DEPARTMENT OF
Managed
Health Care

Health Care Service Plans' Provider Dispute Resolution Mechanisms

2025 Annual Report

March 3, 2026

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I. Executive Summary

The California Department of Managed Health Care (DMHC) ensures health plan members have access to equitable, high-quality, timely, and affordable health care within a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) under the Knox-Keene Health Care Service Plan Act of 1975. The DMHC regulates the vast majority of commercial health plans and products in the large group, small group, and individual markets, including most of the health plans that participate in Covered California. The DMHC also regulates Medi-Cal managed care plans, Medicare Advantage plans, and specialized health plans, including dental and vision plans.

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

As required by Health and Safety Code section 1375.7(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2025 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2024 through September 30, 2025.

Key Findings

Full Service Health Plans

Full service health plans are health plans that provide all of the basic health care services and mandated benefits required under the Knox-Keene Act.

- There are 57 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f).[1]
- Full service health plans processed approximately 215 million claims in the reporting period. Approximately 1.2% of these claims resulted in disputes.

[1] There were 99 licensed full service health plans on September 30, 2025. However, 42 licensed full service health plans are excluded from the report because they are licensed only for Medicare products, are operating as a county organized health system, exempt from Health and Safety Code section 1367(h), or had no enrollment in California.

- Full service health plans received approximately 2.6 million provider disputes for the reporting period.
- Approximately 97% of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.
- Approximately 92% of provider disputes filed with full service health plans involved claims payment issues.
- Providers prevailed in 29% of all disputes and health plans upheld their original determinations in 63% of the disputes. Eight percent of the disputes were pending at the time the full service health plans reported this data to the DMHC.

Specialized Health Plans

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

- There are 36 licensed specialized health plans subject to the provider dispute reporting requirements of section 1375.7(f).
- Specialized health plans processed approximately 40 million claims in the reporting period. Less than a tenth of 1% (0.04%) of these claims were the subject of a payment dispute.
- Specialized health plans received 17,127 provider disputes for the reporting period. Approximately 88% of disputes involved claims payment issues.
- Specialized health plans reported 39% of all provider disputes were resolved in favor of the provider, 56% were upheld by the plans, and 5% of disputes were pending as of September 30, 2025.

Capitated Providers

Capitated providers are providers such as hospitals, risk bearing organizations, or provider groups that contract with a full service health plan to assume the financial risk and pay claims for the provision of health care services to the members.

- Full service health plans reported data on 232 capitated providers.
- Capitated providers processed approximately 61 million claims and received approximately 1.3 million provider disputes in the reporting period.
- Approximately 93% of disputes involved claims payment issues.
- Approximately 29% of all reported provider disputes with capitated providers were resolved in favor of the provider.

II. Introduction

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards for payment of provider claims for services rendered on or after January 1, 2004.[2]

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

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

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

(3) The timeliness of dispute resolution determinations; and

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

Health plans are required to summarize their provider dispute results in three categories:

- Claim Payment Disputes - Provider complaints relating to the health plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.
- Utilization Management Disputes - Provider complaints relating to medical necessity and authorization determinations.
- Other Disputes - Provider complaints relating to non-monetary issues, such as member eligibility and assignment matters, and provider credentialing and certification.

This report reflects information reported by health plans for October 1, 2024 through September 30, 2025.

[2] See California Code of Regulations, Title 28, sections 1300.71 and 1300.71.38.

The DMHC conducts regular auditing activities, and reviews quarterly and annual claims payment and dispute resolution reports to monitor the industry's compliance with claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71. The DMHC implements appropriate corrective actions for any identified claims payment deficiencies and monitors them accordingly.

Providers who are not satisfied with the resolution of their disputes may contact the DMHC Provider Complaint Section. Additional information regarding the provider complaint process can be found in the DMHC's Provider Complaint Section.

The claim and provider dispute examination results are located in the DMHC's Financial Examination Reports Section.

