REPORT OF HEALTH CARE SERVICE PLANS' PROVIDER DISPUTE RESOLUTION MECHANISMS

2012 ANNUAL REPORT

March 15, 2013

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I.

Executive Summary

The Department of Managed Health Care (DMHC) licenses and regulates health care service plans in California and in so doing, protects the rights of consumers and health care providers while maintaining the financial stability of the managed health care system.

State law requires health care service plans (health plans) to pay health care providers accurately and in a timely fashion for services provided and to maintain a fast, fair, and cost-effective system for processing and resolving provider claim disputes (California Health and Safety Code section 1367(h)). Health plans are required to annually report the number, type, and summaries of provider claim payment disputes, describe the resolutions including terms and timeliness, and explain how health plans are addressing trends or patterns in disputes. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups[1].

As required by Health and Safety Code section 1375.7(e), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2012 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of plan, including full service health plans and specialized health plans, from October 1, 2011 through September 30, 2012.

KEY STATISTICS:

<u>Full Service Health Plans</u>:

Full Service Health Plans are health plans that provide all of the basic health care services and mandated benefits requirement under the Knox-Keene Act.

- There are 36 licensed full service health plans in California subject to the reporting requirements of Section 1375.7(e). Eighteen licensed, full service health plans are excluded from the report because they only provide Medicare products, and are therefore exempt from Health and Safety Code section 1367(h).

- Full service health plans processed approximately 106 million claims in the reporting period.

- Full service health plans received 602,999 provider disputes for the reporting period.

- California's seven largest full service health plans[2] provide health care benefits to over 16 million (77%) of the approximately 21 million full service health plan enrollees.

[1] Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is a set amount of prepaid money received or paid out, based on the number of enrollees assigned to an organization, rather than on the level of services delivered. This arrangement is usually expressed in units of PMPM (per member per month).

[2] California's seven largest full service plans are Aetna Health of California, Blue Cross of California, California Physicians' Services (Blue Shield of California), Cigna HealthCare of California, Health Net of California, Kaiser Foundation Health Plan, and United Health Care of California.

- Approximately 76 percent of the reported provider disputes were filed with the seven largest full service health plans.

- The seven largest full service health plans processed more than 91 million claims, accounting for 86 percent of all claims filed by full service health plans in California.

- Approximately 93 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days from the date of receipt.

- Ninety-one percent of provider disputes with full service health plans involved claims payment and/or billing problems.

- Providers prevailed in 37 percent of all disputes; plans prevailed in 50 percent of the disputes, with 13 percent of the disputes pending.

- Less than one-percent (0.51%) of all claims processed by full service health plans resulted in a claim payment/billing dispute.

Specialized Health Plans:

Specialized Health Plans are health plans that provide coverage in a single specialized area of care such as vision, dental, behavioral health and chiropractic health plans.

- There are 44 licensed specialized health plans subject to the provider dispute reporting requirements.

- Specialized health plans processed approximately 25 million claims in the 2012 reporting period.

- Specialized health plans received 16,214 provider disputes for the reporting period.

- Specialized health plans reported that 57 percent of all provider disputes were resolved in favor of the provider, an increase of 10 percent from the 2011 reporting period.

- Thirty-eight percent of disputes involving claims payment and billing issues resolved were in favor of the plan versus 61 percent in favor of the provider. This is a shift from 2011 which showed 50 percent of disputes resolved in favor of the plan and 44 percent in favor of the provider.

- Dental plans reported more than half (53%) of all specialized health plan provider disputes. Dental plan enrollment accounted for 58 percent of the total enrollment for specialized health plans required to report.

- Nearly three-quarters (71%) of provider disputes with specialized plans involved claims payment and/or billing problems.

Capitated Providers:

Capitated Providers are providers that have contracted with a health plan to assume the financial risk for the provision of health care services to the plan's enrollees. Capitated providers include hospitals and medical groups.

- Plans reported data on 294 capitated providers.
- Capitated providers processed approximately 36 million claims and received 493,591 provider disputes in the 2012 reporting period.
- Ninety-seven percent of disputes involved claims payment and/or billing problems.
- Thirty-five percent of all reported provider disputes with capitated providers were resolved in favor of the provider.

II.

Introduction/Background

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards for payment of provider claims for services rendered on or after January 1, 2004.[3]

In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require plans to submit to the DMHC the Annual Plan Dispute Resolution Mechanism Report, which is public information, and contains the following:

(1) Information on the number and types of providers utilizing the dispute resolution mechanism;

(2) a summary of the disposition of all provider disputes, including an informative description of the type, term, and resolution;

(3) the timeliness of dispute resolution determinations; and

(4) a detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care, and are required to report dispute results.

[3] See California Code of Regulations, title 28, sections 1300.71 and 1300.71.38.

Plans summarized their provider dispute results in three categories:

- Claims Payment/Billing Disputes -- Provider complaints relating to the plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.

- Utilization Management Disputes -- Provider complaints relating to medical necessity and authorization determinations.

