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Health and Human Services Agency  
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[www.dmhc.ca.gov](http://www.dmhc.ca.gov)

**DATE:** February 2, 2018

**ACTION:** Notice of Rulemaking Action  
Title 28, California Code of Regulations

**SUBJECT:** Methodology for Determining Average Contracted Rate; Default Reimbursement Rate; Adding section 1300.71.31 and amending section 1300.71 in Title 28, California Code of Regulations; Control No. 2017-5223.

**PUBLIC PROCEEDINGS:**

Notice is hereby given that the Director of the Department of Managed Health Care (“DMHC”) proposes to add and amend regulations under the Knox-Keene Health Care Service Plan Act of 1975 (“Knox-Keene Act<sup>1</sup>”). The proposed regulations implement Assembly Bill (“AB”) 72<sup>2</sup> by specifying a standardized methodology that health care service plans (“health plans”) and their delegated entities (collectively, “payors”) shall use to compute the average contracted rate (“ACR”) for health care services subject to the AB 72 surprise balance billing protection, beginning January 1, 2019. The proposed regulation further clarifies key terms and concepts relevant to proper reimbursement of noncontracting individual health professionals (“noncontracting providers”), and makes conforming changes to an existing DMHC regulation on claims settlement practices.

This rulemaking action proposes to add section 1300.71.31 (“Methodology for Determining Average Contracted Rate; Default Reimbursement Rate”), and amend section 1300.71 (“Claims Settlement Practices”), in Title 28, California Code of Regulations (“CCR”). Before undertaking this action, the Director of the DMHC (“Director”) will conduct written public proceedings, during which time any interested person, or such person’s duly authorized representative, may present statements, arguments, or contentions relevant to the action described in this notice.

**PUBLIC HEARING:**

No public hearing is scheduled. Any interested person, or his or her duly authorized representative, may submit a written request for a public hearing pursuant to Section 11346.8(a) of the Government Code. The written request for hearing must be received

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<sup>1</sup> Health & Saf. Code, §§ 1340, et seq.

<sup>2</sup> Assem. Bill No. 72 (Bonta, Chapter 492, Statutes of 2016).

by the DMHC’s contact person, designated below, no later than 15 days before the close of the written comment period.

**WRITTEN COMMENT PERIOD:**

Any interested person, or his or her authorized representative, may submit written statements, arguments or contentions (hereafter referred to as comments) relating to the proposed regulatory action by the DMHC. Comments must be received by the DMHC, Office of Legal Services, **by 5 p.m. on March 19, 2018.** which is hereby designated as the close of the written comment period.

Please address all comments to the Department of Managed Health Care, Office of Legal Services, Attention: Jennifer Willis, Senior Counsel. Comments may be transmitted by regular mail, fax, or email:

Website: <http://www.dmhc.ca.gov/LawsRegulations.aspx#open>  
Email: [regulations@dmhc.ca.gov](mailto:regulations@dmhc.ca.gov)  
Mail: Department of Managed Health Care  
Office of Legal Services  
Attn: Jennifer Willis, Senior Counsel 980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
Fax: (916) 322-3968

Please note: If comments are sent via email or fax, there is no need to send the same comments by mail delivery. All comments, including via email, fax, or mail, should include the author’s name and a U.S. Postal Service mailing address so the DMHC may provide commenters with notice of any additional proposed changes to the regulation text.

Please identify the action by using the DMHC’s rulemaking title and control number, **Methodology for Determining Average Contracted Rate; Default Reimbursement; Control No. 2017-5223**, in any of the above inquiries.

**CONTACTS:** Inquiries concerning the proposed adoption of these regulations may be directed to:

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AND

**Emilie Alvarez**  
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DMHC Office of Legal Services  
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Emilie.alvarez@dmhc.ca.gov

### **AVAILABILITY OF DOCUMENTS:**

The DMHC has prepared and has available for public review the Initial Statement of Reasons, text of the proposed regulation and all information upon which the proposed regulation is based (rulemaking file). This information is available by request to the Department of Managed Health Care, Office of Legal Services, 980 9<sup>th</sup> Street, Sacramento, CA 95814, Attention: Regulations Coordinator.

The Notice of Proposed Rulemaking Action, the proposed text of the regulation, and the Initial Statement of Reasons are also available on the DMHC's website at <http://www.dmhc.ca.gov/LawsRegulations.aspx#open>.

