SPECIAL EDITION

2025 ANNUAL REPORT

DEPARTMENT OF
Managed
Health Care

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Governor
State of California

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Secretary
Health and Human Services Agency

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Department of Managed Health Care

DMHC Mission & Vision

Our Mission

The mission of the Department of Managed Health Care (DMHC) is to ensure health plan members have access to equitable, high-quality, timely, and affordable health care within a stable health care delivery system.

Our Approach

The DMHC accomplishes this important mission by:

- REGULATING health plans
- ENFORCING California's strong consumer protection laws
- ASSISTING health plan members

Our Vision

The DMHC's vision is to improve health care access, quality, and value to empower all Californians to live healthier lives.

This vision will be realized when all Californians under the DMHC's jurisdiction can easily access high-quality, affordable health care.

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Message from the Secretary

In 2025, we mark several important health care milestones in our state, including the 25th anniversary of the creation of the Department of Managed Health Care (DMHC). Established a quarter century ago, the DMHC was the first state agency dedicated exclusively to protecting consumers' health care rights. Since its founding, the Department has worked diligently to safeguard those rights, including ensuring access to critical protections such as the ability to appeal a health plan's denial of care and to request an Independent Medical Review by a neutral third party.

This year also marks the 50th anniversary of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the 15th anniversary of the Affordable Care Act (ACA). Together, these landmark achievements transformed health care in California. The Knox-Keene Act established one of the nation's strongest frameworks for consumer protection and health plan oversight, positioning the DMHC as the primary regulator of most health care coverage in California. The ACA significantly expanded access to affordable health coverage and strengthened consumer rights. As coverage expanded through Medi-Cal and Covered California, millions more Californians gained access to health care under plans regulated by the DMHC.

As the health care landscape continues to evolve, the DMHC remains a steadfast advocate for California consumers. In 2025, the Department provided critical leadership in responding to unprecedented federal changes affecting health coverage, helping preserve access to preventive care, immunizations, and other essential health services while providing clear guidance to health plans and consumers.

The DMHC also demonstrated exceptional leadership during the 2025 Southern California wildfires, responding swiftly to support affected health plan members and ensure continued access to medically necessary care and prescription medications during a time of extraordinary need.

For 25 years, the DMHC has helped ensure Californians can count on strong consumer protections, meaningful oversight, and access to quality health care. I commend the Department for its unwavering commitment to advancing and protecting consumers' health care rights and congratulate its dedicated staff on this important milestone. Together, these efforts reflect the Department's enduring commitment to a healthy California for all.

Kim Johnson
Secretary
California Health and Human Services Agency

Message from the Director

This was a big year for the Department of Managed Health Care (DMHC) as we celebrated the Department's 25th anniversary alongside the 50th anniversary of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the 15th anniversary of the Affordable Care Act (ACA). Together, these anniversaries reflect decades of progress toward a more accessible, equitable and accountable health care system. This report highlights the DMHC's accomplishments over the past quarter century in celebration of the Department's continued commitment to protecting the health care rights of Californians.

Established under the framework of the Knox-Keene Act, the DMHC was created as the nation's first regulator dedicated exclusively to overseeing health plans with a strong consumer protection mission. The ACA further transformed the health care marketplace by significantly expanding coverage and bringing millions of new members into health plans overseen by the DMHC.

It is an honor to lead the DMHC during such an important time, as we continue to build on the Department's longstanding legacy. The DMHC's new strategic plan reinforces our commitment to ensuring health plan members have access to equitable, high-quality, timely, and affordable health care within a stable health care delivery system. Our strategic priorities remain focused on strengthening oversight, enforcing California's consumer protection laws and advancing policies that safeguard and enhance health plan member protections.

As we recognize the DMHC's 25 years of service, I also want to acknowledge the Department's dedicated employees whose professionalism, expertise and public service make this work possible. Their commitment continues to drive the Department's success and its ability to respond to the evolving needs of California consumers.

Protecting California health plan members remains critically important as federal actions continue to shape the health care landscape. In 2025, California took action to safeguard access to preventive health care services, including immunizations that protect against respiratory syncytial virus (RSV), influenza and COVID-19. The DMHC supported these efforts by providing guidance and information to DMHC-licensed health plans, while continuing to ensure that health plan members have access to appropriate COVID-19 vaccines, testing and treatment.

The DMHC also plays an essential role in supporting Californians during emergencies and natural disasters. Following the 2025 Southern California wildfires, the Department worked to ensure impacted health plan members

had continued access to medically necessary care through their health plans, including medications, medical equipment and supplies. The DMHC provided critical consumer assistance resources and outreach to affected communities, including support through the Department's Help Center.

The DMHC Help Center remains a cornerstone of the Department's consumer protection mission, providing assistance to individuals experiencing issues related to their health plan, including access to care. The Help Center offers free services in all languages and can be reached at 1-888-466-2219 or through the Department's website at www.DMHC.ca.gov.

Mary Watanabe

Director
Department of Managed Health Care

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DEPARTMENT OF
Managed Health Care

2025

25 years of protecting health care rights

3.2 MILLION
HEALTH PLAN MEMBERS ASSISTED

The DMHC Help Center educates health plan members about their health care rights and ensures their rights are protected. This is accomplished by helping health plan members resolve complaints against their health plan, including coverage disputes, billing issues and access to health care services.

30.2 MILLION

Californians' health care rights are protected by the DMHC

139
LICENSED HEALTH PLANS

- 98 FULL SERVICE
- 41 SPECIALIZED

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

$296.1 MILLION

saved on Health Plan Premiums through the Rate Review Program since 2011

$73.9 MILLION

recovered from health plans on behalf of health plan members

78% of health plan member appeals (IMRs) to the DMHC resulted in the health plan member receiving the requested service or treatment from their health plan

$259.3 MILLION

in payments recovered to physicians and hospitals

$214.3 MILLION

in fines assessed against health plans for violating the law

KNOW YOUR HEALTH CARE RIGHTS

DEPARTMENT OF Managed Health Care

In California, health plan members have the right to:

- basic health care services
- give informed consent for treatment
- choose your primary doctor
- an appointment when you need one (timely access to care)
- see a specialist when medically necessary
- receive treatment for all behavioral health conditions (mental health/substance use)
- get a second doctor's opinion
- know why your plan denies a service or treatment
- understand your health problems and treatments
- know your out-of-pocket costs & if you met your deductible or out-of-pocket max
- see a written diagnosis (description of your health problem)
- accurate provider directories from your health plan
- file a complaint or ask for an Independent Medical Review (an appeal of your health plan's denial of services or treatment through an independent process)
- a copy of your medical records (you may be charged)
- translation and interpreter services
- 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
- not be excluded from health plan coverage because of a pre-existing condition
- guaranteed availability to renew or purchase commercial health plan coverage
- fertility & infertility coverage (large employer plans must cover diagnosis and treatment, including in vitro fertilization (IVF)

The mission of the Department of Managed Health Care (DMHC) is to ensure health plan members have access to equitable, high-quality, timely, and affordable health care within 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.

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

If you have an issue with your health plan, you should file a complaint, also called a grievance or appeal, with your plan. If you do not agree with your plan's response or your plan takes more than 30 days to respond to your complaint, you can contact the DMHC Help Center. If the issue is urgent, you should contact the DMHC Help Center immediately.

The DMHC Help Center provides assistance in all languages, and services are provided at no cost to health plan members. Go to **www.DMHC.ca.gov** or call **1-888-466-2219 (TDD: 1-877-688-9891)**.

Celebrating Significant Anniversaries

In 2025, the Department of Managed Health Care (DMHC) celebrated the 25th anniversary of the Department, along with the 15th anniversary of the Affordable Care Act (ACA) and the 50th anniversary of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

DMHC's 25th Anniversary

The creation of the DMHC was a significant defining moment for consumer health care rights, as the first agency in the country fully dedicated to the oversight of managed care health plans. The DMHC is the primary regulator for the majority of California's health coverage, including all state-regulated health maintenance organizations (HMOs), also referred to as managed care plans. The DMHC has evolved over the past 25 years to keep pace with the many changes in the managed care marketplace. Significant consumer protections under the DMHC include the Independent Medical Review program, which allows health plan members to appeal health plan denials through an independent process; the Department's oversight and monitoring of the financial solvency of health plans and provider groups to prevent failures that could disrupt the delivery of health care for millions; and the ability to hold health plans accountable through enforcement actions.

ACA's 15th Anniversary

The ACA was enacted 15 years ago, expanding health care access to millions of Californians who previously could not afford health care coverage. After the ACA passed, California became the first state to create a health benefit exchange, Covered California. The ACA's implementation dramatically dropped California's uninsured rate from more than 17% to 5.9% between 2014 and 2024.[1] During that same period, enrollment in DMHC-licensed health plans increased nearly 23% following implementation of the ACA.

Knox-Keene Act's 50th Anniversary

Enacted in 1975, the Knox-Keene Act created a groundbreaking framework for strong consumer protections and accountability in the health care industry. Fifty years later, the DMHC continues to work under this framework while refining, strengthening and improving the Knox-Keene Act to sustain robust consumer protections as the health care industry evolves.

25 YEARS

OF PROTECTING HEALTH CARE RIGHTS

Introduction

The DMHC regulates the majority of state-regulated health coverage in California, including 96% of commercial and public health plan enrollment.[2] In 2025, the Department's budget was $180.3 million and 814 positions. The DMHC is funded by assessments on licensed health plans.

The DMHC regulates licensed managed care health plans and assists health plan members with resolving disputes with those plans. The Department licenses health plans that operate in California, monitors plan operations, and reviews the financial stability of health plans and medical groups to ensure health plans are providing appropriate care to members. The DMHC also reviews proposed health plan premium rate changes to protect members from unreasonable or unjustified increases. The Department's efforts improve transparency and accountability in health plan premium rate setting. As of the end of 2025, the DMHC assisted approximately 3.2 million consumers through the DMHC Help Center.

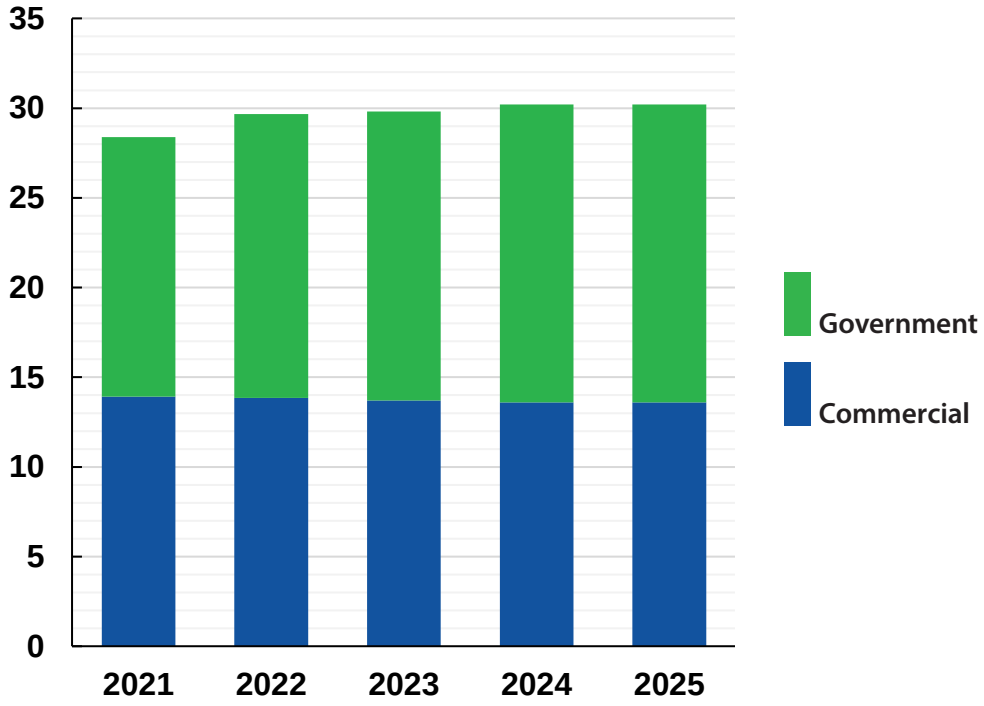
In 2025, 139 full service health plans licensed by the DMHC provided health care services to more than 30.2 million Californians. This included approximately 13.6 million health plan members in commercial products and approximately 16.6 million health plan members in government-sponsored products, like Medi-Cal and Medicare plans. In addition to full service health plans, the DMHC oversees 41 specialized health plans, including chiropractic, dental, vision, psychological (behavioral health) and pharmacy.

Over the DMHC's history, there have been several federal and state sponsored initiatives to improve and expand access to health care. The Department continues to implement new laws and regulations, take action against health plans that break the law and provide direct assistance to health plan members through the DMHC Help Center.

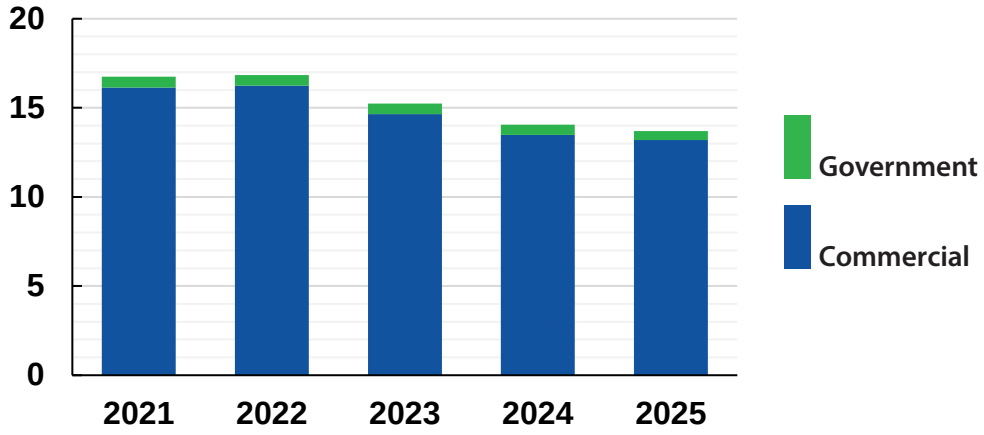
The DMHC licenses and regulates the full scope of managed care models, including Health Maintenance Organizations (HMO), as well as Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Point-of-Service (POS) products and Medi-Cal managed care plans. The Department also licenses and conducts financial reviews of Medicare Advantage and Part D plans. The enrollment overview charts[3] on the next page illustrate how enrollment under DMHC oversight is distributed among the different types of managed care plans.

