COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, OCTOBER 23, 2020

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

CASE NO. INS-2020-00136

Ex Parte: In the matter of Adopting
New Rules Governing Balance Billing for
Out-of-Network Health Care Services

ORDER ADOPTING RULES

By Order to Take Notice ("Order") entered July 10, 2020, insurers, health care providers, and all other interested persons were ordered to take notice that subsequent to September 1, 2020, the State Corporation Commission ("Commission") would consider the entry of an order adopting new rules in Chapter 405 of Title 14 of the Virginia Administrative Code, entitled "Rules Governing Balance Billing for Out-of-Network Health Care Services" (hereinafter referred to as "Rules"), recommended to be set out at 14 VAC 5-405-10 through 14 VAC 5-405-90, unless on or before September 1, 2020 any person objecting to the adoption of said Rules filed a request for hearing with the Clerk of the Commission ("Clerk").

The Order also required insurers, health care providers, and all other interested persons to file their comments in support of or in opposition to the proposed Rules with the Clerk on or before September 1, 2020.

The proposed Rules are necessary as a result of action by the 2020 General Assembly, specifically Acts of Assembly Chapter 1080 (HB 1251) and Chapter 1081 (SB 172). This legislation, in part, adds §§ 38.2-3445.01 through 38.2-3445.07 to Chapter 34 of Title 38.2 of the Code. These sections become effective January 1, 2021. The provisions of the Bureau's proposed Rules are intended to establish requirements and processes to carry out the provisions

of these new Code sections, which protect consumers from "surprise" balance billing from out-of-network providers for emergency health care services or nonemergency ancillary and surgical services received at an in-network facility. The proposed Rules also set forth procedures for the use of arbitration between health carriers and out-of-network providers to address reimbursement disputes concerning balance billing.

Following entry of the Order to Take Notice, the Bureau received comments from twenty-four (24) stakeholders, including health insurance carriers, health insurance providers, a consumer advocacy organization, and individual citizens. The comments generally were supportive of the proposed Rules and some addressed certain issues for further consideration. No requests for a hearing were filed with the Clerk.

The majority of comments received related to the following three categories: (i) the definitions of "clean claim" and "geographic area" as set forth in 14 VAC 5-405-20; (ii) the jurisdictional scope of balance billing protections as set forth in 14 VAC 5-405-30 A and G; and (iii) the arbitration process as set forth in 14 VAC 5-405-40. The Bureau carefully evaluated all comments and developed a Response to Comments ("Response"), which was filed with the Clerk on October 16, 2020.

As a result of comments filed and additional review by the Bureau, the Response recommends several amendments to the proposed Rules.

First, the Response revises definitions in 14 VAC 5-405-20, including the following:

- "Arbitrator" has been revised to allow only individuals – instead of entities – to apply as an arbitrator;
- "Clean claim" has been revised to remove the timeframe requirement to file a claim;

- The definition of "geographic area" has been removed to allow carriers, providers, and arbitrators more flexibility in resolving balance billing disputes; and
- The definitions of "self-funded group health plan" and "group health plan" have been removed and replaced with "elective group health plan" to avoid confusion about the types of group health plans that may opt-in to the balance billing requirements.

Second, the Response amends 14 VAC 5-405-30 by removing language limiting the prohibition on balance billing to out-of-network providers "located in Virginia." This language has been removed from subsection A for consistency with the statute as written, and subsection G has been removed.

Third, regarding 14 VAC 5-405-40, the Response notes that a Notice of Intent to Arbitrate form has been developed and timeframes have been clarified or changed for consistency with the statute.

Fourth, the Response revises arbitrator qualifications in 14 VAC 5-405-50 to allow for applications from individuals only, consistent with the revised definition of "arbitrator." Additionally, the Response clarifies and revises the conflict of interest requirements to require disclosure to the parties.

Fifth, the Response revises 14 VAC 5-405-60 C to indicate that the Commission will not request adjustments to the data set but will instead accept and implement adjustments in accordance with statutory requirements.

Sixth, consistent with the removal of the definition of "self-funded group plan" and inclusion of the definition of "elective group health plan," the Response replaces reference in 14 VAC 5-405-80 from "self-funded group health plan" to "elective group health plan."

Finally, the Response includes other technical amendments to the proposed Rules for clarification or correction, revises the Notice of Consumer Rights based on comments received, and now includes other related forms that were not developed previously.

NOW THE COMMISSION, having considered the proposal to adopt new Rules, the comments filed, the Bureau's Response and the amendments recommended by the Bureau as a result of the comments, is of the opinion that the attached new Rules and appurtenant forms should be adopted, effective January 1, 2021.

Accordingly, IT IS ORDERED THAT:

(1) Chapter 405 of the new Rules entitled "Rules Governing Balance Billing for Out-of-Network Health Care Services," set out at 14 VAC 5-405-10 through 14 VAC 5-405-90 and forms which are attached hereto and made a part hereof, are hereby ADOPTED effective January 1, 2021.

(2) The Bureau of Insurance forthwith shall give notice of the adoption of the new Rules to all carriers licensed in Virginia to write accident and sickness insurance and to all Life & Health interested persons.

(3) The Commission's Division of Information Resources forthwith shall cause a copy of this Order, together with the revisions to the Rules, to be forwarded to the Virginia Registrar of Regulations for appropriate publication in the *Virginia Register of Regulations*.

(4) The Commission's Division of Information Resources shall make available this Order and the attached amendments to the Rules on the Commission's website: scc.virginia.gov/pages/Case-Information.

(5) The Bureau shall file with the Clerk of the Commission a certificate of compliance with the notice requirements of Ordering Paragraph (2) above.