III. Full Service Health Plans

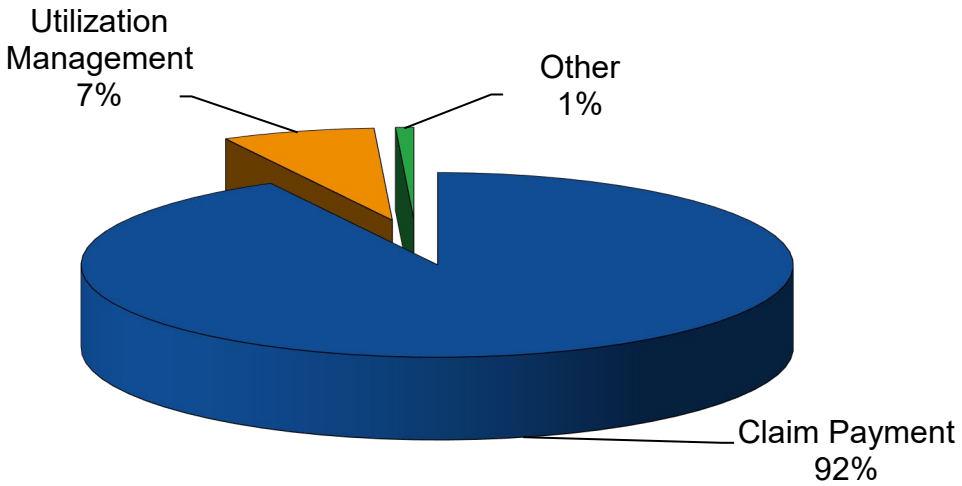
This report reflects information reported by health plans for October 1, 2024 through September 30, 2025.

Of the 99 licensed full service health plans, data from 57 full service health plans are included in this report. Forty-two licensed full service health plans are excluded from the report because they met one or more of the following criteria: licensed only for Medicare products, operate as a county organized health system, exempt from Health and Safety Code section 1367(h), were in pre-operations, or have no enrollment in California.

The 57 full service health plans reported approximately 215 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested, or denied. The reporting full service health plans received 2,579,351 provider disputes during the 2025 reporting period. This represents a 20% increase in the total amount of claims processed, and 16% increase in disputes since 2024.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 92% of the full service health plan provider disputes (See Chart 1).

Chart 1
Provider Disputes – Full Service Health Plans



Total Number of Claim Payment Disputes:	2,379,164
Total Number of Utilization Management Disputes:	178,933
Total Number of Other Disputes:	21,254

Regulations require the health plans to resolve 95% of all completed provider disputes within 45 working days. Collectively, the full service health plans reported that 97% of all provider disputes were resolved within 45 working days.

Twelve health plans reported noncompliance with the 45 working day requirement to resolve disputes. Health plans that fall below the 95% compliance requirement are required to file and implement a corrective action plan that is monitored by the DMHC quarterly and reviewed as part of the health plan's routine financial examination. Deficient health plans reported that timeliness standards were not met due to a variety of factors. These factors include staffing issues, integration issues with new vendors, and an increased volume of provider disputes caused by the implementation of claim system changes or inaccurate claim determinations. Health plans indicated that corrective action plans have been instituted to improve timeliness going forward. The corrective actions include adding additional staff to process disputes, implementing new processes for inventory management, implementing new tools to improve dispute turnaround time and monitor for claim system failure, collaborating with providers to reduce avoidable disputes, conducting routine monitoring to increase oversight for dispute processing, and educating claims processing staff. Health plans collectively improved in their provider dispute resolution timeliness percentages by three percentage points from 94% in 2024 to 97% in 2025.

Provider Disputes Compared to Claims

Approximately 79% of provider claims processed were paid or adjusted by the health plans, and 21% were contested or denied. Nearly all claims (approximately 98%) were processed within 45 working days.

Approximately 215 million claims were processed during the reporting period. Over two million (2,579,351) of these claims were disputed by providers. This represents approximately 1.2% of all claims processed by full service health plans.