You may obtain a copy of the final statement of reasons once it has been prepared by making a written request to the Regulation Coordinator named above.

### **AVAILABILITY OF MODIFIED TEXT:**

The full text of any modified regulation, unless the modification is only non-substantial or solely grammatical in nature, will be made available to the public at least 15 days before the date the DMHC adopts the regulation. A request for a copy of any modified regulation(s) should be addressed to the Regulations Coordinator. The Director will accept comments via mail, fax, or email on the modified regulation(s) for 15 days after the date on which the modified text is made available. The Director may thereafter adopt, amend or repeal the foregoing proposal substantially as set forth without further notice.

### **AUTHORITY AND REFERENCE:**

Pursuant to Health and Safety Code section 1341.9, the DMHC is vested with all duties, powers, purposes, responsibilities and jurisdiction as they pertain to health plans and the health care service plan business.

Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind regulations as necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms as are necessary to carry out the provisions of the Knox-Keene Act.

Health and Safety Code section 1371.31 grants the Director authority to specify a methodology that plans and delegated entities shall use to determine the average contracted rates ("ACR") for services most frequently subject to Health and Safety Code section 1371.9. Pursuant to AB 72, payors may be required to pay the ACR to noncontracting individual health professionals ("noncontracting providers"), as reimbursement for nonemergency health care services rendered under specified circumstances.

Health and Safety Code section 1371.9 (the anti-surprise billing statute), 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.

### **INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:**

Existing law, the Knox-Keene Act, provides for the licensure and regulation of health plans by the DMHC.

Existing law requires a health plan to appropriately reimburse claims submitted by health care providers, and to make available to contracted and noncontracted providers a dispute resolution mechanism to challenge the amount of reimbursement for those claims. Existing regulations define “reimbursement of a claim,” i.e. what the payor should pay a health care service provider, according to whether the health care service was emergent or non-emergent, the type of the health plan product (e.g., Preferred Provider Organization), and the contracting status of the health care service provider.

Existing law requires, for health care services subject to Health and Safety Code section 1371.9, effective July 1, 2017, unless otherwise agreed to by the noncontracting individual health professional and the health plan, that a health plan or its delegated entity shall reimburse the greater of the ACR or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the health care services were rendered. Existing law does not specify what methodology the payor must use to calculate its ACR for payment during calendar years 2017 and 2018, except that the payor must include its highest and lowest contracted rates for types of health care services from calendar year 2015.

Existing law directs the DMHC, by January 1, 2019, to specify a standardized methodology that health plans and delegated entities shall use to determine the ACR for services most frequently subject to section 1371.9. This methodology shall take into account, at minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an ACR shall also ensure that the health plan includes the highest and lowest contracted rates for the health care service. Throughout the process of developing this standardized methodology, the DMHC shall consult with interested parties, and hold the first stakeholder meeting by July 1, 2017.<sup>3</sup>

This rulemaking action implements the requirement for the DMHC to develop a standardized methodology for use by payors in determining the ACR for health care

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<sup>3</sup> The DMHC held the required stakeholder meeting on June 26, 2017, as well as an additional stakeholder meeting on September 12, 2017.

services most frequently subject to Health and Safety Code section 1371.9. In other words, this proposed regulation specifies how a payor shall calculate the ACR.

### **BROAD OBJECTIVES AND SPECIFIC BENEFITS OF THE REGULATION:**

Pursuant to Government Code section 11346.5(a)(3)(C), the broad objective of this regulation is to specify the standardized methodology that payors shall use to determine the ACR for health care services most frequently subject to Health and Safety Code section 1371.9 in a manner that is consistent with the statute and that results in uniformly appropriate reimbursement to noncontracting providers for AB 72 health care service claims. To that end, the objective of proposed subdivision (a) is to define key terms and phrases that are necessary for compliance with Health and Safety Code section 1371.31. These definitions will ensure that payors do not employ widely varying definitions of these key terms, which would potentially result in unfair variation in reimbursement to noncontracting providers. These definitions will also provide uniformity in key terms, resulting in the broad benefit of clarity for complying payors, as well as efficient compliance and enforcement review by the DMHC.