(6) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

A COPY hereof shall be sent electronically by the Clerk of the Commission to: C. Meade Browder, Jr., Senior Assistant Attorney General, Office of the Attorney General, Division of Consumer Counsel, at mbrowder@oag.state.va.us, 202 N. 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and a copy hereof shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

Project 6423

STATE CORPORATION COMMISSION, BUREAU OF INSURANCE

CHAPTER 405

RULES GOVERNING BALANCE BILLING FOR OUT-OF-NETWORK HEALTH CARE SERVICES

14VAC5-405-10. Purpose and scope.

The purpose of this chapter is to set forth rules and procedures that address balance billing and the use of arbitration between health carriers and out-of-network providers pursuant to the provisions of §§ 38.2-3445 through 38.2-3445.07 of Chapter 34 (§ 38.2-3400 et seq.) of Title 38.2 of the Code of Virginia. This chapter shall apply to all health benefit [and managed care] plans [~~that use a provider network offered~~ issued and delivered] in this Commonwealth except as provided for in § 38.2-3445.06 of the Code of Virginia.

14VAC5-405-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Arbitrator" means an individual [~~or entity~~] included on a list of arbitrators approved by the commission pursuant to [~~14VAC5-405-40~~ 14VAC5-405-50] .

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child, or any other child eligible for coverage under the health benefit plan.

"Clean claim" means a claim (i) [~~that is received by the carrier within 90 days of the service being provided to the enrollee unless submission of the claim within 90 days is not possible due to the provider receiving inaccurate information about the enrollee or the enrollee's coverage; (ii)~~] that has no material defect or impropriety, including any lack of any reasonably required substantiation documentation, that substantially prevents timely payment from being made on the claim; and [~~(iii)~~ (ii)] that includes [~~appropriate~~ required] Internal Revenue Service documentation [~~necessary~~] for the carrier to process payment. A [~~failure by the provider to submit a clean claim will not remove the claim from being subject to this chapter~~ carrier shall notify the person submitting the claim of any defect or impropriety] .

"Commercially reasonable payment" or "commercially reasonable amount" means payments or amounts a carrier is required to reimburse a health care provider for out-of-network services pursuant to § 38.2-3445.01 [and § 38.2-3445.02] of the Code of Virginia.

"Commission" means the State Corporation Commission.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract, or plan covering the eligible employee.

["Elective group health plan" means (i) a self-funded group health plan providing or administering an employee welfare benefit plan as defined in § 3(1) of ERISA, 29 USC § 1002(1), that is self-insured or self-funded with respect to such plan and that establishes for its enrollees a network of participating providers, or a self-funded group health plan for local government employees, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees; and (ii) elects to participate in the requirements of §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia by notifying the commission in accordance with 14VAC5-405-80.]

"Emergency medical condition" means, regardless of the final diagnosis rendered to an enrollee, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition (i) a medical screening examination as required under § 1867 of the Social Security Act (42 USC § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 USC § 1395dd (e)(3)) to stabilize the patient.

"Enrollee" means a policyholder, subscriber, covered person, participant, or other individual covered by a health benefit plan.

"ERISA" means the Employee Retirement Income Security Act of 1974 (29 USC § 1001 et seq.).

"Facility" means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

[~~"Geographic area" means any of the following: (i) for the purpose of determining a cost-sharing requirement under a health benefit plan, a geographic rating area established by the commission; or (ii) for the purpose of providing data to assist in determining a commercially reasonable amount and resolving payment disputes, the health planning region as defined at § 32.1-102.1 of the Code of Virginia, the geographic rating area established by the commission, or other geographic region representative of a market for health care services as determined by a working group established pursuant to § 38.2-3445.03 of the Code of Virginia.~~]

[~~"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.~~]

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. ["Health benefit plan" also includes an elective group health plan.] "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431 of the Code of Virginia.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Initiating party" means the health carrier or out-of-network provider that requests arbitration pursuant to § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40.

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"Managed care plan" means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01 of the Code of Virginia.

"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"Provider group" means a group of multispecialty or single specialty health care [~~providers~~ professionals] who contract with a facility to exclusively provide multispecialty or single specialty health care services at the facility.

["Receipt" means five calendar days after mailing or the date of electronic transmittal.]

[~~"Self-funded group health plan" means an entity providing or administering an employee welfare benefit plan, as defined in ERISA, 29 USC § 1002(1), that is self-insured or self-funded with respect to such plan and that establishes for its enrollees a network of participating providers. A self-funded group health plan also includes the state employee health plan and group health plans for local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers, and retirees.~~]

"Surgical or ancillary services" means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

"Written" or "in writing" means a written communication that is [~~only~~] electronically transmitted. [Paper communication is discouraged.]

14VAC5-405-30. Balance billing for out-of-network services.

A. Pursuant to § 38.2-3445.01 of the Code of Virginia, no out-of-network provider shall balance bill or attempt to collect payment amounts from an enrollee other than those described in subsection B of this section for:

1. Emergency services provided to an enrollee by an out-of-network provider [~~located in Virginia~~] ; or

2. Nonemergency services provided to an enrollee at an in-network facility [~~located in Virginia~~] if the nonemergency services involve [otherwise] covered surgical or ancillary services provided by an out-of-network provider.

