BALANCE BILLING ARBITRATION PROCESS

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
JUNE 2021

COMMONWEALTH OF VIRGINIA

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June 30, 2021

The Honorable Janet D. Howell
Chair, Senate Finance & Appropriations Committee
Senate of Virginia

The Honorable Luke E. Torian
Chair, House Appropriations Committee
Virginia House of Delegates

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

The Honorable Jeoin A. Ward
Chair, House Labor & Commerce Committee
Virginia House of Delegates

In accordance with subsection I of § 38.2-3445.02 of the Code of Virginia, the State Corporation Commission has prepared its first annual report summarizing the dispute resolution information provided by arbitrators to be posted on its website and submitted to the Chairs of the House Committee on Labor and Commerce and Committee on Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and Appropriations annually by July 1.

On behalf of the State Corporation Commission, here is the report prepared by the Bureau of Insurance.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

Executive Summary

In 2020, the Virginia General Assembly passed House Bill 1251/Senate Bill 172 (Chapter 1080 and Chapter 1081 of the Virginia Acts of Assembly) codified as §§ 38.2-3445-38.2-3445.07 of Chapter 34 of Title 38.2 of the Code of Virginia, effective January 1, 2021, to prohibit the balance billing of enrollees by out-of-network health care providers for emergency services or by out-of-network surgical or ancillary service providers at an in-network facility for any amount other than the enrollee's applicable cost-sharing requirements.

Under the law, if a provider disputes the amount to be paid by the health carrier for services rendered to an enrollee, the provider and the health carrier shall make a good faith effort to reach a resolution on the amount of the reimbursement. If the health carrier and the provider do not agree to a commercially reasonable payment, either party may seek to resolve the dispute by arbitration.

The State Corporation Commission was directed to establish a framework for arbitration of such disputes to include (i) a timeline for the proceedings; (ii) a method for choosing an arbitrator; (iii) establishment of arbitrator fees; (iv) required and optional factors for the arbitrator to consider; (v) non-disclosure agreements; (vi) reporting requirements; and (vii) an appeals process for appeals based on specified abuse of arbitration proceedings . The Commission was authorized to adopt rules and regulations governing the arbitration process.

In 2020, the Commission promulgated its Rules Governing Balance Billing for Out-of-Network Health Care Services (14VAC5-405-10 et seq.) The Rules, also effective January 1, 2021, apply to all health benefit and managed care plans issued and delivered in this Commonwealth except as provided for in § 38.2-3445.06 of the Code of Virginia.

The Commission was also directed to prepare an annual report summarizing the dispute resolution information provided by arbitrators to be posted on its website and submitted to the Chairs of the House Committee on Labor and Commerce and Committee on Appropriations and the Senate Committee on Commerce and Labor and Committee on Finance and Appropriations annually by July 1.

For this first annual report, the Commission gathered data through May 31, 2021 on the arbitration process for billing disputes between out-of-network health care providers and health carriers:

- The first request eligible for balance billing arbitration was accepted on March 10, 2021.

- A total of 120 arbitration requests were received through May 31, 2021, of which 102 requests were accepted as eligible.

- Of the three arbitration decisions rendered by arbitrators during the reporting period, one arbitration was decided in favor of the health carrier, and two arbitrations were decided in favor of the provider.

Introduction and Legislative Overview

In 2020, the Virginia General Assembly passed House Bill 1251/Senate Bill 172 (Chapter 1080 and Chapter 1081 of the Virginia Acts of Assembly) codified as §§ 38.2-3445-38.2-3445.07 of Chapter 34 of Title 38.2 of the Code of Virginia, effective January 1, 2021. The new provisions provide, among other things, that when an enrollee receives emergency services from an out-of-network health care provider or receives out-of-network surgical or ancillary services at an in-network facility, the enrollee is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement and such cost-sharing requirement cannot exceed the cost-sharing requirement that would apply if the services were provided in-network.