- Other Disputes -- Provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

This report reflects information reported by health plans for October 1, 2011 through September 30, 2012.

III.

Full Service Health Plans

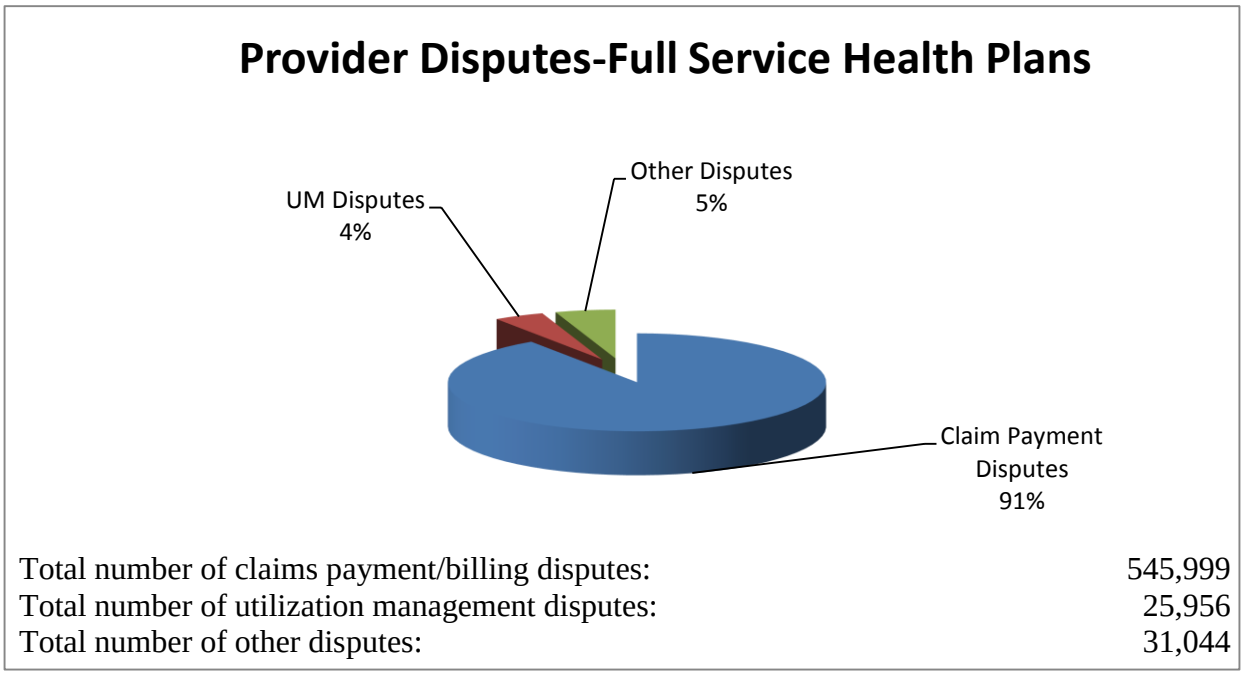
Of the 54 licensed full service health plans, data from 36 is included in this report. Eighteen licensed, full service health plans are excluded because they provide only Medicare products, and are therefore exempt from Health and Safety Code section 1367(h).

The 36 full service health plans reported a total of 106 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested or denied.

The reporting full service health plans received 602,999 provider disputes during the 2012 reporting period. This represents a decrease of 26 percent in disputes over the 2011 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 91 percent of the full service health plan provider disputes.

Chart 1



Total number of claims payment/billing disputes:	545,999
Total number of utilization management disputes:	25,956
Total number of other disputes:	31,044

Approximately 93 percent of all provider disputes processed by full service health plans were reported as resolved within 45 working days from the date of receipt. This does not fall within the timeframes set forth in the regulation. Regulations require 95 percent of all complete provider disputes to be resolved within 45 working days. In 2011, 95 percent of provider disputes were resolved within 45 days.

For provider disputes not resolved within the prescribed timeframe, some health plans described corrective action measures instituted to ensure future compliance with the timeliness standards. Examples of self-reported corrective actions included initiating weekly reports to monitor processing timeliness and hiring additional temporary staff to clear dispute backlogs.

Additionally, plans contracted capitated providers worked with plans to identify responsibility of risk for certain services. Plans formed provider dispute resolution oversight committees to discuss processing performance and emerging trends. Plans also performed root cause analysis on provider dispute data in an effort to understand the concerns of providers. One plan that recently went through a system conversion used the provider dispute process to identify any potential system issues the conversion may have caused. Disputes upheld by plans were identified and plans outreached to provider billers in an effort to educate them on using the correct contract reimbursement rates.

The DMHC monitors the health plans' corrective actions through its financial examinations and by analyzing complaints received by the department's Provider Complaint Unit. Additionally, reports on quarterly corrective action plans for capitated providers are created by the capitated provider and monitored by the health plans, to ensure corrective action plans are competed/fulfilled within required time frames. The department's continued outreach and monitoring of corrective action plans has improved health plan compliance with processing claims and disputes within regulatory timeframes.

