REPORT OF HEALTH CARE SERVICE PLANS' PROVIDER DISPUTE RESOLUTION MECHANISMS

2013 ANNUAL REPORT

June 18, 2014

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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(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2013 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, 2012 through September 30, 2013.

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 41 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f). Twenty-four licensed, full service health plans are excluded from the report because they provide Medicare products, and are therefore exempt from Health and Safety Code section 1367(h).

- Full service health plans processed more than 109 million claims in the 2013 reporting period. 798,999, or 0.73 percent, of these claims resulted in a provider dispute. The majority of provider disputes (679,109, or 85% of provider disputes) were claim payment/billing disputes.

- Full service health plans received 798,999 provider disputes for the reporting period.

[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).

- California's seven largest full service health plans[2] provide health care benefits to over 16 million (72 percent) of the approximately 23 million full service health plan enrollees.

- California's seven largest full service health plans processed more than 89 million claims, accounting for 82 percent of all claims filed by full service health plans in California.

- Approximately 65 percent of the reported provider disputes were filed with the seven largest full service health plans.

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

- Approximately 91 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.

- Providers prevailed in 37 percent of all disputes; plans upheld their original determinations in 52 percent of the disputes, and 11 percent of the disputes are pending as of the date of this report.

Specialized Health Plans:

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

- There are 52 licensed specialized health plans subject to the provider dispute reporting requirements.

- Specialized health plans processed more than 24 million claims in the 2013 reporting period. 19,884, or 0.008%, of these claims resulted in a provider dispute. The majority of provider disputes (15,868, or 80% of provider disputes) were claim payment/billing disputes.

- Providers prevailed in 56 percent of all provider disputes with specialized health plans, a decrease of one percent from the 2012 reporting period.

- Plans upheld their original determinations in 43 percent of the claims payment and billing disputes. This is a shift from the 2012 reporting period which showed 38 percent of disputes were upheld in favor of the plan.

- Approximately 80 percent of provider disputes with specialized health plans involved claims payment and/or billing problems.

[2] California's seven largest full service plans are Aetna Health of California, Anthem 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.

- More than half (56 percent) of all specialized health plan provider disputes were with dental plans. Dental plans accounted for 57 percent of the total enrollment in specialized health plans required to report.

Capitated Providers:

Capitated providers are providers that have contracted with a full service health plan to assume financial risk and pay claims for the provision of health care services to the plan's enrollees.

- Full service and specialized health plans reported data on 291 capitated providers. This includes risk bearing organizations (RBOs), capitated hospitals, and certain other provider groups that do not meet the definition of an RBO.

- Capitated providers processed approximately 39 million claims and received 548,166 provider disputes in the 2013 reporting period.

- Nearly all (97 percent) disputes involved claims payment and/or billing problems.

- Thirty-six 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

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

(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.

Plans are required to summarize 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, 2012 through September 30, 2013.

III.

Full Service Health Plans

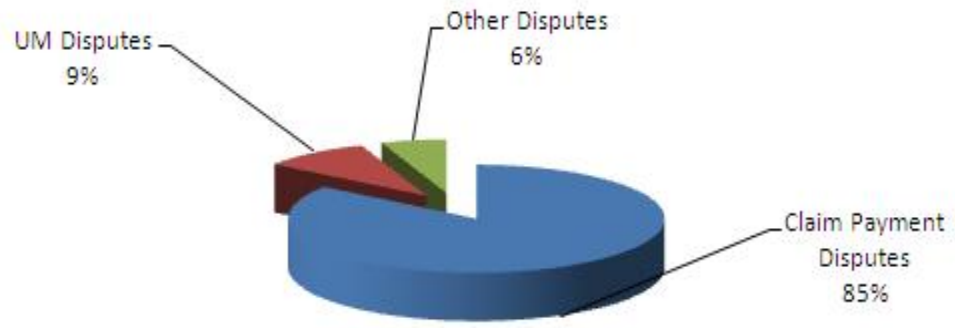
Of the 65 licensed full service health plans, data from 41 full service health plans is included in this report. Twenty-four licensed, full service health plans are excluded because they only offer Medicare products, and are therefore exempt from Health and Safety Code section 1367(h).