B. An enrollee who receives services described in subsection A of this section is obligated to pay the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract, which shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographic area. When there is no median in-network contracted rate for the specific services provided, the enrollee's cost-sharing requirement shall be determined as provided in § 38.2-3407.3 of the Code of Virginia. An enrollee who is enrolled in a high deductible health plan associated with a Health Savings Account or other health plan for which the carrier is prohibited from providing first-dollar coverage prior to the enrollee meeting the deductible requirement under 26 USC § 223(c)(2) or any other applicable federal or state law may be responsible for any additional amounts necessary to meet deductible requirements beyond those described in this subsection, including additional amounts pursuant to subsection E of this section and owed to the out-of-network provider in 14VAC5-405-40, but only to the extent that the deductible has not yet been met and not to exceed the deductible amount.

C. When a clean claim is received pursuant to the provisions of subsection A of this section, the health carrier shall be responsible for:

1. Providing an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing requirement determined under this subsection;

2. Applying the in-network cost-sharing requirement under subsection B of this section and any cost-sharing requirement paid by the enrollee for such services toward the in-network maximum out-of-pocket payment obligation;

3. Making commercially reasonable payments for services other than cost-sharing requirements directly to the out-of-network provider without requiring the completion of any assignment of benefits or other documentation by the provider or enrollee;

4. Paying any additional amounts owed to the out-of-network provider through good faith negotiation or arbitration directly to the out-of-network provider; and

5. Making available to a provider through electronic or other method of communication generally used by a provider to verify enrollee eligibility and benefits information regarding whether an enrollee's health benefit plan is subject to the requirements of this section.

D. If the enrollee pays the out-of-network provider an amount that exceeds the amount determined under subsection B of this section, the out-of-network provider shall be responsible for:

1. Refunding to the enrollee the excess amount that the enrollee paid to the provider within 30 business days of receipt [of the later of payment or notice that the enrollee's managed care plan is subject to the requirements of this section] ; and

2. Paying the enrollee interest computed daily at the legal rate of interest stated in § 6.2-301 of the Code of Virginia beginning on the first calendar day after the 30 business days for any unrefunded payments.

E. The amount paid to an out-of-network provider for health care services described in subsection A of this section shall be a commercially reasonable amount [, based on payments for the same or similar services provided in a similar geographic area] . Within 30 calendar days of receipt of a clean claim from an out-of-network provider, the carrier shall offer to pay the provider a commercially reasonable amount. Disputes between the out-of-network provider and the carrier regarding the commercially reasonable amount shall be handled as follows:

1. If the out-of-network provider disputes the carrier's payment, the provider shall notify the carrier in writing [and negotiate in good faith] no later than 30 calendar days after [the earlier of] receipt of payment or payment notification from the carrier;

[~~2. The carrier and provider shall have 30 calendar days from the date of the notice described in subdivision E 1 of this subsection to negotiate in good faith;~~] and

[~~3.~~ 2.] If the carrier and provider do not agree to a commercially reasonable payment amount within the good faith negotiation period and either party [~~chooses~~ acts within the required timeframes] to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration as provided in § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40. A carrier may not require a provider to reject or return claim payment as a condition of pursuing further arbitration.

F. A health carrier shall not be prohibited from [(i)] informing enrollees in a nonemergency situation of the availability of in-network facilities that employ or contract with only in-network providers that render surgical and ancillary services [; or (ii) offering plan designs that encourage enrollees to utilize specific in-network health care providers] .

[~~G. The requirements of this chapter only apply to out-of-network services rendered in Virginia. A carrier's payment for covered services received outside Virginia by an out-of-network provider shall be in accordance with 45 CFR §147.138. An enrollee's payment responsibility for~~

~~services received by an out-of-network provider outside Virginia may be based on such federal rules that allow balance billing.~~]

14VAC5-405-40. Arbitration process.

A. If a good faith negotiation does not result in resolution of the dispute, the health carrier or provider may initiate arbitration by providing [~~written~~ the] notice of intent to arbitrate [form] to the commission and the non-initiating party within 10 calendar days following completion of the good faith negotiation period. The notice shall state the initiating party's final payment offer. [Failure to timely submit the notice of intent to arbitrate shall negate the party's opportunity to seek arbitration for the claim or claims that were the subject of the untimely notice.]

B. [~~Within 30 calendar days following receipt of the notice of intent to arbitrate, the non-initiating party shall provide its final payment offer to the initiating party.~~] Agreement between the parties may be reached at any time in the process. [The arbitration will then be terminated.] The claim shall [then] be paid within 10 calendar days and the matter closed upon agreement [~~or after the arbitration decision~~] .

C. The commission shall maintain a list of qualified arbitrators and each arbitrator's fixed fee on its website.

1. Within five calendar days of the notice of intent to arbitrate, the initiating party shall notify the commission of either agreement on an arbitrator from the list or that the parties cannot agree on an arbitrator.

2. If the parties cannot agree on an arbitrator, within [~~three business~~ five calendar] days the commission shall provide the parties with the names of five arbitrators from the list. Within five calendar days, each party is responsible for reviewing the list of five arbitrators and notifying the commission if there is an apparent conflict of interest with any of the arbitrators on the list. Each party may veto up to two of the named arbitrators. If one name

remains, that arbitrator shall be chosen. If more than one name remains, the commission shall choose the arbitrator from the remaining names.

3. Once the arbitrator is chosen, the commission shall notify the parties and the arbitrator within [~~three business~~ five calendar] days.

4. The arbitrator's fee is payable within 10 calendar days of the assignment of the arbitrator with the health carrier and the provider to divide the fee equally.

D. Both parties shall agree to [and execute] a nondisclosure agreement [~~provided by the commission and executed~~] within 10 business days following receipt of the notice of intent to arbitrate.