Provider Disputes Compared to Claims

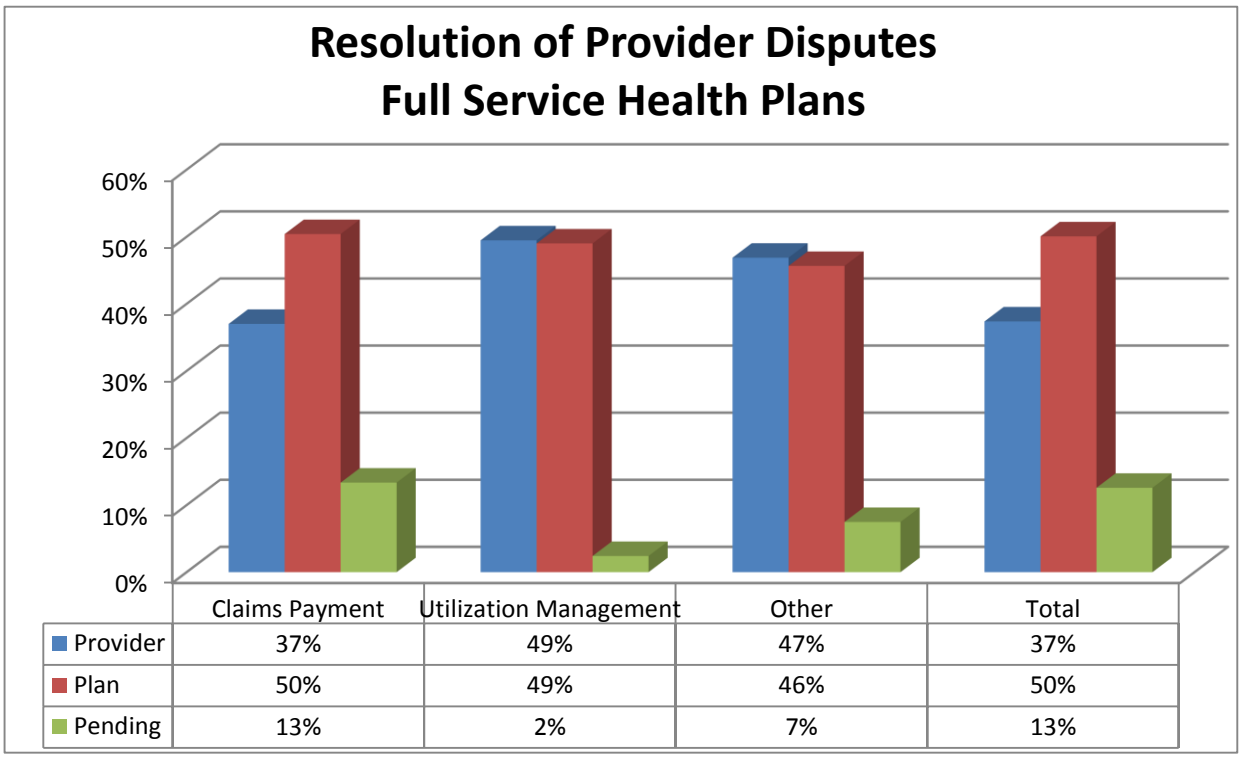
Of the 106 million claims processed during the reporting period, there were approximately 546,000 provider disputes contesting the plans' reimbursement determinations. This represents less than one percent (0.51%) of all claims processed by full service health plans.

Approximately 83 percent of provider claims processed were paid or adjusted, and 17 percent were contested or denied. Nearly all claims (approximately 99%) were processed within 45 working days from the date of receipt.

Disposition of Full Service Health Plan Provider Disputes

In 2012, the full service health plans reported 37 percent of all disputes between providers and health plans were resolved in favor of the provider, a decrease of one percent from 2011. Of the 602,999 provider disputes submitted, 225,360 (37%) were determined in favor of the provider, 301,825 (50%) in favor of the plan, and 75,814 (13%) were pending review as of September 30, 2012. (See Chart 2).

Chart 2



	Claims Payment	Utilization Management	Other	Total
Provider	37%	49%	47%	37%
Plan	50%	49%	46%	50%
Pending	13%	2%	7%	13%

Seven Largest Full Service Health Plans

California's seven largest full service health plans provide health care benefits to over 16 million enrollees, representing 77 percent of the approximately 21 million enrollees enrolled in health plans licensed by the DMHC. In 2012, 76 percent of provider disputes were filed with these seven plans. They processed more than 91 million claims, accounting for 86 percent of all claims filed by full service health plans in California. (See Table 1).