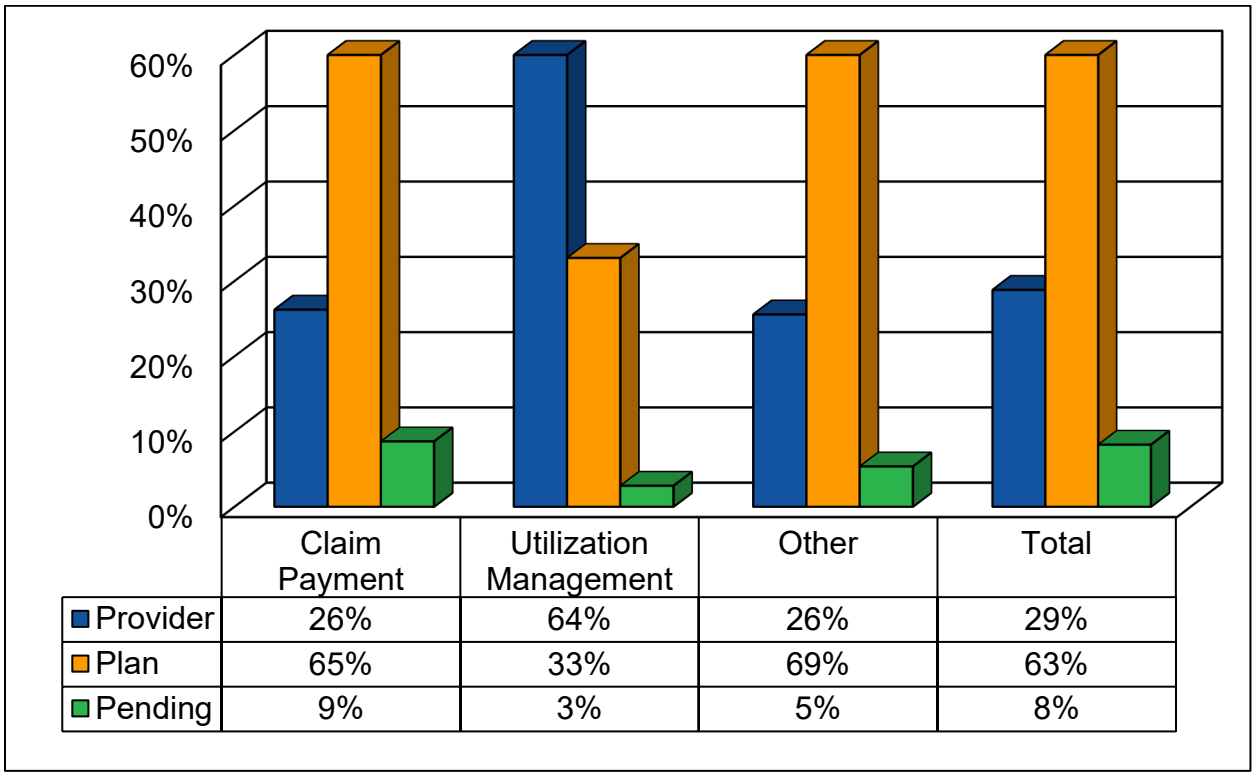
Disposition of Full Service Health Plan Provider Disputes

For the 2025 reporting period, full service health plans reported that 29% of all disputes between providers and health plans were resolved in favor of the provider compared to 30% of provider disputes in 2024.

Of the 2,579,351 provider disputes submitted, 743,341 (29%) disputes resolved in favor of the provider, 1,623,270 (63%) in favor of the plan, and 212,740 (8%) were pending review as of September 30, 2025 (See Chart 2).

Chart 2

Resolution of Provider Disputes – Full Service Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	26%	64%	26%	29%
Plan	65%	33%	69%	63%
Pending	9%	3%	5%	8%

Seven Largest Full Service Health Plans

California's seven largest full service health plans[3] provide health care benefits to approximately 18.8 million members, representing 62% of the over 30.2 million members enrolled in health plans licensed by the DMHC. For the 2025 reporting period, approximately 71% of provider disputes were filed with these seven plans. Collectively, they processed approximately 154 million claims, accounting for roughly 72% of all claims processed by full service health plans in California (See Table 1).

[3] California's seven largest full service health plans are Blue Cross of California (Anthem Blue Cross), Blue Cross of California Partnership Plan, Inc., California Physicians' Service (Blue Shield of California), Health Net Community Solutions, Inc., Inland Empire Health Plan (IEHP), Kaiser Foundation Health Plan, Inc. (Kaiser Permanente), and Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan).