E. Within [~~five calendar days after receiving notification of the final selection of an arbitrator~~ 30 calendar days following receipt of the notice of intent to arbitrate] , each party shall provide written submissions in support of its position [as well as the final payment offers] directly to the arbitrator. [At this time, the non-initiating party also shall provide its final offer to the initiating party.] Each party shall include in its written submission the evidence and methodology for asserting that the amount proposed to be paid is or is not commercially reasonable. Any party that fails to make a written submission required by this subsection without good cause shown will be in default. The arbitrator shall require the defaulting party to pay or accept the final payment offer of the non-defaulting party and may require the defaulting party to pay the entirety of the arbitrator's fee.

F. The arbitrator shall consider the following factors in reviewing the submissions of the parties and making a decision requiring payment of the final offer amount of either the initiating or non-initiating party:

1. The evidence and methodology submitted by the parties to assert that their final offer amount is reasonable;

2. Patient characteristics and the circumstances and complexity of the case, including time and place of service and type of facility, that are not already reflected in the provider's billing code for the service;

3. The arbitrator may also consider other information that a party believes is relevant as part of their original written submission, including data sets developed pursuant to § 38.2-3445.03 of the Code of Virginia. The arbitrator shall not require extrinsic evidence of authenticity for admitting such data sets.

G. Within 15 calendar days after receipt of the parties' written submissions, the arbitrator shall issue a written decision requiring payment of the final offer amount of either of the parties. The arbitrator shall notify the parties and the commission of this decision. The decision shall include an explanation by the arbitrator of the basis for the decision and factors relied upon in making the decision and copies of all written submissions by each party. The decision shall also include information required to be reported to the commission, including the name of the health carrier, the name of the provider, the provider's employer or business entity in which the provider has an ownership interest, the name of the facility where services were provided, and the type of health care service at issue. [The claim shall be paid within 10 calendar days after the arbitration decision.]

H. Within 30 calendar days of receipt of the arbitrator's decision, either party may appeal to the commission in accordance with the provisions of 5VAC5-20-100 B based only on one of the following grounds: (i) the decision was substantially influenced by corruption, fraud, or other undue means; (ii) there was evident partiality, corruption, or misconduct prejudicing the rights of any party; (iii) the arbitrator exceeded his powers; or (iv) the arbitrator conducted the proceeding contrary to the provisions of § 38.2-3445.02 of the Code of Virginia, and commission rules in such a way as to materially prejudice the rights of the party.

I. A single provider is permitted to bundle claims for arbitration. Multiple claims may be addressed in a single arbitration proceeding if the claims at issue (i) involve identical health carrier or administrator and provider parties; (ii) involve claims with the same or related Current Procedural Technology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, or in the case of facility services, Diagnosis Related Group (DRG) codes, Revenue Codes, or other procedural codes relevant to a particular procedure, and (iii) occur within a period of two months of one another. Provider groups are not permitted to bundle claims for arbitration if the [health care] professional providing the service is not the same.

J. All written submissions and notifications required under this section shall be submitted electronically. Individual information related to any arbitration is confidential and not subject to disclosure.

14VAC5-405-50. Arbitrator qualifications and application.

A. Any person meeting the minimum qualifications of an arbitrator may submit an application on a form prescribed by the commission. An application fee of up to $500 may be required. The commission shall review the application within 30 days of receipt and notify the arbitrator of its decision.

B. An arbitrator approved by the commission shall meet the following minimum qualifications:

1. Any professional license the arbitrator has is in good standing;

2. Training in the principles of arbitration or dispute resolution by an organization recognized by the commission;

3. Experience in matters related to medical or health care services;

4. Completion of any training made available to the applicants by the commission;

5. Experience in arbitration or dispute resolution; and

6. Any other information deemed relevant by the commission.

C. The applicant shall supply the following information to the commission as part of the application process:

1. Number of years of experience in arbitrations or dispute resolutions;

2. Number of years of experience engaging in the practice of medicine, law, or administration responsible for one or more of the following issues: health care billing disputes, carrier and provider or facility contract negotiations, health services coverage disputes, or other applicable experience;

3. The names of the health carriers for which the arbitrator has conducted arbitrations or dispute resolutions;

4. Membership in an association related to health care, arbitration or dispute resolutions and any association training related to health care or arbitration or dispute resolution;

5. A list of specific areas of expertise in which the applicant conducts arbitrations;

6. Fee to be charged for arbitration that shall reflect the total amount that will be charged by the proposed arbitrator, inclusive of indirect costs, administrative fees, and incidental expenses; and

7. Any other information deemed relevant by the commission.

D. Before accepting any appointment, an arbitrator shall [~~ensure that there is no~~ disclose to the parties any potential] conflict of interest that would adversely impact the arbitrator's independence and impartiality in rendering a decision in the arbitration. A conflict of interest [~~includes~~ may include] (i) current or recent ownership or employment [~~of the arbitrator or a close family member by~~ with] any health carrier; (ii) [~~serving as or having been employed by~~ current or recent ownership or employment with] a physician, health care provider, or a health care

facility; or (iii) having a material professional, familial, or financial conflict of interest with a party to the arbitration to which the arbitrator is assigned. [~~A close family member is generally a spouse, child, or other person living in your home for whom you provide more than half of their financial support.~~]

E. An arbitrator shall ensure that arbitrations are conducted within the specified timeframes and that required notices are provided in a timely manner.

F. The arbitrator shall maintain records and provide reports to the commission as requested in accordance with the requirements set out in § 38.2-3445.02 of the Code of Virginia and 14VAC5-405-40.

G. The commission shall immediately terminate the approval of an arbitrator who no longer meets the qualifications or requirements to serve as an arbitrator. Failure to disclose any known facts that a reasonable person would consider likely to affect the impartiality of the arbitrator in the arbitration proceeding shall serve as potential grounds for termination.

14VAC5-405-60. Data sets.