Table 1
Provider Disputes by Plan

Name of Health Plan	Enrollment	Approximate Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved in Favor of Provider	Percentage of Disputes Resolved Within 45 Working Days
Kaiser Foundation Health Plan, Inc.	7,004,013	1,406,597	77,478	15,419	54,980	7,079	20%	99%
Anthem Blue Cross	3,242,017	54,391,424	146,220	57,569	87,411	1,240	39%	82%
Blue Shield (California Physicians Service)	2,374,349	10,967,211	79,345	38,991	39,174	1,180	49%	95%
Health Net of California, Inc.	2,071,177	20,146,295	125,832	38,356	41,577	45,899	30%	99%
Aetna Health of California, Inc.	856,242	3,297,306	10,558	4,225	5,189	1,144	40%	98%
United Health Care of California	828,415	825,659	10,006	5,111	4,895	0	51%	99%
Cigna Healthcare of California, Inc.	216,025	559,908	8,200	4,854	3,346	0	59%	99%
Total - Seven Largest Health Plans	**16,592,238**	**91,594,400**	**457,639**	**164,525**	**236,572**	**56,542**	**36%**	**92%**
All Other Full Service Health Plans	4,824,690	14,487,070	145,360	60,835	65,253	19,272	42%	95%
Total - All Full Service Health Plans	**21,416,928**	**106,081,470**	**602,999**	**225,360**	**301,825**	**75,814**	**37%**	**93%**

Health plans that fall below the 95 percent compliance requirement are required to file and implement a corrective action plan that will be monitored on a quarterly basis by the DMHC and reviewed as part of the health plan's routine examination.

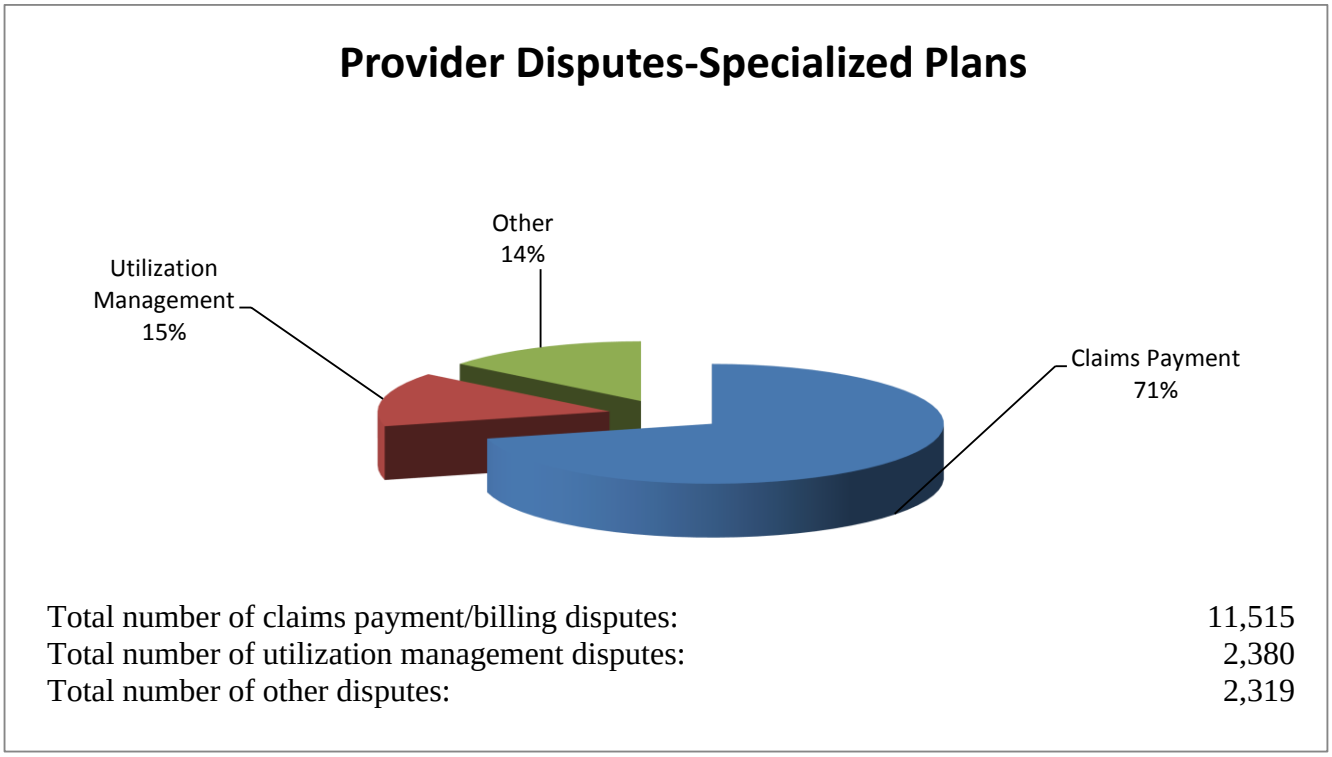
Anthem Blue Cross self-reported noncompliance with the provider dispute resolution timeliness requirement. The Plan experienced an unanticipated and significant increase in provider dispute inventory due to a reorganization of work distribution and ownership. This increase caused a backlog in dispute inventory. As part of their corrective action plan to the DMHC the Plan increased overtime coverage of staff and brought in additional resources to process the backlog of disputes.