Table 1
Seven Largest Full Service Health Plans

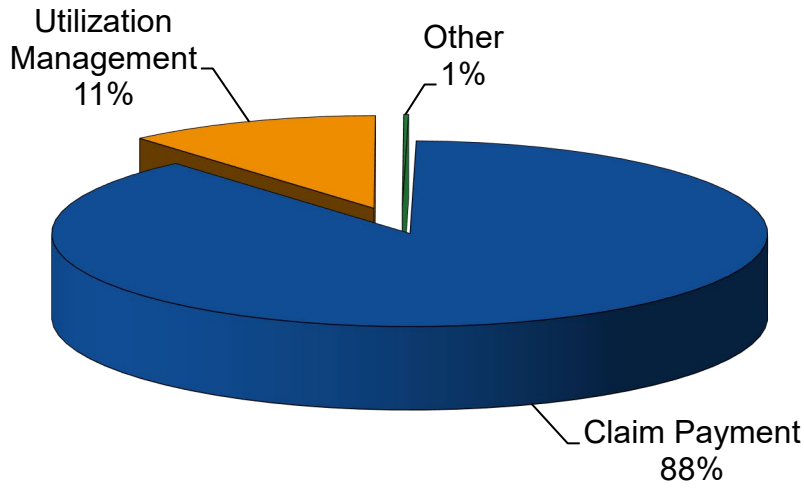
Health Plan	Enrollment as of 9/30/25	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	2,119,739	52,665,924	338,238	127,020 (37%)	211,212 (62%)	6 (1%)	98%
Blue Cross of California Partnership Plan, Inc.	791,239	5,906,097	251,684	128,773 (51%)	122,903 (48%)	8 (1%)	97%
Blue Shield of California	2,300,489	32,273,034	310,352	46,169 (15%)	236,246 (76%)	27,937 (9%)	96%
Health Net Community Solutions, Inc.	1,572,707	9,070,371	120,090	33,308 (28%)	75,549 (63%)	11,233 (9%)	99%
Inland Empire Health Plan	1,528,130	20,123,643	157,004	15,174 (10%)	109,457 (70%)	32,373 (20%)	93%
Kaiser Permanente	7,899,786	11,447,196	292,993	48,836 (17%)	221,327 (75%)	22,830 (8%)	100%
L.A. Care Health Plan	2,547,127	22,871,926	364,093	88,029 (24%)	195,148 (54%)	80,916 (22%)	97%
Total - Seven Largest Health Plan	**18,759,217**	**154,358,191**	**1,834,454**	**487,309 (27%)**	**1,171,842 (64%)**	**175,303 (9%)**	**98%**
All Other Full Service Health Plans	**11,641,762**	**60,295,176**	**744,897**	**256,032 (34%)**	**451,428 (61%)**	**37,437 (5%)**	**96%**
Total - All Full Service Health Plans	**30,400,979**	**214,653,367**	**2,579,351**	**743,341 (29%)**	**1,623,270 (63%)**	**212,740 (8%)**	**97%**

IV. Specialized Health Plans

There are 40 licensed specialized health plans and data from 36 specialized health plans are included in this report. Specialized health plans licensed only for Medicare products or that have no enrollment in California are excluded from the report.

The 36 specialized health plans processed approximately 40 million provider claims and received 17,127 provider disputes. There was a 26% increase in the number of disputes in the 2025 reporting period compared to 2024. Approximately 93% of the provider disputes were resolved within 45 working days and a majority of provider disputes submitted to specialized health plans involved claim payment disputes. Chart 3 shows the breakdown of provider disputes.

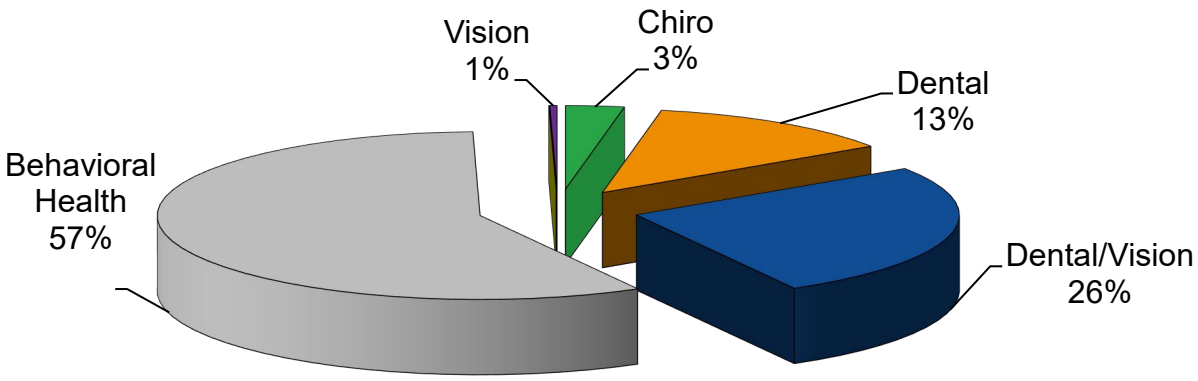
Chart 3
Provider Disputes – Specialized Health Plans