A. The commission shall contract with Virginia Health Information or its successor to establish a data set and business process to provide health carriers, health care providers, and arbitrators with data to assist in determining commercially reasonable payments and resolving payment disputes for out-of-network medical services rendered by health care providers. This contractor will develop the data sets and business process in collaboration with health carriers and health care providers. The data set shall be reviewed by the advisory committee established pursuant to § 32.1-276.7:1 of the Code of Virginia.

B. The 2020 data set shall be based upon the most recently available full calendar year of claims data drawn from commercial health plan claims and shall not include claims paid under Medicare or Medicaid or other claims paid on other than a fee-for-service basis. The 2020 data

set shall be adjusted annually for inflation by applying the Consumer Price Index-Medical Component as published by the Bureau of Labor Statistics of the U.S. Department of Labor to the previous year's data set.

C. The commission may [~~request~~ implement] other adjustments to the data sets [~~as it deems necessary~~ in accordance with § 38.2-3445.03 of the Code of Virginia] .

14VAC5-405-70. Notification to consumers.

A. The notice of consumer rights shall be in a standard format provided by the commission and available on the commission's website.

B. A health carrier shall provide an enrollee with:

1. A clear description of the [~~health~~ managed care] plan's out-of-network health benefits outlined in the plan documents that also explains the circumstances under which the enrollee may have payment responsibility in excess of cost-sharing amounts for services provided out-of-network;

2. The notice of consumer rights delivered with the plan documents; and

3. An explanation of benefits [~~containing claims from out-of-network providers~~] that clearly indicates whether the enrollee may or may not be subject to balance billing [if it contains claims from out-of-network providers] .

C. A health carrier shall update its website and provider directory no later than 30 days after the addition or termination of a participating provider.

D. A health care facility shall provide the notice of consumer rights to an enrollee at the time any nonemergency service is scheduled and also along with the bill. A health care facility shall provide the notice of consumer rights to an enrollee with any bill for an emergency service. The

notice may be provided electronically. However, a posted notice on a website will not satisfy this requirement.

E. A health care provider shall provide a notice of consumer rights upon request and post the notice on its website, along with a list of carrier provider networks with which it contracts. If no website is available, a health care provider shall provide to each consumer a list of carrier provider networks with which it contracts and the notice of consumer rights. [This list shall be updated on a regular basis.]

14VAC5-405-80. [~~Self-funded~~ Elective] group health plans may opt-in.

A. [~~A self-funded~~ An elective] group health plan [~~that elects to participate in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia,~~] shall provide notice to the commission and to [~~the~~ its] third-party administrator [~~of the self-funded group health plan~~] of their [~~election~~ opt-in] decision on a form prescribed by the commission. The completed form must include an attestation that the [~~self-funded~~ elective] group health plan has elected to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and this chapter, except as described in subsection E of this section. The form will be posted on the commission's public website for use by [~~self-funded~~ elective] group health plans.

B. [~~A self-funded~~ An elective] group health plan [~~that elects to opt-in~~] shall reflect in its coverage documents its participation pursuant to subsection A of this section. The [~~self-funded~~ elective] group health plan or plan administrator shall submit the required form electronically to the commission at least 30 days prior to the effective date. No other documents are required to be filed with the commission.

C. [~~A self-funded~~ An elective] group health plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the [~~self-funded~~ elective] group health plan's plan year.

D. [~~A self-funded~~ An elective] group health plan's election occurs on an annual basis. [A An elective] group [health plan] may choose to automatically renew its election to opt in to §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia on an annual basis or it may choose to renew on an annual basis until the commission receives advance notice from the plan that it is terminating its election as of either December 31 of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commission at least 30 days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

E. [~~Self-funded~~ Elective] group health plan sponsors and their third-party administrators may develop their own internal processes related to member notification, member appeals, and other functions associated with any fiduciary duty to enrollees under ERISA [, if applicable] .

F. A list of all [~~participating entities~~ elective group health plans] shall be posted on the commission's public website, to be updated at least each quarter. Posted information shall include relevant plan information.

G. A carrier that administers [~~a self-funded~~ an elective] group health plan shall, at the time of coverage verification [through electronic and other methods of communication generally used by a provider to verify enrollee eligibility and benefits information] , make information available to a provider of the [~~group's~~ elective group health plan's] participation in the provisions of this chapter.

14VAC5-405-90. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.

FORMS (14VAC5-405)

Notice of Consumer Rights [~~(URL to be provided)~~] , Form 405-A (eff. 1/2021)

Elective Group Health Plan Opt-In, Form 405-B (eff. 1/2021)

Elective Group Health Plan Change/Termination, Form 405-C (eff. 1/2021)

Notice of Intent to Arbitrate, Form 405-D (eff. 1/2021)

Arbitrator Application, Form 405-E (eff. 1/2021)]

Form 405-A (eff. 1/2021)

BALANCE BILLING PROTECTION FOR OUT-OF-NETWORK SERVICES

Starting January 1, 2021, Virginia state law may protect you from "balance billing" when you get:

- ***EMERGENCY SERVICES*** from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital; or
- ***NON-EMERGENCY SURGICAL OR ANCILLARY SERVICES*** from an out-of-network lab or health care professional at an in-network hospital, ambulatory surgical center or other health care facility.

What is balance billing?

