.[3] The legislation prohibited out-of-network health care providers from balance billing enrollees for any amount other than the enrollee's applicable cost-sharing requirements for emergency services, and for surgical or ancillary services at an in-network facility. This prohibition became law on January 1, 2021 and is codified at Code § 38.2-3445.01.

Under the law prohibiting balance billing of enrollees, a health carrier's required payment to the out-of-network provider for the services rendered to an enrollee must be a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. However, if the provider disputes the amount to be paid by the health carrier, the provider and the health carrier are required to make a good faith effort to reach a resolution on the amount of the reimbursement. Should the health carrier and the provider not agree to a commercially reasonable payment and either party wants to take further action to resolve the dispute, the dispute will be resolved by arbitration.

This annual report:

(i) presents information reported by health carriers to the Bureau on the number of out-of-network claims paid;
(ii) studies changes in provider participation in health carrier networks and variances in payment levels if providers are reinstated following termination;
(iii) assesses the potential impact of these changes in network participation or payment levels for emergency services on premiums; and
(iv) presents an update on the number and type of claims resolved by arbitration, including variations between the initial payment and final settled amounts.

The Bureau's first annual report submitted in December 2021 was based on data for CYs 2017 through 2020, and the second half of FY21 from January 1, 2021 through June 30, 2021. This year's report provides data and analysis for claims data for FY 2022, and on arbitration resolutions from November 1, 2021 through October 31, 2022.

(i) Counts of Out-of-Network Claims Paid[4]

Number of out-of-network emergency services claims paid: CYs 2017-2020; January 1, 2021 to June 30, 2021; and FY 2022:

The following two tables show that during the four-year period prior to the implementation of the law, the number of emergency claims paid to in-state, out-of-network providers averaged 50.2%. Since the inception of the law, the in-state, out-of-network claim counts have averaged 46.3%.

[3] Chapters 1080 and 1081, respectively, Virginia Acts of Assembly – 2020 Session.

[4] Virginia balance billing protections generally apply to in-state, out-of-network provider claims. Out-of-state, out-of-network provider claims are not eligible for arbitration. Data for non-emergency services was only collected for the second half of FY 2021 in the first data call and for all of FY 2022 in the second data call.

Emergency Services Claims Paid – Prior to 1-1-2021			
CY	Out-of-Network, Provider In-State Claim Counts	Out-of-Network, Provider Out-of-State Claim Counts	% In-State Out-of-Network Claim Counts
2017	17,184	20,550	45.5%
2018	21,300	18,667	53.3%
2019	21,123	18,159	53.8%
2020	20,149	21,673	48.2%
4-Year Total	79,756	79,049	50.2%

Emergency Services Claims Paid –1-1-2021 and after				
Period	Total Reported Emergency Claims Paid	Out-of-Network, In-State Provider Claim Counts	Out-of-Network, Out-of-State Provider Claim Counts	% Of In-State, Out-of-Network Provider Claims
H2 FY 2021 (1-1-2021 to 6-30-2021)	26,356	11,041	15,315	41.9%
FY 2022 (7-1-2021 to 6-30-2022)	44,201	21,646	22,555	49.0%
18 Month Total	70,557	32,687	37,870	46.3%

The following table shows a slight increase in the number of emergency services claims paid by health carriers during the first full period after implementation of the law compared to before implementation.

Emergency Services Claims Paid Comparison Pre-Law to Post-Law		
In-State Out-of-Network Emergency Services Claim Counts		
Count of Last 12 Month Period Claims Pre-Law Change (Ending 12-31-2020)	Count of First 12 Month Period Claims Post-Law Change (Ending 6-30-2022)	% Change
20,149	21,646	+7%

Number of out-of-network claims paid (surgical and ancillary non-emergency) at an in-network facility: January 1, 2021 – June 30, 2022:

As shown in the following table, the in-state, out-of-network provider claim counts averaged 40.7% of the total reported claims paid over the entire 18-month period, with a range of 38.3% in the first full FY 2022, compared to 47.0% in the second half of FY 2021.