The 41 full service health plans reported a total of 109 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 798,999 provider disputes during the 2013 reporting period. This represents a 33 percent increase in disputes over the 2012 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 85 percent of the full service health plan provider disputes. (See Chart 1)

Chart 1



Total number of claims payment/billing disputes:	679,109
Total number of utilization management disputes:	74,834
Total number of other disputes:	45,056

Regulations require plans to resolve 95 percent of all complete provider disputes within 45 working days. Approximately 91 percent of all provider disputes processed by full service health plans were reported as resolved within the required 45 working days from the date of receipt. This is a two percent decrease over the prior reporting period. 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 include initiating weekly reports to monitor processing timeliness, developing a system to determine the root cause of disputes, providing education to billers/providers, and hiring additional temporary staff to clear dispute backlogs.

The DMHC monitors the health plans' corrective actions through its financial examinations and by analyzing provider complaints received by the DMHC's Provider Complaint Unit.

Provider Disputes Compared to Claims

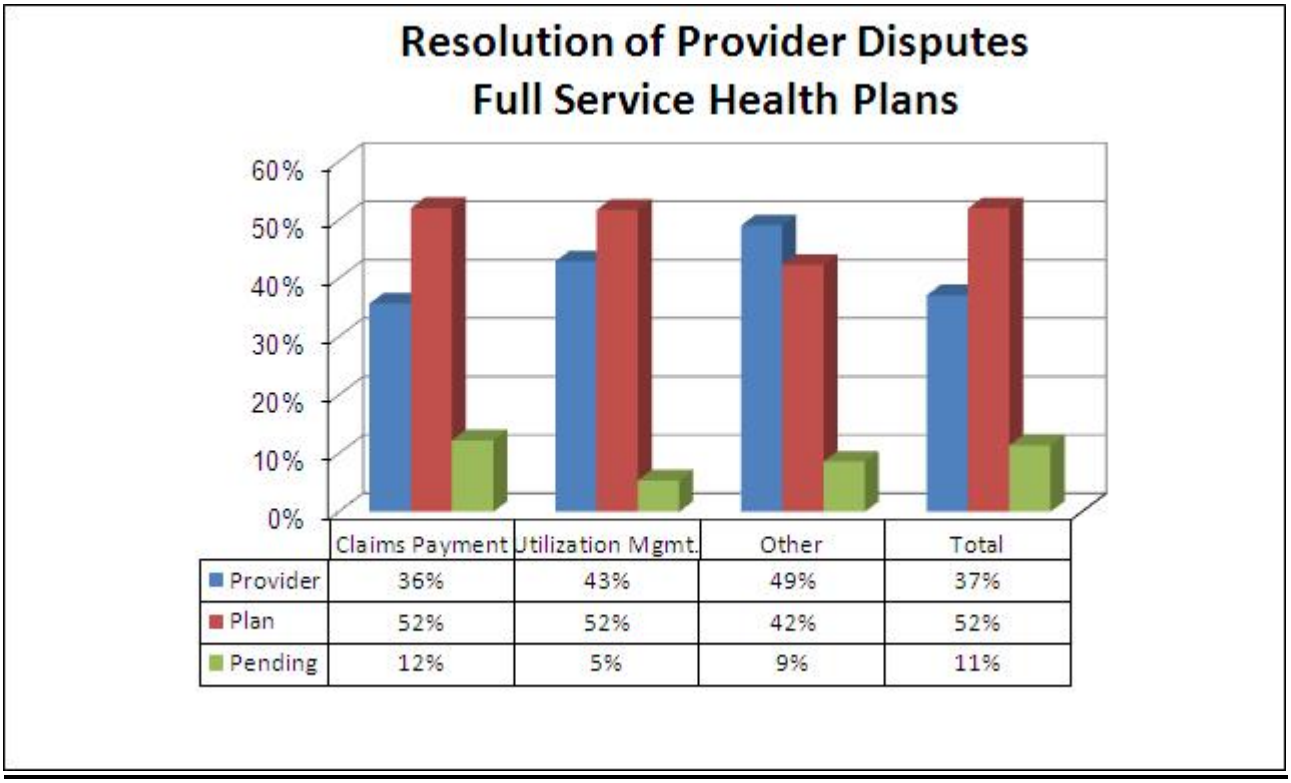
Approximately 84 percent of provider claims processed were paid or adjusted, while 16 percent were contested or denied. Nearly all claims (approximately 99 percent) were processed within 45 working days from the date of receipt.