Enrollment Overview

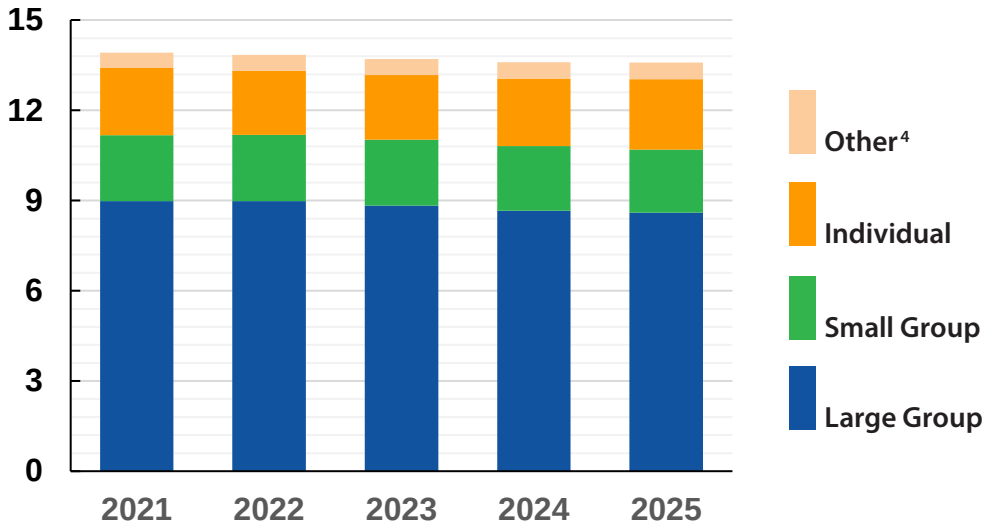
Full Service Enrollment (In Millions)



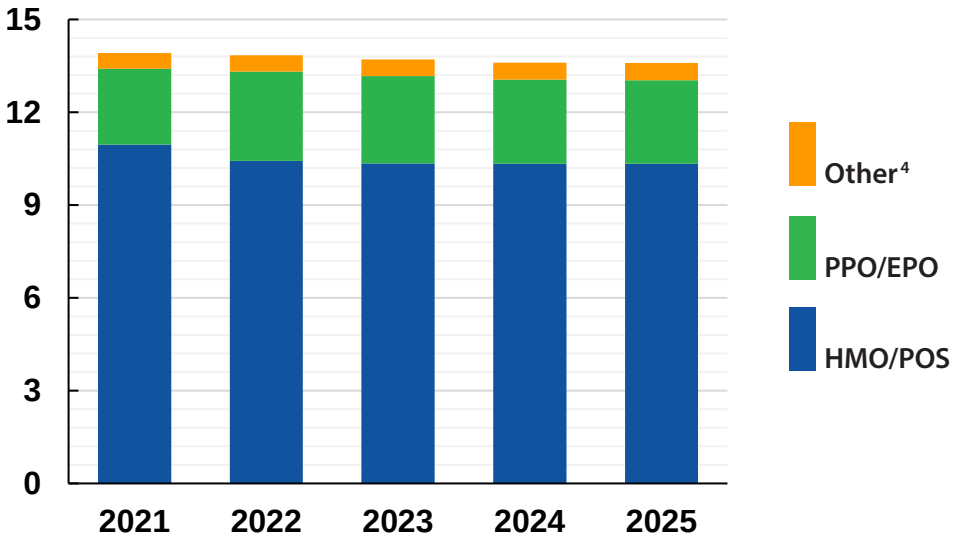
Specialized Enrollment (In Millions)



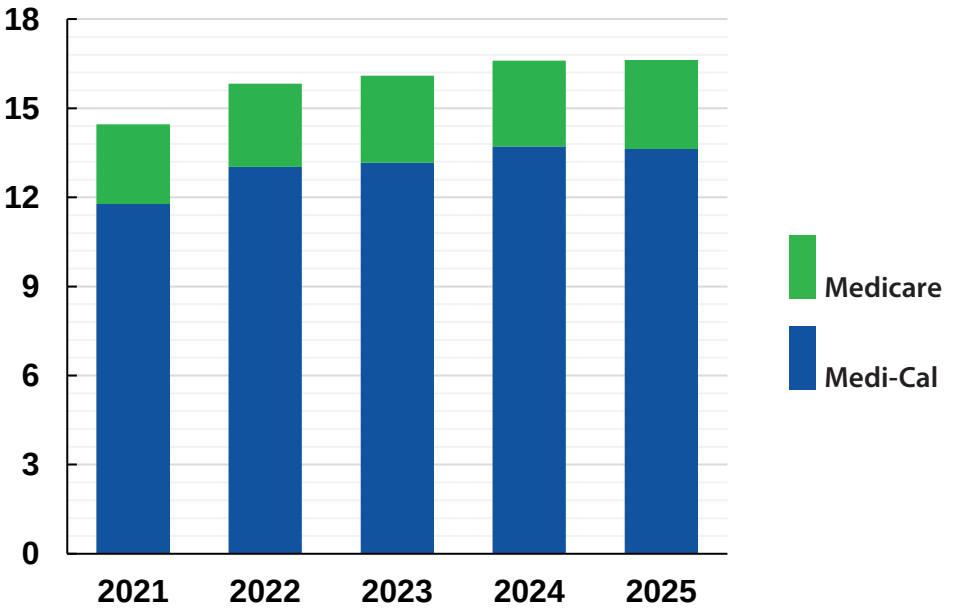
Commercial Enrollment by Market (In Millions)



Commercial Enrollment by Product (In Millions)



Government Enrollment by Type (In Millions)



25 Years of Consumer Protection

1999-2000

Department of Managed Health Care (DMHC) Established

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

1999

Financial Solvency Standards Board (FSSB)

The FSSB was established as the first of its kind in the country. The FSSB was created to advise 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 for providers and health plans. (Senate Bill (SB) 260, 1999)

2000

Consumer Assistance

The newly created consumer-focused DMHC opened the Department's Help Center. The DMHC Help Center works to assist health care consumers to resolve issues with health plans and monitors consumer and provider complaints for evidence of systemic health plan regulatory compliance problems.

2001

Independent Medical Review (IMR)

California established the IMR program, a legally binding system for independent and external review of health plan denials of care. (AB 55, 1999)

2003

Continuity of Care

The DMHC worked to secure legislation to provide continuity of care to at-risk health plan members following disruptive transfers of more than three million Californians affected by provider contract terminations. Continuity of care allows members to continue receiving care from a doctor, medical group or hospital for a limited time after the health plan's contract with the provider ends under specified circumstances. This could include when there is a scheduled surgery or procedure, a pregnancy or terminal illness. (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 improved provider rights and required 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 merged, affecting control of Blue Cross of California. In 2005, PacifiCare of California merged with UnitedHealth Group. The DMHC conducted a thorough review of the mergers and potential impacts on consumers, and worked with the plans to make more than $450 million in community benefits for California consumers (including commitments from related companies regulated by the California Department of Insurance (CDI)).

2005

Provider Solvency

In the wake of several high-profile failures of medical groups contracted with health plans, legislation imposed stricter financial responsibilities on risk-bearing organizations (RBOs) and required 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 established the Provider Solvency Unit to oversee and monitor RBO financial filings.

2008

Balance Billing Prohibition

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

Cancellations and Rescissions

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

2010

Timely Access to Care

The DMHC implemented landmark regulations to ensure Californians get timely access to care when they need it. The regulations made California the first state in the nation to provide health plan members 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 to care. (AB 2179, 2010)

2010-2014

Affordable Care Act (ACA) Implementation

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

2011

Consumer Assistance Program

The DMHC received the first of several federal ACA grants to work with the Office of the Patient Advocate, the CDI 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 resulted 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 established a premium rate review program to provide the public with information to enhance transparency around 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 convened 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. (SB 946, 2011)

2013

Coverage for Medical Therapies

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

ACA Compliance

The DMHC worked under tight timelines to review health plan products, provider networks and rate filings, ensuring 2014 coverage met new federal and state requirements for the first-year plans offering coverage on the Health Benefit Exchange.

2014

Access to Mental Health Care

The Department conducted a routine survey of behavioral health services in Kaiser Foundation Health Plan (Kaiser Permanente) and assessed $4 million in penalties for deficiencies in timely access to care. The DMHC later reached a landmark three-year agreement with the health plan to ensure health plan members 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 access to care and resulted in an unacceptable member experience. Both plans were required under the agreement to improve the accuracy of their provider directories and to reimburse members 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 of California 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. Health Net agreed to invest $140 million to improve health outcomes and support California's health care infrastructure for underserved groups, including $50 million over five years to improve encounter data for the Medi-Cal health care delivery system. The plan also agreed to keep key operations in California, including building a service center in the state.

Provider Directory Standard

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 protections against out-of-network providers from balance billing health plan members when the member did everything right and went to an in-network facility, commonly known as "surprise billing." (AB 72, 2016)

Independent Dispute Resolution Process

To remove health plan members from the middle of billing disputes, a default reimbursement rate was created for 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. (AB 72, 2016)

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 conducted 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 health plan members because the plans had inappropriately applied cost sharing out of compliance with the 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 (PBM)

The DMHC convened a Task Force on Pharmacy Benefit Management Reporting to determine what information related to pharmaceutical costs, health plans or their contracted PBMs should report to the DMHC. (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 improper denials and delays of care for health plan members. In addition to the fines, the health plans agreed to corrective actions to improve plan oversight of delegated entities.

Health Plan Member Grievances

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

2020-2023

COVID-19 Response

The DMHC worked to mitigate the spread and severity of COVID-19 while ensuring health plan members had continued access to health care services during a public health emergency caused by a worldwide pandemic. During the state's ongoing pandemic response, the DMHC directed plans to expand access to vaccinations and testing, and supported the state's hospitals and other parts of the health care delivery system.

Upholding Health Plan Member Protections

The DMHC took enforcement action against a health plan that violated important health plan member protections. This included $1.2 million in fines against Blue Cross of California Partnership Plan, Inc. for the plan's failure to timely implement two IMR determinations to authorize coverage for medically necessary services. The Medi-Cal managed care plan had failed to timely authorize the services for the member after receiving the IMR decisions.

2021

Behavioral Health Investigations

The DMHC implemented strategies to strengthen enforcement of behavioral health parity laws, including focused investigations of commercial health plans. The DMHC began conducting focused behavioral health investigations of licensed commercial health plans to identify the challenges and barriers health plan members may face in obtaining behavioral health care and to identify systemic changes that can be made to improve the delivery of care.

California Mental Health & Substance Use Parity

The Department worked to ensure health plans complied with California's strengthened mental health parity law by requiring commercial health plans to provide full coverage for the treatment of all mental health conditions and substance use disorders. The law also established specific standards for medically necessary treatment and criteria for the use of clinical guidelines. The DMHC required health plans to demonstrate compliance through plan contracts, policies and procedures, and clinical guidelines. (SB 855, 2020)

2022

Timely Access to Care Standardized Reporting Methodology

To strengthen the Department's ability to oversee health plan compliance with the timely access standards, the DMHC developed a standardized methodology for health plans to measure and report compliance with the timely access standards. Adopted by regulation in 2022, the standardized methodology allows the Department to review each individual health plan network's ability to deliver timely appointments, ascertain whether each health plan network met the established rate of compliance and compare performance across all health plans.

Health Equity

The DMHC adopted standard health equity and quality measures for health plans, promoting the equitable delivery of high-quality health care services for all health plan members. The Department convened the Health Equity and Quality Committee, a diverse group of experts representing consumers, health plans, providers and others, to make recommendations on the health equity and quality measures to be adopted. (AB 133, 2021)

Behavioral Health Care Timely Access Standard

The DMHC worked to implement a new timely access standard for behavioral health care follow-up appointments. The new standard requires health plans to provide non-urgent follow-up appointments with non-physician mental health care or substance use disorder providers within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. (SB 221, 2021)

2022-2024

Protecting Health Care Rights & Holding Plans Accountable

The DMHC and the Department of Health Care Services took a $55 million enforcement action against Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan) following significant violations in the plan's core functions, including failures in the plan's handling of health plan member grievances, processing requests to authorize member care, and inadequate oversight of the plan's contracted provider entities to deliver timely care to the plan's members.

2023

Protecting Access to Behavioral Health Care

The DMHC reached a $200 million settlement agreement with Kaiser Permanente to make significant changes to the plan's delivery of behavioral health care. The settlement agreement included a $50 million fine and required Kaiser Permanente to take corrective actions to address deficiencies in the plan's delivery and oversight of behavioral health care. Kaiser Permanente also pledged to make significant investments, totaling $150 million over five years, into programs to improve the delivery of behavioral health services for all Californians beyond Kaiser Permanente's existing obligations to its members under the law.

2023-2024

Transgender, Gender Diverse, or Intersex (TGI) Working Group

The DMHC established the TGI Working Group. The Working Group made recommendations for future consideration related to quality measures and setting a quality standard for patient experience to measure cultural competency related to the TGI community and made recommendations on a training curriculum for health plan staff working with TGI health plan members in the delivery of health care services. The DMHC convened several working group meetings throughout 2023 and conducted listening sessions around the state to hear directly from the TGI community. The TGI Working Group issued its final Transgender, Gender Diverse, or Intersex Working Group Recommendations Report in 2024. (SB 923, 2022)

2024

Provider Payment Disputes

The DMHC took enforcement actions, including $8.5 million in fines, against Blue Cross of California Partnership Plan, Inc. and Anthem Blue Cross for failing to address claims payment disputes in a timely manner from doctors, hospitals and other health care providers. California law requires health plans to have a Provider Dispute Resolution process whereby providers can submit a dispute related to payment of claims for health care services provided to plan members. Delayed payments strain the finances of doctors, hospitals and other providers, which can disrupt the health care delivery system and potentially impact the care of health plan members.

Protecting Consumers

The DMHC took action to protect consumers by ensuring health plans are licensed, which provides important protections in the law. Specifically, the Department took an enforcement action against Spring Care, Inc. (Spring Health) for operating without a license. Under the action, Spring Health was required to become licensed and was fined $1 million for offering health care services without a license.

2025

Access to Preventive Care

Following several changes at the federal level, California worked to protect access to preventive care services for Californians, and enacted a new law requiring health plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or recommended by the California Department of Public Health, with no cost sharing or prior authorization for health plan members. This action protects the ongoing coverage of COVID-19 vaccines, as well as respiratory syncytial virus (RSV) and flu vaccines,

with no cost sharing or prior authorization for health plan members. The DMHC also worked with health plans and issued APL 25-015 to ensure licensed health plans follow these new requirements. (AB 144, 2025)

Essential Health Benefits & Benchmark Plan

Following public input, the DMHC submitted an application on behalf of the state to the federal Centers for Medicare & Medicaid Services (CMS) to update California's ACA benchmark plan. The application included expanding coverage requirements for essential health benefits in the individual and small group markets in California to include services to evaluate, diagnose and treat infertility, including in vitro fertilization and artificial insemination, an annual hearing exam and hearing aids, and expanded durable medical equipment (DME) benefits, including coverage for mobility devices such as walkers, manual and power wheelchairs and scooters, among other new DME coverage.

Emergency Response

Following devastating fires in Southern California, the Governor proclaimed a state of emergency in January 2025. The DMHC directed licensed health plans to take actions to support impacted health plan members, including speeding up approvals for care, replacing lost prescriptions or quickly arranging for care at other facilities. The Department also created a resource guide to provide impacted health plan members with helpful information, including how to contact their health plan, how to file a complaint and how to contact the DMHC Help Center.

