Ethics & Fairness in Carrier Business Practices Work Group Report

A Report Submitted to the Chairs of the Senate Committee on Commerce and Labor and the Committee on Education and Health and the House of Delegates Committee on Commerce and Energy and the Committee on Health, Welfare and Institutions pursuant to Chapters 527 and 691, Virginia Acts of Assembly, 2023 Session

December 1, 2023

COMMONWEALTH OF VIRGINIA

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December 1, 2023

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

The Honorable L. Louise Lucas
Chair, Education and Health Committee
Senate of Virginia

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

The Honorable Robert D. Orrock, Sr.
Chair, Health, Welfare, and Institutions Committee
Virginia House of Delegates

Dear Senator Saslaw, Senator Lucas, Delegate Kilgore and Delegate Orrock:

On behalf of the State Corporation Commission, the Bureau of Insurance hereby submits the report of the Ethics and Fairness in Carrier Business Practices Work Group convened pursuant to Chapters 527 and 691 of the Virginia Acts of Assembly, 2023 Session.

Sincerely,

Scott A. White
Commissioner of Insurance

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Executive Summary

Pursuant to Chapters 527 and 691 of the 2023 Virginia Acts of Assembly (Chapters 527/691), and on behalf of the State Corporation Commission (Commission), the Bureau of Insurance (Bureau) convened the Ethics & Fairness in Carrier Business Practices Work Group (E&F Work Group) to evaluate and develop recommendations for the implementation of fair business standards by health insurance carriers as set out in the Ethics & Fairness in Carrier Business Practices Act (§ 38.2-3407.15 of the Code of Virginia, hereinafter referred to as the E&F Act).

The E&F Work Group included representatives of the Virginia Hospital & Healthcare Association; the Virginia Association of Health Plans; and the Medical Society of Virginia. The Bureau encouraged the participation of other carrier and provider stakeholders, resulting in nearly 40 participants representing nine organizations routinely attending the virtual meetings. The Work Group agreed on seven consensus recommendations, including the following proposed changes to the E&F Act:

- Handle additional documentation requests and responses electronically to enhance the ability to match documents to claims and expedite processing. Specify that all contracts and contract amendments be delivered exclusively in electronic format and that the delivery method and location should be agreed to by both parties and memorialized via fully executed contract amendments;

- Require carriers to make available in the provider contract (to include the provider manual and relevant clinical guidelines) specific guidance regarding the documents and information required to be submitted by providers for payment of claims. The guidance should be easy to find, thorough, and easily accessible online.

- Establish a reasonable and consistent time limit for withholding or offsetting claims for known overpayments and duplicate claims;

- Require carriers to make available an electronic means for providers to determine if a member's health plan is fully insured or self-funded beginning no later than July 1, 2025;

- Specify that carrier and provider subdelegates and vendors adhere to the requirements of the E&F Act, given that carriers and providers employ multiple vendors to perform tasks; and

- Clarify that carriers must apply payment timeliness requirements and related interest provisions to the resulting payments owed when the carrier overturns the denial of a claim following a review of a dispute; and

- Require parties to confer and compare their respective data at the claim level before submitting complaints to the Bureau to review.

Additionally, the Bureau presented the E&F Work Group with enhancements to its provider complaint form and improvements to its complaints review process. The Bureau will post the complaint investigation timeframes on its website.

The Bureau is willing to continue facilitating discussions as stakeholders work towards consensus on remaining issues.

Background

In 1999, the Virginia General Assembly enacted the E&F Act, which established standards that health insurance carriers must include in provider contracts and adhere to in the processing and payment of claims. It requires carriers to pay clean claims within 40 days of claim receipt, contact health care providers within 30 days if further claim information or documentation is required, and establish reasonable policies for giving providers notice of and detailed information concerning carrier claims processing procedures. The E&F Act gave the Bureau enforcement authority.

Since January 2021, providers have submitted 27 E&F complaints to the Bureau for investigation. Providers have indicated that this number of complaints is not representative of claim payment delays by carriers that providers have been experiencing since 2021. Providers have found carrier requirements for what is considered a "clean claim" to be increasingly difficult to meet, resulting in the start of the 40-day "clock" for carriers to pay claims delayed while the provider completes its submission.

