2020 ANNUAL REPORT

CELEBRATING 20 YEARS OF CONSUMER PROTECTION

DEPARTMENT OF
Managed
Health Care

Gavin Newsom
Governor
State of California

Mark Ghaly MD, MPH
Secretary
Health and Human Services Agency

Mary Watanabe
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 SECRETARY

This year we celebrate the 20th anniversary of the creation of the Department of Managed Health Care. Over the past 20 years, the Department has protected the health care rights of millions of Californians. This includes saving consumers hundreds of millions of dollars through the rate review program, ensuring consumers receive needed care under the Independent Medical Review program, and holding health plans accountable to provide timely and accessible health care to consumers.

In the face of the unprecedented events brought on by the COVID-19 pandemic over the last year, the Department has demonstrated its commitment to serving California's health care consumers. The Department worked closely with the California Health and Human Services Agency and its other departments to reduce the spread and mitigate impacts of the virus, to protect California's most vulnerable populations. The Department took actions to expand access to health care during this time, such as creating and extending special enrollment periods for uninsured Californians to gain health care coverage, directing health plans to cover the cost of vaccines, requiring health plans cover testing, and expanding the coverage of telehealth services.

In addition to the 20th anniversary of the Department, we also celebrate the 45th anniversary of the Knox-Keene Act and the 10th anniversary of the Affordable Care Act. California enacted the strongest patient protection health care laws in the nation when the Knox-Keene Act was established in 1975, which set the foundation for the Department's regulation of health plans. In 2000, the Department was created as the first state agency in the nation exclusively dedicated to protecting consumers' health care rights. After the Affordable Care Act was passed in 2010, California was the first

state in the nation to enact legislation creating a health benefit exchange, which we know as Covered California. Today, California continues to be a leader as we work together to create a system to provide accessible, affordable, and equitable health care for all.

Since its inception, the Department has continued to uphold a strong regulatory program to meet the needs of California's diverse population. I congratulate the Department and its employees for their dedication to our great state and the Department's mission.

Mark Ghaly MD, MPH

Secretary

California Health and Human Services Agency

MESSAGE FROM THE DIRECTOR

The year 2020 reminded us that regardless of the challenges we may encounter, the Department of Managed Health Care (DMHC) will always remain committed to protecting consumers' health care rights and ensuring a stable health care delivery system. In 2020, the DMHC responded to the COVID-19 pandemic by working tirelessly to ensure that the health care rights of consumers were not compromised during this public health emergency. We also celebrated the 45th anniversary of the Knox-Keene Act, the 20th anniversary of the DMHC and the 10th anniversary of the Affordable Care Act (ACA). It is an honor to be a part of these important milestones and present the accomplishments the Department has achieved over the past 20 years.

The DMHC worked to respond to changes brought on by COVID-19 in 2020, all while also adjusting to the new way of operating in our daily lives. DMHC employees quickly transitioned to work remotely to adhere to stay at home orders and continued providing important services to support health care consumers, health plans and providers. With all of these changes, the DMHC continued to be productive and had a number of record accomplishments, including issuing a record-breaking number of All Plan Letters (APLs) to health plans, reviewing the highest number of health plan rate filings in one year as well as reviewing new financial filings, and staying on top of all of the many changes that happened in the health care industry during a world-wide pandemic.

We worked closely with state and local leaders, health plans, providers, consumer advocates and other stakeholders in supporting actions to respond to COVID-19. The Department issued many APLs providing guidance and information to health plans. This included notifying health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees. The DMHC remained focused on ensuring affordability and continued access to care for health plan enrollees. More information on the Department's actions and guidance is included later in this report.

The Department also implemented new laws and took enforcement action against health plans that violated consumers' health care rights. Significant enforcement actions included penalizing health plans that failed to timely authorize medically necessary services for enrollees, stopping the improper denials of emergency room claims and violations of state and federal mental health parity laws.

I am personally committed to ensuring that health plan enrollees have access to appropriate and needed behavioral health care services and this will continue to be a focus for the DMHC in the years ahead. The COVID-19 pandemic and resulting stay at home orders, job losses and virtual learning for students have caused significant stress on individuals and families. The need for behavioral health services has never been greater. Specifically, the Department is focused on implementing Senate Bill (SB) 855 (Wiener, 2020), which strengthened California's mental health parity statute to help improve consumers' access to quality mental health and substance use disorder services. In addition, the DMHC is also working on conducting focused behavioral health investigations of all full-service commercial health plans to assess whether enrollees have consistent access to medically necessary behavioral health care services. These investigations will begin in 2021.

The DMHC Help Center is a valuable resource to anyone facing issues with their health plan, including access to services or care. The DMHC Help Center can be reached at 1-888-466-2219 or www.HealthHelp.ca.gov and always offers free assistance in all languages.

The DMHC has made tremendous progress over the past 20 years, and you can see many of the highlights of these accomplishments in this report. As we look forward, the Department will continue to focus on the COVID-19 response, how we can better hold health plans accountable for reducing health disparities and improving health outcomes for enrollees, and continuing to improve equal and affordable health care access for all Californians.

As we celebrate our 20th anniversary, I remain impressed by the DMHC's dedicated employees who have relentlessly continued to work hard to achieve our mission during a very challenging year.

Mary Watanabe

Director
Department of Managed Health Care

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DEPARTMENT OF
Managed Health Care

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20 YEARS
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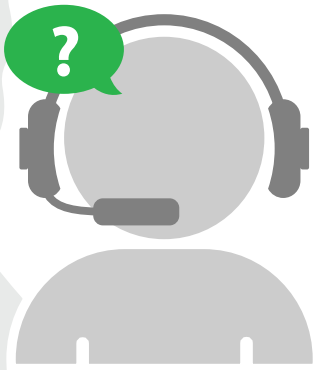


2.5 MILLION
CONSUMERS ASSISTED

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.

27.7 MILLION
CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

95% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

132
LICENSED HEALTH PLANS

87 FULL SERVICE

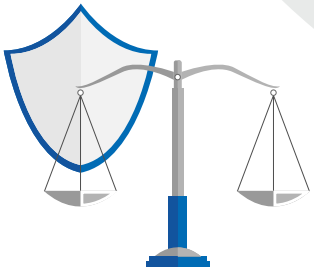
45 SPECIALIZED

$36.1 MILLION
dollars recovered from health plans on behalf of consumers

$296.1 MILLION
dollars saved on Health Plan Premiums through the Rate Review Program since 2011

$40.3 MILLION in 2020

$165.1 MILLION
dollars in payments recovered to physicians and hospitals



INDEPENDENT MEDICAL REVIEW (IMR)

Approximately **68%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan.

$83.6 MILLION
dollars assessed against health plans that violated the law

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 all mental health and substance use 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 (TDD: 1-877-688-9891) or at www.HealthHelp.ca.gov. ALL SERVICES ARE FREE.

Celebrating Significant Anniversaries

In 2020, we celebrated the 20th anniversary of the DMHC, along with the 10th anniversary of the enactment of the Affordable Care Act (ACA), and the 45th anniversary of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Some of the important health care accomplishments achieved over the years are highlighted below each significant anniversary.

20 Years

The DMHC was created in 2000 as the first agency in the country dedicated solely to the regulation of managed health care plans and consumer assistance. Today, the Department continues to protect consumers' health care rights and ensures a stable health care delivery system.

- More than 2.5 million consumers have received assistance and support through the Help Center which offers complaint resolution through telephone and online assistance
- 132 health plans (45 specialized and 87 full service) provide health coverage to nearly 27.7 million Californians
- More than $165.1 million in payments owed to physicians and hospitals have been recovered
- More than $83.6 million in fines and penalties have been assessed on health plans that violated the law, and the DMHC has imposed changes in health plan operations to protect consumer rights
- More than $296 million have been saved on health plan premiums through the Department's Rate Review Program
- Approximately 68% of consumer appeals (Independent Medical Reviews) to the DMHC have resulted in the consumer receiving the requested service or treatment from their health plans

10 Years

Enacted on March 23, 2010, the ACA has reshaped the nation's health care landscape.

- As soon as the ACA passed, the DMHC provided leadership and support to craft and implement new laws and regulations
- The DMHC received $9.2 million in federal ACA grants to enhance consumer assistance and created strategic partnerships to help California consumers prepare for and understand ACA coverage options
- Under strict timelines, the DMHC conducted focused reviews of dozens of new health plan products and provider networks to ensure compliance with state and federal laws and consumer protections
- Enrollment in DMHC-licensed health plans has increased nearly 44% over 2013 enrollment, the last year before the ACA was fully implemented

45 Years

California's groundbreaking managed care law, the Knox-Keene Act, laid the foundation for robust regulation and consumer protections. The DMHC works with a large array of partners, including policymakers, other state agencies and stakeholders to continuously improve Knox-Keene Act standards as the managed care industry and the needs of consumers evolve.

20 YEARS

of Consumer Protection

Introduction

Twenty years ago, the DMHC was created as the first state department in the country solely dedicated to regulating managed health care plans and assisting consumers to resolve disputes with their health plans. The creation of the Department in 2000 capped decades of California's leadership in consumer protection in the oversight of managed health care.

With the enactment of the Knox-Keene Act 45 years ago, California took an early lead in regulating and helping to shape the managed health care industry. The Knox-Keene Act has been refined, strengthened and improved over the years adjusting to market shifts and changing consumer needs and expectations. Further enhanced through enactment of federal health care reforms, the Knox-Keene Act continues to provide a comprehensive framework for consumer rights and health plan standards unparalleled in other states. The many protections included in the Knox-Keene Act set the stage for the DMHC to effectively implement health care reform under the ACA in California. Enacted in 2010, the ACA changed the fundamental rules of health insurance markets making it easier for consumers to obtain coverage regardless of age, health status or income. The DMHC continues to work with policymakers, other state agencies, health plans, stakeholders and enrolled consumers to implement the ACA.

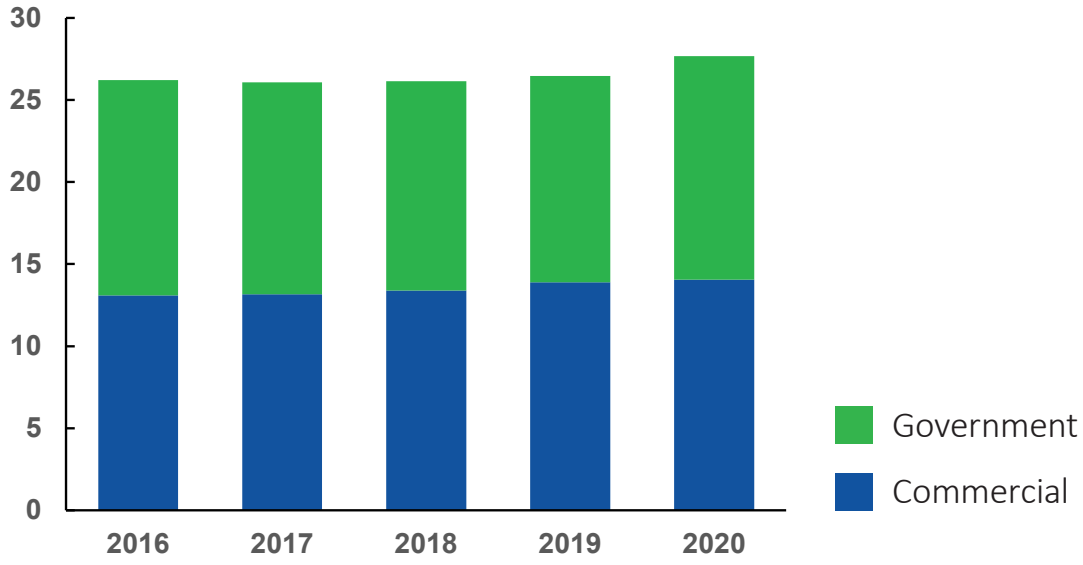
Over the Department's 20-year history, California has launched several initiatives to improve and expand access to health care for all Californians. As an ongoing effort to achieve our mission, the Department continues to implement new laws and regulations, takes action against health plans that violated consumers' health care rights and offers direct assistance to consumers through the DMHC Help Center. As of the end of 2020, the Department has directly assisted approximately 2.5 million consumers through the DMHC Help Center.

The DMHC now regulates the majority of state-regulated health care coverage in California including 95% of commercial and government health plan enrollment. In 2020, 87 full-service health plans licensed by the DMHC provided health care services to more than 27.7 million Californians. This included more than 14 million commercial enrollees and approximately 13.6 million government enrollees[1]. In addition to full-service health plans, the DMHC oversees 45 specialized health plans including chiropractic, dental, vision, behavioral health (psychological) and pharmacy. In 2020, the DMHC's budget was $92,485,000 with 505 positions. The DMHC is funded by assessments on its regulated health plans.