Non-Emergency Services Claims Paid – 1-1-2021 and after (Surgical or ancillary services provided by an out-of-network provider at an in-network facility)				
Fiscal Year (FY)	Total Reported Surgical or Ancillary Claims Paid	In-State, Out-of-Network Provider Claim Counts	Out-of-State, Out-of-Network Provider Claim Counts	% Total In-State Out-of-Network Provider Claim Counts
H2 FY 2021 (1-1-2021 to 6-30-2021)	69,429	32,653	36,776	47.0%
FY 2022 (7-1-2021 to 6-30-2022)	182,570	69,929	112,641	38.3%
18 Month Total	259,999	102,582	149,417	40.7%

Once the Bureau has an additional year of data subsequent to the change in the law, additional comparisons involving emergency and non-emergency out-of-network services can be evaluated in future reports.

(ii) Health Care Provider Network Contracts Terminated and Reinstated

Carriers provided the Bureau with information on the number and identity of providers of emergency and non-emergency surgical and ancillary services whose network participation terminated during FY 2022. This information shows which provider contracts the carriers reinstated (*See* the links in Attachments A-P1 and A-P2).

Reporting carriers listed 105 different reasons for terminating a provider. The Bureau classified these into nine categories. This table shows that when a stated reason was listed for a provider's termination, 22.9% of overall terminations were involuntary or administrative, 19.3% were provider initiated, and 6.9% were due to credentialling issues.

Summary of the reasons for network contract terminations:

FY 2022 Network Contract Termination Summary								
Stated Reason for Termination	Plan Initiated	% Plan Initiated	Provider Initiated	% Provider Initiated	Mutually Initiated	% Mutually Initiated	FY 2022 Totals	% of FY 2022 Totals
No specific reason given	1,420	24.8%	2,853	41.1%	52	6.7%	4,325	32.1%
Provider initiated	-	-	2,600	37.5%	3	0.4%	2,603	19.3%
Voluntary	132	2.3%	57	0.8%	316	40.6%	505	3.8%
Relocation/ Move/ Left Group	113	2.0%	516	7.4%	-	-	629	4.7%
Involuntary/ Administrative	2,680	46.7%	27	0.4%	368	47.3%	3,075	22.9%
Retired/ Deceased/ Closed	84	1.5%	409	5.9%	39	5.0%	532	4.0%
Credentialling issue	930	16.2%	1	0.0%	-	-	931	6.9%
Failure to meet network criteria	345	6.0%	412	5.9%	-	-	757	5.6%
Provider resigned from at least one, but not all, networks	29	0.5%	67	1.0%	-	-	96	0.7%
Totals	5,733	100.0%	6,942	100.0%	778	100.0%	13,453	100.0%

Summary of the differences and the extent of differences in payment levels prior to termination and after reinstatement:

Reporting carriers identified 484 providers who were terminated and reinstated in the same reporting period. Of these, 376 (78%) were reinstated at the same payment level. Only 35 (7%) were reinstated at a higher payment level, and 73 (15%) were reinstated at a lower payment level.

Number of Providers Reinstated in the Same Report Year FY 2022					
Specialty Area	**Greater than 25% lower payment level**	**Lower payment level but less than 25% lower**	**Same payment level**	**Higher payment level but less than 25% higher**	**Greater than 25% higher payment level**
Anesthesiology	-	-	6	-	-
Emergency Medicine	-	-	1	2	-
Hospitalist	-	-	7	-	-
Surgeons	2	2	24	3	2
Other	44	25	322	7	13
Multi-Specialty	-	-	8	-	8
Radiology	-	-	8	-	-

Reporting carriers identified 933 new-to-network providers that were terminated in a prior year. Of this number, 878 (94%) rejoined a network at the same payment level. Only 26 (less than 3%) rejoined at a higher payment level, and 29 (3%) rejoined at a lower payment level.