Pharmacy Benefit Management Reforms

New reforms to increase transparency around the business practices of PBMs in California were passed in 2025. This included new requirements on PBMs to be licensed by the DMHC and to file organizational and financial information with the Department. (AB 116 & SB 41, 2025)

Protecting Consumers

Health plans must be licensed in California to ensure health plan members have important protections, including the right to file an appeal with the DMHC. The DMHC took enforcement action against Modern Health California, P.C. (MHPC), including a $2 million fine, for operating without a license.

THE DMHC'S ROLE IN DISASTERS

After disasters in California, including earthquakes, wildfires and flooding, impacted health plan members may need additional assistance to access medically necessary care. During a state of emergency caused by a disaster, the DMHC protects health plan members by requiring DMHC-regulated health plans to take immediate action to ensure continued access to care. The Department may direct plans to shorten timeframes for the approval of care, replace lost prescriptions, or allow members to access appropriate out-of-network providers if in-network providers are unavailable or members are displaced by the disaster.

2025 Southern California Wildfires

In January 2025, Governor Newsom declared a state of emergency in Los Angeles and Ventura counties following the devastating Southern California wildfires. In response, the Department issued an All Plan Letter (APL), directing health plans to ensure their members can access medically necessary health care services, including prescription drugs and replacing medical equipment or supplies for impacted members.

The DMHC also created a resource guide to provide impacted health plan members information on health plan requirements and contact information for health plans in Los Angeles and Ventura counties.

The Department's Know Your Health Care Rights on Accessing Care During Disasters fact sheet, featured on the following page, also provides information on health plan requirements during disasters, including how to file a complaint or contact the DMHC Help Center.

KNOW YOUR HEALTH CARE RIGHTS

DEPARTMENT OF Managed Health Care

Accessing Health Care During Disasters

Health plans are required to help members impacted or displaced by disasters, including earthquakes, wildfires and flooding. During a state of emergency caused by a disaster, the Department of Managed Health Care (DMHC) requires health plans to take actions to support impacted members, including speeding up approvals for care, replacing lost prescriptions, or quickly arranging for care at other facilities if a hospital or provider is not available.

Questions & Information

- Health plans must have a toll-free phone number for questions from health plan members and providers about the loss of health plan ID cards, prescription refills, and health care access.
- Health plans must display contact information on their website and describe how impacted members can continue to access care.

Access to Care

- Health plans must suspend limits on prescription refills and allow impacted members to refill prescriptions without prior approval (prior authorization) at in-network or out-of-network pharmacies. Members using out-of-network pharmacies should have prescription(s) covered at in-network cost-sharing (co-pays, deductibles, etc.).
- Health plans must allow members to access care from appropriate out-of-network providers if in-network providers are unavailable, or if members are displaced.
- Health plans must replace medical equipment or supplies for impacted members.
- Health plans must be flexible in the oversight of care management to ensure members have access to continued care. This includes shortening timeframes for prior approval and referrals and extending the timeframes of existing prior approvals and referrals to remain valid.

Provider Assistance

- Health plans must extend the timeframes, or filing deadlines, for impacted providers to submit claims for payment.

Assistance for health plan members

Impacted health plan members having problems obtaining health care services or assistance should first contact their health plan. If members have problems getting assistance from their plan, they can contact the DMHC Help Center at **www.DMHC.ca.gov** or **1-888-466-2219 (TDD: 1-877-688-9891)**. Members can contact the DMHC Help Center immediately if they are facing an urgent issue. The DMHC Help Center provides help in all languages and all services are free.

COVID-19: A ONCE-IN-A-CENTURY PANDEMIC

California took early and decisive action to respond to the threat of the global pandemic, the extent of which had not previously been seen in our lifetime. The state's response efforts, including the actions under the California Health and Human Services Agency, protected the health of countless Californians and undoubtedly saved lives.

Governor Newsom proclaimed a state of emergency in California on March 4, 2020, to better prepare and enhance the state's response to the world-wide outbreak. Along with the rest of the state, the DMHC faced unprecedented challenges never seen before while taking meaningful actions to mitigate the impacts from the novel virus. While the COVID-19 state of emergency officially ended on February 28, 2023, the DMHC continues to monitor impacts and address the many changes brought on by this once in a lifetime emergency.

Throughout the pandemic, the DMHC worked closely with state and local leaders, health plans, providers and others to ensure health plan members continued to receive needed health care services, providers could continue to safely deliver care, and health plans continued to cover and offer medically necessary services. Most of these actions were taken through APLs issued by the DMHC, and also through executive and legislative actions, when needed.

Since the start of the pandemic in 2020, the Department issued a total of 50 APLs providing direction and guidance to licensed health plans related to COVID-19. This included expanding access by creating and extending special enrollment periods for uninsured Californians to gain health care coverage, directing health plans to cover vaccines and testing, expanding the coverage of telehealth services, and supporting hospitals and other parts of the health care delivery system. The Department also provided direction and guidance to ensure health plans covered and provided ongoing access to COVID-19 testing, vaccines and treatment with no prior authorization or cost sharing.

In 2025, California took action to protect access to important and necessary preventive care services and immunizations, including immunizations for COVID-19. Governor Newsom signed Assembly Bill (AB) 144 to protect access to preventive care services, and the DMHC issued APL 25-015 directing health plans to cover preventative care, including COVID-19 vaccines.

The DMHC created a COVID-19 webpage on the Department's website to make it easy for the public and stakeholders to find information, resources and guidance issued by the DMHC. The Department also created a Coverage Options Fact Sheet to help Californians navigate and find health coverage, and a Know Your Health Care Rights on COVID-19 Tests, Vaccines & Treatment fact sheet to explain health plan coverage requirements.

KNOW YOUR HEALTH CARE RIGHTS

DEPARTMENT OF Managed Health Care

COVID-19 Tests, Vaccines & Treatment

Health plan members have the right to COVID-19 tests, vaccines and treatment with no cost-sharing

Health plans[1] regulated by the Department of Managed Health Care (DMHC) must cover COVID-19 tests, vaccines and treatment[2] with no health plan prior authorization. If you access these services from a provider in your health plan's network, you will not need to pay anything for these services. If you access the services from an out-of-network provider, you may be charged cost-sharing, such as a co-pay or co-insurance.

Did You Know?

- Commercial plans must cover at least eight COVID-19 tests per member, per month.
- Medi-Cal plans must cover up to four COVID-19 tests per member, per month.[3]
- Members may be charged if they obtain tests from out-of-network providers.
- Plans may limit reimbursement to $12/test for COVID-19 tests a member purchases from an out-of-network provider.

Need Help?

- Contact the DMHC Help Center at **www.DMHC.ca.gov** or **1-888-466-2219 (TDD: 1-877-688-9891)**.
- You can also find more information and resources on the **California Department of Public Health's COVID-19 webpage**.

[1] Commercial and Medi-Cal managed care plans regulated by the DMHC.

[2] Treatment means therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care (HSC Section 1342.2 (h)(1)).

[3] Effective 10-1-2024. Learn more from the **Department of Health Care Services (DHCS)**.

2025

ANNUAL REPORT

DMHC Help Center

The DMHC Help Center educates health plan members about their health care rights and ensures their rights are protected. This is accomplished by helping health plan members resolve complaints against their health plans. The DMHC Help Center provides direct assistance in all languages to health plan members through the Department's website, www.DMHC.ca.gov, and a toll-free phone number, 1-888-466-2219.

If a health plan member experiences an issue with their health plan, they can file a complaint, also called a grievance or appeal, with their health plan. If they are not satisfied with their health plan's resolution or if the issue does not get resolved in 30 days, the member should contact the DMHC Help Center for assistance. If a health plan member is experiencing an imminent or serious threat to their health, they can 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 health plan members. Most member problems are resolved through the standard complaint process. Common complaints include cancellation of coverage, billing issues, quality of service, coverage disputes, and access to health care.

The Department's Quick Resolution process can address some health plan member issues through a three-way call between the DMHC, the member and the health plan. Complaints involving serious or urgent medical issues are routed to nurses. The DMHC Help Center is available 24 hours a day, seven days a week to assist health plan members with urgent issues.

The Independent Medical Review (IMR) program is available to health plan members if their health plan denies, modifies or delays a request for a health care service as not medically necessary or as experimental or investigational. Doctors and providers who are independent from the health plan review IMR cases and decide whether the requested health care service should be provided to the health plan member. If an IMR is decided in the member's favor, the health plan must provide the requested health care service or treatment promptly.

Health plan members enrolled in health plans outside of the DMHC's jurisdiction are transferred or referred to the appropriate agency for assistance. In addition to providing direct assistance, the DMHC also contracts with community-based organizations under the Consumer Assistance Program to conduct outreach and provide health plan members with local, in-depth assistance.

WHAT IS THE DMHC HELP CENTER?

The DMHC Help Center assists health plan members with understanding their health care rights, coverage and benefits, and helps to resolve member complaints against 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, visit www.DMHC.ca.gov or call 1-888-466-2219 (TDD: 1-877-688-9891).

2025 Highlights

In 2025, the DMHC Help Center assisted 139,885 Californians, and handled 15,115 complaints and 5,548 IMRs. Approximately 78% of health plan members who submitted an IMR request to the DMHC Help Center received the requested service or treatment.[5]

The community-based Consumer Assistance Program served 10,156 health plan members and conducted 1,773 outreach events throughout California. Through these outreach events, the Department reached 79,683 members to educate them about their health care rights.

Health plan members are protected from surprise medical bills for emergency services and non-emergency services when the non-emergency services are provided by out-of-network providers at contracted facilities. Health plan members are also protected from balance billing from ground and air ambulances. Billing disputes between health plans and out-of-network providers in non-emergency services cases are resolved through a binding Independent Dispute Resolution Process (IDRP) administered by the DMHC.

In 2025, the DMHC received 294 IDRP applications, and an additional 22 IDRPs were carried over from previous years. Of the total 316 IDRPs, 71 were closed, including eight that were ineligible, 21 that completed the process with a determination letter issued, 16 that were non-jurisdictional, two where no application fee was received, five in which the initiating party was non-responsive, and 19 were withdrawn. There were 245 cases pending as of December 31, 2025.

The DMHC Help Center also assists providers with claims payment disputes against health plans. The DMHC Help Center received 19,540 provider complaints and recovered $17,728,662 in payments for providers in 2025.

2025 BY THE NUMBERS

HELP CENTER

139,885 CALIFORNIANS ASSISTED[6]

116,814 TELEPHONE INQUIRIES

15,115 HEALTH PLAN MEMBER COMPLAINTS[7]

5,548 IMRs CLOSED[8]

$11.6 M RECOVERED FOR HEALTH PLAN MEMBERS

2,408 NON-JURISDICTIONAL REFERRALS

19,540 PROVIDER COMPLAINTS

$17.7 M RECOVERED PROVIDER PAYMENTS

71 NON-EMERGENCY SERVICES IDRP CASES COMPLETED

DMHC Milestones

2000

The newly formed DMHC opens the Department's Help Center.

THE DMHC HELP CENTER: PROVIDER COMPLAINTS

To ensure the health care delivery system can continue to provide services to health plan members, it is important for hospitals, doctors and other health care providers to receive accurate and timely payments from health plans. The DMHC Help Center's Provider Complaint Branch is responsible for processing complaints from providers to ensure prompt and accurate payment according to the law. The Provider Complaint Branch handles single-claim and multiple-claims complaints, emergency services complaints and non-emergency services complaints.

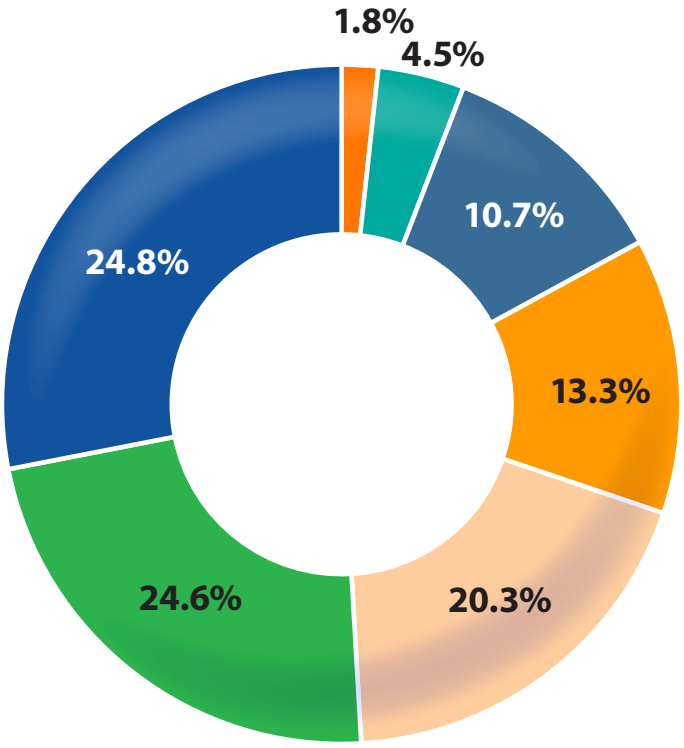
Providers and health plans can also go through the DMHC's IDRP for non-emergency services. An IDRP allows providers and health plans to dispute whether payment of a specified rate was appropriate. An external reviewer analyzes the claim and determines the justified rate the health plan should pay the provider for the claim.

The DMHC Help Center conducts reviews and identifies 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.DMHC.ca.gov.

DMHC Help Center Assistance: Provider Complaint – Payment Dispute

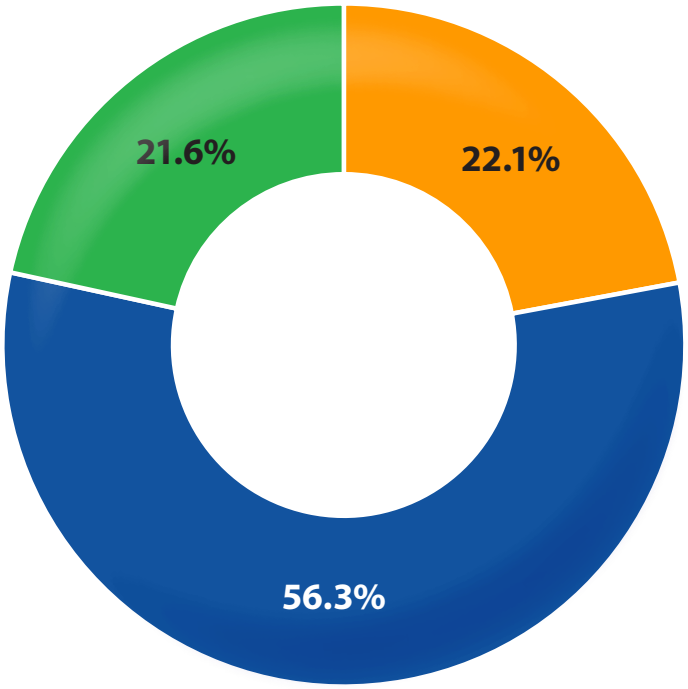
A provider submitted a complaint to the DMHC Help Center Provider Complaint Branch disputing a health plan's denied payment for hospital inpatient services for a patient who suffered a traumatic brain injury. The health plan denied 15 days of care based on a lack of medical necessity. Through the Provider Complaint Branch's review, it was determined the health plan failed to consider itemized records submitted during the Provider Dispute Resolution process. As a result of the Provider Complaint Branch's review, the health plan overturned its original denial and issued payment to the provider, including interest, totaling over $70,000.

