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, 2025

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
COMMISSIONERS
JEHMAL T. HUDSON • SAMUEL T. TOWELL • KELSEY A. BAGOT

December 1, 2025

Transmitted via Email

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

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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). Then, as provided under subsection C of § 38.2-3445.2 of the Code, the Bureau must notify the chairs of the House of Delegates Committee on Labor and Commerce and the Senate Committee on Commerce and Labor of this and other information reported to the Bureau no later than December 1st of each year.

Accordingly, 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 on 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.

Key takeaways from the Bureau's analysis of the data include the following:

- Slightly more than one-half of out-of-network emergency services (60.3%), and slightly fewer than one-half of out-of-network non-emergency ancillary and surgical services (42.9%) are provided at in-network facilities in Virginia and are fully subject to Virginia's laws;

[1] Chapters 1080 and 1081, respectively, of the 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.

- The overwhelming majority (82%) 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 re-joined 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;

- Similar to the prior period, of the 263 resolved arbitration decisions:
  - 135 (51%) were decided in favor of the health carrier, and
  - 128 (49%) were decided in favor of the provider; and

- The percentage of bundled arbitrations increased from 36% in 2022, peaked at 53% in 2023, decreased to 34% in 2024 and increased to 37% in 2025, with anesthesia arbitrations showing the most significant fluctuations throughout this period.

Annual Data Reports

Pursuant to subsection F of § 38.2-3445.01 of the Code, a health carrier must pay an out-of-network provider a commercially reasonable amount for the services rendered to an enrollee 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 health carrier are required to make a good faith effort to resolve the reimbursement amount. Should they not agree to a commercially reasonable payment amount 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 fifth annual report prepared by the Bureau. Claims data and analysis is provided based on the Commonwealth's fiscal year (FY) from July 1st through June 30th for the year referenced, with FY 2025 data for this report covering the period from July 1, 2024, through June 30, 2025. Information on arbitration resolutions is reported for the period November 1st through October 31st for the year referenced, with the 2025 reporting period covering the period from November 1, 2024, through October 31, 2025.

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

Number of out-of-network emergency services claims paid

As shown in Table 1, during the three-year period prior to implementation of Virginia's balance billing law, the number of emergency claims paid to in-state, out-of-network providers averaged 51.7%. As shown in Table 2, for the last three fiscal years the in-state, out-of-network claim counts have averaged 60.3%. After rising to a three-year high of 65.3%, the number fell back to the pre-2021 average in FY 2025. Based on this, it continues to appear that 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.

Table 1. 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%

Table 2. Out-of-Network Emergency Services Claims Paid, FYs 2023-25

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 2023	53,501	32,243	21,258	60.3%
FY 2024	82,382	53,773	28,609	65.3%
FY 2025	44,846	22,988	21,858	51.3%
3 Year Total	180,729	109,004	71,725	60.3%

[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 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 out-of-network non-emergency services claims paid

As shown in the Table 3, the in-state, out-of-network provider claim counts averaged 42.9% of the total reported claims paid over the entire three-year period, with a range of 39.7% in FY 2023, rising to 45.8% in FY 2024, with FY 2025 decreasing to 43.5%.

Table 3. Non-Emergency Services Claims for Surgical or Ancillary Services Provided by an Out-of-Network Provider at an In-Network Facility, FYs 2023-25

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 2023	142,381	56,559	85,822	39.7%
FY 2024	129,044	59,150	69,894	45.8%
FY 2025	100,481	43,672	56,809	43.5%
3 Year Total	371,906	159,381	212,525	42.9%

(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 2025. This information also showed which provider contracts were reinstated by the carriers (see Attachments A-P1 and A-P2).

Health carriers listed 136 different reasons for terminating provider contracts. The Bureau grouped these into nine categories. As shown in Table 4, where carriers included a reason for provider terminations: 38.9% were voluntary, 25.3% were for relocations/moves/left group, 9.6% were involuntary/administrative, 8.9% were for licensing/credentialling issues, and 6.9% were for the provider resigning from at least one, but not all networks.