A health carrier's required payment to the out-of-network provider for the services rendered to an enrollee shall be a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. If, however, 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 f 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.

The State Corporation Commission was directed to establish a framework for arbitration of such disputes to include (i) a timeline for the proceedings; (ii) a method for choosing an arbitrator; (iii) establishment of arbitrator fees; (iv) required and optional factors for the arbitrator to consider; (v) non-disclosure agreements; (vi) reporting requirements; and (vii) an appeals process for appeals based on specified abuse of arbitration proceedings .

The Commission was authorized to adopt rules and regulations governing the arbitration process.

The State Corporation Commission contracted with Virginia Health Information (VHI) to establish a data set and business protocols to provide health carriers, providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving disputes. The Commission, in consultation health carriers, providers, and consumers, developed standard language for a notice of consumer rights regarding balance billing. The Commission, the Board of Medicine, and the Commissioner of Health are authorized to levy fines and take action against a health carrier, health care practitioner, or medical care facility, respectively, for a pattern of violations of the prohibition against balance billing. Carriers or provider are prohibited from initiating arbitration with such frequency as to indicate a general business practice.

The enacted provisions do not apply to an entity that provides or administers self-insured or self-funded plans; however, such entities may elect to be subject to such provisions.

The Commission adopted rules and regulations governing the arbitration process.

The Commission was directed to prepare an annual report summarizing the dispute resolution information provided by arbitrators, including information related to the matters decided through arbitration as well as the following information for each dispute resolved through arbitration:

- the name of the carrier,
- the name of the health care provider,
- the health care provider's employer or the business entity in which the provider has an ownership interest,
- the health care facility where the services were provided, and
- the type of health care services at issues.

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

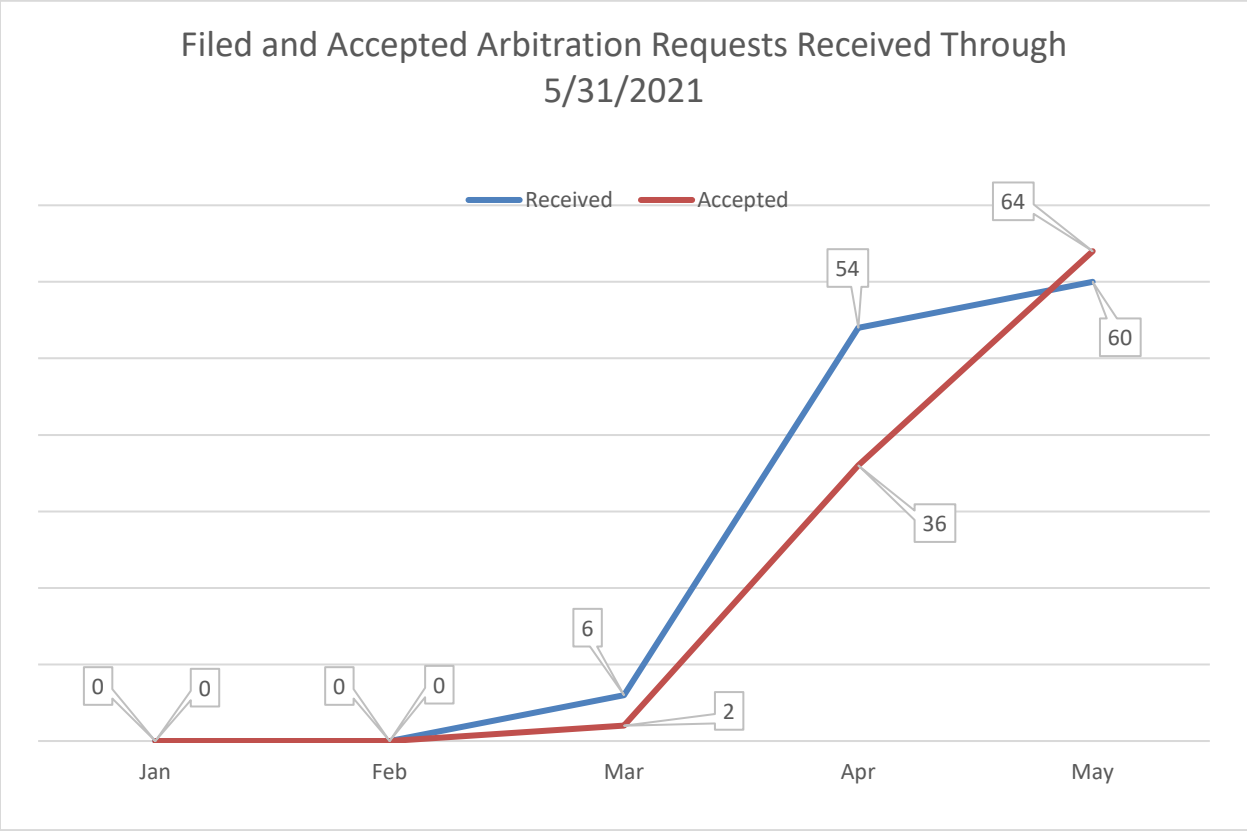
Arbitration Process for Billing Disputes Data Analysis