More specifically, subdivision (a)(1) has the benefit of defining ACR and clarifying which calendar year to use as a source of rate data for the ACR calculation. It also has the benefit of specifying a retrospective base year, to give payors time to settle the relevant contracted claims and assemble a complete data set for the ACR calculation.

Subdivision (a)(2) defines “default reimbursement rate,” which has the benefit of clarifying that Health and Safety Code section 1371.31 requires payors to reimburse *the greater of* two alternatives: the ACR or 125 percent of the Medicare rate. This has the benefit of addressing confusion among stakeholders, and simplifying the regulation by establishing an overall term for the required reimbursement under Health and Safety Code section 1371.31.

Subdivision (a)(3) has the benefit of defining “geographic region” for the purpose of the ACR consistent with the way the statute<sup>4</sup> defines it for the Medicare-based alternative default reimbursement rate. This consistency with the statute results in the benefit that it will be easier for payors to compare the ACR to the 125 percent Medicare rate because the rates will be from the same geographic region.

Subdivision (a)(4) defines “integrated health system” which, in combination with proposed subdivision (a)(9) and (d), has the benefit of clarifying the scope of Health and Safety Code section 1371.31(a)(3)(C). This results in the benefit that payors with business models that result in too few relevant health care services claims will understand that they must reference a statistically credible database in order to determine the ACR. This, in turn, results in the benefit of proper payment of a statistically sound ACR to noncontracting providers.

Subdivision (a)(5) defines “Medicare rate” and has the benefit of addressing stakeholder confusion about two aspects of the Medicare default alternative: which

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<sup>4</sup> Health and Safety Code section 1371.31(a).

year's Medicare rate to use, and whether to use the "participating" ("par") or "non-participating" ("non-par") Medicare rate for a given health care service. The regulation specifies that the Medicare rate from the year in which the health care service was rendered is the relevant Medicare rate. This clarification has the benefit of paying noncontracting providers according to the most recent appropriate Medicare rate. Further, the regulation's use of the "par" Medicare rate results in the benefit that the payor will compare the average *contracted* rate to the analogous Medicare rate: the "participating" rate.

Subdivision (a)(6) has the benefit of clarifying the scope of the Rule by identifying relevant "payors".

Subdivision (a)(7) has the benefit of resolving confusion about which health care services are "most frequently" subject to Health and Safety Code section 1371.9. This is important because the proposed methodology is mandatory only for those health care services. The benefit of the proposed threshold of 80 percent of statewide claims experience is that it fairly implements the statute's requirement to capture the "most frequent" health care services. It is also known to be a workable threshold because the DMHC has observed this 80 percent threshold in use by payors required to comply with AB 72.

Subdivision (a)(8) has the benefit of defining "services subject to section 1371.9" in a manner that is consistent with the statute. It also has the benefit of resolving confusion over whether health care services that fall under AB 72 must occur in an in-network facility (which is not always required).

Subdivision (a)(9) defines "statistically significant," and results in the benefit of clarity of this term for payors, who will understand what number of claims is considered so low that the plan must refer to a statistically credible database in order to determine the ACR. This has the benefit of answering questions the DMHC has received from stakeholders and ensuring that the ACR is statistically sound.

Subdivision (a)(10) has the benefit of referring interested stakeholders to the relevant statute, Health and Safety Code section 1371.9, subdivision (f), for other relevant definitions, which will prevent confusion about other key terms in AB 72.

Subdivision (b) has the benefit of clarifying when a payor *must* use the proposed Rule's methodology, instead of a different methodology, to determine the ACR. This provision also has the benefit of clarifying that a payor *may* use the proposed Rule's methodology to determine the ACR for all health care services subject to Health and Safety Code section 1371.9, and that any alternative methodology must still comport with the statute's requirement for an average of contracted commercial rates paid for the same or similar health care services in the geographic region. This provision addresses stakeholder confusion about which health care services are mandatorily subject to the Rule's standardized methodology, and has the benefit of avoiding an unduly prescriptive ACR methodology standard for other, non- "most frequently subject to section 1371.9", health care services.