Reasons for network contract terminations

Table 4. Summary of Network Contract Terminations, FY 2025

Reason for Termination	Carrier Initiated	% Carrier Initiated	Provider Initiated	% Provider Initiated	Mutually Initiated	% Mutually Initiated	FY 2025 Totals	% of FY 2025 Totals
Involuntary/ administrative	4,211	31.7%	21	0.1%	219	38.6%	4,451	9.6%
Relocation/ move/left Group	339	2.6%	11,414	34.9%	37	6.5%	11,790	25.3%
Voluntary	0	0.0%	18,146	55.4%	0	0.0%	18,146	38.9%
Licensing/ credentialling Issue	4,018	30.2%	20	0.1%	114	20.1%	4,152	8.9%
Provider Initiated	0	0.0%	723	2.2%	0	0.0%	723	1.6%
Failure to meet network criteria	26	0.2%	0	0.0%	49	8.6%	75	0.2%
No specific reason given	1,396	10.5%	769	2.3%	0	0.0%	2,165	4.6%
Retired/ deceased/ closed	330	2.5%	1,418	4.3%	147	25.9%	1,895	4.1%
Provider resigned from at least one, but not all, networks	2,963	22.3%	239	0.7%	2	0.4%	3,204	6.9%
Totals	13,283		32,750		568		46,601	

Differences in payment levels prior to termination and after reinstatement

Health carriers identified 658 providers that were terminated and reinstated in the same reporting period. Of these, as shown in Table 5, 375 (57.0%) were reinstated at the same level, 122 (18.6%) were reinstated at a higher payment level, and 161 (24.4%) were reinstated at a lower payment level. Of the 122 reported to have been reinstated at a higher level, 110 were in the “Other” category. None of the four emergency medicine reinstatements were reinstated at a higher level.

Table 5. Number of Providers Reinstated in the Same Reporting Period, FY 2025

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	3	4	2	-
Emergency Medicine	-	1	3	-	-
Hospitalist	-	-	-	-	-
Surgeons	5	8	25	6	2
Other	61	82	337	100	10
Multi-Specialty	-	-		-	-
Radiology	-	-	6	2	-
Lab/Pathology	-	-	-	-	-
Totals	67	94	375	110	12

As shown in Table 6, health carriers identified 314 new-to-network providers that were terminated in a prior year. Of these, 100% rejoined a network at the same payment level.

Table 6. Number of New Providers in FY 2025 that Terminated in a Prior 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	-	-	5	-	-
Surgeons	-	-	2	-	-
Other	-	-	307	-	-
Multi-Specialty	-	-	-	-	-
Radiology	-	-	-	-	-
Lab/Pathology	-	-	-	-	-
Totals	-	-	314	-	-

(iii) Potential Premium Impact of Changes 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 2025. 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 information from the latest reporting period, the Bureau analyzed claims data representative of the Virginia commercial health insurance market for three full fiscal years. The Bureau compared FY 2023-2025 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 annual reports.

Table 7. Emergency Services (ES) – Allowed Claims, FYs 2023-25

	2017 Oliver Wyman Data ($)	% of Total	FY 2023 ($)	% of Total	FY 2024 ($)	% of Total	FY 2025 ($)	% of Total
Total Claims	13,654,387,985		3,941,136,711		5,504,120,091		5,636,990,328	
ES	1,507,903,281	11.0	502,136,9678	12.7	657,377,776	11.9	784,587,799	13.9
ES for Non-Par Providers	8,251,403	0.1	24,332,897	0.6	52,130,082	0.9	33,348,352	0.6
ES for Non-Par Providers in Virginia	4,728,430	0.03	10,776,835	0.3	26,576,018	0.5	13,385,645	0.2

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

The results in Table 7 show that emergency claims from non-participating providers in Virginia during this reporting period represented 0.2% of total allowed claims and, as in previous reports, were in the range of 0.2% to 0.5%.

To determine the potential impact on premiums, allowed claims would have to be adjusted based on the underlying plan designs of the surveyed carriers. While this has not been possible from a practical standpoint, either in this report or in previous reports, the Bureau would expect the impact on paid claims to be similar to the impact on allowed claims. Applying typical claim costs of between 70% to 90% of premium to the impact on allowed claims, the data would indicate that emergency claims for non-participating providers in Virginia continue to represent an estimated 0.14% to 0.45% of premium.

As reported in previous annual reports, continuing to use the information from Table 7, 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 materially impacted.

