AB 72
Implementation Update

July 19, 2017

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AB 72 Overview

Effective July 1, 2017:

- Prohibits Surprise Balance Billing.
- Establishes a Default Reimbursement Rate.

Effective September 1, 2017:

- Establishes a binding and mandatory Independent Dispute. Resolution Process (IDRP). Access to legal remedies is preserved.

Effective January 1, 2019:

- Requires the DMHC to finalize regulations establishing a standard Average Contracted Rate (ACR) methodology.

Surprise Balance Billing

What is Surprise Balance Billing?

Occurs when an enrollee is balance billed the difference between the amount a noncontracting individual health professional charged and the amount the health plan paid, under specified circumstances.

“Services subject to HSC Section 1371.9”

When enrollees receive covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional.

Default Reimbursement Rate

Effective July 1, 2017:

For services rendered subject to HSC section 1371.9, unless otherwise agreed to by the noncontracting health professional and the plan, the plan shall reimburse the **greater** of:

- The Average Contracted Rate (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 regions in which the services were rendered.

Default Reimbursement Rate

Average Contracted Rate

The average of the ***contracted commercial rates*** paid by the health plan or delegated entity for the same or similar services in the geographic region in calendar year 2015.

Default Reimbursement Rate

Date of Service	Average Contracted Rate (ACR)
July 1, 2017 – December 31, 2017	ACR based on Calendar Year 2015 rates and Filed with the DMHC by July 1, 2017
January 1, 2018 – December 31, 2018	ACR adjusted by Consumer Price Index for Medical Services
January 1, 2019 - Ongoing	ACR based on the standard methodology defined in regulations

Average Contracted Rate Filing

By July 1, 2017, each health care service plan and delegated entity that pays claims shall provide the following to the DMHC:

- Data listing its average contracted rates for the services most frequently subject to Section 1371.9 in each geographic region for calendar year 2015;
- Its methodology for determining the average contracted rate. The methodology shall include the highest and lowest contracted rates for calendar year 2015;
- The policies and procedures used to determine the average contracted rates.

July 1, 2017 Filing Documents

Average Contracted Rate Filing Documents:

- ACR Filing Overview
- Attachment 1: ACR Data Worksheet Instructions
- Attachment 2: ACR Data Worksheet
- Attachment 3: ACR Methodology Worksheet and Instructions
- Attachment 4: Policy and Procedure Instructions

Standardized Methodology

By January 1, 2019, DMHC must develop a standardized methodology for calculating the average contracted rate (ACR) for services most frequently subject to Health and Safety Code Section 1371.9.

- Plans and delegated entities will use this methodology to calculate the average contracted rate for services rendered on or after January 1, 2019.
- Plans and delegated entities are still required to pay the greater of 125% of Medicare or the Average Contracted Rate.

Standardized Methodology

- The methodology must take into account:
  - Information from IDRP
  - Specialty of the individual health professional
  - Geographic region in which services are rendered
- The methodology must include the highest and lowest contracted rate

ACR Calculation

Unweighted mean

$$\text{ACR} = \frac{\text{sum of all contract rates}}{\text{total number of contract rates}}$$

Example

For three contract rates of $10, $15, and $18:

$$\text{Unweighted ACR} = \frac{(10+15+18) = 43}{3} \quad \text{or} \quad \$14.33$$

ACR Calculation

Weighted mean

$$\text{ACR} = \frac{\text{sum (contract rate x \# of claims paid at rate)}}{\text{total number of claims}}$$

Example

For the same contract rates of $10, $15, and $18, and there are 5, 2, and 1 number of claims, respectively:

$$\text{Weighted ACR} = \frac{(10x5 + 15x2 + 18x1) = 98}{8} \quad \text{or} \quad \$12.25$$

Other Considerations

- Geographic Regions
  - Use Medicare regions or other regions
  - Geographic location based on address where service is provided
- Type of Provider or Provider Specialty
- Services with Payment Modifiers (i.e. -50 or -51 for bilateral or multiple procedures)

Other Considerations

- Services “Most Frequently Subject To”
- Claim Amount – before or after member cost sharing
- Medicare Rate
- Anesthesia Services

Other Considerations

- Which claims to include in calculation
  - Claims adjustments
  - Denied claims
  - Disputed payments
  - Payments for providers with risk sharing arrangements
  - MOUs
  - Time period and claims run out
  - Sub-capitated providers
  - Case rates

Implementation Timeline

Activity	Date
Stakeholder Meeting to Solicit Input on Standardized Average Contracted Rate Methodology and IDRP	June 26, 2017
Default Reimbursement Rate Filing Deadline and Effective Date	July 1, 2017
Independent Dispute Resolution Process (IDRP) Implemented	September 1, 2017
Formal Rulemaking Process	October 2017 – December 2018
Timely Access and Network Adequacy Report Filings	March 31, 2018
Regulations Effective	January 1, 2019
DMHC Report to the Legislature	January 1, 2019

Questions?