IV.

Specialized Health Plans

California's 44 licensed, specialized health plans processed approximately 25 million health care claims and reported receiving 16,214 provider disputes during the 2012 reporting period, a three percent decrease from 2011[4]. Similar to full service health plan reporting results, the majority of provider disputes (71%) submitted to specialized health plans are claims payment/billing disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3



Total number of claims payment/billing disputes:	11,515
Total number of utilization management disputes:	2,380
Total number of other disputes:	2,319

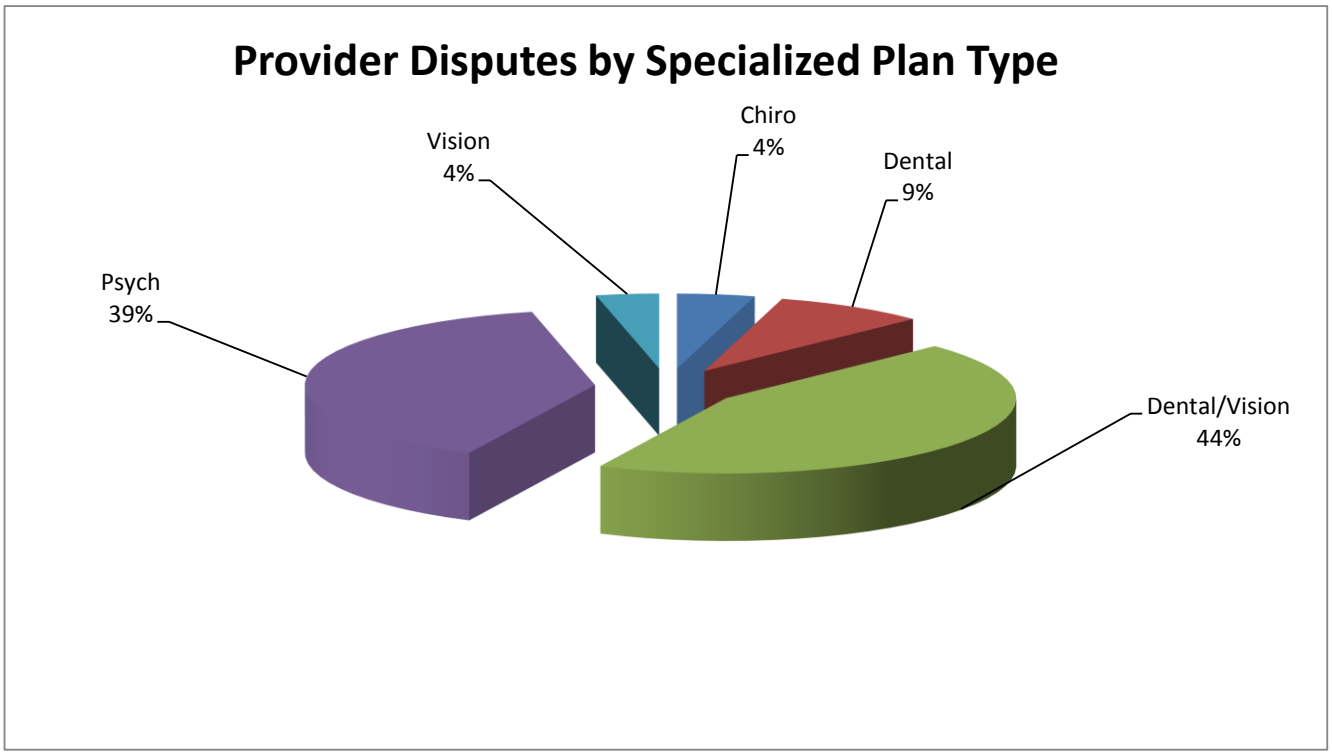
Specialized health plans reported that 99 percent of all provider disputes were resolved within 45 working days from the date of receipt. Several specialized health plans noted a decrease in the number of disputes submitted this year. Disputes were primarily related to timely claim filing deadlines.

[4] There are a total of 52 licensed specialized health plans; however, eight specialized health plans are not subject to the provider dispute resolution reporting requirements, these included three discount health and five pharmacy plans.

Contracted providers are required to submit claims within 90 days of the date of the service provided. Specialized plans continue to educate and remind providers of the claims timely filing requirements

Of the 16,214 total provider disputes submitted to specialized health plans during the 2012 reporting period, dental plans (including dental/vision plans) accounted for over half of the disputes, followed by mental health plans with 39 percent, chiropractic plans at four percent, and vision plans at four percent. (See Chart 4). Please note in Chart 4 below, provider disputes for Delta Dental of California are included as "Dental/Vision" disputes. Delta Dental of California makes up a significant portion of total specialized enrollment, reporting over 17 million enrollees for the quarter ended September 30, 2012.