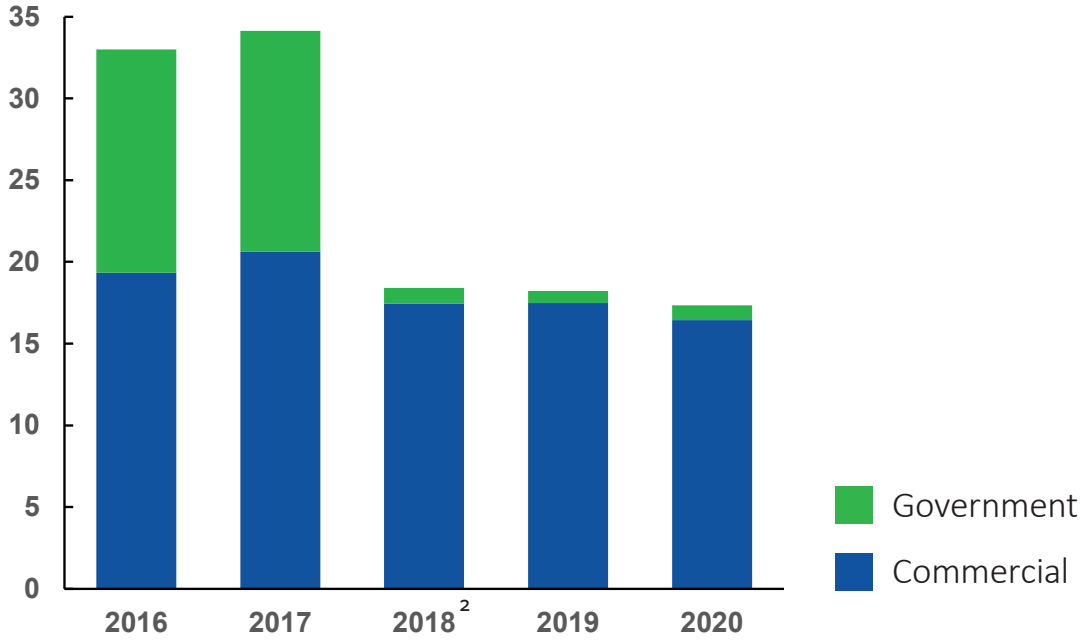
As California celebrates the many historic managed health care milestones, this report highlights current accomplishments, the regulatory history of the Knox-Keene Act and the emerging challenges and opportunities facing the Department and the managed health care industry. The DMHC remains committed to protecting consumers' health care rights and ensuring a stable health care delivery system.

Enrollment Overview

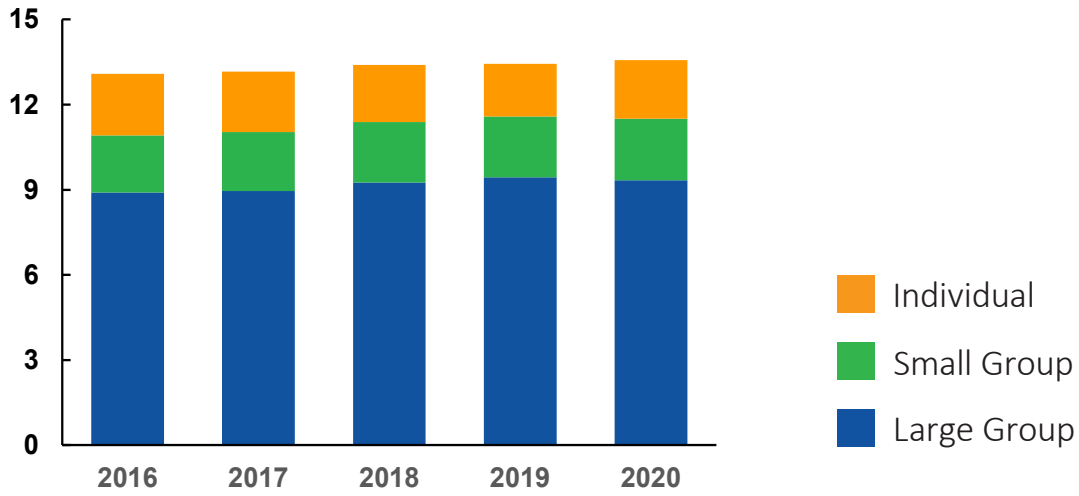
Full Service Enrollment (In Millions)



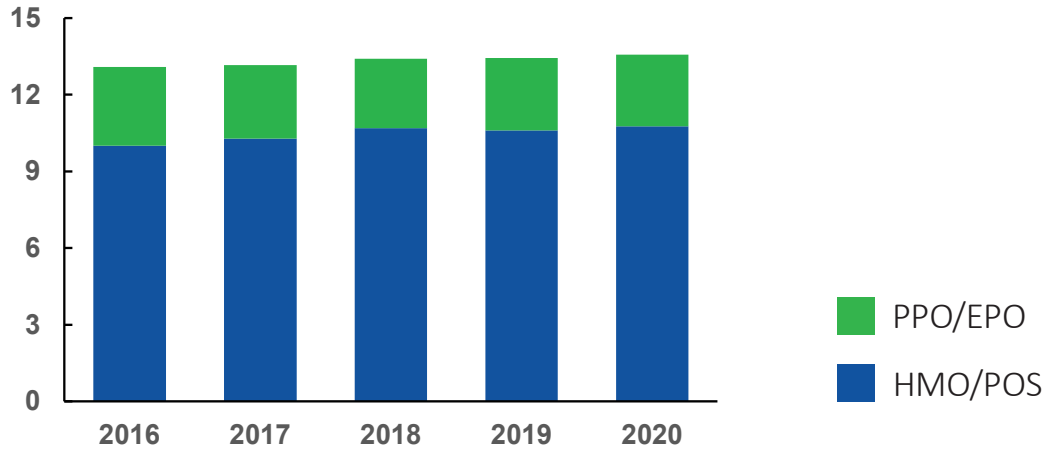
Specialized Enrollment (In Millions)



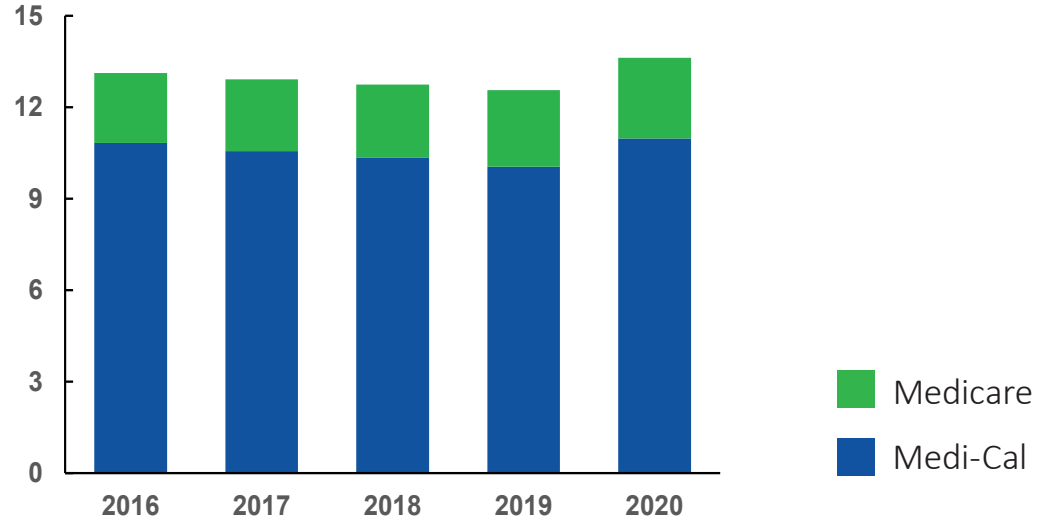
Commercial Enrollment by Market (In Millions)



Commercial Enrollment by Product (In Millions)



Government Enrollment by Type (In Millions)



TIMELINE OF 20 YEARS OF CONSUMER PROTECTION

1999-2000

DMHC Established

The DMHC is created as the first stand-alone state department in the nation dedicated solely to the regulation of health care plans and the provision of consumer assistance to resolve problems with health plans. (AB 78, 1999)

1999

Financial Solvency Standards Board (FSSB)

The FSSB is established with eight-members—the Director and seven members appointed by the Director. The board is the first of its kind in the country. The FSSB advises the Director on matters of financial solvency affecting the delivery of health care services. In the early years, the board focused on how to develop and implement a standardized set of financial solvency benchmarks that all providers and health plans would be required to follow. (SB 260, 1999)

2000

Consumer Assistance

The newly created consumer focused DMHC opens the Help Center. The DMHC Help Center's trained staff assists consumers to resolve issues with health plans and monitors complaints for evidence of systemic health plan regulatory compliance problems.

2001

Independent Medical Review

California establishes the Independent Medical Review program, a legally binding system for external review of health plan denials of care. Since the program's inception, the DMHC has overseen nearly 40,000 reviews of plan denials (including overturned, reversed and upheld decisions). (AB 55, 1999)

2003

Continuity of Care

Following disruptive transfers of more than three million Californians affected by provider contract terminations, the DMHC works to secure legislation to provide continuity of care to at-risk patients. This allows terminally ill and pregnant consumers, and others with scheduled surgeries or procedures, to continue care with a terminated provider under specified circumstances. (AB 1286, 2003)

Timely Claims Payment

The DMHC issued regulations requiring health plans to establish a fast, fair and cost-effective dispute resolution process with providers. These regulations require health plans to pay provider claims timely and accurately pursuant to specific regulatory criteria. (AB 1455, 2003)

2004-2005

Community Investments

In 2004, WellPoint and Anthem Blue Cross corporations merge, affecting control of Blue Cross of California. In 2005, PacifiCare of California merges with UnitedHealth Group. The DMHC conducts a thorough review of the mergers and potential impacts on consumers, and negotiates concessions associated with the corporate changes, including more than $450 million in community benefits for California consumers (including commitments from related companies regulated by California Department of Insurance).

2005

Provider Solvency

In the wake of several high-profile failures of medical groups contracted with health plans, legislation imposes stricter financial responsibilities on risk-bearing organizations (RBOs) and requires health plans to report on risk arrangements. After engaging external stakeholders and the FSSB in an extensive regulatory review process to establish appropriate financial survey reporting requirements and criteria, the DMHC establishes the Provider Solvency Unit to oversee and monitor RBO financial filings.

2008

Balance Billing Prohibition

The practice of billing patients for disputed balances above what the health plan pays is commonly referred to as "balance billing." The DMHC enacts regulations protecting consumers from balance billing by emergency providers. The courts repeatedly affirm the balance billing prohibition.

Cancellations and Rescissions

The DMHC investigates and achieves a groundbreaking settlement with California's five largest health plans, including fines totaling nearly $14 million, for rescinding coverage after enrollees sought treatment or filed a claim. The Department requires the health plans to make major system changes and to contact more than 3,000 consumers with an offer of coverage and the opportunity to submit claims for out-of-pocket expenses.

2010

Timely Access to Care

The DMHC implements landmark regulations to ensure Californians get timely access to care when they need it. The regulations make California the first state in the nation to provide patients with predictable wait times for appointments, timeliness of referrals and response times for health plan telephone triage. It took eight years of negotiations, but the DMHC emerged with a strong, direct way to eliminate unnecessary delays for consumers. (AB 2179, 2010)

2010-2014

ACA Implementation

The DMHC provides early leadership and technical expertise to support enactment of state legislation implementing the ACA and works diligently to update health plan standards and regulatory practices in advance of full implementation in 2014.

2011

Consumer Assistance Program

The DMHC receives the first of several federal ACA grants to work with the Office of the Patient Advocate, the California Department of Insurance and local community-based legal services advocates to enhance and expand consumer education and assistance. Additionally, the DMHC was designated California's Consumer Assistance Program, receiving federal grants to enhance consumer assistance and education efforts in the state.

Provider Claims Payment

Routine financial examinations for the claims payment practices and provider dispute resolution mechanism requirements of the seven largest full-service health plans result in $1.6 million in penalties, $1.8 million in additional paid provider claims and $4.4 million in interest and penalties paid to providers.

Rate Review Program

The DMHC establishes a premium rate review program to provide the public with information to enhance consumer understanding about rate changes in the individual and small group markets and promote more accountability within the health care industry. (SB 1163, 2010)

2012

Autism Advisory Task Force

The DMHC convenes the Autism Advisory Task Force. The Task Force developed recommendations regarding medically necessary behavioral health treatment for individuals with autism or pervasive developmental disorder, as well as the appropriate qualifications, training and education for providers of such treatment.

2013

Coverage for Medical Therapies

The DMHC takes action against six large health plans for improper denials of medically necessary therapies, such as speech and occupational therapy, and requires the health plans to reimburse enrollees for out-of-pocket costs incurred.

ACA Compliance

The DMHC works under tight timelines to review health plan products, provider networks and rate filings ensuring 2014 coverage meets new federal and state requirements.

2014

Access to Mental Health Care

The Department conducts a routine survey of behavioral health services in Kaiser Foundation Health Plan (Kaiser Permanente) and assesses $4 million in penalties for deficiencies in timely access to care. The DMHC later reached a landmark 3-year agreement with the health plan to ensure enrollees receive timely access to behavioral health services.

2015

Accurate Provider Directories

The DMHC imposed a combined $600,000 penalty against California Physicians' Service (Blue Shield of California) and Blue Cross of California (Anthem Blue Cross) for inaccurate provider

directories, which limited enrollee access to care and resulted in an unacceptable consumer experience. Both plans were required under the agreement to improve the accuracy of their provider directories and to reimburse enrollees who may have been negatively impacted by inaccuracies in the published provider directories.

Health Plan Merger

The DMHC approved Blue Shield of California's acquisition of Care1st Health Plan. The Department's approval included several conditions requiring Blue Shield to improve access in the Medi-Cal program as the plan entered this new market segment. Blue Shield also agreed to invest $200 million to help strengthen the health care delivery system and support consumer assistance programs. As part of these investments, the plan was required to develop an industry-led solution to improve the accuracy of health plan provider directories.

