BALANCE BILLING AND ARBITRATION

Annual Report

Submitted to the Chairs of the Senate Committee on Commerce and Labor and House of Delegates Committee on Commerce and Energy, pursuant to 38.2-3445.2 C of the Code of Virginia

December 1, 2023

COMMONWEALTH OF VIRGINIA

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December 1, 2023

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

The Honorable Terry G. Kilgore
Vice Chair, House Commerce and Energy Committee
Virginia House of Delegates

Dear Senator Saslaw and Delegate Kilgore:

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 report related to balance billing and arbitration, including: (i) claims and provider network information collected by the Bureau; (ii) the potential impact of changes in network participation or payment levels for emergency services on health insurance premiums during Fiscal Year 2023; and (iii) information on claims resolved by arbitration.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

Table of Contents

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 balance billing[2] 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 legislation became law on January 1, 2021, and is codified at § 38.2-3445.01 of the Code of Virginia (Code).

Section 38.2-3445.2 C of the Code directs the State Corporation Commission (Commission) to submit a report annually by December 1 that: (i) presents information reported to the Bureau by health insurance carriers (health carriers) on the number of out-of-network claims[3] 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, including any difference between the initial payment and final settled amounts. On behalf of the Commission, the Bureau makes the following findings:

- About one-half of out-of-network emergency services (52.3%) and out-of-network non-emergency ancillary and surgical services (40.4%) 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 60% from Calendar Year (CY) 2020 to Fiscal Year (FY) 2023;

- A large majority (72%) of providers reinstated in the same year in which their contract terminated were reinstated at the same payment level as their previous contract;

- All new network providers 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] Balance billing occurs when a healthcare provider bills a patient for the difference between the provider's charge and the allowed amount under the patient's insurance plan. This typically happens when a patient receives care from an out-of-network provider, and the insurer covers only a portion of the bill.
[3] A claim is a request for payment submitted to the insurance carrier for services performed by the health care provider.

- In similar percentages to the prior period, of the 256 resolved arbitration decisions:
    - 159 arbitrations (62%) were decided in favor of the health carrier, and
    - 97 arbitrations (38%) in favor of the provider; and

- The percentage of bundled arbitrations increased from 24% in 2021, to 53% in 2023, 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.[4] 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 § 38.2-3445.01 of the Code.

Under the balance billing law, 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 resolve the reimbursement amount. 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.

In accordance with § 38.2-3445.2 C of the Code, 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 [from November 1, 2022, through October 31, 2023], including variations between the initial payment and final settled amounts.

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

The Bureau's first annual report submitted in December 2021 was based on data for CYs 2017 through 2020, and the second half of FY 2021 from January 1, 2021, through June 30, 2021. This year's report provides data and analysis for claims for FY 2022, and arbitration resolutions from November 1, 2022, through October 31, 2023.[5]

(i) Counts of Out-of-Network Claims Paid[6]

Number of out-of-network emergency services claims paid

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 52.3%. Given the slight change in numbers to date, the law has not significantly impacted the pattern of out-of-network emergency services claims.

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

Out of Network 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	26,356	11,041	15,315	41.9%
FY 2022	44,201	21,646	22,555	49.0%
FY 2023	53,501	32,243	21,258	60.3%
30 Month Total	124,058	64,930	59,128	52.3%

[5] For purposes of this report, H2 FY 2021 is the period 1-1-2021 to 6-30-2021, FY 2022 the period 7-1-2021 to 6-30-2022, and FY 2023 the period 7-1-2022 to 6-30-2023.

[6] 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. This report is focused primarily on the impact of the legislation on in-state, out-of-network claims and provides information on out-of-state utilization as a comparative tool to measure changes over time. Data for non-emergency services was only collected for the second half of FY 2021 in the first data call, for all of FY 2022 in the second data call and for all of FY 2023 in the latest data call.

The following table shows a 60% increase in the number of in-state emergency services claims paid by health carriers during the second full period after implementation of the law compared to the number 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 Second full 12 Month Period Claims Post-Law Change (Ending 6-30-2023)	% Change
20,149	32,243	+60%

Number of Non-Emergency Services out-of-network claims paid

As shown in the following table, the in-state, out-of-network provider claim counts averaged 40.4% of the total reported claims paid over the entire 30-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, with the third year in between at 39.7%.