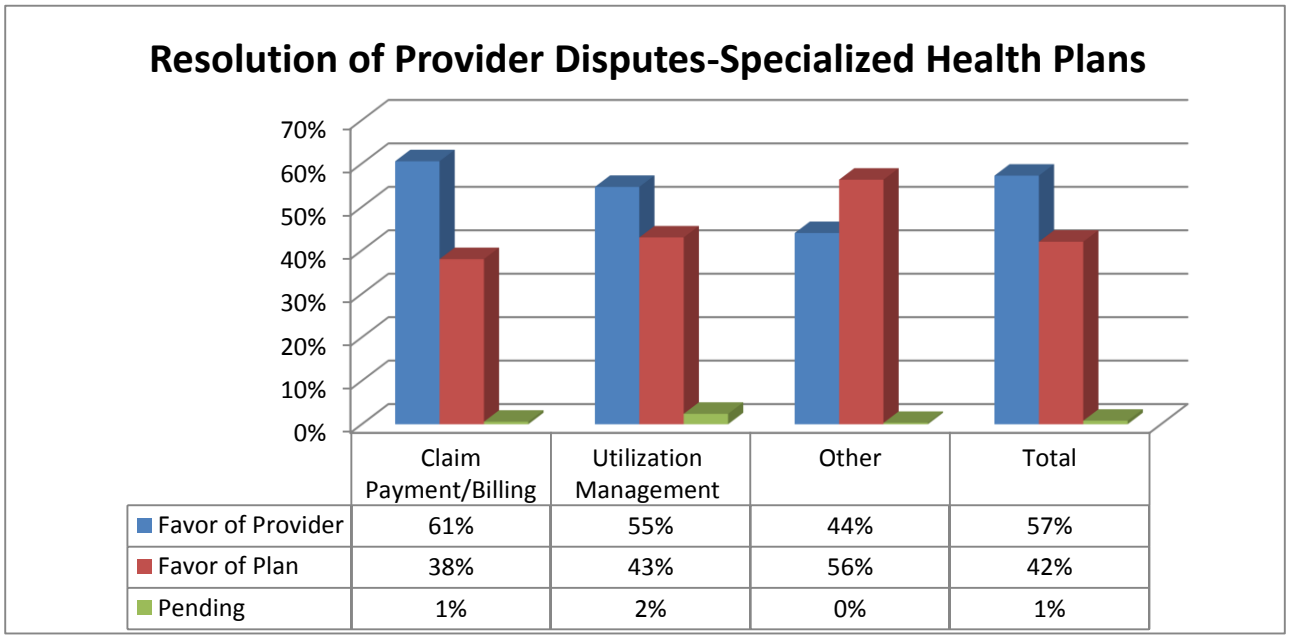
Chart 4



Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 57 percent of all provider disputes were resolved in favor of the provider, an increase of ten percent from the 2011 reporting period. Sixty-one percent of disputes involving claims payment and billing issues were resolved in favor of the provider versus 38 percent in favor of the plan. This is a shift from 2011 which showed disputes involving claims payment and billing issues at 44 percent in favor of the provider and 50 percent in favor of the plan. Utilization management disputes are resolved in favor of providers slightly more than half (55%) the time and other disputes are more often resolved in favor of health plans. (See Chart 5).

Chart 5



	Claim Payment/Billing	Utilization Management	Other	Total
Favor of Provider	61%	55%	44%	57%
Favor of Plan	38%	43%	56%	42%
Pending	1%	2%	0%	1%

V.