2016

Health Plan Dashboard

As part of its commitment to transparency, the DMHC launched the Health Plan Dashboard, an online tool that aggregates public data sets reported by health plans and the DMHC.

Health Plan Merger

The DMHC approved Centene's acquisition of Health Net and applied several conditions to improve access and quality of care. This included investing $140 million to improve health outcomes and support California's health care infrastructure for underserved groups. The plan also agreed to keep key operations in California including building a service center in the state.

Provider Directory Standards

The DMHC released Uniform Provider Directory Standards. These uniform standards were developed to help ensure consistency in how information is displayed across provider directories. (SB 137, 2015)

2017

Surprise Billing

The DMHC implemented AB 72 which protects consumers against out-of-network providers from balance billing consumers when the consumer did everything right and went to an in-network facility, commonly known as "surprise billing." (AB 72, 2016)

Independent Dispute Resolution Process

To remove consumers from the middle of billing disputes, AB 72 created a default reimbursement rate for these out-of-network or non-contracted providers. The DMHC Help Center launched an Independent Dispute Resolution Process (IDRP) as a mechanism for non-contracted providers or health plans to dispute the default reimbursement amount.

2018

Mental Health Parity

The Department completed its comprehensive review of 25 full-service commercial health plans' benefit designs and methodologies for providing mental health services and focused medical surveys to assess whether plans implemented Mental Health Parity and Addiction Equity Act (MHPAEA) compliant benefit designs into practice. As a result of this focused

compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA.

Prescription Drug Cost Transparency

The DMHC issued the first Prescription Drug Cost Transparency Report, for Measurement Year 2017. In accordance with newly enacted legislation, the DMHC must prepare an annual report summarizing the findings and the impact of prescription drug costs on health care premiums. (SB 17, 2017)

Health Plan Mergers

The DMHC approved CVS's acquisition of Aetna, Inc., Optum, Inc.'s acquisition of DaVita Health Plan of California, and Cigna Corporation's acquisition of Express Scripts. The Department's approval of these mergers included important conditions to improve plan performance and access to care for enrollees. As a part of the conditions imposed by the DMHC, a combined total of $358 million was committed to be invested to support California's health care delivery system.

2019

Pharmacy Benefit Management

The DMHC convened a Task Force on Pharmacy Benefit Management (PBM) Reporting to determine what information, related to pharmaceutical costs, health plans or their contracted pharmacy benefit managers should report to the DMHC. The DMHC submitted the Task Force's recommendations to the Legislature. (AB 315, 2018)

Delegate Oversight

The DMHC took enforcement action against 12 DMHC-regulated health plans, including $1.9 million in fines, for the plans' lack of oversight of a delegated medical group. The poor oversight led to the improper denials and delays of enrollees' care. In addition to the fines, the health plans agreed to corrective actions to improve plan oversight of delegated entities.

Enrollee Grievances

The DMHC reached an agreement with Anthem Blue Cross to correct the plan's repeated failures to properly identify and handle enrollee grievances and appeals, including a $2.8 million fine and an $8.4 million investment in the plan's consumer grievances and appeals process. The plan also agreed to several corrective actions to make important consumer-protective improvements to how the plan handles consumer grievances and appeals.

Emergency Response

After the earthquakes, wildfires and power shutoffs that occurred throughout California, the Governor declared a State of Emergency in the affected areas. In response to the declarations, the DMHC took action including sending out All Plan Letters reminding health plans of their obligations under a declared state of emergency. A non-emergency hotline was established to help medically vulnerable Californians and health care facilities find additional resources in their communities during the power shutoffs.

COVID-19 Response

The DMHC took action to protect consumers' health care rights and ensure a stable health care delivery system during the COVID-19 pandemic. The Department worked closely with state and local leaders, health plans, providers and other stakeholders in supporting actions and providing guidance to health plans to mitigate the spread and severity of COVID-19, and ensure enrollees had continued access to health care services. More information on the DMHC's actions can be found in the next section of this report.

Upholding Consumer Protections

The DMHC took enforcement actions against health plans that violated important consumer protections. This includes $1.2 million in fines against Blue Cross of California Partnership Plan, Inc. (Blue Cross) for the plan's failure to timely implement two Independent Medical Review (IMR) determinations to authorize coverage for medically necessary services. The Medi-Cal managed care plan had failed to timely authorize the enrollees' services after receiving the IMR decisions.

2020

Annual Report

Response to COVID-19

The DMHC, along with the rest of the state, the nation and the world, faced unprecedented challenges brought on by the COVID-19 pandemic. The Department continued to prioritize its mission as it worked to address all of the changes brought on by this once in a lifetime emergency. The DMHC worked closely with many stakeholders including state and local leaders, health plans, providers and others, as the Department focused on ensuring enrollees continued to receive needed health care services, providers could continue to provide care, and health plans continued to cover and offer medically necessary services.

The DMHC took several actions in 2020 to support the state's response efforts. This included providing guidance to health plans through many All Plan Letters (APLs). Some of the key issues the DMHC issued guidance on included:

- directing health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees,
- directing health plans to remove administrative burdens on hospitals during the COVID-19 surge,
- ensuring stability in health plan provider networks,
- ensuring health plans provided continued and safe access to care for health plan enrollees through telehealth, and requiring plans to reimburse providers for telehealth services at the same rate as if the services were delivered in-person,
- requiring health plans to offer a special enrollment period to make sure Californians had an available path to affordable health care coverage,
- reminding health plans to comply with California non-discrimination requirements, and about resources to help mitigate negative health outcomes to members due to the COVID-19 emergency, and
- enacting new reporting requirements on health plans to ensure health plans sufficiently support providers with Personal Protective Equipment (PPE) and other COVID-19 supplies to safely deliver services to plan enrollees.

The DMHC created a new COVID-19 web page on the Department's website to make it easy for the public and stakeholders to find information, resources and guidance. The Department also created several consumer-friendly fact sheets, including on the topics of vaccines, testing and health care coverage.

The COVID-19 pandemic caused many changes in the health care industry and within the DMHC. In March 2020, the Department transitioned nearly all employees to telework to adhere to new stay at home orders and state guidance. The Department also made adjustments to how it conducted its work, including changing all on-site financial exams and medical surveys to be completed remotely. In addition, some employees were redirected to support the state's COVID-19 response, including working with local counties on contact tracing.

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 in all languages 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 independent of the health plan review these matters and make an independent determination about whether the requested service should be provided. If an IMR is decided in the consumer's favor, the health 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 DMHC provides assistance to all California health care consumers through the Help Center. The DMHC Help Center assists consumers with understanding their health care rights and benefits, and helps to resolve complaints and coverage issues between health plan enrollees and health plans.

The DMHC Help Center provides these services for free and help is available in all languages. To contact the DMHC Help Center for assistance call 1-888-466-2219 (TDD: 1-877-688-9891) or visit www.HealthHelp.ca.gov.

2020 Highlights

In 2020, the DMHC Help Center assisted 119,760 health care consumers, and handled 10,570 complaints and 3,793 IMRs. Approximately 68% of consumers who submitted an IMR request to the DMHC Help Center received the service or treatment they requested[3].

The community-based Consumer Assistance Program served 9,394 consumers and conducted 1,319 outreach events throughout California despite many impacts under the COVID-19 emergency. Through these Consumer Assistance Program outreach events, the Department reached 61,658 consumers to educate consumers about their health care rights.

AB 72 (2016), which prohibits providers from surprise balance billing health plan enrollees, 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 2020, the DMHC received 23 IDRP applications, and one IDRP was carried over from 2019. Of those, 11 were incomplete, ineligible, non-jurisdictional or non-responsive; one completed the process with a determination letter issued; and, 12 were pending as of December 31, 2020.

In addition to providing consumer assistance, the DMHC Help Center assists providers with claims payment disputes with health plans. The DMHC Help Center received 6,767 provider complaints and recovered $11,627,333 in payments for providers.

2020 BY THE NUMBERS

HELP CENTER

119,760 CONSUMERS ASSISTED[4]

103,830 TELEPHONE INQUIRIES

10,570 CONSUMER COMPLAINTS[5]

3,793 IMRs CLOSED[6]

$2 M RECOVERED FOR CONSUMERS

1,567 NON-JURISDICTIONAL REFERRALS

6,767 PROVIDER COMPLAINTS

$11.6 M RECOVERED PROVIDER PAYMENTS

1 AB 72 IDRP CASES COMPLETED

On average, approximately 68% of enrollees that submitted IMR requests to the DMHC received the requested service or treatment.

Behavioral Health Coverage Changes

California health plan enrollees have the right to treatment for all medically necessary mental health and substance use disorder conditions. SB 855 (2020) strengthened California's mental health parity laws by requiring commercial health plans to provide full coverage for the treatment of all mental health conditions and substance use conditions, under the same terms and conditions applied to other medical conditions. The law also establishes specific standards for what is considered a medically necessary treatment and creates criteria for clinical guidelines for assessing medical necessity.

Under this new law, health plans must cover the full spectrum of all medically necessary treatment in all settings for enrollees. This includes the following settings, when medically necessary:

- Sessions with a therapist
- Medication to manage enrollees' condition
- Out-patient Intensive Treatment
- In-patient Residential treatment

The law also mandates that if an enrollee cannot find an appropriate mental health provider in their health plan network, the health plan must arrange and pay for out-of-network services at no additional cost to the enrollee.

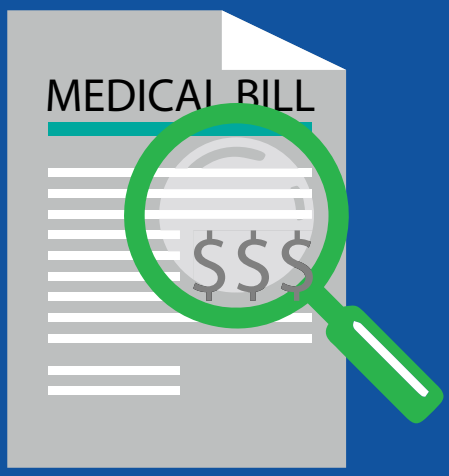
Additionally, the law includes financial protections. Health plans cannot charge more for mental health and substance use disorder services than for physical health conditions. This includes enrollee cost-sharing obligations, such as co-pays, deductibles, maximum annual and lifetime benefits and other out-of-pocket expenses.

Health plan enrollees having trouble accessing behavioral health care treatment or services, should first contact their health plan at the member services phone number on their health plan member card. Their health plan will review the grievance and should ensure the enrollee is able to timely access medically necessary care.

If the enrollee does not agree with their health plan's response, they should contact the DMHC Help Center at www.HealthHelp.ca.gov or by calling 1-888-466-2219. Contact the DMHC Help Center immediately for urgent issues, such as a facility trying to discharge the enrollee, but the enrollee disagrees that they are ready to be discharged.

DMHC HELP CENTER PROVIDER COMPLAINT UNIT

The DMHC recognizes that it is important for hospitals, doctors and other providers to receive accurate payments in a timely manner. The DMHC Help Center's Provider Complaint Unit is responsible for processing complaints from providers to ensure prompt and accurate payment according to the law. The Provider Complaint Unit handles individual complaints, complaints with multiple claims, emergency service complaints and non-emergency service complaints.

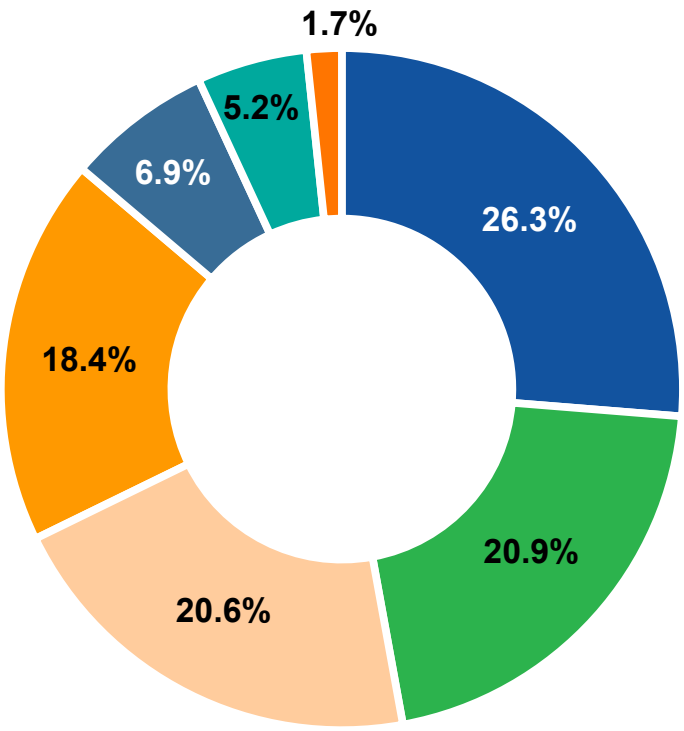


The DMHC established an Independent Dispute Resolution Process (IDRP) for emergency and non-emergency services. An IDRP allows providers and payors to dispute whether payment of a specified rate was appropriate. An external reviewer goes over the claim and determines which rate is justified.