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)				
Period	**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	69,429	32,653	36,776	47.0%
FY 2022	182,570	69,929	112,641	38.3%
FY 2023	142,381	56,559	85,822	39.7%
30 Month Total	394,380	159,141	235,239	40.4%

(ii) Health Care Provider Network Contracts Terminated and Reinstated

Carriers provided the Bureau with the number and identity of providers of emergency and non-emergency surgical and ancillary services whose network participation terminated during FY 2023. This information also shows which provider contracts were reinstated by the carriers (*see* the links in Attachments A-P1 and A-P2).

Carriers listed 152 different reasons for terminating a provider. The Bureau classified these into nine categories. When carriers included a reason for terminating a provider, 46.9% of overall terminations were involuntary or administrative, 18.9% were due to relocation, moving, or leaving a group, and 10.8% were voluntary on part of the provider.

Reasons for network contract terminations

Network Contract Termination Summary FY 2023								
Reason for Termination	**Plan Initiated**	**% Plan Initiated**	**Provider Initiated**	**% Provider Initiated**	**Mutually Initiated**	**% Mutually Initiated**	**FY 2023 Totals**	**% of FY 2023 Totals**
Involuntary/ Administrative	6,176	80.9%	0	0.0%	436	74.2%	6,612	46.9%
Relocation/ Move/ Left Group	31	0.4%	2,576	44.0%	58	9.9%	2,665	18.9%
Voluntary	0	0.0%	1,524	26.0%	0	0.0%	1,524	10.8%
Licensing/ Credentialling Issue	1,215	15.9%	3	0.05%	10	1.7%	1,228	8.7%
Provider Initiated	10	0.1%	728	12.4%	3	0.5%	741	5.3%
Failure to meet network criteria	0	0.0%	450	7.7%	0	0.0%	450	3.2%
No specific reason given	175	2.3%	240	4.1%	11	1.9%	426	3.0%
Retired/ Deceased/ Closed	31	0.4%	296	5.1%	70	11.9%	397	2.8%
Provider resigned from at least one, but not all, networks	1	0.01%	42	0.72%	0	0.0%	43	0.3%
Totals	7,639	100.0%	5,859	100.0%	588	100.0%	14,086	100.0%

Differences in payment levels prior to termination and after reinstatement

Carriers identified 640 providers terminated and reinstated in the same reporting period. Of these, 460 (72%) were reinstated at the same payment level. Only 76 (12%) were reinstated at a higher payment level, and 104 (16%) were reinstated at a lower payment level.

Number of Providers Reinstated in the Same Reporting Period FY 2023					
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	-	-	1	1	-
Emergency Medicine	-	2	-	-	-
Hospitalist	-	-	5	-	-
Surgeons	2	7	16	6	1
Other	44	47	433	57	9
Multi-Specialty	-	-	2	-	-
Radiology	1	1	3	2	-

Reporting carriers identified 164 new-to-network providers that were terminated in a prior year. Of this number, all 164 (100%) rejoined a network at the same payment level.

Number of New Providers in PY 2023 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	-	-	-	-	-
Emergency Medicine	-	-	-	-	-
Hospitalist	-	-	10	-	-
Surgeons	-	-	8	-	-
Lab/Pathology	-	-	3	-	-
Other	-	-	171	-	-
Multi-Specialty	-	-	2	-	-
Radiology	-	-	-	-	-

(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 2023. 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.

With the latest reporting period, the Bureau was able to analyze claims data representative of the Virginia commercial market for two full fiscal years. The Bureau compared the FY 2023 results to those produced by Bureau actuarial consultant Oliver Wyman in the "Report of the Virginia Balanced Billing Work Group" (December 31, 2019) and from the Bureau's previous reports.

Emergency Services (ES) Allowed Claims								
	2017 Oliver Wyman Data ($)	% of Total	CY 2020 ($)	% of Total	FY 2022 ($)	% of Total	FY 2023 ($)	% of Total
Total Claims	13,654,387,985		1,047,907,558		6,653,187,847		3,941,136,711	
ES	1,507,903,281	11.0	218,144,598	20.8	333,222,357	5.0	502,136,9678	12.7
ES for Non-Par Providers	8,251,403	0.1	8,251,403	0.8	41,424,246	0.6	24,332,897	0.6
ES for Non-Par Providers in Virginia	4,728,430	0.03	4,728,430	0.5	19,407,766	0.3	10,776,835	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 were in the range of 0.2% to 0.5% as in previous reports.

