2019

ANNUAL REPORT

DEPARTMENT OF
Managed
Health Care

Gavin Newsom, Governor
State of California

Mark Ghaly MD, MPH, Secretary
Health and Human Services Agency

Shelley Rouillard, Director
Department of Managed Health Care

DMHC MISSION, VALUES & GOALS

MISSION

The Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

- Educate and assist California's diverse health care consumers
- Cultivate a coordinated and sustainable health care marketplace
- Regulate fairly, efficiently and effectively
- Foster a culture of excellence throughout the organization

MESSAGE FROM THE DIRECTOR

Many changes occurred in 2019 for the State of California and the DMHC. Governor Gavin Newsom took office in January and launched a series of initiatives to improve and expand access to health care for all Californians. As the new Administration ramped up, the DMHC diligently continued our work to achieve our mission of protecting consumers' health care rights and ensuring a stable health care delivery system.

The DMHC had many accomplishments in 2019, many of which are described in this report. The Department implemented new laws, took action against health plans that violated consumers' health care rights and continued to offer direct assistance to consumers through the Help Center. We saved consumers money by reviewing health plans' premium rates, and negotiated lower rates with four health plans. This saved California consumers in the individual and small group markets nearly $30 million in premiums.

The DMHC acted quickly to protect the health care rights of California's most vulnerable populations during the natural disasters and public safety power shutoffs that occurred throughout California in the fall. The Department ensured health plans took critical action to ensure these vulnerable individuals were able to obtain needed services and supplies when Governor Newsom declared a state of emergency. The Department worked with plans to speed up approvals for care, replace lost prescriptions and ID cards, and quickly arrange health care at other facilities if a hospital or doctor's office was not available due to the emergency. Staff throughout the Department stepped up to assist these vulnerable populations by staffing a statewide hotline to provide resources to those impacted by the power shutoffs.

The DMHC convened a Task Force on Pharmacy Benefit Management (PBM) Reporting, as required by Assembly Bill (AB) 315 (Wood, 2018) and facilitated four Task Force meetings. The purpose of the Task Force was to determine what information, related to pharmaceutical costs, health care service plans or their contracted pharmacy benefit managers should report to the DMHC. The DMHC submitted the Task Force's recommendations to the Legislature in February 2020.

As a condition of approving health plan mergers, the DMHC often negotiates undertakings which the acquiring health plan must accomplish. Two major initiatives, the Symphony Provider Directory and Encounter Data Improvement, made great strides in 2019. These industry initiatives require collaboration across the health care industry to reduce health plan and provider burden in keeping health plan provider directories up-to-date, and to improve the quality, accuracy and timeliness of encounter data. I am proud of the progress both initiatives made in 2019 and of the industry leaders who are making them successful.

We continued the DMHC Academy to develop the future leaders of the DMHC and graduated two cohorts in 2019. Since launching the Academy in 2017, the Department has trained nearly 100 staff on topics such as the history and purpose of the DMHC and the Knox Keene Act, an overview of the industry we regulate and the evolution of California's health care delivery system, consumers' health care rights, the DMHC's relationships with the Health and Human Services Agency and our sister departments including the Department of Health Care Services and Covered California, and the impact of the DMHC on the health care delivery system.

The DMHC Help Center offers assistance to Californians in all languages for free. If a consumer is having a problem with their health plan, they can file a grievance with their plan. If they are not satisfied with their health plan's resolution of the grievance or if the grievance has not been resolved after 30 days, they should contact the DMHC Help Center at 1-888-466-2219 or www.HealthHelp.ca.gov.

If a consumer is experiencing an imminent or serious threat to their health, they should contact the DMHC Help Center immediately. There is no cost to a consumer for filing a complaint, and the DMHC Help Center can assist consumers in all languages. Help on urgent matters is available 24 hours a day, seven days a week.

I am very grateful to all the DMHC staff for their talent, productivity and dedication to our mission, even under very stressful circumstances. They are the epitome of dedicated public servants and I am proud of them all.

Sincerely,

Shelley Rouillard

Director

Department of Managed Health Care

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DEPARTMENT OF
Managed Health Care

2019

$256 MILLION

dollars saved on Health Plan Premiums through the Rate Review Program

$115.2 MILLION

dollars in payments recovered to physicians and hospitals

2.4 MILLION CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

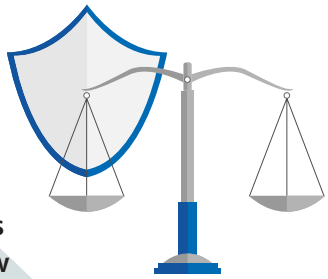
26.4 MILLION

CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

96% of commercial and public health plan enrollment is regulated by the DMHC

$80 MILLION

dollars assessed against health plans that violated the law



$34 MILLION

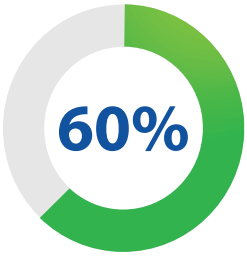
dollars recovered from health plans on behalf of consumers

125

LICENSED HEALTH PLANS

80 FULL SERVICE

45 SPECIALIZED



INDEPENDENT MEDICAL REVIEW (IMR)

Approximately **60%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan.

DEPARTMENT OF Managed Health Care

KNOW YOUR HEALTH CARE RIGHTS

In California, health plan members have the right to:

- basic health care services
- choose your primary doctor
- an appointment when you need one (timely access to care)
- see a specialist when medically necessary
- receive treatment for certain mental health conditions
- get a second doctor's opinion
- know why your plan denies a service or treatment
- understand your health problems and treatments
- translation and interpreter services
- give informed consent when you have a treatment
- file a complaint and ask for an Independent Medical Review (an external appeal of your plan's denial of services or treatment)
- a copy of your medical records (you may be charged)
- continue to see your doctor, even if they no longer participate in your plan (under certain circumstances)
- be notified of an unreasonable rate increase
- not be illegally balance billed by a health care provider
- see a written diagnosis (description of your health problem)

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

How can you get help from the DMHC?

The DMHC protects you by making sure your health plan follows the law and ensures health plans are spending money in a way that helps you.

Most people who live in California are enrolled in a health plan regulated by the DMHC. Because of this, the DMHC Help Center is a good place to start if you have a problem with your health plan.

The DMHC Help Center assists consumers with understanding their health care rights, benefits and to resolve health plan issues.

If you are having issues with your health plan, you should file a grievance with your plan. If you are not satisfied with your health plan's resolution of the grievance or have been in your plan's grievance system for 30 days, you should contact the DMHC Help Center for assistance. If your issue is urgent, you should contact the DMHC Help Center immediately.

The DMHC Help Center provides help in all languages. Help is available by calling 1-888-466-2219 or at www.HealthHelp.ca.gov. ALL SERVICES ARE FREE.

Introduction

Created by consumer-sponsored legislation in 1999, the DMHC regulates the majority of health coverage in California including 96% of commercial and public health plan enrollment. In 2019, the DMHC's budget was $94,465,000 with 482 positions. The DMHC is funded by assessments on its regulated health plans.

The DMHC began operations in 2000 as the first state department in the country dedicated solely to regulating managed health care plans and assisting consumers to resolve disputes with those plans. The Department educates consumers about their health care rights, helps them resolve complaints with their health plans, assists consumers in navigating their health coverage and ensures consumers can access necessary health care services. As of the end of 2019, the DMHC has assisted approximately 2.4 million consumers.

In 2019, 80 full service health plans licensed by the DMHC provided health care services to more than 26 million Californians. This included approximately 13.9 million commercial enrollees and approximately 12.6 million government enrollees.

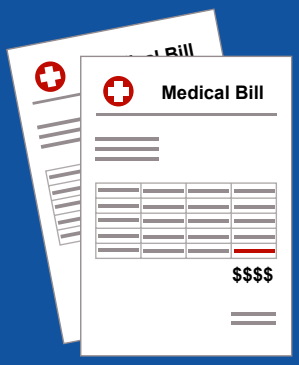
In addition to full service health plans, the DMHC oversees 45 specialized health plans including chiropractic, dental, vision, psychological (behavioral health) and pharmacy.

The DMHC licenses and regulates the full scope of managed care models, including all Health Maintenance Organizations (HMO) in California, as well as Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Point-of-Service (POS) products and Medi-Cal managed care plans. The Department also licenses and conducts financial reviews of Medicare Advantage and Part D plans. The enrollment overview charts[1] on the next page illustrate how enrollment under the DMHC is distributed between commercial and government enrollment.

SURPRISE BALANCE BILLING

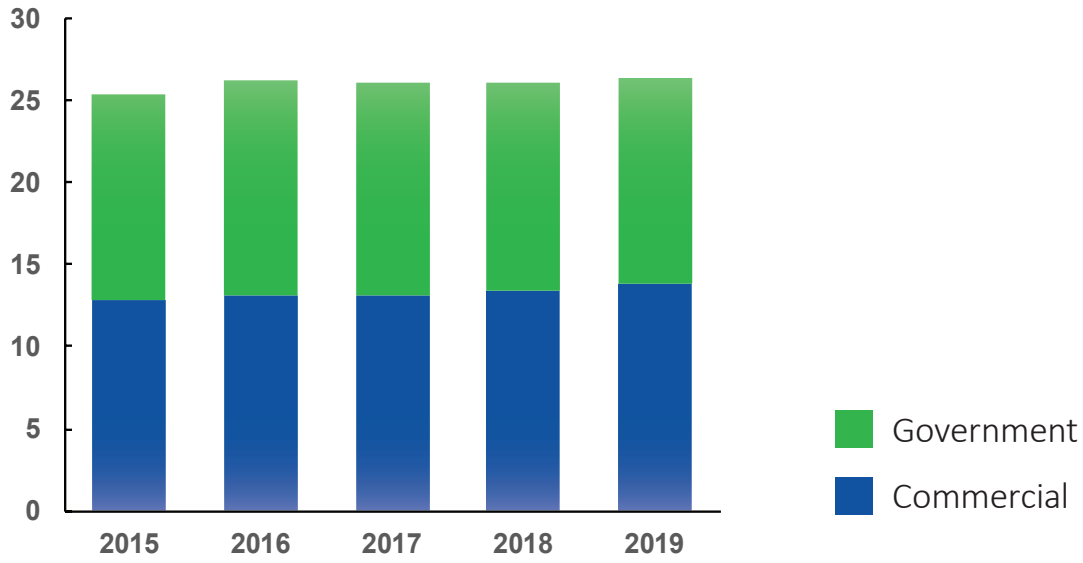
Health care consumers in DMHC-regulated plans are protected from surprise balance billing. Under a law passed in 2016, consumers are protected from being put in the middle of billing disputes between health plans and out-of-network providers. Consumers can be billed only for their in-network cost-sharing when they use an in-network facility such as a hospital.

File a grievance/complaint with your health plan if you have received a surprise bill. Your health plan will review your grievance and should tell the provider to stop billing you. If you do not agree with your health plan's response or the plan takes more than 30 days to fix the problem, you can file a complaint with the DMHC Help Center by calling 1-888-466-2219 or at www.HealthHelp.ca.gov.

