BALANCE BILLING AND ARBITRATION

Annual Report

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

State Corporation Commission
Bureau Of Insurance

December 1, 2024

COMMONWEALTH OF VIRGINIA

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December 1, 2024

The Honorable R. Creigh Deeds
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Jeion A. Ward
Chair, Labor and Commerce Committee
Virginia House of Delegates

Dear Senator Deeds and Delegate Ward:

In accordance with subsection C of § 38.2-3445.2 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. The report (i) presents information reported by health carriers to the Bureau on the number of out-of-network claims paid; (ii) studies the 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.

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 became law on January 1, 2021, and is codified at §§ 38.2-3445.01 through 38.2-3445.07 of the Code of Virginia (Code). It prohibits 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.

Pursuant to subsections A and B of § 38.2-3445.2 of the Code, health carriers offering individual or group health insurance coverage are required to submit certain claims, network, and other information to the Bureau of Insurance (Bureau). The Bureau must notify the Chairs of the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor of this and other information reported to the Bureau in accordance with subsection C of § 38.2-3445.2 of the Code no later than December 1 of each year. This report (i) presents information on the number of out-of-network claims[3] paid by health carriers; (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. Based on the Bureau's analysis of the data provided, the key takeaways include the following:

- Slightly more than one-half of out-of-network emergency services (59.8%), and slightly fewer than one half of out-of-network non-emergency ancillary and surgical services (40.9%) are provided at an in-network facility in Virginia and are fully subject to Virginia's laws;

- The overwhelming majority (93%) of providers reinstated in the same year in which their contract terminated were reinstated at the same payment level as their previous contract;

- The overwhelming majority (89%) of new network providers rejoined at the same payment level as under 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;

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[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 healthcare provider.

- In similar percentages to the prior period, of the 271 resolved arbitration decisions:
    - 156 (58%) were decided in favor of the health carrier, and
    - 115 (42%) were decided in favor of the provider; and

- The percentage of bundled arbitrations increased from 24% in 2021 to 36% in 2022, peaked at 53% in 2023, and then decreased to 34% in 2024, with emergency medicine arbitrations showing the most significant fluctuations throughout this period.

Annual Data Reports

Under Virginia's 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 subsection C of § 38.2-3445.2 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, including variations between the initial payment and final settled amounts.

This is the Bureau's third annual report and provides data and analysis for claims for FY 2024, and arbitration resolutions from November 1, 2023, through October 31, 2024.[4]

[4] For purposes of this report, FY 2024 is the period 7-1-2023 to 6-30-2024.

(i) Counts of Out-of-Network Claims Paid[5]

Number of out-of-network emergency services claims paid

During the three-year period prior to the implementation of the law, the number of emergency claims paid to in-state, out-of-network providers averaged 51.7%. Since the inception of the law, the in-state, out-of-network claim counts have averaged 59.8%. While the percentage has increased in the numbers to date, the law has not significantly impacted the pattern of out-of-network emergency services claims, especially considering any potential impacts of COVID-19, which cannot be isolated from the data.

Out-of-Network Emergency Services Claims Paid (Prior to 1-1-2021)			
Period	**Out-of-Network, Provider In-State Claim Counts**	**Out-of-Network, Out-of-State Provider Claim Counts**	**% In-State, Out-of-Network Claim Counts**
CY 2018	21,300	18,667	53.3%
CY 2019	21,123	18,159	53.8%
CY 2020	20,149	21,673	48.2%
3-Year Total	62,572	58,499	51.7%

Out-of-Network Emergency Services Claims Paid (7-1-2021 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**	**% In-State, Out-of-Network Provider Claim Counts**
FY 2022	44,201	21,646	22,555	49.0%
FY 2023	53,501	32,243	21,258	60.3%
FY 2024	82,382	53,773	28,609	65.3%
3 Year Total	180,084	107,662	72,422	59.8%

[5] 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 under Virginia's balance billing law. 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.

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 40.9% of the total reported claims paid over the entire 3-year period, with a range of 38.3% in FY 2022, compared to 39.7% in FY 2023, with FY 2024 increasing to 45.8%.