For this first annual report, the Commission gathered data through May 31, 2021 on the arbitration process for billing disputes between out-of-network health care providers and health carriers.

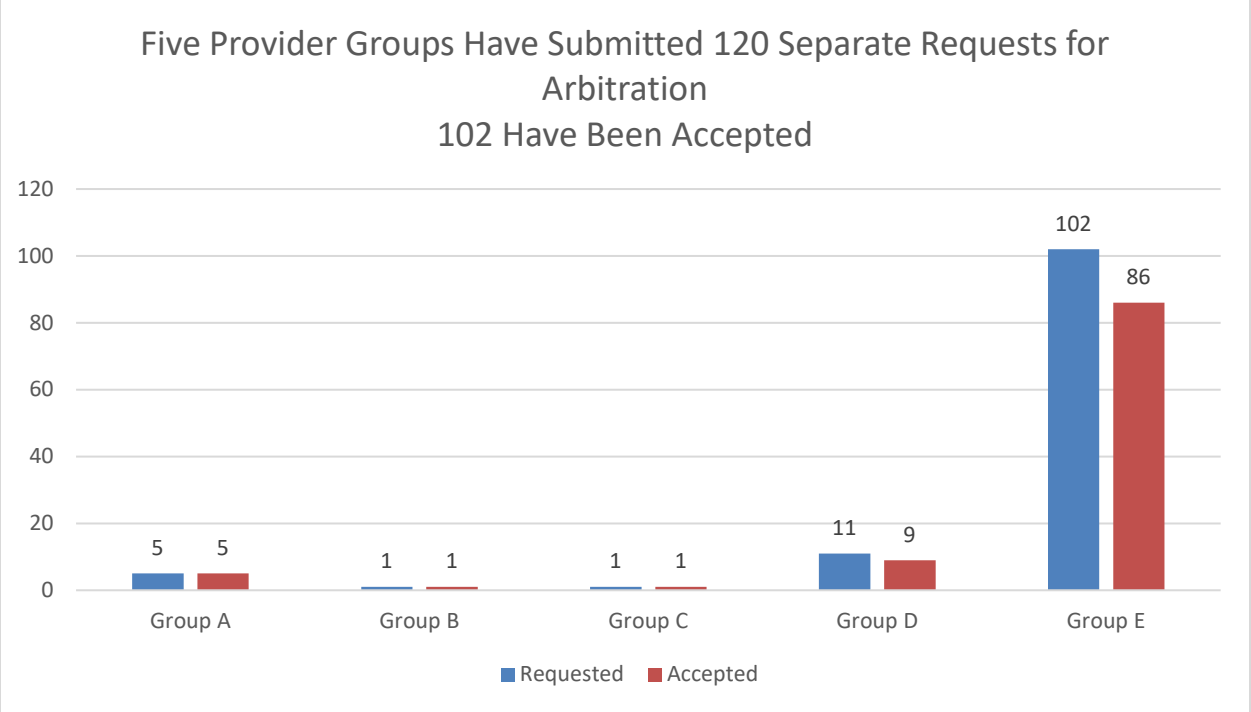
Because of the limited data available for the reporting period through May 31, 2021, the current data does not yet support trend analysis. This initial set of data does create a foundation for future reports and analyses.

