STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, CALIFORNIA CODE OF REGULATIONS
SECTIONS 1300.71 and 1300.71.31

INITIAL STATEMENT OF REASONS

AVERAGE CONTRACTED RATE METHODOLOGY AND DEFAULT RATE

(Control No. 2017-5223)

Pursuant to Government Code section 11346.2, the Director of the Department of Managed Health Care ("DMHC") submits this Initial Statement of Reasons in support of the proposed adoption of section 1300.71.31 and proposed amendment of section 1300.71, in title 28 of the California Code of Regulations ("CCR").

I. AUTHORITY

California Health and Safety Code section 1341, subdivision (a), authorizes the DMHC to regulate "health care service plans." Health and Safety Code Section 1345, subdivision (f)(1), defines a "health care service plan" as "any person who undertakes to arrange for the provision of health care subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services in return for a prepaid or periodic charge paid by or on behalf of subscribers or enrollees."

Health and Safety Code section 1344 grants the Director of the DMHC ("Director") authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act").

Health and Safety Code section 1371.31, enacted by Assembly Bill (AB) 72 (Bonta, 2016), grants the Director the authority to specify a methodology that health care service plans ("health plans") and delegated entities (collectively, "payors") shall use to determine the average contracted rates ("ACR") for health care services most frequently subject to Health and Safety Code section 1371.9.

Health and Safety Code section 1371.9, enacted by AB 72, requires that if an enrollee receives covered health care services from an in-network facility at which, or as a result of which, the enrollee receives services from a non-contracted individual health professional, the enrollee shall pay no more than the same amount the enrollee would have paid if the health care services were received from a contracted individual health professional. Health plans are required to have this provision in their contracts on or after July 1, 2017.

II. Specific Problems Addressed, and Necessity of Regulations

Overview of AB 72

In 2016, the Legislature enacted AB 72[1] to end the problem of "surprise balance billing" for nonemergency services. Surprise balance billing occurs when a health plan's enrollee receives covered health care services from an in-network facility at which, or as a result of which, the enrollee receives services from a noncontracting individual health professional (also known as an "out-of-network provider" or "noncontracting provider") and the enrollee is billed by the noncontracting provider more than the enrollee's in-network cost-sharing amount. For example, an enrollee may go to an in-network hospital for nonemergency, covered surgery. During the surgery, an anesthesiologist who is not contracted with the enrollee's health plan may provide anesthesia to the enrollee. The enrollee's health plan often does not pay the noncontracting provider's entire bill. Prior to AB 72, that noncontracting provider could balance bill the enrollee for the remainder of the bill. AB 72 protects the enrollee by prohibiting such surprise balance billing.

AB 72 not only prohibits balance billing under the circumstances described above, but it also ensures that the noncontracting provider receives reasonable reimbursement for the health care services provided. AB 72 does so by establishing a default reimbursement rate that the health plan will pay the noncontracting provider. The health plan and noncontracting provider can always agree to an amount other than the default reimbursement rate, and enrollees who have a health plan with out-of-network benefits may voluntarily choose to receive and pay for out-of-network services. However, absent those circumstances, the payor will pay the noncontracted provider the default reimbursement rate.

The default reimbursement rate is the greater of the ACR or 125 percent of the amount Medicare reimburses on a fee-for services basis for the same or similar health care services in the general geographic region in which the services were rendered. Since the default reimbursement rate is the greater of these two rates, the rates are sometimes called the ACR alternative and the Medicare alternative. If one party is unsatisfied after either paying or receiving the default payment, the party may bring the case before the independent dispute resolution process, as established by AB 72.[2]

AB 72 defines ACR as the average of the contracted commercial rates paid by the payor for the same or similar health care services in the geographic region. In other words, the ACR generally means the average amount the payor would have paid a *contracted* provider. AB 72 required payors to file with the DMHC, by July 1, 2017, certain ACR data and related information. Per Health and Safety Code section 1371.31, the information

[1] On October 13, 2016, the Association of American Physicians and Surgeons, Inc. (AAP&S) filed a lawsuit in the United States District Court for the Eastern District of California, alleging that AB 72 violates the United States and California Constitutions. (*AAP&S v. Edmund G. Brown, Jr., et al*, case number 2:16-cv-02441-MCE-EFB, in progress 2018).

[2] This independent dispute resolution process is not part of this proposed rulemaking action.

submitted must include the methodology used to determine the ACR, including the highest and lowest contracted rates for calendar year 2015. This data and information will be used to pay the applicable default reimbursement rate during calendar year 2017. For calendar year 2018, payors must use the same ACR data and information, with the payment adjusted based on the Consumer Price Index (CPI) for Medical Care Services.[3] The fact that the ACR is currently based on the payor's own methodology gives payors some flexibility in the computation of the ACR during 2017 and 2018. Again, absent some other agreement, the payor will pay the noncontracting provider the default reimbursement rate, which is *the greater of* the ACR, or 125 percent of the applicable Medicare rate.

Overview of Proposed Regulation

Although payors currently use their own methodology, as required by AB 72, by 2019, the DMHC *must* specify a standardized methodology. The standardized methodology will be what all payors use to determine the ACR for health care services most frequently subject to Health and Safety Code section 1371.9 (the anti-surprise balance billing statute) from 2019 onward. At a minimum, this methodology shall take into account (1) information from the independent dispute resolution process, (2) the specialty of the individual health professional, (3) the geographic region in which the health care services are rendered, and (4) the highest and lowest contracted rates for those health care services.

As required by the Legislature, this proposed regulation ensures that payors compute the ACR in a manner that best reflects the statutory definition of the ACR. This methodology addresses the four minimum statutorily-required considerations noted above, as well as other necessary elements identified during the ACR methodology development stakeholder process. By providing payors with a standard way to compute the ACR for the health care services most frequently subject to Health and Safety Code section 1371.9, the methodology ensures a uniformly reasonable default reimbursement for noncontracting providers. It also generally clarifies how payors must comply with the requirement to pay the AB 72 default reimbursement rate. These proposed regulations also make a minor amendment to existing Rule 1300.71, regarding claims settlement practices, to reference the new proposed Rule 1300.71.31.

The specific problems addressed and the necessity of the proposed regulations are described in greater detail in the following paragraphs.

Specific Problems Addressed and Necessity of Regulation

As a whole, subdivision (a) of proposed title 28, CCR section 1300.71.31 (hereinafter "Rule 1300.71.31"), addresses the problem of ambiguity in key terms and phrases used in Health and Safety Code section 1371.31 that are necessary for compliance with AB 72's default rate requirement. Without this subdivision, payors would likely employ widely varying definitions, and would have no assurance that the DMHC would find those varying definitions to be compliant with the law. Uniformity in key terms has the benefit of clarity for complying entities, as well as efficient compliance and enforcement review by the

[3] The CPI adjustment serves as a temporary inflator, which is used to adjust the payor's 2015 ACR data.

DMHC. These definitions are also necessary to ensure reasonable uniformity in payment of the required AB 72 default rate, which ensures that noncontracting providers are paid appropriately by all payors subject to AB 72.

Subdivision (a)(1) defines “average contracted rate” in a manner that is both consistent with the statute, and that clarifies that for services most frequently subject to Health and Safety Code section 1371.9, the average is a claims-volume weighted mean, which is further clarified in proposed subdivision (c). This subdivision also clarifies the relevant period of time (“applicable calendar year”) that should be considered when the payor calculates the ACR. Although the statute specifies that payors shall base the ACR on calendar year 2015 for reimbursements during 2017-18, that base year applies only until the DMHC establishes “the standardized methodology under paragraph (3)” of subdivision (a) of Health and Safety Code section 1371.31, i.e., until this proposed regulation is promulgated. After that time, 2015 is no longer the base year for ACR data. Therefore, this definition is necessary to address what year’s contracted rates the payors will use to develop the ACR.