Provider representatives indicated that some providers are unaware of their ability to file complaints with the Bureau and the correct process for filing. Therefore, some provider complaints were sent in batches via letters or emails from provider groups, hospitals, and professional associations. Many claims contained in these submissions did not fall under the Bureau's regulatory purview, including Medicare and Medicaid complaints, as well as those of self-funded health plans. However, this fact was not evident to either the provider or the Bureau when the complaints were submitted. The Bureau's review of these submissions to determine the applicability of the E&F Act required significant time, with considerable correspondence with the carriers as claims were identified, reviewed, and finalized. While the provider complaints suggested large scale non-compliance with the E&F Act, information received from the carriers indicated substantial compliance and payment delays that were not solely the fault of carriers. It was clear to the Bureau that communications had broken down between providers and carriers.

The Bureau, being unable to determine the extent of carrier non-compliance with the information it was able to gain from providers and carriers, employed its market conduct investigation resources to perform a detailed review of certain provider complaints over a defined period of time. While approximately 99.5 percent of the claims reviewed through the investigation were found to have been processed timely, the case resulted in a

monetary settlement for the carriers' alleged violations of § 38.2-3407.15 B 1 of the E&F Act, and agreement by the carriers to take corrective action to increase compliance with this section going forward, subject to additional penalties or other actions if they fail to do so.

During the 2023 Session of the General Assembly, House Bill 1739, and Senate Bill 927 (the legislation) were introduced at the request of provider stakeholders in response to the following provider concerns:

- Alleged claims processing delays by carriers, especially for claims exceeding certain dollar amounts;

- Repeated requests by carriers for additional information when providers believed they had previously provided it or were not initially aware of the need for the information;

- Providers being unable to easily locate and use the Bureau's provider complaint process; and

- The Bureau's inability to determine carrier compliance as swiftly as the provider complainants hoped.

The legislation, as initially introduced, directed the Commission to determine if a carrier had failed to implement minimum fair business standards as required by the Code. It allowed the Commission to require a carrier to make an interim payment to a complainant for the claims in controversy and to require the carrier to submit a corrective action plan within 30 days of the Commission's determination. After significant discussions but no agreement among interested parties on any of these concerns outlined above, the General Assembly amended the legislation to create a work group led by the Bureau to:

(i) evaluate the effectiveness of the current process that the Bureau utilizes when complaints are filed related to prompt payment of claims and

(ii) develop recommendations regarding improvements to the process such as establishing a timeframe and requirement for:
   (a) submission of complaints and acknowledgement of receipt;
   (b) requests for additional documentation or information needed to make a determination; and
   (c) completion of a determination about a complaint, including the rationale and explanation of any recommendations for the carrier or complainant to promote accuracy of claims submission and prompt payment of claims.

In connection with the complaint process, the Bureau was directed to ensure that the complaint form be easily accessible to providers and the public. The legislation also directed the E&F Work Group to "develop recommendations to promote compliance with the Ethics & Fairness in Carrier Business Practices Act to ensure prompt payment of claims and other recommendations to improve the timeliness of the claims process." Finally, it outlined the composition of the E&F Work Group as noted in the Executive Summary.

Bureau Improvements to the Current Review Process for an E&F Complaint

Provider Complaint Form

The Bureau has received 27 E&F provider complaints from January 2021 through the present. During the discussions regarding the proposed 2023 legislation, provider representatives indicated difficulties providers faced in ascertaining how to request the Bureau's assistance. They indicated the Provider Complaint form was difficult to locate on the Bureau's website, and the process of submitting a complaint was not a friendly process, requiring paper or fax transmission.

Chapters 527/691 directed the Bureau to make the Provider Complaint form easily accessible to providers and other members of the public. The Bureau worked within the requirements of its webpage design to revise its *File A Complaint* web page accordingly. The new fillable Provider Complaint form includes instructions to assist providers and is located under the drop-down menu, File Your Complaint/Appeal by Mail or Fax, and may be accessed at https://scc.virginia.gov/pages/File-an-Insurance-Complaint-(1).

