



*Right Care
at the
Right Time*

Department of Managed Health Care
Annual Report 2005

Your **RIGHTS** as an HMO Patient:

- **You have the right to see a primary care physician who is located near you.**
Your HMO must assign you to a primary care physician who is located within 15 miles (or a 30-minute drive) of your home or workplace.
- **You have the right to a second opinion.**
If you disagree with the diagnosis or the way your doctor proposes to treat you, and have discussed the matter with your doctor, you may request to see another physician for a second opinion. In many cases the HMO must pay for a second opinion.
- **You have the right to be referred to a specialist when medically necessary.**
Your HMO must provide a referral to a qualified specialist when it is medically necessary for you to see one.
- **You have the right to select an obstetrician/gynecologist as your primary care physician.**
If you are a woman, your HMO must permit you to see a participating obstetrician/gynecologist without obtaining a referral from your primary care physician.
- **You have the right to a quick response when requesting authorization for a medical referral.**
In most cases your HMO must provide an answer to your physician's request for a treatment authorization within five business days of the HMO's receipt of the request (or 72 hours if the request is urgent).
- **You have the right to file a grievance with your HMO.**
If you are dissatisfied with the health care that you received from your HMO, you have the right to file a grievance with your HMO. The HMO must resolve the grievance within 30 days (or within three days if the grievance is urgent).
- **You have the right to receive emergency care without prior authorization.**
If you reasonably believe that you need immediate care to avoid placing your health at serious risk, you may seek emergency care by dialing "911" or by going to the nearest emergency facility without seeking prior authorization from your HMO.
- **You have the right to uninterrupted health care.**
If you have to change HMOs or your doctor is no longer under contract with your HMO during the course of treatment, your HMO must have policies in place to guarantee that you will not suffer from an interruption in medically necessary care.
- **You have the right to inspect your medical records kept by your provider.**
You can ask to review your own medical records. If you believe that they are incomplete or incorrect, you have the right to add a written addendum with respect to any item or statement in your records. There may be a fee to review your medical records.
- **You have the right to contact the California Department of Managed Health Care's HMO Help Center for assistance, toll free at 1-888-HMO-2219, or TDD 1-877-688-9891 if you can't resolve a problem with your HMO.**

Your **RESPONSIBILITIES** as an HMO Patient:

The following suggestions, while not required by law, can help you obtain the highest quality of care from your HMO:

- Read and understand your HMO Evidence of Coverage/Contract and keep it handy for easy reference.
- Always be prepared to discuss your healthcare problems during your visit with your doctor.
- Ask your doctor questions if you are not clear about your diagnosis or treatment plan.
- Demand appropriate, necessary care.
- Keep good records of your medical history, including diagnosis and treatment information.
- Know about and use preventive health care services offered by your HMO.
- Be an active participant: ask questions, read, and inquire.
- Learn how to become your best advocate.
- Keep your membership card handy.
- Know the phone number of your HMO Member Services.

A MESSAGE FROM DIRECTOR LUCINDA "CINDY" EHNES



To California consumers, health plans, physicians and other health care providers:

Over the past year, the DMHC team has worked hard to ensure that members receive the right care at the right time. To meet this mission, we have tackled a number of extremely complex issues impacting both the health care industry and California consumers.

Consumer protection is our primary job, and it is one we do well. During 2005, our 24/7 HMO Help Center assisted more than 113,000 members to resolve their health plan problems. In any month, the Help Center handles up to 10,000 calls. As a result of the Help Center's intervention, members were reimbursed more than \$1 million for services that they had been charged in error.

Affordability of health benefits is of critical concern to everyone. The DMHC has worked aggressively to ensure that California's managed care system can continue to offer some of the lowest premiums in the nation. We also focused on more cost-effective information technology improvements – rolling out a new e-filing system that allows health plans to submit new product filings and required financial reports; piloting a new Web site portal to help the public easily offer comments and suggestions on important issues, such as new regulations; and launching a major Web site redesign that will now offer much more consumer information and make it easier to navigate to find important information.

Also in 2005, after extensive review, we approved the merger of UnitedHealth Group and PacifiCare of California, securing more than \$250 million in community benefits for California consumers. This money will be used to improve health care information technology infrastructure in rural and underserved communities, give consumers more choice through development of new HMO products, improve medical education in key areas of the state, and provide other investments in health care projects designed to serve low-income populations.

Another key area we concentrated on was reducing the complexity of written health plan and DMHC documents for consumers. We view it as essential that consumers better understand the important health care rights guaranteed them by California law, as well as their own role and responsibilities in accessing appropriate health services.

We believe in fostering strong managed care networks that deliver high quality, cost efficient health care services. We commit to the public to continue to identify additional avenues for making California's health care system the best and most affordable in the nation.

Sincerely,

A handwritten signature in black ink that reads "Cindy Ehnes". The signature is written in a cursive, flowing style.

Lucinda "Cindy" Ehnes

Director

TABLE OF CONTENTS

About The Department	1
Consumer Assistance	2
HMO Help Center	2
Telephone Assistance.....	3
Independent Medical Review (IMR)	4
Consumer Complaint Resolution Options.....	6
Provider Complaints	10
Contract Disputes and Continuity of Care Issues	11
Stakeholder Interaction	12
Advisory Boards & Committees.....	12
Stakeholder Outreach	12
Efficiency Through Technology	16
Regulatory Activities	17
Issues and Challenges.....	18
Health Plan Surveys.....	18
Licensing	19
Financial Oversight	20
Enforcement.....	23
Legal Services.....	23
Health Plan Assessments	24
Innovation	25
New Product Development	26
Technological Solutions.....	26
Statistics	
Independent Medical Review Results By Health Plan.....	Appendix A, 28
Complaint Results By Category & Health Plan.....	Appendix B, 31
Plans Licensed Through the Department of Managed Health Care	Appendix C, 38
Enforcement Case Load Tracking	Appendix D, 41
Fines Associated with Violation Trends During 2005.....	Appendix E, 42
2-Year Comparison: Amount of Fines per Health & Safety Code.....	Appendix E, 42
Assessment Process	Appendix F, 43
Assessments By Type	Appendix G, 44
Comparison of Health Plan Revenue & Administrative Expenses to Annual Assessments	Appendix H, 45

About The Department

Mission

The people of the Department of Managed Health Care work toward an affordable, accountable and robust managed care delivery system that promotes healthier Californians.