MEMBER COMPLAINTS RESOLVED IN 2025



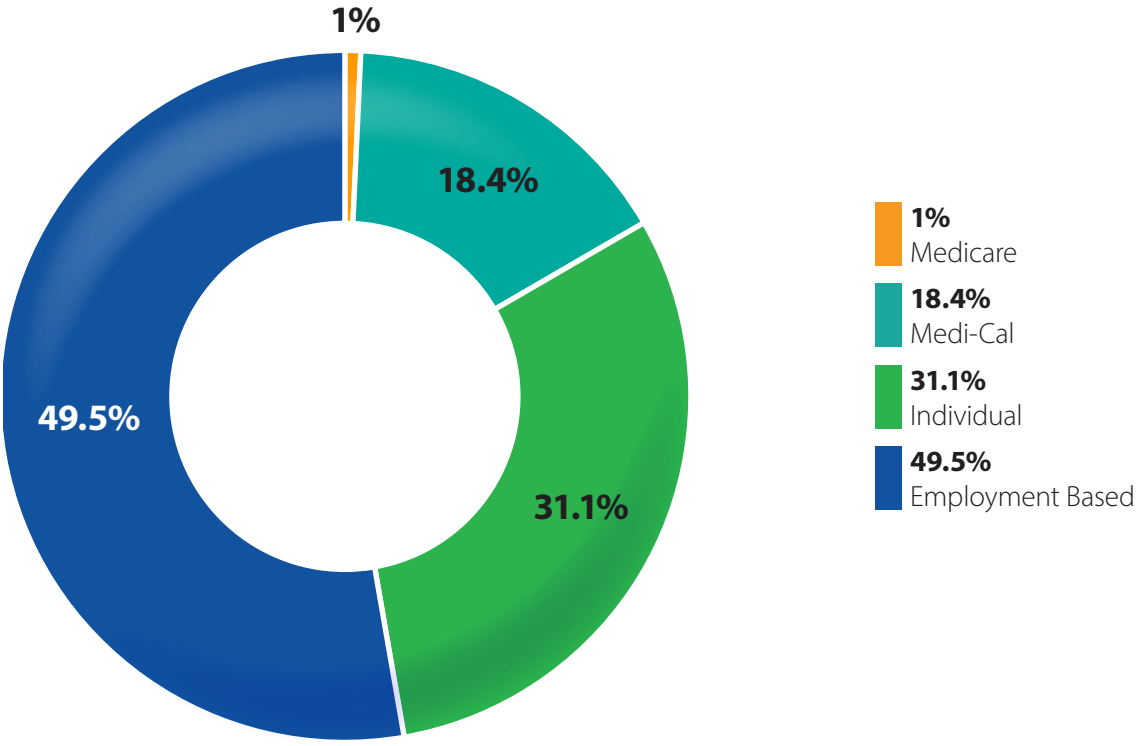
- **1.8%** Coordination of Benefits
- **4.5%** Enrollment
- **10.7%** Access to Care
- **13.3%** Provider Customer Service
- **20.3%** Health Plan Customer Service
- **24.6%** Benefits/Coverage
- **24.8%** Claims/Financial

IMRs RESOLVED IN 2025 BY OUTCOME

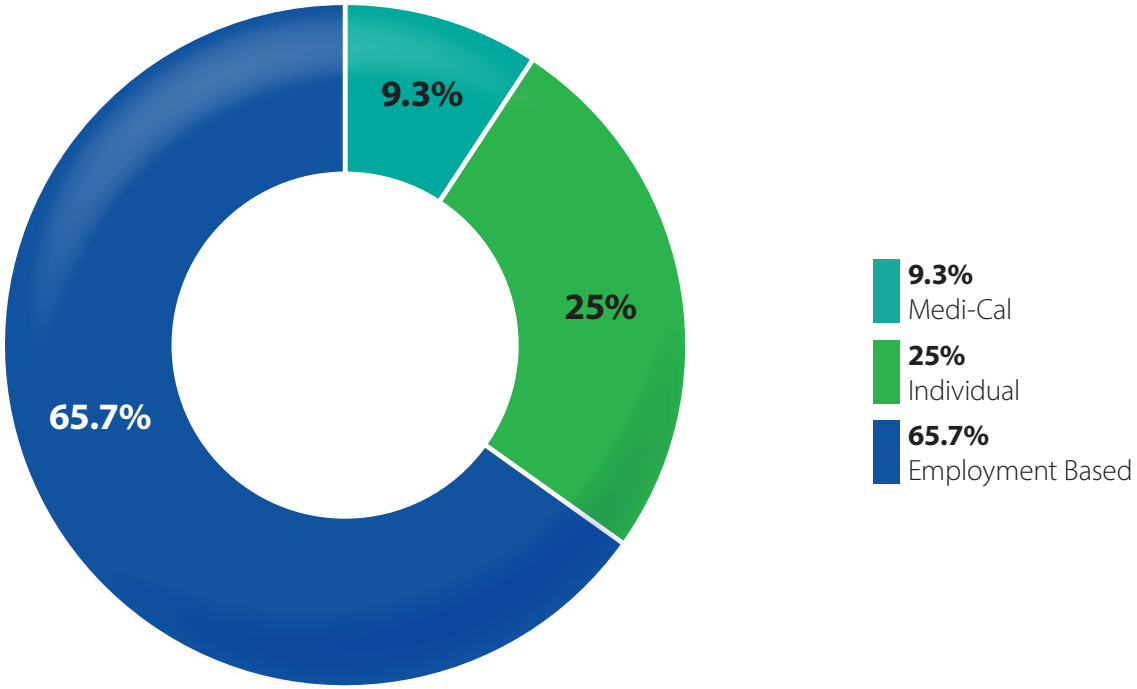


- **21.6%** HP Reversal %
- **22.1%** Upheld HP %
- **56.3%** Overturned HP %

MEMBER COMPLAINTS RESOLVED IN 2025 BY COVERAGE TYPE



IMRs RESOLVED IN 2025 BY COVERAGE TYPE



KNOW YOUR HEALTH CARE RIGHTS

DEPARTMENT OF Managed Health Care

Behavioral Health Care

Health plans must provide coverage for medically necessary treatment

- California law requires all commercial health plans to provide coverage for medically necessary treatment of mental health and substance use disorders (behavioral health) at the same cost as physical health conditions.
- Medically necessary treatment may include sessions with a therapist, medication to manage your condition, outpatient intensive treatment, and inpatient residential treatment.
- Health plans may cover treatment for: generalized anxiety disorders, post-traumatic stress disorder (PTSD), depression, schizophrenia, all substance use conditions, eating disorders (bulimia and anorexia nervosa), and bipolar disorder.

Health plans must provide behavioral health appointments in a timely manner

- Health plans must offer members a nonurgent behavioral health appointment within the timely access standard of **10 business days** from the time requested.
- For treatment of ongoing conditions, health plans must offer follow-up behavioral health appointments within **10 business days** of the prior appointment.
- A qualified health care provider may extend the waiting time for an appointment if they determine a longer waiting time will not be harmful to the member's health.

Timely Access to Care

Non-Urgent Care

MENTAL HEALTH APPOINTMENT CARE (NON-PHYSICIAN)[1]

10 business days

Follow-Up Care

MENTAL HEALTH/SUBSTANCE USE DISORDER FOLLOW-UP APPOINTMENT (NON-PHYSICIAN)

10 business days from prior appointment

Health Plan Members Have Rights

Health plan members have a right to receive timely and geographically accessible behavioral health services. If an in-network provider is not available, the health plan must arrange and cover out-of-network services at no additional cost to the member.

Members having trouble accessing behavioral health treatment or services should first contact their health plan. If the member does not agree with their plan's response, they can file a complaint with the DMHC at **www.DMHC.ca.gov** or by calling **1-888-466-2219 (TDD: 1-877-688-9891)**. Members with an urgent issue may seek immediate assistance from the DMHC.

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

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, template contracts with doctors and hospitals, provider networks, mental health parity, and complaint and grievance systems. This includes evidence of coverage documents, which are a health plan's contract or agreement issued to plan members, outlining the coverage offered by the plan.

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 with the Department 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.

As part of the ongoing oversight of licensed health plans, the DMHC reviews health plan mergers and acquisitions to ensure they do not adversely impact the plan's members or the stability of California's health care delivery system. Health plans intending to merge or consolidate with any entity, including another health plan, must obtain prior approval from the DMHC. As required under the law, the Department obtains an independent analysis for major mergers and holds a public meeting. The Department has the authority to approve mergers that meet the requirements in the law or disapprove mergers that may substantially lessen competition or would not meet the strong consumer protections in the law.

New reforms to increase transparency around the business practices of pharmacy benefit managers (PBMs) in California were passed in 2025. This included new requirements on PBMs to be licensed by the DMHC and to file organizational and financial information with the Department. Prior to these requirements, PBMs contracted with DMHC-licensed health plans to administer drug benefits were required to register with the Department.

DMHC Help Center Assistance: Benefits/Coverage Complaint – Out-of-Network Care

Carrie,[9] enrolled in a government-sponsored Medi-Cal Managed Care Plan, wanted to continue treatment with a specialist for a chronic heart condition after recently changing health plans. The health plan denied the request because the specialist was out-of-network, which means the provider was not contracted with the health plan. Carrie submitted a complaint with the DMHC Help Center. After the DMHC Help Center's review, the health plan determined the specialist was under contact with the health plan, making the provider in network. The health plan approved Carrie's request to continue treatment with the specialist.

2025 Highlights

The DMHC issues APLs to provide guidance and information to health plans, including an annual APL regarding newly enacted laws. The legislative APL instructs health plans on changes and new requirements to health plan operations and processes. The Department issued 21 APLs in 2025.

The DMHC responded to the Southern California wildfires, which destroyed homes and businesses and displaced health plan members and health care providers. The DMHC issued APL 25-001 to ensure health plans provided members with continued access to health care services, including medically necessary care, in areas affected by the disaster. In addition, the Department issued APL 25-005, directing health plans to extend the timeframes for impacted providers to submit claims, lengthen the duration of existing prior authorizations, and allow displaced providers to operate from mobile clinics or temporary locations.

In 2025, the DMHC worked to improve and standardize the templates used by all commercial full service health plans to describe the benefits offered to their health plan members (AB 118, 2023). The new law authorizes the Department to develop standardized templates for various documents, including the Evidence of Coverage, Disclosure Form, Schedule of Benefits, Explanation of Benefits, and Cost-Share Summary. The DMHC issued APL 25-004 to inform health plans of the initial updates to sections of the Evidence of Coverage and Disclosure Form.

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 benefit 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 plans. The DMHC reviewed 37 QHP and QDP filings in 2025 to ensure compliance with the consumer protections in federal and state laws.

In 2025, the DMHC received two transactions involving a merger, consolidation or acquisition of a health plan. The two transactions remained under review by the Department at the end of 2025. The DMHC has received

2025 BY THE NUMBERS

PLAN LICENSING

4 NEW LICENSES ISSUED

5,805 EVIDENCES OF COVERAGE REVIEWED

1,141 ADVERTISEMENTS REVIEWED

37 COVERED CALIFORNIA FILINGS REVIEWED[10]

21 ALL PLAN LETTERS ISSUED

290 MATERIAL MODIFICATIONS (SIGNIFICANT CHANGES) RECEIVED

2 HEALTH PLAN MERGERS & ACQUISITIONS REVIEWED

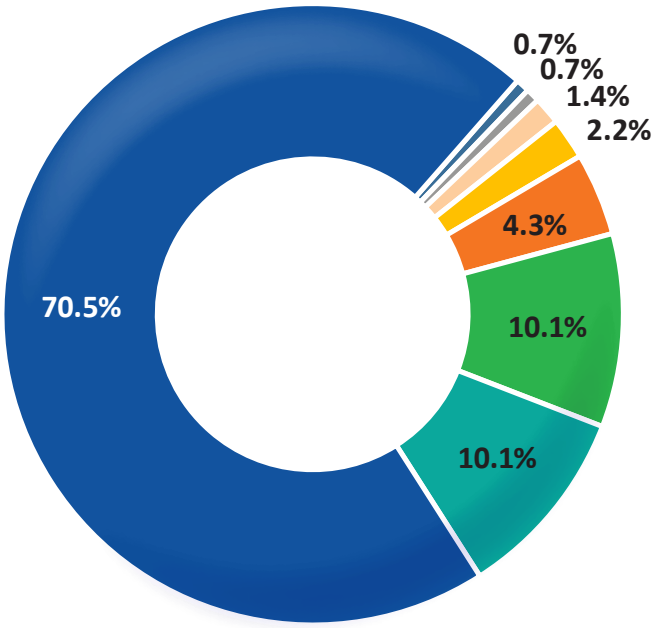
21 PBM REGISTRATION APPLICATIONS REVIEWED

DMHC Milestones

2010–2014

The DMHC supported the ACA, ensuring health plans met Covered California coverage requirements.

LICENSED PLANS IN 2025



0.7%
1 Dental/Vision

0.7%
1 Discount

1.4%
2 Pharmacy

2.2%
3 Chiropractic/Acupuncture

4.3%
6 Vision

10.1%
14 Behavioral Health (Psychological)

10.1%
14 Dental

70.5%
98 Full Service

52 transactions, including one major merger, since the DMHC's authority over the review of health plan mergers was expanded in 2019.

The DMHC has a total of 14 registered PBMs. In 2025, the DMHC received a total of 21 PBM registration applications which included nine amended PBM applications and 12 new PBM applications. Of the 12 new applications, 11 did not qualify to register with the DMHC because they did not contract with a DMHC-licensed health plan, contracted with a plan only offering Medicare Advantage products, or did not provide sufficient services to a DMHC-licensed health plan to be required to register, and one application remained under review at the end of 2025.

The DMHC also continued to monitor and review plan compliance with Provider Directory requirements. 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.

In 2025, the DMHC issued new licenses to four health plans, including three Medicare Advantage plans and a behavioral health specialized plan, Modern Life CA, Inc.

DMHC Help Center Assistance: Independent Medical Review (IMR) – Medical Necessity

Xavier,[9] enrolled in a commercial health plan through his employer, requested an MRI of his shoulder after completing physical therapy with minimal improvement. His health plan, a Preferred Provider Organization (PPO), denied the MRI as not medically necessary. Xavier contacted the DMHC Help Center and applied for an IMR. The IMR determined his request was medically necessary based on prior X-rays. The health plan's denial was overturned, and Xavier received authorization for the MRI.