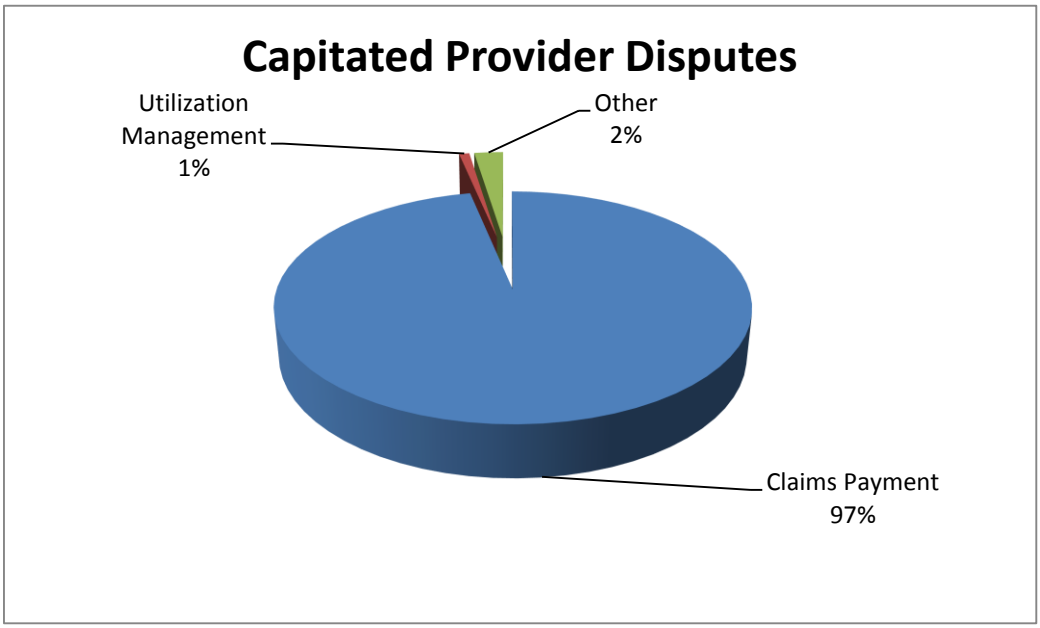
Capitated Providers

All health plans are required to compile and provide a dispute resolution report for each capitated provider with whom they contract. Based upon the number of filings received, the DMHC has identified 294 capitated providers that are contracted with full service health plans.

Health plans report a total of 493,591 provider disputes filed with capitated providers during the reporting period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. The contracted capitated providers must also file annually to their health plans. The reporting requirements for capitated providers are similar to full service and specialized health plan reporting.

Capitated providers processed approximately 36 million claims in 2012. Nearly all provider disputes (97%) received by capitated providers involved claim payment and billing issues. Chart 6 reflects the breakdown of provider complaints with capitated providers.

Chart 6



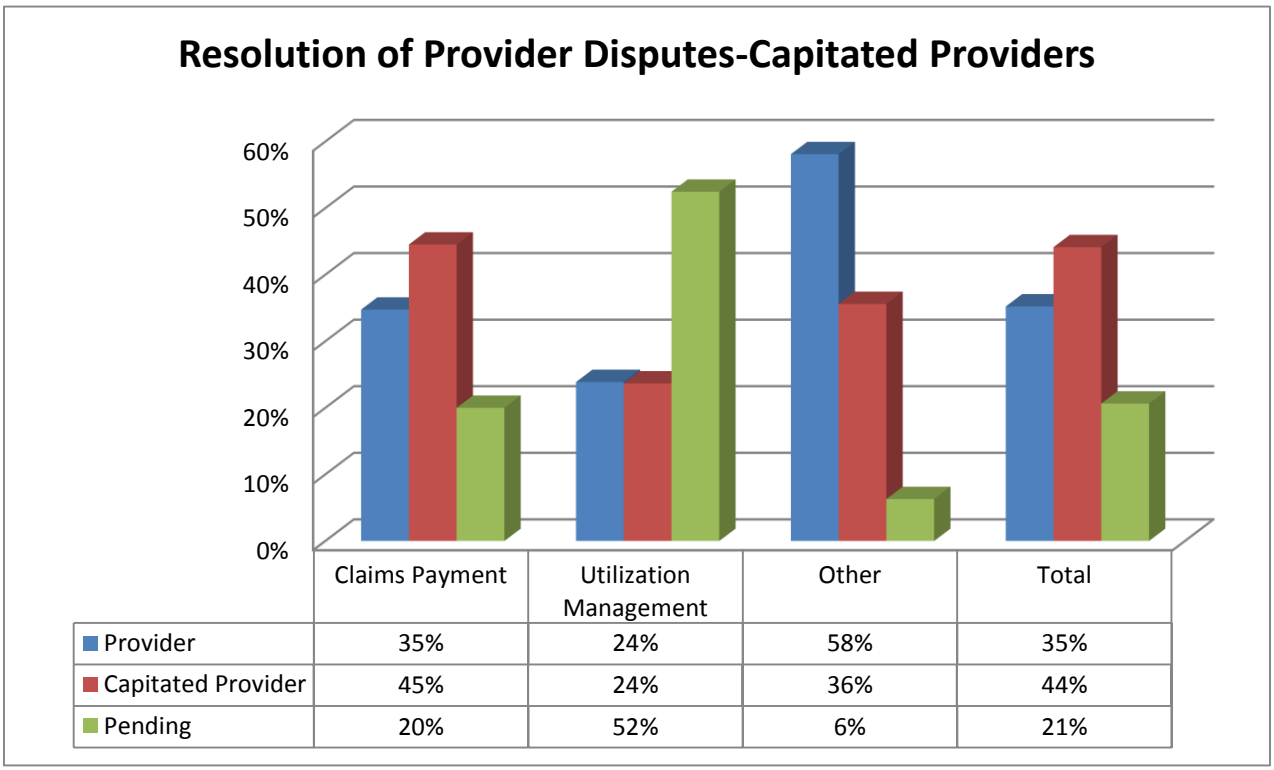
Total number of claims payment/billing disputes:	477,396
Total number of utilization management disputes:	4,268
Total number of other disputes:	11,927

Approximately 92 percent of claims processed were paid or adjusted and eight percent of the claims processed were contested or denied. In addition, capitated providers processed approximately 99 percent of claims within regulatory time frames.