Total Number of Claim Payment Disputes:	15,133
Total Number of Utilization Management Disputes:	1,957
Total Number of Other Disputes:	37

Of the 17,127 provider disputes submitted to specialized health plans during the 2025 reporting period, behavioral health plans accounted for approximately 57% of the disputes, followed by dental plans (including dental/vision plans) with 39% of the disputes, chiropractic plans with 3%, and vision plans with 1%. (See Chart 4).

Chart 4
Provider Disputes by Type of Specialized Health Plans

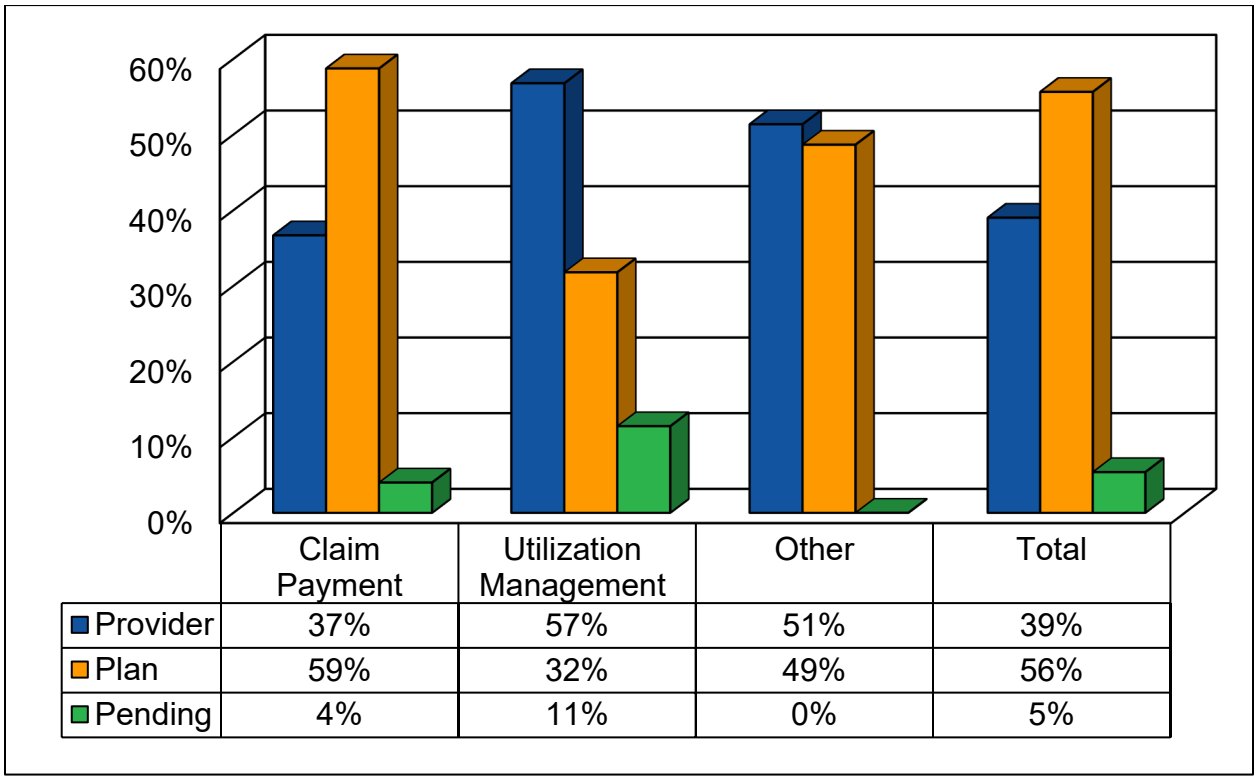


Total Disputes by Specialized Plan Type	2025
Behavioral Health	9,890
Dental/Vision	4,495
Dental	2,178
Chiropractic	502
Vision	62

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 39% of all provider disputes were resolved in favor of the provider, a five percent decrease from the prior year. Thirty-seven percent of disputes involving claims payment issues were resolved in favor of the provider while 59% of disputes were resolved in favor of the plan, and four percent were pending at year-end. Utilization management disputes were resolved in favor of providers 57% of the time, 32% were in favor of the plan, and 11% were pending at year-end. Other disputes were resolved in favor of providers 51% of the time and 49% in favor of the plan (See Chart 5).