DMHC Help Center staff perform analyses on unfair payment patterns and emerging trends on all provider complaints. The Department uses this information to help identify criteria for audits of health plans and their delegated entities.

Providers looking for more information or to dispute a payment can visit the DMHC website at www.HealthHelp.ca.gov.

CONSUMER COMPLAINTS RESOLVED IN 2020

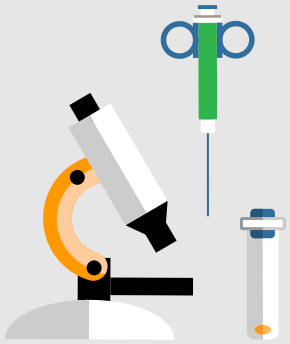


- **1.7% -** Coordination of Benefits[7]
- **5.2% -** Enrollment
- **6.9% -** Access to Care
- **18.4% -** Provider Customer Service
- **20.6% -** Health Plan Customer Service
- **20.9% -** Benefits/Coverage
- **26.3% -** Claims/Financial

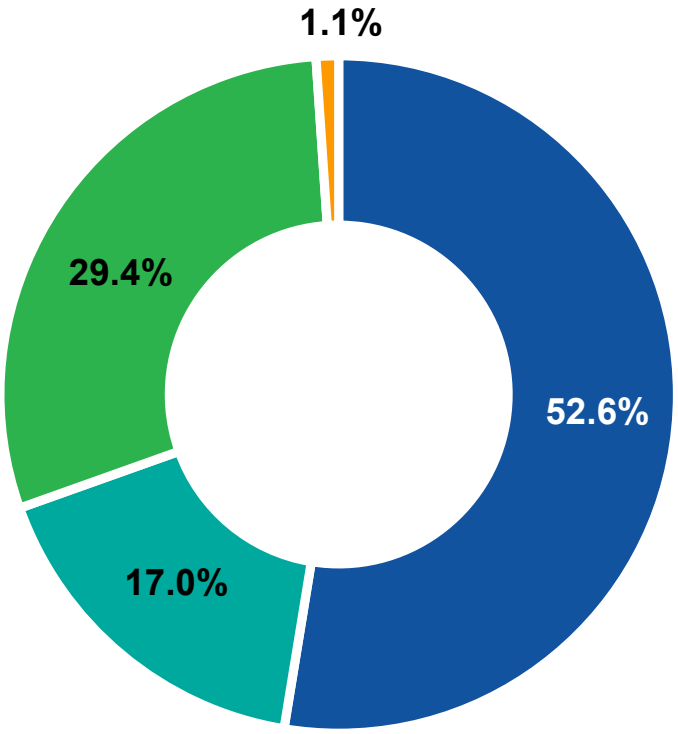
Interspersed throughout this report are consumer stories of assistance the DMHC Help Center provided during 2020. The names of enrollees have been changed to protect their identities.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL DISPUTE

Jesse, a Small Group HMO plan member, needed either a Magnetic Resonance Imaging (MRI) procedure or a biopsy performed. He called his health plan's member services center to compare the cost of the MRI and biopsy. He was told the cost of an MRI was over $2,000 and a biopsy was $800. Jesse decided to have a biopsy expecting a bill for $800. However, he received a bill for almost $4,000. He appealed to his health plan, but the plan upheld their denial. He then filed a complaint with DMHC Help Center. The DMHC requested the phone recordings between the health plan and Jesse. The health plan responded saying Jesse was charged for services in addition to the biopsy which caused the total charges to be different, and the health plan agreed to waive Jesse's cost share amount that exceeded the $800.

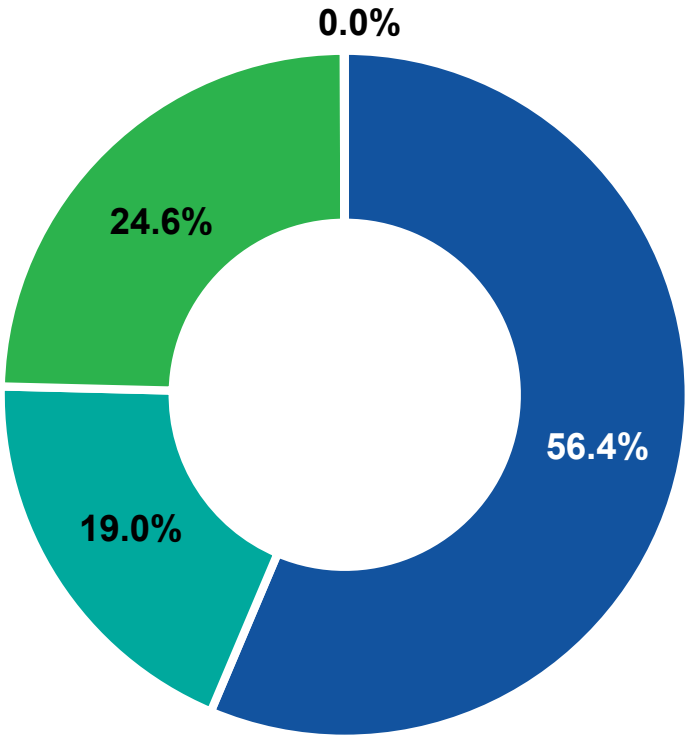


CONSUMER COMPLAINTS RESOLVED IN 2020 BY COVERAGE TYPE



- **1.1% -** Medicare
- **17.0% -** Medi-Cal
- **29.4% -** Individual
- **52.6% -** Employment Based

IMRs RESOLVED IN 2020 BY COVERAGE TYPE



- **0.0% -** Medicare
- **19.0% -** Medi-Cal
- **24.6% -** Individual
- **56.4% -** Employment Based

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.

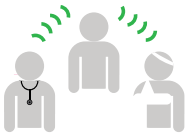
Timely Access to Care Requirements

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 (TDD: 1-877-688-9891) 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 health plans and any changes made to plan 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.

2020 Highlights

The DMHC issues All Plan Letters (APLs) to provide guidance and information to health plans. The Department issued a record 43 APLs in 2020. A large number of APLs issued in 2020 were focused on the state's response to the COVID-19 pandemic. This includes issuing guidance to health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees, requiring health plans to remove administrative burdens on hospitals during the COVID-19 surge, ensuring stability in health plan provider networks, and enacting new reporting requirements to ensure health plans are sufficiently supporting providers with Personal Protective Equipment (PPE) and other COVID-19 supplies to safely deliver services to plan enrollees.

Additionally, the Department issued guidance on preventive health services coverage for Human Immunodeficiency Virus (HIV) preexposure prophylaxis (PrEP) with no cost sharing, and continued to provide guidance to health plans regarding the obligation to provide enrollees access

2020 BY THE NUMBERS

PLAN LICENSING

7 NEW LICENSES ISSUED

4,993 EVIDENCES OF COVERAGE REVIEWED

1,161 ADVERTISEMENTS REVIEWED

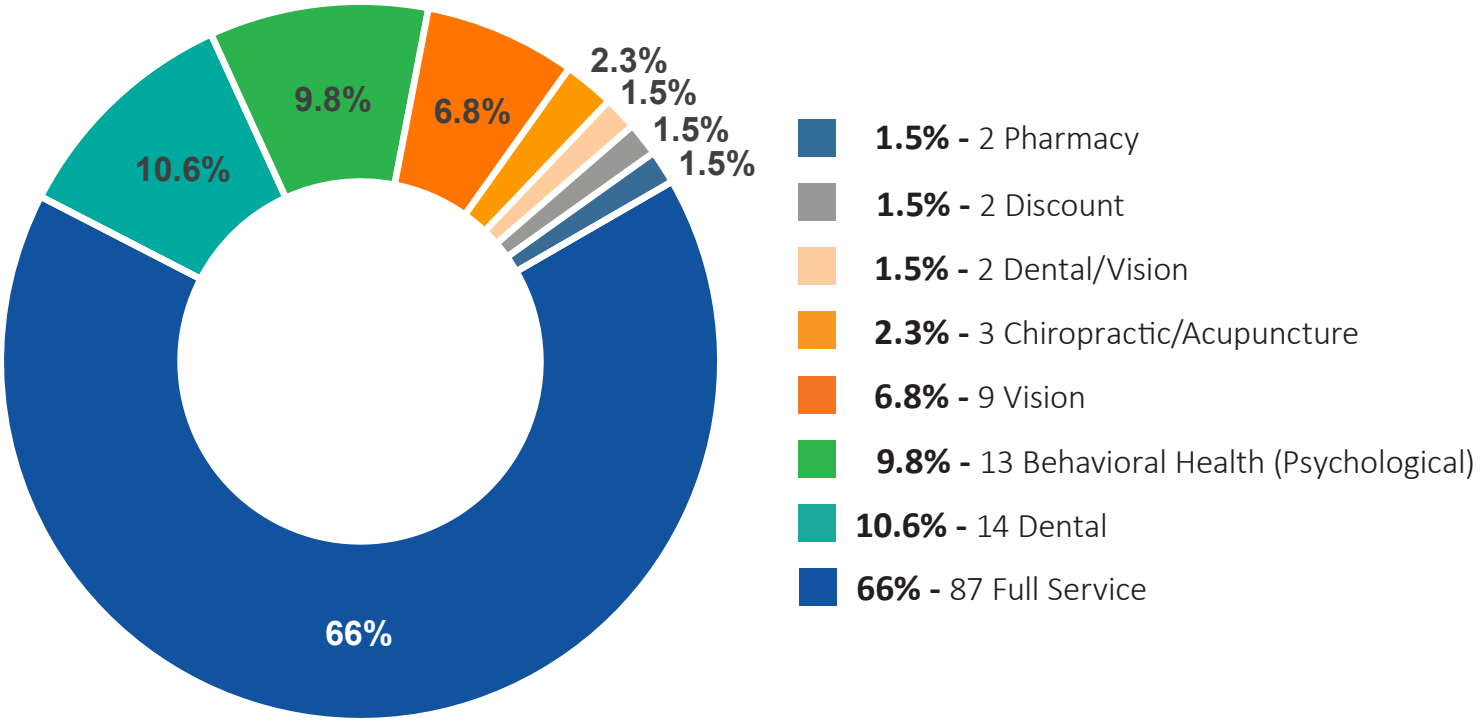
44 COVERED CALIFORNIA FILINGS REVIEWED[8]

43 ALL PLAN LETTERS

195 MATERIAL MODIFICATIONS (SIGNIFICANT CHANGES) RECEIVED

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

LICENSED PLANS IN 2020



to health services when impacted by natural disasters under a declared state of emergency, such as wildfires and extreme weather.

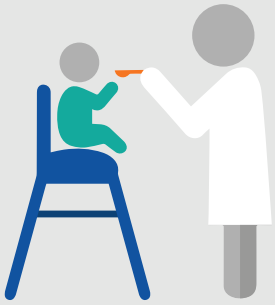
Following the passage of SB 855 (2020), the Department met with stakeholders including the bill's sponsors, behavioral health providers, consumer advocacy groups, health plans, the California Association of Health Plans, the Association of California Life and Health Insurance Companies and California Department of Insurance to discuss implementation to ensure health plans comply with the amendments made by this new law to California's mental health parity law. The law requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. The DMHC created a consumer fact sheet to help educate enrollees on the new law, and will be working on regulations in 2021.

On an annual basis, the DMHC reviews all Qualified Health Plans (QHP) and Qualified Dental Plans (QDP) applying to offer benefits for the upcoming plan year through Covered California, the state's Health Benefits Exchange. This process involves the review of each plan for compliance with Covered California's Patient Centered Benefit Plan Designs, including cost sharing, actuarial value compliance, and contract amendments between full service and specialized health care service plans. The DMHC reviewed 44 QHP and QDP filings in 2020 to ensure compliance with the consumer protections in both the ACA and Knox-Keene Act.

AB 315 (2018) established various contracting requirements between pharmacy benefit managers (PBMs) and health plans. The bill created a new requirement requiring PBMs that contract with health plans to administer drug benefits to register with the DMHC. In 2019, the Department established a PBM registration process. Since then, the DMHC has received 29 applications and registered 16 PBMs by the end of 2020. Many PBMs that applied for registration did not qualify because they did not contract with a DMHC-regulated health plan.

The DMHC also continued to monitor and review plan compliance with the Uniform Provider Directory Standards established by SB 137 (2015). 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.

DMHC HELP CENTER ASSISTANCE: COORDINATION OF CARE (CONTINUITY OF CARE)



Jessica, a minor with an Individual plan PPO coverage, was diagnosed with feeding difficulties, developmental delay, gross motor delay, speech delay, and other serious medical conditions. Her mother asked her health plan to cover her twice weekly oral-motor feeding therapy with an out-of-network provider that had been treating Jessica since birth. Jessica's health plan denied the request and redirected her back to an in-network provider. After unsuccessfully going through the health plan's appeal process, Jessica's mother filed a complaint with the DMHC Help Center. The DMHC Help Center was able to demonstrate that the identified in-network providers were only treating patients via telehealth, and due to the severity of Jessica's condition, in-person services were required. Jessica's health plan agreed to authorize continued oral-motor feeding therapy with the requested out-of-network provider.

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 surveys 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 are like audits, and 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 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 networks are required to have an adequate number of providers to deliver care to enrollees 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" to the DMHC 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 for "continuity of care," where they can continue to see their doctor or hospital, under certain circumstances, for a limited time after the termination.