Through leadership and partnership, the Department shares responsibility with everyone in managed care to ensure aggressive prevention and high quality health care, as well as cost-effective regulatory oversight.

Vision

To be nationally recognized health care policy experts and establish national benchmarks for Health Maintenance Organization regulation, policy, patient advocacy and consumer awareness.

Who We Are & What We Do

The Department of Managed Health Care (Department or DMHC), a first-in-the-nation consumer rights agency, helps Californians resolve problems with their Health Maintenance Organization (HMO or health plan) to facilitate access to appropriate care. We are working for a stable, solvent and affordable managed health care system. We also seek to return the industry back to its roots of better preventive health care so that Californians are healthier and so that precious resources are preserved for those who are ill. We license and regulate California HMOs through the authority of the Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act or Act). We also provide HMO oversight through financial exams and medical surveys. In addition, we develop legislation to address emerging consumer and industry issues.

How We Serve Consumers

The DMHC's HMO Help Center is often the only legal resource many patients will have available in

navigating a complex health system. While other DMHC sections attempt to balance the views of all stakeholders, the HMO Help Center actively advocates at all times for the best interests of enrollees. It is our job both to ensure HMO enrollees know they can call for help, and to continuously improve the quality of that support.

- We are available to consumers 24 hours a day, 7 days a week through our HMO Help Center. The HMO Help Center provides services for both English and Spanish speaking consumers, in addition to telephonic translation services available in over 100 other languages, and a TDD device for the hearing impaired.
- We promote consumer education regarding their health care rights and responsibilities and respond to health care concerns.
- We make every effort to expeditiously resolve issues with health plans, physicians and other providers. Consumer complaints are typically reviewed and resolved within 30 days, or within days if there is an urgent medical need.
- We develop partnerships with other organizations in order to share health care concerns, information and solutions with everyone involved in the health care delivery system.
- We continually evaluate our business processes, looking for new ways to deliver services to all customers in a more timely, efficient and professional manner.
- We are a vital and energetic organization charged with protecting and advocating for HMO consumers. We approach our regulatory responsibilities with professionalism, and embrace collaboration to ensure the very best service for consumers.
- We advocate for affordable, quality health care for all Californians.

"Often the only legal resource many patients will have, the HMO Help Center actively advocates at all times for the best interests of enrollees."

Cindy Ehnes
Director

Consumer Assistance

HMO Help Center

The HMO Help Center is dedicated to ensuring that consumers understand their health care rights and receive prompt and effective responses to their health plan concerns. During 2005, the HMO Help Center assisted 113,132 consumers in resolving their health plan problems via telephone assistance, quick resolutions, early reviews, urgent case resolutions, complaint resolutions, or Independent Medical Reviews. With services *available 24 hours a day, 7 days a week*, the HMO Help Center is readily accessible to assist the consumers we serve. Patients' rights advocates, health care professionals, and consumer service representatives are available to help resolve issues with a health plan ranging from a simple paperwork mix-up to a complex medical issue.

Consumers often contact the Department when they are being charged for services that they feel should be covered by their health plan. *The amount of money consumers saved in 2005 as a result of the HMO Help Center's intervention was \$1,165,736.* This total reflects claim disputes that expressly identified a dollar amount reimbursement. The amount reported does not include non-reimbursable costs associated with surgery or other procedures that were initially denied by the health plan, but later authorized.

HMO Help Center Mission

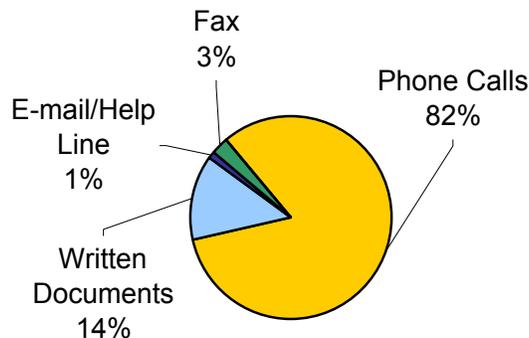
The mission of the HMO Help Center is to provide information to consumers regarding health care

issues, to ensure that health plans are accountable to members for providing required health care services and for appropriately addressing member complaints.

How We Help

- We provide readily accessible assistance to health care consumers to resolve their health plan coverage concerns and problems.
- We provide timely review of, and response to, complaints regarding health plans and requests for information.
- We routinely monitor health plans to ensure they comply with the law and fulfill their obligations to members and, where necessary, identify and seek appropriate corrective action.
- We identify systemic issues in an effort to improve the managed health care delivery system.
- We make ourselves available to consumers by telephone, correspondence, e-mail, fax and in-person visits.
- We promote open lines of communication within government agencies and with health plans, hospitals, physicians, nurses and other providers to assure early intervention for the resolution of patient/member issues.

Consumer Method of Contact in 2005



Information Requests

In 2005, the HMO Help Center received over 7,000 consumer requests for informational pamphlets, forms

or specific sections of California's patients' rights laws. According to consumer preference, this information is either mailed to the consumer or the consumer is instructed on how to obtain the information from the Department's Web site <www.hmohelp.ca.gov>.

Requests for Information by Type	Number
Complaint Packet	3,268
Phone Number	1,134
IMR Packet	696
COBRA Packet	315
Supplemental Materials	232
Knox-Keene Act	91
The HMO Senior Guide	81
OPA Report Card	61
HMO Help Center Brochure	12
Booklet for Uninsured	5
Other	1,218
Total Number of Requests for 2005	7,113

Telephone Assistance

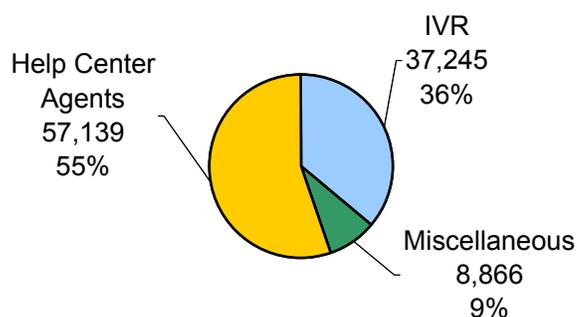
The HMO Help Center's first priority is customer service. In addition to responding to formal complaints and requests for Independent Medical Reviews, the HMO Help Center responded to thousands of calls from consumers requesting general information or assistance. The HMO Help Center received between 7,500 and 10,000 calls each month from consumers, about seven percent of which resulted in a formal complaint or an Independent Medical Review. In 2005, the HMO Help Center provided telephone support services in 20 different languages.

