

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814**

FINAL TEXT OF REGULATION

AVERAGE CONTRACTED RATE METHODOLOGY (AB 72)

December 24, 2018

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**Title 10. Investment
Chapter 5: Insurance Commissioner
Subchapter 2: Policy Forms and Other Documents
Adopt Article 5.5: Average Contracted Rate Methodology**

Adopt Section 2238.10. Definitions.

(a) For purposes of this article, the following definitions apply:

(1) “Average contracted rate” means the average of the contracted commercial rates paid by a health insurer for the same or similar health care services in the baseline year in the geographic region in which the service was provided, for services most frequently subject to Insurance Code section 10112.8. This rate is then adjusted to the date the service was rendered by using the inflation adjustment described in Insurance Code section 10112.82(a)(2)(B).

(2) “Baseline year” is calendar year 2015.

(3) “Bundled payments” means a single payment for all services to treat a condition or provide a given treatment. Bundled payments may also include facility fees and other charges.

(4) “Geographic region” for the calculation of the average contracted rate means:

(A) For individual and small group coverage: the same geographic regions listed in Insurance Code section 10753.14(a)(2)(A); and

(B) For large group coverage: the same geographic region as the Medicare Physician Fee Schedule locality structure pursuant to Section 1848 of the Social Security Act (42 U.S.C. Section 1395w-4(e)(6)).

(5) “Modifiers” mean codes applied to the service code that make the service description more specific and may adjust the reimbursement rate or affect the processing or payment of the code billed.

(6) “Same or similar services” means a health care service billed under the same service code, or a comparable code under a different procedural code system. The use of a different service code

as a proxy for the service code ordinarily applicable to the actual service shall only be applied in a special or unique circumstance.

(7) “Service code” means the code that describes a service using the Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS).

(8) “Service unit” means the number of times the service described by a particular service code was provided per claim for reimbursement.

(b)(1) “Services most frequently subject to Section 10112.8” means, for the purpose of this article, the health care service codes, which, in aggregate, comprise the top 80 percent of the health insurer’s statewide claims volume, determined by number of claims, when ranked in descending order beginning with the service codes with the highest number of claims, for all market segments for health care services subject to Insurance Code section 10112.8 for each of the following specialties:

(A) Anesthesiology

(B) Pathology

(C) Radiology

(2) In addition to the health care services for the three specialties listed in subdivision (b)(1), “services most frequently subject to Section 10112.8” also includes all other services subject to Insurance Code section 10112.8, which, in aggregate, comprise the top 80 percent of the health insurer’s statewide claims volume, determined by number of claims, when ranked in descending order beginning with the service codes with the highest number of claims, for all market segments for services other than those determined using subdivision (b)(1).

(3) If a health insurer offers commercial health coverage in multiple market segments, the same list of most frequent services subject to Insurance Code section 10112.8, as described in subdivision (b)(1) and (2), shall be used for each market segment.

(c) The definitions in subdivision (f) of Insurance Code section 10112.8 apply for purposes of this article.

Note: Authority cited: Sections 10112.8 and 10112.82, Insurance Code. Reference: Sections 10112.8 and 10112.82, Insurance Code.

Adopt Section 2238.11. Methodology for Calculation of Average Contracted Rate.

The reimbursement rate for services subject to Insurance Code section 10112.8 is the average contracted rate or 125 percent of the Medicare fee-for-service rate, whichever is greater, unless otherwise agreed to by the noncontracting individual health professional and the insurer or as determined through the independent dispute resolution process pursuant to Insurance Code section 10112.81.

(a) The average contracted rate for services most frequently subject to Section 10112.8, other than anesthesia services, shall be calculated by dividing the total payment for a service code by the total number of paid service units for that service code in each geographic region across all commercial policies regulated by the Commissioner during the baseline year, then adjusted to the date the service was rendered using the inflation adjustment method described in Insurance Code section 10112.82(a)(2)(B).

(b) The average contracted rate for anesthesia services most frequently subject to Section 10112.8 shall be calculated by first determining the average anesthesia conversion factor. The average anesthesia conversion factor shall be calculated by dividing the total payment for anesthesia services by the sum of all base units, time units, and physical status modifier units paid for those services, in each geographic region across all commercial policies regulated by the Commissioner during the baseline year, then adjusted to the date the service was rendered using the inflation adjustment method described in Insurance Code section 10112.82(a)(2)(B). This inflation-adjusted average anesthesia conversion factor shall then be multiplied by the sum of the base unit, time unit, and physical status modifier units of the patient to determine the reimbursement rate for the covered health care service as of the date the service was rendered.