- An **"IN-NETWORK"** health care provider has signed a contract with your health insurance plan. Providers who haven't signed a contract with your health plan are called **"OUT-OF-NETWORK"** providers.
- In-network providers have agreed to accept the amounts paid by your health plan after you, the patient, has paid for all required cost sharing (copayments, coinsurance and deductibles for covered services).
- But, if you get all or part of your care from out-of-network providers, you could be billed for the difference between what your plan pays to the provider and the amount the provider bills you. This is called "balance billing."
- The new Virginia law prevents certain balance billing, ***but it does not apply to all health plans.***

Applies	May Apply	Does Not Apply
o Fully insured managed care plans, including those bought through HealthCare.gov o The state employee health plan o Group health plans that opt-in	o Employer-based coverage o Health plans issued to an employer outside Virginia o Short-term limited duration plans	o Health plans issued to an association outside Virginia o Health plans that do not use a network of providers o Limited benefit plans

How can I find out if I am protected?

Be sure to check your plan documents or contact your health plan to find out if you are protected by this law. When you schedule a medical service, ask your health care provider if they are in-network. Insurers are required to tell you (on their websites or on request) which providers are in their networks. Hospitals and other health care providers also must tell you (on their websites or on request) which insurance plans they contract with as in-network providers. Whenever possible, you should use in-network providers for your health care to avoid paying more.

After you receive medical services, your health plan will send you an "Explanation of Benefits" (EOB) that will tell you what you must pay the provider. Save the EOB and check that any bills you receive are not more than the amount listed.

When you *cannot* be balance billed:

If the new law applies to your health plan, an out-of-network provider can no longer balance bill or collect more than your plan's in-network cost-sharing amounts for either (1) emergency care or (2) when you receive lab or professional services (like surgery, anesthesiology, pathology, radiology, and hospitalist services) at an in-network facility.

What should I know about these situations?

Your cost-sharing amount will be based on what your plan usually pays an in-network provider in your area. These payments must count toward your in-network deductible and out-of-pocket limit. If the out-of-network provider collects more than this from you, the provider must refund the excess with interest.

Exception: If you have a high deductible health plan with a Health Savings Account (HSA) or a catastrophic health plan, you must pay any additional amounts your plan is required to pay to the provider, up to the amount of your deductible.

What if I am billed too much?

If you are billed an amount more than your payment responsibility shown on your EOB, or you believe you've been wrongly billed, you can file a complaint with the State Corporation Commission's (SCC) Bureau of Insurance.

To contact the SCC for questions about this notice visit: scc.virginia.gov or call: 1-877-310-6560.

Elective Group Health Plan Opt-in Form

Each self-funded group health plan specified in § 38.2-3445.06 A of the Code of Virginia and self-funded coverage specified in § 38.2-3445.06 C of the Code of Virginia may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia. Such a plan is known as an "elective group health plan."

Complete and **submit this form electronically** to the Virginia State Corporation Commission Bureau of Insurance at BBVA@scc.virginia.gov for each health plan offered by the sponsor with a unique Group Identification Number.

This form must be submitted at least **30 days in advance** of the effective date of the election to participate. The effective date for participation can be **January 1** of any year or the **first day of the group health plan's plan year.**

The effective date for termination must be **December 31** of any year or the **last day of the group health plan's plan year.**

Elective Group Health Plan Information

Please indicate that the elective group health plan is either a (*check one*):

☐ self-funded ERISA group health plan ☐ self-funded non-ERISA local governmental plan

The group health plan must be one of these two types of plans to be eligible to opt in.

Health Plan Name: _____

Number of covered lives in Virginia enrolled in your plan: _____

Group Identification Number: _____

Employer/Sponsor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Designated contact name for inquiries: _____

Phone: _____ Email: _____

Opt-in duration:

☐ One year

☐ Automatic renewal (continuous until terminated by providing notice at least 30 days prior to the end of a calendar year or plan year)

Opt-in effective date:_____ **Opt-in Termination effective date:**_____

Form 405-B (eff. 1/2021)

Your Contact Information (person completing the form)

Name: _____

Phone: _____ Email: _____

Are you a third-party administrator ("TPA") of an elective group health plan? Yes _____ No _____

If Yes, skip to the TPA Information section below.

The TPA must be notified of the decisions identified on this form.

Please provide the name of person contacted at the TPA: _____

Contact was made by: ___ phone ____ email ____ other (explain) _____

Third-party Administrator Information

*If you self-administer, please include your own information.

Administrator Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Name of designated contact for inquiries: _____

Phone: _____ Email: _____

Elective Group Health Plan Opt-in Attestation

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) hereby elects _____ (name of health plan) to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. _____ (name of employer/sponsor) consents to have the information included in this submission appear in the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor name) to elect _____ (name of health plan) to participate in and be bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules.

Signature _____

Title _____

Date _____

Elective Group Health Plan
Opt-in Change/Request for Termination

Each self-funded group health plan specified in § 38.2-3445.06 A of the Code of Virginia and self-funded coverage specified in § 38.2-3445.06 C of the Code of Virginia may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia. Such a plan is known as an "elective group health plan." Each elective group health plan may opt-in to the balance billing and arbitration requirements set forth in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia.

To change opt-in information, to terminate from the opt-in, or make a change to previously submitted information, complete and submit the form as follows:

- **To change opt-in information**, please complete this form, identifying the updated information. If this form contains updated information, please sign the attestation and check here: ☐
- **To terminate from the opt-in or make a change to previously submitted information, complete** and **submit this form electronically** to the Virginia State Corporation Commission Bureau of Insurance at BBVA@scc.virginia.gov for each affected health plan offered by the sponsor with a unique Group Identification Number.