Of the 109 million claims processed during the reporting period, there were approximately 679,000 provider disputes contesting the full service health plans' reimbursement determinations. This represents less than one percent (0.64 percent) of all claims processed by full service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2013 reporting period, full service health plans reported that 37 percent of all disputes between providers and health plans were resolved in favor of the provider. This was the same percentage of disputes resolved in favor of the provider for the 2012 reporting period. Of the 798,999 provider disputes submitted, 296,676 (37 percent) were resolved in favor of the provider, 411,228 (52 percent) in favor of the plan, and 91,095 (11 percent) were pending review as of September 30, 2013. (See Chart 2).

Chart 2



	Claims Payment	Utilization Mgmt.	Other	Total
Provider	36%	43%	49%	37%
Plan	52%	52%	42%	52%
Pending	12%	5%	9%	11%

Seven Largest Full Service Health Plans

California's seven largest full service health plans provide health care benefits to over 16 million enrollees, representing 72 percent of the approximately 23 million enrollees enrolled in health plans licensed by the DMHC. For the 2013 reporting period, 76 percent of provider disputes were filed with these seven plans. Collectively, they processed more than 89 million claims, accounting for 82 percent of all claims processed 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.	7,113,057	1,579,302	70,762	13,917	51,694	5,151	20%	99%
Anthem Blue Cross	3,054,997	53,308,158	236,444	86,037	147,216	3,191	36%	87%
Blue Shield (California Physicians Service)	2,446,176	10,082,951	70,061	36,681	33,244	136	52%	94%
Health Net of California, Inc.	1,161,992	20,600,716	119,466	32,627	39,600	47,239	27%	98%
United Health Care of California	826,587	773,127	9,243	4,175	5,068	0	45%	99%
Aetna Health of California	587,073	3,078,392	10,596	4,631	5,257	708	44%	99%
Cigna Healthcare of California, Inc.	199,567	462,600	6,613	3,744	2,869	0	57%	99%
Total - Seven Largest Health Plans	**15,380,449**	**89,885,246**	**523,185**	**181,812**	**284,948**	**56,425**	**35%**	**93%**
All Other Full Service Health Plans	7,581,323	19,471,114	275,814	114,902	126,922	34,670	42%	87%
Total - All Full Service Health Plans	**22,961,772**	**109,356,360**	**798,999**	**296,714**	**411,870**	**91,095**	**37%**	**91%**

