CELEBRATING MOMENTOUS ANNIVERSARIES

2014 ANNUAL REPORT

DEPARTMENT OF
Managed
HealthCare

Edmund G. Brown, Jr., Governor
State of California

Diana S. Dooley, Secretary
Health and Human Services Agency

Shelley Rouillard, Director
Department of Managed Health Care

DMHC MISSION, VALUES AND GOALS

MISSION

The DMHC protects consumers' health care rights and ensures a stable health care delivery system.

CORE VALUES

- **Integrity**
- **Leadership**
- **Commitment to Service**

GOALS

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

MESSAGE FROM THE SECRETARY

In 2015, we mark many important anniversaries in California's legacy as a leader in the health care marketplace. This year we celebrate the 40th anniversary of the Knox-Keene Act, the 15th anniversary of the California Department of Managed Health Care (DMHC) and the 5th anniversary of the Affordable Care Act (ACA).

With the passage of the Knox-Keene Act in 1975, California enacted the strongest patient protection laws in the nation. When the DMHC was founded in 2000, it became the first government department in the nation exclusively dedicated to protecting consumers' health care rights. California continued its leadership after the ACA was enacted in 2010, by becoming the first state in the nation to enact legislation creating a health benefit exchange. Covered California, the state's exchange, has become a national model demonstrating the success of the ACA.

In all of these anniversaries we celebrate how truly ground-breaking California has been in implementing a meaningful regulatory program that meets the changing needs of California's consumers and the health care marketplace.

I congratulate the DMHC and its dedicated employees for continuing to provide leadership in protecting consumers' rights and laying a strong foundation for health care regulation in California.

Diana S. Dooley, JD
Secretary
California Health and Human Services Agency

MESSAGE FROM THE DIRECTOR

I am proud to present this report in celebration of so many momentous anniversaries this year: the 15th anniversary of the Department of Managed Health Care (DMHC); the 40th anniversary of the Knox-Keene Health Care Service Plan Act of 1975; and, the 5th anniversary of federal health care reform. This report highlights the many accomplishments and successes the Department has achieved over the years, celebrates California's decades of leadership in health care, and serves as the annual report for 2014.

The DMHC protects the health care rights of more than 25 million Californians. I take this work very seriously, as I have spent more than 25 years working as a consumer advocate. I am excited to be at the helm of the Department during this historic time in California, and I strive to always consider the impacts our decisions have on consumers.

The DMHC's mission is to protect consumers' health care rights and ensure a stable health care delivery system. We are committed to fulfilling this mission by ensuring the Department's work reflects our core values of integrity, leadership and commitment to service.

The DMHC Help Center is the heart of the Department, fielding consumer inquiries and questions about health care coverage and identifying the best and most appropriate recourse for resolving consumer complaints. In 2014, the Help Center assisted more than 100,000 consumers. This is an increase of nearly 60 percent from the previous year, and is directly related to the substantial increase in the number of consumers obtaining coverage as a result of the Affordable Care Act.

I want to encourage all Californians experiencing an issue with their health plan, or who have questions about their coverage, to contact our Help Center for assistance at 888-466-2219 or online at www.HealthHelp.ca.gov.

Looking forward, we will be paying close attention to the changes occuring in the health care marketplace, in particular, scrutinizing recent health plan merger proposals. These proposed transactions have generated a significant amount of public interest, and the DMHC's review will be thorough, structured and deliberative. Before approving these mergers or acquisitions, the DMHC will ensure they ultimately benefit Californians.

In closing, I would like to thank both current and former DMHC employees for their dedication to our mission as well as their integrity, leadership and commitment to service. I am honored to serve the people of California as the Director of the DMHC with such mission-driven people.

Shelley Rouillard
Director
Department of Managed Health Care

TABLE OF CONTENTS

CELEBRATING MOMENTOUS ANNIVERSARIES

15 YEARS

The Department of Managed Health Care (DMHC) was created in 2000 as the first agency in the country dedicated solely to the regulation of managed health care plans and consumer assistance. The Department is consumer focused and dedicated to solution-oriented regulation.

- **More than 1.6 million consumers have received assistance and support through the Help Center which offers complaint resolution through telephone and online assistance**
- **More than 121 health plans provide health and specialized health coverage to more than 25 million Californians**
- **More than $50 million in payments owed to physicians and hospitals has been recovered**
- **More than $53 million in fines and penalties have been assessed on health plans that violated the law, and the DMHC has imposed changes in health plan operations to protect consumer rights**
- **DMHC has saved Californians more than $100 million in health care premiums through its premium rate review program**

5 YEARS

Enacted on March 23, 2010, the federal Affordable Care Act (ACA) is reshaping the nation's health care landscape.

- **As soon as the ACA passed, the DMHC provided leadership and support to craft and implement new laws and regulations**
- **The DMHC received $9.2 million in federal ACA grants to enhance consumer assistance and created strategic partnerships to help California consumers prepare for and understand ACA coverage options**
- **Under strict timelines, the DMHC conducted focused reviews of dozens of new health plan products and provider networks to ensure compliance with state and federal laws and consumer protections**
- **After one full year of ACA implementation, enrollment in DMHC-licensed health plans increased 28 percent over 2013 enrollment levels**