Number of New Providers in FY 2022 that Terminated in a Previous Year					
Specialty Area	**Less than 25% lower payment level**	**Lower payment level but less than 25% lower**	**Same payment level**	**Higher payment level but less than 25% higher**	**Greater than 25% higher payment level**
Anesthesiology	-	-	2	-	1
Emergency Medicine	-	1	3	-	-
Hospitalist	-	-	6	2	-
Surgeons	-	3	20	2	-
Lab/Pathology	-	-	3	-	-
Other	10	15	831	16	5
Multi-Specialty	-	-	3	-	-
Radiology	-	-	10	-	-

(iii) Bureau's Assessment of the Potential Premium Impact Based on Changes in Network Participation and Payment Levels for Emergency Services

To assess the potential premium impact of changes to network participation and payment levels for emergency services, the Bureau used information from a data call to health carriers offering coverage in Virginia's commercial market during FY 2022. The goal was to isolate claims for emergency services delivered by non-participating providers within Virginia since these represent potential arbitration claims, and then determine how changes in these claims could potentially impact premiums.

The data provided by carriers for this year's report is more accurate than that provided in the previous year's report. As a result, the Bureau was able to analyze claims data representative of the Virginia commercial market. The Bureau compared the FY 2022 results to those produced by Bureau actuarial consultant Oliver Wyman in the "Report of the Virginia Balanced Billing Work Group" (December 31, 2019). The results from that report were based on information from 2017 as well as the previous reported data (approximately 60% of the Virginia market) from the report covering CY 2020 and the second half of FY 2021.

Emergency Services (ES) – Allowed Claims								
	2017 Oliver Wyman Data ($)	**% of Total**	**CY 2020 ($)**	**% of Total**	**Jan-Jun 2021 (H2 FY 2021) ($)**	**% of Total**	**FY 2022 (July 1, 2021-June 30, 2022) ($)**	**% of Total**
Total Claims	13,654,387,985		1,047,907,558		1,295,553,685		6,653,187,847	
ES	1,507,903,281	11.0	218,144,598	20.8	147,405,735	11.4	333,222,357	5.0
ES for Non-Par Providers	8,251,403	0.1	8,251,403	0.8	5,768,307	0.4	41,424,246	0.6
ES for Non-Par Providers in Virginia	4,728,430	0.03	4,728,430	0.5	2,513,681	0.2	19,407,766	0.3

Note: "Par" is short for "Participating."

The results show that emergency claims from non-participating providers in Virginia during this reporting period represented 0.3% of total allowed claims and fell in the range of 0.2% to 0.5% as reported in previous reports.

As in the previous report, to determine the impact on premiums, allowed claims must be adjusted based on the underlying plan designs of the carriers surveyed. Although this is not possible, the impact on paid claims is expected to be similar to the impact on allowed claims.

Premiums have two major components: paid claims and administrative expenses. Administrative expenses are generally 10% to 30% of premium, leaving 70% to 90% of premium represented by claims. Applying these percentages to the allowed claims impact, the data indicated that emergency claims for non-participating providers in Virginia represent an estimated 0.21% to 0.45% of premium.

Using the information from the "Emergency Services – Allowed Claims" table, and given the minimal impact on premium, emergency claims for non-participating providers would have to change substantially relative to other claims for premiums to be impacted materially.

(iv) Arbitration Resolution Information

- Of the 810 arbitration decisions rendered by arbitrators since the inception of the process, 509 arbitrations (63%) were decided in favor of the health carrier, and 301 arbitrations (37%) were decided in favor of the provider.

- For this reporting period, there were a total of 264 arbitration decisions rendered, with 153 arbitrations (58%) decided in favor of the health carrier, and 111 (42%) decided in favor of the provider.[5]

Arbitration Resolution Information broken down by specialty:

Arbitrations Decided Through From 11-1-2021 to 10-31-2022			
Specialty	**Total Number Decided**	**Number Decided in Favor of Plans**	**Number Decided in Favor of Providers**
Emergency Medicine	109	72	37
Anesthesia	127	68	59
Reconstructive Surgery	28	13	15
Total	264	153	111

[5] *See* the link in Attachment B for information showing the claims resolved by arbitration, including the name of the provider, the carrier, the provider's affiliated entity or employer, the facility where services were rendered, the service type, and which party the decision favored (November 1, 2021 to October 31, 2022).