This form must be submitted at least **30 days in advance** of the election to terminate, and as soon as possible to identify a change. The effective date for termination must be **December 31** of any year or the **last day of the group health plan's plan year.**

Elective Group Health Plan Information

Health Plan Name: _____

(☐Check here if changed and provide previous name) _____

Number of covered lives in Virginia enrolled in your plan: _____

Group Identification Number: _____

(☐Check here if changed and provide previous number) _____

Employer/Sponsor Name: _____

(☐Check here if changed and provide previous name) _____

Address: _____ *(☐Check here if changed)*

City: _____ State: _____ Zip: _____

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Designated contact name for inquiries: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Opt-in duration:

☐ One year *(☐Check here if changed)*

☐ Automatic renewal (continuous until terminated by providing notice with this form at least 30 days prior to the end of a calendar year or plan year) *(☐Check here if changed)*

Opt-in effective date:_____ *(☐Check here if changed)*

Opt-in Termination effective date:_____ *(☐Check here if changed)*

Your Contact Information (person completing the form)

Name: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Are you a third-party administrator ("TPA") of an elective group health plan? ☐Yes ☐ No

If Yes, skip to the TPA Information section below.

The TPA must be notified of the decisions identified on this form.

Please provide the name of person contacted at the TPA: _____

Contact was made by: ☐ phone ☐ email ☐ other (explain) _____

Third-party Administrator Information

*If you self-administer, please include your own information.

Administrator Name: _____

(☐Check here if changed and provide previous name) _____

Address: _____ *(☐Check here if changed)*

City: _____ State: _____ Zip: _____

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Name of designated contact for inquiries: _____ *(☐Check here if changed)*

Phone: _____ *(☐Check here if changed)*

Email: _____ *(☐Check here if changed)*

Elective Group Health Plan Opt-in Attestation for Changes

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) requests the changes noted above related to _____ (name of health plan) that participates in and is bound by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. _____ (name of employer/sponsor) consents to have the information included in this updated information, as applicable, appear in the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor name) to act on behalf of _____ (name of health plan) to request these changes.

Signature _____

Title _____

Date _____

Elective Group Health Plan Opt-in Termination Attestation

CERTIFICATION:

By submission of this form, _____ (name of employer/sponsor) hereby elects to end participation of _____ (name of health plan) in the program afforded by §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules. This provides the State Corporation Commission Bureau of Insurance the authority to remove group health plan information from the directory of elective group health plans posted on the website of the State Corporation Commission Bureau of Insurance.

I, _____ (name of authorized representative), attest that I have been designated by _____ (employer/sponsor) to submit the termination of _____ (name of health plan) for participation in §§ 38.2-3445 through 38.2-3445.07 of the Code of Virginia and applicable rules.

Signature _____

Title _____

Date _____

Form 405-D (eff. 1/2021)

To be completed by SCC	SCC Tracking Number:
(rec'd date)	

Notice of Intent to Arbitrate Form

Please complete this form and send it to: BBVA@scc.virginia.gov
Attach a copy of both the notice of payment and payment, if both are available.

This request must be submitted to both the SCC and the non-initiating party within 40 days of the earlier of the initial notice of payment or payment. If not, the request will be rejected.

Claim Payment Negotiation History	Is the patient's plan regulated by the SCC Bureau of Insurance, the state employee health plan, or is it an elective group health plan? *(See Information on back)* Yes No **If "no", do not submit this request.**
Date initial payment(s), including notice of payment(s) received by provider (attach copies):	
Date notice was provided to Non-initiating Party putting claim payment into dispute:	
Date of completion of 30-day period of good faith negotiation:	Name, phone number and email address of the party initiating arbitration:
Date of request to SCC to initiate arbitration:	
Date notice to initiate arbitration was provided to non-initiating party:	

The party requesting arbitration is a:	Health care facility:		License type:	
	Health care professional:		Specialty type:	
	Other health care provider:		Type:	
	Carrier or third-party administrator (TPA):			

Description of health care services provided (including any applicable CPT codes):
Is this request for multiple claims *(must be the same carrier, TPA and provider)*?
Group/plan number (or numbers if multiple claims):
Claim number (or numbers if multiple claims):
Date(s) of service: (if multiple claims, note the date of service for each claim – *must be within two months of one another*)
Carrier or TPA payment amount(s) for each claim:
Initiating party's final offer:
Name of non-initiating party, and name, phone number and email address of its contact person:

Please review important information on the back of this form prior to submitting this request.

Information and Instructions

- Only claim payments made in connection with managed care plans regulated by SCC, the state employee health plan, and self-funded group health plans and other defined eligible health plans according to § 38.2-3445.06 of the Code of Virginia and applicable rules, that have elected to participate in balance billing protections can use the arbitration process, referred to as "elective group health plans." Examples of health benefit plans that are not included are:

  Medicare and Medicaid
  Federal Employee Health Benefit Plans

- Please check the list of elective group health plans at scc.virginia.gov to determine whether a plan has elected to participate in balance billing protections for their members.

- An out-of-network provider or facility providing emergency services or non-emergency services if those services involve surgical or ancillary services at an in-network facility may submit this arbitration request to both the SCC and the non-initiating party if it is believed that the payment made for the covered services was not a commercially reasonable amount. A carrier or an elective group plan may also submit a request for arbitration.

- Upon SCC review and acceptance of a request for arbitration, both the initiating and non-initiating parties must choose an arbitrator from a list of arbitrators approved by the SCC. If the parties cannot agree on an arbitrator, the SCC will choose one and notify the parties, using the process outlined in § 38.2-3445.02 of the Code of Virginia or applicable rules. Within 10 business days of the initiating party notifying the SCC and the non-initiating party of intent to initiate arbitration, both parties must agree to and execute a nondisclosure agreement.