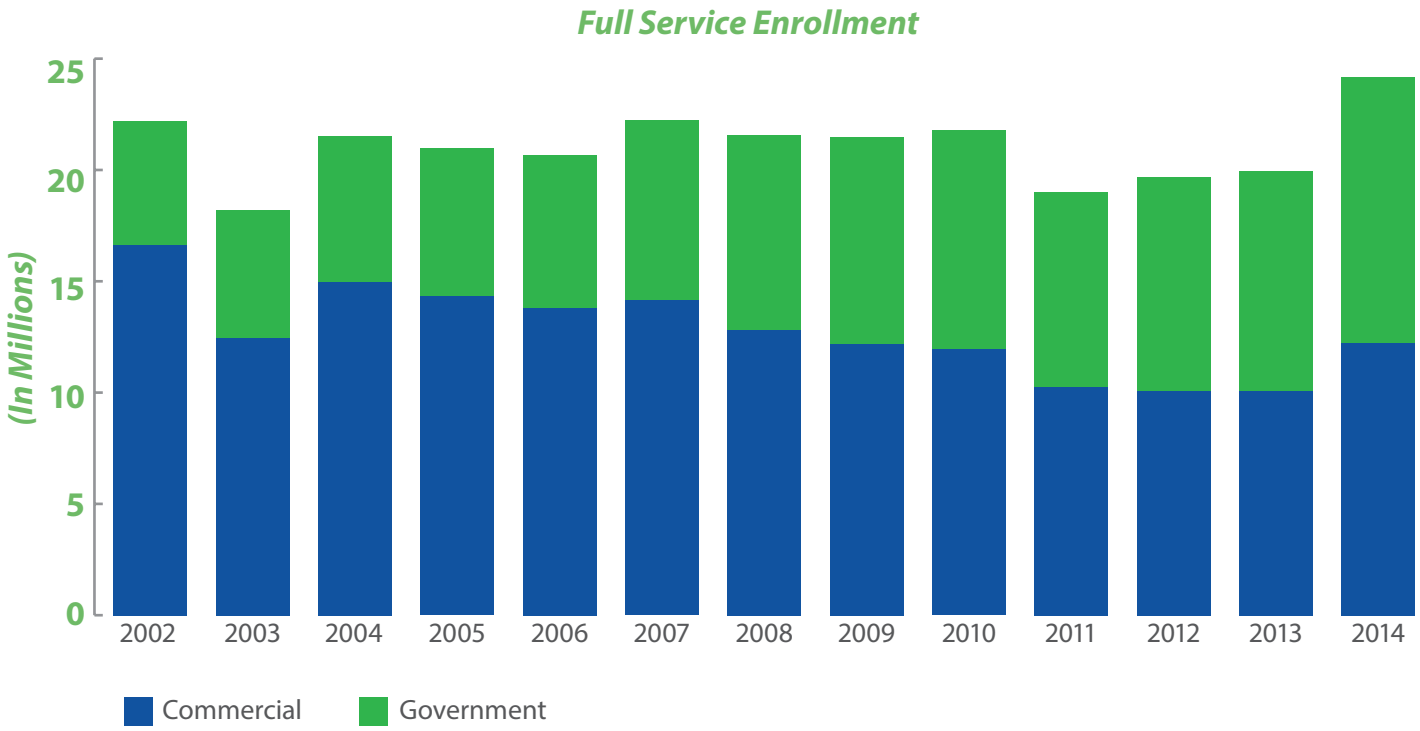
40 YEARS

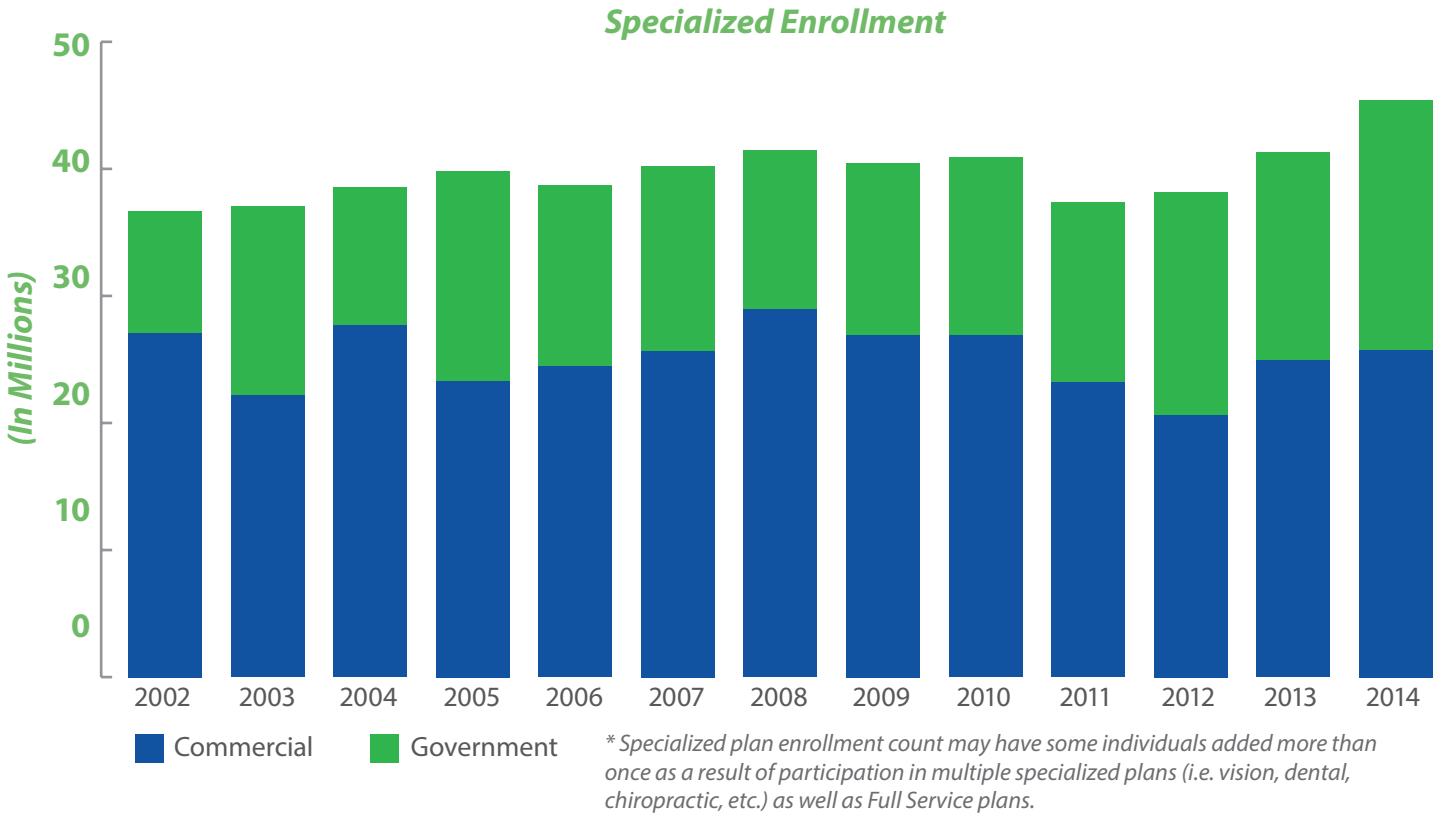
California's groundbreaking managed care statute, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), laid the foundation for robust regulation and consumer protections. The DMHC works with a large array of partners, including policymakers, other state agencies and stakeholders to continuously improve Knox-Keene standards as the managed care industry and the needs of consumers evolve.

DEPARTMENT OF Managed HealthCare

THE DMHC CELEBRATES MOMENTOUS ANNIVERSARIES

Fifteen years ago, the DMHC was created as the first state department in the country solely dedicated to regulating managed health care plans and assisting consumers to resolve disputes with health plans. Since then, the DMHC has assisted and empowered nearly 1.6 million consumers by educating them about their rights and helping them resolve complaints, navigate their coverage, and access needed health care services. The DMHC currently licenses 121 health plans (71 full service and 50 specialized plans) providing health care and specialized health care to more than 25 million Californians, representing 91% of the large-group market, 82% of the individual market and 77% of the small-group market[1]. In 2002, the first enrollment-reporting year under the DMHC, 99 health plans reported enrollment of just over 22 million.





** Specialized plan enrollment count may have some individuals added more than once as a result of participation in multiple specialized plans (i.e. vision, dental, chiropractic, etc.) as well as Full Service plans.*

The creation of the DMHC in 2000 capped decades of California leadership in consumer protection in oversight of managed health care. The DMHC administers a robust body of law, the Knox-Keene Act, this year marking 40 years since its landmark passage. With the enactment of Knox-Keene, California took an early lead in regulating and helping to shape the managed health care industry in the state. Knox-Keene has been refined, strengthened and improved over the years adjusting to market shifts and changing consumer needs and expectations. Further enhanced through enactment of federal health care reforms, Knox-Keene continues to provide a comprehensive framework for consumer rights and health plan standards unparalleled in other states.

The many protections included in Knox-Keene set the stage for the DMHC to effectively implement the ACA in California. For five years now, the DMHC has been working with policymakers, other state agencies, health plans, stakeholders and enrolled consumers to implement the ACA. After a full year of ACA coverage expansions and unprecedented market reforms, the DMHC is seeing a dramatic enrollment increase in its licensed health plans, particularly in Medi-Cal and individual coverage. This expansion includes consumers and employers obtaining new coverage through California's health benefit exchange, known as Covered California.

The ACA changed the fundamental rules of health insurance markets making it easier for consumers to obtain coverage regardless of age, health status or income. While the potential benefits to consumers are substantial, the law's complexities also mean that many consumers, some of whom have comprehensive health coverage for the very first time, face new questions and challenges. These challenges reinforce the need for the DMHC to help consumers understand and effectively use their health coverage.

As California celebrates these historic milestones, this report highlights current accomplishments, the Knox-Keene regulatory program history and the emerging challenges and opportunities facing the Department and the managed health care industry. The DMHC remains committed to improving the consumer health care experience through effective regulation, responsive consumer assistance and marketplace oversight.

15 YEARS OF CONSUMER PROTECTION

California leads the nation in setting high standards and expectations for health plan operations and health care delivery systems. California is in the forefront in identifying coverage and care issues where consumers need greater protection and developing innovative safeguards.

The DMHC has presided over many historic firsts in consumer health care rights. The table below highlights notable accomplishments from the DMHC's first 15 years.

MAJOR ACCOMPLISHMENTS: FIRST 15 YEARS OF THE DMHC

1999-2000 **DMHC Established.** The DMHC is created as the first stand-alone state department in the nation dedicated solely to the regulation of health care plans and the provision of consumer assistance to resolve problems with health plans. *[AB 78, Chapter 525, Statutes of 1999]*

1999 **Financial Solvency Standards Board (FSSB).** The FSSB is established under Section 1347.15 of the Knox-Keene Act. The board consists of eight-members—the Director and seven members appointed by the Director. The board is the first of its kind in the country. The board advises the Director on matters of financial solvency affecting the delivery of health care services. In the early years, the board focused on how to develop and implement a standardized set of financial solvency benchmarks that all providers and health plans would be required to follow. *[SB 260, Chapter 529, Statutes of 1999]*

2000 **Consumer Assistance.** The newly created consumer-focused DMHC opens the Help Center. The Help Center's trained staff assists consumers to resolve issues with health plans and monitors complaints for evidence of systemic health plan regulatory compliance problems.

2001 **Independent Medical Review.** California establishes the Independent Medical Review program, a legally binding system for external review of health plan denials of care. Since the program's inception, the DMHC has overseen nearly 19,000 reviews of plan denials (including overturned, reversed and upheld decisions). *[AB 55, Chapter 533, Statutes of 1999]*

2003 **Continuity of Care.** Following disruptive transfers of more than three million Californians affected by provider contract terminations, the DMHC works to secure legislation to provide continuity of care to at-risk patients. This allows terminally ill and pregnant consumers, and others with scheduled surgeries or procedures, to continue care with a terminated provider under specified circumstances. *[AB 1286, Chapter 591, Statutes of 2003]*

2003 **Timely Claims Payment.** The DMHC issues regulations requiring health plans to establish a fast, fair and cost-effective dispute resolution process with providers. These regulations require health plans to pay provider claims timely and accurately pursuant to specific regulatory criteria. *[AB 1455, Chapter 827, Statutes of 2000; 28 CCR 1300.71 and 1300.71.38 (2003)]*

2004-2005 **Community Investments.** In 2004, WellPoint and Anthem Blue Cross corporations merge, affecting control of Blue Cross of California. In 2005, PacifiCare of California merges with UnitedHealth Group. The DMHC conducts a thorough review of the mergers and potential impacts on consumers, and negotiates concessions associated with the corporate changes, including more than $450 million in community benefits for California consumers (including commitments from related companies regulated by California Department of Insurance). *[Chapter 941, Statutes of 1975]*

2005 **Provider Solvency.** In the wake of several high profile failures of medical groups contracted with health plans, legislation imposes stricter financial responsibilities on risk-bearing organizations (RBOs) and requires health plans to report on risk arrangements. After engaging external stakeholders and the FSSB in an extensive regulatory review process to establish appropriate financial survey reporting requirements and criteria, the DMHC establishes the Provider Solvency Unit to oversee and monitor RBO financial filings. *[SB 260, Chapter 529, Statutes of 1999]*.

2008 **Balance Billing Prohibition.** The practice of billing patients for disputed balances above what the health plan pays is commonly referred to as "balance billing." The DMHC enacts regulations protecting consumers from balance billing by emergency providers. The courts repeatedly affirm the balance billing prohibition. *[AB 138, Chapter 941, Statutes of 1975; 28 CCR 1300.71.39 (2008)]*

2008 **Cancellations and Rescissions.** The DMHC investigates and achieves a groundbreaking settlement with California's five largest health plans, including fines totaling nearly $14 million, for rescinding coverage after enrollees sought treatment or filed a claim. The Department requires the health plans to make major system changes and to contact more than 3,000 consumers with an offer of coverage and the opportunity to submit claims for out-of-pocket expenses.

2008 **Right Care Initiative.** Created to measurably improve clinical outcomes through enhancing the practice of patient-centered evidence based medicine. The Right Care Initiative is a public-private collaborative effort focused on preventing premature disability and death from heart attacks, strokes and diabetic complications.

2010 **Timely Access to Care.** The DMHC implements landmark regulations to ensure Californians get timely access to care when they need it. The regulations make California the first state in the nation to provide patients with predictable wait times for appointments, timeliness of referrals and response times for health plan telephone triage. It took eight years of negotiations, but the DMHC emerged with a strong, direct way to eliminate unnecessary delays for consumers. *[AB 2179, Chapter 797, Statutes of 2002; 28 CCR 1300.67.2.2 (2010)]*

2010-2014 **ACA Implementation.** The DMHC provides early leadership and technical expertise to support enactment of state legislation implementing the ACA and works diligently to update health plan standards and regulatory practices in advance of full implementation in 2014.