Chart 5
Resolution of Provider Disputes - Specialized Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	37%	57%	51%	39%
Plan	59%	32%	49%	56%
Pending	4%	11%	0%	5%

V. Capitated Providers

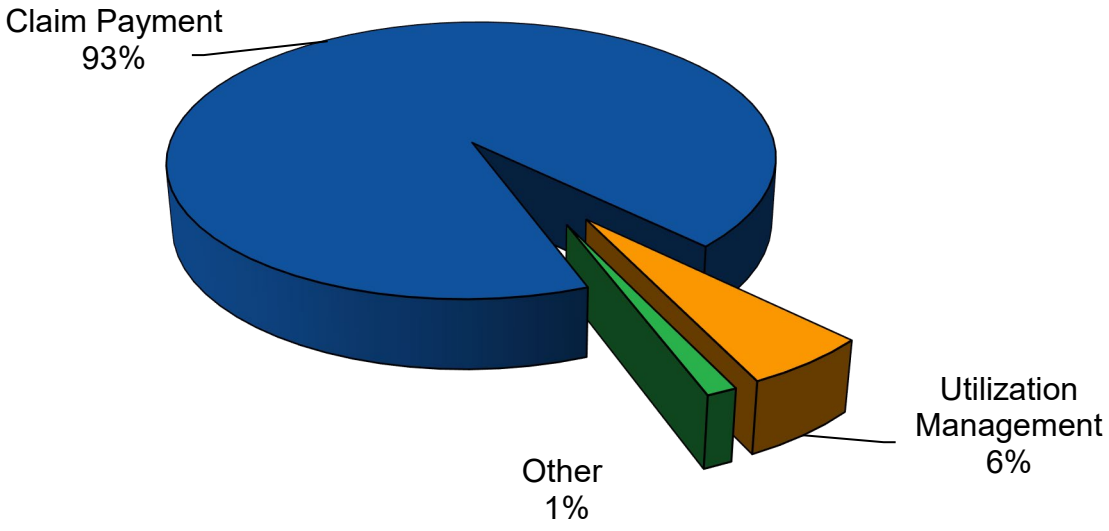
Capitated providers contract with health plans and are responsible for processing and paying claims. Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's members. Capitation is a prepaid amount received or paid out, based on the number of members assigned to an organization. This arrangement is usually expressed in units or per member per month (PMPM) payments.

All health plans are required to compile and provide a dispute resolution report for each capitated provider or provider group. Based upon the number of filings received, the DMHC has identified 232 capitated providers that were contracted with full service health plans.

Health plans reported a total of 1,286,061 provider disputes filed with capitated providers during the reporting period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. Capitated providers must also file an annual provider dispute report with each of its contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 61 million claims in the 2025 reporting period. Ninety-three percent of provider disputes involved claim payment issues. Chart 6 reflects the breakdown of provider disputes.

Chart 6
Provider Disputes – Capitated Providers



Total Number of Claim Payment Disputes:	1,196,775
Total Number of Utilization Management Disputes:	71,888
Total Number of Other Disputes:	17,398