Subdivision (c) contains the proposed Rule's methodology implementing the ACR using a claims volume-based mean, adjusted at the time of reimbursement by the applicable payment modifiers. This approach has the benefit of aligning with the statutory definition of ACR, which is based on the average of the contracted commercial rates *paid*. The claims weighted mean approach also has the benefit of avoiding undue disruption in the health care marketplace, since this approach is already used by many payors in compliance with AB 72. The subdivision also excludes from the ACR calculation rates that are not reflective of "rates paid." This provision of the Rule is consistent with Health and Safety Code section 1371.31, subdivision (a).

Subdivision (c)(2) results in the benefit that the payor shall include the highest and lowest contracted rates for a health care service, as required by Health and Safety Code section 1371.31, even if the payor paid zero claims at those highest and lowest rates. The benefit is that this provision implements Health and Safety Code section 1371.31, subdivision (a)(3)(A), which expressly requires the standardized ACR methodology developed by the DMHC to "ensure that plans include the highest and lowest contracted rates." This provision also has the benefit of ensuring that the ACR accounts for the full range of a payor's contracted rates, which will result in a fair ACR.

Subdivision (c)(3) has the benefit of ensuring that payors appropriately "stratify" the ACR for a given health care service (identified by CPT or other code) according to the statutorily required considerations: geographic region and provider specialty. It also requires stratification by provider type (e.g. non-physician or physician), and facility type (e.g., hospital or ambulatory surgery center). This will result in the benefit that the payor will develop ACRs payable under AB 72 that accurately reflect the equivalent in-network reimbursement.

Subdivision (c)(4) clarifies that payors shall calculate ACRs for each health care service code prior to any later adjustment by payment modifiers. This has the benefit of establishing a base ACR reflective of the contracted rates, which are typically described in contracts as "allowed amounts," with payment modifiers applied at the time the payor reimburses the provider. However, this provision also has the benefit of specifying the two payment modifiers, 26 (professional component) and 27 (technical component), which are typically developed as stand-alone contracted rates. Therefore, this provision has the benefit of ensuring that modifiers applied to particular cases in the payor's pool of ACR data do not unduly skew the payor's calculation of the ACR.

Subdivision (c)(5) clarifies that, while modifiers and other factors should be not be included when the payor calculates the base ACR, the appropriate modifiers should be applied when the payor reimburses the noncontracting provider pursuant to AB 72. This has the benefit of keeping the ACR consistent with existing standard health care service billing and reimbursement practices, and ensuring reimbursement in accordance with the payor's policies.

Subdivision (c)(6) clarifies that, with respect to anesthesiology services, the anesthesia "conversion factor" is the value that must be averaged in light of claims volume under each payor contract. In other words, the conversion factor is the appropriate "allowed amount" for the purpose of the calculation of the mean rate. This provision further

clarifies that the sum of the applicable “units” and physical status modifiers should be applied to that averaged conversion factor, when the payor reimburses the noncontracting anesthesiologist, consistent with proposed subdivision (c)(5). This has the benefit of accounting for the billing complexities attendant to anesthesiology services in a manner that is not disruptive or unfair to those providers, and is consistent with Health and Safety Code section 1371.31.

Subdivision (c)(7) clarifies which claims should be excluded when a payor calculates the ACR for a health care service. This provision has the benefit of excluding from the ACR calculation claims that do not accurately reflect the commercial rates paid by the payor, consistent with Health and Safety Code section 1371.31(a). This subdivision excludes case rates and global rates, which are single rates negotiated for an entire course of treatment that involves more than one health care service code. This subdivision also excludes other claims that cannot be readily converted to per-code rates: claims paid pursuant to capitation, risk sharing arrangements, and sub-capitation. However, regarding case and global rates, there is an exception: payors shall not exclude from the ACR calculation claims when a health care service code, itself, includes several services (e.g., CPT code 59400, for Vaginal Delivery, Antepartum and Postpartum Care Procedures). This provision has the benefit of including relevant health care service rates in the payor’s ACR calculation, which ensures payment of the default rate consistent with Health and Safety Code section 1371.31(a). This subdivision (c) also excludes from the ACR calculation disputed claims, denied claims, and claims not in final disposition status. This provision has the benefit of excluding claims that do not reflect the rates “paid,” consistent with Health and Safety Code section 1371.31(a), resulting in proper calculation of the ACR, and proper payment of noncontracting providers.