In the proposed Rule, the “applicable calendar year” is defined as two years prior to the current year. For 2019, when the regulation takes effect, the applicable calendar year will be 2017; for 2020, the applicable calendar year will be 2018, and so on. This retrospective base year will give payors enough time to gather the contract and claims data and compute the ACR. It also allows enough time for resolution of most of the claims for health care services incurred during that calendar year (i.e., it allows time for submission of the claim, claims processing by the payor, and completion of the internal dispute resolution processes). The benefit is clarifying how payors comply with Health and Safety Code section 1371.31, giving payors enough time for a complete ACR data set, and ensuring uniform computation and payment of the AB 72 default reimbursement rate.

Subdivision (a)(2) defines “default reimbursement rate.” This provision addresses the confusion and misunderstanding expressed by many payors about what amount is proper to pay pursuant to AB 72. There is confusion about whether the default reimbursement rate is simply the ACR, or whether a payor may simply choose to pay the Medicare alternative. This proposed definition would clarify that AB 72 requires payors to reimburse *the greater* of the ACR or the applicable Medicare rate. This will make clear that the payor must compare those two alternative rates, and pay the greater amount. This ensures that payors understand the required payment for compliance with the law, and ensures that noncontracting providers are reimbursed appropriately.

Subdivision (a)(3) defines “geographic region.” This proposed definition applies the statute’s Medicare definition of geographic region to both of the default reimbursement rate alternatives: the Medicare alternative and the ACR alternative. This definition is necessary because, although the ACR in the statute references “geographic region” where the health care service was rendered, the statute does not actually define the meaning of “geographic region.” Using the same geographic region for both the Medicare and the ACR alternative has the benefit of facilitating an easier comparison of the two amounts, thus making it simpler for payors to determine which amount is greater and then

properly pay the default reimbursement rate.

Subdivision (a)(4) defines “integrated health system,” which like (a)(9) and subdivision (d), discussed below, is necessary to clarify and implement subdivision (a)(3)(C) of Health and Safety Code section 1371.31. That statutory provision directs health plans with a certain business model to refer to a database for ACR data. The DMHC proposes to clarify that the pertinent health plan model an “integrated health system.” The proposed definition is necessary because it describes the business model that would result in the health plan paying a statistically insignificant number or dollar amount of AB 72 claims, meaning the plan shall refer to a statistically credible database to determine the ACR. This helps to ensure efficient compliance review by the DMHC, and clarifies application of the statute for health plans that would otherwise be uncertain about whether they shall refer to a database for rate data.

Subdivision (a)(5) defines “Medicare rate” in accordance with subdivision (a)(1) of Health and Safety Code section 1371.31, and clarifies the applicable year and the applicable type of Medicare rate. This definition clarifies that the Medicare rate from the year in which the health care service is rendered is the relevant value for the default reimbursement rate. This definition further clarifies that the “par” Medicare rate (short for the rate for a provider who “participates” in the Medicare program and accepts Medicare assignment) is the relevant rate. This clarification is necessary so that payors know which Medicare rate to compare to the ACR for the purpose of payment of the default rate. Using the year in which the health care service was rendered is consistent with Medicare payment, and makes sense in light of the fact that the rate effective in the year in which the service was rendered will be available, and does not depend on collating a previous year’s data (which is a concern for the ACR alternative). Additionally, the “par” Medicare rate is necessary since it is akin to the average “contracted” rate alternative, allowing for an appropriate comparison of the two rates for the purpose of payment of the default reimbursement rate. These points of clarification address questions received from stakeholders during the informal process, and will result in the benefit that payors will know what Medicare rate is relevant to payment of the default reimbursement rate, leading to uniformly appropriate payment of that rate.

Subdivision (a)(6) defines “payor.” This definition is necessary to clarify that the default reimbursement rate requirements apply to both health plans and entities to which the health plan delegated the responsibility for payment of health care claims (see Health and Safety Code section 1371.31(c)). This definition further clarifies and specifies that the relevant delegated duty of the delegated entity is the responsibility for payment of claims *subject to Health and Safety Code section 1371.9*, the primary anti-surprise balance billing statute. This is necessary to define the scope of the regulation, which applies only to claims subject to Health and Safety Code section 1371.9. This definition avoids confusing entities that are delegated responsibility only for non-AB 72 claims, who might otherwise believe they are subject to the regulation. This provision has the benefit of addressing informal stakeholder questions received during the July 2017, ACR filing process, and avoiding confusion about payment of claims or filings pursuant to this proposed rule.

Subdivision (a)(7) defines “services *most frequently* subject to [Health and Safety Code]

section 1371.9." This definition is necessary because use of the DMHC's ACR methodology is mandatory only for those types of health care services. In preparation for the July 1, 2017, filing of ACR data for the services "most frequently subject to" Health and Safety Code section 1371.9 (pursuant to Health and Safety Code section 1371.31(a)(2)), many filers requested guidance from the DMHC regarding those types of health care services, or what the appropriate threshold is to determine what health care services are "most frequently subject to" Health and Safety Code section 1371.9. In order to address this confusion, it is necessary to define "services most frequently subject to" so that payors understand which health care services are subject to this proposed regulation's ACR methodology. This ensures that there is reasonably uniform application of the proposed methodology by all payors. This regulation specifies that health care services "most frequently subject to" Health and Safety Code section 1371.9 are the top health care services that, when added together, comprise at least 80 percent of the payor's statewide claims volume for health care services subject to Health and Safety Code section 1371.9 in the applicable calendar year. Some payors utilized this threshold in the July 1, 2017 ACR filing, and both the DMHC and the payors found it to be a workable and fair standard.

Subdivision (a)(8) defines "services subject to [Health and Safety Code] section 1371.9." It is necessary to clarify this definition because only those health care services are subject to AB 72, and without clarification, payors may not know which health care services to reimburse according to the AB 72 default reimbursement rate. Further, this definition clarifies that Health and Safety Code section 1371.9 applies an either/or, disjunctive test for relevant noncontracted health care services that either occur at a contracted facility where the enrollee received covered health care services, "or" as a result of those health care services received. This provision is necessary to clarify that AB 72 applies to some noncontracted services that are not rendered in the contracted health facility.[4] It has the benefit of addressing stakeholder questions received about AB 72 during the informal stakeholder process, and ensuring that enrollees are protected by AB 72 to the full extent the Legislature intended.

Subdivision (a)(9) defines "statistically significant," which is necessary to clarify and implement subdivision (a)(3)(C) of Health and Safety Code section 1371.31. That subdivision of the statute states that if, based on a health plan's model, the health plan does not pay a "statistically significant" number or dollar amount of claims subject to AB 72, then the health plan shall use the rate data from a credible database to compute the health plan's ACR. This definition addresses the problem that the term "statistically significant" is ambiguous and, if left undefined, could be interpreted in widely varying ways by health plans. It does not impose a prescriptive standard to what "dollar amount" of claims are statistically significant, because that standard is likely dependent upon on the payor's overall claims volume (i.e., it should be a relative standard.) The proposed definition, which specifies that five or more claims are statistically significant, has the benefit of greater clarity regarding which payors should refer to a statistically credible database in order to determine the ACR.

[4] For example, if an enrollee has blood drawn at an in-network facility but it is sent for processing to an out-of-network lab and the resulting report is read by a noncontracting pathologist, the pathology services would be subject to Health and Safety Code section 1371.9 because they were "a result of" a service rendered at an in-network facility.

Subdivision (a)(10) clarifies that the definitions in subdivision (f) of Health and Safety Code section 1371.9 apply for the purpose of this proposed regulation. This provides necessary clarification that the proposed definitions are in addition to those already contained in the statute. The provision has the benefit of clarifying that the noted definitions are not exhaustive, and referring interested individuals to the relevant statutory definitions.

Subdivision (b) clarifies which health care services are subject to the proposed Rule's standardized ACR methodology. Subdivision (b), as a threshold matter, clarifies that the methodology applies only to health care services subject to Health and Safety Code section 1371.9. Subdivision (b) also addresses the confusion regarding whether the AB 72 default reimbursement rate, itself, is mandatory for *all* health care services subject to Health and Safety Code section 1371.9, or only to those health care services "most frequently subject to" the statute. Pursuant to subdivision (a)(1) of Health and Safety Code section 1371.31, the payor must pay the default reimbursement rate for health care services subject to Health and Safety Code section 1371.9 – not only those "most frequently" subject to that section.