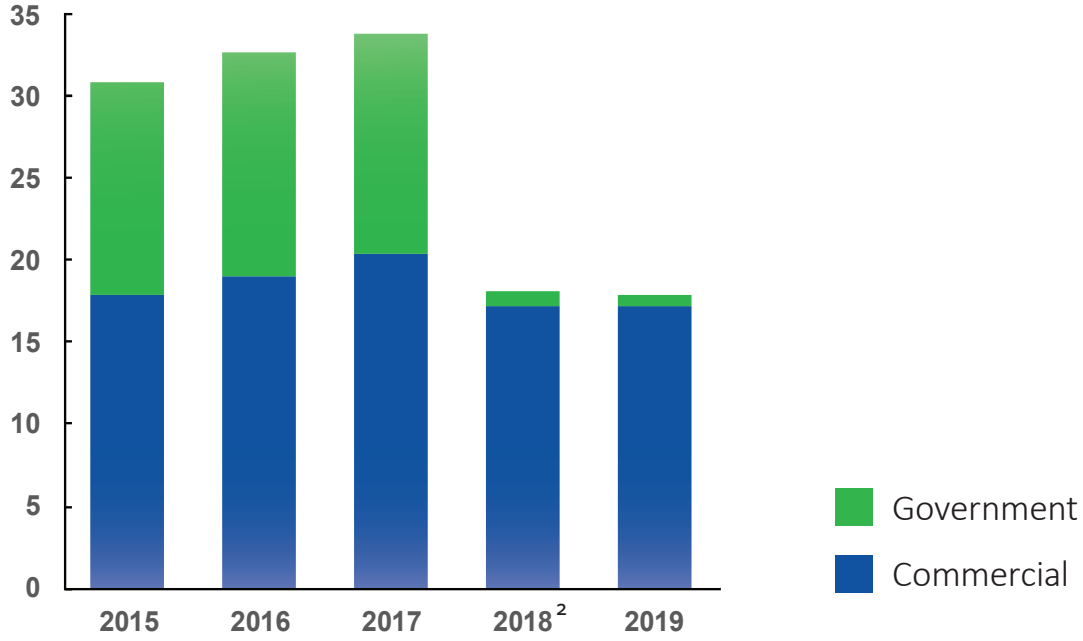


Enrollment Overview

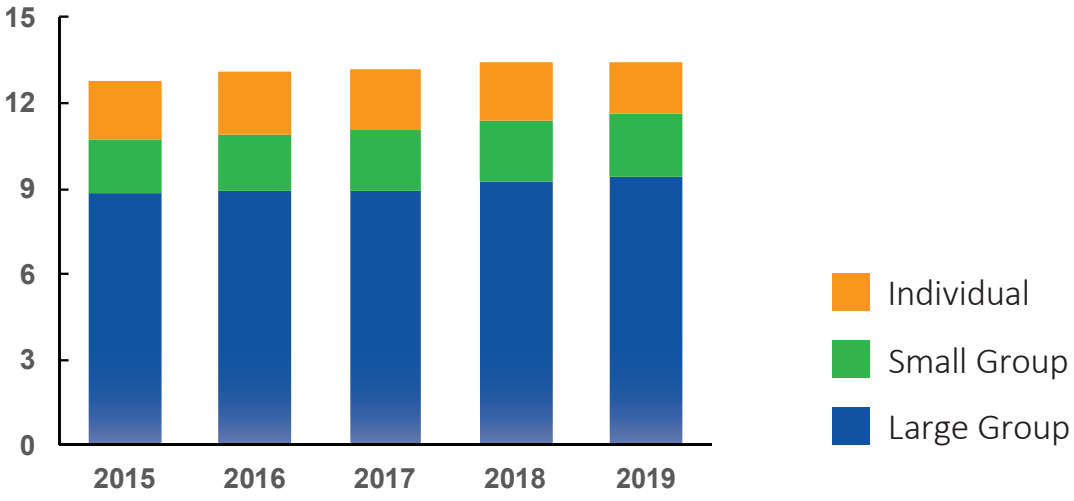
Full Service Enrollment (In Millions)



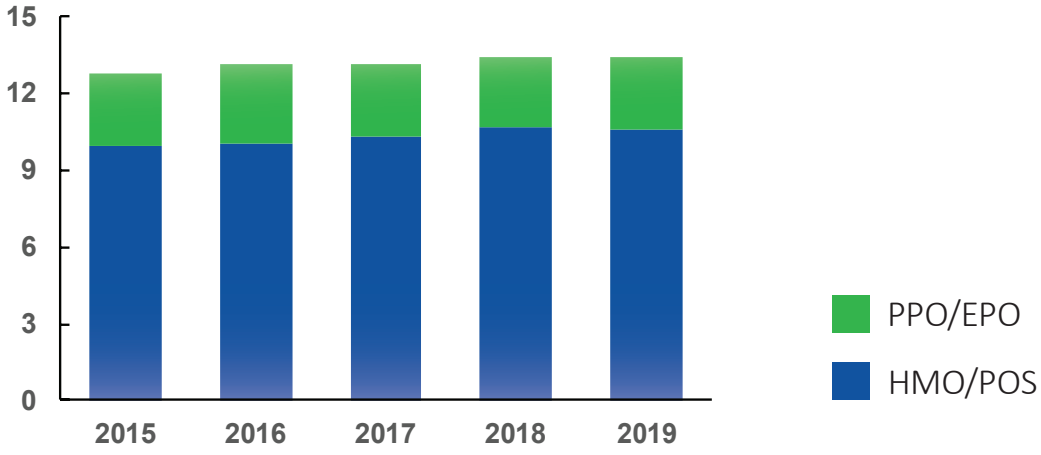
Specialized Enrollment (In Millions)



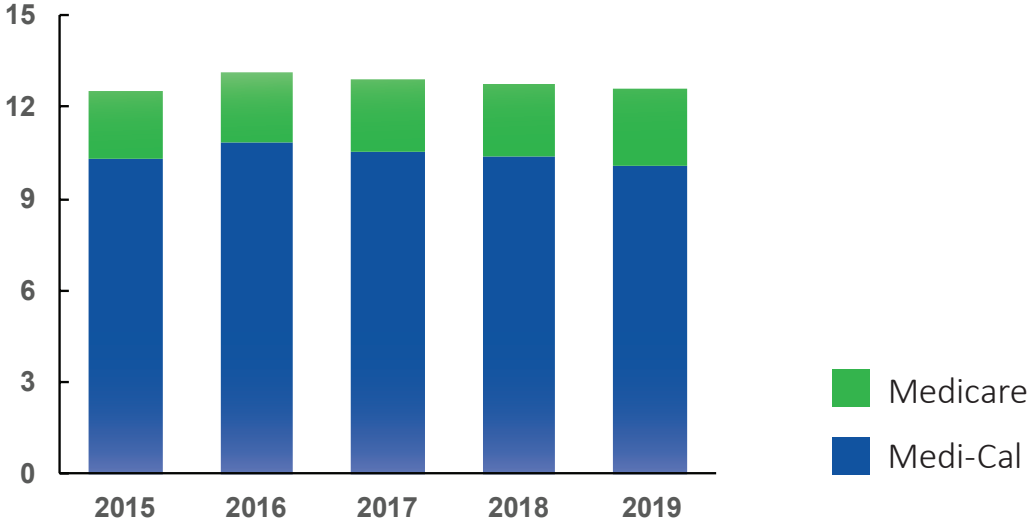
Commercial Enrollment by Market (In Millions)



Commercial Enrollment by Product (In Millions)



Government Enrollment by Type (In Millions)



DMHC Help Center

The DMHC Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage and assists consumers in getting timely access to appropriate health care services. The DMHC Help Center provides direct assistance to health care consumers through the Department's website, www.HealthHelp.ca.gov, and a toll-free phone number, 1-888-466-2219.

If a consumer is experiencing an issue with their health plan, they can file a grievance with their plan. If they are not satisfied with their health plan's resolution of the grievance or if the grievance has not been resolved after 30 days, they should contact the DMHC Help Center for assistance. If a consumer is experiencing an imminent or serious threat to their health, they should contact the DMHC Help Center immediately.

Through a team of health care analysts, nurses and attorneys, the DMHC Help Center uses a variety of mechanisms to assist consumers. Most consumer problems are resolved through the standard complaint process. Common complaints include cancellation of coverage, billing issues, quality of service, coverage disputes and access complaints.

The Department's Quick Resolution process addresses consumer issues through a three-way call between the DMHC, the consumer and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Independent Medical Review (IMR) program is available to consumers if a health plan denies, modifies or delays a request for a service as not medically necessary or as experimental or investigational. Doctors outside of the plan review these matters and make an independent determination whether the service should be covered. If an IMR is decided in the consumer's favor, the plan must provide the requested service or treatment promptly. All IMR decisions are reported on the DMHC's website with a summary of the issue and outcome for each case.

Consumers with plans and issues outside of the DMHC's jurisdiction who contact the Help Center are transferred or referred to the appropriate agency for assistance. In addition to providing direct consumer assistance, the DMHC also contracts with community-based organizations under the Consumer Assistance Program to provide consumers with local, in-depth assistance.

WHAT IS THE DMHC HELP CENTER?

The Department of Managed Health Care provides assistance to all California health care consumers through the Help Center. The Help Center assists consumers with understanding their health care rights and benefits and resolves health plan issues.

The Help Center provides help in all languages. Help is available by calling 1-888-466-2219 or at www.HealthHelp.ca.gov. All services are free.

2019 Highlights

In 2019, the DMHC Help Center assisted 132,931 health care consumers, and handled 10,521 complaints and 3,595 IMRs. Nearly 60% of consumers who submitted an IMR request to the DMHC Help Center received the service or treatment they requested[3].

The DMHC Help Center launched a new Customer Relations Management (CRM) database in late 2018. Staff use this modernized interface to track and work on consumer cases with improved efficiency for the DMHC, health plans and consumers. Additionally, with the new system, the DMHC Help Center is able to track more than one complaint category per case to more accurately capture consumer concerns. 2019 is the first full year of data captured under this new system.

AB 72 (Bonta, 2016), which prohibits providers from surprise balance billing consumers, also required the DMHC to create an Independent Dispute Resolution Process (IDRP) as a mechanism for non-contracted, non-emergency providers or health plans to dispute the default provider payment amount. In 2019, the DMHC received 32 IDRP applications. Of those, nine were ineligible, non-jurisdictional or withdrawn, and 22 completed the process and a determination letter was issued. One IDRP was pending as of December 31, 2019.

The community-based Consumer Assistance Program served 13,670 consumers and conducted 1,920 outreach events throughout California to educate consumers about their health care rights. Through these outreach events, the Department reached 238,619 consumers.

In addition to providing consumer assistance, the DMHC Help Center assists providers who have claims payment disputes with health plans. In 2019, the DMHC Help Center received 6,711 provider complaints and recovered $10,944,138 in payments for providers.

2019 BY THE NUMBERS

HELP CENTER

132,931 CONSUMERS ASSISTED[4]

117,306 TELEPHONE INQUIRIES

10,521 CONSUMER COMPLAINTS[5]

3,595 IMRs CLOSED[6]

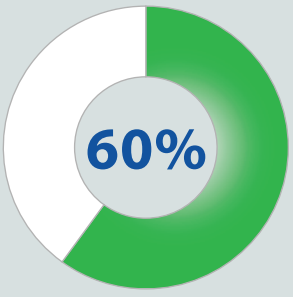
$4.5 M RECOVERED FOR CONSUMERS

1,509 NON-JURISDICTIONAL REFERRALS

6,711 PROVIDER COMPLAINTS

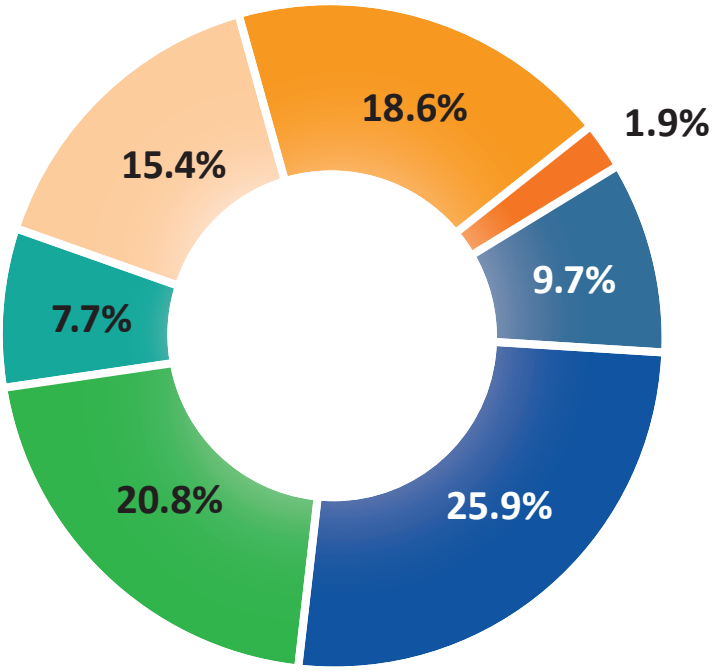
$11 M RECOVERED PROVIDER PAYMENTS

22 AB 72 IDRP CASES COMPLETED



On average, approximately 60% of enrollees that submitted IMR requests to the DMHC received the requested service or treatment.