In combination with subdivision (a)(4)’s definition of “integrated health system,” subdivision (d) has the benefit of clarifying how such systems shall comply with the requirement to pay the default reimbursement rate. This has the benefit of addressing stakeholder confusion over which payors must reference a statistically credible database in order to determine the ACR, consistent with subdivision (a)(3)(C) of Health and Safety Code section 1371.31.

Subdivision (e) has the benefit of addressing stakeholder confusion about the overall default reimbursement rate scheme set out in AB 72. This ensures that payors and noncontracting providers understand that they remain free to negotiate a reimbursement rate other than the default reimbursement rate. This subdivision also clarifies that enrollees may voluntarily exercise their out-of-network benefits, meaning the payor would base reimbursement on the enrollee’s Evidence of Coverage (see Health and Safety Code section 1371.31(b)). This subdivision clarifies that the payor shall pay *the greater of* the ACR or 125 percent of the Medicare rate, meaning that payors will understand their obligations under Health and Safety Code section 1371.31, and noncontracting providers will receive the appropriate default reimbursement. Finally, subdivision (e)(2) requires the payor to indicate how it is satisfying the requirement to pay the default reimbursement rate (i.e., whether it paid the ACR, or the Medicare rate, etc.), resulting in the benefit of efficient compliance review by the DMHC.

Subdivision (f) has the benefit of providing guidance to payors on how and when they must file their statutorily-required “policies and procedures” that implement this Rule’s standardized methodology. The due date of August 15, 2019, has the benefit of aligning with existing financial reporting requirements, resulting in less of a burden on payors.

Finally, the proposed amendment to Rule 1300.71, subdivision (a)(3), has the benefit of preventing confusion over how proposed Rule 1300.71.31 interacts with the existing Rule 1300.71 regarding claims settlement practices and the meaning of “reimbursement of a claim.” This provision clarifies that Rule 1300.71 remains in effect for non-AB 72 claims, meaning the proposed Rule will not disrupt claims payment for non-AB 72 claims for health care services, which are the vast majority of claims.

### **COMPARISON WITH EXISTING REGULATIONS:**

The regulation proposed in this rulemaking action is neither inconsistent nor incompatible with existing state regulations. The DMHC compared the following related existing regulation, California Code of Regulations, title 28, section 1300.71, and found no inconsistency or incompatibility with the proposed regulation.

### **ALTERNATIVES CONSIDERED:**

Pursuant to Government Code section 11346.5, subdivision (a)(13), a rulemaking agency must determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency (1) would be more effective in carrying out the purpose for which the action is proposed, (2) would be as effective and less burdensome to affected private persons than the proposed action, or (3) would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law. As described in the Initial Statement of Reasons for this rulemaking action, the DMHC has not determined that any known alternatives meets standards (1)-(3), described above.

The DMHC invites interested persons to present statements or arguments with respect to alternatives to the requirements of the proposed regulations during the written comment period.

### **PURPOSE OF THE REGULATION:**

Prior to AB 72, payors paid health care service claims from health care providers according to the payor’s contracted arrangements, as specified in Rule 1300.71(a)(3), and other applicable law. Before AB 72, there was no specific reimbursement standard for noncontracted health care services connected to covered care received in an in-network facility, such as a hospital.<sup>5</sup> Further, for those types of health care services, noncontracting providers could balance bill health plan enrollees directly, causing both mental and financial hardship for impacted enrollees. However, since the Legislature

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<sup>5</sup> Health and Safety Code section 1371.9.

enacted AB 72, effective July 1, 2017, noncontracting providers may not balance bill enrollees for these health care services, and payors shall reimburse noncontracting providers the default reimbursement rate: the greater of the ACR or 125 percent of the applicable Medicare rate.

Although payors have flexibility to compute the ACR for payment during calendar years 2017 and 2018, the Legislature directed the DMHC to develop a standardized methodology that payors shall use to pay AB 72 claims, effective January 1, 2019. In other words, by January 1, 2019, the DMHC must specify how payors will calculate the ACR.

Accordingly, the purpose of this regulation is to implement that standardized methodology, consistent with the broad objectives outlined in the previous sections of this Notice.