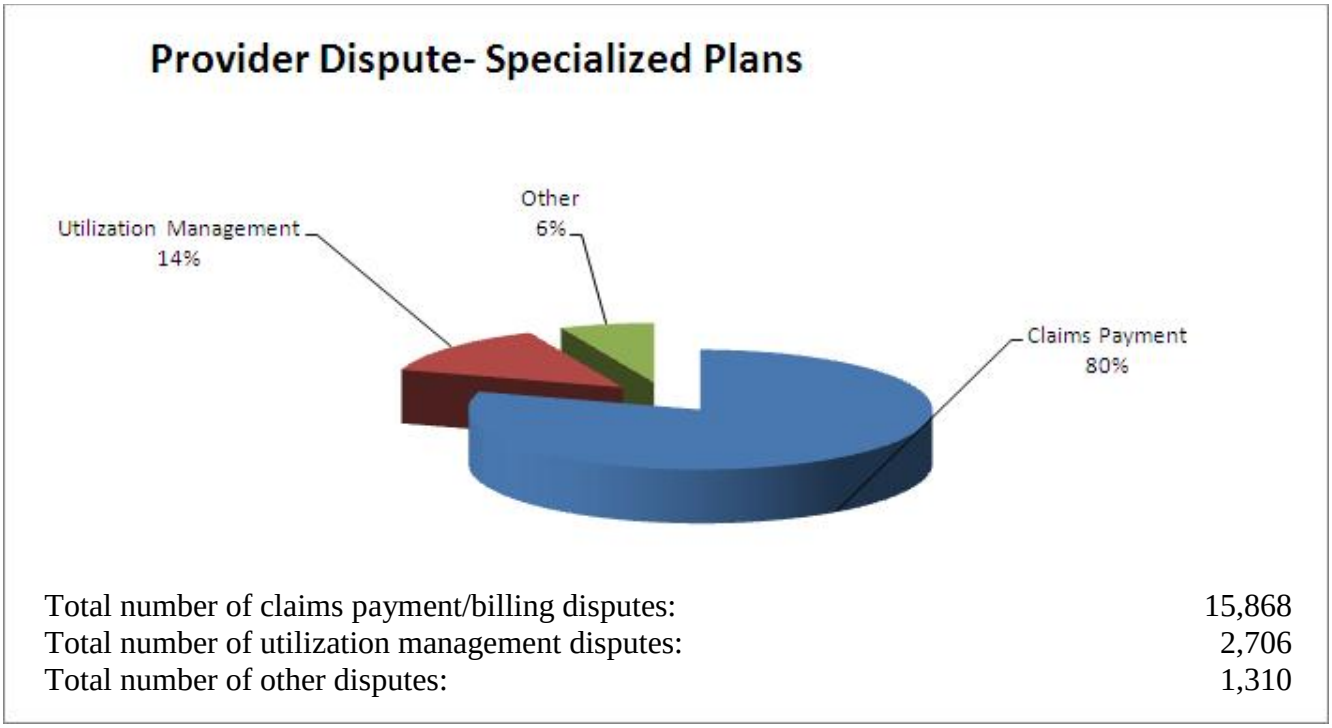
Health plans that fall below the 95 percent compliance requirement for resolving disputes within 45 days are required to file and implement a corrective action plan that is monitored on a quarterly basis by the DMHC and reviewed as part of the health plan's routine financial examination.

IV.

Specialized Health Plans

During the 2013 reporting period, California's 52 specialized health plans processed approximately 24 million provider claims and received 19,884 provider disputes. Specialized health plans noted an increase in the number of provider disputes. Health plans reported 19,884 disputes in 2013 versus 16,214 disputes in 2012. This is a 23 percent increase over 2012[4] reporting period. Of these disputes, 94 percent were resolved within 45 working days from the date of receipt. The majority of provider disputes (80 percent) submitted to specialized health plans involved claims payment/billing disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3