DMHC HELP CENTER ASSISTANCE: ENROLLMENT/HEALTH PLAN CUSTOMER SERVICE

Monica, and her husband, Joe, Exclusive Provider Organization (EPO) health plan members, discovered their health plan had canceled their coverage when Joe attempted to get a prescription filled just days before his scheduled surgery. Monica and Joe had been paying their monthly premiums through auto payment and said they never received notice there was a problem with the payments. Monica and Joe were prepared to pay any past due premiums, but their health plan refused to reinstate their coverage. Monica contacted the DMHC Help Center for assistance. The DMHC Help Center discovered a problem with the health plan's notices of cancellation to Monica and Joe. The health plan agreed to reinstate their coverage, allowing Joe to reschedule his surgery.

2020 Highlights

Ensuring access to timely and appropriate behavioral health care treatment and services, including compliance with state and federal mental health parity laws continues to be a high priority for the DMHC. The DMHC received approval in the 2020-21 state budget to conduct focused investigations of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with parity and assess whether enrollees have consistent access to medically necessary behavioral health care services. To prepare for the focused investigations that will begin in 2021, the DMHC hired two, full-time permanent staff, selected an external consultant and began drafting the scope of work and compliance tools that will be utilized throughout the focused investigations.

On June 12, 2020, the DMHC submitted the amended timely access regulation to the Office of Administrative Law. The purpose of this regulation is to set a standardized methodology for how health plans report timely access to care requirements and annual network requirements to the DMHC. This regulation will help the DMHC ensure health plans are meeting timely access to care requirements, and allow for meaningful comparisons of timely access to care information across health plans. Once the regulation is adopted, the DMHC will be able to better hold health plans accountable.

The DMHC conducted a non-routine survey of Aetna Health of California Inc. (Aetna) following one of Aetna's former Medical Directors stating that he did not independently review relevant medical records and relied solely on information provided by nurses when performing utilization management (UM) review. This information raised questions about whether Aetna's other Medical Directors were making similar UM determinations without conducting an appropriate medical assessment. The non-routine survey report was issued in 2020 with the DMHC's findings which identified two uncorrected deficiencies around the plan's UM oversight. The Department required Aetna to submit additional information around its corrective action efforts to address the deficiencies, and will assess the plan's progress in making corrections to comply with UM oversight at the follow-up survey.

2020 BY THE NUMBERS

PLAN MONITORING

27 ROUTINE SURVEYS

18 FOLLOW-UP SURVEYS

2 NON-ROUTINE SURVEYS[9]

3 MHPAEA FOCUSED FOLLOW-UP SURVEYS

121 UNIQUE HEALTH PLAN NETWORKS REVIEWED[10]

44 TIMELY ACCESS COMPLIANCE REPORTS REVIEWED[11]

301 BLOCK TRANSFERS RECEIVED

65 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 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 examinations, reviewing claims payment practices and monitoring corrective action plans. As of December 31, 2020, the DMHC had 199 registered RBOs.

The DMHC annually reviews health plans compliance with 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 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.

2020 Highlights

Due to an increase in provider complaints involving Anthem Blue Cross Medicare Supplement claims, the DMHC imposed a Corrective Action Plan (CAP) to address the plan's unfair claims payment practices. The DMHC required Anthem Blue Cross to remediate all impacted Medicare Supplement claims from January 1, 2017 going forward. As part of the CAP that was completed in November 2020, Anthem Blue Cross processed approximately 120,000 claims and providers received claims payments of $26.3 million and nearly $9.2 million in interest.

The DMHC conducted a non-routine financial examination of California Health and Wellness Plan due to several claims processing deficiencies identified during the DMHC's 2019 routine financial examination. The DMHC imposed a CAP on the plan to correct claims denials and payment accuracy issues. As a result, the plan remediated more than 18,000 claims and paid providers an additional $793,000 in claims payments and $501,000 in interest and penalties, as of December 2020.

In 2020, six health plans were required to issue rebate checks totaling $102.6 million to enrollees for failing to meet the minimum MLR for 2019:

- Aetna Health of California, Inc. reported a MLR of 77.7% and paid rebates of $2.3 million in the small group market.
- Anthem Blue Cross reported a MLR of 77.8% and paid rebates of $53.3 million in the small group market.
- Blue Shield of California reported a MLR of 79% and paid $34.9 million in rebates in the small group market.
- Health Net of California, Inc. reported a MLR of 77.8% and paid $9.9 million in rebates in the small group market.
- Community Care Health Plan, Inc. reported a MLR of 82.6% and paid rebates of $1.3 million in the large group market.
- U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California) reported a MLR of 57.8% and paid rebates of $859,350 in the large group market.

The updated regulation for RBOs went into effect on October 1, 2019, and the first financial filings were received on February 15, 2020. The updated regulation requires plans to file detailed financial statements and supplemental information on a quarterly and annual basis. In addition, the updated regulation made changes to the Department's grading criteria in financial oversight that went into effect on October 2, 2020. As part of these changes, RBOs must now maintain tangible net equity based on premium revenues or medical expenses, whichever is higher.

2020 BY THE NUMBERS

FINANCIAL OVERSIGHT

70 FINANCIAL EXAMINATIONS COMPLETED[12]

2,677 FINANCIAL STATEMENTS REVIEWED[13]

$102.6 M MLR REBATES[14]

$27.9 M CLAIM AND DISPUTED PAYMENTS REMEDIATED

$10.4 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 nearly $300 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 health 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. The DMHC holds a public meeting in accordance with statute to increase transparency of large group rate changes. Starting July 1, 2020, health plans with large group products had to file information regarding the methodology, factors, and assumptions used to determine rates with the DMHC. Reviewing the methodology, factors and assumptions used by these plans in developing the rates provides greater transparency and assurance to large group contract holders that the methods the plans are using to develop rates are reasonable.

Health plans in the commercial market must also 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. The annual report is also available on the DMHC website.

REVIEW & COMMENT ON HEALTH PLAN PROPOSED RATE CHANGES

The DMHC makes it easy for the public to view and comment on health plan proposed rates. Visit **www.RateReview.DMHC.ca.gov** for more information and to review and submit comments.

2020 Highlights

In 2020, the DMHC reviewed 54 individual and small group rate filings. As a result of the Department's review and negotiations with health plans, the DMHC saved consumers $40.3 million in premiums. Anthem Blue Cross agreed to reduce both its proposed small group and grandfathered individual rate increases, saving consumers approximately $36.6 million. Health Net of California, Inc. also reduced its small group rate increase, saving consumers approximately $3.7 million.

Health plans submitted their first annual large group filings under AB 731 (2019) to the DMHC on September 2, 2020. The DMHC reviewed 37 filings from 23 health plans.

In October 2020, the DMHC received 25 prescription drug cost filings from commercial health plans for Measurement Year (MY) 2019. The DMHC includes this information in an annual report on the impact of the cost of prescription drugs on health plan premiums. Among other findings, the MY 2019 report revealed that health plans paid an increase of $1 billion on prescription drugs since 2017, including an increase of $600 million in 2019.

In March 2020, the DMHC held a public meeting to discuss the 2019 large group aggregate rate data, as well as the prescription drug costs reported by health plans in the large group rate market.

2020 BY THE NUMBERS

RATE REVIEW

91 RATE FILING REVIEWS COMPLETED[15]

25 PRESCRIPTION DRUG COST FILINGS REVIEWED

158 RATE FILINGS RECEIVED[16]

0 RATES FOUND UNREASONABLE

3 REDUCED (MODIFIED) RATES

$40.3 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES

$296.1 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES SINCE 2011

> ***Since January 2011, the DMHC has saved Californians $296.1 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 plan 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 2020, the first $1 million in fines collected by the DMHC was transferred to the Steven M. Thompson Physician Corps Loan Repayment Program to be used to encourage physicians to practice in medically underserved areas. The remaining funds were transferred to the Health Care Services Plan Fines and Penalties Fund to support the Medi-Cal program.

2020 Highlights

In 2020, the DMHC assessed $3,720,750 in fines for enforcement actions taken against health plans. The Department's enforcement actions in 2020 involved many diverse legal issues, including failures to timely implement IMR decisions, wrongfully denying emergency services claims payment, violations of state and federal mental health parity laws and improperly denying basic health care services.

Some of the significant enforcement actions taken by the DMHC in 2020 are described below:

The DMHC imposed fines totaling $1.2 million against Blue Cross of California Partnership Plan, Inc. (Blue Cross) for its failure to timely implement two IMR decisions adopted by the DMHC. California law requires health plans to authorize the services within five working days of receiving an IMR determination accepted by the Department. After the DMHC Help Center intervened, the enrollees were able to get the services they needed. In one case, the service was not authorized until 200 days after the plan was legally required to authorize the service. Due to this delay, the plan was fined $1 million. In the second case, the service was not authorized for 41 days after the legal requirement and the plan was fined $205,000 for that violation. Blue Cross acknowledged its failure to comply with the law and agreed to pay the fine and complete a CAP to settle the issue. The plan updated their internal policies to ensure proper IMR handling in the future and paid the imposed penalty.

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

Helene, a Large Group HMO plan member, was diagnosed with Stage 3 breast cancer. She filed a complaint with the DMHC regarding an interruption in her immunotherapy infusions due to a contract change between her health plan and provider. Helene requested to continue receiving treatment from her existing oncologist. Her health plan denied her request for continuity of care and referred her to an in-network oncologist, but the in-network oncologist was unable to arrange timely treatment. The DMHC Help Center reached out to the plan and the plan agreed to cover the remaining infusions with the out-of-network oncologist, consistent with completion of covered services.

The DMHC ordered Aetna Health of California, Inc. (Aetna) to stop wrongfully denying payment for emergency medical services and fined the plan $500,000. The Department's order also required Aetna to review and remediate claims wrongfully denied since February 1, 2017. The Department previously took enforcement action against Aetna for improperly denying coverage for enrollees' emergency medical services. Aetna entered into settlement agreements with the DMHC in 2015 and 2016 and paid $135,000 in fines, in addition to implementing CAPs requiring training for employees handling claims for emergency services and reimbursement for emergency services.

The DMHC also imposed a $120,000 penalty against Aetna for its continued failure to cover speech therapy services. In September 2014, Aetna and the DMHC entered into a settlement agreement that required the plan to provide speech therapy services as a basic health care service, regardless of whether an enrollee's speech impediment or developmental disability had a physical cause. In 2017, the DMHC's medical survey of the plan found the plan continued to cite to a national clinical policy in support of its denials of speech therapy services that contradicted the terms of the September 2014 settlement agreement with the DMHC. The Department concluded that Aetna violated both the law and settlement agreement by failing to cover basic health care services. The plan acknowledged its failure by implementing a CAP and paying the penalty.

The DMHC imposed a $65,000 penalty against Community Health Group for its failure to provide basic health care services by improperly denying medically necessary speech therapy to treat autism in violation of the California Mental Health Parity Act. The enrollee was a minor with a developmental disability, cerebral palsy, autism spectrum disorder, intractable epilepsy, chromosomal abnormalities and abnormal speech. The enrollee's primary care physician provided a referral for an evaluation to

2020 BY THE NUMBERS

ENFORCEMENT

706 CASES OPENED

146 CASES CLOSED WITH A PENALTY

$3.7 M PENALTIES ASSESSED

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

receive speech therapy services in addition to the services received once a week at the enrollee's school. Community Health Group improperly denied the provider's request. The DMHC determined the speech therapy services legally qualified as ambulatory care services. In denying speech therapy, the plan denied a basic health care service. The plan acknowledged its failure by paying a fine and implementing a CAP including training staff to recognize Medi-Cal managed care plans may not impose service limitations on Early and Periodic Screening, Diagnostic and Treatment benefits, including speech therapy.

The DMHC imposed a $25,000 penalty against Ventura County Health for its failure to correct deficiencies identified in a focused survey regarding compliance with MHPAEA. Ventura County Health failed to calculate financial requirements in accordance with the MHPAEA regulations. In addition to paying the penalty, Ventura County Health provided proof that all enrollees who were charged incorrect cost-sharing amounts for mental health or substance use disorder services were reimbursed directly by the providers and, in some instances, by the plan.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL/ COVERAGE OF FERTILITY PRESERVATION

Serena, a Large Group HMO plan member, was diagnosed with lymphoma. She required chemotherapy treatment that could cause infertility. She underwent fertility preservation procedures before starting chemotherapy. Her health plan covered the treatments, but charged her copayments based on the infertility benefits of her Evidence of Coverage. Serena submitted a complaint to the DMHC Help Center, because she thought her copayments should be calculated under her benefits for basic health care services. After the DMHC Help Center intervened, Serena's health plan agreed to reprocess her copayments under her benefits for basic health care services.

Celebrating 10 Years of the Affordable Care Act (ACA)

California has been a national leader in the implementation of ACA. As a result, California's uninsured rate has fallen from 17% to 7.1%. The number of uninsured Californians has dropped by 3.7 million[17]. The DMHC has played an active role in California's implementation of the ACA since its passage in 2010, working as a partner with other state agencies, legislators, health plans, providers and stakeholders. As a result, California has remained ahead of the curve in executing health reform. This section briefly highlights ACA implementation activities of the DMHC to date.