Bureau staff also researched alternative electronic complaint submission options for providers besides paper mail or fax transmission and established a new email address for providers' use in submitting their complaints to the Bureau by electronic mail. The email address is LHprovidercomplaints@scc.virginia.gov. Additionally, the Bureau added instructions to its website for providers to submit complaints through the Consumer Online Portal. Providers will need to complete the Provider Complaint form and upload it, along with the provider contract and supporting documentation, to the portal when submitting a complaint in this manner.

Bureau Complaint Process

The Bureau has an internal provider complaint review process with timelines for acknowledging the complaint, requiring carriers to respond to complaints, and updating the complainant. Additionally, the Commission's Rules Governing Unfair Claim Settlement Practices (14VAC5-400-50 B) currently requires a carrier to respond to the Commission's inquiry within 15 calendar days.

The Bureau acknowledges that some provider complaints that were submitted via methods other than the designated submission process of the Provider Complaint form were not acknowledged timely, and those same provider complaints did not receive

regular updates on the progress of the Bureau's investigation. The Bureau provided the E&F Working Group with its established process to acknowledge receipt of a complaint within two business days; request information from the carrier that must be provided within 15 calendar days (an extension may be granted if necessary); and update the complainant every 20 business days for complaints that are submitted via the Provider Complaint form through the appropriate means of submission.

In accordance with Chapters 527/691, the Bureau commits to adhering to the timelines of the process when the complaints are submitted using the instructions on the Provider Complaint form. The Bureau will post the process and related timelines on its web site. Providers are encouraged to use the Bureau's Provider Complaint form and one of the established methods of submission to receive timely acknowledgements and updates.

Chapters 527/691 call for the E&F Work Group to develop recommendations for improvements that include timeframes and requirements for completion of a complaint determination, to include recommendations the Bureau will offer to the carrier or complainant to submit, and process claims more accurately and promptly. The Bureau is not in a position to recommend actions or advice as to how a provider or carrier can more efficiently submit and process claims, respectively. However, the consensus recommendations detailed in the section below should make the complaint process more efficient by suggesting stakeholders must attempt to confer prior to complaint submission; providing for the electronic exchange of information between stakeholders; clarifying timeframes set out in the E&F Act; and providing a mechanism for providers to determine claims that are applicable to the E&F Act.

Bureau Remedies for Compliance

The Bureau's current process is to investigate the provider's complaint to determine whether the carrier's actions that are the source of the complaint are compliant with Virginia laws and regulations. If the Bureau finds alleged non-compliance, it will address the issue with the carrier and communicate the resolution to the provider.

When the Bureau is unable to make a determination of compliance based on the information provided through the complaint and investigation process, or when the provider alleges non-compliant actions persist when the Bureau's findings do not align with the alleged non-compliant actions, the Bureau does consider additional measures of investigation, such as target market conduct examinations.

The Bureau has the authority to examine and investigate carriers under §§ 38.2-1317.1 and 38.2-200 of the Code of Virginia. Such investigations may be prompted by:

- Market analysis (§ 38.2-1317.2)
- Complaints of non-compliance or violations
- An insurer's internal compliance audit

If a formal action resulting in a settlement order is issued to a carrier, the completed case will be posted to the Bureau's Regulatory Actions webpage.

Consensus Recommendations

The following seven consensus recommendations were developed by the E&F Work Group stakeholders. The Bureau reviewed and offered comments before the consensus recommendations were finalized. In accordance with the E&F Work Group's directive, the recommendations address its efforts to:

- Implement reasonable and transparent business practices;
- Simplify sections of the Code that are not uniformly understood by all parties or are difficult to interpret for enforcement purposes in their current form; and
- Eliminate requirements or policies that impede getting business done and add little or no value.

Consensus Recommendation #1:

#1A: Additional Documentation Requests (ADRs) and ADR responses should be handled electronically. Electronic handling will enhance the ability to match documents to claims and expedite processing.

#1B: The E&F Act should clearly state that all contracts and amendments shall be delivered exclusively in electronic format. The delivery method and location should be agreed to by both parties and memorialized via fully executed contract amendments.

Electronic processes should be phased in by no later than January 1, 2026 and will eliminate the use of fax transmission.