Over 6,600 individuals called with problems outside our jurisdiction, and we connected them to the appropriate oversight agency or patient organization to address their concerns. The HMO Help Center agents strive to be an effective resource for all types of health care concerns, not only those dealing with HMOs.

The Department is also committed to opening the lines of communication between health plans, hospitals, physicians, and other providers to assure early intervention for the resolution of consumer issues.

Calls Answered by HMO Help Center in 2005

Total Calls Answered = 103,250



Consumers Deserve 24/7 Availability

The HMO Help Center is available 24 hours a day, 7 days a week, to respond to consumer issues. Because health care problems often occur outside of regular business hours, we believe that consumers need a reliable resource to assist them during all hours.

"In these days of rationed care, big bureaucracies, and for-profit health care providers who seem to value profits above patients, DMHC is a breath of fresh air! If it were not for DMHC's help and intervention, we would never have been able to get the (treatment) that our child needed. Thank you, thank you, thank you!"

John N. Heathcliff
Los Angeles, California

Automated Responses to Inquiries

When consumers call the HMO Help Line at (888) HMO-2219, they can always reach a live person to assist them. Consumers initially receive immediate assistance from the digital Interactive Voice Response (IVR) system and may opt to speak with the staff of the HMO Help Center. The HMO Help Center's IVR system provides:

- Telephone numbers for the major full service health plans and other specialized plans, such as vision or dental.
- General information regarding the HMO Help Center.

- Instructions to register a complaint or an Independent Medical Review.
- COBRA, HIPAA, Medicare and Medi-Cal information.
- Recent changes in health plan or medical group services.
- The Department's Web site address for additional information <www.dmhc.ca.gov>.

There were 37,245 calls (nearly 36 percent of all calls) resolved through the HMO Help Center's IVR system during 2005.

"I am positive (DMHC) involvement contributed to a prompt resolution. In these situations, your agency is the last bastion of hope for the 'average' citizen.

Cleopatra Bullard
Rialto, California

Independent Medical Review

An Independent Medical Review (IMR) provides health plan members the opportunity to receive an outside review of their health care dispute from doctors and other health care professionals, completely independent of the member's health plan.

The IMR program has enabled members to receive treatment or medical care previously denied by their health plans. We believe that the success of this program has encouraged health plans to resolve potential cases internally to the member's satisfaction.

Three types of disputes are eligible for IMR:

1. Denials based on a finding that a requested treatment is experimental or investigational for life-threatening or seriously debilitating medical conditions.
2. Services that are denied, delayed, or modified by the health plan or one of its contracting medical

providers based on a finding that the service is not medically necessary.

3. Disputes concerning a health plan's failure to reimburse the member for out-of-plan emergency or urgent medical services.

The Department determines whether a case involves an issue that is eligible for an IMR. The health plan must have an opportunity to assess and resolve the issue through its standard grievance process. By law, before an IMR application is eligible for review, an independent review organization comprised of physician and medical specialists conducts the actual reviews.

Health plans are assessed a fee for the reviews. There is no charge to the member for the application, processing, or resolution of an IMR.

The Director of the Department must formally adopt the IMR determination. If the health plan's decision is overturned, the health plan is required to implement the findings within five days.

Health plans may request that an otherwise eligible case be withdrawn from IMR when it decides to reverse its previous denial of requested services. If the reversal fully resolves the member's concerns, the case will be withdrawn but the health plan is required to explain why the dispute was not resolved in the grievance process. While such resolutions are encouraged, the Department reviews requests to withdraw cases from the IMR process to ensure the dispute was appropriately assessed by the health plan's treatment authorization and grievance systems. There were 31 withdrawn cases in 2005 compared with 52 in 2004.

In 2005, there were 989 members who had been denied health care services involving medical necessity, or the proven effectiveness of certain treatments, that received IMRs. Thirty-three percent of the health plan decisions were overturned and consumers received services that otherwise would have been denied. (Please refer to [Appendix A](#) for IMR results by health plan.)

IMR Resolutions: Upheld vs. Overturned

IMR Type	Upheld		Overturned		With-drawn	Total
Experimental / Investigational	158	75%	54	25%	4	216
Medical Necessity	487	65%	259	35%	27	773
Total Resolutions	645	67%*	313	33%*	31	989

* Percentage totals do not include withdrawals.

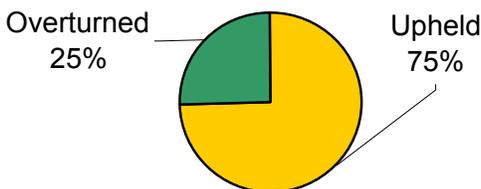
Twenty-two percent of the 989 reviews were based on health plan denials of a service considered to be experimental or investigational. Twenty-five percent of these were overturned. The remaining reviews were based on health plan denials of a service considered to be not medically necessary. Thirty-five percent of these were overturned.

The following graphs illustrate the information on the total number of IMRs in 2005 and identify whether or not the independent review organization upheld or overturned the health plan’s original denial. Results are provided separately for experimental/investigational reviews and medical necessity reviews.

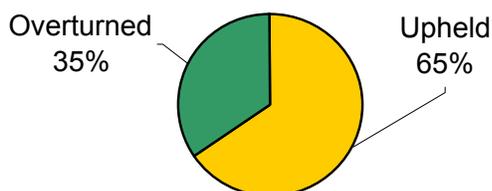
Upheld—The review organization upheld the health plan’s original denial.

Overturned—The review organization overturned the health plan’s original denial, and the health plan is now required to provide the service to the patient.

216 Experimental/Investigational IMRs Upheld vs. Overturned in 2005



773 Medical Necessity IMRs Upheld vs. Overturned in 2005



Standard vs. Expedited Reviews

Generally, IMR cases are processed (through completion) within 30 days of qualification of the application. However, in certain circumstances, an IMR can be processed on an expedited basis.

For a service that has been denied based upon the finding that it is *experimental or investigational*, the IMR can be expedited if the patient’s physician states that the treatment would be significantly less effective if not done promptly. In these cases, IMR processing is completed within nine days.

For a service that has been denied, delayed or modified based upon the finding that it is *not medically necessary*, the IMR can be expedited if there is an imminent and serious threat to the health of the patient. In these cases, IMR processing is completed within seven days or less.

The chart below provides information on the number of IMRs that were processed as *standard* versus *expedited*.