CONSUMER COMPLAINTS RESOLVED IN 2019



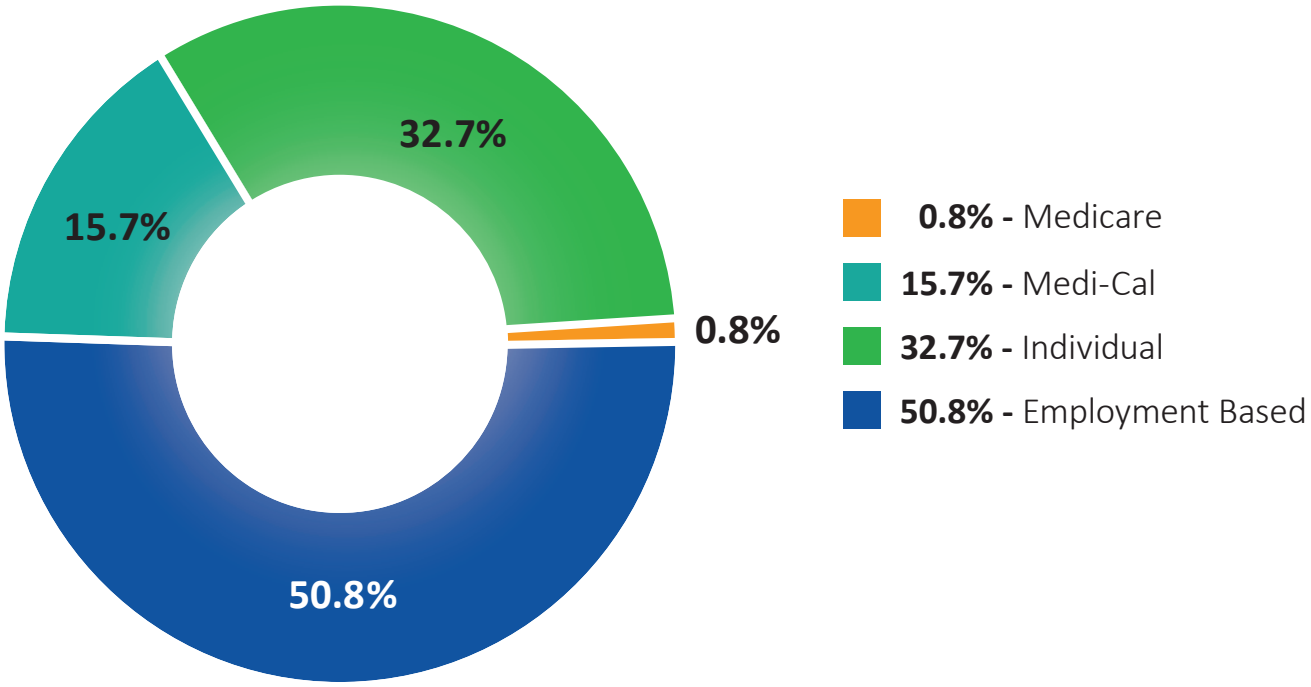
- **1.9% -** Coordination of Benefits[7]
- **7.7% -** Enrollment
- **9.7% -** Access to Care
- **15.4% -** Health Plan Customer Service
- **18.6% -** Provider Customer Service
- **20.8% -** Benefits/Coverage
- **25.9% -** Claims/Financial

Interspersed throughout this report are consumer stories of assistance the DMHC Help Center provided during 2019. The names of enrollees have been changed to protect their identities.

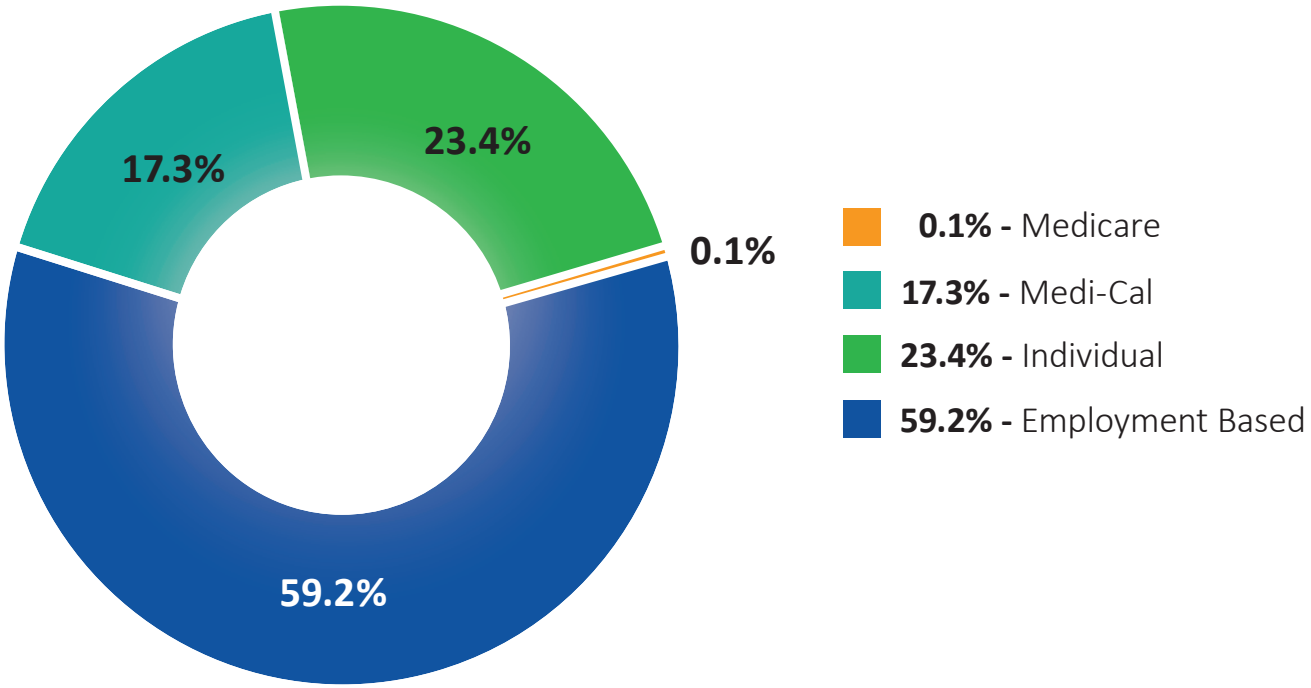
DMHC HELP CENTER ASSISTANCE: ENROLLMENT DISPUTE

Chris, a minor with a condition that requires monthly infusion treatments, was a member of a Small Group PPO health plan through his family's Cal-COBRA. The employer group unexpectedly canceled the plan, leaving Chris uninsured for one month until his parents could secure new coverage. Chris received the necessary infusion treatment during the month he was not covered. His parents contacted the DMHC Help Center for assistance to get Chris health plan coverage for that month, because they could not afford to pay $40,000 out-of-pocket for the infusion treatment. The DMHC Help Center worked with the Cal-COBRA health plan to get Chris coverage for that month and ensured the health plan worked with the provider that treated Chris to cover the infusion at the in-network rate.

CONSUMER COMPLAINTS RESOLVED IN 2019 BY COVERAGE TYPE



IMRs RESOLVED IN 2019 BY COVERAGE TYPE



DEPARTMENT OF Managed Health Care

Timely Access to Care

In California, health care consumers have the right to an appointment when needed.

The law requires health plans licensed by the DMHC to make primary care providers and hospitals available within specific geographic and time-elapsed standards. Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

Urgent Care

prior authorization **not required** by health plan
2 days

prior authorization **required** by health plan
4 days

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN
10 business days

SPECIALTY CARE PHYSICIAN
15 business days

Mental Health Appointment
(non-physician[1])
10 business days

Appointment
(ancillary provider[2])
15 business days

[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury such as physical therapy.

Timely Access to Care Requirements

DISTANCE
Provide access to a primary care provider or a hospital within 15 miles or 30 minutes from where enrollees live or work.

AVAILABILITY
Your health plan should have telephone services available on a 24/7 basis.

INTERPRETER
Interpreter services must be coordinated with scheduled appointments for health care services to ensure interpreter services are provided at the time of the appointment.

Unable to get an Appointment Within the Timely Access Standard?

If you are not able to get an appointment within the timely access standard, you should first contact your health plan for assistance at the toll-free number listed on your health plan card.

The DMHC Help Center is available at 1-888-466-2219 or www.HealthHelp.ca.gov to assist you if your health plan does not resolve the issue. The DMHC Help Center will work with you and your health plan to ensure you receive timely access to care.

If you believe you are experiencing a medical emergency, dial 9-1-1 or go to the nearest hospital. If your health issue is urgent, but not an emergency, and does not require prior approval or authorization from your health plan, you have the right to get care within 48 hours.

The waiting time for an appointment may be extended if a qualified health care provider has determined and made record that a longer waiting time will not be harmful to the enrollee's health.

Plan Licensing

Health plans in California must be licensed by the DMHC. As part of the licensing process, the DMHC reviews all aspects of the health plan's operations, including benefits and coverage (e.g., Evidences of Coverage), template contracts with doctors and hospitals, provider networks, mental health parity and complaint and grievance systems.

After licensure, the DMHC monitors the health plans and any changes they make to their operations, including changes in service areas, contracts, benefits or systems. Health plans are required to file changes as amendments or material modifications, depending on the scope of the change. The DMHC also periodically identifies specific licensing issues for focused examination or investigation.

2019 Highlights

The DMHC reviews proposed health plan mergers with the primary focus of ensuring compliance with the strong consumer protections and financial solvency requirements in the law, ensuring enrollees have continued access to appropriate health care services.

In 2019, the DMHC reviewed and approved Centene's acquisition of DMHC-licensed plans WellCare of California, Inc. and WellCare Prescription Insurance, Inc. The DMHC also approved Anthem, Inc.'s (Anthem) purchase of Beacon Health Options, Inc. (Beacon) which owns Beacon Health Options of California, Inc. (formerly ValueOptions of California, Inc.), a DMHC-licensed health plan that provides employee assistance program services.