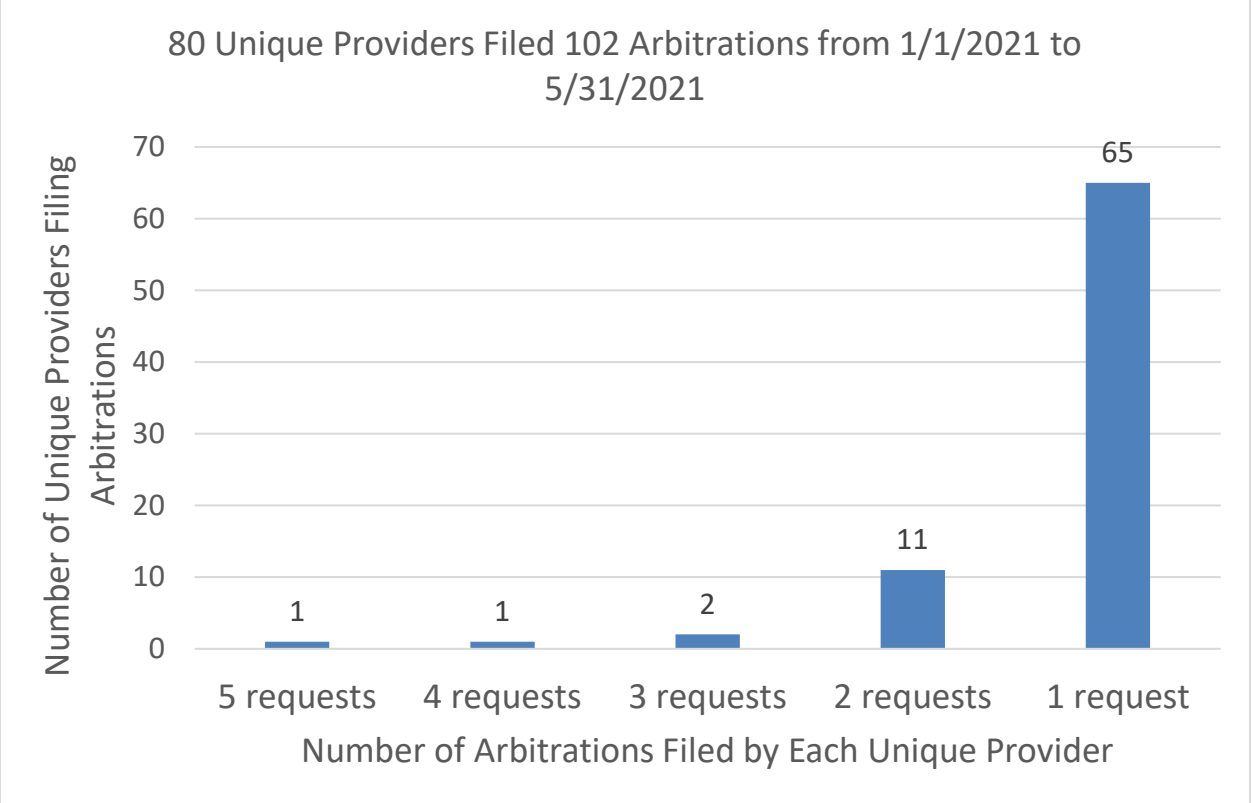
The Commission's Bureau of Insurance received its first request for arbitration on March 4, 2021. The request was rejected as ineligible because it was submitted as a bundled request but did not meet the criteria for a bundled request since it was made on behalf of multiple providers. The first two requests accepted as eligible for arbitration were closed upon request of the parties after agreeing to an additional thirty-day negotiation period for each case. The first request that was assigned to an arbitrator was accepted as eligible for arbitration on April 6, 2021.