Standard vs. Expedited Cases Closed Through IMR in 2005

IMR Type	Standard Resolved	Expedited Resolved	Total
Experimental/Investigational IMR	173	39	212
Medical Necessity IMR	695	51	746
Withdrawn IMR			31
Total	868	90	989

Continuing Care IMRs

IMR cases often involve “continuing care” where the health plan has issued a medical necessity denial for services that are expected to continue for some time. The most common situations involve denials of prescription drugs, speech therapy, or continued admission to facilities. In several cases there has been a question of how long the plan must continue to authorize the care. While the reviewing physician is at many times unable to define a future point in time when, for example, a patient can safely be transferred to a lower level of care, a variety of solutions to this problem are used. The Department encourages its reviewing physicians to identify the significant aspects of

the patient’s medical history, as well as the known treatment plan, and set out the important factors used in analyzing the alternative treatments. The Department has advised health plans to work with providers prior to performing a post-IMR utilization review to ascertain whether there have been changes in the patient’s condition warranting the review. Health plans were advised that failure to do so might be construed as a violation of the Department’s order.

Consumer Complaint Resolution Options

In addition to resolving health plan denials through the Department’s IMR program, the HMO Help Center strives to resolve consumer issues at the first possible level in the shortest amount of time. Based on the circumstances presented by the member, the HMO Help Center uses one of four resolution processes for consumers:

1. Quick Resolution—An *informal* process that resolves consumers’ concerns within hours or a few days.
2. Urgent Case Resolution—An *informal* process that addresses urgent clinical issues that cannot wait 30 days to go through the formal complaint process.
3. Early Review—A *formal* process that addresses time-sensitive non-clinical issues prior to the member’s participation in the health plan’s grievance and appeal process.
4. Complaint Resolution—A *formal* process that resolves complaints within 30 days. This process follows the member’s requirement by law to participate in the health plan’s 30-day grievance and appeal process.

Quick Resolution

The HMO Help Center utilizes the informal Quick Resolution process to resolve consumer complaints within hours or a few days. In some cases, our agents bring a representative from the health plan on the line with the consumer in a three-way call to

expedite resolution and eliminate additional delays. Many issues can be resolved quickly by opening the lines of communication between the health plan and the consumer. In 2005, there were 606 calls resolved through the Quick Resolution process. The HMO Call Center enhanced the this process by implementing the following changes:

- Worked more closely with the clinical and nursing staff to expand the Quick Resolution process to improve and expedite resolution of consumer complaints/issues.
- Expanded the Quick Resolution staff by four new positions.
- Hosted meetings between Help Center staff and health plans to discuss and train them on our processes.
- Changed and distributed new guidelines and developed internal mechanisms to identify key characteristics that qualify complaints for quick resolutions.

All these factors have contributed to the overall increase the number of Quick Resolutions compared to prior years. If either party decides to pursue the issue via a formal complaint or Independent Medical Review, the issue is immediately transitioned from the Quick Resolution process to the appropriate formal dispute resolution process.

Quick Resolution Issues Received in 2005

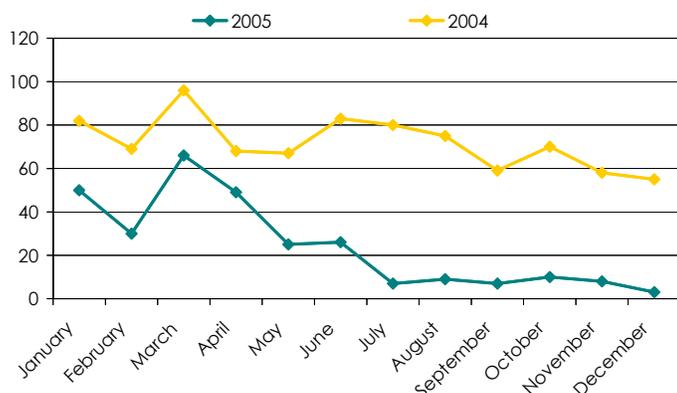
Quick Resolution Issues	No. of Issues	% of Issues
Enrollment or Cancellation	112	19%
Claim Payment	99	16%
Medical Appointment	83	14%
Provider Access/Change & Block Transfers	54	9%
Coordination of Care	44	7%
Access to Member Services/Benefit Info.	41	7%
CalCobra/Cobra/HIPAA	36	6%
Prescription Issues	21	3%
Medical Record Access	17	3%
Other	99	16%
Total	606	100%

Urgent Case Resolutions

Consumers often call the HMO Help Center with issues that cannot wait 30 days to complete a health plan's formal complaint process. These complaints involve delays or denials in refilling prescription medications, delays in obtaining appointments or surgery for pressing health care issues, premature release from a hospital or facility, or an inability to obtain a referral for treatment.

In 2005, there were 290 urgent complaints that required an immediate resolution compared to 862 in 2004. Urgent complaints were generally referred to our clinical nurses who worked with the consumer and the health plan to resolve the issue.

2-Year Comparison of Urgent Cases



The overall number of urgent complaints has steadily decreased during the past three years. As the health plans gained greater experience with the Department, met adherence to the Knox-Keene Act, and collaborated with the HMO Help Center clinical staff, they became more likely to resolve clinical matters in favor of the member without HMO Help Center intervention. In addition, the changes implemented in the Quick Resolution process have affected the number of urgent cases being directed to our clinical nurses.

During the Quick Resolution process, cases were more thoroughly reviewed before being sent through the Urgent Review process, further decreasing the number of cases.

Urgent Complaints Received in 2005

Urgent Complaint Type	Number
Access/Referral Issue	73
Rx/Medication Supply	39
Benefit Issue	25
Denied Treatment	22
Diagnostic Test Access	16
Early Discharge - Facility	16
Acute Pain	9
Experimental Treatment	7
Chronic Pain Management	5
Mental Health Services	4
Durable Medical Equipment	3
Problems with Pregnancy	3
Poor Health Plan Communication	2
Medical Group Closure	1
Other	65
Total Number for 2005	290

Our staff is available 24 hours a day, 7 days a week, to resolve urgent issues. The Department is also responsible for assuring that health plan contacts are available 24 hours a day, 7 days a week, to help respond to these urgent issues.