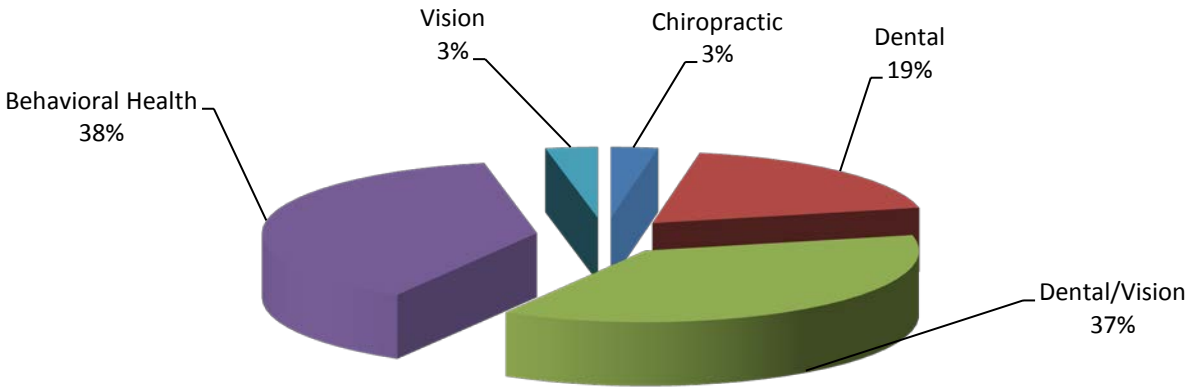


Total number of claims payment/billing disputes:	15,868
Total number of utilization management disputes:	2,706
Total number of other disputes:	1,310

Of the 19,884 total provider disputes submitted to specialized health plans during the 2013 reporting period, dental plans (including dental/vision plans) accounted for over 50 percent of the disputes, followed by mental health plans with 39 percent, chiropractic plans at three percent, and vision plans at three percent (See Chart 4). This is the fourth year dental plans have reported the largest number of disputes in the specialized health plan category.

[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 include three discount health plans and five pharmacy plans.

Chart 4



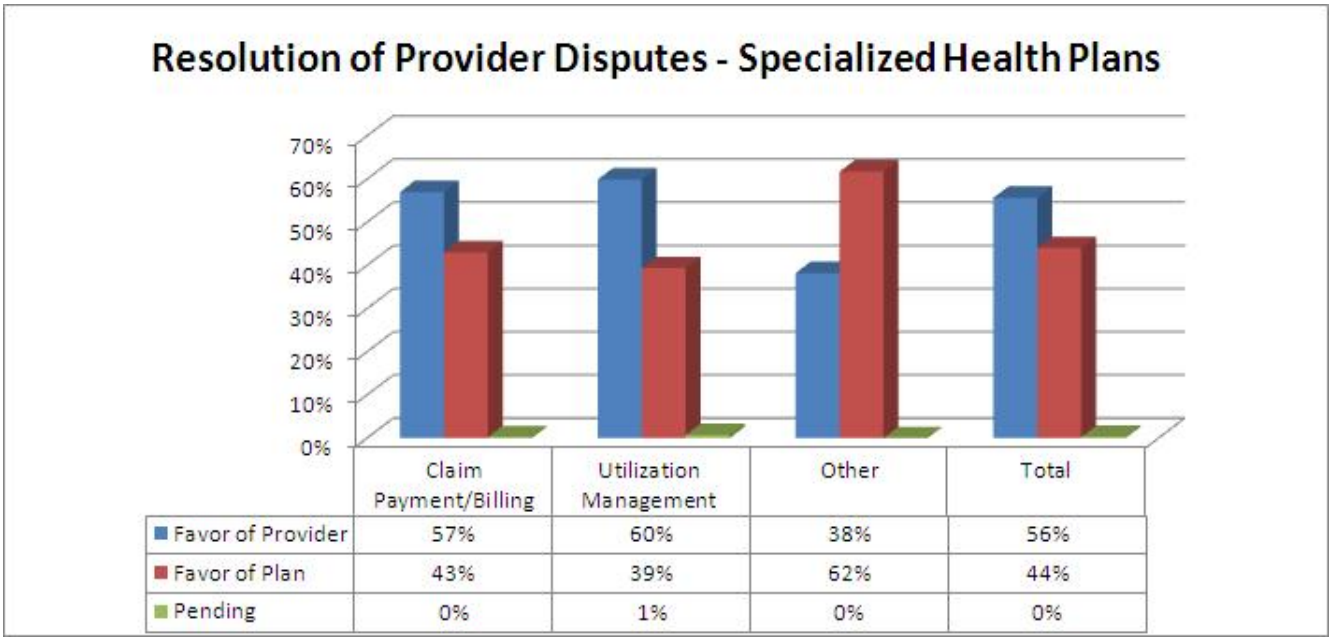
Total disputes by Specialized Plan Type	2013
Behavioral Health	7,647
Vision	613
Chiropractic	551
Dental/Vision	11,073

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 56 percent of all provider disputes were resolved in favor of the provider, a decrease of one percent from the 2012 reporting period. Fifty-seven percent of disputes involving claims payment and billing issues were resolved in favor of the provider versus 43 percent in favor of the plan. Utilization management disputes are resolved in favor of providers 60 percent of the time, while other disputes are more often resolved in favor of health plans. (See Chart 5).