Subdivision (b)(1) further clarifies and implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31 by stating that payors shall use the methodology in this proposed regulation to determine the ACR for health care services "most frequently subject to [Health and Safety Code] section 1371.9." The benefit of this provision is that it clarifies when payors must use this regulation's methodology to compute the ACR.

Subdivision (b)(2) clarifies and implements subdivision (a)(1) and (a)(3)(A) of Health and Safety Code section 1371.31. It provides that, while the default reimbursement rate applies to all health care services subject to Health and Safety Code section 1371.9, calculating the ACR using this proposed regulation's standardized ACR methodology is required only for health care services "most frequently subject to" that statute. This provision further clarifies that, for *other* services subject to Health and Safety Code section 1371.9, a payor *may* use the regulation's ACR methodology or it may, instead, employ a different methodology. Therefore, this proposed regulation clarifies that the payor has flexibility in how it determines the ACR for services that are not "most frequently subject to" Health and Safety Code section 1371.9. This has the benefit of clarifying how payors must comply with AB 72, while avoiding an overly prescriptive approach to determining ACR.

Subdivision (b)(3) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31, which expressly requires the standardized methodology to take into account information from the independent dispute resolution process (see Health and Safety Code section 1371.30). This provision has the benefit of fulfilling the requirement of the statute without the DMHC imposing a prescriptive standard, which would be impossible in light of the fact that the independent dispute resolution process did not begin until September of 2017, and no information is currently available from that process.

Subdivision (c) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31, by specifying the methodology payors shall use to determine the ACR for health

care services most frequently subject to Health and Safety Code section 1371.9. Subdivision (a)(3)(F) of Health and Safety Code section 1371.31 required the DMHC to consult with interested parties throughout the process of developing the ACR standards, including the Department of Insurance (CDI), payors, providers, and others, and to hold the first stakeholder meeting no later than July 1, 2017. The DMHC complied with this requirement, and held its first stakeholder meeting on the ACR methodology on June 26, 2017, and held an additional stakeholder meeting on September 12, 2017.

Subdivision (c)(1) implements subdivision (a) of Health and Safety Code section 1371.31 by specifying that payors shall calculate the ACR as a health care service claims volume-based mean,[5] for each health care service procedure code.

Example:
For hypothetical health care service code "Z", and for a particular combination of the elements described in subdivision (c)(3) of this proposed Rule, the payor's allowed amounts under its various contracts are: Contract A ($10), Contract B ($15), Contract C ($12). During the applicable calendar year, the payor paid 25 claims under Contract A, 30 claims under contract B, and 45 claims under contract C.
Accordingly:
($10x25)+($15x30)+($12x45) / (100 total claims)
= a base ACR rate of $12.40 for CPT code Z.

This approach to calculating the ACR is necessary to implement the statutory definition of ACR, which is the average of the commercial rates "paid" by the payor, as specified. This has the benefit of including in the average the number of claims paid at each contracted rate, and avoiding unduly weighting the average in favor of low-volume contracts. Since a large majority of payors currently use a claims-weighted mean approach for the ACR, this proposed Rule also has the benefit of avoiding undue disruption to existing business operations.

Subdivision (c)(2) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31, which requires the DMHC's standardized ACR methodology to "ensure that the plan includes the highest and lowest contracted rates." While this regulation uses a claim-volume based mean to calculate the ACR, this subdivision specifies that the payor is required to include the highest and lowest contracted rates in that calculation. Therefore, the calculation of "mean" for those highest and lowest contracted rates must be based on at least one (1) claim paid at that rate. This is because if zero claims were paid at that rate, then that rate would effectively be excluded from the average, in direct conflict with the statute. This provision therefore has the benefit of ensuring that the payor's highest and lowest contracted rates are included in compliance with AB 72.

Subdivision (c)(3) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31, which contains the minimum statutorily required elements that must be taken into account in the DMHC's standardized ACR methodology. This provision requires that the payor calculate the ACR for health care service codes most frequently subject to Health

[5] A "mean" is a type of average, where the sum of data points is divided by the number of data points.

and Safety Code section 1371.9 for each combination of these factors: geographic region, provider type and specialty, and facility type. Geographic region and provider specialty are expressly required by the statute. Further, the stakeholder process leading up to the July 1, 2017, ACR filing demonstrated to the DMHC that "provider type" (such as "physician" or "non-physician") and facility type (such as "hospital" or "ambulatory surgery center") often result in differing contracted rates for the same health care services. Therefore, it is necessary for payors to determine and pay the ACR in light of the application of each of these factors.

Partial Example:
For hypothetical health care service code "Z", the payor would calculate the mean, pursuant to the proposed Rule, for each of the following combinations:

- Geographic region [A], Non-physician, Hospital = $__ base ACR
- Geographic region [A], Physician, Hospital = $__ base ACR
- Geographic region [A], Specialist [X], Hospital = $__ base ACR
- Geographic region [A], Non-physician, Ambulatory Surgery Center = $__ base ACR
- Geographic region [A], Physician, Ambulatory Surgery Center = $__ base ACR
- Geographic region [A], Specialist [X], Ambulatory Surgery Center = $__ base ACR
- Geographic region [B], Non-physician, Hospital = $__ base ACR

Subdivision (c)(4) implements and clarifies subdivision (a)(3) of Health and Safety Code section 1371.31 by stating that the payor shall calculate the ACR pursuant to this Rule using un-modified health care service procedure codes, except as specified. Payment modifiers should not factor into calculation of the base ACR, pursuant to subdivision (c)(1) of this proposed Rule. This provision has the benefit of clarifying that the ACR for a given service code is a base rate, with any necessary reimbursement modification for the specific case applied at the time of reimbursement. It also allows for the ACR to be easily compared to the Medicare rate, as the Medicare rate is similar to an unmodified allowed amount. In contrast, an ACR methodology that would require separate calculation of each health care service code for each possible modifier would exponentially increase the number of ACRs a payor would have to calculate. That approach would be inappropriate because payment modifiers should be applied according to the particular claim at hand, consistent with subdivision (c)(5) of the proposed Rule. However, there is an exception for payment modifiers "26" (professional component) and "27" (technical component) because those modifiers are typically developed by payors as stand-alone rates. In other words, payors typically have a contracted rate each for CPT code "Z": "Z with modifier 26", and "Z with modifier 27," as distinct rates. Therefore, it is necessary to treat health care service codes with those modifiers as distinct codes for the purpose of ACR calculation.

Subdivision (c)(5) implements subdivision (a) of Health and Safety Code section 1371.31 by clarifying that, after determining that the base ACR calculated pursuant to this Rule, the payor shall make appropriate, claim-specific adjustments to the reimbursement to the noncontracted provider. Although, as stated above, it is appropriate to exclude most modifiers from the calculation of the base ACR pursuant to proposed subdivisions (c)(1)-(3), the relevant modifiers and other factors should be applied to the reimbursement due to the noncontracting provider, at the time of reimbursement. This has the benefit of

ensuring that the payment is consistent with contracted rates paid, as required by Health and Safety Code section 1371.31.

Subdivision (c)(6) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31, which requires the standardized ACR methodology to take into account health care service provider specialty. Specifically, the DMHC learned during the informal stakeholder process that anesthesia services are typically billed by multiplying an anesthesiology "conversion factor" by the sum of certain "units" applicable to a claim (including base units, time units, and physical status modifiers). Accordingly, this provision specifies that, for anesthesiology services, the "conversion factor" in each of the payor's contracts is the applicable "allowed amount" that should be averaged to determine the base ACR. This provision further explains that the relevant units are among the factors by which a particular AB 72 claim for reimbursement of anesthesiology services should be adjusted, consistent with proposed (c)(5). This has the benefit of addressing the anesthesiology specialty and its attendant, unique billing requirements, thus ensuring proper payment of the default reimbursement rate, as required by Health and Safety Code section 1371.31.