A total of 120 arbitration requests were received through May 31, 2021, of which 102 requests were accepted as eligible.

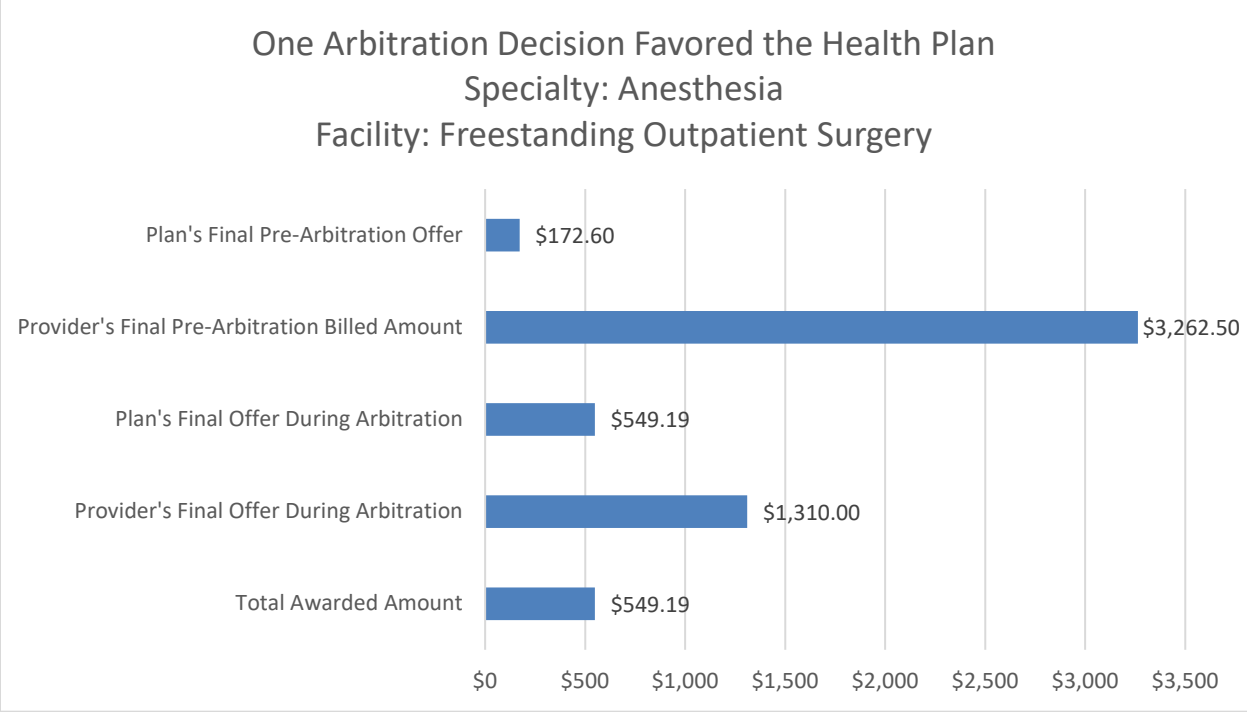


These 102 eligible arbitration requests have been submitted by five provider groups on behalf of 80 health care professionals.