KNOW YOUR HEALTH CARE RIGHTS

DEPARTMENT OF Managed Health Care

Timely Access to Care

Health plans must ensure their network of providers, including doctors, can provide health plan members an appointment within specific timeframes.

A qualified health care provider may extend the waiting time for an appointment if they determine a longer waiting time will not be harmful to the member's health.

Urgent Care

prior authorization **not required** by health plan	prior authorization **required** by health plan
48 hours	**96** hours

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN	SPECIALTY CARE PHYSICIAN
10 business days	**15** business days

Mental Health Appointment
(non-physician[1])

10 business days

Appointment
(ancillary provider[2])

15 business days

Follow-Up Care

Mental Health / Substance Use Disorder Follow-Up Appointment
(non-physician)

10 business days from prior appointment

Timely Access to Care Requirements

DISTANCE

A primary care provider / hospital within 15 miles or 30 minutes from where health plan members live or work

AVAILABILITY 24/7

Telephone services to talk to your health plan should be available 24/7

INTERPRETER

Interpreter services must be coordinated and provided with scheduled appointments for health care services

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. The DMHC Help Center is available at **www.DMHC.ca.gov** or by calling **1-888-466-2219 (TDD: 1-877-688-9891)** 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.

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

[2] Examples of ancillary services include lab work, physical therapy, or diagnostic testing, such as a mammogram or MRI.

Plan Monitoring

The DMHC assesses and monitors health plan networks and delivery systems for compliance with the requirements in state law (Knox-Keene Act). The Department evaluates health plan operations for compliance through medical surveys, or audits. Routine medical surveys of each licensed health plan are conducted every three years. The DMHC may also conduct a non-routine survey when a specific issue or problem requires a focused review of a health plan's operations. Medical surveys examine health plan operations related to access and availability of services, utilization management, quality improvement, continuity and coordination of care, language access, and grievance and appeal systems. The evaluation of grievance and appeal systems ensures health plans timely review, resolve and respond to member complaints.

When a medical survey identifies deficiencies, the Department requires health plans to submit corrective action plans 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.

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

When a contract is ending between a health plan and a hospital or provider group, the DMHC assesses the adequacy of the health plan's provider network and how health plan members affected by the change will continue to receive care. Health plans must submit a "Block Transfer Filing" to the DMHC when there is a pending contract termination with a hospital or provider group impacting 2,000 or more of the health plan's members. The DMHC's review includes an assessment of the health plan's remaining network of providers and hospitals to

DMHC Help Center Assistance: Claims/Financial Complaint – Benefits Dispute

Lisa,[9] enrolled in a commercial health plan in the individual market, was incorrectly assigned to a different medical group by her plan. As a result, her established providers were considered out-of-network without her knowledge, and she was billed more than $900 for prenatal visits and an ultrasound. Lisa submitted a complaint to the DMHC Help Center, and her health plan approved a correction to her assigned medical group. The plan also reprocessed her prenatal visits as in network, saving Lisa from costly out-of-network bills.

ensure affected members can continue to access and receive care. Health plans must also provide timely written notification to affected members, including important notices such as information about a process called "continuity of care," where a member can continue to see their doctor or hospital, under certain circumstances, for a limited time after the health plan's contract ends with that provider or hospital.

The DMHC is currently conducting focused Behavioral Health Investigations (BHIs) of full service commercial health plans licensed by the DMHC. The goal of the BHIs is to understand the challenges health plan members experience with accessing behavioral health services, despite the many protections in the law. The DMHC is taking a phased approach with an average of four to five health plans per phase. The investigations are a separate focused review of the health plans and not a part of the DMHC's routine medical surveys.

The DMHC is working toward ensuring the equitable delivery of high-quality health care services and outcomes for all health plan members. In 2022, the Department established the Health Equity and Quality (HEQ) Committee and adopted the committee's recommendations for a set of standard health equity and quality measures and a benchmark. All licensed full service and behavioral health plans, including Medi-Cal managed care plans, were required to start collecting data on the measures in 2023. Health plans have reported 2023 and 2024 HEQ data, and the Department is working to publish the first annual HEQ Compliance Report and plan-specific performance findings reports.

2025 Highlights

In California, health plan members have the right to receive timely access to care. Health plans must ensure their network of providers, including doctors, have availability to provide health plan members with timely health care services, including certain types of appointments within specific timeframes.

2025 BY THE NUMBERS

PLAN MONITORING

22 ROUTINE SURVEYS COMPLETED

24 FOLLOW-UP SURVEYS COMPLETED

1 NON-ROUTINE SURVEY COMPLETED

109 UNIQUE HEALTH PLAN NETWORKS REVIEWED[11]

38 TIMELY ACCESS COMPLIANCE REPORTS REVIEWED[12]

393 BLOCK TRANSFERS RECEIVED[13]

216 MATERIAL MODIFICATIONS RECEIVED

DMHC Milestones

2010

The DMHC implements landmark regulations to ensure Californians have timely access to care.

The Department evaluates compliance with the timely access standards through an annual review of timely access compliance reports submitted by health plans. The health plan compliance reports include data from health plan timely access monitoring and the results from the provider appointment availability survey. The survey measures the percentage of providers offering an appointment within the required timely access standards. Health plans that do not meet timely access standards must submit corrective action plans to the DMHC and may be subject to disciplinary action.

In 2025, the DMHC reviewed the timely access compliance reports submitted by 38 health plans. The Department issued the annual Timely Access Report and updated the Department's website to incorporate the new year of data in the Health Plan Timely Access Data dashboard. This interactive dashboard provides greater transparency into how health plans meet the timely access standards and includes filters to sort by health plan, product type, provider type and appointment type.

In addition to monitoring health plan networks for compliance with timely access standards, the DMHC reviews most health plan networks for compliance with network adequacy requirements on an annual basis. The DMHC developed new network adequacy regulations in 2024 which revised the standards and methodologies plans use to report network data with the goal of improving provider network monitoring by the Department. Plans reported network filings with these new requirements for the first time in 2025. This included new standards for primary care doctors, specialists and mental health professionals, including providers accepting new patients.

At the end of 2025, the DMHC issued guidance to health plans under APL 25-019, including network adequacy standards with specified distance standards for additional specialist physicians, facility-based providers and ancillary providers, new mental health utilization standards, as well as updates to existing standards and measurement methodologies, including provider-enrollee ratio standards for primary care providers.

The DMHC also completed a non-routine survey of Kaiser Permanente. The DMHC opened a non-routine survey in 2022 following an increase in complaints to the DMHC Help Center. The survey reviewed the plan's statewide compliance with providing timely behavioral health appointments to members and identified 20 violations. The plan is addressing the deficiencies as part of a Corrective Action Work Plan under a $200 million Settlement Agreement with the DMHC.

DMHC Help Center Assistance: Independent Medical Review (IMR) – Medical Necessity

Brody,[9] a child enrolled in a commercial health plan through his parents' employer, needed weekly one-on-one speech therapy, and his parents made a request to their plan. Their health plan denied the speech therapy services as not medically necessary due to Brody's lack of progress. Brody's parents applied for an IMR through the DMHC Help Center and provided medical records supporting Brody's progress and need for weekly speech therapy. The IMR overturned the health plan's denial and determined Brody's weekly speech therapy was medically necessary.

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 organizations, 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 verify 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 delivering professional health care services to health plan members assigned to the RBO by accepting a fixed monthly payment from health plans. This arrangement is typically referred to as "capitation."

RBOs are subject to financial solvency requirements and 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. At the end of 2025, the DMHC had 211 registered RBOs.

The DMHC annually reviews health plan 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, the plan must provide rebates to members and other purchasers, such as employers.

The DMHC also licenses Medicare Advantage health plans in California. However, the Department's jurisdiction over these plans is limited to administrative and financial solvency issues.

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

DMHC Help Center Assistance: Independent Medical Review (IMR) – Emergency Services

Sven,[9] enrolled in a commercial health plan through his employer, requested coverage for services he received in the emergency room and related hospital stay. Sven received a bill for over $20,000 because his plan denied the emergency services. Sven applied for an IMR through the DMHC Help Center. The IMR found the emergency services and hospital stay were medically necessary and overturned the health plan's denial, saving Sven from a large out-of-pocket bill.

2025 Highlights

The DMHC completed a total of 71 financial examinations in 2025, including 45 financial examinations of health plans. The DMHC imposed corrective action plans on 38 health plans for claims processing deficiencies. Through corrective action plans, health plans are required to remediate provider claims and implement processes to ensure providers are paid accurately for services provided to health plan members. The health plans reprocessed the impacted claims and paid providers $11,557,923, including interest and penalties.

In 2025, three health plans were required to issue MLR rebates totaling $15.3 million for failing to meet the minimum MLR requirement during 2024:

- ACN Group of California, Inc. (OptumHealth Physical Health of California) reported an MLR of 68.8% and paid $2,147 in rebates in the small group market; and an MLR of 71.2% and paid $342,221 in rebates in the large group market.
- UnitedHealthcare Benefits Plan of California reported an MLR of 78.5% and paid $13.4 million in rebates in the small group market.
- U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California) reported an MLR of 74.4% and paid $1.6 million in rebates in the large group market.

The DMHC conducted 24 claims and provider dispute examinations of RBOs. As a result of the examinations, 15 RBOs were required to file corrective action plans to address claims processing deficiencies. Collectively, the RBOs remediated claims in the amount of $2,973,348, including additional payments, interest and penalties.

The DMHC also issued three new licenses for Medicare Advantage plans: Ventura County Medi-Cal Managed Care Commission, Elite Health Plan, Inc. and LaSalle Health Plan, Inc. The Department has limited oversight of Medicare Advantage plans, including financial solvency and administrative capacity.

2025 BY THE NUMBERS

FINANCIAL OVERSIGHT

71 FINANCIAL EXAMINATIONS COMPLETED[14]

2,888 FINANCIAL STATEMENTS REVIEWED[15]

46 MLR REPORTS REVIEWED

$15.3 M MLR REBATES[16]

$7.1 M CLAIM AND DISPUTED PAYMENTS REMEDIATED

$7.4 M INTEREST AND PENALTIES PAID

287 MATERIAL MODIFICATIONS RECEIVED (FINANCIAL IMPACT)

DMHC Milestones

1999

The Financial Solvency Standards Board is established as the first of its kind in the country, advising the DMHC's director on the financial stability of the health care delivery system.

Rate Review

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 since the Department's rate review program started in 2011. Proposed premium rate changes for individual or small group health plans must be filed with the DMHC. Additionally, health plans that offer large group products must provide information regarding the methodology, factors and assumptions used to determine rates to the DMHC. Upon receiving a notice of a rate change from a health plan, the large group contract holder (employer)[17] can request the DMHC review the rate change within a specified timeframe.

Actuaries perform an in-depth review of proposed premium rate changes submitted by health plans and require health plans demonstrate the changes are supported by data, including underlying medical costs and trends. The DMHC's rate review program holds health plans accountable through transparency and ultimately has saved consumers hundreds of millions of dollars from health plans modifying rate changes after the DMHC's review.

The Department does not have the authority to approve or deny rate increases. 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 offering individual, small group and large group commercial coverage must file annual aggregated rate information with the DMHC. The DMHC holds a public meeting every other year to increase transparency of health plan premium rate changes.

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 Health Care Premium Rates and Prescription Drug Cost Transparency public meeting.

The DMHC has an informative and user-friendly premium rate review section on the Department's public website at www.RateReview.DMHC.ca.gov that makes it easy for the public to view and submit public comments on health plan proposed rate changes.

REVIEW & COMMENT ON HEALTH PLAN PROPOSED RATE CHANGES

The DMHC makes it easy for the public to view and provide comments on health plan proposed rate changes. Visit www.RateReview.DMHC.ca.gov for more information, to review rate filings and to submit comments.

2025 Highlights

The DMHC reviewed 51 individual and small group rate filings in 2025. The DMHC reviewed proposed premium rate changes to ensure that the rate changes were supported by data, including underlying medical costs and trends. Additionally, the DMHC reviewed 37 large group filings for the methodology, factors or assumptions that would affect the rate paid by a large group employer or contract holder. The Department did not find any unreasonable or unjustified rate changes.

Health plans that offer commercial products in the individual, small group and large markets must annually report information to the DMHC, including premiums, cost sharing, benefits, enrollment, and trend factors. The DMHC reviewed aggregate rate filings for 13 individual market, 13 small group market and 22 large group market health plans. The DMHC aggregated the information across all reporting plans and published the Health Plan Aggregate Premium Rate Report for Measurement Year 2025.

In 2025, approximately 2.57 million health plan members purchased individual health care coverage and the overall average monthly premium was $684; approximately 2.17 million health plan members had small group health care coverage and the average monthly premium was $707; and approximately 7.49 million health plan members renewed their coverage in the large group market and the average monthly premium was $689.

The DMHC published the Prescription Drug Cost Transparency Report for Measurement Year 2024, which looks at the impact of the cost of prescription drugs on commercial health plan premiums. Among other findings, the report revealed that health plan spending on prescription drugs increased by $6.2 billion since 2017, including an increase of almost $1.3 billion in 2024.

Starting in 2025, health plans that offer dental services are required to file information regarding the methodology, factors and assumptions used to determine rates with the DMHC. The Department reviewed 58 dental rate filings in 2025 and did not find any unreasonable or unjustified rate changes.

2025 BY THE NUMBERS

RATE REVIEW

146 RATE FILING REVIEWS COMPLETED[18]

25 PRESCRIPTION DRUG COST FILINGS REVIEWED

48 ANNUAL AGGREGATE RATE FILINGS REVIEWED

$296.1 M HEALTH PLAN MEMBER SAVINGS THROUGH NEGOTIATED MODIFIED RATES SINCE 2011

DMHC Milestones

2010

The DMHC established a premium rate review program to enhance transparency around premium rate changes in the commercial market and promote more accountability within the health care industry.

Enforcement

The DMHC takes timely action against health plans that break the law. The primary purpose of an enforcement action is to change a health plan's behavior to come into compliance with the law. Enforcement actions include issuing cease and desist orders, imposing administrative penalties (fines), freezing enrollment and requiring corrective actions. In addition to these administrative actions, the DMHC may pursue litigation, when necessary, to ensure health plans follow the law.

In 2025, 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. For fiscal year 2025-26, the next $4,900,000 was transferred to the Health Care Payments Data Fund to support the collection of data on health care costs, utilization, quality and equity. Any remaining funds are transferred to the Health Care Services Plan Fines and Penalties Fund to support the Medi-Cal program.

DMHC Help Center Assistance: Claims/Financial Complaint – Payment Dispute

Maria,[9] enrolled in a commercial health plan through the individual market on the state's health benefit exchange, Covered California, received kidney stone removal surgery. Her health plan, an HMO, covered the surgery but did not cover the anesthesia services received during the surgery. The anesthesia provider billed Maria and sent the bill to collections. Maria submitted a complaint to the DMHC Help Center. As a result of the Department's review of the case, the health plan found a provider billing error and informed the provider they could not bill Maria for these services as an in-network provider. The health plan submitted a corrected claim on the provider's behalf, and Maria was only responsible for her cost-sharing under her contract with her health plan. The health plan also followed up with the provider to remove the medical bill from collections.