Statutory Changes and Regulatory Guidance

The DMHC provided technical expertise for updating California laws to make them consistent with the ACA. California passed legislation to guarantee availability of coverage for children and to allow them to stay on their parents' policy until age 26[18]. State legislation ensured coverage for preventive health care services without cost sharing, eliminated annual and lifetime dollar limits on benefits and established California's benchmark for essential health benefits as minimum coverage in the individual and small group markets[19]. California's chosen Essential Health Benefits benchmark plan is a Knox-Keene licensed benefit plan, Kaiser Small Group HMO 30. Each state's benchmark plan sets the minimum benefits requirements for all coverage under individual and small group coverage. As such, the Knox-Keene Act's comprehensive approach to benefits became the standard for all coverage in the individual and small group markets in California.

The state Legislature also authorized the DMHC to review premium rate filings and enforce MLR requirements[20]. Market reforms for individual and small employer coverage guaranteed availability of coverage without preexisting condition limitations and imposed standard rating rules, prohibiting rates based on expected claims use or health status. California had already enacted many of these market reforms, including guaranteed availability and renewal for small employers and guaranteed renewability for individuals.

The additional ACA protections also paved the way for individuals to have guaranteed coverage at reasonable rates due to the individual health coverage mandate. In 2019, the U.S. Congress eliminated the penalty for the ACA's individual mandate and California enacted an individual mandate in state law, imposing a tax penalty on Californians who go without health coverage that became effective on January 1, 2020. California also enacted new and expanded subsidies to increase coverage and promote affordability. The individual mandate, along with the state subsidy improved access for low-income and middle-income Californians to purchase affordable coverage, and ensures a healthy risk pool and more stable health insurance market.

As illustrated by the following chart, which offers a comparison of the standards required by the Knox-Keene Act prior to the passage of the ACA, California was a national leader in providing health plan enrollees robust health care protections even before the enactment of the ACA.

Following passage of ACA-related reforms, the DMHC developed detailed rules, guidance and regulatory review procedures. Leading up to 2014, the first year of full implementation of the ACA, the DMHC reviewed a significant increase of health plan products and rate filings, including filings for Qualified Health Plans selected to participate in Covered California as well for products offered off the exchange. Now the DMHC reviews these filings annually. The DMHC's review includes network adequacy, standard benefit designs, essential health benefits, and benefit and rate change notices for individual and small employer contracts.

Health Plan Standards in Knox-Keene Act and the ACA

	Knox-Keene Act Pre-ACA	ACA Provision
Minimum Benefits	For individual, small group, and large group coverage, mandates basic health care services as a minimum, if medically necessary	For individual and small group coverage, mandates essential health benefits as a minimum
Comprehensive Coverage	Prohibits denial based on fixed dollar or service limits	Prohibits annual and lifetime dollar limits on essential health benefits
Preventive Health Care Services	For individual, small group, and large group coverage, mandates coverage of preventive health care services as a basic health care service	For individual and small group coverage, mandates coverage of preventive health care services as essential health benefit; requires coverage for certain preventive services without any enrollee cost sharing
Emergency Services	For individual, small group, and large group coverage, mandates coverage of emergency services as a basic health care service, including out-of-area emergencies Requires uniform cost sharing for out-of-network and in-network emergency services	For individual and small group coverage, mandates coverage of emergency services as an essential health benefit Prohibits higher deductibles, co-payments and co-insurance for out-of-network emergency services than those charged for in-network emergency services
Provider Choice	For individual, small group, and large group coverage, allows enrollees to select any available participating primary care provider Allows enrollees to access care from a participating obstetrician-gynecologist (OB-GYN) providers without a referral	For individual, small group, and large group coverage, allows enrollee to select any available participating primary care provider Allows enrollees to access care from a participating OB-GYN provider without a referral
Network Adequacy	Requires readily available and accessible primary, specialty, institutional and ancillary services, subject to specific time and distance standards, physician-enrollee ratios and appointment waiting time standards	For individual and small group coverage offered through the Exchange, requires qualified health plans to offer a sufficient choice of providers in number and type to ensure that all services will be accessible without unreasonable delay

	Knox-Keene Act Pre-ACA	ACA Provision
Independent External Review	Establishes the Independent Medical Review (IMR) program (1999), allowing enrollees to request binding independent review of health plan decisions that deny, modify or delay coverage of requested services based on medical necessity	Requires issuers to have an independent external review process much like IMR. CMS determined the Knox-Keene Act IMR program complies with the ACA
Guaranteed Availability	Guaranteed availability for small group coverage (1992) Limited guaranteed availability in the individual market: HIPAA coverage, conversion coverage, continuation coverage, Cal-COBRA	Guaranteed availability for individual, small group, and large group coverage
Pre-existing Condition Exclusions	For small group coverage, limited the pre-existing condition exclusion period to six months For individual and large group coverage, limited pre-existing condition exclusion periods to six or twelve months, depending on the number of enrollees	For individual, small group, and large group coverage, prohibits all pre-existing condition exclusions
Guaranteed Renewability	For individual, small group, and large group coverage, guaranteed renewability except in cases of nonpayment, fraud or good cause	For individual, small group, and large group coverage, guaranteed renewability, with limited exceptions, including nonpayment, fraud, or issuer ceases to offer product/exits market

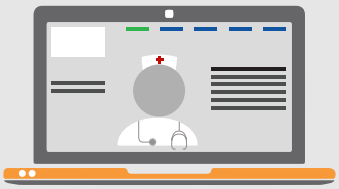
ACA Education and Information

Starting in 2010, the DMHC Help Center received federal ACA Consumer Assistance Program grant funds to develop statewide media materials, enhance the consumer facing website, and expand the Help Center's capacity to help educate and inform consumers about the coverage opportunities and changes in the ACA. The Department developed toolkits including resource guides and fact sheets for individuals, families and small businesses to help them understand their rights to keep coverage, gain new coverage or file a grievance or appeal. In addition, the DMHC awarded a portion of the grant funds to the Health Consumer Alliance, a network of nine community-based legal services organizations, to provide local, one-on-one assistance to individuals and families navigating the post-ACA health coverage market. As part of the grant, the DMHC worked with experts and stakeholders to develop accessible educational materials for individuals with physical, developmental, intellectual and sensory disabilities.

The DMHC no longer receives federal grant funding for ACA education and outreach. However, the Department has maintained its Consumer Assistance Program beyond the federal funding and continues to help consumers understand their rights and receive the care they need. Through the Consumer Assistance Program, the DMHC contracts with community-based organizations to provide consumers with local, in-depth assistance. Over the last five years, the DMHC's Consumer Assistance Program has served 63,788 consumers and conducted 9,847 outreach events. Through these outreach events, the Department has reached more than 633,000 consumers.

DMHC HELP CENTER ASSISTANCE: BENEFITS / COVERAGE – INACCURATE PROVIDER DIRECTORY

Paul, a Large Group PPO health plan member, obtained heath care services from a provider that he found on his employer group's health plan website. Paul's health plan denied the provider's claims because the provider was not contracted with Paul's health plan. After making several unsuccessful appeals to his health plan, Paul filed a complaint with the DMHC Help Center. The DMHC Help Center worked with Paul to get proof the provider was listed incorrectly on his employer's health plan website. Based on this information, Paul's health plan agreed to cover the services due to the inaccurate information on his employer group's heath plan website.



Creation of the DMHC Emphasizes Consumer Protection

The Department of Corporations administered a comprehensive regulatory framework through the Knox-Keene Act. However, as enrollment in managed care plans in California accelerated throughout the 1990s, policymakers and others began to question whether health plans were effectively balancing access, care and quality with costs. Managed care plans in the state kept California premiums historically among the lowest in the country but the growing national focus on quality brought a new level of scrutiny to health plan policies and management strategies. The resulting "managed care backlash" led to a wave of more stringent legislative and regulatory requirements imposed on health plans.

It was in this environment that the DMHC was created. Legislation to transfer oversight of health plans from the Department of Corporations to a new "state agency devoted exclusively to the licensing and regulation of managed health care" came as part of a sweeping package of bills sponsored by consumer advocacy organizations, dubbed the Patient Bill of Rights. AB 78 (1999) required the new DMHC to establish a consumer-focused Help Center and amended the original legislative intent of the Knox-Keene Act to reinforce the DMHC's role in addressing consumer complaints.

The new consumer-focused DMHC opened in July 2000 to assist consumers and ensure the accessibility and the quality of health care services offered by the health plans it licenses.

THE PATIENT BILL OF RIGHTS

- Guaranteed coverage for second opinions
- Time limits for utilization review and mandated disclosure of the criteria health plans use in denying coverage
- Independent external medical review to resolve disputes related to denials, delays, or modifications of coverage for health services
- Improvements in the external review system for coverage of experimental treatments
- Consumer right to sue an HMO for damages related to denials or delays in care
- Standards to assure the solvency of medical groups under contract with health plans, and
- Additional mandated benefits, including mental health parity, contraception, hospice, cancer screening, and coverage for diabetic supplies

Historical Timeline of the Knox-Keene Act[21]

1929-1945

Early prepaid health plan models emerge in California (Ross-Loos, Permanente Health Plan and Blue Shield of California).

1946

California Supreme Court rules that Blue Shield of California and other prepaid health plans are not in the business of insurance and are not subject to the jurisdiction of the Insurance Commissioner. (*California Physicians' Service v. Garrison* (1946) 28 Cal.2d 790)

1965

Knox-Mills Health Plan Act requires health care service plans to register with the California Attorney General (AB 419, 1965). More than 100 health plans register including Ross-Loos, Kaiser Permanente, Blue Shield of California and Family Health Plan, along with specialized dental and mental health plans.

1972

California Waxman-Duffy Prepaid Health Plan Act (AB 1496, 1972) sets standards for the growing number of prepaid health plans in Medi-Cal under the oversight of the Department of Health Services.

1973

Congress passes the Federal Health Maintenance Organization Act and coins the term "HMO" for the first time. The Act establishes comprehensive benefits, community rating, financial reserve standards and other requirements.

1975

Knox-Keene Health Care Service Plan Act of 1975 transfers health care service plans from the Attorney General to the Commissioner of Corporations (AB 138, 1975) and establishes a comprehensive framework of regulatory oversight and consumer protections.

1982

Legislature authorizes disability insurers to selectively contract with health care providers, paving the way for the Insurance Commissioner to also license and regulate PPOs, as health insurance products (AB 3480, 1982).

1993

Legislature authorizes Knox-Keene plans to develop point-of-service (POS) contracts (SB 1221, 1993).

1995

Legislature requires the Department of Corporations (DOC) to establish a toll-free number to receive consumer complaints and inquiries (SB 689, 1995).

1996

Legislation creates the Managed Health Care Improvement Task Force to report on the status of health coverage and make recommendations on the appropriate role for government oversight and regulation of managed care (AB 2343, 1996). Legislation requires the DOC to establish an HMO Ombudsperson to resolve and respond to consumer complaints (SB 1936, 1996).

1998

Managed Care Task Force recommends the creation of a new state department to regulate health care service plans and to phase in regulation of medical groups and other provider entities that bear substantial risk for health care services.

1999

Legislature passes 21-bill package known as the Patient Bill of Rights, which establishes the DMHC and transfers responsibility of regulating health care service plans under the Department (AB 78, 1999).

DMHC HELP CENTER ASSISTANCE: COORDINATION OF CARE (CONTINUITY OF CARE) / HEALTH PLAN CUSTOMER SERVICE

Miguel, a minor enrolled in a Medi-Cal Managed Care health plan, was diagnosed with autism and language impairment. His mother contacted the DMHC Help Center because his health plan would not authorize continued speech therapy services from the provider after the provider's contract with the plan was terminated. The DMHC Help Center informed Miguel's health plan that the speech therapy services from the newly terminated provider qualified for completion of covered services under California law, and the health plan authorized continued services from the provider.

Looking Ahead

The Department has a proud history of consumer-protective achievements and a consumer-focused approach to the regulation of health plans in California. For over 20 years, the DMHC has continued to build on California's leadership and regulation of managed health care delivery systems. Much has happened over these two decades, including significant changes brought on by the passage of the ACA ten years ago.

Looking forward, the Department will continue to provide consumer assistance and regulatory enforcement activities while staying on top of the emerging challenges facing the health care delivery system. This includes a continued focus on the changes and challenges presented by the COVID-19 pandemic, and supporting the state's ongoing recovery efforts. As California moves on to a new normal, the DMHC will play an important role in ensuring the enduring stability of the health care delivery system and consumer access to needed and delayed care caused by the pandemic.

Additionally, the Department remains focused on ensuring all health care enrollees can obtain timely and appropriate access to care. This includes making sure that health plan enrollees can access appropriate behavioral health care services when they need them.

The DMHC will also continue ongoing efforts to achieve the Department's overall mission including implementing new laws and regulations, ensuring the financial stability of health plans and risk bearing organizations, conducting health plan surveys and financial examinations, assessing the adequacy of plan networks to ensure timely access to care, taking action against health plans that violate consumers' health care rights and providing direct assistance to consumers through the DMHC Help Center.

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 was 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 nearly 68% of the cases qualified by the Department for the IMR program in 2020.

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 (10,061), quick resolutions (440), and urgent cases (69) in 2020. 8,286 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 2020. 2,592 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 The non-routine surveys released in 2020 were for Aetna Health of California, Inc. and Anthem Blue Cross (Dental).