AB 315 (Wood, 2018) established various contracting requirements between pharmacy benefit managers (PBMs) and health plans. The bill requires PBMs, which contract with health plans to administer drug benefits, to register with the DMHC. In 2019, the Department established a PBM registration process. The DMHC

2019 BY THE NUMBERS

PLAN LICENSING

4 NEW LICENSES ISSUED

4,443 EVIDENCES OF COVERAGE REVIEWED

1,377 ADVERTISEMENTS REVIEWED

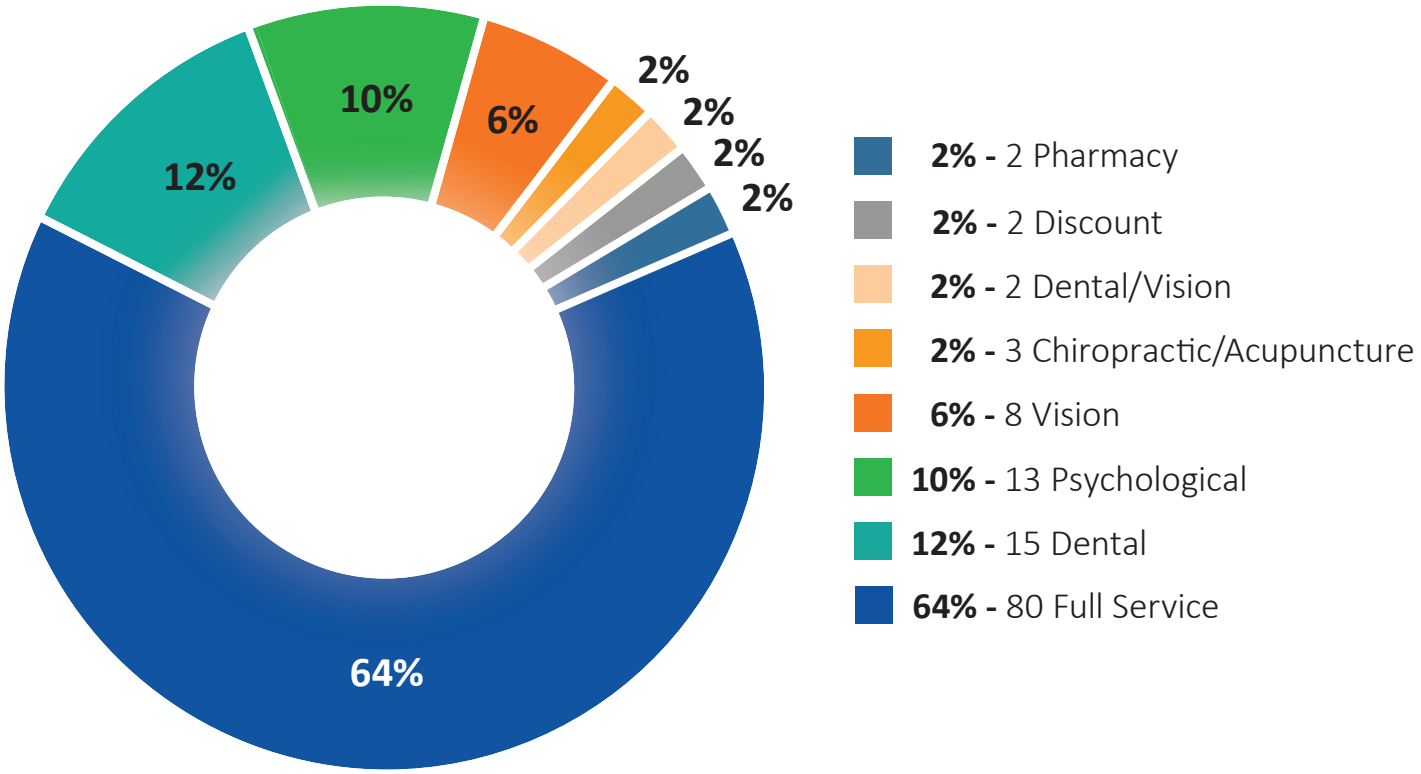
44 COVERED CALIFORNIA FILINGS REVIEWS[8]

24 ALL PLAN LETTERS

248 MATERIAL MODIFICATIONS (SIGNIFICANT CHANGES) RECEIVED

> ***"Health plans in California must be licensed by the DMHC."***

LICENSED PLANS IN 2019



received 29 PBM registration applications in 2019. The DMHC also continued to monitor plan compliance with the Uniform Provider Directory Standards. Health plans must publish and maintain accurate, complete and up-to-date provider directories. All health plans must have publicly available provider directories on their website, make weekly updates to those directories and provide consumers with simple ways to report directory errors.

To maintain consumer protections and ensure a stable health care delivery system, the Department implemented a new regulation, referred to as the "General Licensure Requirements" regulation, in 2019. The regulation clarifies the types of risk assumption that may trigger a requirement to obtain a license from the DMHC or an exemption from licensure (California Code of Regulations, title 28, section 1300.49). The DMHC provided guidance granting a phase-in period for subject entities to comply with the new rule and allowed entities to submit expedited requests for exemption.

The DMHC issues All Plan Letters (APLs) to provide guidance and information to health plans. The Department issued 24 APLs in 2019 on various topics primarily relating to compliance with newly enacted laws and regulations. The DMHC also provided guidance to health plans regarding their obligation to provide enrollees with continued access to health services when they are impacted by a declared state of emergency. All DMHC APLs are available on the Department's website.

Plan Monitoring

The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act. The Department evaluates compliance through onsite surveys (audits) of health plan operations. A routine survey of each licensed health plan is performed every three years. The DMHC also conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. The surveys examine health plan practices related to access and availability of services, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievances and appeals.

When a survey identifies deficiencies, the DMHC requires corrective actions and may refer deficiencies to the Office of Enforcement for further investigation. Enforcement referrals typically occur when there are repeat deficiencies or when the health plan's corrective actions do not adequately correct the deficiencies. Survey findings, including corrective actions, are issued in public reports posted to the DMHC's website.

The DMHC monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic proximity of in-network providers to enrollee residences or work locations, provider-to-patient ratios and timely access to care. For some provider types, health plans must meet specific time and distance standards. Health plans are required to develop networks that have an adequate number of providers to deliver access to care in a timely manner. This includes a requirement that plans ensure their network of providers can offer enrollees an appointment within a specific number of days or hours.

When a contract terminates between a health plan and a hospital or provider group, the DMHC assesses how the enrollees affected by the termination will continue to receive care. Health plans must submit a "Block Transfer Filing" when a contract termination with a hospital or provider group affects 2,000 or more enrollees. The DMHC ensures the health plan's remaining network adequately supports the affected enrollee population and requires the health plan to timely notify its affected enrollees, in writing, of the contract termination. The DMHC also requires health plans to notify affected enrollees that they may qualify to keep their doctor or hospital for a limited time, under certain circumstances. This is called "continuity of care."

DMHC HELP CENTER ASSISTANCE: COVERAGE/ BENEFITS DISPUTE & OUT-OF-NETWORK CARE

Alex, a Medi-Cal Managed Care HMO member suffering from stage 4 mesothelioma, filed a complaint with the DMHC Help Center requesting to go to an out-of-network academic medical center's comprehensive mesothelioma program. During the Help Center's investigation, his health plan referred him to an in-network oncologist. Alex saw the in-network oncologist for a consultation, but the in-network oncologist agreed that he needed to be seen at the academic medical center, because the tumor was rare and outside of the in-network oncologist's area of expertise. With the Help Center's intervention, Alex's health plan agreed to authorize care with the out-of-network provider.

2019 Highlights

Ensuring access to behavioral health services, including compliance with state and federal law continues to be a high priority for the DMHC. Following the release of the final federal rules for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), the DMHC required health plans to conform to the new requirements.

In 2018, the Department completed a comprehensive review of 25 full-service commercial health plans' benefit designs and methodologies for providing mental health services. The DMHC also conducted focused medical surveys to assess whether plans put MHPAEA compliant benefit designs into practice. In 2019, the DMHC continued its oversight of health plan compliance with MHPAEA and issued seven MHPAEA Follow-Up Reports.

In 2019, the DMHC continued to work on the mandatory methodology health plans are required to follow in measuring timely access compliance. The RAND Corporation (RAND) published a research report titled "Options for Improving Timely Access to Care Reporting in California." The RAND report made a number of recommendations, many of which the DMHC had already incorporated into the mandatory methodology.

Following a five-year multi-stakeholder engagement process, the DMHC is working to update the timely access regulation. The proposed regulation will include a rate of compliance standard that each health plan network must meet. After the timely access regulation is approved by the Office of Administrative Law, the DMHC will begin reporting timely access data by health plan network, and holding the plans accountable to meet the rate of compliance standard. The DMHC will continue its collaborative efforts with stakeholders, including health plans, providers and consumer advocates, to further assess and improve enrollees' timely access to health care services.

2019 BY THE NUMBERS

PLAN MONITORING

36 ROUTINE SURVEYS

17 FOLLOW-UP SURVEYS

1 NON-ROUTINE SURVEY

7 MHPAEA FOCUSED FOLLOW-UP SURVEYS

117 UNIQUE HEALTH PLAN NETWORKS REVIEWED[9]

43 TIMELY ACCESS COMPLIANCE REPORTS REVIEWED[10]

240 BLOCK TRANSFERS RECEIVED

81 MATERIAL MODIFICATIONS RECEIVED

> ***The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act.***

Financial Oversight

The DMHC works to ensure stability in California's health care delivery system by actively monitoring the financial status of health plans and provider groups, known as Risk Bearing Organizations (RBOs), to make sure they can meet their financial obligations to consumers and other purchasers.

The DMHC reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. To monitor and corroborate reported information, the DMHC conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. Routine examinations focus on health plan compliance with financial and administrative requirements that include reviewing the plan's claims payment practices and provider dispute resolution processes.

The DMHC annually reviews health plan compliance with the federal Affordable Care Act (ACA) Medical Loss Ratio (MLR) requirements of 85% in the large group market and 80% in the individual and small group markets. MLR is the percentage of health plan premiums that a health plan spends on medical services and activities that improve quality of care. If a health plan does not meet the minimum MLR threshold, it must provide rebates to consumers and other purchasers, such as employers.

The DMHC does not license provider organizations, but monitors the financial solvency of RBOs. An RBO is a physician-owned provider group that, in its contracts with health plans, pays claims and assumes financial risk for the cost of all health care services (inpatient and outpatient) for each enrolled person assigned to the RBO by accepting a fixed monthly payment. This arrangement is typically referred to as "capitation."

RBOs are subject to financial solvency requirements and regular financial reporting. The DMHC monitors the financial stability of RBOs by analyzing financial filings, conducting financial and/or claims examination, reviewing claims payment practices, and monitoring corrective action plans.

The DMHC reviews the financial status of all licensed health plans and registered RBOs at the Financial Solvency Standards Board (FSSB) public meetings. The FSSB meets quarterly and advises the Director on matters of financial solvency that affect the delivery of health care services. FSSB members offer a broad range of experience and expertise including perspectives from actuaries, hospital and provider executives, health plan executives and consumer advocates.

DMHC HELP CENTER ASSISTANCE: PAYMENT DISPUTE

Sandy, a Small Group HMO dental plan member, contacted the DMHC Help Center because her dentist's office had reported her account to collections for an unpaid balance of about $200. Sandy stated she had paid all of her copayments. After reviewing the payment information, Sandy's dental plan and the Help Center discovered the provider had overcharged Sandy more than $1,000 in copayments. Sandy's dentist was required to refund her the amount she paid over her copayment responsibility.

2019 Highlights

In 2019, four full service health plans were required to issue rebate checks to employers for failing to meet the minimum MLR requirement of 80% in the small group market and 85% in the large group market for 2018. Health plans filed MLR information for calendar year 2018 in 2019. Health plans paid $71,753,506 in MLR rebates for calendar year 2018 for the small and large group markets.

- Aetna Health of California, Inc. reported an MLR of 79.3% for 2018 and paid rebates of $911,000 in the small group market.
- Blue Cross of California (Anthem Blue Cross) reported an MLR of 77.2% for 2018 and paid rebates of $61 million in the small group market.
- California Physicians' Service (Blue Shield of California) reported an MLR of 79.7% for 2018 and paid $9.6 million in rebates in the small group market.
- Community Care Health Plan, Inc. reported an MLR of 84.8% for year 2018 and paid $94,111 in rebates in the large group market.
- U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California), a specialized plan, failed to meet the minimum MLR requirement of 85% in the large group market. It reported an MLR of 36.3% for 2018 and paid rebates of $50,042.