2025 Highlights

In 2025, the DMHC assessed $15,868,000 in fines through enforcement actions taken against health plans. The Department's enforcement actions involved diverse legal issues, including health plan failures in meeting timely access standards, the timely handling of health plan member complaints, sending accurate denial letters to members, and operating without a license. Some of the significant enforcement actions taken by the DMHC in 2025 are highlighted below.

The DMHC took enforcement action against Modern Health California, P.C. (MHPC), including a $2 million fine, for operating as a specialized health plan in California without a license. The Department found MHPC was illegally operating as an Employee Assistance Program (EAP) in California without a health plan license. MHPC stopped operating as an unlicensed plan, and MHPC's affiliate, Modern Life CA, Inc., became licensed to legally operate in California.

The DMHC fined three plans owned by Centene Corporation a total of $1.7 million for failing to meet appointment timely access standards. The DMHC fined Health Net of California, Inc. $1.2 million, Human Affairs International of California $300,000 and Health Net Community Solutions, Inc. $200,000. Health plans conduct annual surveys of their provider networks to assess compliance with the state's timely access to care standards and report the results of the surveys to the DMHC. In this case, all three plans failed to report minimum rates of compliance with timely access standards for certain provider networks.

The DMHC fined Kaiser Permanente $819,500 for failing to handle health plan member complaints, also called grievances or appeals, in a timely manner. California law requires health plans to acknowledge receipt of a standard grievance within five calendar days and to resolve a standard grievance and send a written resolution to the member within 30 calendar days. The DMHC Help Center referred several member complaints to the Department's Office of

2025 BY THE NUMBERS

ENFORCEMENT

833 CASES OPENED

282 CASES CLOSED WITH A PENALTY

$15.9 M PENALTIES ASSESSED

DMHC Milestones

2008

The DMHC reaches a groundbreaking settlement with five major California health plans, including nearly $14 million in fines, for rescinding coverage after health plan members sought treatment or filed claims.

Enforcement for further investigation, which found Kaiser Permanente failed to timely handle complaints in 61 cases. This included failure to timely provide the written acknowledgment of the receipt of the grievance within five calendar days in 14 cases, and failure to timely respond to the member's standard grievance within 30 calendar days of receipt of the grievance in 54 cases.

The DMHC fined Anthem Blue Cross $750,000 for sending thousands of denial letters to health plan members with the wrong regulator's information related to members' appeal rights. In this case, a PBM for Anthem Blue Cross sent 5,252 denial letters to the plan's members with incorrect information on the regulator the member can appeal to if they disagree with the plan's denial. The health plan was also required to implement corrective actions to ensure accurate information is included in denial letters.

The DMHC fined Blue Cross of California Partnership Plan, Inc. $550,000 for failing to timely implement an IMR determination, delaying a health plan member's medically necessary treatment. In this case, a health plan member requested an in-home therapy evaluation and in-home therapy services for a medical condition. The plan denied the member's request, and the member contacted the DMHC Help Center to request an IMR. The independent reviewer determined the in-home evaluation and therapy were medically necessary and overturned the plan's denial. The plan acknowledged the IMR determination and authorized the in-home evaluation, but it did not include the in-home therapy services in its authorization letter to the health plan member causing further delays for the member to receive in-home therapy.

The DMHC fined Cigna HealthCare of California, Inc. (Cigna) $500,000 for improperly reviewing and denying health care claims payments submitted by providers as not medically necessary. The Department also found that Cigna's medical necessity review for certain claims did not comply with the health plan's policy for modifying or denying claims. Cigna agreed to re-review the denied claims where the non-compliant review process was used and implement corrective actions to revise its health care claims payment review process.

The DMHC fined Blue Cross of California Partnership Plan, Inc. $500,000 for failing to correct deficiencies

DMHC Help Center Assistance: Quick Resolution – Access to Care

Hendrik,[9] enrolled in a commercial health plan through his employer, required a monthly injection for a chronic condition. The earliest appointment available with a Primary Care Physician (PCP) was four months away. Hendrik needed his PCP to approve his medication, and his attempts to reach his health plan's member services for help were unsuccessful. Hendrik contacted the DMHC Help Center for assistance, and the Department was able to resolve his issue through the Quick Resolution process, which is a three-way call with the plan, the member and the DMHC Help Center. The plan assigned Hendrik to a new medical group with immediate availability and scheduled an appointment for the next day.

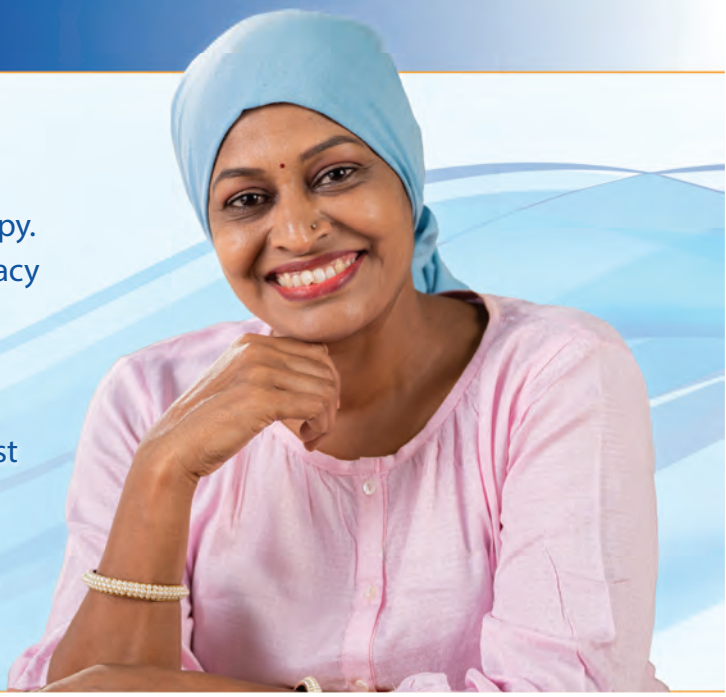
identified in a medical survey, or audit, of the plan's operations. The Department's medical survey of the plan identified several deficiencies, including failing to properly handle and resolve health plan member complaints, also called grievances or appeals. The plan agreed to implement corrective actions to address all remaining deficiencies, including staff training and making changes to its policies and procedures.

The DMHC fined UnitedHealthcare Benefits Plan of California $475,000 for failing to timely implement IMR decisions, which delayed medical care. In addition, the plan's failure to carry out timely IMR decisions led to delays in providers being paid. The plan agreed to take corrective actions, including providing the Department with updated procedures involving IMRs and grievances.

The Department fined California Physicians' Service (Blue Shield of California) $300,000 for mishandling several claims payments and delaying reimbursement payments to a plan member for approved care over a five-year period. In this case, Blue Shield of California approved a plan member's request for health care services from an out-of-network provider at an in-network rate. The plan then denied or mishandled payments for 36 claims connected to the delivery of these services from 2020 through 2024. The DMHC Help Center resolved the plan member's complaints and referred the matter to the Department's Office of Enforcement for further investigation. Blue Shield of California completed corrective actions to improve claims processing, including educating the plan's staff and improving the documentation of claims.

DMHC Help Center Assistance: Access to Care Complaint – Authorized Care Delay

Polly,[9] enrolled in a commercial health plan through her employer, was diagnosed with late-stage inoperable breast cancer and requested Fulvestrant injection therapy. Polly had access issues and complained that her pharmacy and medical office blamed each other for ordering and delivery difficulties, causing Polly to miss her monthly dose. Polly submitted a complaint with the DMHC Help Center. As a result, her health plan expedited her request for injection therapy and scheduled her future doses. The health plan also followed up with the pharmacy and medical office regarding their responsibilities for ordering and scheduling medication deliveries.



50 YEARS

OF ADVANCING HEALTH CARE COVERAGE IN CALIFORNIA

15 Years of the Affordable Care Act (ACA)

California has been a national leader in the implementation of the ACA. As a result, California's uninsured rate has fallen from 17% to 5.9%.[1] Nearly two million Californians are enrolled in health insurance through Covered California, the state's ACA marketplace.[19] 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, policymakers, health plans, providers and other stakeholders. As a result, California has remained ahead of the curve in executing health care reforms.

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.[20] 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.[21] 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.[22] 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 members 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 as 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 Requirements
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 an essential health benefit; requires coverage for certain preventive services without any health plan member 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, copayments and coinsurance 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 health plan members to select any available participating primary care provider Allows members to access care from a participating obstetrician-gynecologist (OB-GYN) provider without a referral	For individual, small group and large group coverage, allows health plan members to select any available participating primary care provider Allows members 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 Requirements
Independent External Review	Establishes the Independent Medical Review (IMR) program (1999), allowing health plan members 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 and 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 12 months, depending on the number of health plan members	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

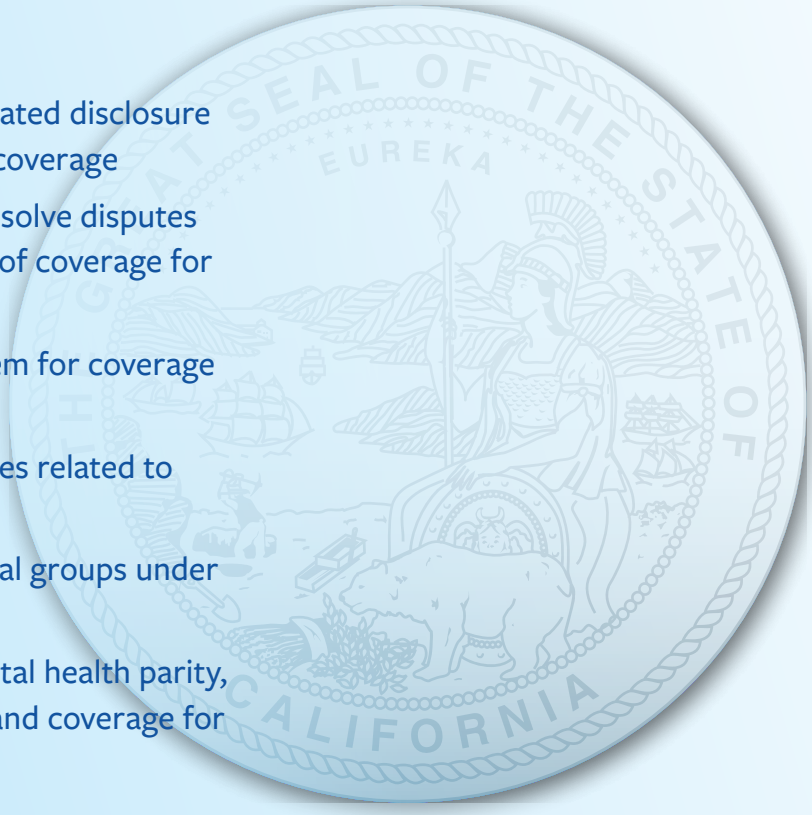
Creation of the DMHC & Consumer Protection

Managed care plans in California significantly expanded in the 1990s, accelerated by enrollment growth. Policymakers and others questioned how health plans operated and if they were balancing access and quality of care with costs. Historically, managed care plans kept California premiums 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. As a result, California amended its managed care law, the Knox-Keene Act, to increase health plan oversight and establish a system to resolve health plan member complaints.

The establishment of the DMHC 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 reinforced the DMHC's role in addressing health plan member complaints. The DMHC opened as a stand-alone department in July 2000 to regulate health plans focused on consumer protection and quality of care.[23]

THE PATIENT BILL OF RIGHTS

- Guaranteed coverage for second opinions
- Time limits on 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
- Specific mandated benefits, including mental health parity, contraception, hospice, cancer screening and coverage for diabetic supplies



Historical Timeline of the Knox-Keene Act

1929-1945

Early prepaid health plan models emerge in California (Ross-Loos, Permanente Health Plan and Blue Shield of California).[23]

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).

Notes

1 The State of Health Coverage in California: Progress, Disparities, and Policy Threats, California Budget & Policy Center, October 2025. https://calbudgetcenter.org/resources/california-health-coverage-progress-disparities-and-policy-threats/#:~:text=3.%20California's%20Uninsured%20Rate%20Reached,health%20care%20access%20for%20all

2 California Health Care Foundation, California Health Insurers, Enrollment Almanac — 2025 Edition, December 16, 2025. https://www.chcf.org/resource/california-health-insurers-enrollment-almanac/

3 The enrollment charts include the following enrollment types reported by plans and searchable in the Health Plan Financial Summary Report: POS Large Group, PPO Large Group, HMO Large Group, EPO Large Group, POS Small Group, PPO Small Group, HMO Small Group, EPO Small Group, PPO Individual, POS Individual, HMO Individual, EPO Individual, EAP, IHSS, Medi-Cal Managed Care, Medi-Medi, Medicare Advantage, Medicare Fee For Service and Medicare Supplement. Healthy Families and AIM enrollment were also reported in previous years when those programs were active.

4 "Other" enrollment consists of Medicare Supplement enrollment.

5 Health plan members received the requested services in 77.9% of the cases qualified by the Department for the IMR program in 2025.

6 Individuals may have received more than one form of assistance throughout the year.

7 Health plan member complaints are comprised of standard complaints (14,740) quick resolutions (365) and urgent cases (10) in 2025. 11,525 of the standard complaints were resolved by the DMHC and are included in the health plan member complaint summary report in the Appendix. Of the remaining cases, most were sent back to the health plan to address through the grievance process.

8 IMRs are comprised of cases that were resolved by the DMHC or closed for any reason other than non-jurisdictional in 2025. 3,743 of the IMRs were resolved by the DMHC and are included in the IMR summary report in the Appendix. The remaining cases were closed because the health plan member had not yet gone through the health plan grievance process, the member did not respond to requests for information, the case was withdrawn by the member, or the case was ineligible for IMR.

9 Names and photos were changed to protect the privacy of health plan members. The outcomes of each DMHC Help Center case are specific to the circumstances and details of each individual.

10 Includes review of Qualified Health Plan filings and Qualified Dental Plan filings.

11 109 Networks reviewed in 2025 were for Reporting Year 2025 Annual Network Reporting.

12 38 Timely Access compliance reports reviewed in 2025 were for Measurement Year 2024.

13 393 Block Transfer filings received in 2025; 284 hospital and 109 provider group filings.

14 45 health plan financial examinations, two MLR examinations, and 24 RBO financial examinations.

15 1,521 health plan financial statements reviewed and 1,367 RBO financial statements reviewed.

16 Rebates for calendar year 2024 were paid in 2025.

17 The large group coverage must be experience rated in whole or blended.

18 This includes 13 individual market health plan premium rate filings, 38 small group rate filings, 37 large group rate filings and 58 dental rate filings.