As in the previous report, to determine the impact on premiums, allowed claims would have to be adjusted based on the underlying plan designs of the carriers surveyed. Although this is not possible, the Bureau would expect the impact on paid claims 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 indicates that emergency claims for non-participating providers in Virginia continue to represent an estimated 0.21% to 0.45% of premium.

As reported previously, continuing to use the information from the "Emergency Services – Allowed Claims" table, and given the minimal estimated 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 1,066 arbitration decisions rendered by arbitrators since the inception of the process, 669 arbitrations (63%) have been decided in favor of the health carrier, and 397 arbitrations (37%) have been decided in favor of the provider.

For this reporting period, there were a total of 256 arbitration decisions rendered, with 159 arbitrations (62%) decided in favor of the health carrier, and 97 (38%) decided in favor of the provider.[7]

Arbitrations Decided From 11 1 2022 to 10 31 2023			
Specialty	**Total Number Decided**	**In Favor of Plans**	**In Favor of Providers**
Emergency Medicine	196	140	56
Anesthesia	10	1	9
Reconstructive Surgery	50	18	32
Total	256	159	97

The percentage share of arbitration decisions by provider specialty changed significantly from 2022 to 2023, with the majority changing from anesthesia (48.1% in 2023) to emergency medicine (76.6% in 2023). Overall, plans prevailed in the majority of decisions (62%), up from 58% in the prior year. For this purpose, a plan refers to a health insurance carrier or self-funded group health plan that has opted in participating in the balance billing arbitration process.[8]

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**	
	2022	**2023**	**2022**	**2023**	**2022**	**2023**
Emergency Medicine	41.3%	76.6%	66.1%	71.4%	33.9%	28.6%
Anesthesia	48.1%	3.9%	53.5%	10.0%	46.5%	90.0%
Reconstructive Surgery	10.6%	19.5%	46.4%	36.0%	53.6%	64.0%
Overall			58%	62%	42%	38%

The following two tables show a small increase in the average award amount for emergency medicine claims over the reporting period, as well as a tripling of the average award amount for anesthesia. It should be noted that this increase has only 10 arbitrations included in the 2023 calculation, with the provider winning 9 of the 10.

[7] *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, 2022, to October 31, 2023).

[8] Elective group health plans are plans that are self-funded and are not regulated by Virginia. In order to offer balance billing protections for their enrollees, the plan must opt-in to the balance billing law.

This winning ratio by the provider, combined with the relatively few arbitrations, accounts for this increase in the average award amount.

A Comparison of Average Award Amounts for Arbitrations Decided During the 2022 and 2023 Reporting Periods						
Specialty	**2022 Provider's Pre Arbitration Average Offer**	**2023 Provider's Pre Arbitration Average Offer**	**2022 Plan's Pre Arbitration Offer**	**2023 Plan's Pre Arbitration Offer**	**2022 Average Awarded Amount**	**2023 Average Awarded Amount**
Emergency Medicine	$1,727.19	$1,878.73	$435.59	$477.40	$778.23	$865.06
Anesthesia	$1,078.48	$2,152.70	$426.52	$1,290.46	$718.06	$2,138.02
Plastic and Reconstructive Surgery	$25,234.57	$21,632.67	$2,487.38	$2,821.79	$13,789.94	$16,098.18

A Comparison of the % of Bundled Arbitrations Decided During the 2021, 2022, and 2023 Reporting Periods			
Specialty	**% Bundled in 2021**	**% Bundled in 2022**	**% Bundled in 2023**
Emergency Medicine	26%	62%	67%
Anesthesia	18%	20%	30%
Plastic and Reconstructive Surgery	0%	7%	0%
Totals	24%	36%	53%

The increase in bundled[9] 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, and reminded the parties involved in payment disputes of the requirement to engage in good faith negotiation and reminded carriers of the requirement in 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.

[9] 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 Reinstated 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 11-1-2022 through 10-31-2023