Subdivision (c)(7) implements subdivision (a)(3)(A) of Health and Safety Code section 1371.31 by clarifying which claims should be excluded when a payor calculates the ACR for a health care service. Subdivision (c)(7)(i) addresses case rates and global rates, for instances where a payor has negotiated with a provider to pay a single rate for an entire course of treatment even if it involves several distinct services. An example of this scenario would be a knee replacement case, where all services (surgery, anesthesia, post-op recover, etc.) would be included under one rate. This provision clarifies that case rates and global rates should be excluded when the ACR is being calculated because the ACR is calculated for a single health care service code. Including case and global rates would require payors to break down the case or global rates to separate rates for each involved health care service code. Those rates would not reflect actual contracted commercial rates, and therefore would be outside the scope of Health and Safety Code section 1371.31. However, there is an exception to the exclusion of case rates only where the health care service code itself (rather than a case rate defined in the payor's contract) represents a course of treatment. One example is CPT code 59400 for Vaginal Delivery, Antepartum and Postpartum Care Procedures. In other words, the exceptions are those health care service codes that reflect a case rate because, in that instance, it is possible for the payor to calculate the per-code ACR, and so those claims should be included in calculation of the ACR.

Further, for the same reasons applicable to (c)(7)(i), subdivision (c)(7)(ii) clarifies that payors should exclude from the ACR calculation claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation, which are flat payments to providers, per enrollee/per month, and which cannot feasibly be separated into per-code contracted rates.

Subdivision (c)(7)(iii) clarifies that denied claims should be excluded from the ACR calculation, which is necessary because those claims are outside the definition of ACR,

which is based on “rates *paid*” (see Health and Safety Code section 1371.31(a)).

Finally, subdivision (c)(7)(iv) clarifies that payors should exclude from the calculation of ACR claims those that are not in final disposition status (i.e., rates that are not the final amount paid by the payor), including disputed claims. This is because it would be inappropriate to include in the ACR calculation rates that were ultimately paid at a different amount after the conclusion of the payor’s claims settlement practices and provider dispute process. That is, the ACR calculation should be based on the final amount paid by the payor, in order to implement the statutory ACR definition based on the “rates paid” (see Health and Safety Code section 1371.31(a)).

Subdivision (d) implements and clarifies subdivision (a)(3)(C) of Health and Safety Code section 1371.31. In subdivision (d)(1), the proposed regulation clarifies that the relevant “model” for the purpose of the statute is the “integrated health system.” This provision addresses the problem that the statute indicates that the database shall be used when a health plan has a statistically insignificant number or dollar amount of AB 72 claims “based on the health care service plan’s model,” without elaboration. This lack of elaboration has resulted in confusion about which health plans shall refer to a database for rate data. This provision of the regulation would clarify that the relevant health plan model is one where the enrollees receive all health care services from a fully integrated provider network. This provision resolves the ambiguity in the statute, and clarifies how health plans should determine the ACR for the purpose of paying the default reimbursement rate.

Subdivision (d)(2) clarifies and implements how the payor who operates an integrated health system shall use the database. This provision addresses the problem that some payors who operate integrated health systems were uncertain about whether or how they should pay the AB 72 default reimbursement rate. This subdivision has the benefit of clarifying that the integrated system payor should use the database as a source of rate data for the purpose of the ACR.

Subdivision (e) clarifies and implements the requirement of Health and Safety Code section 1371.31 to pay the default reimbursement rate for health care services subject to AB 72. In subdivision (e)(1), the proposed regulation clarifies that the default reimbursement rate applies when the payor and noncontracted provider have not agreed to a different rate, and outside of circumstances where an enrollee with an out-of-network benefit (such as a Preferred Provider Organization) has voluntarily sought care from a noncontracting provider. This provision addresses the confusion about what circumstances require payment of the AB 72 default reimbursement rate. It has the benefit of clarifying how payors must comply with the default reimbursement rate. It also has the benefit of effectuating the Legislature’s intent that health plans and providers should remain free to negotiate reimbursement rates, and that enrollees who have a health plan with out-of-network benefits should be free to exercise that coverage option.

Subdivision (e)(2) requires the payor to indicate on claims payment documents the manner by which the payor satisfied the requirement to pay the default reimbursement rate (i.e., whether the payor paid the ACR alternative, or the Medicare alternative, etc.) This provision addresses the problem that, without this information, it will be difficult for the

DMHC to determine a payor's compliance with the AB 72 default reimbursement rate requirements, either for the purpose of compliance review or enforcement actions. This proposed requirement has the benefit of facilitating efficient review by the DMHC.

Subdivision (f) implements Health and Safety Code section 1371.31 by specifying what documents payors must file with the DMHC. Subdivision (a)(3)(B) of Health and Safety Code section 1371.31 expressly requires this filing, and this regulation clarifies that it must be filed by August 15, 2019, which is the due date for quarterly financial filings required under other sections of the Health and Safety Code. This has the benefit of informing payors of when to submit the required filing, and has the benefit of leveraging an existing financial filing due date, which may lessen the impact on payors. The regulation imposes this one-time reporting requirement for policies and procedures (with follow-up submissions, if the payor chooses to amend the documents) related to the payor determination of the ACR. The DMHC has determined that the reporting requirement contained in this regulation is necessary for the health, safety or welfare of the people of the State of California.

This regulation package also proposes to amend the existing Rule 1300.71, regarding claims settlement practices, by referencing the proposed Rule 1300.71.31. This reference clarifies that the existing claims settlement rules continue to apply for non-AB 72 claims, and forestalls confusion about whether proposed Rule 1300.71.31 conflicts with existing Rule 1300.71.

DOCUMENTS RELIED UPON

- Health and Safety Code sections 1371.31, 1371.9;
- Title 28 CCR Rule 1300.71;
- Informal Comments to AB 72 Independent Dispute Resolution Process (IDRP), California Association of Health Plans, July 17, 2017;
- Essential Hospitals Institute, Integrated Health Care, Literature Review, available at http://2c4xez132caw2w3cpr1il98fssf-wpengine.netdna-ssl.com/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf;
- Report from Maximus, Inc.: Recommendations for Standardized Methodology for Calculation of ACRs Under AB72; and,
- California Health Benefits Review Program, Analysis of California Assembly Bill AB 533, Out-of-Network Coverage, a Report to the 2015-2016 California State Legislature, January 7, 2016.

REASONABLE ALTERNATIVES TO THE REGULATION

Pursuant to Government Code Section 11346.2(b)(4)(A), the DMHC shall describe reasonable alternatives that were considered by the DMHC or that have otherwise been identified or brought to the attention of the DMHC and that are proposed as more

effective in carrying out the purpose for which the above action is proposed, or are proposed as equally effective and less burdensome to affected private persons than the proposed action, or are proposed as more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The DMHC conducted numerous pre-notice discussions pursuant to Government Code section 11346.45. Through written and verbal comments submitted during stakeholder workshops, and through review of the ACR methodologies currently used by payors, the DMHC considered many alternative approaches presented by the stakeholders. Based on written and verbal comments from stakeholders, the DMHC developed the proposed regulation. The DMHC finalized the proposed regulation after considering written comments from stakeholders. The proposed regulation meets the demands of the individuals and businesses that will utilize the regulation on a daily basis.

The following alternatives were considered:

As a threshold matter, the DMHC considered whether it was even necessary to promulgate a regulation to specify the ACR methodology. As noted previously, payors are currently required to use their own methodology to determine the ACR and pay the default rate for AB 72 claims. Accordingly, the DMHC considered whether payors could be allowed to continue using their own methodologies. However, the DMHC determined that forgoing rulemaking in favor of the status quo is not a reasonable alternative to the proposed regulation because AB 72, as stated in Health and Safety Code section 1371.31(a)(3), expressly requires the DMHC to specify a *standardized* ACR methodology. To satisfy that Legislative directive, it is necessary for the proposed Rule to clarify and specify the type of average that payors shall use, the data that shall be put into the average formula, and the meaning of key terms necessary for compliance with Health and Safety Code section 1371.31. However, the DMHC has observed that a large majority of payors already use a claims-weighted mean approach for the ACR methodology, and so the proposed regulation will not have a large effect on the way in which those payors calculate their ACRs.