19 Covered California Reaches Landmark Achievement with Nearly 2 Million Enrolled as Open Enrollment Concludes, Covered California, February 2025. https://www.coveredca.com/newsroom/news-releases/2025/02/20/covered-california-reaches-landmark-achievement-with-nearly-2-million-enrolled-as-open-enrollment-concludes/#:~:text=Since%20Covered%20California%20launched%20in,had%20marketplace%20coverage%20since%202014.

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

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

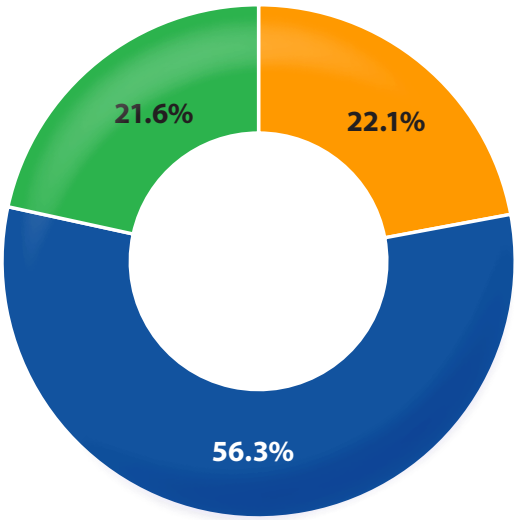
22 Premium rate review (SB 1163, 2010) and Medical Loss Ratios, Annual and Lifetime Benefit Limits (SB 51, 2011)

23 Making Sense of Managed Care Regulation in California, California Health Care Foundation, November 2001. https://www.chcf.org/wp-content/uploads/2017/12/PDF-MakingSenseManagedCareRegulation.pdf

2025 Independent Medical Review Summary Report

78%

of cases that qualified for the Department's IMR program resulted in the member receiving the requested service or treatment from their health plan.*



21.6%
IMR cases reversed by health plan

22.1%
IMR cases upheld by IMRO

56.3%
IMR cases overturned by IMRO

Report Overview

The Annual Independent Medical Review (IMR) Summary Report displays the number and types of IMRs resolved during the 2025 calendar year by health plan. The Department resolved 3,743 IMRs.

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

Enrollment data was provided to the Department by health plans in their quarterly financial filings. Enrollment data reflects the fourth quarter of 2025 for the population of members within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2025, may have had enrollment earlier in the year, received a license in 2025 or did not have enrollment within the DMHC Help Center's jurisdiction.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review by the Department, and resolved (closed) within calendar year 2025. Cases pending at the end of 2025 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 2025. 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 IMR data is reported under the primary plan.

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

* Members received the requested services in 77.9% of the cases qualified by the Department for the IMR program in 2025.

California Department of Managed Health Care

2025 Independent Medical Reviews 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																								
Alameda Alliance For Health	402,356	5	0.12	0	0	0.0%	0	0.0%	0	0.0%	5	2	40.0%	0	0.0%	3	60.0%	0	0	0.0%	0	0.0%	0	0.0%
Blue Cross of California (Anthem Blue Cross)	2,127,638	1,036	4.87	101	36	35.6%	57	56.4%	8	7.9%	930	163	17.5%	617	66.3%	150	16.1%	5	0	0.0%	3	60.0%	2	40.0%
Blue Cross of California Partnership Plan, Inc.	768,647	20	0.26	1	0	0.0%	1	100.0%	0	0.0%	19	7	36.8%	5	26.3%	7	36.8%	0	0	0.0%	0	0.0%	0	0.0%
California Physicians' Service (Blue Shield of California)	2,265,258	1,303	5.75	215	96	44.7%	93	43.3%	26	12.1%	1080	169	15.6%	713	66.0%	198	18.3%	8	0	0.0%	7	87.5%	1	12.5%
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	427,533	4	0.09	1	0	0.0%	1	100.0%	0	0.0%	3	0	0.0%	0	0.0%	3	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Net Community Solutions, Inc.	1,546,268	36	0.23	3	2	66.7%	1	33.3%	0	0.0%	32	6	18.8%	13	40.6%	13	40.6%	1	0	0.0%	0	0.0%	1	100.0%
Health Net of California, Inc.	533,085	246	4.61	20	7	35.0%	11	55.0%	2	10.0%	225	31	13.8%	106	47.1%	88	39.1%	1	0	0.0%	1	100.0%	0	0.0%
Inland Empire Health Plan (IEHP)	1,520,315	86	0.57	7	2	28.6%	4	57.1%	1	14.3%	79	36	45.6%	22	27.8%	21	26.6%	0	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7,891,341	323	0.41	1	0	0.0%	0	0.0%	1	100.0%	322	129	40.1%	104	32.3%	89	27.6%	0	0	0.0%	0	0.0%	0	0.0%
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	2,497,633	67	0.27	5	1	20.0%	2	40.0%	2	40.0%	62	9	14.5%	22	35.5%	31	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Molina Healthcare of California	586,341	23	0.39	1	0	0.0%	1	100.0%	0	0.0%	22	7	31.8%	6	27.3%	9	40.9%	0	0	0.0%	0	0.0%	0	0.0%
San Joaquin County Health Commission (Health Plan of San Joaquin)	408,002	6	0.15	1	0	0.0%	0	0.0%	1	100.0%	5	3	60.0%	0	0.0%	2	40.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Over 400,000:	**20,974,417**	**3,155**	**1.50**	**356**	**144**	**40.4%**	**171**	**48.0%**	**41**	**11.5%**	**2784**	**562**	**20.2%**	**1608**	**57.8%**	**614**	**22.1%**	**15**	**0**	**0.0%**	**11**	**73.3%**	**4**	**26.7%**
FULL SERVICE – ENROLLMENT UNDER 400,000																								
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.**	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 Health of California Inc.	183,628	26	1.42	1	0	0.0%	1	100.0%	0	0.0%	25	5	20.0%	14	56.0%	6	24.0%	0	0	0.0%	0	0.0%	0	0.0%
AIDS Healthcare Foundation (Positive Healthcare)	900	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%
Align Senior Care 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%
Alignment Health Advantage 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%
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%
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	183,749	9	0.49	3	1	33.3%	0	0.0%	2	66.7%	6	1	16.7%	1	16.7%	4	66.7%	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%
BZ Health Network of California, Inc. (Blue Zones Health Network 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%
California Health and Wellness Plan (CA Health and Wellness)	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 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%
CCA Health Plans of California, Inc. (CCA Health 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%
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%
Central 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%
Champion 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)	350,761	4	0.11	0	0	0.0%	0	0.0%	0	0.0%	4	4	100.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Children's Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Chinese Community Health Plan (Balance by CCHP)	6,871	2	2.91	1	1	100.0%	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%
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.	107,924	17	1.58	2	0	0.0%	2	100.0%	0	0.0%	15	5	33.3%	4	26.7%	6	40.0%	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.	15,860	2	1.26	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	2	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Family Care 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%
Community Health Group	9,378	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)	267,907	6	0.22	3	3	100.0%	0	0.0%	0	0.0%	3	0	0.0%	2	66.7%	1	33.3%	0	0	0.0%	0	0.0%	0	0.0%
County of Ventura (Ventura County Health Care Plan)	9,068	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%
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%
Elite 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%
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%
Family Choice 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%
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%
Golden Bay Health, Inc. (Golden Bay 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%
Guidant 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%
Healthy Valley 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%
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%
Humana Health Plan of Texas, 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 County Local Health Authority (Community Health Plan of Imperial Valley)	97,368	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%

California Department of Managed Health Care

2025 Independent Medical Reviews 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	%
Kern Health Systems	399,242	22	0.55	0	0	0.0%	0	0.0%	0	0.0%	22	6	27.3%	9	40.9%	7	31.8%	0	0	0.0%	0	0.0%	0	0.0%
L.A. Care Health Plan Joint Powers Authority	51,765	5	0.97	0	0	0.0%	0	0.0%	0	0.0%	5	1	20.0%	1	20.0%	3	60.0%	0	0	0.0%	0	0.0%	0	0.0%
LaSalle 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%
MedCare Partners, Inc. (MedCare Partners 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%
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)	16,477	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	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%
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%
New Century Health Plan, Inc. (UCLA Health Medicare Advantage Plan)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
On Lok Senior Health Services	2,067	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	0	2	0.00	1	1	100.0%	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%
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%
PIH Health Care Solutions	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%
PromiseCare 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%
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%
Rios 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%
San Francisco Health Authority (San Francisco Health Plan)	188,097	3	0.16	1	0	0.0%	1	100.0%	0	0.0%	2	0	0.0%	0	0.0%	2	100.0%	0	0	0.0%	0	0.0%	0	0.0%
San Mateo Health Commission (Health Plan of San Mateo)	143,217	4	0.28	1	1	100.0%	0	0.0%	0	0.0%	3	1	33.3%	1	33.3%	1	33.3%	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)	54,484	7	1.28	0	0	0.0%	0	0.0%	0	0.0%	7	1	14.3%	2	28.6%	4	57.1%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	288,487	7	0.24	0	0	0.0%	0	0.0%	0	0.0%	7	2	28.6%	0	0.0%	5	71.4%	0	0	0.0%	0	0.0%	0	0.0%
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Central California Alliance for Health)***	731	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	20,834	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.	18,592	2	1.08	1	1	100.0%	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%
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	154,291	68	4.41	8	1	12.5%	3	37.5%	4	50.0%	60	8	13.3%	35	58.3%	17	28.3%	0	0	0.0%	0	0.0%	0	0.0%
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	60,865	1	0.16	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%
Starlife Holdings Inc. (Starlife 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%
Sutter Health Alliance (Sutter Health Plan)	118,260	47	3.97	2	1	50.0%	1	50.0%	0	0.0%	45	7	15.6%	29	64.4%	9	20.0%	0	0	0.0%	0	0.0%	0	0.0%
UHC of California (UnitedHealthcare of California)	377,613	109	2.89	15	9	60.0%	6	40.0%	0	0.0%	94	13	13.8%	28	29.8%	53	56.4%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Benefits Plan of California	331,671	194	5.85	33	13	39.4%	20	60.6%	0	0.0%	161	26	16.1%	115	71.4%	20	12.4%	0	0	0.0%	0	0.0%	0	0.0%
Universal Care, Inc. (Bright HealthCare)**	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%
Universal 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%
Ventura County Medi-Cal Managed Care Commission (Gold Coast 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%
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	132,485	50	3.77	9	5	55.6%	4	44.4%	0	0.0%	41	3	7.3%	34	82.9%	4	9.8%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Under 400,000:	**3,592,592**	**587**	**1.63**	**81**	**37**	**45.7%**	**38**	**46.9%**	**6**	**7.4%**	**505**	**83**	**16.4%**	**279**	**55.2%**	**143**	**28.3%**	**1**	**0**	**0.0%**	**1**	**100.0%**	**0**	**0.0%**
Total All Full Service Plans:	**24,567,009**	**3,742**	**1.52**	**437**	**181**	**41.4%**	**209**	**47.8%**	**47**	**10.8%**	**3,289**	**645**	**19.6%**	**1,887**	**57.4%**	**757**	**23.0%**	**16**	**0**	**0.0%**	**12**	**75.0%**	**4**	**25.0%**
CHIROPRACTIC																								
ACN Group of California, Inc. (OptumHealth Physical Health of California)	89,530	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
American Specialty Health Plans 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.	64,980	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:	**154,510**	**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	10,599	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.	82,816	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. (DentaQuest)	116,456	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.	184,112	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)	6,125	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.	107,468	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	24,961	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)	530,130	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

2025 Independent Medical Reviews 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 Dental Care	72,399	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)	168,540	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%
Starmount Managed Dental of California, Inc. (Unum Dental HMO 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%
UDC Dental California, Inc. (United Dental Care of California, Inc.)	21,210	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.	46,558	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)	110,091	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:	**1,481,465**	**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	3,712,962	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
First Dental Health	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 Dental/Vision:	**3,712,962**	**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																								
The CDI Group, Inc.	32,649	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:	**32,649**	**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)																								
Carelon Behavioral Health of California, Inc.	286,195	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Claremont Behavioral Services, Inc. (Claremont EAP)	103,851	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	165,893	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Empathia Pacific, Inc. (LifeMatters)	95,145	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%
Evernorth Behavioral Health of California, Inc.	68,547	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.	153,080	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health and Human Resource Center, Inc. (Aetna Resources for Living)	1,812,813	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	75,558	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%
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%
Magellan Health Services of California, Inc. - Employer Services	712,176	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%
Modern Life CA, 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%
Spring Care of California, Inc. (Spring Health)	116,007	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%
TELUS Health (California) Ltd. (LifeWorks)	72,623	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)	776,957	1	0.01	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%
Total Behavioral Health (Psychological):	**4,438,845**	**1**	**0.00**	**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%**
VISION																								
EyeMax Vision 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%
EYEXAM of California, Inc.	435,203	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)	222,715	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%
FYidoctors 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%
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	9,943	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	3,253,040	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:	**3,920,901**	**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:	**13,741,332**	**1**	**0.00**	**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%**
Grand Totals:	**38,308,341**	**3,743**	**0.98**	**437**	**181**	**41.4%**	**209**	**47.8%**	**47**	**10.8%**	**3,290**	**645**	**19.6%**	**1,888**	**57.4%**	**757**	**23.0%**	**16**	**0**	**0.0%**	**12**	**75.0%**	**4**	**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 was 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.

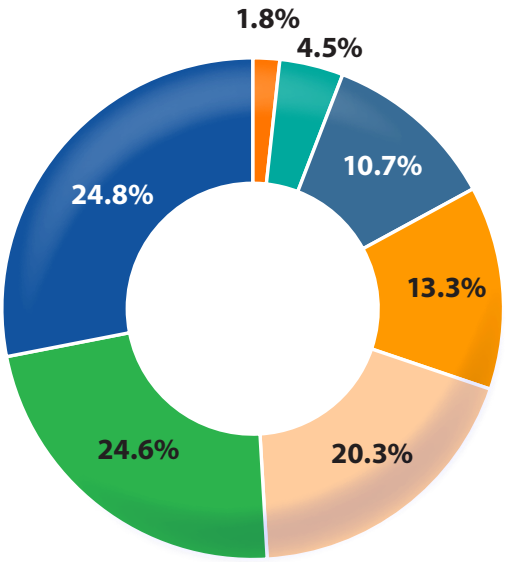
Grey shading indicates that the plan surrendered its license in 2025.

*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

2025 Health Plan Member Complaint Summary Report



1.8%
Coordination of Benefits

4.5%
Enrollment

10.7%
Access to Care

13.3%
Provider Customer Service

20.3%
Health Plan Customer Service

24.6%
Benefits/Coverage

24.8%
Claims/Financial

Report Overview

The Annual Complaint Summary Report displays the number and types of complaints resolved during the 2025 calendar year by health plan. A health plan member'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 each health plan's enrollment during the year, the number of complaints resolved for each health plan, the number of complaints per 10,000 members, and the number of issues for each complaint category.