Following a routine financial examination, the DMHC imposed a corrective action plan on California Health and Wellness Plan that required the plan to remediate provider claims due to incorrect claim denial and payment accuracy issues. As a result, the plan remediated close to 15,000 provider claims and paid providers an additional $4.6 million, including interest and penalties, as of December 2019.

The DMHC also conducted financial examinations on 24 RBOs in 2019. As a result, all 24 RBOs were required to remediate underpaid claims. In total, the RBOs paid an additional $762,000 in payment, interest and penalties to providers.

2019 BY THE NUMBERS

FINANCIAL OVERSIGHT

67 FINANCIAL EXAMINATIONS COMPLETED[11]

2,383 FINANCIAL STATEMENTS REVIEWED[12]

$72 M MLR REBATES[13]

$6.4 M CLAIM AND DISPUTED PAYMENTS REMEDIATED

$1.7 M INTEREST AND PENALTIES PAID

"The DMHC works to ensure stability in California's health care delivery system."

Rate Review

Since January 2011, the DMHC has saved Californians approximately $256 million in health care premiums through the premium rate review program for individual and small group health plans. Under state law, proposed premium rate changes for individual or small group health plans must be filed with the DMHC. Actuaries perform an in-depth review of the health plan's proposed changes and require health plans to demonstrate the proposed rate changes are supported by data, including underlying medical costs and trends. The DMHC does not have the authority to approve or deny rate increases; however, the Department's rate review efforts hold health plans accountable through transparency, ensure consumers get value for their premium dollar and save Californians money.

If the DMHC finds a health plan rate change is not supported, the DMHC negotiates with the plan to reduce the rate, called a modified rate. If the health plan refuses to modify its rate, the Department can find the rate to be unreasonable. When the DMHC finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

Additionally, health plans that offer large group coverage must file annual aggregated rate information with the DMHC. Although the DMHC does not review large group rates, the DMHC holds a public meeting in accordance with statute to increase transparency of large group rate changes.

The Department has an informative and user-friendly premium rate review section on its public website that makes it easy for the public to view and comment on health plan proposed rates.

Health plans in the commercial market also must annually file certain prescription drug cost information with the DMHC. The DMHC summarizes the data and the impact of prescription drug costs on health care premiums into an annual report and shares this information at the public meeting on large group rates.

DMHC HELP CENTER ASSISTANCE: CONTINUITY OF CARE

Susan, a Large Group HMO member, was enrolled in a retirement HMO plan while undergoing chemo therapy, but switched to another HMO plan during open enrollment. Susan continued receiving chemo therapy services with her previous provider while waiting to establish care with an oncologist in her new HMO plan. She was denied chemo therapy services as her new plan considered her prior oncologist out-of-network. The health plan also told her she did not qualify for Continuity of Care (COC) since she switched health plans voluntarily. The member filed a complaint with the DMHC Help Center, and the health plan approved her request for COC, saving the member almost $6,000 in chemotherapy services.

2019 Highlights

In 2019, the DMHC reviewed 60 individual and small group rate filings. As a result of its review and negotiations with health plans, the DMHC saved consumers approximately $30 million. Anthem Blue Cross, Chinese Community Health Plan, Health Net of California, Inc., Kaiser Foundation Health Plan, Inc. (Kaiser Permanente), and MediExcel Health Plan agreed to reduce their proposed rate increases.

In October 2019, the DMHC received 26 prescription drug cost filings from commercial health plans for measurement year 2018. The DMHC takes this information and compiles an annual report to analyze the impact of the cost of prescription drugs on health plan premiums.

In March 2019, the DMHC held a public meeting to discuss the 2018 large group aggregate rate data, as well as the prescription drug costs reported by health plans.

2019 BY THE NUMBERS

RATE REVIEW

60 RATE FILING REVIEWS COMPLETED

127 RATE FILINGS RECEIVED[14]

0 RATES FOUND UNREASONABLE

5 REDUCED (MODIFIED) RATES

$29.6 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES

$256 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES SINCE 2011

"Since January 2011, the DMHC has saved Californians $256 million in health care premiums."

Enforcement

To protect consumers, the DMHC takes timely action against health plans that violate the law. The primary purpose of enforcement action is to change the plan's behavior to comply with the law. Enforcement actions include issuing cease and desist orders, imposing administrative penalties (fines), freezing enrollment and requiring corrective actions. When necessary, the DMHC may pursue litigation to ensure health plans follow the law.

In 2019, the first $1 million in fines collected by the DMHC were transferred to the Steven M. Thompson Physician Corps Loan Repayment Program to encourage physicians to practice in medically underserved areas by helping repay medical school loans. The remaining funds were transferred to the Health Care Services Plan Fines and Penalties Fund to support the Medi-Cal program.

2019 Highlights

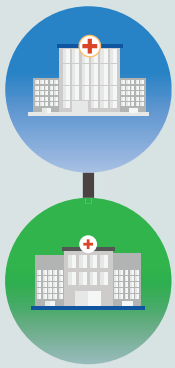
In 2019, the DMHC assessed $6,952,000 in fines through enforcement actions taken against health plans and providers. The Department's enforcement actions in 2019 involved many diverse legal issues, including issues involving poor oversight of delegated medical groups leading to the improper denial or delay in care for enrollees, systemic enrollee grievance and appeals violations, improperly charging enrollees for preventative services, improperly attempting to recoup overpayment of claims to providers, and denying services for transgender individuals. The DMHC also took enforcement action to protect enrollees from illegal balance billing practices.

Some of the significant enforcement actions taken by the DMHC in 2019 are described below:

The DMHC took enforcement action, including a $1.9 million fine, against 12 DMHC-regulated health plans for their lack of oversight of a delegated medical group, Employee Health Systems (EHS) Medical Group and its management services organization, SynerMed. Poor oversight led to the improper denials and delays of enrollees' care. The Department opened an investigation after receiving whistleblower complaints in 2017, and issued a cease and desist order in December 2017 directing the health plans to terminate their contracts with EHS because of the immediate potential for enrollee harm specifically due to improper restrictions placed on access to providers. Under the law, health plans are responsible for ensuring compliance even when they delegate or contract out certain functions.

DMHC HELP CENTER ASSISTANCE: INDEPENDENT MEDICAL REVIEW (IMR): MEDICAL NECESSITY

Larry, a male in an Individual HMO plan, requested out-of-network cancer treatment. He filed a complaint with the Help Center, because his plan denied the out-of-network services as not medically necessary, even though his cancer treatment from in-network providers was ineffective. After completing the DMHC's IMR process, Larry's treatment was determined to be medically necessary. His health plan agreed to cover future treatment at an out-of-network facility that could provide services to treat his cancer. The health plan also agreed to reimburse the consumer more than $15,000 for the out-of-pocket expenses he paid for out-of-network services.



The health plans agreed to Corrective Action Plans (CAP), which included conducting outreach to enrollees that may have been impacted by the activities of EHS and SynerMed, and taking measures to improve their oversight of delegated entities by implementing live and on-site audits, conducting systems integrity testing and developing other tools to protect against fraudulent activity.

The DMHC reached a settlement agreement with Anthem Blue Cross to make improvements regarding how the plan handles consumer grievances and appeals. This agreement was developed to correct the plan's failure, over many years, to properly identify and resolve enrollee grievances and appeals. Anthem Blue Cross agreed to a CAP to significantly change the way the plan handles enrollee grievances. Additionally, Anthem Blue Cross invested $8.4 million to improve its consumer grievances and appeals functions and paid a penalty of $2.8 million. Health plans are required to have grievance and appeal processes to assist consumers in resolving issues with their health plans. A health plan's grievance program informs enrollees of their full grievance and appeal rights and protections afforded to them under the law. A robust grievance program also allows health plans to track and trend grievances for the purpose of uncovering systemic problems, thereby providing the opportunity for quality improvement. In this case, Anthem's failure to properly identify and resolve enrollee grievances deprived its enrollees of their rights to contact the DMHC Help Center for assistance.

California law requires each licensed full service health plan to designate a contact person who will respond to the DMHC within one hour when the plan is contacted regarding an urgent matter outside of normal business hours. The DMHC imposed a penalty of $100,000 against Kaiser Permanente for its failure to respond to the Department within this timeframe and required the plan to take corrective actions to prevent recurrence. The Department's Help Center received a call from the mother of a special needs enrollee who had an urgent medical need. The Department's clinical nurse attempted several times to contact the plan's designated contact person but did not receive a call back until nearly 24 hours later. In the interim, the enrollee's family transported the child to an in-network hospital where the enrollee received care.

The DMHC fined Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan) $75,000 for the illegal recoupment of claims paid to providers. California law limits the ability of plans to recoup overpayments from providers. Plans may not attempt to collect overpayments from providers more than a year after the overpayments were made, except in cases of fraud or material misrepresentation on the part of the provider. In 2018, L.A. Care attempted to collect $111 million from 6,019 providers for alleged overpayments that were more than a year old. The plan did not allege fraud or material misrepresentation on the part of the providers in any of these cases. Following the DMHC's intervention, L.A. Care ceased its collection efforts and returned all unlawfully collected funds.

The Department fined Anthem Blue Cross $100,000 after the plan incorrectly charged enrollees a copayment for oral contraceptive prescriptions. The Knox-Keene Act prohibits plans from charging any copays for preventative services. The errors occurred between February 2013 and September 2016, impacting all policy types. Anthem Blue Cross confirmed 786 instances of incorrect charges for a total of $84,988. The plan reimbursed all 558 enrollees a total of $113,206, which included $26,639 in interest. Anthem Blue Cross also revised its claims automation process to prevent recurrence, and trained the plan's staff and delegated medical groups about not charging copays for preventative services.

The DMHC fined Aetna $50,000 for denying enrollee requests for gender reassignment services. The Knox-Keene Act prohibits health plans from imposing exclusions or limitations on coverage because of an individual's sex or sexual orientation. The enrollee's physician requested authorization from the enrollee's medical group for sexual reassignment surgery. In June 2014, the medical group denied the request, stating it was not a covered benefit. The plan then upheld the denial, citing an exclusion for "...[t]ranssexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a Member's physical characteristic from the Member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems." The Department determined the plan's justification for the denial violated the Insurance Gender Nondiscrimination Act ("IGNA") (Health and Safety Code section 1365.5). As part of the corrective action, Aetna revised its internal policies and procedures to ensure that authorization requests for gender reassignment services were not delegated to medical groups, but were instead reviewed by the plan.

The DMHC settled a lawsuit against an Orange County doctor who was illegally balance billing health plan enrollees. Balance billing happens when a doctor or provider bills the enrollee for a balance not paid by the health plan, and California law protects enrollees covered by health plans regulated by the DMHC from this practice. The settlement required Dr. Nancy B. Way to stop all illegal balance billing, to conduct an audit to determine the amount of illegally collected balance billing payments she received from enrollees and reimburse the entire amount with interest. Additionally, Dr. Way was required to pay a $13,000 civil penalty.

2019 BY THE NUMBERS

ENFORCEMENT

1,275 CASES OPENED

397 CASES CLOSED WITH A PENALTY

$7 M PENALTIES ASSESSED

"To protect consumers, the DMHC takes timely action against health plans that violate the law."

Notes

1 The enrollment charts include the following enrollment types reported by plans and searchable in the Health Plan Financial Summary Report: Point of service - Large Group, PPO - Large Group, Group (Commercial), Point of Service - Small Group, PPO - Small Group, Small Group, PPO - Individual, Point of Service - Individual, Individual, IHSS, Medi-Cal Risk, Medicare Risk (Medicare Advantage), Medicare Cost (Fee For Service) and Medicare Supplement. Healthy Families and AIM enrollment were also reported in previous years when those programs were active.