#### **SUMMARY OF FISCAL IMPACT:**

- Mandate on local agencies and school districts: None
- Cost or Savings to any State Agency: None
- Direct or Indirect Costs or Savings in Federal Funding to the State: None
- Cost to Local Agencies and School Districts Required to be Reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None
- Costs to private persons or businesses directly affected: The DMHC has determined that this regulation will have cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action. As described in the Economic Impact Assessment in the Initial Statement of Reasons for this rulemaking action, the impact on private persons and businesses is estimated to be minimal, because the majority of payors are likely substantially compliant with core components of the proposed methodology (resulting in minimal change to the ACR), and because administrative costs associated with training staff and updating systems are unlikely to be substantial.
- Effect on Housing Costs: None
- Other non-discretionary cost or savings imposed upon local agencies: None

#### **DETERMINATIONS:**

The DMHC has made the following initial determinations:

- The DMHC has determined the regulation will not impose a mandate on local agencies or school districts, nor are there any costs requiring reimbursement by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.
- The DMHC has determined the regulation will have no significant effect on housing costs.
- The DMHC has determined the regulation minimally affects a small number of

small businesses. Health care service plans are not considered a small business under Government Code Section 11342.610(b) and (c). An estimated range of 974-2505 individual providers may be impacted, but the proportion of those that are small businesses is unknown. Further, of non-health plan payors, an estimated four percent may be small businesses. Please see the Economic Impact Assessment in the Initial Statement of Reasons and the Economic and Fiscal Impact Statement for this rulemaking action for additional information about this initial determination.

- The DMHC has determined the regulation will not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. Please see the Economic Impact Assessment in the Initial Statement of Reasons for this rulemaking action for additional information about this initial determination.
- The DMHC has determined that this regulation will have no cost or savings in federal funding to the state.
- Pursuant to Government Code section 11346.3(d), 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. The proposed regulation is a benefit to health plans by requiring them to submit policies and procedures used to determine the ACR in compliance with Health and Safety Code section 1371.31 and the proposed Rule. This filing is expressly required by Health and Safety Code section 1371.31(a)(3)(B). Submission of this statutorily-required filing concurrent with other required financial filings will allow for ease of filing submission, while also allowing the DMHC to efficiently review the policies and procedures and ensure that payors are appropriately implementing the ACR requirement. This will help ensure stability for the impacted parties and is necessary to protect 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.

**RESULTS OF THE ECONOMIC IMPACT ANALYSIS (Government Code sections 11346.3(b), 11346.5(a)(10)):**

The Initial Statement of Reasons for this rulemaking action describes the basis for the following Economic Impact Analysis results:

- **Creation or Elimination of Jobs Within the State of California**  
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 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. 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 Elimination of Existing Businesses Within the State of California**

The proposed regulation will neither create new businesses nor eliminate existing businesses. Businesses are already required to determine the ACR for services subject to Health and Safety Code section 1371.9, and the methodology in the proposed Rule regulation has a narrow application. 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 unhappy, it may bring the matter to the independent dispute resolution process and argue for a different reimbursement amount. Accordingly, 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.

- **Expansion of Businesses Currently Doing Business Within the State of California**

The proposed Rule will not significantly affect the expansion of businesses currently doing business within the state of California. Prior to the enactment of AB 72, certain payors were required to pay noncontracted providers who provided certain services the reasonable and customary value of those services pursuant to Title 28 Rule 1300.71. Other payors had claims processing systems in place to pay according to the terms of the particular Evidence of Coverage. The methodology to determine the ACR created by this proposed Rule will require payors to take into consideration some of the same factors currently used to pay claims, and therefore the required workload 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.

- **Benefits of the regulation to the health and welfare of California residents, worker safety, and the state's environment**

By giving direction regarding how payors should compute the ACR, the regulation provides certainty for the relevant parties. This certainty 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 certainty may also help ensure that enrollees have access to health services because noncontracting providers will know they will be properly paid the AB 72 default reimbursement rate. Proper reimbursement of noncontracting providers may, in turn, prevent attempts to balance bill the enrollee, which is impermissible under

AB 72, and which would cause financial hardship for individual patients. This regulation will not adversely affect the health and welfare of California residents, worker safety, or California's environment.

## **BUSINESS REPORT**

This rulemaking package clarifies existing law under AB 72 and gives direction on how payors should compute the ACR for noncontracted providers. The need for this regulation to apply to businesses is necessary for the health, safety or welfare of the people of the State of California.