Early Review

If a member is involved in a time-sensitive dispute requiring intervention prior to a health plan's thirty day grievance and appeal process, staff performs an early review of the case. During 2005, the early review process was applied to 139 cases. Examples of these types of reviews include:

- HIPAA, Cal-COBRA, or federal COBRA deadline issues.
- Cancellation of coverage deadline issues.
- Continuity of care issues involving a severe medical condition that requires the member to receive care from the same physician or medical group for a specified period of time. Some of these issues are addressed in the urgent and quick resolution process referenced in this report.
- Health plan delays in implementing a Departmental decision or agreed upon resolution.

Complaint Resolution

Consumers file formal complaints about benefit and coverage disputes, claims and billing problems, eligibility, inadequate access to care, and attitude or service concerns. Disputes regarding denials of service may qualify for an IMR. The HMO Help Center has developed the infrastructure necessary to ensure that complaints are resolved and that we are responsive to California's health plan members.

Complaints are researched and resolved by a team of HMO Help Center staff that includes consumer service representatives, analysts, patients' rights attorneys, and clinical staff. However, before a complaint is eligible for review, the health plan, through its own grievance and appeals process, must have an opportunity to assess and resolve the issue within 30 days (or 72 hours for expedited urgent grievances).

A member may submit a complaint to the HMO Help Center by telephone, letter, e-mail, in-person, or by completing a consumer complaint form available on the Department's Web site <www.hmohelp.ca.gov>. Though it is not a requirement to complete the consumer complaint form, it facilitates the complaint resolution process by assuring that the HMO Help Center receives all the information necessary to resolve a complaint. We review all written information provided by both the member and the health plan, including relevant medical records. *There is no charge to the member to file a complaint with the HMO Help Center.*

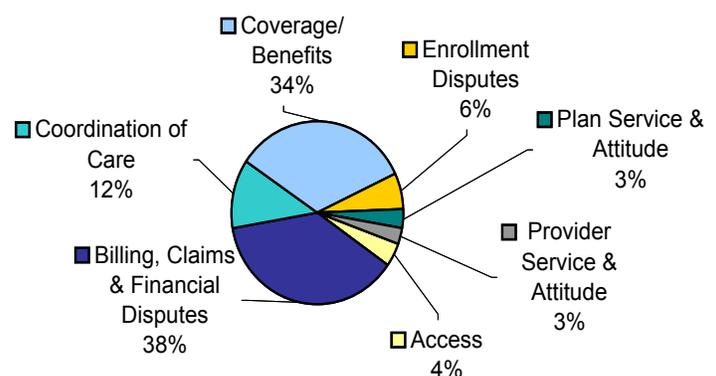
If research determines that the issue is not critically time sensitive, it will be resolved through the standard 30-day complaint process. The HMO Help Center will then issue a written explanation of the complaint decision. If the complaint is resolved in the member's favor, the health plan is required to provide and cover the disputed service or take other appropriate action as defined by the Department. If the complaint is not resolved in the member's favor, the member may pursue other remedies, as defined in the health plan's Evidence of Coverage (EOC).

A significant number of requests for assistance are outside the Department's jurisdiction. If we cannot assist the consumer, we will connect them with the appropriate organization who can. As a result, our staff are required to have full knowledge and understanding of programs sponsored by other state and federal agencies as well as advocacy groups. HMO Help Center staff consistently refer consumers to organizations such as: Health Rights Hotline, Centers for Medicare & Medicaid Services, Major Risk Medical Insurance Board, Department of Health Services, Department of Insurance, Department of Consumer Affairs, CalPERS, Department of Labor, and the Health Insurance Counseling and Advocacy Program.

Data on all incoming complaints, regardless of type, are entered into the HMO Help Center's automated case management system. Accurate data collection and maintenance of the automated case management system enables us to identify systemic issues and track emerging issues.

In 2005, the HMO Help Center researched and analyzed the following types of complaints:

Complaint Categories



Complaint Response

We focus on effectively resolving individual consumer complaints. If systemic problems are discovered as a result of multiple complaints, the issues are referred to the appropriate Departmental

COMPLAINT TYPE DEFINITIONS

Accessibility - These complaints include: long wait times for appointments, lack of availability of primary care or specialty physicians, delay or failure to respond to patient requests for authorization or referrals, difficulty changing primary care providers or medical groups, and difficulty obtaining medical records, etc.

Attitude & Service of Health Plan - These complaints include: health plan staff behavior (including attitude, communication, rudeness), complaints about slow responses to inquiries, grievances, and request for plan materials, etc.

Attitude & Service of Provider - These complaints include: physician or office staff behavior (including attitude, communication, rudeness, rushed appointment), the physical condition of a hospital or physician office, complaints about slow responses to inquiries, etc.

Billing, Claims & Financial Disputes - These complaints include: claims disputes (including slow payment, insufficient payment or disputes about co-pays or co-insurance), and premium disputes (including refund requests and premium increases).

Coordination of Care - These complaints include: lack of coordination among multiple specialty areas, discharge planning or early release, inadequate diagnosis, inadequate treatment, or the failure of a physician to order a sufficient level of care or length of treatment. These also include complaints about the inability to continue treatment with an established provider.

Coverage & Benefits Disputes - These complaints include: disagreement about whether a service is covered under the member's evidence of coverage and how it may be covered, refusal to refer to a specialist or out of network provider when the service is available within the network, a denial of ancillary services on the basis that benefit maximums have been reached, etc.

Enrollment Disputes - These complaints include: false or misleading marketing information, disputes regarding enrollment and underwriting issues, continuation of group coverage, and cancellation or termination of coverage.

office for further action. (Please refer to [Appendix B](#) for complaint results by category and health plan.)

Written complaints received by the HMO Help Center are reviewed by a complaint analyst, who gathers the relevant facts and supporting documentation and then informs the member of the Department's intended action. The analyst coordinates efforts between health plan administrators and the HMO Help Center's clinical and legal staff to resolve the complaint. The analysts work cooperatively with the Major Risk Medical Insurance Board, the Health Insurance Counseling and Advocacy Program, the Department of Health Services' Medi-Cal program administrators, and the Department of Insurance to research and resolve complex cases. Reports of discovery and resolution are shared with the appropriate organization when necessary.

Regardless of the outcome, the member is notified of the Department's decision in writing.