Pursuant to Government Code section 11346.2(b), the DMHC considered whether a performance standard, rather than a prescriptive standard, for the ACR methodology would be a reasonable alternative. For example, a performance standard might specify that the ACR methodology shall be a statistically credible average of a payor's relevant commercial rates paid. However, the DMHC determined that this type of performance standard would be inconsistent with Health and Safety Code section 1371.31(a)(3), which requires the DMHC to specify a *standardized* ACR methodology. Otherwise, payors will employ widely varying methodologies, and the proposed Rule would fail to satisfy the statutory requirement to specify a "standardized" methodology. However, the DMHC will consider all reasonable alternatives submitted during the public comment period.

The DMHC considered basing the ACR methodology on the number of payor contracts, rather than basing it on claims paid under each contract. Under a contract-based approach, the denominator in the mean calculation would be the payor's number of contracts, rather than the total number of claims paid for a code. However, the DMHC

has rejected the contract based mean because it is not consistent with the definition of ACR in Health and Safety Code section 1371.31(a), which is based on the average of claims *paid*, and thus should take into account the actual payment of claims at a given rate.

Similarly, the DMHC considered what kind of "average" is appropriate for calculation of the ACR. Specifically, the DMHC considered the alternative of using the "median"[6] as the basis for determining the ACR. The DMHC rejected the "median" alternative because it does not sufficiently include the payor's highest and lowest contracted rates, as required by Health and Safety Code section 1371.31. As noted above, the DMHC determined that a "mean" is the necessary average for the purpose of the ACR methodology.

The DMHC considered using the "non-participating" ("non-par") Medicare rate as the baseline for the Medicare alternative for the default reimbursement rate, rather that the "participating" Medicare rate. However, the DMHC has rejected the non-par approach because it is not analogous to the other default reimbursement rate alternative: the ACR.

The DMHC considered either defining "geographic region" for the ACR alternative according to rating regions or remaining silent as to this definition in the proposed regulation. However, the DMHC rejected these alternatives because it is necessary to use a definition consistent with the meaning of "geographic region" for the Medicare alternative, in order to allow the payor to compare the alternative default reimbursement rates, and pay the greater of them, consistent with Health and Safety Code section 1371.31.

The DMHC considered defining services "most frequently" subject to Health and Safety Code section 1371.9 according to the most frequent code occurrences (e.g., the top ten codes), but determined that this would be inappropriate because a single number of codes could not be chosen that would reliably include the majority of AB 72 claims for all payors. Similarly, the DMHC rejected an approach that would simply apply to the top percentage of health care service claims because that approach does not ensure that most AB 72 claims will be defined using the standardized methodology, which is inconsistent with Health and Safety Code section 1371.31's requirement for a standardized methodology. The DMHC also considered defining the term "most frequently subject to [Health and Safety Code] section 1371.9" according to the top percentage of AB 72 claims within broad service categories (e.g., anesthesia services), instead of across all service categories. However, the DMHC determined that a category-based approach could exclude some of the more frequently-claimed health care service codes, which is inconsistent with Health and Safety Code section 1371.31.

The DMHC considered defining "statistically significant" according to claims volume criteria used in the Medicare and TRICARE programs, but rejected those approaches since reimbursement under those programs is based on a percentile of billed charges

[6] A "median" is the value at the midpoint of a range of values.

and is therefore more prone to influence by outliers and requires a higher threshold for statistical significance, compared to reimbursement based on ACR.

The DMHC considered requiring the ACR to be calculated for each unique combination of procedure code and payment modifier, but rejected this approach because it is infeasible and would greatly diminish the sample sizes available for calculating the ACR by distributing the same root service code across multiple modified variants.

The DMHC considered addressing the unique billing concerns attendant to anesthesia services by requiring calculation of the average rate for each anesthesia service code, but rejected this approach as inconsistent with the way contracted anesthesia claims are actually paid (based on application of a conversion factor to the sum of relevant units), meaning that approach would be inconsistent with Health and Safety Code section 1371.31.

The DMHC considered whether the health care service code could be an appropriate proxy for health care provider "specialty." However, the DMHC rejected this approach because the statute expressly requires the methodology to take into account provider specialty, and the DMHC currently lacks assurance that the health care service code always indicates provider specialty.

The DMHC considered categorically excluding from the Rule health care services either incurred by specific provider types or incurred in particular settings. The DMHC rejected this approach because it is not necessary and could exclude services that are properly subject to AB 72, under certain circumstances.

The DMHC will consider all reasonable alternatives submitted by members of the public during the comment period.

BENEFIT OF THE REGULATION

This regulation is intended to implement the AB 72 solution to the problem of "surprise balance billing" of enrollees by ensuring that the noncontracting provider receives reasonable reimbursement for the costs of the provided non-emergency health care services. AB 72 and this regulation do this by establishing a default reimbursement rate that the health plan will pay the noncontracting provider. The health plan and noncontracting provider can always agree to an amount other than the default reimbursement rate, and enrollees who have a health plan with out-of-network benefits may voluntarily choose to receive and pay for out-of-network services. However, absent those circumstances, the health plan or delegated entity will pay the default reimbursement rate for the health care services. The default reimbursement rate is the greater of the ACR or 125 percent of the amount Medicare reimburses on a fee-for services basis for the same or similar health care services in the general geographic region in which the services were rendered. If one party is unsatisfied after either paying or receiving the default payment, the party may bring the case before the independent

dispute resolution process, as established by AB 72.[7]

ECONOMIC IMPACT

The DMHC has determined that the proposed Rule will not have a significant statewide economic impact.

As required by AB 72, the proposed regulation establishes a standardized methodology that payors shall use to determine the ACR for services most frequently subject to surprise balance billing, starting in January 2019. As noted in this document, this methodology will factor into how a health plan pays a noncontracting provider's "claims" for reimbursement for health care services.

I. Baseline for Economic Impact: The AB 72 Default Reimbursement Rate

To assess the economic impact of this proposed regulation, the DMHC considered the "baseline" status under existing laws and regulations governing payment of AB 72-type claims. While the proposed methodology established by the DMHC will be new, payors have always had to determine what rate to pay noncontracted providers.

Prior to enactment of AB 72 and until July 1, 2017, for non-Preferred Provider Organization (PPO) and non-Point of Service (POS) health coverage, Rule 1300.71(a)(3)(B) required payors to reimburse noncontracted providers the "reasonable and customary value for the health care services" based on information that took into account six factors (often referred to as the "*Gould*" criteria or factors[8]). Determining the reimbursement rate on a case-by-case basis for each service after considering six factors was a time-consuming and detailed process for payors. In fact, some payor-stakeholders explained that application of the *Gould* factors – required under pre-AB 72 law – often necessitated expert economic analyses and extensive collection of information related to the rates that the provider received from other payors.

In contrast, pre-AB 72, for services rendered to PPO and POS enrollees by noncontracted providers, payors did not have to apply the *Gould* factors, but they still had to use the claims payment process. Specifically, the PPO or POS payor would pay the noncontracted provider the amount set forth in the Evidence of Coverage (or "EOC," a document describing health coverage). This reimbursement under PPO and POS products still involved claims processing work for the payor, typically including determination of the maximum allowed amount for a service and evaluation of other claim-related factors that impacted the final reimbursement from the payor to the noncontracted provider. In sum, noncontracted claims payment has always been a required task for payors under existing law, even prior to AB 72.

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[7] This independent dispute resolution process is not part of this proposed rulemaking action.

[8] The *Gould* factors are: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case.

An additional factor in the baseline standard for noncontracted claims payment is AB 72, itself. After the Legislature enacted AB 72, by July 1, 2017, payors submitted to the DMHC the data listing their average contracted rates, their own methodology for determining the average contracted rate, and their policies and procedures to determine the average contracted rate for noncontracted services subject to 1371.9.[9] This data shows that the payors have already established individual methodologies to determine the ACR as required by the statute. And, as further required by statute (Health and Safety Code section 1371.31), since July 1, 2017, payors have used the default reimbursement rate to pay AB 72 claims. Payment based on the default reimbursement rate requires payors to pay either the ACR, based on the payor's methodology, or the applicable Medicare rate, whichever is greater.[10] Importantly, the default reimbursement rate is not necessarily the final reimbursement, as either the payor or the noncontracting provider may challenge the reimbursement amount by submitting a payment dispute to the AB 72 Independent Dispute Resolution Process (IDRP).[11] Through IDRP, an independent review organization will evaluate the information submitted by the parties and determine the appropriate reimbursement amount. The IDRP is not part of this rulemaking action.