- Once the arbitrator has been chosen, the SCC will send the arbitrator a copy of the Notice of Intent to Arbitrate Form. Both parties have 30 days from the date of notice of intent to arbitrate to make written submissions to the arbitrator. The non-initiating party must provide the initiating party their final offer at this time. The arbitrator's fee is payable within 10 calendar days of the assignment of the arbitrator, with the health carrier and the provider to divide the fee equally. A party that fails to make timely written submissions without good cause shown will be in default and agrees to pay the final offer amount submitted by the party not in default. The arbitrator also can require the party in default to pay expenses incurred to date in the course of arbitration, including the arbitrator's fee.

- No later than 15 calendar days after the receipt of the parties' written submissions, the arbitrator will: Issue a written decision requiring payment of the final offer amount of either the initiating party or the non-initiating party, notify the parties of its decision, and provide the decision as well as additional information described in § 38.2-3445.02 E of the Code of Virginia and applicable rules regarding the decision to the SCC.

Timeline

Day 0: Out-of-network provider submits clean claim to carrier/payer.
Day 30: Carrier/payer pays out-of-network provider.
Day 60: Provider may dispute payment by notifying carrier/payer. Parties are engaged in good faith negotiation.
Day 70: Carrier/payer or provider can request arbitration by sending this form to the SCC and to the non-initiating party. Initiating party must include their final offer with request.
Day 80 (business): Nondisclosure agreement signed 10 business days after request to initiate arbitration is made.
Day 90: Arbitrator is chosen. Commission notifies initiating and non-initiating parties of chosen arbitrator and copies chosen arbitrator.
Day 100: Both parties must make written submissions in support of final offer.
Day 100: Parties each pay arbitrator their half of the applicable fee.
Day 115: Arbitrator issues decision.
Day 125: Claim payment is made.

Parties can come to an agreement at any time during this process. Claim must be paid within 10 days of agreement.

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
ARBITRATOR APPLICATION

Please submit this completed form to BBVA@scc.virginia.gov to apply to be an Arbitrator.

Section 38.2-3445.02 of the Code of Virginia directs the State Corporation Commission (SCC) to develop a list of approved arbitrators for use by parties pursuing arbitration of out-of-network balance billing disputes.

The law sets up a process for a baseball style of arbitration that includes:

- a timeline;
- a method for choosing an arbitrator; and
- factors for consideration by the arbitrator before a written decision is issued by the arbitrator requiring payment of the final offer amount of either party to the arbitration.

The SCC proposed Rules Governing Balance Billing for Out-of-Network Health Care Services at 14VAC5-405-50 that outline the minimum qualifications for potential arbitrators. After submission of an application, the SCC will inform the individual of its decision. If selected, the arbitrator's name, fees and other information submitted with the application will appear in a searchable directory on the SCC webpage, available to the public, as well as to health care providers and carriers participating in arbitration.

The SCC will make information available on its website for potential applicants, including applicable webinars and training information regarding the new arbitration process.

Contact Information
Arbitrator Name:
Firm Name, if applicable:

Provide the contact information to which an Arbitration Request should be sent (electronic delivery will be used in most cases)
Email:
Phone:
Fax:
Address:

Please list the fee(s) to be charged for arbitration through this process. The fee(s) stated below must be the final amount, inclusive of indirect costs, administrative fees, and incidental expenses.
Fee(s) for individual claim:
Fee(s) for bundled claims:
Address/manner for paying arbitration fee:

Arbitration/Dispute Resolution Experience

Arbitration certification/other professional license, including year admitted/year license issued:

Report any professional license not in good standing:

Membership in associations related to healthcare, arbitration or dispute resolution:

Completion of any professional arbitration association courses (course name, description and date completed):

Legal practice/health professional positions:

Indicate number of years' experience, percentage of dedication to any of the following activities, and if the following were conducted for health carriers, please provide the name(s):

- Health care billing disputes:
- Carrier and provider/facility contract negotiations:
- Health services coverage disputes:
- Coding expertise or experience (also explain the expertise or experience):
- Practicing attorney:
- Arbitration experience:
- Other applicable experience (include any specific areas of arbitration expertise not identified above):

List your most recent training related to healthcare or dispute resolutions by the American Arbitration Association, the American Health Lawyers Association or a similar entity:

Indicate the name of any training you completed for arbitrator applicants made available by the SCC:
Note: There may be a period when the training has not been developed.

Conflict of Interest

Do you represent insurance carriers: __ Yes, I do __Yes, my firm does __ No
If yes to either, designate the percentage of yours/your firm's practice dedicated to this activity:

Do you represent providers or facilities: __ Yes, I do __ Yes, my firm does __ No
If yes to either, designate the percentage of yours/your firm's practice dedicated to this activity:

Please indicate any (i) current or recent ownership of, or partial ownership of; (ii) material professional, familial, or financial conflict of interest; or (iii) employment with, any health carrier, or health care professional, health care facility or other health care provider:

If applicant performs external reviews for health carriers or independent external reviews, please disclose that here:

Affirmation

Affirmation (to be signed by the individual):

I, _____, do hereby certify that I will adhere to the rules of the arbitration process, and arbitrator reporting requirements and deadlines established pursuant to § 38.2-3445.02 of the Code of Virginia and applicable Rules Governing Balance Billing for Out-of-Network Health Care Services. I agree that neither me nor my firm will use information gained through this arbitration process for any other purpose. I will arbitrate all matters coming before me faithfully and with fairness to all parties and perform all associated duties with due diligence and good faith. I will disclose information, including any potential conflicts of interest to the parties and the Commission as required by applicable rules. My signature acknowledges that the information provided in this application is true and correct and that I have read and understand the requirements of § 38.2-3445.02 of the Code of Virginia, and I agree to be bound by it, along with applicable rules.

Signed_____

Date_____