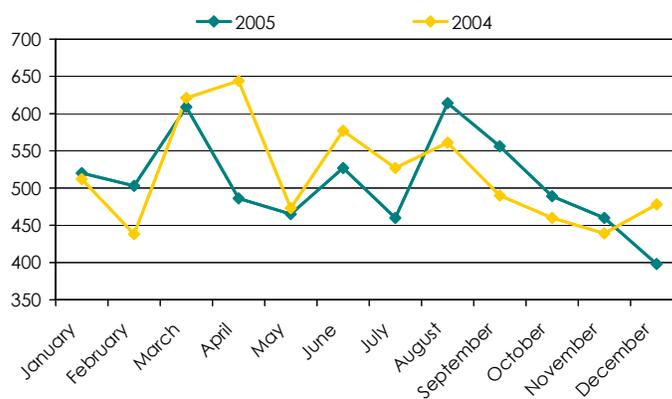
Volume of Formal Complaints Received

From January 1 through December 31, 2005, consumers filed 6,087 formal complaints in comparison to 6,220 filed in 2004. Of the 6,087

complaints filed in 2005 and those carried over from 2004, there were a total of 6,136 cases closed during 2005.

The following chart is a summary of the number of complaints received by month.

2-Year Comparison
Number of Complaints Received By Month
(Does not include IMRs)



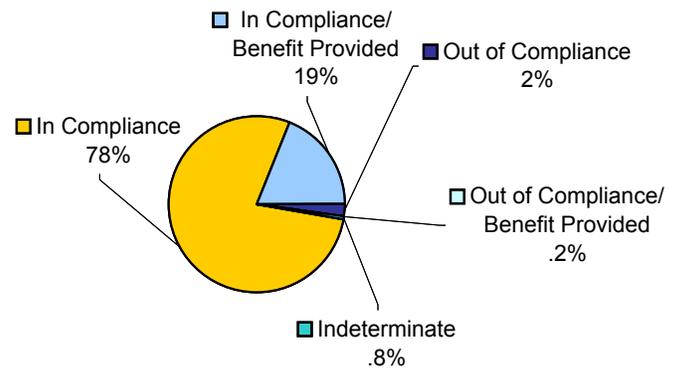
Complaint Compliance Determinations

California's patients' rights laws are embodied in the Knox-Keene Act. The HMO Help Center

resolves disputes using one or more of the following determinations, in accordance with the Act:

- **In Compliance**—Based upon staff’s review of complaint documents (including the health plan’s response to the complaint), no violations of California’s patients’ rights laws were found.
- **In Compliance / Benefit Provided**—The health plan initially denied a service or benefit and then reversed its position by providing the service or benefit after the member accessed the health plan’s grievance system or submitted a complaint to the HMO Help Center. Even after the health plan decision reversal, the facts and circumstances of the case warranted a final finding that the actions taken by the health plan complied with California’s patients’ rights laws.
- **Out of Compliance**—Based upon review of complaint documents (including the health plans’ response to the complaint), staff identified a specific violation of California’s patients’ rights laws.
- **Out of Compliance / Benefit Provided**—The health plan initially denied a service or benefit and then reversed its position by providing the service or benefit after the member accessed the health plan’s grievance system or submitted a complaint to the HMO Help Center. Even after the health plan decision reversal, the facts and circumstances of the case warranted a finding that the actions taken by the health plan did not comply with California’s patients’ rights laws.
- **Indeterminate**—This determination is used in two scenarios: (1) there was insufficient evidence to indicate non-compliance on the part of the health plan; or (2) a compliance determination may not have been applicable.

Compliance with Patients’ Rights Laws - 2005



Provider Complaints

AB 1455 (2000 – Scott) (Chapter 827, Statutes of 2000) added sections 1371.36, 1371.37, 1371.38 and 1371.39 to the Health and Safety Code to prohibit health plans from engaging in unfair payment practices. The prohibited practices include the failure to process complete and accurate claims, reducing or denying complete and accurate claims, failing to make timely pay claims, and failing to automatically include interest. The legislation also amended section 1367(h) to require health plans to maintain a dispute resolution mechanism for providers and authorized the Department to investigate whether payers are engaging in unfair payment patterns.

Pursuant to AB 1455, the Department promulgated extensive regulations establishing specific claims settlement standards. These regulations apply to both health plans and their capitated providers that have been delegated claim payment responsibility. These regulations define the term “unfair payment pattern” as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. These regulations also set forth minimum dispute resolution standards for both health plans and their capitated providers including the issuance of written determination within 45-days of receipt of a payment dispute that addresses the provider’s specific complaint.

These changes led the Department to establish the Provider Complaint Unit (PCU), which became

operational on September 20, 2004. This process allows the Department to track provider complaints to determine whether any health plans are engaged in demonstrable and unjust payment patterns prohibited by the law, or by its implementing regulations.

On June 1, 2005, the Provider Complaint System was enhanced to allow providers to submit multiple “like” claim disputes. This system saves time for providers or their representatives by allowing them to submit “bulk” or multiple “like” complaints through the Department’s Web portal without filling out a complete form for each individual claim.

Through December 31, 2005, the PCU received over 2,130 complaints and closed approximately 1,979 complaints. The complaints closed break down as follows:

- 53% Did not complete the Payer’s Dispute Resolution process.
- 12% Non-jurisdictional.
- 11% Provider non-responsive to request for documentation.
- 4% Duplicates or misdirected complaints.
- 3% Payer was found out of compliance and referred to Enforcement.
- 2% A technical violation was found and corrected; payer was issued a warning letter.
- 15% No violation was identified.

The PCU’s activities have resulted in California providers receiving additional compensation of more than \$322,000.

Contract Disputes and Continuity of Care Issues

The HMO Help Center provides assistance to members whose health plan, medical group, or hospital is unable to reach agreement on contract negotiations by informing them of their rights and what will happen if they lose their doctor, hospital or medical group.

These contract terminations result in potential disruptions in the delivery of covered health care services for California managed care consumers. Consumers are protected in these circumstances under the Continuity of Care laws that became effective in 2004. These laws state that a member has the right to continue service with a terminating provider for a period of time under the following circumstances:

- If the member has an acute condition – for as long as the condition lasts.
- If the member has a serious chronic condition – until the course of treatment is completed and the terminating provider can safely transition care to another provider up to 12 months.
- If the member is pregnant.
- If the member has a “terminal” illness – as long as the person lives.
- Care of a child under three years old – treatment can continue up to 12 months.
- For surgery or other procedure already authorized by the health plan.

In 2005, the Help Center assisted over 1,000 consumers in understanding their options in these contract terminations and in facilitating expedited appeals with health plans when needed to ensure that continuity of care rights were met.

“We all have a common goal: to make sure Californians are healthier.”