II. Scope of Impact: Type and Prevalence of Relevant Health Care Service Claims

The universe of claims that will be subject to the proposed Rule is limited. Health care services subject to the Rule, i.e., health care services subject to Health and Safety Code section 1371.9, are services delivered only under specific circumstances. The only relevant circumstances are when the health plan enrollee receives covered health care services at a contracting health facility at which, or as a result of which, the enrollee receives nonemergency services from a noncontracting individual health professional. Further, Medi-Cal managed care plans and other specified entities contracting with the Department of Health Care Services are categorically exempt from the Rule and the requirement to use the default reimbursement rate. Additionally, health care services rendered by a noncontracting provider that were voluntarily consented-to by an enrollee with an out-of-network benefit (such as a PPO plan), as well as health care services for which the payor and noncontracting provider agreed upon other reimbursement, are not subject to the proposed Rule. Taken together, these parameters mean that AB 72 and this proposed Rule apply to a small portion of total claims for health care services.

Regarding the likely prevalence of relevant health care services claims, a 2016 California Health Benefits Review Program (CHBRP) estimate is instructive. CHBRP analyzed AB 72's predecessor legislation, AB 533.[12] AB 533 applied to a nearly identical set of health care services, so the CHBRP estimate of the prevalence of relevant claims under AB 533 is fairly applicable to AB 72.[13] In its 2016 analysis, CHBRP estimated that of the

[9] Health and Safety Code section 1371.31, subdivision (a)(2).
[10] Health and Safety Code section 1371.31, subdivision (a).
[11] Health and Safety Code sections 1371.30-31.
[12] Assembly Bill (AB) 533 (Bonta, Reg. Sess. 2015-2016). The substance of AB 533 was incorporated into AB 72, as amended June 15, 2016.
[13] Note that the rest of the CHBRP report may be inapplicable for the purpose of assessing the impact of this proposed Rule, as it analyzed the impact of AB 533 (AB 72's predecessor) on the then-existing market. First, the "baseline" for the proposed Rule is post-AB 72, where payors are statutorily required to pay the

California enrollees with health care coverage subject to the surprise balance billing legislation, 0.63% would have a surprise medical bill for inpatient services, and 0.20% would have a surprise medical bill for outpatient services, for a total of **0.83%** of enrollees.[14] The DMHC anticipates that this estimated prevalence of surprise bills – i.e., claims that are now subject to Health and Safety Code section 1371.9– shows the percentage of health care service claims that could be impacted by the proposed Rule under AB 72.

III. Assessment of Impact on Noncontracted Provider Reimbursement

As noted above, payors have been statutorily required by AB 72 to determine and pay the default reimbursement rate since July 1, 2017. However, from July 1, 2017 to December 31, 2018, within certain broad parameters, payors have flexibility to determine their own ACR methodology.[15] The methodology currently used by payors may result in a different ACR reimbursement than that which will result from the proposed Rule's methodology. Accordingly, for the purpose of assessing the proposed Rule's impact on noncontracted provider reimbursement, the DMHC considered the difference between the ACR resulting from the payor-established methodologies in use as of July 1, 2017, and the standardized methodology in the proposed Rule.

Payors submitted information about their ACRs by July 1, 2017, pursuant to Health and Safety Code section 1371.31(a)(2).[16] The DMHC anticipates that this statutorily-required filing shows what ACR methodologies are currently used by relevant payors. The DMHC identified the payor filings submitted by July 1, 2017 that were complete and contained information and data necessary to assess the payor's ACR methodology.[17] In filings from 131 payors, the DMHC observed that 123 (94 percent) employ an ACR methodology based on a "mean" weighted by health care service claims volume. Therefore, the proposed Rule's requirement to use a claims-volume weighted mean will require no substantive change to the way in which the ACR is calculated and will have no economic

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default reimbursement rate. In contrast, the CHBRP report baseline was pre-default rate, as it analyzed the impact *of the AB 533 legislation, itself,* on the marketplace. Second, AB 533's default rate was 100% of Medicare rate, in contrast to the default rate under AB 72, which is the greater of 125 percent of the Medicare rate or the average contracted rate. Therefore, the CHBRP discussion of the impact of the AB 533 default rate is inapplicable to this proposed Rule.

[14] California Health Benefits Review Program, Analysis of California Assembly Bill AB 533, Out-of-Network Coverage, a Report to the 2015-2016 California State Legislature, January 7, 2016, at p. 6.

[15] The statute imposed some broad parameters around the ACR methodology from 7-1-17 to 12-31-2018. Specifically, the payor's methodology had to be an average of contracted commercial rates paid by the payor for the same or similar services in the geographic region, including the highest and lowest contracted rates for calendar year 2015. (Health and Safety Code section 1371.31(a)).

[16] The data regarding a payor's CY 2015 ACR for services most frequently subject to Health and Safety Code section 1371.9, filed pursuant to Health and Safety Code section 1371.31(a)(3)(E) is statutorily deemed to be confidential. Therefore, that data will not be disclosed.

[17] Some payors required to file ACR information pursuant to Health and Safety Code section 1371.31(a)(2) did not file information with detail sufficient to determine or replicate the ACR methodology, and so are excluded from the sample of existing ACR methodologies. For example, four payors described an ACR methodology based on varying percentages of the Medicare rate, but because detailed information about these methodologies is unavailable and because that method is not comparable to the proposed Rule's ACR methodology, these payors are excluded from this discussion.

impact on 94 percent of payors.[18]

Among the other six percent of the sample (eight payors), the DMHC observed payors using the following types of "average" for the purpose of determining the ACR:

- Two payors (1.5 percent) employ an "unweighted median,"
- Five payors (3.8 percent) employ a "weighted median," and
- One payor (0.76 percent) employs a "midrange."

The proposed Rule's requirement to use a claims-volume weighted mean, instead of those other methodologies, may affect the reimbursement paid to noncontracting providers by these eight payors. Actual contracted rates vary depending on the payor, as well as depending on a particular payor's contract, and data regarding individual contracted rates and numbers of services reimbursed at those contracted rates is not available.[19] Accordingly, the DMHC estimated the impact of the proposed Rule's standardized methodology for averaging contracted rates by applying a set of hypothetical data to each of the observed ACR methodologies.

i. Table 1: Hypothetical contracted rate and claims volume data:

For a given health care service subject to Health and Safety Code section 1371.9:	
Payor's contracted rates	**Number of claims**
Contract A: $50	10
Contract B: $60	12
Contract C: $70	10
Contract D: $75	20
Contract E: $80	22
Contract F: $95	14
Contract G: $110	8
Contract H: $130	3
Contract I: $150	1

[18] See Table 2, below, Calculation column, for a description of averages using mean, weighted and unweighted median, and midrange.