2011 **Consumer Assistance Program.** The DMHC receives the first of several federal ACA grants to work with the Office of the Patient Advocate, the California Department of Insurance and local community-based legal services advocates to enhance and expand consumer education and assistance. Additionally, the DMHC was designated California's Consumer Assistance Program, receiving federal grants to enhance consumer assistance and education efforts in the state.

2011 **Provider Claims Payment.** Routine financial examinations for the claims payment practices and provider dispute resolution mechanism requirements of the seven largest full-service health plans result in $1.6 million in penalties, $1.8 million in additional paid provider claims and $4.4 million in interest and penalties paid to providers.

2011 **Rate Review Program.** The DMHC establishes a premium rate review program to provide the public with information to enhance consumer understanding about rate changes in the individual and small group markets and promote more accountability within the health care industry. *[SB 1163, Chapter 661, Statutes of 2010]*

2012 **Transparency and Consumer Involvement.** The DMHC awards a grant to Consumers Union to bolster the Department's health plan rate review process. Consumers Union provides consumer-focused feedback on health plan rate filings and works with the Department on innovative ways to increase public engagement in the rate review process.

2012 **Autism Advisory Task Force.** The DMHC convenes the Autism Advisory Task Force. The Task Force developed recommendations regarding medically necessary behavioral health treatment for individuals with autism or pervasive developmental disorder, as well as the appropriate qualifications, training and education for providers of such treatment.

2013 **Coverage for Medical Therapies.** The DMHC takes action against six large health plans for improper denials of medically necessary therapies, such as speech and occupational therapy, and requires the health plans to reimburse enrollees for out-of-pocket costs incurred.

2013 **ACA Compliance.** The DMHC works under tight timelines to review health plan products, provider networks and rate filings ensuring 2014 coverage meets new federal and state requirements.

2013-2014 **Access to Mental Health Care.** The Department conducts a routine survey of behavioral health services in Kaiser and assesses $4 million in penalties for deficiencies in timely access to care.

2014 **Provider Directories.** The DMHC conducts non-routine surveys of Anthem Blue Cross and Blue Shield provider networks and directories for the individual market, resulting in significant corrective action plans and penalties.

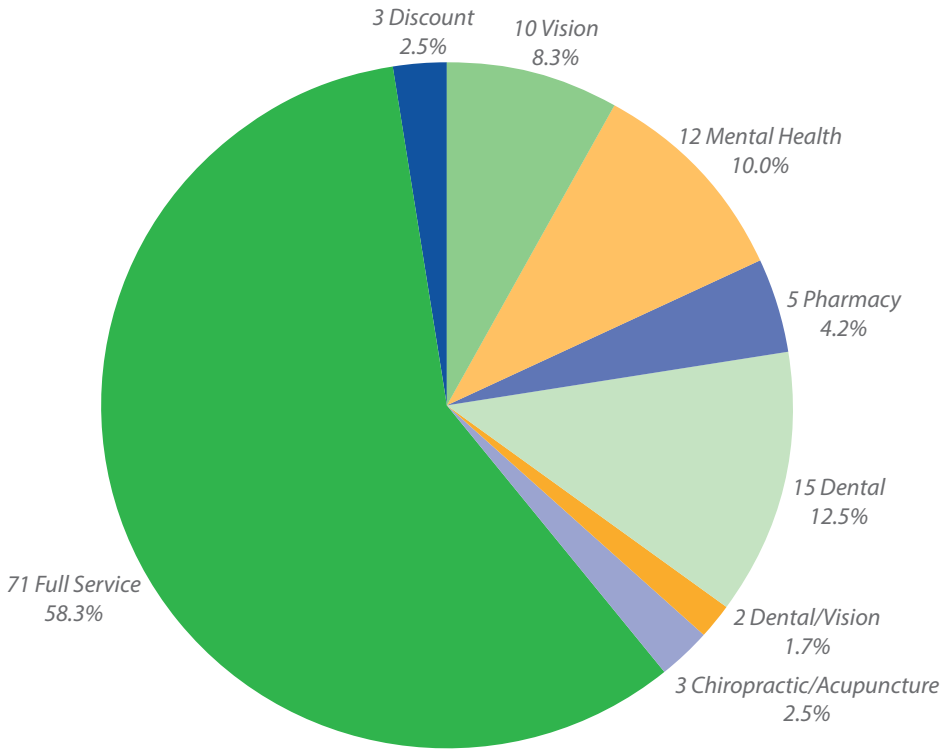
15 YEARS OF CONSUMER PROTECTION

The DMHC's current priorities reflect its legislative mandate as well as the history and evolution of the industry it regulates. For decades, California has been a testing ground in the development of pioneering managed care models and continues to be a laboratory for innovation. The Department's focus is to protect the rights of managed care enrollees while advancing coverage models that maximize access, quality and affordability. The DMHC does this by educating consumers about their rights and responsibilities, ensuring the financial stability of managed care plans, enforcing robust regulatory standards and assisting Californians in navigating the changing health care landscape.

Today, the DMHC licenses the full scope of managed care models, including all HMOs in the state, some Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs), and Point-of-Service products. The DMHC regulates the largest portion of enrollment in all three commercial insurance markets—individual, small group and large group. At the end of 2014, the DMHC regulated 82 percent of the individual market, 77 percent of the small-group market, and 91 percent of the large-group market. The DMHC also regulates health plans that provide services to nearly eight million Medi-Cal Managed Care enrollees.

In addition to full service health care plans, the DMHC licenses specialized health plans (e.g., dental, vision, behavioral health and pharmacy), discount health plans, and employee assistance programs. The DMHC currently licenses 71 full-service plans and 50 specialized plans.

Licensed Health Care Service Plans



2014 ANNUAL REPORT

To accomplish its goals, the DMHC is organized around six key functions: Consumer Help Center, Health Plan Licensing, Health Plan Surveys, Financial Oversight, Rate Review and Enforcement. The section below describes each of these functions in more detail and highlights recent activities and accomplishments.

CONSUMER HELP CENTER *

The Help Center is the heart of DMHC's consumer-focused approach, including consumer education, assistance and complaint resolution. The Help Center works with consumers to resolve coverage issues and other complaints and provides timely review and response to complaints (by law within 30 days). The Help Center is dedicated to ensuring that consumers understand their rights and receive prompt and effective responses to their health care concerns. Help Center patient rights advocates, health care professionals, and consumer service representatives are available to help consumers and provide services in 148 different languages.

The Help Center also administers the Independent Medical Review (IMR) Program, offering enrollees an external review of health plan denials of services. The IMR offers an objective review of enrollee medical requests by doctors outside their health plan. The IMR is available when a health plan denies, modifies or delays a health care service or treatment. Overall, enrollees receive the requested health care services under an IMR review in approximately 60 percent of cases[2].

2014 BY THE NUMBERS:

Help Center

102,067
Consumers assisted

92,257
Telephone inquiries

7,940[3]
Consumer complaints

1,870
Independent medical reviews

2014 Highlights

With full implementation of federal health reform in 2014, the Help Center saw a dramatic increase in the number of consumers seeking assistance. The year over year increase was nearly 60 percent, from 64,115 in 2013 to 102,067 in 2014. The graph on page 9 shows the breakdown of the types of complaints received in 2014.

The DMHC's partnership with California community-based organizations provides consumers with local hands-on assistance with enrollment into health coverage, filing of complaints and appeals, and informational materials about health coverage and health care reform. During 2014, approximately 15,386 consumers in California were educated and assisted through these partnerships.

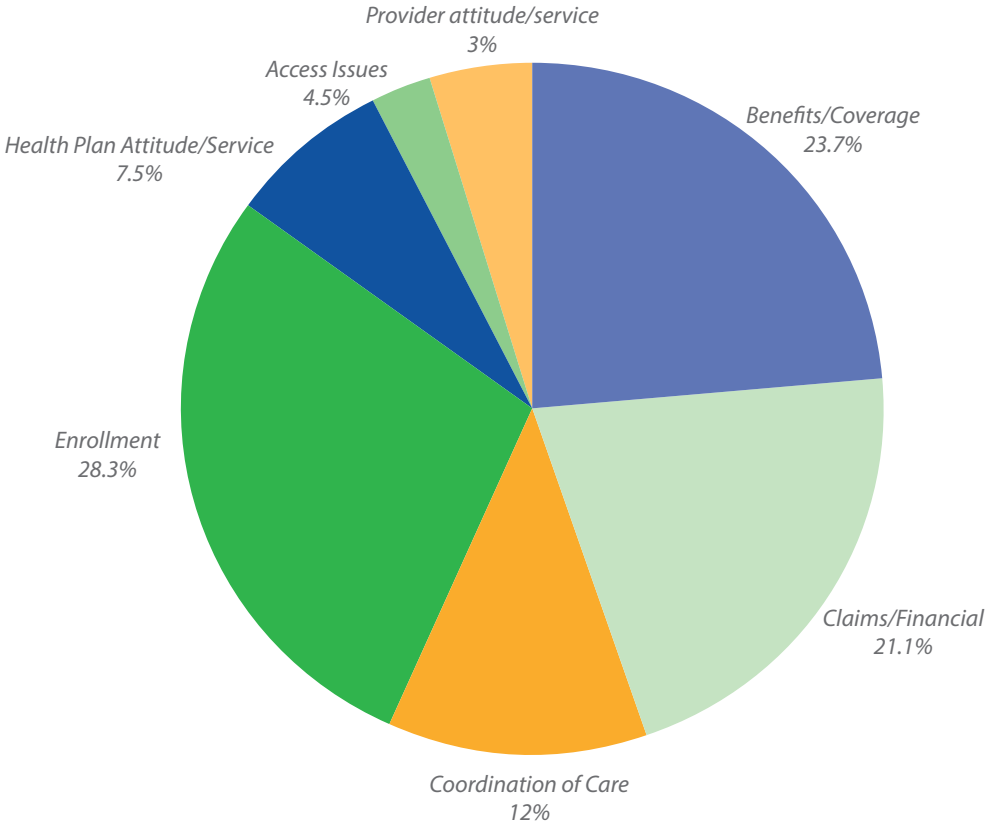
* This report was updated in July 2016 to include corrected data for consumers assisted and independent medical reviews.