Cindy Ehnes
Director

Stakeholder Interaction

The Department is accountable to its external stakeholders which include, but are not limited to: members and patients; health plans; physicians and other providers; advocacy groups; legislators; and federal, state, and county agencies. Our philosophy holds that distinct business entities can work together in a mutually beneficial relationship. We all have a common goal: to make sure Californians are healthier.

Advisory Boards & Committees

The Financial Solvency Standards Board is an independent body that continues to provide input to the Department. Two other advisory groups, the Clinical Advisory Panel and the Advisory Committee on Managed Health Care, both ended by law in May 2005.

Financial Solvency Standards Board

The purpose of the Financial Solvency Standards Board (FSSB) is to advise the Director on matters of financial solvency that affect the delivery of health care services. The FSSB also develops and recommends financial solvency requirements and standards relating to health plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions. Additionally, the FSSB periodically monitors and reports on the implementation and results of the financial solvency laws, and reviews proposed regulation changes. Disputes regarding the reimbursement of health care claims is the most frequent issue brought to the FSSB by providers.

Stakeholder Outreach

We work with our stakeholders to form cooperative working relationships. In order to interact successfully together, we reach out to stakeholders to develop consensus-based solutions.

HMO Help Center Health Plan Newsletter

The HMO Help Center publishes a Health Plan Advisory Newsletter to promote better communication between the HMO Help Center and the health plans. Articles feature such topics as regulatory and statutory updates, tips for responding to HMO Help Center requests for medical and benefit information, updates on the HMO Help Center’s operational complaint processes, the HMO Help Center’s referral process, and IMR process requirements.

HMO Help Center Statewide Forums

The HMO Help Center met with health care partners in statewide forums to identify the needs of health care consumers and develop collaborative approaches to resolving their issues:

- The Director, Assistant Deputy Director and Assistant Chief Counsel attended the *State of Our State Forum* on Healthcare Quality Measurement and Improvement at U.C. Berkeley.
- Staff attended the *15th Semi-Annual Inter-Agency Health Forum*. Representatives from the Department of Insurance, the Department of Labor, and the Centers for Medicare and Medicaid Services were in attendance.
- Staff attended the *Cultural and Linguistics Community Forum*. Forum organizers were advocacy groups that assist individuals with interpreter services and provide public interest legal services for discrimination cases.
- Established working relationships with major stakeholders concerning mental health services in California – consumer advocates, provider groups and local and state mental health systems- in conjunction with a review of how

behavioral health plans are delivering services with a specific focus on the implementation of the mental health parity law, AB88. Staff convened or attended meetings with one or more stakeholder groups to obtain background and to assist in shaping the Department's actions in this complex area.

- Provided training on managed care issues to legal staff at *Protection and Advocacy, Inc.*, a non-profit organization that provides legal assistance to the disabled, particularly in state Regional Centers.

The HMO Help Center also provided speakers for conferences that promoted awareness of managed care consumer rights and responsibilities and Departmental expectations of health plans. Conferences included:

Mental Health Focused Surveys, sponsored by the California Association of Health Plans.

Obesity Seminar, sponsored by the California Association of Health Plans.

Protecting Patient Rights Within Managed Healthcare, sponsored by the California Dental Association.

HMO Help Center Compliance Oversight

HMO Help Center staff dedicated resources toward the following efforts:

- Developed and implemented an outreach-training program focused on improving health plan grievance responses. The program, which uses a case study approach, was presented to health plan representatives in Sacramento and Los Angeles in conjunction with the Division of Plan Survey health plan training.
- Provided legal analysis and advice regarding the redesigning of the Department's Web site.
- Worked closely with UC Berkeley on a health literacy project to deliver health information in an easily understood and consumer-friendly manner.

- Reviewed health plan filings relating to product changes made by Medicare supplement issues required in connection with the new Part D prescription drug benefit.
- Reviewed health plan licensure filings relating to Quality of Care Review Systems, in addition to continuing the review of health plan filings pertaining to the grievance process, IMR, and arbitration.

HMO Help Center Educational Outreach

The HMO Help Center provided educational outreach within California regarding the Department's mission, patients' rights, and the role the Department serves in assisting members with their health care disputes. The following efforts were made:

- Distributed more than 50,000 brochures to libraries across California.
- Visited four health plans to discuss the Quick Resolution process to promote the collaborative efforts that enhance our overall ability to expeditiously process and resolve consumer issues.
- Continues to partner with the California Department of Insurance (CDI) to fulfill the requirements of the SB 1913, Joint Senior Level Work Group Project, coordinating internal functions and processes with CDI to ensure that the regulatory split of authority over health care plans does not adversely impact consumers. The HMO Help Center staff was educated on each agency's regulatory authority and complaint resolution process, and refined internal work processes with the aim of reducing confusion regarding jurisdiction over individual consumer issues.
- Encouraged health plans to make information readily available to members regarding coverage for Phenylketonuria to avoid barriers that would impose an undue burden in obtaining coverage as required by statute (Health and Safety Code Section 1374.56).

- Designed a training program for staff on the Knox-Keene Act compliance requirements relating to grievances and IMRs. The program focused on health plan responses to member grievances, the Department's complaint process, and IMR applications. In addition, the program addressed specific health plan issues concerning the grievance process.

HMO Help Center Health Literacy Project

Starting in early 2004, the HMO Help Center began working with the University of California, Berkeley, School of Public Health, Health Research for Action to understand the impact of health literacy on California managed health care consumers. In 2005, the HMO Help Center made significant improvements that impact all of the consumers we serve by rewriting all of our consumer correspondence with the goal of keeping the reading level at or below a 9th grade level. We also undertook a major Web site redesign project to make it easier for consumers to understand how managed care plans work, where to go for the information they need, how to work with their plan to resolve disputes, and how to find the information they need to file a formal complaint or IMR with the Department. The redesigned Web site is scheduled to "go live" in the summer of 2006.

HMO Help Center Outreach to the Health Care Community

The Department has worked with the California health care community to promote understanding of the Department's mission and patients' rights and the role we serve in assisting members with their health care disputes. In 2005, the following efforts were made:

- Meetings were conducted with seven health-related consumer groups to discuss the Department's role and how we may be able to assist them concerning certain medical services and treatments. Efforts continue to reach all organizations representing the mandated health benefits covered in the law.
- In conjunction with the Department's comprehensive review of issues concerning mental health parity provisions in the Knox-Keene Act, the HMO Help Center held a series of meetings with mental health providers and consumer groups to assess current issues relating to access and availability of mental health services by full-service and specialty managed care plans.
 - The HMO Help Center participated in *KCRA-TV's "Call 3"* program. This enabled viewers to call in and ask about health plans and related issues. Experienced agents from our Call Center staffed the "*Call 3 Hotline*," making appropriate referrals and providing educational services.