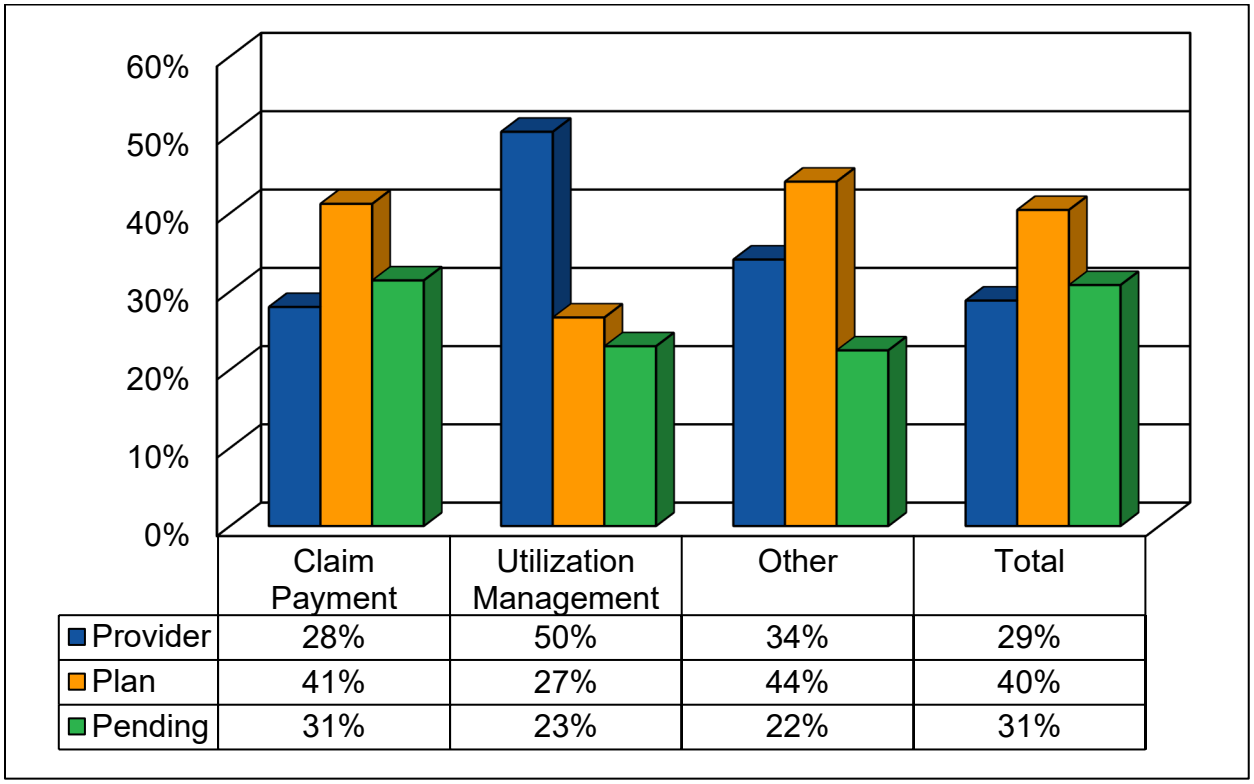
Approximately 85% of all claims processed were paid or adjusted and 15% of the claims processed were contested or denied. Capitated providers processed approximately 99% of claims within the 45-day statutory requirement. For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes.

Disposition of Capitated Providers' Provider Disputes

The capitated providers had an approximately 29% increase in the number of disputes in the 2025 reporting period compared to 2024. Of the 1,286,061 provider disputes submitted, 29% were resolved in favor of the provider, 40% were resolved in favor of the plan, and 31% were pending review as of September 30, 2025.

Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7
Resolution of Provider Disputes – Capitated Providers