Interspersed throughout this report are examples of consumer assistance provided by the Help Center during 2014. Look for more blue boxes for additional examples of the DMHC's efforts to protect consumers' health care rights. The names of the enrollees have been changed to protect their identity.

Consumer Help Center Assistance: Continuity of Care

Casey has Stage IV cancer and wanted to continue to see her oncologist when she was transferred to another health plan. After being contacted, the DMHC Help Center clinical staff reached out to Casey's new health plan and was able to get the request for continuity of care approved. Casey was able to get an appointment with her oncologist when she needed it.

Breakdown of Complaints Received in 2014



HEALTH PLAN LICENSING

Health plans in California must apply for and obtain a license to operate as a health care service plan. As part of the licensing process, the DMHC reviews all aspects of a health plan's operations. The initial licensing review includes proposed benefits and coverage documents (Evidence of Coverage), contracts with doctors and hospitals, provider networks, and complaint and grievance systems. The Department also evaluates post-licensure changes that health plans make in their operations, service areas, contracts or benefits. Health plans are required to file these changes as amendments or material modifications, depending on the scope of the change. The DMHC also periodically identifies specific licensing issues for focused examination or investigation.

Additionally, the Department monitors provider networks and accessibility of services, including standards for geographic proximity to enrollees, physician-patient ratios and timely access to care. As part of this monitoring, the DMHC receives and reviews annual health plan timely access compliance reports and will review full-service and behavioral health plan networks annually starting in 2015.

As part of its analysis to determine accessibility of services, the DMHC reviews health plan reports about provider contract terminations involving more than 2,000 patients, known as "block transfer filings," and makes sure that the health plan's remaining network is adequate to support its enrollee population. The Department conducted focused reviews of provider networks in the transition of children from the Healthy Families Program to Medi-Cal and on the emerging provider networks in Covered California. In coordination with the Department of Health Care Services, the DMHC conducts quarterly reviews of Medi-Cal managed care plan provider networks.

2014 Highlights

In 2014, the DMHC took steps to improve the quality of future timely access and network reports. The Department adopted a model methodology for assessing timely access compliance and uniform online reporting tools, including a standardized template for health plans to report provider networks. This is a significant undertaking for the DMHC and as part of this effort the Department has added new staff, new technology and improved data tracking.

Also in 2014, the DMHC launched an in-depth review of health plan compliance with federal mental health parity rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, which the federal government has delegated to the states for oversight. The DMHC coordinated focused reviews related to the ACA expansion of mental health benefits in Medi-Cal, and the Cal MediConnect demonstration project to coordinate care for individuals dually eligible for Medi-Cal and Medicare.

2014 BY THE NUMBERS:

Licensing

8
New license applications

288
Evidence of coverage documents

600
Advertisements

600
Block transfer filings

153
Material modifications (significant changes)

HEALTH PLAN SURVEYS

The DMHC monitors consumer complaint data and conducts surveys of health plan operations to evaluate health plan compliance with Knox-Keene. The DMHC managed care and clinical professionals conduct onsite examinations of all licensed health plans every three years and issue public reports on survey findings. Medical surveys examine health plan practices related to health care service accessibility, utilization management, quality improvement, continuity and coordination of care, language accessibility and member grievances and appeals.

As warranted, the DMHC refers deficiencies to its Office of Enforcement for further review and imposes corrective actions. Since its inception in 2000, the Department has conducted 29 unscheduled ("non-routine") investigations of health plan processes including cancellations of coverage, claims payment procedures, quality assurance issues, grievance and appeals processes, utilization management systems, and provider directories and networks.

2014 BY THE NUMBERS:

Health Plan Surveys

18
Routine surveys conducted

4
Non-routine surveys conducted

6
Follow-up surveys conducted

2014 Highlights

The DMHC conducted non-routine surveys of Anthem Blue Cross and Blue Shield of California provider directories and networks for the individual market and found deficiencies related to the accuracy of each health plan's provider directories. The Department also conducted a non-routine survey of Molina's utilization management and appeals systems and found systemic deficiencies. Molina implemented a corrective action plan to correct the deficiencies. The deficiencies identified in both of these surveys were referred to the DMHC Office of Enforcement for further investigation.

Consumer Help Center Assistance: Coverage Dispute

Jaime was 30 weeks pregnant when her OB/GYN dropped her as a patient because the provider did not accept Medi-Cal. However, Jaime's primary coverage was commercial and her secondary coverage was through Medi-Cal. Jaime had an urgent need to see her OB/GYN due to complications with her pregnancy and contacted the DMHC Help Center. DMHC Help Center clinical staff coordinated with the enrollee, the Medi-Cal Managed Care Ombudsman's Office, the health plan and the OB/GYN to resolve the confusion resulting in the provider agreeing to continue seeing Jaime as a patient.

FINANCIAL OVERSIGHT

The DMHC works to ensure stability in California's health care delivery system by actively monitoring the financial stability of health plans and medical groups to make sure plans, and the provider groups they contract with, can meet financial obligations to purchasers and consumers.

The DMHC reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements, that are submitted in the initial application and as post-licensure amendments or material modifications. To monitor and follow-up on reported information, the DMHC conducts routine financial examinations of each health plan every three years and initiates non-routine financial examinations as needed. Routine examinations focus on health plan compliance with financial and administrative requirements that include the review of claims payment and provider dispute resolution processes.

Starting in 2011, the DMHC annually reviews health plan compliance with the ACA Medical Loss Ratio (MLR) requirements of 85 percent in the large group market and 80 percent 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 the quality of care. If the plans do not meet the minimum MLR threshold, they must provide rebates to consumers.

Risk Bearing Organizations (RBO) are provider groups that, in their contracts with health plans, assume some financial risk for the cost of health care services by accepting fixed monthly payments for each enrolled person assigned to the RBO. This arrangement is typically referred to as "capitation." RBOs are subject to financial reserve requirements and regular financial reporting. The DMHC monitors the financial stability of RBOs through analysis of financial filings, corrective action plans and financial examinations. The Department investigates and provides regulatory oversight of claims payment disputes between providers and health plans, including investigating provider complaints to identify unfair payment practices and unfair billing patterns for possible enforcement action.

2014 Highlights

The DMHC's review of health plan MLR annual reports for the 2013 coverage year (as filed on June 1, 2014) resulted in slightly more than $5.5 million in rebates to consumers. Plans in the small group market, that did not meet the MLR requirement, issued rebates averaging $23. Plans in the large group market, that did not meet the MLR requirement, issued rebates averaging $328.

Through focused review and monitoring of financial information, the DMHC uncovered serious financial viability issues and other challenges at Alameda Alliance for Health, a Medi-Cal managed care plan. As a result, the DMHC seized the plan and appointed a conservator in May 2014. The plan is now experiencing sustained improvement in major financial and operational indicators such as timely payment of provider claims, increased reserves and improved customer service.

The DMHC conducted in-depth reviews of the financial filings of eight new plans in 2014, helping to expand consumer coverage choices and to maintain a vibrant and competitive health care marketplace.

2014 BY THE NUMBERS:

Financial Oversight

63
Financial examinations

1,958
Financial statements reviewed

$5.54 M
MLR rebates (CY 2013)

$973,976
Additional claim and dispute payments remediated

$154,216
Additional interest and penalties paid

RATE REVIEW

In 2011, the DMHC implemented premium rate review consistent with the ACA to assess whether health plan proposed rate increases are unreasonable or unjustified. Health plans must provide detailed information to the Department and the public to justify premium increases. The DMHC reviews proposed health plan rate increases, analyzes the justification provided and educates the public to expand consumer understanding of how premium rates are established. Even though the Department does not have the authority to reject any unreasonable rate changes, its in-depth actuarial review improves accountability in rate setting and often results in the health plans reducing rates that are found unreasonable. As a result of this work, the DMHC has saved Californians more than $100 million in health care premiums since 2011.

2014 Highlights

Thanks to the DMHC rate review program, enrollees were saved $41.6 million in 2014. For example, Anthem Blue Cross, for its small group business, initially requested 12-month rate increases averaging 15.2 percent to take effect on October 1, 2014. After review by, and discussions with the DMHC, Anthem Blue Cross agreed to lower this average rate increase, saving consumers approximately $35 million.

Rate Review Since 2011

50 Average number of rate filing reviews per year

6 Number found unreasonable

14 Number of reduced rates

$101 M Consumer savings through negotiated rate reductions

2014 BY THE NUMBERS:

Rate Review

53
Number of rate filing reviews completed

1
Number found unreasonable

2
Number of reduced rates

$41.6 M
Consumer savings through negotiated rate reductions

Consumer Help Center Assistance: Access

Maria discovered a lump in her breast and went in to see her Primary Care Physician who referred her for a mammogram and an ultrasound. Maria contacted the DMHC Help Center after she had tried to set up an appointment but was told the referral didn't go through. More than a month passed and she had already tried contacting her health plan but was not getting assistance. The DMHC contacted her health plan who then contacted her provider and directed them to submit an urgent referral request. After receiving the referral, the health plan granted authorization and Maria was given an appointment for the mammogram and ultrasound.

ENFORCEMENT

The DMHC works to aggressively monitor and take timely action against health plans that violate the law. The Department enforces the law through investigations, structured settlements and corrective action plans, fines and other penalties, and litigation when necessary. In the past 15 years, the DMHC has assessed more than $53 million in fines and penalties against health plans. The Department also has imposed program and system changes in health plan operations to protect consumer rights and ensure compliance with the letter and the spirit of Knox-Keene.