2 Delta Dental of California and the Department of Health Care Services made a change in their contractual arrangement in January 2018, whereby Delta Dental of California is no longer the fiscal intermediary of the Medi-Cal dental program. As a result, Delta Dental of California's Medi-Cal enrollment declined by approximately 13 million lives.

3 Enrollees received the requested services in 58.9% of the cases qualified by the Department for the IMR program in 2019.

4 This includes consumers who may have received more than one form of assistance throughout the year.

5 Consumer complaints are comprised of standard complaints (10,035), quick resolutions (414), and urgent cases (72) in 2019. 8,252 of the standard complaints were resolved by the DMHC and are included in the complaint report in the Appendix. Of the remaining cases, most were sent back to the health plan to address through the grievance process.

6 IMRs closed are comprised of cases that were resolved by the DMHC or closed for any reason other than non-jurisdictional in 2019. 2,694 of the IMRs were resolved by the DMHC and are included in the IMR report in the Appendix. The remaining cases were closed because the consumer had not yet gone through the health plan grievance process, the consumer did not respond to requests for information, or the case was ineligible for IMR.

7 The category "Coordination of Benefits" has also been previously referred to as "Quality of Care."

8 Includes review of Qualified Health Plan filings and Qualified Dental Plan filings

9 Networks reviewed in 2019 for Measurement Year 2018

10 Timely Access compliance reports reviewed in 2019 for Measurement Year 2018

11 43 Health Plan Financial Examinations and 24 RBO Financial Examinations

12 1,187 Health Plan Financial Statements Reviewed and 1,196 RBO Financial Statements Reviewed

13 Rebates for calendar year 2018, paid in 2019

14 The DMHC does not conduct rate review of annual aggregate rate filings.

2019 Independent Medical Review Summary Report

Report Overview

60%
of enrollee cases that qualified for the Department's IMR program received the requested services they needed.*

14%
of IMR cases were reversed by the health plan after the DMHC received the IMR application.

45%
of cases previously denied by health plans were overturned by the IMRO.

41%
of cases were upheld by the IMRO.

The Annual Independent Medical Review (IMR) Summary Report displays the number and types of IMRs resolved during the 2019 calendar year, by health plan. The Department resolved 2,693 IMRs.

The Report identifies each health plan's enrollment during the year, the number of IMRs resolved for each health plan, the number of IMRs per 10,000 enrollees, the number of IMRs upheld or overturned by the Independent Medical Review Organization (IMRO), and the number of IMRs that the health plan reversed.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2019 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2019, may have had enrollment earlier in the year or received a license during 2019.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review, and resolved (closed) within calendar year 2019. Cases pending at the end of 2019 and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2019. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of IMRs per 10,000 enrollees is displayed to illustrate the volume of IMRs for a plan in a manner that considers the wide variations in plan enrollment. When comparing plans, a lower number of IMRs per 10,000 enrollees indicates fewer IMRs were resolved per capita. As a result, a plan with a higher overall number of resolved IMRs may still show fewer IMRs per 10,000 enrollees than another plan with fewer overall resolved IMRs.

This information is provided for statistical purposes only. The Director of the Department of Managed Health Care has neither investigated nor determined whether the complaints within this summary are reasonable or valid.

* Enrollees received the requested services in 58.9% of the cases qualified by the Department for the IMR program in 2019.

California Department of Managed Health Care

2019 Independant Medical Review by Health Plan

Plan Type and Name	Enrollment	Total IMRs Resolved	IMRs per 10,000**	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
FULL SERVICE – ENROLLMENT OVER 400,000																								
Blue Cross of California (Anthem Blue Cross)	2,978,242	706	2.37	254	132	52.0%	115	45.3%	7	2.8%	449	152	33.9%	241	53.7%	56	12.5%	3	0	0.0%	2	66.7%	1	33.3%
California Physicians' Service (Blue Shield of California)	2,669,626	998	3.74	263	125	47.5%	104	39.5%	34	12.9%	733	258	35.2%	385	52.5%	90	12.3%	2	0	0.0%	1	50.0%	1	50.0%
Health Net Community Solutions, Inc.	1,359,725	48	0.35	4	3	75.0%	1	25.0%	0	0.0%	44	16	36.4%	14	31.8%	14	31.8%	0	0	0.0%	0	0.0%	0	0.0%
Health Net of California, Inc.	517,182	71	1.37	11	3	27.3%	7	63.6%	1	9.1%	59	20	33.9%	20	33.9%	19	32.2%	1	1	100.0%	0	0.0%	0	0.0%
Inland Empire Health Plan (IEHP)	1,214,113	42	0.35	7	4	57.1%	1	14.3%	2	28.6%	35	18	51.4%	11	31.4%	6	17.1%	0	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7,057,606	283	0.40	3	3	100.0%	0	0.0%	0	0.0%	276	162	58.7%	94	34.1%	20	7.2%	4	3	75.0%	0	0.0%	1	25.0%
Local Initiative Health Authority for L.A. County (L.A. Care Health Plan)	2,133,525	111	0.52	3	0	0.0%	2	66.7%	1	33.3%	107	47	43.9%	42	39.3%	18	16.8%	1	0	0.0%	1	100.0%	0	0.0%
Molina Healthcare of California	477,670	21	0.44	0	0	0.0%	0	0.0%	0	0.0%	21	5	23.8%	10	47.6%	6	28.6%	0	0	0.0%	0	0.0%	0	0.0%
UHC of California (UnitedHealthcare of California)	412,138	62	1.50	9	5	55.6%	4	44.4%	0	0.0%	49	21	42.9%	23	46.9%	5	10.2%	4	1	25.0%	2	50.0%	1	25.0%
Total Full Service - Enrollment Over 400,000 :	**18,819,827**	**2,342**	**1.24**	**554**	**275**	**49.6%**	**234**	**42.2%**	**45**	**8.1%**	**1773**	**699**	**39.4%**	**840**	**47.4%**	**234**	**13.2%**	**15**	**5**	**33.3%**	**6**	**40.0%**	**4**	**26.7%**
FULL SERVICE – ENROLLMENT UNDER 400,000																								
Access Senior HealthCare, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Adventist Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Better Health of California Inc	19,791	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Health of California, Inc.	203,961	13	0.64	5	2	40.0%	2	40.0%	1	20.0%	8	1	12.5%	4	50.0%	3	37.5%	0	0	0.0%	0	0.0%	0	0.0%
Aids Healthcare Foundation (Positive Healthcare)	616	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Alameda Alliance for Health	250,191	19	0.76	0	0	0.0%	0	0.0%	0	0.0%	19	9	47.4%	9	47.4%	1	5.3%	0	0	0.0%	0	0.0%	0	0.0%
Alignment Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Alta Med Health Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
AmericasHealth Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Arcadian Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aspire Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Blue Shield of California Promise Health Plan	84,085	8	0.95	1	0	0.0%	1	100.0%	0	0.0%	7	3	42.9%	3	42.9%	1	14.3%	0	0	0.0%	0	0.0%	0	0.0%
Brown and Toland Health Services	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Health and Wellness Plan (California Health & Wellness)	195,176	14	0.72	1	1	100.0%	0	0.0%	0	0.0%	13	6	46.2%	3	23.1%	4	30.8%	0	0	0.0%	0	0.0%	0	0.0%
Care Improvement Plus South Central Insurance	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CareMore Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Central Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Children's Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Chinese Community Health Plan	13,653	2	1.46	0	0	0.0%	0	0.0%	0	0.0%	2	1	50.0%	0	0.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Choice Physicians Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna HealthCare of California, Inc.	153,409	21	1.37	4	2	50.0%	1	25.0%	1	25.0%	17	2	11.8%	8	47.1%	7	41.2%	0	0	0.0%	0	0.0%	0	0.0%
Community Care Health Plan, Inc.	11,365	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Health Group	252,720	9	0.36	1	1	100.0%	0	0.0%	0	0.0%	8	5	62.5%	1	12.5%	2	25.0%	0	0	0.0%	0	0.0%	0	0.0%
Contra Costa County Medical Services (Contra Costa Health Plan)	180,180	12	0.67	1	0	0.0%	1	100.0%	0	0.0%	11	7	63.6%	3	27.3%	1	9.1%	0	0	0.0%	0	0.0%	0	0.0%
Dignity Health Provider Resources, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EPIC Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	351,063	25	0.71	0	0	0.0%	0	0.0%	0	0.0%	25	8	32.0%	11	44.0%	6	24.0%	0	0	0.0%	0	0.0%	0	0.0%
Global Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Golden State Medicare Health Plan (Golden State Health Plan)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Net Health Plan of Oregon, Inc. (Health Net Medicare of California)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Heritage Provider Network, Inc. (Heritage Medical Systems)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Imperial Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Inter Valley Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Kern Health Systems	250,459	31	1.24	1	1	100.0%	0	0.0%	0	0.0%	30	13	43.3%	13	43.3%	4	13.3%	0	0	0.0%	0	0.0%	0	0.0%
Medcore HP (Medcore)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medi-Excel, SA de CV (MediExcel Health Plan)	13,582	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Monarch Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
On Lok Senior Health Services	358	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Optum Health Plan of California (DaVita)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Orange County Health Authority (CalOptima)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

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Plan Type and Name	Enrollment	Total IMRs Resolved	IMRs per 10,000**	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Oscar Health Plan of California	55,894	35	6.26	9	5	55.6%	2	22.2%	2	22.2%	24	8	33.3%	5	20.8%	11	45.8%	2	0	0.0%	0	0.0%	2	100.0%
Partnership HealthPlan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Health Plan Services, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
PRIMECARE Medical Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Prospect Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Assurance	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Network	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
San Francisco Community Health Authority	134,819	2	0.15	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	0	0.0%	2	100.0%	0	0	0.0%	0	0.0%	0	0.0%
San Joaquin County Health Commission (The Health Plan of San Joaquin)	334,929	19	0.57	0	0	0.0%	0	0.0%	0	0.0%	19	7	36.8%	6	31.6%	6	31.6%	0	0	0.0%	0	0.0%	0	0.0%
San Mateo Health Commission (Health Plan of San Mateo)	109,039	17	1.56	0	0	0.0%	0	0.0%	0	0.0%	17	6	35.3%	8	47.1%	3	17.6%	0	0	0.0%	0	0.0%	0	0.0%
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County (Valley Health Plan)	38,656	2	0.52	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	2	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	242,425	20	0.82	1	0	0.0%	1	100.0%	0	0.0%	19	8	42.1%	7	36.8%	4	21.1%	0	0	0.0%	0	0.0%	0	0.0%
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)	586	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
SCAN Health Plan	13,214	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Scripps Health Plan Services, Inc. (Scripps Health Plan)	14,336	1	0.70	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Seaside Health Plan	227	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sequoia Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sharp Health Plan	130,701	22	1.68	3	2	66.7%	1	33.3%	0	0.0%	19	5	26.3%	10	52.6%	4	21.1%	0	0	0.0%	0	0.0%	0	0.0%
Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA Health Plan)	52,549	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Stanford Health Care Advantage	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sutter Health Plan (Sutter Health Plus)	93,987	23	2.45	0	0	0.0%	0	0.0%	0	0.0%	23	6	26.1%	12	52.2%	5	21.7%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Benefits Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Community Plan of California, Inc.	12,007	2	1.67	0	0	0.0%	0	0.0%	0	0.0%	2	2	100.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Universal Care, Inc. (Brand New Day)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Ventura County Health (Ventura County Health Care)	13,301	1	0.75	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Vitality Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Western Health Advantage	127,851	39	3.05	7	3	42.9%	4	57.1%	0	0.0%	30	9	30.0%	17	56.7%	4	13.3%	2	2	100.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Under 400,000 :	**3,355,130**	**337**	**1.00**	**34**	**17**	**50.0%**	**13**	**38.2%**	**4**	**11.8%**	**299**	**106**	**35.5%**	**123**	**41.1%**	**70**	**23.4%**	**4**	**2**	**50.0%**	**0**	**0.0%**	**2**	**50.0%**
Total All Full Service Plans:	**22,174,957**	**2,679**	**1.21**	**588**	**292**	**49.7%**	**247**	**42.0%**	**49**	**8.3%**	**2072**	**805**	**38.9%**	**963**	**46.5%**	**304**	**14.7%**	**19**	**7**	**36.8%**	**6**	**31.6%**	**6**	**31.6%**
CHIROPRACTIC																								
ACN Group of California, Inc. (OptumHealth Physical Health of California)	74,107	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
American Specialty Health Plans, Inc. (ASHP)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Landmark Healthplan of California, Inc.	69,290	0	0.00	0		0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Chiropractic:	**143,397**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DENTAL																								
Access Dental Plan	507,840	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Dental of California Inc.	137,561	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Dental Network, Inc.	77,757	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna Dental Health of California, Inc.	214,878	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Consumer Health, Inc. (Bright Now! Dental)	16,893	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dedicated Dental Systems, Inc.	2,680	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Benefit Providers of California, Inc.	171,392	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Health Services	93,784	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	12,280	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Jaimini Health Inc. (Primecare Dental Plan)	4,712	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Liberty Dental Plan of California, Inc. (Personal Dental Services)	375,285	4	0.11	0	0	0.0%	0	0.0%	0	0.0%	4	1	25.0%	0	0.0%	3	75.0%	0	0	0.0%	0	0.0%	0	0.0%
Managed Dental Care	113,361	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UDC Dental California, Inc. (United Dental Care of California, Inc.)	32,064	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
United Concordia Dental Plans of CA, Inc.	98,519	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