10 Networks reviewed in 2020 were for Measurement Year 2019.

11 Timely Access compliance reports reviewed in 2020 were for Measurement Year 2019.

12 43 Health Plan Financial Examinations, 3 Health Plan Medical Loss Ratio Exams and 24 RBO Financial Examinations.

13 1,445 Health Plan Financial Statements Reviewed and 1,232 RBO Financial Statements Reviewed.

14 Rebates for calendar year 2019, paid in 2020.

15 This includes 14 individual market health plan premium rate filings, 40 small group rate filings, and 37 large group rate filings. The total number of rate filings increased from previous years as a result of AB 731 (2019), which required health plans to file large group rate filings with the DMHC starting in 2020.

16 The DMHC does not review annual aggregate rate filings.

17 How Many In Your Area Are Covered by the Affordable Care Act?, California HealthCare Foundation, 2020. Available online at: https://www.chcf.org/publication/how-many-your-area-are-covered-affordable-care-act/#easy-footnote-bottom-2-43290.

18 Guaranteed Coverage for Children (AB 2244, 2010) and Dependent Coverage up to age 26 (SB 1088, 2010).

19 Preventive services (AB 2345, 2010) and Essential health benefits (AB 1453, 2012; SB 951, 2012).

20 Premium rate review (SB 1163, 2010) and Medical Loss Ratios, Annual and Lifetime Benefit Limits (SB 51, 2011).

21 Excerpted from Making Sense of Managed Care Regulation in California, California HealthCare Foundation, 2001. Available online at: https://www.chcf.org/publication/making-sense-of-managed-care-regulation-in-california/

2020 Independent Medical Review Summary Report

Report Overview

68%
of enrollee cases that qualified for the Department's IMR program received the requested services they needed.*

15%
of IMR cases were reversed by the health plan after the DMHC received the IMR application.

53%
of cases previously denied by health plans were overturned by the IMRO.

32%
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 2020 calendar year, by health plan. The Department resolved 2,592 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 2020 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2020, may have had enrollment earlier in the year or received a license during 2020.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review, and resolved (closed) within calendar year 2020. Cases pending at the end of 2020 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 2020. 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.

* Enrollees received the requested services in 67.9% of the cases qualified by the Department for the IMR program in 2020.

California Department of Managed Health Care

2020 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	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)	2,236,665	534	2.39	136	54	39.7%	74	54.4%	8	5.9%	397	109	27.5%	253	63.7%	35	8.8%	1	0	0.0%	0	0.0%	1	100.0%
Blue Cross of California Partnership Plan, Inc.	808,082	56	0.69	2	0	0.0%	1	50.0%	1	50.0%	54	12	22.2%	22	40.7%	20	37.0%	0	0	0.0%	0	0.0%	0	0.0%
California Physicians' Service (Blue Shield of California)	2,596,281	969	3.73	192	90	46.9%	79	41.1%	23	12.0%	774	188	24.3%	503	65.0%	83	10.7%	3	1	33.3%	2	66.7%	0	0.0%
Health Net Community Solutions, Inc.	1,425,909	80	0.56	5	3	60.0%	2	40.0%	0	0.0%	75	25	33.3%	29	38.7%	21	28.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Net of California, Inc.	570,069	88	1.54	15	5	33.3%	7	46.7%	3	20.0%	72	18	25.0%	28	38.9%	26	36.1%	1	1	100.0%	0	0.0%	0	0.0%
Inland Empire Health Plan (IEHP)	1,326,955	75	0.57	3	1	33.3%	2	66.7%	0	0.0%	72	45	62.5%	18	25.0%	9	12.5%	0	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7,098,996	251	0.35	3	3	100.0%	0	0.0%	0	0.0%	248	123	49.6%	96	38.7%	29	11.7%	0	0	0.0%	0	0.0%	0	0.0%
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	2,316,497	93	0.40	4	3	75.0%	0	0.0%	1	25.0%	88	30	34.1%	41	46.6%	17	19.3%	1	0	0.0%	0	0.0%	1	100.0%
Molina Healthcare of California	501,613	15	0.30	0	0	0.0%	0	0.0%	0	0.0%	15	6	40.0%	4	26.7%	5	33.3%	0	0	0.0%	0	0.0%	0	0.0%
UHC of California (UnitedHealthcare of California)	405,397	64	1.58	8	5	62.5%	3	37.5%	0	0.0%	56	15	26.8%	25	44.6%	16	28.6%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Over 400,000:	**19,286,464**	**2,225**	**1.15**	**368**	**164**	**44.6%**	**168**	**45.7%**	**36**	**9.8%**	**1851**	**571**	**30.8%**	**1019**	**55.1%**	**261**	**14.1%**	**6**	**2**	**33.3%**	**2**	**33.3%**	**2**	**33.3%**
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.	30,071	5	1.66	1	1	100.0%	0	0.0%	0	0.0%	4	1	25.0%	1	25.0%	2	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Health of California Inc.	197,414	12	0.61	1	1	100.0%	0	0.0%	0	0.0%	11	3	27.3%	5	45.5%	3	27.3%	0	0	0.0%	0	0.0%	0	0.0%
AIDS Healthcare Foundation (Positive Healthcare)	691	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	275,726	11	0.40	0	0	0.0%	0	0.0%	0	0.0%	11	6	54.5%	2	18.2%	3	27.3%	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%
AltaMed 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%
Astiva Health, 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%
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	103,414	6	0.58	0	0	0.0%	0	0.0%	0	0.0%	6	1	16.7%	2	33.3%	3	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Brandman 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%
Brown & Toland Health 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%
California Health and Wellness Plan (California Health and Wellness)	206,031	7	0.34	0	0	0.0%	0	0.0%	0	0.0%	7	1	14.3%	4	57.1%	2	28.6%	0	0	0.0%	0	0.0%	0	0.0%
Care Improvement Plus South Central 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%
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%
CHG Foundation (Community Health Group Partnership Plan)	276,672	4	0.14	0	0	0.0%	0	0.0%	0	0.0%	4	2	50.0%	2	50.0%	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	8,713	2	2.30	1	0	0.0%	1	100.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	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.	150,432	17	1.13	6	3	50.0%	0	0.0%	3	50.0%	11	2	18.2%	6	54.5%	3	27.3%	0	0	0.0%	0	0.0%	0	0.0%
Clever Care of Golden State Inc. (Clever Care 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%
Community Care Health Plan, Inc.	11,496	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	6,979	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%
Contra Costa County Medical Services (Contra Costa Health Plan)	202,017	11	0.54	1	1	100.0%	0	0.0%	0	0.0%	10	7	70.0%	3	30.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
County of Ventura (Ventura County Health Care Plan)	12,117	1	0.83	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%
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%
For Your Benefit, 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%
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	374,982	34	0.91	0	0	0.0%	0	0.0%	0	0.0%	34	13	38.2%	15	44.1%	6	17.6%	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%

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Plan Type and Name	Enrollees*	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	%
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.	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%
Hill Physicians Care Solutions, 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%
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, 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%
Kern Health Systems	277,452	26	0.94	0	0	0.0%	0	0.0%	0	0.0%	26	5	19.2%	9	34.6%	12	46.2%	0	0	0.0%	0	0.0%	0	0.0%
Medcore HP	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, S.A. de C.V. (MediExcel Health Plan)	14,062	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%
MemorialCare Select Health Plan	230	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%
Meritage 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%
Monarch 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%
On Lok Senior Health Services	381	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	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%
Oscar Health Plan of California	103,833	44	4.24	4	2	50.0%	1	25.0%	1	25.0%	39	6	15.4%	17	43.6%	16	41.0%	1	1	100.0%	0	0.0%	0	0.0%
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 Health Authority (San Francisco Health Plan)	150,634	3	0.20	1	0	0.0%	0	0.0%	1	100.0%	2	0	0.0%	1	50.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
San Joaquin County Health Commission (Health Plan of San Joaquin)	364,077	13	0.36	1	0	0.0%	1	100.0%	0	0.0%	12	5	41.7%	5	41.7%	2	16.7%	0	0	0.0%	0	0.0%	0	0.0%
San Mateo Health Commission (Health Plan of San Mateo)	122,943	31	2.52	2	0	0.0%	2	100.0%	0	0.0%	29	6	20.7%	21	72.4%	2	6.9%	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)	44,602	5	1.12	0	0	0.0%	0	0.0%	0	0.0%	5	1	20.0%	3	60.0%	1	20.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	271,107	19	0.70	1	0	0.0%	1	100.0%	0	0.0%	18	3	16.7%	10	55.6%	5	27.8%	0	0	0.0%	0	0.0%	0	0.0%
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)***	540	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	13,966	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.	15,253	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	138,970	41	2.95	2	1	50.0%	1	50.0%	0	0.0%	38	9	23.7%	17	44.7%	12	31.6%	1	0	0.0%	1	100.0%	0	0.0%
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	48,484	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)	96,692	20	2.07	2	1	50.0%	1	50.0%	0	0.0%	18	3	16.7%	11	61.1%	4	22.2%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Benefits Plan of California	162,829	8	0.49	0	0	0.0%	0	0.0%	0	0.0%	8	3	37.5%	5	62.5%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Community Plan of California, Inc.	19,851	1	0.50	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%
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%
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	101,791	42	4.13	3	2	66.7%	0	0.0%	1	33.3%	39	6	15.4%	23	59.0%	10	25.6%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Under 400,000:	**3,804,452**	**363**	**0.95**	**26**	**12**	**46.2%**	**8**	**30.8%**	**6**	**23.1%**	**335**	**83**	**24.8%**	**164**	**49.0%**	**88**	**26.3%**	**2**	**1**	**50.0%**	**1**	**50.0%**	**0**	**0.0%**
Total All Full Service Plans:	**23,090,916**	**2,588**	**1.12**	**394**	**176**	**44.7%**	**176**	**44.7%**	**42**	**10.7%**	**2,186**	**654**	**29.9%**	**1,183**	**54.1%**	**349**	**16.0%**	**8**	**3**	**37.5%**	**3**	**37.5%**	**2**	**25.0%**
CHIROPRACTIC																								
ACN Group of California, Inc. (OptumHealth Physical Health of California)	73,948	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	%
American Specialty Health Plans of California, 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.	67,027	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 Chiropractic:	**140,975**	**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	317,441	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.	121,251	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.	75,170	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.	209,840	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%
Consumer Health, Inc. (Newport Dental Plan)	6,194	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.	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%
Dental Benefit Providers of California, Inc.	161,201	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	71,684	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)	10,071	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)	384,551	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 Dental Care	100,538	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%
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	1,229	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%
UDC Dental California, Inc. (United Dental Care of California, Inc.)	26,279	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 California, Inc.	85,288	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 Dental Services, Inc. (Western Dental Plan)	144,429	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:	**1,715,166**	**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/VISION																								
Delta Dental of California	5,062,584	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)	245,894	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:	**5,308,478**	**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																								
First Dental Health	28,546	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.	36,000	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%
Total Discount:	**64,546**	**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%**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																								
Beacon Health Options of California, Inc. (Beacon of California)	713,228	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.	137,629	1	0.07	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%
Claremont Behavioral Services, Inc. (Claremont EAP)	50,882	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	144,184	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)	148,945	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.	81,719	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, Inc. (Aetna Resources for Living)	1,481,951	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	120,849	1	0.08	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.	28,610	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, Inc. - Employer Services	847,574	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 Department of Managed Health Care

2020 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	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	%
Managed Health Network	652,249	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)	795,646	2	0.03	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	1	50.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Behavioral Health (Psychological):	**5,203,466**	**4**	**0.01**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**4**	**0**	**0.0%**	**2**	**50.0%**	**2**	**50.0%**	**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.	99	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.	325,512	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)	191,695	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.	47,937	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 Plan of America	14,912	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	4,040,009	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%
Visique Vision Solutions 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%
Total Vision:	**4,620,164**	**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:	**17,052,795**	**4**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**4**	**0**	**0.0%**	**2**	**50.0%**	**2**	**50.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Grand Totals:	**40,143,711**	**2,592**	**0.65**	**394**	**176**	**44.7%**	**176**	**44.7%**	**42**	**10.7%**	**2,190**	**654**	**29.9%**	**1,185**	**54.1%**	**351**	**16.0%**	**8**	**3**	**37.5%**	**3**	**37.5%**	**2**	**25.0%**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

"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.

Grey shading indicates that the plan surrendered its license in 2020.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions Code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

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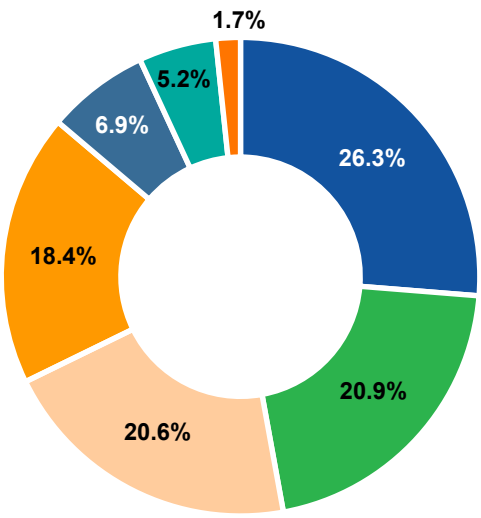
2020 Consumer Complaint Summary Report

Report Overview



1.7% - Coordination of Benefits

5.2% - Enrollment

6.9% - Access to Care

18.4% - Provider Customer Service

20.6% - Health Plan Customer Service

20.9% - Benefits/Coverage

26.3% - Claims/Financial

The Annual Complaint Summary Report displays the numbers and types of complaints, by health plan, resolved by the Department during the 2020 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 Benefits, 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 2020, 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 2020 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2020, may have had enrollment earlier in the year or received a license during 2020.