Proposed Statutory Language in Support of Recommendations #1A and #1B:

> Consensus #1 A
> § 38.2-3407.15 B 2
> 2. A carrier shall, within 30 days after receipt of a claim, ~~request electronically or in writing from~~ notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information ~~and documentation~~ that ~~the carrier reasonably believes~~ will be required to process and pay the claim ~~or to determine if the claim is a clean claim~~. Upon receipt of the additional information ~~requested under this subsection~~ necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person

submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims. Beginning no later than January 1, 2026, all notifications and information required under this section shall be delivered electronically. ~~however, n~~ Nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. ~~Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.~~

Consensus #1 B
Placement in § 38.2-3407.15 to be determined
Beginning no later than July 1, 2025, provider contracts, related amendments, and notices shall be delivered by the carrier to providers exclusively in an electronic format other than electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider and be included in the provider contract. Beginning no later than January 1, 2026, the provider shall submit contracts, amendments, and notices to carriers exclusively in electronic format other than electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider and be included in the provider contract.

Consensus Recommendation #2:

Carriers should provide specific guidance regarding the documents and information required to be submitted by providers for claims to be paid in (i) the provider contract and/or the provider manual and (ii) relevant clinical guidelines. The guidance should be easy to find, thorough, and easily accessible online. This guidance would include at a minimum:

- Type of provider identification required;
- Type of patient identification required;
- How services provided should be identified using a generally accepted system of procedure or service coding, or, if applicable, a methodology required in the provider contract;
- How to provide appropriate information to establish that prior authorization was obtained, where applicable; and
- The supplementation, specific to the service provided, that the carrier will require in order to pay the claim.

Stakeholders agree that the “clean claim” definition should be refined so that it is more objective and may be understood by all parties involved in the claim payment process.

Proposed Statutory Language in Support of Recommendation #2

§ 38.2-3407.15 A

"Clean claim" means a claim that does all the following: ~~(i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or~~

1. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and addresses.
2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee.
3. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required in the provider contract. The claim shall include a complete listing of all relevant diagnosis, procedure, and service codes, as well as any applicable modifiers.
4. Specifies the date and place of service.
5. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services.
6. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract.

Regardless of the above criteria, a claim shall be considered a "clean claim" if ~~(ii) with respect to which~~ a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

Consensus Recommendation #3:

In order to enhance efficiency, accuracy, and clarity, stakeholders recommend amending Virginia Code § 38.2-3407.15. B 7 and 8 of the E&F Act to establish a reasonable and consistent time limit for withholding or offsetting claims for known overpayments and duplicate claims. Currently, the E&F Act requires the lesser of 12 months or "the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided." This standard creates unnecessary confusion and administrative work for both carriers and providers. Stakeholders recommend eliminating the "lesser of" language from Virginia Code § 38.2 3407.15 B 7 and 8, making 12 months the timeframe, and incorporating into the E&F Act an option to allow for withholding and offsetting claims after that 12-month time frame if the provider and the carrier agree that it is the preferred method for correcting the overpayment.

Additionally, revisions were made to align more closely with other transitions to electronic-only communications in the consensus recommendations.

Proposed Statutory Language in Support of Recommendation #3:

§ 38.2-3407.15 B 7 and 8

7. No carrier shall impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed ~~the lesser of (a)~~ 12 months. Notwithstanding subdivision (iii) of this subsection, a provider and a carrier may agree in writing that the recoupment by withholding or offsetting against future payments may occur after the 12-month limit for the imposition of the retroactive denial. ~~the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided.~~ Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim. Beginning no later than January 1, 2026, this notification and all related provider responses shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by the carrier and provider and be included in the provider contract.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted. Beginning no later than January 1, 2026, all written communications, explanations, and related provider responses applicable to this section shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by the carrier and provider and be included in the provider contract.

Consensus Recommendation #4:

Prompt pay requirements apply only to fully insured products, which is a source of confusion for providers and should be clarified in the E&F Act. Currently, there is no consistently available process by which providers may determine whether a patient is covered by a health plan subject to Virginia insurance laws and regulations. Stakeholders recommend changes to § 38.2-3407.15 B 9 to specify that beginning no later than July 1, 2025, carriers will be required to make available through electronic means a way for providers to determine whether a member's health plan is fully insured or self-funded.