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				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Western Dental Services, Inc. (Western Dental Plan)	168,423	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental:	**2,027,429**	**4**	**0.02**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**4**	**1**	**25.0%**	**0**	**0.0%**	**3**	**75.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DENTAL/VISION																								
Delta Dental of California	4,837,000	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
SafeGuard Health Plans, Inc. (MetLife)	276,349	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental/Vision:	**5,113,349**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DISCOUNT																								
Association Health Care Management, Inc. (Family Care)*	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
First Dental Health (New Dental Choice)	31,062	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
The CDI Group, Inc.	37,041	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Discount:	**68,103**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
PHARMACY																								
SilverScript Insurance Company	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare Prescription Insurance, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Pharmacy:	**0**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
PSYCHOLOGICAL																								
Beacon Health Options of California, Inc. (Beacon of California)	616,070	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna Behavioral Health of California, Inc.	145,364	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Claremont Behavioral Services, Inc. (Clarement EAP)	37,370	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CONCERN: Employee Assistance Program	135,312	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Empathia Pacific, Inc. (LifeMatters)	158,562	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Advocate West, Inc.	74,953	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health and Human Resource Center (Aetna Resources for Living)	1,514,080	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Holman Professional Counseling Centers	134,223	1	0.07	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Human Affairs International of California (HAI-CA)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana EAP and Work-Life Services of California Inc.	27,564	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Magellan Health Services of California-Employer Services	926,412	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Managed Health Network	780,116	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	1,209,730	9	0.07	1	0	0.0%	1	100.0%	0	0.0%	8	3	37.5%	5	62.5%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Psychological:	**5,759,756**	**10**	**0.02**	**1**	**0**	**0.0%**	**1**	**100.0%**	**0**	**0.0%**	**9**	**3**	**33.3%**	**6**	**66.7%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
VISION																								
Envolve Vision, Inc. (Envolve Benefit Options)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EyeMax Vision Plan, Inc.	79	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EYEXAM of California, Inc.	426,790	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
FirstSight Vision Services, Inc. (America's Best Vision Plan)	174,799	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medical Eye Services, Inc.	48,299	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Eye Care, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision First Eye Care, Inc.*	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Plan of America	15,229	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Service Plan (VSP)	4,189,248	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Vision:	**4,854,444**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Total Specialty Plans:	**17,966,478**	**14**	**0.01**	**1**	**0**	**0.0%**	**1**	**100.0%**	**0**	**0.0%**	**13**	**4**	**30.8%**	**6**	**46.2%**	**3**	**23.1%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Grand Totals:	**40,141,435**	**2,693**	**0.67**	**589**	**292**	**49.6%**	**248**	**42.1%**	**49**	**8.3%**	**2085**	**809**	**38.8%**	**969**	**46.5%**	**307**	**14.7%**	**19**	**7**	**36.8%**	**6**	**31.6%**	**6**	**31.6%**

*Grey shading indicates that the plan surrendered its license in 2019.

**The DMHC displays the number of complaints per 10,000 enrollees in each plan to illustrate the volume of complaints for that plan in a manner that considers the wide variations in plan enrollment numbers. When comparing plans, a lower number of complaints per 10,000 enrollees in a plan indicates that fewer complaints were submitted per capita. As a result, a plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

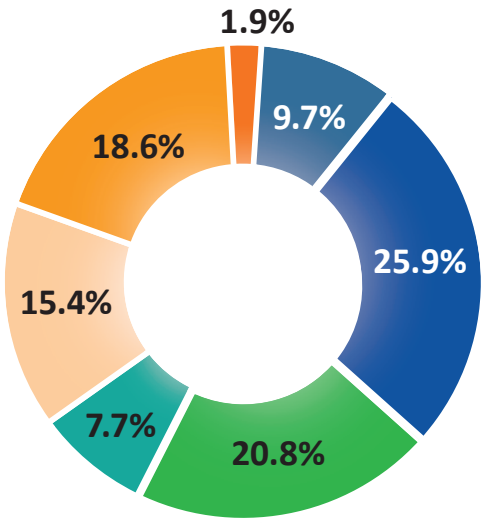
"Upheld by IMR" means that the review organization upheld the health plan's denial.

"Overturned by IMR" means that the review organization overturned the health plan's denial and the plan is required to authorize the requested service.

"Rev. by Plan" means that the health plan reversed its denial prior to the review organization making a determination and the plan decided to authorize the requested service.

2019 Consumer Complaint Summary Report

Report Overview



1.9% - Coordination of Benefits

7.7% - Enrollment

9.7% - Access to Care

15.4% - Health Plan Customer Service

18.6% - Provider Customer Service

20.8% - Benefits/Coverage

25.9% - Claims/Financial

The Annual Complaint Summary Report displays the numbers and types of complaints, by health plan, resolved by the Department during the 2019 calendar year. An enrollee's complaint may include more than one issue. A complaint consisting of multiple distinct issues is counted as one resolved complaint. Specific complaint issues are categorized in seven categories: Access to Care, Benefits/Coverage, Claims/Financial, Enrollment, Coordination of Care, Health Plan Customer Service, and Provider Customer Service.

The Report identifies the number of complaints resolved for each health plan, the health plan's enrollment during 2019, the number of complaints per 10,000 members, and the number of issues for each complaint category.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2019 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2019, may have had enrollment earlier in the year or received a license during 2019.

Data represents resolved complaints which were determined to be within the Department's jurisdiction, eligible for review by the Department, and resolved (closed) within calendar year 2019. Cases pending at the end of the calendar year and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2019. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of complaints per 10,000 enrollees is displayed to illustrate the volume of complaints for a plan in a manner that considers the wide variations in plan enrollment numbers. When comparing plans, a lower number of complaints per 10,000 enrollees indicates fewer complaints were resolved per capita. As a result, a plan with a higher overall number of resolved complaints may still show fewer complaints per 10,000 enrollees than another plan with fewer overall resolved complaints.

This information is provided for statistical purposes only. The Director of the Department of Managed Health Care has neither investigated nor determined whether the complaints within this summary are reasonable or valid.

California Department of Managed Health Care

2019 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees	Complaints per 10,000**	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS***		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
FULL SERVICE – ENROLLMENT OVER 400,000																		
Blue Cross of California (Anthem Blue Cross)	1,170	16.0%	2,978,242	3.93	120	0.40	358	1.20	639	2.15	106	0.36	39	0.13	274	0.92	148	0.50
California Physicians' Service (Blue Shield of California)	1,869	25.6%	2,669,626	7.00	138	0.52	726	2.72	814	3.05	356	1.33	75	0.28	485	1.82	113	0.42
Health Net Community Solutions, Inc.	248	3.4%	1,359,725	1.82	135	0.99	69	0.51	17	0.13	8	0.06	12	0.09	38	0.28	106	0.78
Health Net of California, Inc.	322	4.4%	517,182	6.23	56	1.08	97	1.88	150	2.90	36	0.70	7	0.14	103	1.99	67	1.30
Inland Empire Health Plan (IEHP)	114	1.6%	1,214,113	0.94	37	0.30	43	0.35	5	0.04	3	0.02	4	0.03	31	0.26	51	0.42
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	2,604	35.7%	7,057,606	3.69	295	0.42	574	0.81	994	1.41	367	0.52	39	0.06	576	0.82	1421	2.01
Local Initiative Health Authority for L.A. County (L.A. Care Health Plan)	541	7.4%	2,133,525	2.54	209	0.98	124	0.58	145	0.68	23	0.11	19	0.09	109	0.51	178	0.83
Molina Healthcare of California	76	1.0%	477,670	1.59	19	0.40	20	0.42	33	0.69	5	0.10	1	0.02	24	0.50	18	0.38
UHC of California (UnitedHealthcare of California)	350	4.8%	412,138	8.49	39	0.95	189	4.59	134	3.25	10	0.24	7	0.17	83	2.01	35	0.85
Total Full Service – Enrollment Over 400,000:	**7,294**	**100.0%**	**18,819,827**	**3.88**	**1,048**	**0.56**	**2,200**	**1.17**	**2,931**	**1.56**	**914**	**0.49**	**203**	**0.11**	**1,723**	**0.92**	**2,137**	**1.14**
FULL SERVICE – ENROLLMENT UNDER 400,000																		
Access Senior HealthCare, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Adventist Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aetna Better Health of California Inc.	10	1.3%	19,791	5.05	9	4.55	2	1.01	1	0.51	0	0.00	2	1.01	3	1.52	4	2.02
Aetna Health of California, Inc.	67	8.9%	203,961	3.28	6	0.29	25	1.23	35	1.72	3	0.15	3	0.15	10	0.49	6	0.29
Aids Healthcare Foundation (Positive Healthcare)	0	0.0%	616	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Alameda Alliance for Health	37	4.9%	250,191	1.48	9	0.36	19	0.76	3	0.12	3	0.12	2	0.08	6	0.24	14	0.56
Alignment Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Alta Med Health Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
AmericasHealth Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Arcadian Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aspire Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Blue Shield of California Promise Health Plan	17	2.3%	84,085	2.02	9	1.07	8	0.95	0	0.00	2	0.24	0	0.00	6	0.71	4	0.48
Brown and Toland Health Services	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
California Health and Wellness Plan (California Health & Wellness)	23	3.1%	195,176	1.18	8	0.41	3	0.15	13	0.67	0	0.00	0	0.00	6	0.31	4	0.20
Care Improvement Plus South Central Insurance Company	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CareMore Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Central Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Children's Health Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Chinese Community Health Plan	10	1.3%	13,653	7.32	0	0.00	1	0.73	10	7.32	0	0.00	0	0.00	2	1.46	5	3.66
Choice Physicians Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna HealthCare of California, Inc.	34	4.5%	153,409	2.22	4	0.26	16	1.04	17	1.11	1	0.07	0	0.00	6	0.39	3	0.20
Community Care Health Plan, Inc.	0	0.0%	11,365	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Health Group	14	1.9%	252,720	0.55	6	0.24	6	0.24	1	0.04	0	0.00	0	0.00	4	0.16	7	0.28
Contra Costa County Medical Services (Contra Costa Health Plan)	20	2.7%	180,180	1.11	7	0.39	6	0.33	4	0.22	0	0.00	0	0.00	6	0.33	14	0.78
Dignity Health Provider Resources, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EPIC Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	38	5.1%	351,063	1.08	14	0.40	13	0.37	3	0.09	0	0.00	3	0.09	7	0.20	26	0.74
Global Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Golden State Medicare Health Plan (Golden State Health Plan)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Net Health Plan of Oregon, Inc. (Health Net Medicare of California)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Heritage Provider Network, Inc. (Heritage Medical Systems)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Imperial Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Inter Valley Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Kern Health Systems	6	0.8%	250,459	0.24	4	0.16	4	0.16	1	0.04	0	0.00	1	0.04	0	0.00	2	0.08
Medcore HP (Medcore)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medi-Excel, SA de CV (MediExcel Health Plan)	0	0.0%	13,582	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Monarch Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
On Lok Senior Health Services	1	0.1%	358	27.93	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	27.93