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 2020. 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 2020. 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.

California Department of Managed Health Care

2020 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)	1,104	15.3%	2,236,665	4.94	42	0.19	285	1.27	691	3.09	83	0.37	21	0.09	419	1.87	102	0.46
Blue Cross of California Partnership Plan, Inc.	100	1.4%	808,082	1.24	33	0.41	52	0.64	11	0.14	4	0.05	3	0.04	28	0.35	39	0.48
California Physicians' Service (Blue Shield of California)	1,922	26.7%	2,596,281	7.40	105	0.40	693	2.67	949	3.66	254	0.98	64	0.25	687	2.65	162	0.62
Health Net Community Solutions, Inc.	333	4.6%	1,425,909	2.34	108	0.76	120	0.84	26	0.18	3	0.02	15	0.11	116	0.81	190	1.33
Health Net of California, Inc.	358	5.0%	570,069	6.28	41	0.72	98	1.72	175	3.07	36	0.63	8	0.14	154	2.70	59	1.03
Inland Empire Health Plan (IEHP)	142	2.0%	1,326,955	1.07	32	0.24	56	0.42	14	0.11	5	0.04	7	0.05	38	0.29	66	0.50
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	2,317	32.2%	7,098,996	3.26	244	0.34	583	0.82	832	1.17	202	0.28	18	0.03	588	0.83	1279	1.80
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	520	7.2%	2,316,497	2.24	115	0.50	143	0.62	181	0.78	16	0.07	26	0.11	166	0.72	142	0.61
Molina Healthcare of California	62	0.9%	501,613	1.24	13	0.26	13	0.26	20	0.40	5	0.10	2	0.04	28	0.56	17	0.34
UHC of California (UnitedHealthcare of California)	337	4.7%	405,397	8.31	20	0.49	191	4.71	119	2.94	5	0.12	15	0.37	118	2.91	40	0.99
Total Full Service – Enrollment Over 400,000:	**7,195**	**100.0%**	**19,286,464**	**3.73**	**753**	**0.39**	**2,234**	**1.16**	**3,018**	**1.56**	**613**	**0.32**	**179**	**0.09**	**2,342**	**1.21**	**2,096**	**1.09**
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.	11	1.3%	30,071	3.66	7	2.33	7	2.33	1	0.33	0	0.00	0	0.00	4	1.33	4	1.33
Aetna Health of California Inc.	57	6.8%	197,414	2.89	6	0.30	25	1.27	25	1.27	2	0.10	3	0.15	19	0.96	4	0.20
AIDS Healthcare Foundation (Positive Healthcare)	0	0.0%	691	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	4.4%	275,726	1.34	10	0.36	13	0.47	3	0.11	1	0.04	2	0.07	10	0.36	15	0.54
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
AltaMed 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
Astiva Health, 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
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	23	2.7%	103,414	2.22	6	0.58	7	0.68	2	0.19	0	0.00	1	0.10	9	0.87	12	1.16
Brandman 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
Brown & Toland Health 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
California Health and Wellness Plan (California Health and Wellness)	16	1.9%	206,031	0.78	6	0.29	3	0.15	5	0.24	0	0.00	0	0.00	6	0.29	6	0.29
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
CHG Foundation (Community Health Group Partnership Plan)	11	1.3%	276,672	0.40	2	0.07	8	0.29	0	0.00	0	0.00	0	0.00	3	0.11	3	0.11
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	9	1.1%	8,713	10.33	0	0.00	2	2.30	5	5.74	2	2.30	0	0.00	5	5.74	0	0.00
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.	36	4.3%	150,432	2.39	4	0.27	22	1.46	9	0.60	1	0.07	3	0.20	5	0.33	3	0.20
Clever Care of Golden State Inc. (Clever Care 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
Community Care Health Plan, Inc.	0	0.0%	11,496	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	1	0.1%	6,979	1.43	0	0.00	1	1.43	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Contra Costa County Medical Services (Contra Costa Health Plan)	24	2.9%	202,017	1.19	9	0.45	7	0.35	4	0.20	0	0.00	3	0.15	11	0.54	12	0.59
County of Ventura (Ventura County Health Care Plan)	5	0.6%	12,117	4.13	0	0.00	1	0.83	4	3.30	0	0.00	0	0.00	1	0.83	2	1.65
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
For Your Benefit, 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
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	50	5.9%	374,982	1.33	17	0.45	16	0.43	3	0.08	2	0.05	1	0.03	12	0.32	25	0.67
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

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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
Heritage Provider 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
Hill Physicians Care Solutions, 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
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, 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
Kern Health Systems	19	2.3%	277,452	0.68	2	0.07	9	0.32	3	0.11	1	0.04	1	0.04	7	0.25	6	0.22
Medcore HP	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, S.A. de C.V. (MediExcel Health Plan)	1	0.1%	14,062	0.71	0	0.00	0	0.00	1	0.71	0	0.00	0	0.00	0	0.00	0	0.00
MemorialCare Select Health Plan	0	0.0%	230	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Meritage 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
Monarch 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
On Lok Senior Health Services	0	0.0%	381	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Optum 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
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	142	16.9%	103,833	13.68	5	0.48	61	5.87	63	6.07	13	1.25	4	0.39	42	4.04	11	1.06
Partnership HealthPlan of California***	1	0.1%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	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 Health Authority (San Francisco Health Plan)	17	2.0%	150,634	1.13	5	0.33	6	0.40	2	0.13	1	0.07	0	0.00	2	0.13	12	0.80
San Joaquin County Health Commission (Health Plan of San Joaquin)	23	2.7%	364,077	0.63	7	0.19	11	0.30	1	0.03	0	0.00	0	0.00	6	0.16	12	0.33
San Mateo Health Commission (Health Plan of San Mateo)	24	2.9%	122,943	1.95	13	1.06	8	0.65	0	0.00	0	0.00	1	0.08	4	0.33	5	0.41
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)	25	3.0%	44,602	5.61	2	0.45	12	2.69	9	2.02	1	0.22	1	0.22	7	1.57	8	1.79
Santa Clara County Health Authority (Santa Clara Family Health Plan)	43	5.1%	271,107	1.59	11	0.41	17	0.63	5	0.18	3	0.11	4	0.15	8	0.30	21	0.77
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)***	0	0.0%	540	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%	13,966	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.	5	0.6%	15,253	3.28	2	1.31	2	1.31	1	0.66	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	78	9.3%	138,970	5.61	8	0.58	33	2.37	33	2.37	4	0.29	1	0.07	23	1.66	18	1.30
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	12	1.4%	48,484	2.48	0	0.00	2	0.41	10	2.06	0	0.00	0	0.00	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)	61	7.3%	96,692	6.31	2	0.21	25	2.59	29	3.00	4	0.41	3	0.31	14	1.45	14	1.45
UnitedHealthcare Benefits Plan of California	17	2.0%	162,829	1.04	0	0.00	6	0.37	11	0.68	0	0.00	0	0.00	9	0.55	0	0.00
UnitedHealthcare Community Plan of California, Inc.	1	0.1%	19,851	0.50	0	0.00	1	0.50	0	0.00	0	0.00	0	0.00	0	0.00	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
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.**	2	0.2%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	3	0.00	0	0.00
Western Health Advantage	90	10.7%	101,791	8.84	6	0.59	44	4.32	33	3.24	5	0.49	6	0.59	20	1.96	16	1.57
Total Full Service – Enrollment Under 400,000:	**841**	**100.0%**	**3,804,452**	**2.21**	**130**	**0.34**	**349**	**0.92**	**262**	**0.69**	**40**	**0.11**	**34**	**0.09**	**230**	**0.60**	**210**	**0.55**
Total All Full Service Plans:	**8,036**		**23,090,916**	**3.48**	**883**	**0.38**	**2,583**	**1.12**	**3,280**	**1.42**	**653**	**0.28**	**213**	**0.09**	**2,572**	**1.11**	**2,306**	**1.00**
CHIROPRACTIC																		
ACN Group of California, Inc. (OptumHealth Physical Health of California)	1	100.0%	73,948	0.14	0	0.00	1	0.14	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
American Specialty Health Plans of California, 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%	67,027	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%**	**140,975**	**0.07**	**0**	**0.00**	**1**	**0.07**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**

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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
DENTAL																		
Access Dental Plan	5	9.6%	317,441	0.16	2	0.06	2	0.06	2	0.06	0	0.00	0	0.00	2	0.06	2	0.06
Aetna Dental of California Inc.	10	19.2%	121,251	0.82	0	0.00	3	0.25	6	0.49	0	0.00	0	0.00	1	0.08	5	0.41
California Dental Network, Inc.	6	11.5%	75,170	0.80	1	0.13	1	0.13	2	0.27	3	0.40	0	0.00	1	0.13	1	0.13
Cigna Dental Health of California, Inc.	1	1.9%	209,840	0.05	0	0.00	1	0.05	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Consumer Health, Inc. (Newport Dental Plan)	0	0.0%	6,194	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.	0	0.0%	161,201	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Health Services	0	0.0%	71,684	0.00	0	0.00	0	0.00	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%	10,071	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)	23	44.2%	384,551	0.60	0	0.00	16	0.42	5	0.13	1	0.03	0	0.00	3	0.08	5	0.13
Managed Dental Care	3	5.8%	100,538	0.30	0	0.00	2	0.20	1	0.10	1	0.10	0	0.00	2	0.20	2	0.20
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	0	0.0%	1,229	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UDC Dental California, Inc. (United Dental Care of California, Inc.)	0	0.0%	26,279	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 California, Inc.	0	0.0%	85,288	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Dental Services, Inc. (Western Dental Plan)	4	7.7%	144,429	0.28	1	0.07	3	0.21	0	0.00	0	0.00	0	0.00	1	0.07	3	0.21
Total Dental:	**52**	**100.0%**	**1,715,166**	**0.30**	**4**	**0.02**	**28**	**0.16**	**16**	**0.09**	**5**	**0.03**	**0**	**0.00**	**10**	**0.06**	**18**	**0.10**
DENTAL/VISION																		
Delta Dental of California	178	98.9%	5,062,584	0.35	3	0.01	73	0.14	93	0.18	17	0.03	2	0.00	80	0.16	51	0.10
SafeGuard Health Plans, Inc. (MetLife)	2	1.1%	245,894	0.08	0	0.00	2	0.08	0	0.00	0	0.00	0	0.00	0	0.00	1	0.04
Total Dental/Vision:	**180**	**100.0%**	**5,308,478**	**0.34**	**3**	**0.01**	**75**	**0.14**	**93**	**0.18**	**17**	**0.03**	**2**	**0.00**	**80**	**0.15**	**52**	**0.10**
DISCOUNT																		
First Dental Health	0	0.0%	28,546	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%	36,000	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Dental/Vision:	**0**	**0.0%**	**64,546**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
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**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																		
Beacon Health Options of California, Inc. (Beacon of California)	0	0.0%	713,228	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.	1	8.3%	137,629	0.07	0	0.00	0	0.00	1	0.07	0	0.00	0	0.00	0	0.00	0	0.00
Claremont Behavioral Services, Inc. (Claremont EAP)	0	0.0%	50,882	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%	144,184	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%	148,945	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%	81,719	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, Inc. (Aetna Resources for Living)	0	0.0%	1,481,951	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	2	16.7%	120,849	0.17	1	0.08	0	0.00	0	0.00	0	0.00	0	0.00	1	0.08	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%	28,610	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, Inc. - Employer Services	0	0.0%	847,574	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%	652,249	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)	9	75.0%	795,646	0.11	1	0.01	7	0.09	1	0.01	0	0.00	0	0.00	3	0.04	3	0.04
Total Behavioral Health (Psychological):	**12**	**100.0%**	**5,203,466**	**0.02**	**2**	**0.00**	**7**	**0.01**	**2**	**0.00**	**0**	**0.00**	**0**	**0.00**	**4**	**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%	99	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%	325,512	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

California Department of Managed Health Care

2020 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
FirstSight Vision Services, Inc. (America's Best Vision Plan)	0	0.0%	191,695	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%	47,937	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 Plan of America	0	0.0%	14,912	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Service Plan	5	100.0%	4,040,009	0.01	0	0.00	0	0.00	3	0.01	2	0.00	0	0.00	0	0.00	0	0.00
Visique Vision Solutions 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
Total Vision:	**5**	**100.0%**	**4,620,164**	**0.01**	**0**	**0.00**	**0**	**0.00**	**3**	**0.01**	**2**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
Total Specialty Plans:	**250**		**17,052,795**	**0.15**	**9**	**0.01**	**111**	**0.07**	**114**	**0.07**	**24**	**0.01**	**2**	**0.00**	**94**	**0.06**	**73**	**0.04**
Grand Totals:	**8,286**		**40,143,711**	**2.06**	**892**	**0.22**	**2,694**	**0.67**	**3,394**	**0.85**	**677**	**0.17**	**215**	**0.05**	**2,666**	**0.66**	**2,379**	**0.59**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

Grey shading indicates that the plan surrendered its license in 2020.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions Code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

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