Based on the data, specialized health plans have experienced an overall increase in the number of disputes received from providers. This is attributed to an increase in disputes submitted from dental providers.

Chart 5



	Claim Payment/Billing	Utilization Management	Other	Total
Favor of Provider	57%	60%	38%	56%
Favor of Plan	43%	39%	62%	44%
Pending	0%	1%	0%	0%

V.

Capitated Providers

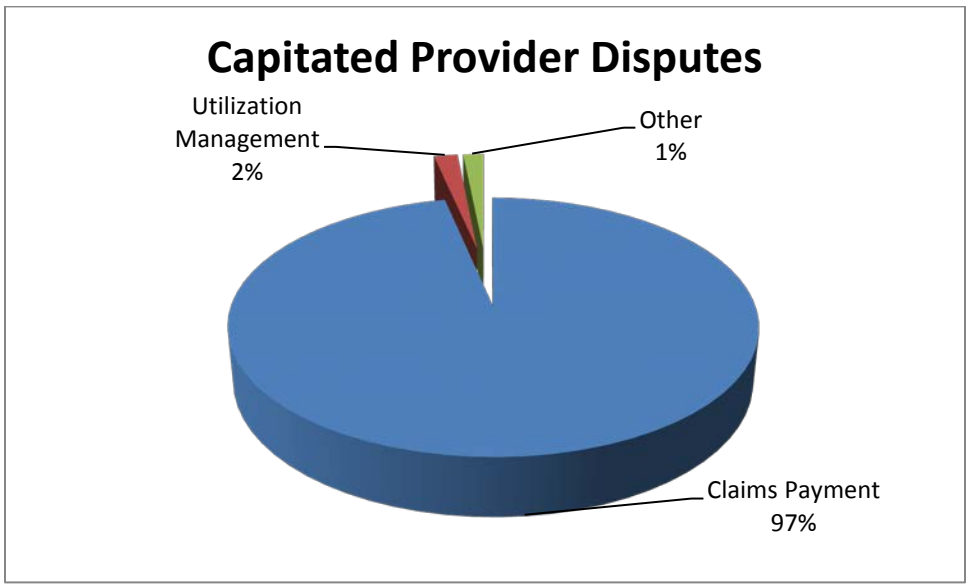
All health plans are required to compile and provide a dispute resolution report for each capitated provider with whom they contract. Based upon the number of filings received, the DMHC has identified 291 capitated providers that contracted with full service health plans.

Health plans report a total of 548,166 provider disputes filed with capitated providers during the reporting period. Capitated providers must file both quarterly and annual provider disputes reports with each of their contracting health plans. The reporting elements for capitated providers are the same for full service and specialized health plan reporting.

Capitated providers processed approximately 40 million claims in 2013. Nearly all provider disputes (97 percent) received by capitated providers involved claim payment and billing issues. Chart 6 reflects the breakdown of provider complaints with capitated providers.

For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes.