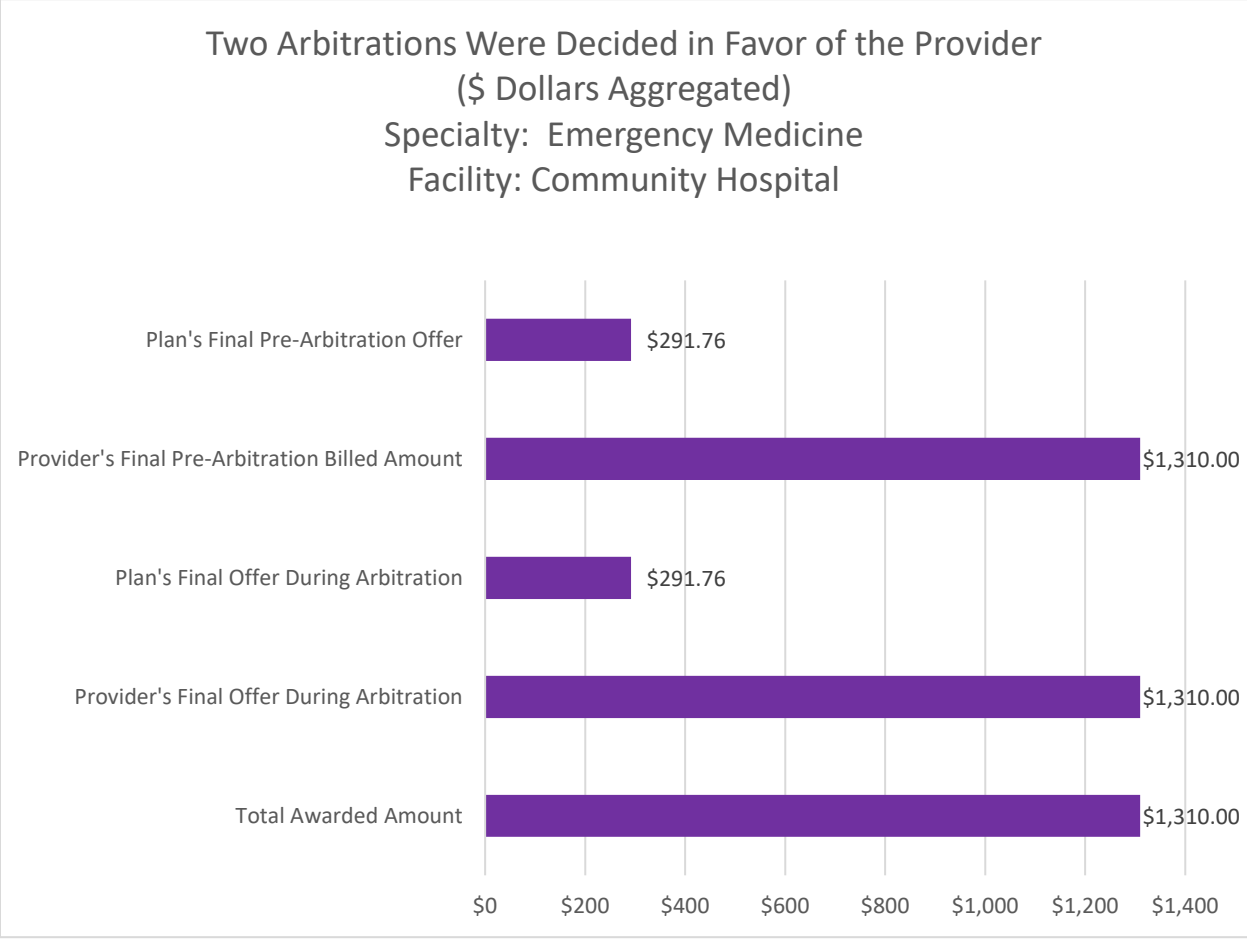




Of the three arbitration decisions rendered by arbitrators during the reporting period, one arbitration was decided in favor of the health carrier, for anesthesia, rendered in a freestanding outpatient surgery center.



The other two arbitrations were decided in favor of the provider. Both were for emergency medicine, rendered in community hospitals.



All three arbitration decisions were rendered by different arbitrators.

All three arbitration decisions were rendered for different carriers.

Both arbitration decisions that went in favor of the provider were for providers in the same practice but were for different individual medical professionals.

The arbitration decision that went in favor of the plan was for a different practice and specialty.