[19] Payor data regarding ACRs in effect as of July 1, 2017, filed pursuant to Health and Safety Code section 1371.31, is statutorily deemed confidential (see footnote 16, *supra*). Additionally, the specific rate and claim data that payors used to develop the confidential ACR data is not available.

ii. Table 2: Hypothetical data applied to observed methods of averaging contracted rates:

Method of averaging	**Calculation**	**Value (ACR)**	**% ACR change relative to Proposed Rule**
Mean weighted by claims volume	(50*10+60*12+70*10+75*20+80*22+95*14+110*8+130*3+150*1) / (10+12+10+20+22+14+8+3+1 = 100)	$79.30	Same. No impact.
Unweighted median	Middle rate from among the nine distinct rates	$80.00	-0.875 percent
Weighted median	Value at which half of the services are reimbursed at or below level	$75.00	+5.423 percent.
Midrange	(150+50)/2	$100.00	-20.7 percent

iii. Anticipated Impact to ACR Amount Paid by Payors to Noncontracting Providers:

As previously stated, the DMHC observed eight impacted payors (or six percent of the payor sample) using an ACR methodology other than a mean weighted by claims volume. Those eight payors have an approximate commercial enrollment of 4,225,568. By ACR methodology type, these impacted payors have the following approximate numbers of enrollees in commercial lines of business[20]:

- Unweighted median: 2,243,500 commercial enrollees
- Weighted median: 1,975,544 commercial enrollees
- Midrange: 6,524 commercial enrollees

As noted in section II, above, the DMHC assumes that 0.83 percent of enrollees may receive health care services subject to Health and Safety Code section 1371.9. The number of enrollees of the impacted payors who therefore may be subject to a surprise medical bill is:

- Unweighted median: 18,621 commercial enrollees
- Weighted median: 16,397 commercial enrollees

[20] Regarding enrollment for these payors, the DMHC used the most current available enrollment information. Where the available enrollment data was not broken down by line of business (i.e., commercial and non-commercial), the DMHC estimated the payors' commercial enrollment by noting the percentage of commercial enrollment observed among payors with known, business line-specific enrollment data, and applying that percentage (79%) to the total enrollment for the payors for which the DMHC lacks business line-specific enrollment data.

- Midrange: 54 commercial enrollees

To assess the proposed Rule's ultimate impact to the ACR reimbursement, the DMHC estimated the current ACR for services most frequently subject to Health and Safety Code section 1371.9 by determining the mean value of ACRs used by impacted payors (i.e., payors that currently use an ACR methodology other than a claims-volume weighted mean).[21] For those impacted payors, the mean value of the ACR for all health care services most frequently subject to Health and Safety Code section 1371.9, and across all payment categories, is $660.38. The DMHC determined this is a reasonable estimate of the baseline ACR currently reimbursed by impacted payors.

Given the estimated number of enrollees who will likely receive a health care service subject to Health and Safety Code section 1371.9 (0.83 percent, as calculated above), and the mean ACR for the services ($660.38, as described above), the DMHC estimates the following *total* value of AB 72 claims for impacted payors to be:

- Unweighted median: 18,621 enrollees * $660.38 = $12,296,935.98
- Weighted median: 16,397 enrollees * $660.38 = $10,828,250.86
- Midrange: 54 enrollees * $660.38 = $35,660,52

Considering the total value of AB 72 claims for impacted payors and the relevant cost or savings impact of the proposed Rule's requirement to use a claims-volume weighted mean to determine the ACR, as described in Table 2, the changes to ACR reimbursement are as follows:

- Unweighted median: $12,296,935.98 * -0.875% results in - $107,598.19
- Weighted median: $10,828,250.86 * +5.423% results in +$587,216.04
- Midrange: $35,660,52 * -20.70% results in -$7,381.73

Based on the estimates above, the net estimated change to ACR reimbursement by impacted payors, resulting from the requirement to use a mean weighted by claims volume rather than their current ACR methodology , is +$587,216.04 - $107,598.19 - $7,381.73 = +$472,236.12. This is a cost to impacted payors, and a savings to noncontracted providers.

iv. Note on Use of the ACR:

The proposed Rule, in addition to establishing the formula used to compute the ACR, defines some key terms that will serve as guidance for when the ACR must be used. It defines "statistically significant" claims as five or more claims for health care services subject to Health and Safety Code section 1371.9 for the applicable calendar year. Of the payors who filed data with the DMHC by July of 2017, only 47 indicated that a set number of health care services were required before a payor calculated the ACR for the particular CPT code. Of those 47, 5 claims was the median and mode value. Accordingly, this

[21] See footnote 16, *supra*.

threshold number should not cause any disruption for most payors.

v. Assessment of Impact on Other Requirements in the Proposed Rule:

The DMHC anticipates that the majority of the economic impact of the proposed Rule will result from the requirement to use a mean weighted by claims volume, as discussed above. The proposed Rule contains other parameters for calculation of the ACR, but those are unlikely to result in significant costs or savings.

- Defining the "applicable calendar year" (i.e., the year that supplies the data the payor shall use to calculate the ACR) according to two years prior to the date in which the applicable service was rendered is necessary because that timeframe allows for the payor to settle the claims and develop a complete data set. Additionally, because it is largely consistent with the current baseline, which also uses a retrospective benchmark year, the DMHC anticipates no known economic impact from this definition.[22] Note that only for calendar year 2018, per AB 72, payors will adjust the base rate of 2015 data using the CPI. The statute authorizes only this <u>one-time</u> use of the CPI inflator.
- Defining "geographic region" for the purpose of the geographically-specific ACR (pursuant to Health and Safety Code section 1371.31), to be the same as the geographic region statutorily defined for the Medicare alternative, is both necessary to facilitate easier comparison of the two default reimbursement rate alternatives, and is how most payors currently define ACR geographic region. Since Medicare locality is a well-known construct that payors already use for the Medicare alternative, and since over 90 percent of payors reportedly use Medicare locality for the ACR geographic region as of July 1, 2017, the DMHC anticipates using the same geographic region for the ACR will result in no significant cost and is consistent with current business practice.
- Defining "integrated health system" and "statistically significant claims" is relevant only to clarifying which payors have so little of their own relevant claims that they shall reference a statistically credible *database*, consistent with Health and Safety Code section 1371.31(a)(3)(C), to determine the ACR. Since these payors already use such databases, the DMHC anticipates no cost from these provisions of the proposed Rule. The DMHC understands that most of these payors will use the FAIR Health database, which has been in existence since 2009 and is a nationally known and trusted database for health care cost data.
- Defining "Medicare rate" as the rate from the year in which the service was rendered will result in no cost, as this is consistent with current Medicare billing practices. Additionally, specifying the relevant Medicare rate (the "par" or "participating" rate), shall result in no cost, because the DMHC anticipates that payors are already using that Medicare rate, since it is slightly lower than the non-par Medicare rate.
- Defining services "most frequently" subject to Health and Safety Code section 1371.9 as those services comprising the top 80 percent of the payor's statewide claims volume means that payors will understand when the use of the proposed Rule's standardized methodology is mandatory. The DMHC anticipates that payors

[22] Health and Safety Code section 1371.31, subdivision (a)(2).

will be required to use the proposed Rule's standardized methodology for at least some health care services subject to Health and Safety Code section 1371.9, and that the particular threshold where that methodology becomes mandatory is a nominal impact to the payor's cost. Pursuant to Health and Safety Code section 1371.31(a)(3)(A), the proposed Rule's standardized methodology is mandatory only for the health care services "most frequently" subject to the statute, but payors are free to use the proposed Rule's standardized methodology for *all* services subject to Health and Safety Code section 1371.9.

- Ensuring that payors include the highest and lowest contracted rates, as expressly required by Health and Safety Code section 1371.31(a)(3)(A) and as described in proposed Rule, subdivision (c)(2), is anticipated to result in a minimal cost. The proposed Rule ensures that payors do not exclude the highest and lowest contracted rates, even if no claims were actually paid at those amounts. If payors were to exclude rates for which no claims were paid, they would fail to meet the statutory requirement to include both the highest and lowest contracted rates in their ACR calculation. However, the DMHC anticipates that including data based on only "one" claim paid at the highest and lowest contracted amounts is unlikely to substantially shift the resulting ACR.
- The DMHC anticipates that requiring calculation of the ACR in consideration of the factors described in the proposed Rule's subdivision (c)(3) will not result in a significant cost. Health and Safety Code section 1371.31(a)(3) requires the proposed Rule's standardized ACR methodology to include geographic region and provider specialty; since these are part of the current baseline, they will have no cost impact. Calculating the ACR in consideration of provider type and facility type, as required by the proposed Rule, is likely to result in minimal cost, because these provisions do not require any change in payment. Rather, these requirements mean that where a payor's contracted rates are already different for different provider types or facility type, they shall calculate a distinct ACR. While there will not be a significant impact to the ACR itself, it is also unlikely that this will have a significant administrative cost. Payors consider some, if not all, of these factors when paying claims already and their claims processing systems are likely automated and easily able to accommodate variations and updates in payment factors as a normal business practice.
- The DMHC anticipates that exclusion of payment modifiers (other than 26 and 27, for professional and technical components, which are typically developed as stand-alone rates) during calculation of ACRs will not result in a significant cost. Payment modifiers affect the amount that a payor reimburses a provider for a particular case. For example, modifier "55" reduces the amount paid for surgical follow-up care. However, factoring payment modifiers into the ACR, and then also applying them to a particular claim for reimbursement would effectively include modifiers <u>twice</u>, which is inappropriate. Excluding the modifiers during ACR calculation, but applying the appropriate, relevant modifiers at the time of reimbursement, will therefore result in an insignificant cost impact.
- The DMHC anticipates that the proposed Rule's provisions regarding calculating the ACR for anesthesia services will not result in a significant impact. According to information received by the DMHC, the requirement to use a conversion factor applied to the sum of relevant units and modifiers is consistent with current billing for

anesthesia services, and should therefore not result in a significant change or cost.