Chart 6



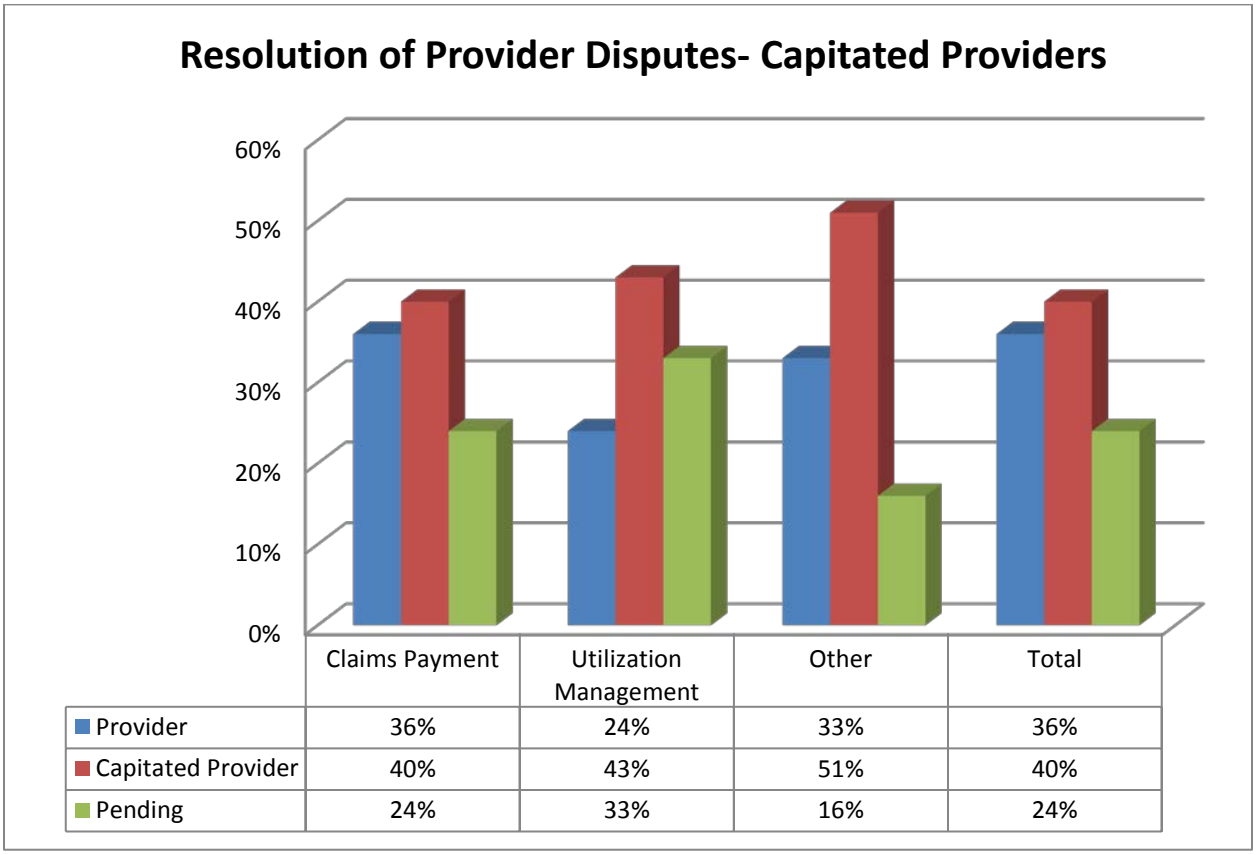
Total number of claims payment/billing disputes:	529,827
Total number of utilization management disputes:	9,848
Total number of other disputes:	8,491

Approximately 92 percent of claims processed were paid or adjusted and 8 percent of the claims processed were contested or denied. In addition, capitated providers processed approximately 99 percent of claims within the 45-day statutory requirement.

Disposition of Capitated Providers' Provider Disputes

In 2013, the number of capitated provider disputes increased 10 percent from 2012. Of the 548,166 provider disputes submitted, 36 percent were resolved in favor of the provider submitting the dispute, 40 percent were resolved in favor of the capitated provider, and 24 percent were pending review as of September 30, 2013. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