In addition, the DMHC takes action against health care providers that unlawfully bill enrollees for amounts not paid by a health plan for emergency services, a practice known as balance billing. The successful legal action against emergency providers engaging in balance billing, including the imposition of significant fines, serves as a deterrent for other providers. As a result, the Department is often successful in getting emergency providers to end the practice of balance billing and to reimburse enrollees who paid for services out of their own pocket. In 2009 the DMHC defended a legal challenge to the balance billing prohibition and received a favorable ruling in the California Supreme Court, making the prohibition settled law[4].

The first one million dollars in fines collected by the DMHC annually is transferred to the Medically Underserved Account for Physicians to be used for a loan repayment program. The remaining funds are transferred to the Major Risk Medical Insurance Fund to be used for the Major Risk Medical Insurance Program (MRMIP).

2014 Highlights

In 2014, the DMHC secured a $4 million penalty from Kaiser Foundation Health Plan, and required Kaiser to take corrective actions after finding that patients needing behavioral health services had to wait, in some cases, many months to see a therapist, in violation of timely access requirements.

Examples of other actions include a $200,000 penalty for Aetna's failure to process claims and provider disputes in a timely manner and a $200,000 penalty for Health Net's failure to maintain the security of protected health information.

Additionally, the DMHC required providers to reimburse enrollees who were illegally balance billed, resulting in payments of more than $223,000.

2014 BY THE NUMBERS:

Enforcement

474
Cases opened

171
Cases closed with a penalty

$7 M
Penalties collected

1
Seizure of health plan

REALIZING HEALTH CARE REFORM

The DMHC has been a leader in California's implementation of the ACA since its passage in 2010, working as a partner with other state agencies, legislators, health plans, providers and stakeholders. As a result, California has remained ahead of the curve in executing health reform. This section briefly highlights ACA implementation activities of the DMHC to date.

STATUTORY CHANGES AND REGULATORY GUIDANCE

The DMHC provided technical expertise for updating California laws to make them consistent with the ACA. California passed legislation to guarantee availability of coverage for children and to allow them to stay on their parents' policy until age 26[5]. 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[6]. California's chosen Essential Health Benefits benchmark plan is a Knox-Keene licensed benefit plan, Kaiser Small Group 30 HMO. Each state's benchmark plan sets the minimum benefits requirements for all coverage under individual and small group coverage. As such, Knox-Keene'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[7]. Market reforms for individual and small employer coverage guaranteed availability of coverage without pre-existing condition limitations and impose 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.

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

Following passage of ACA-related reforms, the DMHC developed detailed rules, guidance and regulatory review procedures. Leading up to 2014, the Department reviewed a significant increase of health plan products and rate filings, including filings for qualified health plans selected to participate in Covered California as well for products offered off the exchange. The DMHC's review included 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 AND THE ACA

	Knox-Keene Act Pre-ACA	ACA Provision
Minimum Benefits	Basic health care services as a minimum for all coverage	Essential health benefits as a minimum in individual and small group coverage
Preventive Health Care Services	Mandatory coverage of preventive health care services as a basic health care service	Coverage for preventive services without any enrollee cost sharing
Comprehensive Coverage	Mandates coverage of basic health care services, if medically necessary, and prohibits denial based on fixed dollar or service limits	Prohibits annual and lifetime dollar limits on essential health benefits
Emergency Services	Requires coverage of emergency services as a basic health care service, including out-of-area emergencies, and requires uniform cost-sharing for out-of-network and in-network emergency services	Prohibits higher deductibles, co-payments and co-insurance for out-of-network emergency rooms than those charged for in-network emergency services
Provider Choice	Access care from a participating obstetrician-gynecologist (OB-GYN) provider without a referral	Access to participating OB-GYN providers without a referral
	Select any available participating primary care provider	Access to any available participating primary care provider
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	Requires qualified health plans in the exchange to offer a sufficient choice of providers in number and type to ensure that all services will be accessible without unreasonable delay
Independent External Review	Establishes Independent Medical Review program (IMR) (1999)	Requires issuers to have an independent external review process much like IMR. CMS ruled IMR complies with the ACA
Guaranteed Availability	Small employer coverage reforms (1992) guarantee availability regardless of group claims experience or health status; no pre-existing condition exclusions	Guaranteed availability for individual and small group coverage with no pre-existing condition exclusions
Guaranteed Renewability	Guaranteed renewal of individual and group coverage except for nonpayment, fraud or carrier ceases to offer product / exits market	Guaranteed renewal for individual and small group coverage with limited exceptions similar to CA law

ACA EDUCATION AND INFORMATION

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

Consumer Help Center Assistance: Delayed Authorization

Charlie was a week away from reconstructive hand surgery and needed authorization for a pre-operation x-ray prior to obtaining the surgery. Charlie contacted the DMHC Help Center because his medical group had not yet provided the authorization. DMHC Help Center clinical staff contacted the health plan and Charlie received authorization for the x-ray.

KNOX-KEENE'S HISTORIC FRAMEWORK

Many of the first managed health care plans in the country began in California. From the start, California's managed care market was different from the mainstream health care market in the rest of the United States, primarily because of the dominant role of large, multispecialty medical groups. California's early managed care delivery model is often referred to as "the delegated model" because of the important role contracted medical groups play in managing the delivery of care on behalf of the health plans, often in return for a monthly per-person or capitation, payment. The managed care model rapidly expanded in California in the 1960's and 1970's, with only limited regulatory oversight by the Attorney General. After several financial scandals involving Medi-Cal "Prepaid Health Plans," the Legislature saw the need for more rigorous state regulation of managed care.

The DMHC's legacy of consumer protection and regulatory innovation has its roots in California's groundbreaking law regulating the emerging managed care industry, the Knox-Keene Health Care Service Plan Act of 1975. As enacted in 1975, Knox-Keene established a regulatory framework focused on consumer protections, and this core purpose has withstood the test of time. Despite important changes and additions in the 40 years since Knox-Keene first passed, the original Act's core requirements for health plans remain the foundation of DMHC's regulation today.

Knox-Keene transformed regulation of health plans from a limited registration program overseen by the Attorney General to a comprehensive and stringent regulatory scheme overseen and enforced by the Commissioner of the Department of Corporations (DOC).

In subsequent years, the Legislature amended Knox-Keene in important ways to improve oversight of health plans and consumer protections. In 1992, the Legislature enacted laws reforming small employer health coverage. In 1995, legislation required the DOC to establish a toll-free consumer complaint line and ombudsperson to respond to and resolve consumers' complaints. In 1999, the Legislature enacted the Patients' Bill of Rights, a package of 21 health-care bills that established a host of new consumer protections. One of the most significant legislative changes in the Patients' Bill of Rights was the creation of the DMHC.

Consumer Help Center Assistance: Enrollment Issue

Peyton and his daughter had recently enrolled in health coverage through Covered California. Peyton's daughter needed dialysis but the family had not yet received their health plan membership cards so he contacted the DMHC Help Center. DMHC Help Center clinical staff contacted the health plan and ensured that the dialysis appointment was scheduled on time.

As enacted in 1975, the original Knox-Keene provisions included:

Definitions and basic jurisdiction of the DOC, including definitions of health care service plans and specialized health plans subject to the Act.

Minimum basic health care services that all health plans must offer regardless of the market or purchaser type.

Health plan standards including, among other things, use of state licensed facilities and health personnel, readily available and accessible care, continuity of care and medical decisions unhindered by fiscal and administrative management monitored through onsite medical surveys every five years. The original Act required filing, regulatory review and prior approval for documents describing plan benefits for consumers as well as material changes to plan operations, provider contracts and advertisements.

Health plan consumer grievance and appeals procedures, subject to DOC approval, for resolution of enrollee complaints, and health plan notice requirements so that consumers know about the right to file a grievance and to appeal plan grievance decisions to DOC.

Solicitation and enrollment provisions governing health plan advertising and marketing, including prior approval by DOC. The original Act prohibited disenrollment or nonrenewal of coverage except for failure to pay, fraud or good cause, and authorized DOC to review enrollee complaints about disenrollment because of health status or utilization.

Financial solvency standards, including financial reporting, minimum reserves (tangible net equity) and demonstration of financial viability subject to the examination of the fiscal and administrative affairs of the plan every five years.

Disciplinary and enforcement provisions including specific grounds for disciplinary action and authority for civil penalties, administrative and judicial remedies, cease and desist orders, and injunctive relief. The original Act also authorized health plans to employ health professionals and conduct peer review activities related to quality of care.

Health plan fees and assessments to support the regulatory program without state general funds.

THE CORE VALUES OF KNOX-KEENE

Legislative Intent Sets the Stage

It is the intent of the Legislature to promote the delivery of health and medical care to the people of the State of California who enroll or subscribe for the services rendered by a health care service plan or specialized health care service plan by:

(a) Assuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Assuring that subscribers and enrollees are educated and informed of the benefits and services available so as to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations, or who use deceptive methods, misrepresentations, or practices inimical to the general purpose of enabling a rational consumer choice in the marketplace.

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from the patient to the providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Assuring that subscribers receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

Source: California Health and Safety Code Section 1342

Notes: Sections (a)-(g) enacted in the original Knox-Keene Act, AB 138, Chapter 941, Statutes of 1975. AB 78 (Chapter 525, Statutes of 1999), which established the DMHC, added Section (h), made technical, grammatical changes and revised Section (c) which originally read "Protecting the potential subscriber and enrollee from" fraudulent solicitation.

CREATION OF THE DMHC EMPHASIZES CONSUMER PROTECTION

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

It was in this environment that the Legislature created the DMHC. Legislation to transfer oversight of health plans from the DOC to a new "state agency devoted exclusively to the licensing and regulation of managed health care" came as part of a sweeping package of bills sponsored by consumer advocacy organizations, dubbed the Patient Bill of Rights. AB 78 (Chapter 525, Statutes of 1999) required the new DMHC to establish a consumer-focused Help Center and amended the original legislative intent of Knox-Keene to reinforce the new Department's role in addressing consumer complaints.