Arbitration Decision Percentages Comparison:

Arbitration decisions by provider specialty changed significantly in 2022, where the majority changed from emergency medicine (41.3% in 2022) to anesthesia (48.1% in 2022). Overall, Plans prevailed in most of the decisions (58%), but this number is down from 65% as reported in the Bureau's 2021 balance billing first report.

A Comparison of Arbitrations Decided During the 2021 and 2022 Reporting Periods						
Specialty	**Total % By Specialty Type**		**% Decided in Favor of Plans**		**% Decided in Favor of Providers**	
Year	**2021**	**2022**	**2021**	**2022**	**2021**	**2022**
Emergency Medicine	75.1%	41.3%	70.5%	66.1%	29.5%	33.9%
Anesthesia	24.7%	48.1%	48.9%	53.5%	51.1%	46.5%
Reconstructive Surgery	0.2%	10.6%	100.0%	46.4%	0.0%	53.6%
Overall			65%	58%	35%	42%

(Plan = Health insurance carrier or self-funded group health plan that has opted-in)

Arbitration Decision Average Dollar Amounts

The following two tables show a significant increase in the average award amount for emergency medicine claims over the reporting period. This is almost entirely attributable to the increase in bundled arbitrations, where two or more similar claims may be arbitrated in a single request.

A Comparison of Average $ Amounts for Arbitrations Decided During the 2021 and 2022 Reporting Periods						
Specialty	**2021 Provider's Pre-Arbitration Average Offer**	**2022 Provider's Pre-Arbitration Average Offer**	**2021 Plan's Pre-Arbitration Offer**	**2022 Plan's Pre-Arbitration Offer**	**2021 Average Awarded Amount**	**2022 Average Awarded Amount**
Emergency Medicine	$1,041.01	$1,727.19	$270.48	$435.59	$487.65	$778.23
Anesthesia	$1,042.19	$1,078.48	$386.34	$426.52	$716.95	$718.06
Plastic and Reconstructive Surgery*	$11,733.15	$25,234.57	$1,150.20	$2,487.38	$1,265.22	$13,789.94
*There was only one arbitration decided for Plastic and Reconstructive Surgery in 2021						

A Comparison of the % of Bundled[6] Arbitrations Decided During the 2021 and 2022 Reporting Periods		
Specialty	**% Bundled in 2021**	**% Bundled in 2022**
Emergency Medicine	26%	62%
Anesthesia	18%	20%
Plastic and Reconstructive Surgery	0%	7%
Totals	24%	36%

The increase in bundled arbitrations is most likely the result of Administrative Letter 2021.04, issued by the Bureau. It set forth standards for the submission of arbitration requests to address and avoid filings with such frequency as to indicate a general business practice; reminded the parties involved in payment disputes of the requirement in Code § 38.2-3445.01 F to engage in good faith negotiation; and reminded carriers of the requirement in Code § 38.2-3445.01 F to pay a commercially reasonable amount.

The limitation on provider group submissions to no more than one arbitration request per provider group (or sole health care professional that is not part of a provider group) during a seven-day period likely also increased the number of bundled claim requests in lieu of single claim requests over the previous reporting period.

[6] A single provider is permitted to bundle claims for arbitration. Multiple claims may be addressed in a single arbitration proceeding if the claims at issue (i) involve identical health carrier or administrator and provider parties; (ii) involve claims with the same or related Current Procedural Technology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, or in the case of facility services, Diagnosis Related Group (DRG) codes, Revenue Codes, or other procedural codes relevant to a particular procedure, and (iii) occur within a period of two months of one another. Provider groups are not permitted to bundle claims for arbitration if the health care professional providing the service is not the same.

Attachments A-P1 and A-P2 – Provider Termination Information

Attachment A-P1 – Providers Terminated and not Reinstated in the Same Year Terminated

Attachment A-P2 – Providers Reinstated in the Same Year Terminated

Attachment B – Arbitrations

Attachment B - Arbitrations Decided from 11-1-2021 through 10-31-2022