California Department of Managed Health Care

2019 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees	Complaints per 10,000**	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS***		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
Optum Health Plan of California (DaVita)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Orange County Health Authority (CalOptima)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Oscar Health Plan of California	81	10.8%	55,894	14.49	3	0.54	24	4.29	43	7.69	5	0.89	2	0.36	20	3.58	9	1.61
Partnership HealthPlan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Health Plan Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PRIMECARE Medical Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Prospect Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Assurance	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Network	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
San Francisco Community Health Authority	8	1.1%	134,819	0.59	3	0.22	2	0.15	1	0.07	1	0.07	0	0.00	2	0.15	4	0.30
San Joaquin County Health Commission (The Health Plan of San Joaquin)	26	3.5%	334,929	0.78	9	0.27	15	0.45	3	0.09	2	0.06	2	0.06	5	0.15	8	0.24
San Mateo Health Commission (Health Plan of San Mateo)	31	4.1%	109,039	2.84	18	1.65	14	1.28	1	0.09	3	0.28	0	0.00	6	0.55	4	0.37
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Santa Clara County (Valley Health Plan)	24	3.2%	38,656	6.21	3	0.78	9	2.33	7	1.81	5	1.29	2	0.52	5	1.29	3	0.78
Santa Clara County Health Authority (Santa Clara Family Health Plan)	59	7.9%	242,425	2.43	22	0.91	38	1.57	3	0.12	0	0.00	6	0.25	8	0.33	9	0.37
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)	0	0.0%	586	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
SCAN Health Plan	0	0.0%	13,214	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scripps Health Plan Services, Inc. (Scripps Health Plan)	13	1.7%	14,336	9.07	2	1.40	5	3.49	5	3.49	1	0.70	1	0.70	2	1.40	2	1.40
Seaside Health Plan	0	0.0%	227	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sequoia Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sharp Health Plan	62	8.3%	130,701	4.74	7	0.54	34	2.60	25	1.91	7	0.54	1	0.08	9	0.69	7	0.54
Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA Health Plan)	18	2.4%	52,549	3.43	0	0.00	1	0.19	17	3.24	0	0.00	1	0.19	0	0.00	0	0.00
Stanford Health Care Advantage	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sutter Health Plan (Sutter Health Plus)	42	5.6%	93,987	4.47	3	0.32	21	2.23	14	1.49	3	0.32	2	0.21	6	0.64	4	0.43
UnitedHealthcare Benefits Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UnitedHealthcare Community Plan of California, Inc.	5	0.7%	12,007	4.16	0	0.00	2	1.67	2	1.67	0	0.00	1	0.83	2	1.67	0	0.00
Universal Care, Inc. (Brand New Day)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Ventura County Health (Ventura County Health Care Plan)	4	0.5%	13,301	3.01	0	0.00	2	1.50	2	1.50	0	0.00	0	0.00	0	0.00	2	1.50
Vitality Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Health Advantage, Inc.	99	13.2%	127,851	7.74	10	0.78	42	3.29	43	3.36	9	0.70	6	0.47	17	1.33	18	1.41
Total Full Service – Enrollment Under 400,000:	**749**	**100.0%**	**3,355,130**	**2.23**	**156**	**0.46**	**312**	**0.93**	**254**	**0.76**	**45**	**0.13**	**35**	**0.10**	**138**	**0.41**	**160**	**0.48**
Total All Full Service Plans:	**8,043**		**22,174,957**	**3.63**	**1,204**	**0.54**	**2,512**	**1.13**	**3,185**	**1.44**	**959**	**0.43**	**238**	**0.11**	**1,861**	**0.84**	**2,297**	**1.04**
CHIROPRACTIC																		
ACN Group of California, Inc. (OptumHealth Physical Health of California)	1	100.0%	74,107	0.13	0	0.00	0	0.00	1	0.13	0	0.00	0	0.00	1	0.13	0	0.00
American Specialty Health Plans, Inc. (ASHP)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Landmark Healthplan of California, Inc.	0	0.0%	69,290	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Chiropractic:	**1**	**100.0%**	**143,397**	**0.07**	**0**	**0.00**	**0**	**0.00**	**1**	**0.07**	**0**	**0.00**	**0**	**0.00**	**1**	**0.07**	**0**	**0.00**
DENTAL																		
Access Dental Plan	12	21.4%	507,840	0.24	2	0.04	5	0.10	4	0.08	1	0.02	1	0.02	4	0.08	3	0.06
Aetna Dental of California Inc.	4	7.1%	137,561	0.29	0	0.00	1	0.07	3	0.22	0	0.00	0	0.00	0	0.00	3	0.22
California Dental Network, Inc.	2	3.6%	77,757	0.26	0	0.00	0	0.00	1	0.13	0	0.00	0	0.00	2	0.26	1	0.13
Cigna Dental Health of California, Inc.	1	1.8%	214,878	0.05	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.05	1	0.05
Consumer Health, Inc. (Bright Now! Dental)	0	0.0%	16,893	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dedicated Dental Systems, Inc.	0	0.0%	2,680	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Benefit Providers of California, Inc.	3	5.4%	171,392	0.18	0	0.00	1	0.06	2	0.12	0	0.00	0	0.00	0	0.00	0	0.00
Dental Health Services	1	1.8%	93,784	0.11	0	0.00	1	0.11	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	0	0.0%	12,280	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Jaimini Health Inc. (Primecare Dental Plan)	0	0.0%	4,712	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Liberty Dental Plan of California, Inc. (Personal Dental Services)	24	42.9%	375,285	0.64	2	0.05	21	0.56	3	0.08	2	0.05	0	0.00	6	0.16	3	0.08
Managed Dental Care	3	5.4%	113,361	0.26	0	0.00	2	0.18	0	0.00	0	0.00	1	0.09	1	0.09	0	0.00

California Department of Managed Health Care

2019 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees	Complaints per 10,000**	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS***		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
UDC Dental California, Inc. (United Dental Care of California, Inc.)	0	0.0%	32,064	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
United Concordia Dental Plans of CA, Inc.	1	1.8%	98,519	0.10	0	0.00	0	0.00	1	0.10	0	0.00	0	0.00	1	0.10	0	0.00
Western Dental Services, Inc. (Western Dental Plan)	5	8.9%	168,423	0.30	1	0.06	2	0.12	2	0.12	0	0.00	0	0.00	1	0.06	1	0.06
Total Dental:	**56**	**100.0%**	**2,027,429**	**0.28**	**5**	**0.02**	**33**	**0.16**	**16**	**0.08**	**3**	**0.01**	**2**	**0.01**	**16**	**0.08**	**12**	**0.06**
DENTAL/VISION																		
Delta Dental of California	126	92.0%	4,837,000	0.26	8	0.02	65	0.13	58	0.12	5	0.01	0	0.00	50	0.10	32	0.07
SafeGuard Health Plans, Inc. (MetLife)	11	8.0%	276,349	0.40	1	0.04	8	0.29	5	0.18	0	0.00	0	0.00	3	0.11	7	0.25
Total Dental/Vision:	**137**	**100.0%**	**5,113,349**	**0.27**	**9**	**0.02**	**73**	**0.14**	**63**	**0.12**	**5**	**0.01**	**0**	**0.00**	**53**	**0.10**	**39**	**0.08**
DISCOUNT																		
Association Health Care Management, Inc. (Family Care)*	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
First Dental Health (New Dental Choice)	0	0.0%	31,062	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
The CDI Group, Inc.	0	0.0%	37,041	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Discount:	**0**	**0**	**68,103**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PHARMACY																		
SilverScript Insurance Company	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare Prescription Insurance, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Pharmacy:	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PSYCHOLOGICAL																		
Beacon Health Options of California, Inc. (Beacon of California)	0	0.0%	616,070	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna Behavioral Health of California, Inc.	0	0.0%	145,364	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Claremont Behavioral Services, Inc. (Claremont EAP)	0	0.0%	37,370	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CONCERN: Employee Assistance Program	0	0.0%	135,312	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Empathia Pacific, Inc. (LifeMatters)	0	0.0%	158,562	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Advocate West, Inc.	0	0.0%	74,953	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health and Human Resource Center (Aetna Resources for Living)	0	0.0%	1,514,080	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	0.0%	134,223	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Human Affairs International of California (HAI-CA)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana EAP and Work-Life Services of California Inc.	0	0.0%	27,564	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Magellan Health Services of California-Employer Services	0	0.0%	926,412	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Managed Health Network	0	0.0%	780,116	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	5	100.0%	1,209,730	0.04	0	0.00	0	0.00	3	0.02	0	0.00	1	0.01	3	0.02	3	0.02
Total Psychological:	**5**	**100.0%**	**5,759,756**	**0.01**	**0**	**0.00**	**0**	**0.00**	**3**	**0.01**	**0**	**0.00**	**1**	**0.00**	**3**	**0.01**	**3**	**0.01**
VISION																		
Envolve Vision, Inc. (Envolve Benefit Options)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EyeMax Vision Plan, Inc.	0	0.0%	79	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EYEXAM of California, Inc.	0	0.0%	426,790	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
FirstSight Vision Services, Inc. (America's Best Vision Plan)	0	0.0%	174,799	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medical Eye Services, Inc.	0	0.0%	48,299	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Eye Care, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision First Eye Care, Inc.*	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Plan of America	1	10.0%	15,229	0.66	0	0.00	0	0.00	1	0.66	0	0.00	0	0.00	1	0.66	0	0.00
Vision Service Plan (VSP)	9	90.0%	4,189,248	0.02	1	0.00	1	0.00	3	0.01	4	0.01	0	0.00	3	0.01	0	0.00
Total Vision:	**10**	**100.0%**	**4,854,444**	**0.02**	**1**	**0.00**	**1**	**0.00**	**4**	**0.01**	**4**	**0.01**	**0**	**0.00**	**4**	**0.01**	**0**	**0.00**
Grand Totals:	**8,252**		**40,141,435**	**2.06**	**1,219**	**0.30**	**2,619**	**0.65**	**3,272**	**0.82**	**971**	**0.24**	**241**	**0.06**	**1,938**	**0.48**	**2,351**	**0.59**

*Grey shading indicates that the plan surrendered its license in 2019.

**The DMHC displays the number of complaints per 10,000 enrollees in each plan to illustrate the volume of complaints for that plan in a manner that considers the wide variations in plan enrollment numbers. When comparing plans, a lower number of complaints per complaints per 10,000 enrollees in a plan indicates that fewer complaints were submitted per capita. As a result, a plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

***The category "Coordination of Benefits" has also been previously referred to as "Quality of Care."

Published June 2020