Disposition of Capitated Providers' Provider Disputes

In 2012, the number of capitated provider disputes increased eight percent from 2011. Of the 493,591 provider disputes submitted, 35 percent were resolved in favor of the provider submitting the dispute, 44 percent were resolved in favor of the capitated provider, and 21 percent were pending review as of September 30, 2012. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



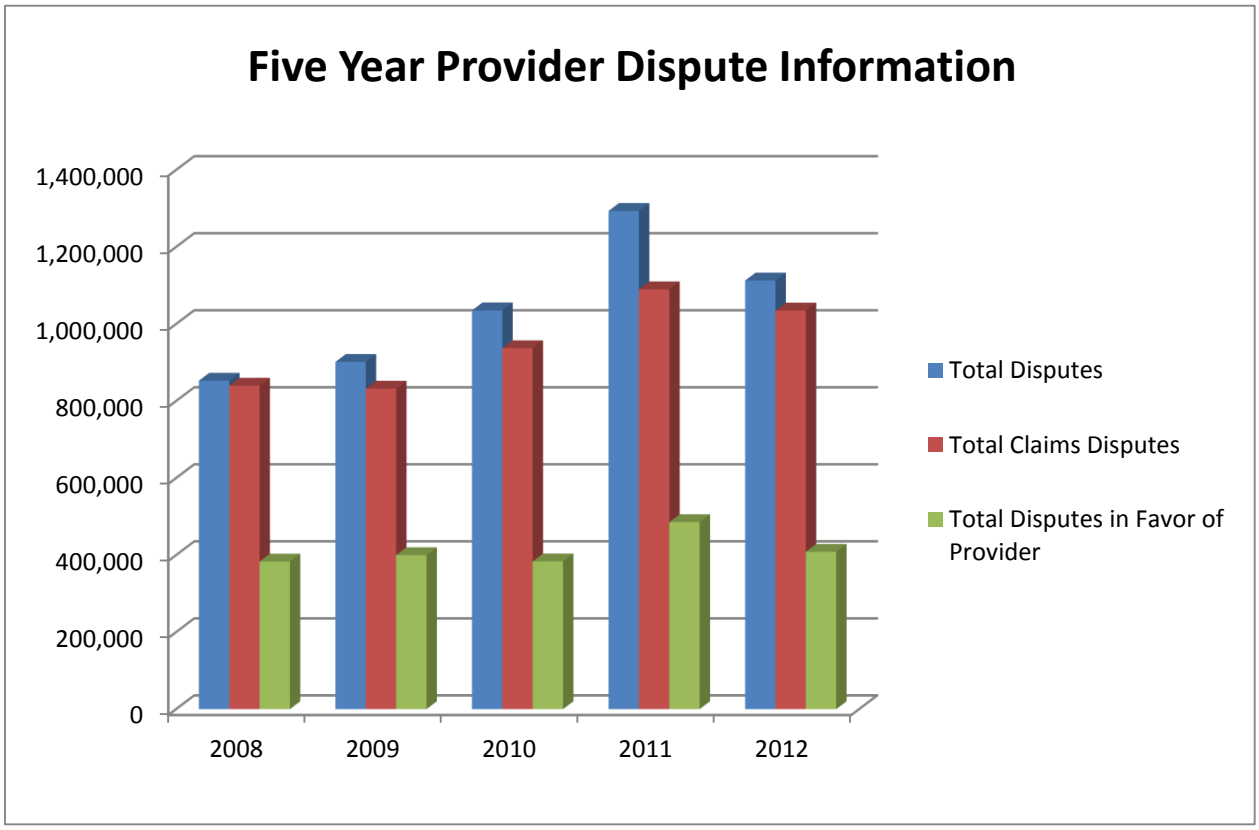
	Claims Payment	Utilization Management	Other	Total
Provider	35%	24%	58%	35%
Capitated Provider	45%	24%	36%	44%
Pending	20%	52%	6%	21%

VI.

Provider Dispute Trends

Chart 8 displays the trend for the volume of disputes reported by Full Service, Specialized and Capitated Providers over a five year period. The blue bar represents the total number of disputes reported, the red bar represents total claims disputes reported and the green bar represents the total number of disputes in favor of the provider reported. The chart shows a decrease in the total number of disputes from 2011 to 2012 and corresponding decreases in claims disputes reported and disputes in favor of the provider. In 2008, 45% of the disputes received were decided in favor of the provider, that percentage decreased in 2012 to 37%. The downward trend of disputes in favor of the provider as a percentage of total disputes has continued from previous years.

Chart 8



VII.

Summary

The provider dispute resolution data summarized in this report is self-reported by plans and capitated providers, and may not include all provider disputes occurring throughout the managed care industry in California. Further, there are substantive differences in the way plans identify, quantify and track provider disputes. The quality and accuracy of this self-reported data is evaluated through the DMHC's regular onsite auditing activities, and review of quarterly and annual claims payment and dispute resolution reports. If the DMHC finds deficiencies, the plans and capitated providers are required to promptly institute appropriate corrective action which the DMHC monitors. In addition, the DMHCs' Provider Complaint Unit continues to monitor the industry's compliance efforts in achieving claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71.