SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741

www.scc.virginia.gov

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Administrative Letter 2021-04

TO: All Carriers Licensed as a Managed Care Health Insurance Plan in Virginia, All Life and Health Interested Parties, Contacts for Self-funded Plans Who Opted-in, and the Submitting Party and Receiving Insurer/Administrator Party to a Previous Arbitration Request

RE: Compliance with Virginia's Arbitration Process for Balance Billing Claims

The Bureau of Insurance administers an arbitration process pursuant to § 38.2-3445.02 of the Code of Virginia that addresses balance billing claims disputes between carriers and providers. Along with the Department of Health and the Board of Medicine, the Bureau shares enforcement authority over providers related to potential patterns of violations of § 38.2-3445.01 without corrective action.

This Administrative Letter:

1. Sets a standard for the submission of arbitration requests to address and avoid filings with such frequency as to indicate a general business practice;
2. Reminds the parties involved in a payment dispute of the requirement in § 38.2-3445.01 F to engage in good faith negotiation; and
3. Reminds carriers of the requirement in § 38.2-3445.01 F to pay a commercially reasonable amount.

Section 38.2-3445.05 D provides that "*no carrier or provider shall initiate arbitration pursuant to § 38.2-3445.02 of the Code with such frequency as to indicate a general business practice*."

The Bureau has determined that certain provider groups are filing arbitration requests with such frequency as to indicate a general business practice. The Bureau acknowledges the difficulty in determining and enforcing compliance with a general business practice standard that is based on a percentage of eligible claims. As a result, we are establishing a limit that may not be exceeded for eligible arbitration requests filed, effective immediately**.** The limit shall be as follows:

> **No more than one (1) arbitration request per provider group (or sole health care professional not part of a provider group) during a seven (7) day period.**

This is an aggregate limit, meaning separate requests are not permitted from the same provider group (or sole health care professional who is not part of a provider group) during any seven-day period regardless of geographic area, CPT code, or carrier involved. Each arbitration request may be a bundle of claims, in accordance with the established rules for bundling claims at 14 VAC 5-405-40 I and must be related to one healthcare professional. All other statutory and regulatory requirements regarding the balance billing arbitration process remain the same.

We also remind both health carriers and providers that § 38.2-3445.01 F requires a 30-day period of good faith negotiation. We have observed that in certain disputes between providers and carriers, there is no difference between a carrier's initial allowed amount offer and the offer made following the good faith negotiation period. This strongly suggests that no good faith negotiations between the parties have occurred. The arbitration process is intended only as a last alternative, and only after a concerted effort has been made by both parties to reach agreement on a commercially reasonable payment amount.

Finally, for the arbitration process to work effectively, it is important for carriers and providers to consider the results of previous arbitration decisions and adjust the payment offer during negotiations as appropriate.

We will continue to monitor the arbitration process to ensure compliance with Virginia law. If a carrier or provider has concerns that the standards and requirements discussed in this letter are not being followed, concerns may be submitted to the Bureau for investigation at: BBVA@scc.virginia.gov.

Any questions concerning this Administrative Letter may be addressed to:

Don Beatty
Deputy Commissioner
Policy, Compliance & Administration Division
Bureau of Insurance
Donald.Beatty@scc.virginia.gov
(804) 786-3366

Cordially,

Scott A. White
Commissioner of Insurance