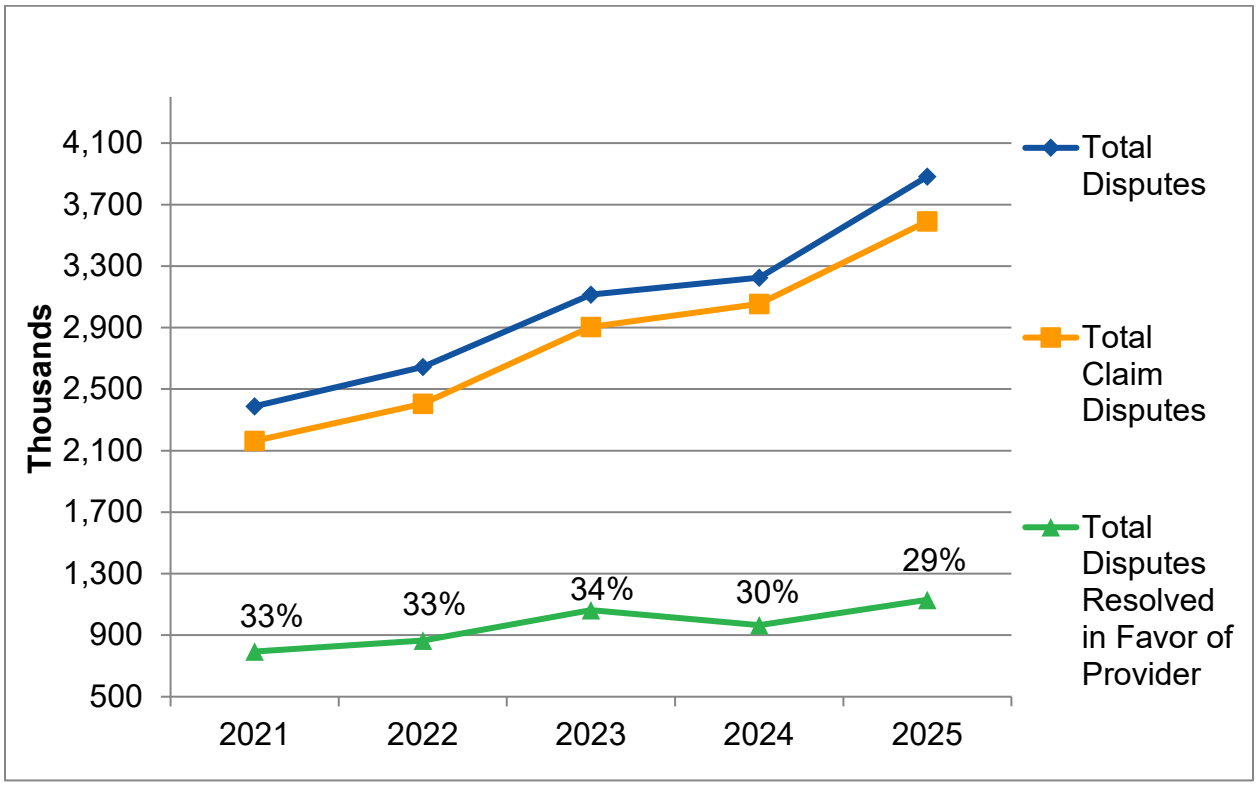
	Claim Payment	Utilization Management	Other	Total
Provider	28%	50%	34%	29%
Plan	41%	27%	44%	40%
Pending	31%	23%	22%	31%

VI. Provider Dispute Trends

Chart 8 displays the trend for the volume of disputes reported by full service health plans, specialized health plans, and capitated providers over a five year period. The blue line represents the total number of disputes reported, the orange line represents total claim disputes reported, and the green line represents the total number of disputes in favor of the provider.

From 2024 to 2025, provider disputes increased from 3.2 million to 3.9 million, representing a 20% increase. The number of disputes resolved in favor of the provider has fluctuated between 29% and 34% over the five-year period. For 2025, 29% of provider disputes were resolved in favor of the provider.

Chart 8
Five Year Provider Dispute Information



VII. Summary

The number of provider disputes represents roughly one percent of the total amount of claims processed for 2025. Health plans reported resolving 97% of provider disputes within the required 45-day time frame, a three percent increase from the prior reporting period.

The percentage of provider disputes resolved by health plans in favor of the provider was 29% in the 2025 reporting period, a one percent decrease from the prior reporting period.

There was a 26% increase in provider disputes received by specialized health plans. Thirty-nine percent of the provider disputes filed were resolved in favor of the provider, a five percent decrease from the prior reporting period.

Approximately 29% of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 31% of these disputes pending as of September 30, 2025.

The provider dispute resolution data summarized in this report is self-reported by health plans and capitated providers. There may be substantive differences in the way health plans and capitated providers identify, quantify, and track provider disputes. The DMHC will continue to work with the health plans to ensure consistent reporting with the updated instructions for the claims and provider dispute reporting by health plans and capitated providers.

In 2024, Governor Newsom signed AB 3275 (Soria) which addressed claims reimbursement. This bill changed the timeframes for health plans to reimburse, contest or deny claims from 30 and 45 working days to 30 calendar days. In addition, member complaints to a health plan about delay or denial of payment of a claim will be treated as a grievance. This bill took effect on January 1, 2026. The DMHC will monitor the impact of these new claims payment requirements on provider disputes and future reports will include information on the impact of AB 3275.