Proposed Statutory Language in Support of Recommendation #4:

> § 38.2-3407.15 B 9
> 9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract. Beginning July 1 2025, carriers shall make available through electronic means a way for providers to determine whether a member is covered by a health plan as defined in this section.

Consensus Recommendation #5:

Stakeholders recommend that the E&F Act state explicitly that subdelegates and vendors are subject to the provisions of the E&F Act so that when carriers delegate duties to vendors to perform utilization management, claims processing, and other tasks, and employed by providers to assist with revenue cycle management and other tasks, they are clearly required to adhere to the provisions of the E&F Act.

Proposed Statutory Language in Support of Recommendation #5:

> § 38.2-3407.15 I
> I. This section shall apply with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 1999, and shall apply to the carrier and provider, regardless of the vendors, subcontractors, and other entities that have been contracted by the carrier or the provider to perform activities applicable to the section.

Consensus Recommendation #6:

Stakeholders agree that the E&F Act should expressly state that payment timeliness requirements and related interest provisions apply to payments owed following a carrier's dispute review. While some carriers assume that prompt pay requirements in the E&F Act apply in cases when a claim denial is overturned upon dispute review, feedback from providers indicate the requirements are not uniformly applied by all carriers.

Proposed Statutory Language in Support of Recommendation #6:

§ 38.2-3407.15 B12
12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the overturn decision is made, consider the claims impacted by the overturn as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

Consensus Recommendation #7:

Stakeholders agree that the prompt payment complaint and complaint resolution process would be improved by adding to the existing E&F Act complaint framework requirements that the parties confer and compare their respective data at the claim level before submitting complaints to the Bureau for review. Such requirements would allow the provider to forego the conferring period if the carrier is not engaging meaningfully in the process.

Proposed Statutory Language in Support of Recommendation #7:

Add § 38.2-3407.15 C
C. When filing a complaint with the Commission for failure to pay claims according to paragraph B1, the provider shall attest in the complaint that it has made a reasonable effort to confer with the carrier in order to resolve the issues related to all claims that are the subject of the complaint and that 30 calendar days have passed from the date of request if the carrier has been responsive to the provider's requests. If, in the judgment of the provider, the carrier has not been responsive, the provider does not have to wait 30 calendar days to file the complaint. The request to confer shall be made to the contact listed for such purpose in the provider contract and shall include supporting documentation sufficient for the carrier to identify the claims in question.

Additional Recommendations from the E&F Work Group

While consensus was reached by the E&F Work Group on the recommendations above, stakeholders had other recommendations that did not garner consensus prior to submission of the report of the E&F Work Group in accordance with its statutory deadline. Stakeholders continue to discuss some of the recommendations to determine whether or not consensus may be reached. Stakeholders have agreed consensus is not possible on others. Discussion will continue on the following issues:

- A definition of a "material contract amendment" in statute so that administrative changes are not considered amendments pursuant to § 38.2 3407 15 B 10, but changes that have material impacts on providers

are clearly specified as amendments and have the applicable protections provided by the E&F Act; and

- The use of tiered standards for carriers to comply with timely claims payment instead of 100 percent compliance.

Recommendations for which there is not consensus by the stakeholders include:

- Provider representatives' recommendations of additional monetary incentives to encourage carriers to pay claims timely, including an increase in the statutory interest rate for late paid claims; and

- Standardization proposals addressing what additional documentation may be required by a carrier from a provider and when a claim submission should be considered complete.

Bureau Recommendation

Through the course of the work group sessions, the stakeholders found a number of provisions of the E&F Act, originally enacted in 1999, which could be improved for the benefit of providers and carriers. Clarifying definitions and timelines, providing for electronic transmissions between the parties, and making available an easily accessible process by which providers may identify the member's health plan as fully insured or self-funded should serve to improve the overall E&F review process significantly. The Bureau is willing to continue facilitating discussions as stakeholders work towards consensus on remaining issues.