Non-Emergency Services Claims Paid (7-1-2021 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**	**% In-State Out-of-Network Provider Claim Counts**
FY 2022	182,570	69,929	112,641	38.3%
FY 2023	142,381	56,559	85,822	39.7%
FY 2024	129,044	59,150	69,894	45.8%
3 Year Total	453,995	185,638	268,357	40.9%

(ii) Health Care Provider Network Contracts Terminated and Reinstated

Health 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 2024. This information also shows which provider contracts were reinstated by the carriers (see links in Attachments A-P1 and A-P2).

Health carriers listed 108 different reasons for terminating providers. The Bureau grouped these reasons into nine categories. Where carriers included a reason for provider terminations, 22.1% were provider initiated, 15.5% were for relocations/moves/left group, 15.5% were voluntary, 13.9% were involuntary/administrative, and 12.9% were for licensing/credentialling reasons.

Reasons for network contract terminations

Network Contract Termination Summary FY 2024								
Reason for Termination	**Plan Initiated**	**% Plan Initiated**	**Provider Initiated**	**% Provider Initiated**	**Mutually Initiated**	**% Mutually Initiated**	**FY 2023 Totals**	**% of FY 2023 Totals**
Involuntary/ administrative	3,175	30.8%	504	3.1%	99	11.6%	3,778	13.9%
Relocation/ move/ left Group	255	2.5%	3,934	24.5%	112	13.2%	4,601	15.8%
Voluntary	0	-	4,213	26.3%	0	-	4,213	15.5%
Licensing/ credentialling Issue	3,804	33.0%	0	-	104	12.2%	3,908	12.9%
Provider Initiated	396	3.8%	5,473	34.1%	144	16.9%	6,013	22.1%
Failure to meet network criteria	405	3.9%	0	-	0	-	405	1.5%
No specific reason given	2,372	23.0%	607	3.8%	4	0.5%	2,983	11.0%
Retired/ deceased/ closed	290	2.8%	1,244	7.8%	147	17.3%	1,681	6.2%
Provider resigned from at least one, but not all, networks	0	-	60	0.4%	241	23.8%	301	1.1%
Totals	10,292	100.0%	16,035	100.0%	851	100.0%	27,178	100.0%

Differences in payment levels prior to termination and after reinstatement

Carriers identified 1,003 providers that were terminated and reinstated in the same reporting period. Of these, 932 (93%) were reinstated at the same payment level. Only 22 (2%) were reinstated at a higher payment level, and 49 (5%) were reinstated at a lower payment level.

Number of Providers Reinstated in the Same Reporting Period FY 2024					
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	-	2	-	-	-
Emergency Medicine	-	-	-	-	-
Hospitalist	-	-	17	-	-
Surgeons	-	-	31	1	-
Other	14	35	912	15	7
Multi-Specialty	-	-	13	-	-
Radiology	-	-	3	-	-
Lab/Pathology	-	-	4	-	-

Reporting carriers identified 692 new-to-network providers that were terminated in a prior year. Of these, 619 (89%) rejoined a network at the same payment level. Only 25 (4%) were reinstated at a higher payment level, and 48 (7%) were reinstated at a lower payment level.

Number of New Providers in FY 2024 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	-	1	3	-	-
Emergency Medicine	-	-	4	-	-
Hospitalist	-	-	11	-	-
Surgeons	-	-	24	1	-
Other	15	32	539	19	5
Multi-Specialty	-	-	26	-	-
Radiology	-	-	12	-	-
Lab/Pathology	-	-	-	-	-

(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 2024. 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 three full fiscal years. The Bureau compared FY 2022-2024 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 ($)	% of Total	FY 2022 ($)	% of Total	FY 2023 ($)	% of Total	FY 2024 ($)	% of Total
Total Claims	13,654,387,985		6,653,187,847		3,941,136,711		5,504,120,091	
ES	1,507,903,281	11.0	333,222,357	5.0	502,136,9678	12.7	657,377,776	11.9
ES for Non-Par Providers	8,251,403	0.1	41,424,246	0.6	24,332,897	0.6	52,130,082	0.9
ES for Non-Par Providers in Virginia	4,728,430	0.03	19,407,766	0.3	10,776,835	0.3	26,576,018	0.5

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

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

As in the previous reports, 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 in the first two reports, 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 1,337 arbitration decisions rendered by arbitrators since the inception of the process, 825 arbitrations (62%) have been decided in favor of the health carrier, and 512 arbitrations (38%) have been decided in favor of the provider.