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

The Patient Bill of Rights passed in 1999 included:

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

HISTORICAL TIMELINE OF THE KNOX-KEENE ACT PRIOR TO THE CREATION OF DMHC[8]

1929-1945	Early prepaid health plan models emerge in California (Ross-Loos, Permanente Health Plan and California Physicians Service (CPS) (Blue Shield).
1946	California Supreme Court rules that CPS (Blue Shield) 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, Chapter 880, Statutes of 1965). More than 100 health plans register including Ross-Loos, Kaiser, Blue Shield and Family Health Plan (FHP), along with specialized dental and mental health plans.
1972	California Waxman-Duffy Prepaid Health Plan Act (AB 1496, Chapter 1366, Statutes of 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, Chapter 941, Statutes of 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, Chapter 329, Statutes of 1982).
1993	Legislature authorizes Knox-Keene plans to develop point-of-service (POS) contracts (SB 1221, Chapter 987, Statutes of 1993).
1995	Legislature requires the DOC to establish a toll-free number to receive consumer complaints and inquiries (SB 689, Chapter 789, Statutes of 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, Chapter 815, Statutes of 1996). Legislation requires the DOC to establish an HMO Ombudsperson to resolve and respond to consumer complaints (SB 1936, Chapter 1095, Statutes of 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, Chapter 525, Statutes of 1999).

LOOKING AHEAD

Since its inception, the DMHC has continued to build on California's leadership and regulation of managed health care delivery systems. The Department has a proud history of achievements, but there is still much more to accomplish. The nation is still in the early stages of ACA implementation and it is too soon to know the full impact of its reforms on health plans, health insurance markets, providers and consumers. With this in mind, the DMHC constantly monitors market changes and adjusts how it regulates health plans and assists consumers to reflect best practices and quality improvements.

Going forward, the DMHC will continue its consumer assistance and regulatory enforcement activities across all areas of its responsibility with an emphasis on current emerging challenges. For 2015, the Department will continue to focus on rigorous monitoring and review of health plan networks and provider directories to ensure that consumers have meaningful choices and timely access to care. The DMHC will continue its in-depth focus on making sure that consumers have timely and appropriate access to adequate mental health and substance use disorder services. The DMHC will also continue to conduct health plan surveys, financial examinations, and investigations to enforce California law.

Finally, the DMHC will continue its consumer focused approach to regulation of health care service plans by protecting consumers' health care rights and ensuring a stable health care delivery system.

NOTES

1 *Wilson, Katherine. Enrollment in Individual Health Plans Up 47% in 2014. Prepared for the California HealthCare Foundation. May 2015. Available online at: http://www.chcf.org/articles/2015/05/enrollment-individual-up*

2 *The percentage fluctuates from year to year but from 2009 through 2014 the overall percentage was 55.73%*

3 *Consumer complaints is comprised of standard complaints (6,453), quick resolutions (1,331) and urgent matters (156).*

4 *See Prospect Medical Group v. Saint John's Emergency Medical Specialists, Inc. (2009) 45 Cal.4th 497.*

5 *Guaranteed Coverage for Children (AB 2244, Chapter 656, Statutes of 2010) and Dependent Coverage up to age 26 (SB 1088, Chapter 660, Statutes of 2010).*

6 *Preventive services (AB 2345, Chapter 657, Statutes of 2010) and Essential health benefits (AB 1453, Chapter. 854, Statutes of 2012; SB 951, Chapter 866, Statutes of 2012).*

7 *Premium rate review (SB 1163, Chapter 661, Statutes of 2010) and Medical Loss Ratios, Annual and Lifetime Benefit Limits (SB 51, Chapter 644. Statutes of 2011).*

8 *Excerpted from Making Sense of Managed Care Regulation in California, California HealthCare Foundation, 2001. Available online at: http://www.chcf.org/publications/2001/12/making-sense-of-managed-care-regulation-in-california*

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

2014 Independent Medical Review IMR Summary Report

Report Overview

The Annual Independent Medical Review (IMR) Summary Report displays the number and types of IMRs resolved during the 2014 calendar year, by health plan. In 2014, the Department resolved 1,821 IMRs.

- **Overall, enrollees received the requested services in 53%* of the cases qualified by the Department for the IMR program.**
- **In nearly one quarter of the cases (24%), the health plan reversed its denial after the Department received the IMR application, but prior to review by the Independent Medical Review Organization (IMRO).**
- **In nearly one third of the cases (29%) the IMRO overturned the health plan's prior denial.**
- **In less than half of the cases (47%) the IMRO upheld the health plan's prior denial.**

The IMR Report identifies each health plan's enrollment during the year, the number of IMRs resolved for each health plan, the numbers of IMRS per 10,000 enrollees, the number of IMRs upheld or overturned by the IMRO, and the number of IMRs that the health plan reversed or withdrew.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the quarterly enrollment figures provided for the fourth quarter of 2014 for the population of enrollees within the Department's jurisdiction.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review, and resolved (closed) within calendar year 2014. Cases pending at the end of 2014 and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

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

**The percentage fluctuates from year to year but from 2009 through 2014 the overall percentage was 55.73%.*

*** This report was updated in July 2016 to include corrected IMR data for OptumHealth Physical Health of California and OptumHealth Behavioral Health of California.*

				Experimental/Investigational IMR						Medical Necessity IMR						ER Reimbursement IMR					
				Upheld by			Overturned by		Reversed by	Upheld by			Overturned by		Reversed by	Upheld by			Overturned by		Reversed by
Plan Type and Name	**Enrollment**	**Total IMRs Resolved**	**Total IMRs per 10,000***	**Total IMRs**	**IMR**	**%**	**IMR**	**%**	**Plan** **%**	**Total IMRs**	**IMR**	**%**	**IMR**	**%**	**Plan** **%**	**Total IMRs**	**IMR**	**%**	**IMR**	**%**	**Plan** **%**
Full Service - Enrollment Over 400,000																					
AETNA Health of California Inc.	478,815	37	0.77	8	5	62.5%	2	25.0%	1 12.5%	21	9	42.9%	3	14.3%	9 42.9%	8	5	62.5%	2	25.0%	1 12.5%
Anthem Blue Cross	3,438,954	709	2.06	313	168	53.7%	105	33.5%	40 12.8%	386	164	42.5%	111	28.8%	111 28.8%	10	4	40.0%	1	10.0%	5 50.0%
Blue Shield of California	2,230,553	401	1.80	99	51	51.5%	35	35.4%	13 13.1%	292	129	44.2%	92	31.5%	71 24.3%	10	4	40.0%	1	10.0%	5 50.0%
Health Net of California Inc.	1,079,182	126	1.17	15	9	60.0%	5	33.3%	1 6.7%	105	38	36.2%	35	33.3%	32 30.5%	6	3	50.0%	0	0.0%	3 50.0%
Inland Empire Health Plan	840,118	22	0.26	1	1	100.0%	0	0.0%	0 0.0%	21	10	47.6%	7	33.3%	4 19.0%	0	0	0.0%	0	0.0%	0 0.0%
Kaiser Permanente Health Plan	6,126,118	262	0.43	9	8	88.9%	0	0.0%	1 11.1%	237	138	58.2%	59	24.9%	40 16.9%	16	6	37.5%	5	31.3%	5 31.3%
L.A. Care Health Plan	1,466,584	31	0.21	2	0	0.0%	0	0.0%	2 100.0%	29	10	34.5%	3	10.3%	16 55.2%	0	0	0.0%	0	0.0%	0 0.0%
UnitedHealthcare of California	449,900	58	1.29	14	6	42.9%	6	42.9%	2 14.3%	36	17	47.2%	8	22.2%	11 30.6%	8	4	50.0%	1	12.5%	3 37.5%
Sub-total:	16,110,224	1646	1.02	461	248	53.8%	153	33.2%	60 13.0%	1127	515	45.7%	318	28.2%	294 26.1%	58	26	44.8%	10	17.2%	22 37.9%
Full Service - Enrollment Under 400,000																					
Alameda Alliance for Health	208,571	7	0.34	0	0	0.0%	0	0.0%	0 0.0%	7	1	14.3%	5	71.4%	1 14.3%	0	0	0.0%	0	0.0%	0 0.0%
California Health & Wellness	138,453	7	0.51	0	0	0.0%	0	0.0%	0 0.0%	7	1	14.3%	0	0.0%	6 85.7%	0	0	0.0%	0	0.0%	0 0.0%
CalViva Health	268,735	3	0.11	0	0	0.0%	0	0.0%	0 0.0%	3	1	33.3%	0	0.0%	2 66.7%	0	0	0.0%	0	0.0%	0 0.0%
Care 1st Health Plan	291,769	26	0.89	1	1	100.0%	0	0.0%	0 0.0%	24	7	29.2%	3	12.5%	14 58.3%	1	0	0.0%	0	0.0%	1 100.0%
CareMore Health Plan	0	1	0.00	0	0	0.0%	0	0.0%	0 0.0%	1	0	0.0%	0	0.0%	1 100.0%	0	0	0.0%	0	0.0%	0 0.0%
Cigna HealthCare of California Inc.	188,194	19	1.01	5	2	40.0%	2	40.0%	1 20.0%	14	5	35.7%	1	7.1%	8 57.1%	0	0	0.0%	0	0.0%	0 0.0%
Community Health Group	199,327	5	0.25	0	0	0.0%	0	0.0%	0 0.0%	5	3	60.0%	1	20.0%	1 20.0%	0	0	0.0%	0	0.0%	0 0.0%
Contra Costa Health Plan	145,313	2	0.14	0	0	0.0%	0	0.0%	0 0.0%	2	0	0.0%	1	50.0%	1 50.0%	0	0	0.0%	0	0.0%	0 0.0%
GEMCare Health Plan, Inc.	12,933	1	0.77	0	0	0.0%	0	0.0%	0 0.0%	1	1	100.0%	0	0.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Health Plan of San Joaquin	247,548	7	0.28	1	1	100.0%	0	0.0%	0 0.0%	6	5	83.3%	1	16.7%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Health Plan of San Mateo	106,580	6	0.56	0	0	0.0%	0	0.0%	0 0.0%	6	2	33.3%	3	50.0%	1 16.7%	0	0	0.0%	0	0.0%	0 0.0%
Kern Health Systems Inc.	165,126	8	0.48	1	0	0.0%	0	0.0%	1 100.0%	7	4	57.1%	2	28.6%	1 14.3%	0	0	0.0%	0	0.0%	0 0.0%
Molina Medical Center	344,334	26	0.76	0	0	0.0%	0	0.0%	0 0.0%	26	11	42.3%	8	30.8%	7 26.9%	0	0	0.0%	0	0.0%	0 0.0%
San Francisco Community Health Authority	103,842	11	1.06	0	0	0.0%	0	0.0%	0 0.0%	11	2	18.2%	5	45.5%	4 36.4%	0	0	0.0%	0	0.0%	0 0.0%
Santa Clara Family Health Plan	199,018	4	0.20	1	0	0.0%	1	100.0%	0 0.0%	3	0	0.0%	2	66.7%	1 33.3%	0	0	0.0%	0	0.0%	0 0.0%
Sharp Health Plan	84,054	7	0.83	0	0	0.0%	0	0.0%	0 0.0%	6	4	66.7%	0	0.0%	2 33.3%	1	1	100.0%	0	0.0%	0 0.0%
Simnsa Health Care	35,989	1	0.28	0	0	0.0%	0	0.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%	1	0	0.0%	0	0.0%	1 100.0%
Sutter Health Plus	6,341	4	6.31	2	1	50.0%	1	50.0%	0 0.0%	2	1	50.0%	1	50.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Valley Health Plan	20,120	1	0.50	0	0	0.0%	0	0.0%	0 0.0%	1	1	100.0%	0	0.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Ventura County Health Care Plan	15,237	1	0.66	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%
Western Health Advantage	108,338	14	1.29	3	3	100.0%	0	0.0%	0 0.0%	9	5	55.6%	3	33.3%	1 11.1%	2	1	50.0%	0	0.0%	1 50.0%
Sub-total:	2,889,822	161	0.56	14	8	57.1%	4	28.6%	2 14.3%	142	54	38.0%	37	26.1%	51 35.9%	5	2	40.0%	0	0.0%	3 60.0%
Total Full Service Plans:	19,000,046	1,807	0.95	475	256	53.9%	157	33.1%	62 13.1%	1269	569	44.8%	355	28.0%	345 27.2%	63	28	44.4%	10	15.9%	25 39.7%
Chiropractic																					
** OptumHealth Physical Health of California	269,368	1	0.04	0	0	0.0%	0	0.0%	0 0.0%	1	1	100.0%	0	0.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Sub-total:	269,368	1	0.04	0	0	0.0%	0	0.0%	0 0.0%	1	1	100.0%	0	0.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
Dental																					
Western DentaL Plan	198,016	1	0.05	0	0	0.0%	0	0.0%	0 0.0%	1	0	0.0%	0	0.0%	1 100.0%	0	0	0.0%	0	0.0%	0 0.0%
Sub-total:	198,016	1	0.05	0	0	0.0%	0	0.0%	0 0.0%	1	0	0.0%	0	0.0%	1 100.0%	0	0	0.0%	0	0.0%	0 0.0%
Psychological																					
Cigna Behavioral Health of California Inc.	169,399	2	0.12	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%
Holman Professional Counseling Centers	133,255	1	0.08	1	1	100.0%	0	0.0%	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	528,128	5	0.09	0	0	0.0%	0	0.0%	0 0.0%	5	2	40.0%	3	60.0%	0 0.0%	0	0	0.0%	0	0.0%	0 0.0%
** OptumHealth Behavioral Health of California	1,300,282	53	0.41	2	0	0.0%	2	100%	0 0.0%	49	25	51.0%	20	40.8%	4 8.2%	2	1	50.0%	0	0.0%	1 50.0%
Sub-total:	2,131,064	61	0.29	3	1	33.3%	2	66.7%	0 0.0%	56	27	48.2%	25	44.6%	4 7.1%	2	1	50.0%	0	0.0%	1 50.0%
Total Specialty Plans:	2,598,448	63	0.24	3	1	33.3%	2	66.7%	0 0.0%	58	28	48.3%	25	43.1%	5 8.6%	2	1	50.0%	0	0.0%	1 50.0%
Grand Totals:	**21,598,494**	**1,870**	**0.87**	**478**	**257**	**53.8%**	**159**	**33.0%**	**62 13.0%**	**1327**	**597**	**45.0%**	**380**	**28.6%**	**350 26.4%**	**65**	**29**	**44.6%**	**10**	**15.4%**	**26 40.0%**