Appendix A

VIRGINIA ACTS OF ASSEMBLY -- 2023 SESSION

CHAPTER 527

An Act to direct the State Corporation Commission's Bureau of Insurance to convene a work group to evaluate and develop recommendations related to the implementation of health carrier fair business standards.

[H 1739]

Approved March 26, 2023

Be it enacted by the General Assembly of Virginia:

1. *§ 1. The State Corporation Commission's (the Commission's) Bureau of Insurance (the Bureau) shall convene a work group to develop recommendations for regulatory and legislative changes necessary to improve the process for determining, pursuant to the Commission's jurisdiction under subsection D of § 38.2-3407.15 of the Code of Virginia, if a carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 of § 38.2-3407.15 of the Code of Virginia in the performance of its provider contracts for the prompt payment of claims. The work group shall (i) evaluate the effectiveness of the current process that the Bureau utilizes when complaints are filed related to prompt payment of claims and (ii) develop recommendations regarding improvements to the process, such as establishing a timeframe and requirements for (a) submission of complaints and acknowledgment of receipt, (b) requests for additional documentation or information needed to make a determination, and (c) completion of a determination about a complaint, including the rationale and explanation of any recommendations for the carrier or complainant to promote accuracy of claims submission and prompt payment of claims. The work group shall also develop recommendations to promote compliance with the Ethics and Fairness in Carrier Business Practices Act (§ 38.2-3407.15 of the Code of Virginia) to ensure prompt payment of claims and other recommendations to improve timeliness of the claims process. In addition to convening the work group, the Bureau shall ensure that the form for submission of complaints is easily accessible to providers and members of the public. The work group shall include representatives of the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, and other relevant parties as identified by the Bureau. The Bureau shall submit a report of the findings and recommendations of the work group to the Chairs of the House Committees on Commerce and Energy and Health, Welfare and Institutions and the Senate Committees on Commerce and Labor and Education and Health no later than December 1, 2023.*

Appendix B

VIRGINIA ACTS OF ASSEMBLY -- 2023 SESSION

CHAPTER 691

An Act to direct the State Corporation Commission's Bureau of Insurance to convene a work group to evaluate and develop recommendations related to the implementation of health carrier fair business standards.

[S 927]

Approved March 27, 2023

Be it enacted by the General Assembly of Virginia:

1. *§ 1. The State Corporation Commission's (the Commission's) Bureau of Insurance (the Bureau) shall convene a work group to develop recommendations for regulatory and legislative changes necessary to improve the process for determining, pursuant to the Commission's jurisdiction under subsection D of § 38.2-3407.15 of the Code of Virginia, if a carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 of § 38.2-3407.15 of the Code of Virginia in the performance of its provider contracts for the prompt payment of claims. The work group shall (i) evaluate the effectiveness of the current process that the Bureau utilizes when complaints are filed related to prompt payment of claims and (ii) develop recommendations regarding improvements to the process, such as establishing a timeframe and requirements for (a) submission of complaints and acknowledgment of receipt, (b) requests for additional documentation or information needed to make a determination, and (c) completion of a determination about a complaint, including the rationale and explanation of any recommendations for the carrier or complainant to promote accuracy of claims submission and prompt payment of claims. The work group shall also develop recommendations to promote compliance with the Ethics and Fairness in Carrier Business Practices Act (§ 38.2-3407.15 of the Code of Virginia) to ensure prompt payment of claims and other recommendations to improve timeliness of the claims process. In addition to convening the work group, the Bureau shall ensure that the form for submission of complaints is easily accessible to providers and members of the public. The work group shall include representatives of the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, and other relevant parties as identified by the Bureau. The Bureau shall submit a report of the findings and recommendations of the work group to the Chairs of the House Committees on Commerce and Energy and Health, Welfare and Institutions and the Senate Committees on Commerce and Labor and Education and Health no later than December 1, 2023.*

Appendix C

Ethics & Fairness Work Group Participants

Stakeholder Organizations Represented

Augusta Health
Ensemble Health Partners
The Virginia Hospital & Healthcare Association
The Virginia Association of Health Plans
The Medical Society of Virginia
Anthem
Oscar
Sentara
Kaiser Permanente