For this reporting period, there were a total of 271 arbitration decisions rendered, with 156 arbitrations (58%) decided in favor of the health carrier, and 115 (42%) decided in favor of the provider.[6]

Arbitrations Decided From 11-1-2023 to 10-31-2024			
Specialty	**Total Number Decided**	**In Favor of Plans**	**In Favor of Providers**
Emergency Medicine	197	138	59
Anesthesia	17	3	14
Reconstructive Surgery	48	10	38
Non-Emergency (Neurology/Monitoring)	9	5	4
Total	271	156	115

Emergency medicine maintained the majority percentage share of arbitration decisions by provider specialty in 2024 (77% in 2023 and 73% in 2024). A new specialty appeared in 2024 – Neurology/Monitoring, with 3% of the arbitration decisions. Overall, plans continued to prevail in the majority of decisions (58%), down from 62% 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 to participating in the balance billing arbitration process.[7]

[6] 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, 2023, to October 31, 2024).
[7] 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.

A Comparison of Arbitrations Decided During the 2023 and 2024 Reporting Periods						
Specialty	**Total % By Specialty Type**		**% Decided in Favor of Plans**		**% Decided in Favor of Providers**	
	2023	**2024**	**2023**	**2024**	**2023**	**2024**
Emergency Medicine	76.6%	72.7%	71.4%	70.1%	28.6%	29.9%
Anesthesia	3.9%	6.3%	10.0%	17.6%	90.0%	82.4%
Reconstructive Surgery	19.5%	17.7%	36.0%	20.8%	64.0%	79.2%
Neurology/Monitoring	0%	3.3%	0%	55.6%	0%	44.4%
Overall			62%	58%	38%	42%

The following table shows a small decrease in the average award amount for emergency medicine, anesthesia, and plastic and reconstructive surgery. Non-emergency (neurology/monitoring) is a new specialty in the 2024 report.

A Comparison of Average Award Amounts for Arbitrations Decided During the 2023 and 2024 Reporting Periods						
Specialty	**2023 Provider's Pre-Arbitration Average Offer**	**2024 Provider's Pre-Arbitration Average Offer**	**2023 Plan's Pre-Arbitration Offer**	**2024 Plan's Pre-Arbitration Offer**	**2023 Average Awarded Amount**	**2024 Average Awarded Amount**
Emergency Medicine	$1,878.73	$1,621.30	$477.40	$414.27	$865.06	$812.42
Anesthesia	$2,152.70	$1,985.52	$1,290.46	$1,214.68	$2,138.02	$1,799.83
Plastic and Reconstructive Surgery	$21,632.67	$19,388.89	$2,821.79	$2,127.28	$16,098.18	$15,139.36
Non-Emergency (Neurology/ Monitoring)	No Decisions	$35,263.51	No Decisions	$1,198.67	No Decisions	$9,811.72

The following table shows that the percentage of bundled arbitrations increased from 24% in 2021, to 36% in 2022, peaked at 53% in 2023, and then decreased to 34% in 2024, with emergency medicine arbitrations showing the most significant fluctuations throughout this period.

A Comparison of the Percentage of Bundled Arbitrations Decided During the Reporting Periods 2021-2024				
Specialty	**% Bundled 2021**	**% Bundled 2022**	**% Bundled 2023**	**% Bundled 2024**
Emergency Medicine	26%	62%	67%	46%
Anesthesia	18%	20%	30%	0%
Plastic and Reconstructive Surgery	0%	7%	0%	0%
Non-Emergency (Neurology/Monitoring)	No Decisions	No Decisions	No Decisions	11%
Totals	24%	36%	53%	34%

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 11-1-2023 through 10-31-2024.