- Excluding certain health care claims from the calculation of the ACR is necessary to comply with Health and Safety Code section 1371.31(a), which defines the ACR according to the average of commercial rates *paid*. The large majority of payors reported excluding case rates, capitated rates, and denied claims from their ACR calculation, which is consistent with the proposed Rule. Some payors reported that they included "disputed" claims, but the DMHC anticipates little impact from the proposed Rule's requirement to exclude disputed claims. This is because the proposed Rule does not require exclusion of claims that were, at one point, disputed. Rather, it requires exclusion of claims that are *currently* disputed, i.e., those not in final disposition status. As noted previously, this exclusion is necessary for consistency with the statutory definition of ACR, based on rates "paid." The DMHC anticipates that the payors who apparently include disputed claims in their ACR calculation were referencing claims that were, at one point, disputed, but were ultimately closed. Accordingly, the proposed Rule's requirement to exclude certain claims from calculation of the ACR is unlikely to result in either cost or savings.
- The DMHC anticipates little cost to payors from the requirement to file policies and procedures (P&Ps). First, the filing itself is purely a statutory requirement (see Health and Safety Code section 1371.31(a)(3)(B)). Second, the DMHC proposes to specify the timing of this requirement by adding onto an existing financial filing requirement, which will lessen the impact of this provision in the proposed Rule. Although adding the P&Ps to that existing filing will slightly add to the content of that filing, the DMHC anticipates that the impact is minimal and absorbable, since the statute itself already required the payors to draft the P&Ps, which is the greater part of the task. Payors will simply have to file an additional document in order to comply with this requirement.

IV. Assessment of Impact on Premiums

Increases in payor costs could ultimately result in higher premiums paid by California health coverage enrollees. However, as noted in the previous sections of this economic impact assessment, the cost impact of the proposed Rule will likely be minimal and it is doubtful that any increase in premiums stemming from this Rule will occur. Again, this is because (1) relatively few payors (six percent of the payor sample) will have to substantially change type of average used in their current ACR methodology in order to comply with the proposed Rule, (2) the proposed Rule's methodology is mandatory only for the top 80 percent of relevant health care services, (3) the total pool of relevant health care service claims is tiny in comparison to total claims volume, and (4) for the great majority payors, the proposed Rule's ACR methodology will result in little change to the payor's reimbursement to noncontracting providers. In sum, these impacts are negligible and will not affect health care coverage premiums.

V. Assessment of Impact on Payors' Administrative Costs

While this proposed Rule requires payors to implement a revised, standardized ACR methodology, any short term administrative costs for payors to implement the methodology should be minimal. As mentioned previously, payors have been using a

methodology to determine the ACR since July 1, 2017, and so the use of the Rule's standardized methodology to determine the ACR will not be a new task. The workload required to compute an ACR using the standardized methodology will be offset by the workload saved by not using their own methodology to compute the ACR for a health care service. While there may be some one-time costs associated with implementation of the standardized ACR, such as training staff or updating software used to process claims, necessary data is unavailable to quantify what, if any, potential administrative costs payors may experience because each payor likely has a different system to process and pay claims. However, it is likely that such administrative costs, if experienced, will be minimal, as software systems and staff have already been processing claims using an ACR. Additionally, as noted above, 94 percent of payors already use an ACR methodology similar to the one proposed in the Rule and so they should not experience great disruption to their processing of claims and determination of the ACR.

The specific economic impact on various categories is as follows:

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Creation or Elimination of Jobs Within the State of California

As described in depth above, no new jobs will be created or eliminated in the state of California as a result of the regulation. This methodology pertains to a narrow subset of health care claims, including only health care services subject to Health and Safety Code section 1371.9. Also, payors will have to determine the ACR using the methodology established by the regulation, and this ACR will in turn be considered as one of the default rate alternatives for purposes of reimbursing the noncontracted provider. As stated above and as required by statute, payors already reimburse noncontracted providers in consideration of the ACR. So, while the way in which payors determine the amount to reimburse providers has changed, the amount of work necessary to determine the amount to reimburse should not increase. In fact, some payors may find their own 2017-18 methodology largely consistent with the proposed regulation, or could find the proposed regulation less onerous than their own methodology. Once established, use of the methodology in the regulation will not be any more difficult than use of the payor's own methodology or the *Gould* criteria. Because the amount of work undertaken by payors will not change significantly, no new jobs will be created or eliminated.

Creation of New Businesses or the Elimination of Existing Businesses Within the State of California

As described in depth above, the proposed regulation will neither create new businesses nor eliminate existing businesses. The methodology implemented by the regulation has a narrow application and will not greatly affect the general rate paid for health care services in California, as it is mandatory only for those services most frequently subject to Health and Safety Code section 1371.9. The methodology used to determine the ACR will lead to a fair reimbursement rate and, if either party is dissatisfied, it may submit the matter to

the independent dispute resolution process and argue for a different reimbursement amount. Accordingly, even if use of the methodology results in an unsatisfactory ACR payment to an individual health professional, businesses should not be significantly affected because the amount is subject to adjudication, and further challenge through any other legal remedy available to the parties. Additionally, the DMHC anticipates no significant impact on the ability of health plan enrollees to receive health care services.[23]

Expansion of Businesses Currently Doing Business Within the State of California

As described in depth above, the proposed regulation will not significantly affect the expansion of businesses currently doing business within the state of California. As stated above, prior to the enactment of AB 72, certain payors were required to reimburse noncontracted providers who provided certain services the reasonable and customary value of those services as determined by considering the *Gould* criteria. Other (PPO/POS) payors had claims processing systems in place to pay according to the terms of the particular EOC. The methodology to determine the ACR created by this regulation will require health plans and delegated entities to take into consideration some of the same factors as the *Gould* criteria and therefore the workload required of payors will not significantly change. Additionally, since July 1, 2017, payors have been using their own methodology to calculate and pay the ACR and so use of the methodology implemented by the regulation will not be entirely new and will not lead to a significant increase in workload.

The Benefits to the Health and Welfare of California Residents

By giving direction regarding how payors should compute the ACR, the regulation provides stability for the impacted parties. This stability will benefit health care consumers within California, as the uniform methodology will result in fewer payment disputes between payors and providers, which may in turn result in faster processing of claims and more efficient billing. This may also help ensure that noncontracted providers continue to render necessary health care services for health plan enrollees, knowing they will be properly paid the AB 72 default reimbursement rate. Proper reimbursement of noncontracting providers will, in turn, prevent attempts to balance bill the enrollee, which is impermissible under AB 72, and which would cause financial hardship for individual consumers. Therefore, this proposed regulation will not adversely affect the health and welfare of California residents, worker safety, or California's environment.

[23] The 2016 CHBRP report on AB 533 estimates no impact to consumer utilization of health services. California Health Benefits Review Program, Analysis of California Assembly Bill AB 533, Out-of-Network Coverage, a Report to the 2015-2016 California State Legislature, January 7, 2016, at pp. 7 -8. In comparison, AB 72 contains a more generous default reimbursement rate, meaning the DMHC anticipates it even less likely that noncontracting providers will refuse to serve health plan enrollees.