This year's findings are similar to previously reported findings, supporting the conclusion that the change in the law has not caused a large influx of out-of-network claims.

(iv) Arbitration Resolution Information

Of the 1,600 arbitration decisions rendered by arbitrators since the inception of the process, 960 arbitrations (60%) have been decided in favor of the health carrier, and 640 arbitrations (40%) have been decided in favor of the provider.

As shown in Table 8, for this reporting period, there were 263 arbitration decisions rendered, with 135 arbitrations (51%) decided in favor of the health carrier, and 128 (49%) decided in favor of the provider.[5]

Table 8. Arbitrations Decided During the 2025 Reporting Period

Specialty	Total Number Decided	In Favor of Plans	In Favor of Providers
Emergency Medicine	152	101	51
Anesthesia	43	15	28
Plastic and Reconstructive Surgery	48	13	35
Neurology/Monitoring	20	6	14
Total	263	135	128

Emergency medicine again accounted for the majority of arbitration decisions by provider specialty in 2025 but fell considerably to 58% from 77% in 2023 and 73% in 2024. The specialty that first appeared in 2024 – Neurology/Monitoring – increased from 3% of the arbitration decisions in 2024 to 8% in 2025. Overall, plans continued to prevail in the majority of decisions (51%), as shown in Table 9, but this percentage continued the decline from 58% in 2024 and 62% in 2023. 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.[6]

[5] See 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, 2024, to October 31, 2025).
[6] Elective group health plans are plans that are self-funded and are not regulated by the Commonwealth of Virginia. To offer balance billing protections for their enrollees, the plan must opt-in to the balance billing law.

Table 9. Comparison of Arbitrations Decided During the 2024 and 2025 Reporting Periods

Specialty	2024 Total % By Specialty Type	2025 Total % By Specialty Type	2024 % Decided in Favor of Plans	2025 % Decided in Favor of Plans	2024 % Decided in Favor of Providers	2025 % Decided in Favor of Providers
Emergency Medicine	72.7%	57.8%	70.1%	65.5%	29.9%	33.6%
Anesthesia	6.3%	16.4%	17.6%	34.9%	82.4%	65.1%
Plastic and Reconstructive Surgery	17.7%	18.3%	20.8%	27.1%	79.2%	72.9%
Neurology/ Monitoring	3.3%	7.6%	55.6%	30.0%	44.4%	70.0%
Overall			58.0%	51.3%	42.0%	48.7%

In Table 10, only anesthesia arbitrations showed an increase in the average amount awarded.

Table 10. Comparison of the Average Amounts Awarded for Arbitrations Decided During the 2024 and 2025 Reporting Periods

Specialty	2024 Provider's Pre-Arbitration Average Offer	2025 Provider's Pre-Arbitration Average Offer	2024 Plan's Pre-Arbitration Average Offer	2025 Plan's Pre-Arbitration Average Offer	2024 Average Awarded Amount	2025 Average Awarded Amount
Emergency Medicine	$1,621.30	$854.50	$414.27	$309.44	$812.42	$603.10
Anesthesia	$1,985.52	$1,983.46	$1,214.68	$953.06	$1,799.83	$1,983.46
Plastic and Reconstructive Surgery	$19,388.89	$15,476.53	$2,127.28	$2,217.97	$15,139.36	$11,904.55
Neurology/ Monitoring	$35,263.51	$4,925.00	$1,198.67	$542.81	$9,811.72	$3,299.92

Table 11 shows that the percentage of bundled arbitrations increased from 36% in 2022, peaked at 53% in 2023, decreased to 34% in 2024 and then increased to 37% in 2025, with anesthesia arbitrations showing the most significant fluctuations throughout this period (30 percentage points from 2023 to 2024).

Table 11. Comparison of the Percentage of Bundled Arbitrations Decided During the 2022 through 2025 Reporting Periods

Specialty	% Bundled 2022	% Bundled 2023	% Bundled 2024	% Bundled 2025
Emergency Medicine	62%	67%	46%	61%
Anesthesia	20%	30%	0%	5%
Plastic and Reconstructive Surgery	7%	0%	0%	2%
Neurology/Monitoring	No Decisions	No Decisions	11%	0%
Totals	36%	53%	34%	37%

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.