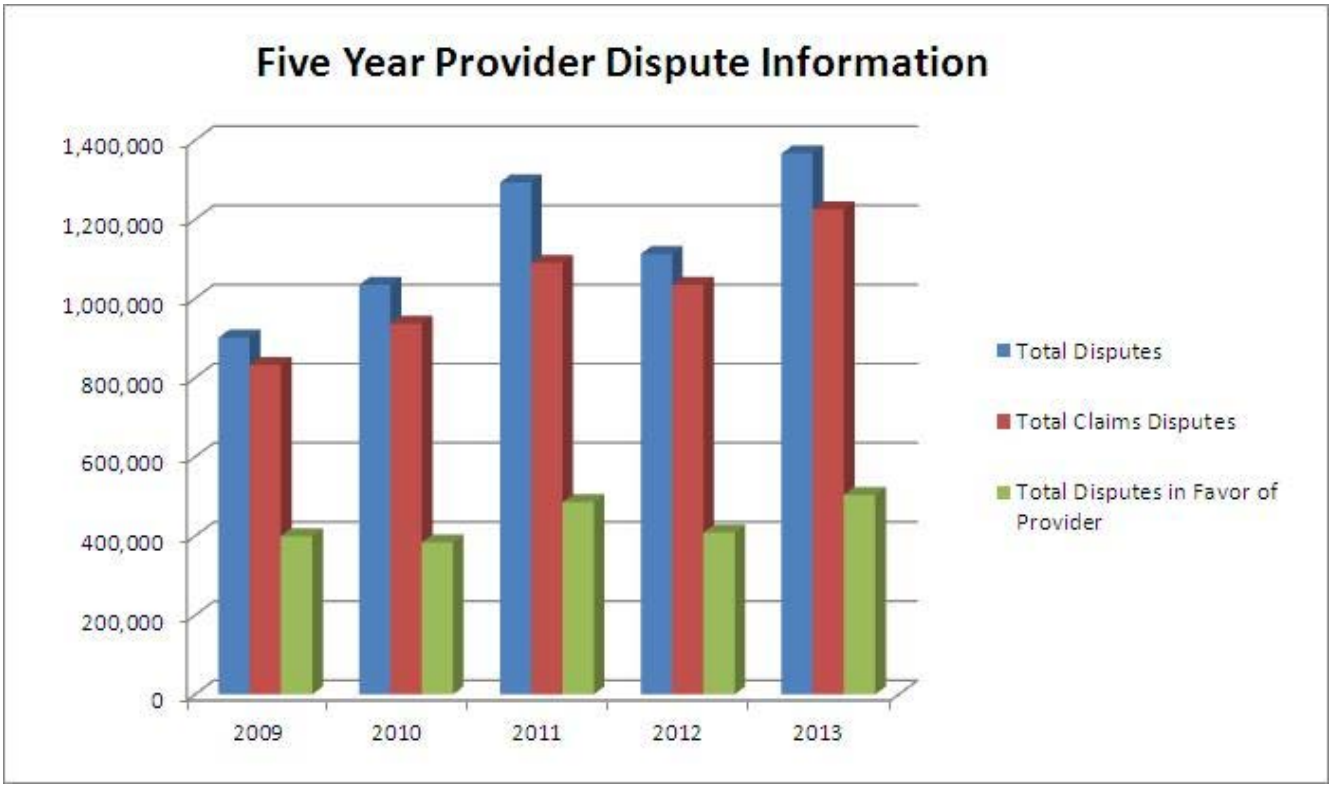
	Claims Payment	Utilization Management	Other	Total
Provider	36%	24%	33%	36%
Capitated Provider	40%	43%	51%	40%
Pending	24%	33%	16%	24%

VI.

Provider Dispute Trends – All Plan Types

Chart 8 displays the trend for the volume of disputes reported by full service plans, specialized plans, 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 an increase in the total number of disputes from 2012 to 2013 and a corresponding increase in the number of claim disputes reported and the number of provider disputes found in favor of the provider. For a five year comparative trend, in 2009, 44 percent of the disputes received were decided in favor of the provider; that percentage decreased in 2013 to 37 percent which indicates more claims were processed correctly upon initial submission.

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. 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 the review of quarterly and annual claims payment and dispute resolution reports. If the DMHC finds claims payment deficiencies, the plans and capitated providers are required to promptly institute appropriate corrective action which the DMHC monitors. In addition, the DMHC Provider Complaint Unit continues to monitor the industry's compliance efforts with the claims payment standards.