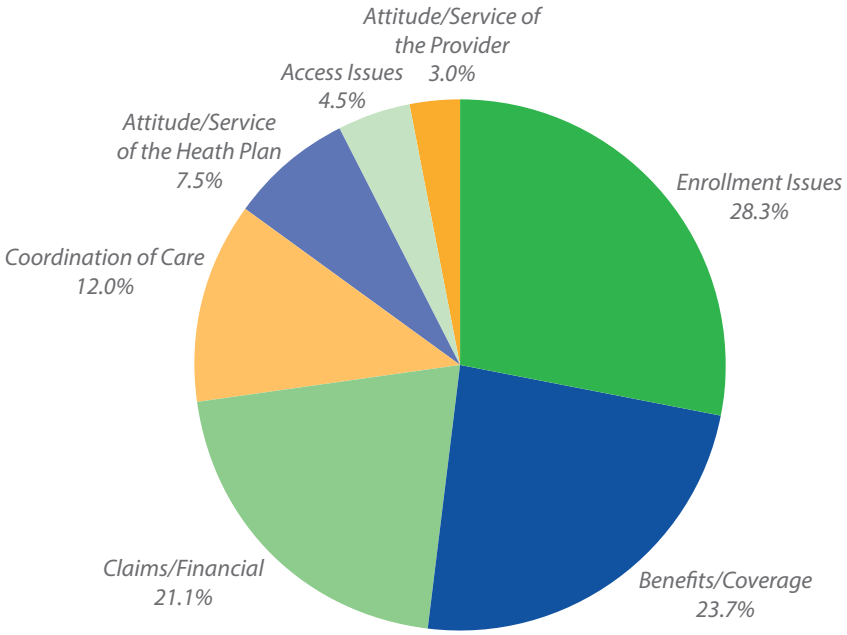
CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

2014 Complaint Summary Report

Report Overview

The Annual Complaint Summary Report displays the numbers and types of complaints, by health plan, resolved by the Department during the 2014 calendar year. An enrollee's complaint may include more than one issue. A complaint consisting of multiple distinct issues is counted as one resolved complaint. Specific complaint issues are categorized in seven categories: Access, Benefits/Coverage, Claims/Financial, Enrollment, Coordination of Care, Attitude/Service of the Health Plan, and Attitude/Service of the Provider.

Annual Complaint Summary Report



The Report identifies the number of complaints resolved for each health plan, the health plan's enrollment during 2014, the number of complaints per 10,000 members, and the number of issues for each complaint category.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the quarterly enrollment figures provided for the fourth quarter of 2014 for the population of enrollees within the Department'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 2014. Cases pending at the end of the calendar year and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