(1) The base units for an anesthesia service code are the American Society of Anesthesiologists Relative Value Guide base units for that service code.

(2) The time unit is measured in 15 minute increments or a fraction thereof.

(3) The physical status modifier in a claim is a standard modifier describing the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

(4) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the health insurer.

(c) In calculating the average contracted rate, a health insurer shall:

(1) Calculate the average contracted rate using the full contracted rate applicable to the service code, without adjustments for cost sharing by the covered person, modifiers (except physical status modifiers in claims for anesthesia services as set forth in subdivision (b)), or payment rules, except that the health insurer shall calculate separate average contracted rates, pursuant to this subdivision, for CPT code modifiers “26” (professional component) and “TC” (technical component).

(2) Include the highest and lowest reimbursed payment rates paid by the health insurer in the calculation.

(3) Limit the calculation to services provided in the baseline year under the health insurer’s commercial health coverage in all market segments in the same geographic area.

(4) Exclude the following:

- (A) Denied service units;
- (B) Service units not in their final dispositions;
- (C) Secondary payments from a coordination of benefit clause;
- (D) Bundled payments;
- (E) Risk sharing, capitation, or other incentive based payments;
- (F) Rate information for programs or products not regulated by the Commissioner, including Medicare, Medi-Cal services, out of state products, self-insured products, other products governed by federal law, and products regulated by the Department of Managed Health Care; and
- (G) Contracted rates for which no claims were received during the baseline year.

(5) Modifiers may be applied to the reimbursement of a service, but shall be excluded from the average contracted rate calculation except to separate professional services from the technical component when calculating the average contracted rate pursuant to paragraph (1) of this subdivision.

(d)(1) If a health insurer's contracted rates differ based on the provider type or specialty for a service code, the average contracted rate shall be calculated separately for each provider type or specialty, as applicable. If, instead, payment for provider services is calculated by applying a modifier code, which varies based on provider type or specialty, to a single contracted rate for a service code, only one average contracted rate, without use of modifiers, shall be calculated.

(2) If a health insurer uses different contracted rates for a service code based on facility type, the average contracted rate shall be calculated separately for each such facility type.

(e) Health insurers may use the average contracted rate methodology described in this section, or another reasonable method, for services not described in subdivision (b) of Section 2238.10 of this article otherwise subject to Insurance Code section 10112.8. The reimbursement rate for these services is the greater of the average contracted rate as determined by this subdivision or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and the insurer.

(f) For the purpose of subdivision (a)(1) of Insurance Code section 10112.82, the Medicare fee-for-service rate shall be the Medicare rate for the service code for the same calendar year in which the services were rendered and shall be determined using the participating provider rate excluding any value-based payment modifier and adjusted for the geographic area.

Note: Authority cited: Sections 10112.8 and 10112.82, Insurance Code. Reference: Sections 10112.8 and 10112.82, Insurance Code.

Adopt Section 2238.12. Reporting.

(a) For each contracting health facility, health insurers shall annually provide to the Department, with the network adequacy report submitted to the Department pursuant to Section 2240.5 of Title 10 of the California Code of Regulations, the following information:

(1) The following payment information for each service subject to Insurance Code section 10112.8:

(A) Service code;

(B) Specialty, as applicable;

(C) Number of times payment was made for that service code to noncontracting individual health professionals; and

(D) Number of times payment was made to a contracting individual health professional for that service code.

(2) The number of noncontracting individual health professionals who submitted claims for reimbursement for services provided at each contracting health facility, separated by specialty.

(3) The number of contracting individual health professionals who submitted claims for reimbursement for services provided at each contracting health facility, separated by specialty.

(b) On or before June 1, 2019, health insurers must submit via the System for Electronic Rates and Forms Filing (SERFF) of the National Association of Insurance Commissioners the policies and procedures used to determine the average contracted rates in compliance with this article. Thereafter, the policies and procedures must be submitted to the Department via SERFF whenever they are amended.

Note: Authority cited: Sections 10112.8 and 10112.82, Insurance Code. Reference: Sections 10112.8 and 10112.82, Insurance Code.