Enrollment data was provided to the Department by health plans in their quarterly financial filings. Enrollment data reflects the fourth quarter of 2025 for the population of members within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2025, may have had enrollment earlier in the year, received a license in 2025 or did not have enrollment within the DMHC Help Center's jurisdiction.

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 2025. Cases pending at the end of 2025 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 2025. 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 complaint data is reported under the primary plan.

The number of complaints per 10,000 members is 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 members indicates fewer complaints were resolved per capita. As a result, a plan with a higher overall number of complaints may still show fewer complaints per 10,000 members than another plan with fewer overall complaints.

California Department of Managed Health Care

2025 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																		
Alameda Alliance For Health	99	1.0%	402,356	2.46	24	0.60	65	1.62	16	0.40	5	0.12	10	0.25	24	0.60	16	0.40
Blue Cross of California (Anthem Blue Cross)	2,119	22.1%	2,127,638	9.96	206	0.97	876	4.12	1165	5.48	145	0.68	51	0.24	750	3.53	230	1.08
Blue Cross of California Partnership Plan, Inc.	98	1.0%	768,647	1.27	58	0.75	33	0.43	7	0.09	3	0.04	7	0.09	28	0.36	24	0.31
California Physicians' Service (Blue Shield of California)	2,583	26.9%	2,265,258	11.40	273	1.21	919	4.06	1519	6.71	240	1.06	67	0.30	992	4.38	230	1.02
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	30	0.3%	427,533	0.70	12	0.28	15	0.35	5	0.12	1	0.02	2	0.05	4	0.09	11	0.26
Health Net Community Solutions, Inc.	245	2.6%	1,546,268	1.58	110	0.71	105	0.68	25	0.16	6	0.04	19		79	0.51	80	0.52
Health Net of California, Inc.	504	5.3%	533,085	9.45	84	1.58	223	4.18	236	4.43	27	0.51	12	0.23	226	4.24	55	1.03
Inland Empire Health Plan (IEHP)	208	2.2%	1,520,315	1.37	61	0.40	115	0.76	21	0.14	3	0.02	9	0.06	55	0.36	58	0.38
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	2,815	29.3%	7,891,341	3.57	660	0.84	1111	1.41	684	0.87	300	0.38	66	0.08	846	1.07	1201	1.52
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	781	8.1%	2,497,633	3.13	255	1.02	310	1.24	224	0.90	32	0.13	53	0.21	227	0.91	196	0.78
Molina Healthcare of California	85	0.9%	586,341	1.45	21	0.36	34	0.58	24	0.41	11	0.19	3	0.05	32	0.55	15	0.26
San Joaquin County Health Commission (Health Plan of San Joaquin)	27	0.3%	408,002	0.66	12	0.29	13	0.32	1	0.02	1	0.02	0	0.00	7	0.17	8	0.20
Total Full Service - Enrollment Over 400,000:	**9,594**	**100.0%**	**20,974,417**	**4.57**	**1,776**	**0.85**	**3,819**	**1.82**	**3,927**	**1.87**	**774**	**0.37**	**299**	**0.14**	**3,270**	**1.56**	**2,124**	**1.01**
FULL SERVICE – ENROLLMENT UNDER 400,000																		
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.**	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 Health of California Inc.	89	6.6%	183,628	4.85	11	0.60	41	2.23	36	1.96	6	0.33	3	0.16	23	1.25	8	0.44
AIDS Healthcare Foundation (Positive Healthcare)	0	0.0%	900	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Align Senior Care 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
Alignment Health Advantage 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
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
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	51	3.8%	183,749	2.78	25	1.36	25	1.36	4	0.22	1	0.05	5	0.27	18	0.98	16	0.87
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
BZ Health Network of California, Inc. (Blue Zones Health Network 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
California Health and Wellness Plan (CA Health and Wellness)	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 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
CCA Health Plans of California, Inc. (CCA Health 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
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
Central 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
Champion 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)	5	0.4%	350,761	0.14	3	0.09	1	0.03	0	0.00	0	0.00	1	0.03	2	0.06	3	0.09
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 (Balance by CCHP)	10	0.7%	6,871	14.55	1	1.46	2	2.91	9	13.10	0	0.00	0	0.00	4	5.82	3	4.37
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.	30	2.2%	107,924	2.78	3	0.28	11	1.02	16	1.48	0	0.00	1	0.09	11	1.02	2	0.19
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.	1	0.1%	15,860	0.63	0	0.00	1	0.63	0	0.00	0	0.00	0	0.00	1	0.63	0	0.00
Community Family Care 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
Community Health Group	0	0.0%	9,378	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Contra Costa County Medical Services (Contra Costa Health Plan)	58	4.3%	267,907	2.16	20	0.75	32	1.19	4	0.15	0	0.00	10	0.37	9	0.34	20	0.75
County of Ventura (Ventura County Health Care Plan)	3	0.2%	9,068	3.31	1	1.10	2	2.21	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
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
Elite 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
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
Family Choice 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
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
Golden Bay Health, Inc. (Golden Bay 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

California Department of Managed Health Care

2025 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
Guidant 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
Healthy Valley 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
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
Humana Health Plan of Texas, 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 County Local Health Authority (Community Health Plan of Imperial Valley)	13	1.0%	97,368	1.34	8	0.82	2	0.21	1	0.10	0	0.00	0	0.00	4	0.41	6	0.62
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
Kern Health Systems	37	2.7%	399,242	0.93	16	0.40	27	0.68	0	0.00	0	0.00	2	0.05	6	0.15	6	0.15
L.A. Care Health Plan Joint Powers Authority	30	2.2%	51,765	5.80	4	0.77	9	1.74	16	3.09	0	0.00	1	0.19	10	1.93	10	1.93
LaSalle 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
MedCare Partners, Inc. (MedCare Partners 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
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)	2	0.1%	16,477	1.21	0	0.00	1	0.61	0	0.00	0	0.00	0	0.00	0	0.00	1	0.61
MemorialCare Select 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
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
New Century Health Plan, Inc. (UCLA Health Medicare Advantage Plan)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
On Lok Senior Health Services	2	0.1%	2,067	9.68	1	4.84	0	0.00	0	0.00	0	0.00	0	0.00	1	4.84	1	4.84
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	9	0.7%	0	0.00	0	0.00	1	0.00	8	0.00	0	0.00	0	0.00	3	0.00	0	0.00
Partnership HealthPlan of California***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PIH Health Care Solutions	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Health Plan Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PRIMECARE Medical Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PromiseCare 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
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
Rios 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
San Francisco Health Authority (San Francisco Health Plan)	19	1.4%	188,097	1.01	6	0.32	6	0.32	3	0.16	0	0.00	2	0.11	8	0.43	2	0.11
San Mateo Health Commission (Health Plan of San Mateo)	11	0.8%	143,217	0.77	5	0.35	6	0.42	1	0.07	0	0.00	0	0.00	2	0.14	1	0.07
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)	48	3.5%	54,484	8.81	12	2.20	32	5.87	12	2.20	5	0.92	4	0.73	17	3.12	4	0.73
Santa Clara County Health Authority (Santa Clara Family Health Plan)	43	3.2%	288,487	1.49	18	0.62	22	0.76	4	0.14	1	0.03	3	0.10	7	0.24	12	0.42
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Central California Alliance for Health)***	0	0.0%	731	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%	20,834	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.	9	0.7%	18,592	4.84	1	0.54	8	4.30	0	0.00	0	0.00	0	0.00	2	1.08	1	0.54
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	104	7.7%	154,291	6.74	12	0.78	55	3.56	45	2.92	3	0.19	6	0.39	27	1.75	30	1.94
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	4	0.3%	60,865	0.66	1	0.16	0	0.00	3	0.49	0	0.00	0	0.00	0	0.00	0	0.00
Starlife Holdings Inc. (Starlife 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
Sutter Health Alliance (Sutter Health Plan)	93	6.9%	118,260	7.86	12	1.01	39	3.30	43	3.64	9	0.76	1	0.08	37	3.13	18	1.52
UHC of California (UnitedHealthcare of California)	337	24.8%	377,613	8.92	51	1.35	198	5.24	129	3.42	6	0.16	5	0.13	129	3.42	58	1.54
UnitedHealthcare Benefits Plan of California	238	17.5%	331,671	7.18	11	0.33	51	1.54	189	5.70	6	0.18	3	0.09	78	2.35	26	0.78
Universal Care, Inc. (Bright HealthCare)**	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
Universal 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
Ventura County Medi-Cal Managed Care Commission (Gold Coast 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
WellCare of California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Health Advantage	111	8.2%	132,485	8.38	22	1.66	45	3.40	45	3.40	13	0.98	1	0.08	36	2.72	17	1.28
Total Full Service - Enrollment Under 400,000:	**1,357**	**100.0%**	**3,592,592**	**3.78**	**244**	**0.68**	**617**	**1.72**	**568**	**1.58**	**50**	**0.14**	**48**	**0.13**	**435**	**1.21**	**245**	**0.68**
Total All Full Service Plans:	**10,951**	**100.0%**	**24,567,009**	**4.46**	**2,020**	**0.82**	**4,436**	**1.81**	**4,495**	**1.83**	**824**	**0.34**	**347**	**0.14**	**3,705**	**1.51**	**2,369**	**0.96**

California Department of Managed Health Care

2025 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
CHIROPRACTIC																		
ACN Group of California, Inc. (OptumHealth Physical Health of California)	0	0.0%	89,530	0.00	0	0.00	0	0.00	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%	64,980	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:	**0**	**0.0%**	**154,510**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
DENTAL																		
Access Dental Plan	4	4.8%	10,599	3.77	2	1.89	1	0.94	1	0.94	0	0.00	0	0.00	1	0.94	0	0.00
Aetna Dental of California Inc.	2	2.4%	82,816	0.24	1	0.12	0	0.00	1	0.12	0	0.00	0	0.00	2	0.24	0	0.00
California Dental Network, Inc. (DentaQuest)	5	6.0%	116,456	0.43	0	0.00	2	0.17	1	0.09	1	0.09	0	0.00	1	0.09	4	0.34
Cigna Dental Health of California, Inc.	3	3.6%	184,112	0.16	0	0.00	2	0.11	0	0.00	2	0.11	0	0.00	0	0.00	0	0.00
Consumer Health, Inc. (Newport Dental Plan)	0	0.0%	6,125	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.	1	1.2%	107,468	0.09	1	0.09	0	0.00	1	0.09	0	0.00	0	0.00	0	0.00	1	0.09
Dental Health Services	2	2.4%	24,961	0.80	0	0.00	0	0.00	2	0.80	0	0.00	0	0.00	0	0.00	2	0.80
Liberty Dental Plan of California, Inc. (Personal Dental Services)	52	62.7%	530,130	0.98	8	0.15	45	0.85	3	0.06	3	0.06	1	0.02	10	0.19	13	0.25
Managed Dental Care	0	0.0%	72,399	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
SafeGuard Health Plans, Inc. (MetLife)	11	13.3%	168,540	0.65	2	0.12	3	0.18	5	0.30	2	0.12	0	0.00	4	0.24	3	0.18
Starmount Managed Dental of California, Inc. (Unum Dental HMO 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
UDC Dental California, Inc. (United Dental Care of California, Inc.)	0	0.0%	21,210	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.	2	2.4%	46,558	0.43	0	0.00	1	0.21	1	0.21	0	0.00	0	0.00	1	0.21	0	0.00
Western Dental Services, Inc. (Western Dental Plan)	1	1.2%	110,091	0.09	0	0.00	0	0.00	1	0.09	0	0.00	1	0.09	0	0.00	1	0.09
Total Dental:	**83**	**100.0%**	**1,481,465**	**0.56**	**14**	**0.09**	**54**	**0.36**	**16**	**0.11**	**8**	**0.05**	**2**	**0.01**	**19**	**0.13**	**24**	**0.16**
DENTAL/VISION																		
Delta Dental of California	477	100.0%	3,712,962	1.28	23	0.06	228	0.61	251	0.68	29	0.08	2	0.01	179	0.48	167	0.45
First Dental 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
Total Dental/Vision:	**477**	**100.0%**	**3,712,962**	**1.28**	**23**	**0.06**	**228**	**0.61**	**251**	**0.68**	**29**	**0.08**	**2**	**0.01**	**179**	**0.48**	**167**	**0.45**
DISCOUNT																		
The CDI Group, Inc.	1	100.0%	32,649	0.31	0	0.00	0	0.00	0	0.00	1	0.31	0	0.00	0	0.00	0	0.00
Total Discount:	**1**	**100.0%**	**32,649**	**0.31**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**1**	**0.31**	**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)																		
Carelon Behavioral Health of California, Inc.	0	0.0%	286,195	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Claremont Behavioral Services, Inc. (Claremont EAP)	0	0.0%	103,851	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%	165,893	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%	95,145	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Evernorth Behavioral Health of California, Inc.	0	0.0%	68,547	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%	153,080	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%	1,812,813	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	0.0%	75,558	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Human Affairs International of California (HAI-CA)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Magellan Health Services of California, Inc. - Employer Services	0	0.0%	712,176	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Modern Life CA, 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
Spring Care of California, Inc. (Spring Health)	0	0.0%	116,007	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
TELUS Health (California) Ltd. (LifeWorks)	0	0.0%	72,623	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)	2	100.0%	776,957	0.03	0	0.00	1	0.01	0	0.00	0	0.00	1	0.01	1	0.01	1	0.01
Total Behavioral Health (Psychological):	**2**	**100.0%**	**4,438,845**	**0.00**	**0**	**0.00**	**1**	**0.00**	**0**	**0.00**	**0**	**0.00**	**1**	**0.00**	**1**	**0.00**	**1**	**0.00**

California Department of Managed Health Care

2025 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
VISION																		
EyeMax Vision 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
EYEXAM of California, Inc.	0	0.0%	435,203	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
FirstSight Vision Services, Inc. (America's Best Vision Plan)	0	0.0%	222,715	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
FYidoctors 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
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%	9,943	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	11	100.0%	3,253,040	0.03	0	0.00	6	0.02	6	0.02	3	0.01	0	0.00	5	0.02	0	0.00
Total Vision:	**11**	**100.0%**	**3,920,901**	**0.03**	**0**	**0.00**	**6**	**0.02**	**6**	**0.02**	**3**	**0.01**	**0**	**0.00**	**5**	**0.01**	**0**	**0.00**
Total Specialty Plans:	**574**	**100.0%**	**13,741,332**	**0.42**	**37**	**0.03**	**289**	**0.21**	**273**	**0.20**	**41**	**0.03**	**5**	**0.00**	**204**	**0.15**	**192**	**0.14**
Grand Totals:	**11,525**	**100.0%**	**38,308,341**	**3.01**	**2,057**	**0.54**	**4,725**	**1.23**	**4,768**	**1.24**	**865**	**0.23**	**352**	**0.09**	**3,909**	**1.02**	**2,561**	**0.67**

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 2025.

*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).

DEPARTMENT OF
Managed
Health Care

Published September 2026