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

2014 Complaint Results by Category and Health Plan

					Access Issues		Benefits / Coverage		Claims / Financial		Enrollment		Coordination of Care		Attitude / Service of Health Plan		Attitude / Service of Provider	
Plan Type and Name	**Complaints Resolved**	**% of Complaints Resolved**	**Enrollment**	**Complaints 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**	**Count**	**Per 10,000**
Full Service - Enrollment Over 400,000																		
AETNA Health of California Inc.	99	1.6%	478,815	2.07	4	0.08	52	1.09	20	0.42	12	0.25	7	0.15	6	0.13	1	0.02
Anthem Blue Cross	1,801	29.7%	3,438,954	5.24	128	0.37	320	0.93	371	1.08	806	2.34	97	0.28	170	0.49	9	0.03
Blue Shield of California	1,593	26.3%	2,230,553	7.14	62	0.28	512	2.30	327	1.47	551	2.47	80	0.36	105	0.47	6	0.03
CalOptima	1	0.0%	633,264	0.02	0	0.00	0	0.00	0	0.00	0	0.00	1	0.02	1	0.02	0	0.00
Health Net of California Inc.	371	6.1%	1,079,182	3.44	20	0.19	94	0.87	63	0.58	150	1.39	25	0.23	31	0.29	2	0.02
Inland Empire Health Plan	24	0.4%	840,118	0.29	4	0.05	9	0.11	1	0.01	6	0.07	3	0.04	2	0.02	0	0.00
Kaiser Permanente Health Plan	1,983	32.7%	6,126,118	3.24	56	0.09	356	0.58	491	0.80	297	0.48	513	0.84	154	0.25	152	0.25
L.A. Care Health Plan	62	1.0%	1,466,584	0.42	5	0.03	12	0.08	5	0.03	21	0.14	12	0.08	2	0.01	5	0.03
Partnership Health Plan of California	0	0.0%	456,211	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UnitedHealthcare of California	130	2.1%	449,900	2.89	0	0.00	81	1.80	27	0.60	8	0.18	11	0.24	3	0.07	1	0.02
Total Full Service - Enrollment Over 400,000:	**6,064**		**17,199,699**	**3.53**	**279**	**0.16**	**1,436**	**0.83**	**1,305**	**0.76**	**1,851**	**1.08**	**749**	**0.44**	**474**	**0.28**	**176**	**0.10**
Full Service - Enrollment Under 400,000																		
Alameda Alliance for Health	11	4.5%	208,571	0.53	3	0.14	5	0.24	0	0.00	1	0.05	1	0.05	2	0.10	0	0.00
California Health & Wellness	4	1.6%	138,453	0.29	0	0.00	3	0.22	0	0.00	0	0.00	1	0.07	0	0.00	0	0.00
CalViva Health	1	0.4%	268,735	0.04	0	0.00	1	0.04	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Care 1st Health Plan	14	5.8%	291,769	0.48	4	0.14	5	0.17	0	0.00	1	0.03	2	0.07	1	0.03	1	0.03
CareMore Health Plan	1	0.4%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00
CenCal Health	1	0.4%	137,638	0.07	0	0.00	1	0.07	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Central California Alliance for Health	0	0.0%	274,855	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	2	0.8%	17,651	1.13	0	0.00	1	0.57	0	0.00	0	0.00	0	0.00	1	0.57	0	0.00
Cigna HealthCare of California Inc.	42	17.3%	188,194	2.23	0	0.00	23	1.22	14	0.74	1	0.05	2	0.11	5	0.27	1	0.05
Community Health Group	1	0.4%	199,327	0.05	0	0.00	1	0.05	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Contra Costa Health Plan	7	2.9%	145,313	0.48	0	0.00	1	0.07	1	0.07	0	0.00	3	0.21	0	0.00	2	0.14
Easy Choice Health Plan, Inc.	1	0.4%	0	0.00	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00	0	0.00
GEMCare Health Plan, Inc.	1	0.4%	12,933	0.77	0	0.00	1	0.77	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Plan of San Joaquin	7	2.9%	247,548	0.28	1	0.04	4	0.16	0	0.00	0	0.00	0	0.00	1	0.04	1	0.04
Health Plan of San Mateo	10	4.1%	106,580	0.94	2	0.19	6	0.56	1	0.09	0	0.00	0	0.00	1	0.09	0	0.00
Humana Health Plan of California Inc.	5	2.1%	0	0.00	1	0.00	1	0.00	0	0.00	2	0.00	1	0.00	0	0.00	0	0.00
Kern Health Systems Inc.	9	3.7%	165,126	0.55	1	0.06	4	0.24	1	0.06	0	0.00	3	0.18	0	0.00	0	0.00
MediExcel Health Plan	0	0.0%	1,295	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Molina Medical Center	23	9.5%	344,334	0.67	3	0.09	6	0.17	1	0.03	7	0.20	3	0.09	3	0.09	0	0.00
On Lok Senior Health Services	0	0.0%	1,291	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
One Health Plan - INACTIVE 2012	1	0.4%	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Positive Healthcare	0	0.0%	863	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
San Francisco Community Health Authority	6	2.5%	103,842	0.58	1	0.10	4	0.39	0	0.00	0	0.00	0	0.00	2	0.19	0	0.00
Santa Clara Family Health Plan	7	2.9%	199,018	0.35	1	0.05	5	0.25	0	0.00	0	0.00	1	0.05	0	0.00	0	0.00
SCAN Health Plan	0	0.0%	8,680	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	13	5.3%	84,054	1.55	0	0.00	8	0.95	1	0.12	2	0.24	0	0.00	2	0.24	0	0.00
Simnsa Health Care	23	9.5%	35,989	6.39	0	0.00	0	0.00	22	6.11	0	0.00	0	0.00	1	0.28	0	0.00
Sutter Health Plus	0	0.0%	6,341	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Universal Care	0	0.0%	2,212	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Valley Health Plan	11	4.5%	20,120	5.47	1	0.50	6	2.98	2	0.99	2	0.99	0	0.00	0	0.00	0	0.00
Ventura County Health Care Plan	2	0.8%	15,237	1.31	0	0.00	2	1.31	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Health Advantage	40	16.5%	108,338	3.69	0	0.00	18	1.66	12	1.11	1	0.09	4	0.37	0	0.00	5	0.46
Total Full Service - Enrollment Under 400,000:	**243**		**3,334,307**	**0.73**	**18**	**0.05**	**106**	**0.32**	**56**	**0.17**	**18**	**0.05**	**22**	**0.07**	**19**	**0.06**	**10**	**0.03**
Total All Full Service Plans:	**6,307**		**20,534,006**	**3.07**														

2014 Complaint Results by Category and Health Plan

					Access Issues		Benefits / Coverage		Claims / Financial		Enrollment		Coordination of Care		Attitude / Service of Health Plan		Attitude / Service of Provider	
Plan Type and Name	**Complaints Resolved**	**% of Complaints Resolved**	**Enrollment**	**Complaints 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**	**Count**	**Per 10,000**
Chiropractic																		
Landmark Healthplan of California Inc.	0	0.0%	108,942	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
OptumHealth Physical Health of California	0	0.0%	269,368	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**		**378,310**	**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	2	5.7%	325,254	0.06	1	0.03	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.03
AETNA Dental of California Inc.	8	22.9%	190,887	0.42	0	0.00	3	0.16	3	0.16	1	0.05	1	0.05	0	0.00	0	0.00
California Dental Network, Inc.	2	5.7%	65,409	0.31	0	0.00	1	0.15	0	0.00	0	0.00	1	0.15	0	0.00	0	0.00
Cigna Dental Health of California Inc.	4	11.4%	204,308	0.20	0	0.00	1	0.05	2	0.10	0	0.00	1	0.05	0	0.00	0	0.00
DDS Inc./DDSI (Dedicated Dental Systems Inc.)	0	0.0%	7,688	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Health Services	1	2.9%	95,690	0.10	0	0.00	0	0.00	1	0.10	0	0.00	0	0.00	0	0.00	0	0.00
Managed Dental Care	0	0.0%	135,967	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Mida Dental	0	0.0%	145,452	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Newport Dental Centers	0	0.0%	47,602	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Personal Dental Services	5	14.3%	337,130	0.15	1	0.03	1	0.03	0	0.00	0	0.00	3	0.09	0	0.00	0	0.00
Primecare Dental Plan	0	0.0%	4,293	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
United Dental Care	1	2.9%	14,031	0.71	0	0.00	0	0.00	0	0.00	1	0.71	0	0.00	0	0.00	0	0.00
Western Dental PLan	12	34.3%	198,016	0.61	1	0.05	0	0.00	3	0.15	0	0.00	6	0.30	0	0.00	2	0.10
Total Dental:	**35**		**1,771,727**	**0.20**	**3**	**0.02**	**6**	**0.03**	**9**	**0.05**	**2**	**0.01**	**12**	**0.07**	**0**	**0.00**	**3**	**0.02**
Dental/Vision																		
Delta Dental Plan of California	85	85.0%	16,096,750	0.05	3	0.00	22	0.01	31	0.02	10	0.01	11	0.01	6	0.00	6	0.00
Golden West Vision-Dental Plan	0	0.0%	30,161	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	15	15.0%	435,646	0.34	0	0.00	4	0.09	7	0.16	0	0.00	3	0.07	1	0.02	1	0.02
Total Dental/Vision:	**100**		**16,562,557**	**0.06**	**3**	**0.00**	**26**	**0.02**	**38**	**0.02**	**10**	**0.01**	**14**	**0.01**	**7**	**0.00**	**7**	**0.00**
Vision																		
EYEXAM of California, Inc.	0	0.0%	402,206	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.	0	0.0%	245,705	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
For Eyes Vision Plan	0	0.0%	13,606	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
March Vision Care, Inc.	0	0.0%	332	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medical Eye Services Inc.	0	0.0%	59,417	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sterling Visioncare	0	0.0%	58,962	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision First Eye Care Inc.	0	0.0%	880	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Plan of America	1	50.0%	12,209	0.82	0	0.00	0	0.00	0	0.00	1	0.82	0	0.00	0	0.00	0	0.00
Vision Service Plan	1	50.0%	5,839,692	0.00	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00	0	0.00
Total Vision:	**2**		**6,633,009**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**2**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
Pharmacy																		
HealthSpring Life & Health Insurance Company	0	0.0%	32,134	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**		**32,134**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
Dental Discount Plan																		
Dental Choice of California Inc.	2	100.0%	364,536	0.05	0	0.00	1	0.03	0	0.00	1	0.03	0	0.00	1	0.03	0	0.00
Gold Plan or My Smile Dental Plan	0	0.0%	16,023	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
New Dental Choice	0	0.0%	29,821	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 Discount Plan:	2		410,380	0.05	0	0.00	1	0.02	0	0.00	1	0.02	0	0.00	1	0.02	0	0.00
Medical Discount Plan																		
Family Care	0	0.0%	2,437	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Medical Discount Plan:	**0**		**2,437**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**

2014 Complaint Results by Category and Health Plan

					Access Issues		Benefits / Coverage		Claims / Financial		Enrollment		Coordination of Care		Attitude / Service of Health Plan		Attitude / Service of Provider	
Plan Type and Name	**Complaints Resolved**	**% of Complaints Resolved**	**Enrollment**	**Complaints 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**	**Count**	**Per 10,000**
Psychological																		
Avante Behavioral Health Plan	0	0.0%	24,837	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna Behavioral Health of California Inc.	0	0.0%	169,399	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%	157,970	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.	0	0.0%	98,244	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
HAI-CA (Human Affairs International of California)	0	0.0%	196,707	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%	133,255	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Horizon Health EAP - Behavioral Services	0	0.0%	739,388	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-EmployerSv	1	14.3%	528,128	0.02	0	0.00	1	0.02	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Managed Health Network	0	0.0%	1,409,013	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
OptumHealth Behavioral Solutions of California	6	85.7%	1,300,282	0.05	0	0.00	2	0.02	1	0.01	1	0.01	1	0.01	0	0.00	1	0.01
ValueOptions of California Inc.	0	0.0%	783,603	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Psychological:	**7**		**5,540,826**	**0.01**	**0**	**0.00**	**3**	**0.01**	**1**	**0.00**	**1**	**0.00**	**1**	**0.00**	**0**	**0.00**	**1**	**0.00**
Grand Total	**6,453**		**51,865,386**	**1.24**	**303**	**0.06**	**1,578**	**0.30**	**1,409**	**0.27**	**1,885**	**0.36**	**798**	**0.15**	**501**	**0.10**	**197**	**0.04**

CELEBRATING MOMENTOUS ANNIVERSARIES

2014 ANNUAL REPORT

Published July 2016

DEPARTMENT OF
Managed
Health Care