"We must sustain and build on our system of care to preserve it for the next generation."

Cindy Ehnes
Director

Office of Enforcement Outreach

The Assistant Deputy Director regularly participates in "reasonable and customary value" stakeholder meetings designed to establish a reimbursement rate for health care providers. Currently, the meetings focus on the implementation of an independent dispute resolution process so that providers have adequate remedies available to be paid properly.

Additionally, the Office of Enforcement participated in weekly conference calls with WATTSHealth Foundation, Inc. to ensure that providers' and members' rights are protected as the plan navigated through its bankruptcy process. This oversight included ensuring that continuity and quality of care to members are not disrupted.

Office of Legal Services Outreach

Throughout 2005, the Office of Legal Services focused increasingly on stakeholder interaction.

Legal Services supported the Department's partnership with stakeholders in the second year of a five-year project to develop a global Electronic Medical Records system and infrastructure in California. Legal Services also lead partnering with health plans, sister agencies, and other stakeholders in the first year of the administration's three-year Obesity Initiative to reduce the incidence of obesity in California. Finally, Legal Services piloted a new regulation development process to provide greater participation with all stakeholders. This process yielded more than three dozen separate meetings, in person, with stakeholders, and numerous teleconferences.

In addition to these meetings and initiatives with stakeholders, the Office of Legal Services solicited comments on the following proposed regulations:

- Language Assistance Program Standards
- Financial Solvency Data Collection, Disclosure Language, Grading, Reviewing and Corrective Action for Risk Bearing Organizations
- Timely Access to Health Care Services
- Block Transfer Filings
- Financial Solvency Definitions
- Public Meetings and Hearings
- Conforming Revisions to Independent Medical Review Regulations
- Conflict of Interest Regulations Amendment
- Outpatient Prescription Drug Co-payments, Coinsurance, Deductibles, Limitations and Exclusions

Office of Legal Services Consumer Participation Program

The Office of Legal Services administers the Consumer Participation Program, which allows the Director to award reasonable advocacy and witness fees to any person or organization representing the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption

of any regulation, order or decision (Health and Safety Code section 1348.9).

The Consumer Participation Program relies on three interactive, Web-based applications as follows: Request for Finding of Eligibility to Participate and Seek Compensation, Petition to Participate in a Proceeding, and Award of Fees.

The Department approved six applications for Request for Finding of Eligibility to Participate and Seek Compensation, and approved 19 applications for Petition to Participate in a Proceeding. In November 2005, an Application for an Award of Advocacy and Witness Fees was received. The Office of Legal Services reviewed the application and issued a Decision on March 10, 2006. The Department awarded Legal Services of Northern California \$7,268.75 for its contribution to the block transfer filings regulatory proceeding.

Division of Licensing Outreach - Department/ Health Plan Ad hoc Workgroup

To support the Business Process Improvement Initiatives to improve the licensing process, the Department/Health Plan Ad hoc Workgroup was launched to seek collaborative input from health plans. The group meets on a bimonthly basis, and has been instrumental in assisting Licensing staff with suggestions for development of filing guidelines and checklists, a product matrix and analysis of exhibits required under CCR 1300.51 of Title 28. As a result of these meetings, the Department developed a listing of periodic required reports and conducted an internal assessment to identify reports that provided limited value and could be considered for elimination. The Department is also seeking methods to improve both internal and external communication with health plans and evaluating mechanisms to ensure a consistent and predictable review process.

Division of Licensing Outreach - Dental Stakeholder Workgroup

Between January and May of 2005, the Department met with dental industry stakeholders including the

California Association of Dental Plans, the California Dental Association, and the Association of Managed Care Dentists to develop a new template whereby dental plans could propose innovative benefit designs intended to reach the dentally uninsured. In a positive example of collaboration, the stakeholders and Department staff together identified ways to assess a dental product's value to members and developed mechanisms to analyze indicators of the product's success at both reaching the uninsured and providing actual savings on dental care. The Department is currently reviewing several product filings utilizing the template developed through the stakeholder meeting process. In 2006, the Department will again convene the stakeholder meetings to assess the next set of priorities.

Division of Financial Oversight Outreach

The Major Risk Medical Board (MRMIB) has contracted with the Division of Financial Oversight to perform a review of medical loss ratios for health plans and insurance companies contracted with MRMIB. In working with MRMIB, the Department is increasing efficiency while at the same time allowing MRMIB to dedicate more funds to providing medical services.

The Division of Financial Oversight is beginning discussions with the Department of Insurance (DOI) in the areas of financial examinations, financial surveillance, compliance examinations and licensing work to share information regarding health plans and insurance companies to better protect members. We are in the process of scheduling a joint examination of a health plan and affiliate insurance company regulated by DOI to share information regarding auditing claims payment processing system.

Efficiency Through Technology

Development of New E-filing Web Portal

Licensed health plans must file all documents for licensing review with the Department electronically through an e-filing system. The Office of Technology and Innovation (OTI) and the Licensing Division

collaborated to develop and implement a new e-filing web portal and document management system within six months. This improvement to the e-filing system has virtually eliminated rejected e-filings by catching previous errors. In-house development of this system resulted in a projected savings of over a million dollars above the anticipated cost of an outside vendor.

Customized Software for the Division of Plan Surveys

The Division of Plan Surveys (DPS) began the development and implementation of a comprehensive technology plan to be completed by June 2006. This plan will support the pre-onsite and onsite survey process. Important priorities include: using technology to ensure efficiency for staff and health plans, standardizing survey activities to the extent possible, and aligning DPS operations with changes taking place in the industry and within other Department divisions.

Public Web Site

The HMO Help Center and the OTI undertook a major Web site redesign project to make it easier for consumers to understand how health plans work, where to go for the information they need, how to work with their plan to resolve disputes, and how to file a formal complaint or IMR with the Department. The redesigned Web site is scheduled to "go live" in the summer of 2006. Consumers will be able to electronically file a complaint against a health plan, find out about how to appeal a health plan treatment decision and find an extensive list of government and private health care resources. It includes important consumer information such as "Understanding Health Plan Costs", "Compare Plans", "High Deductible Plans and Health Savings Accounts", "Tips to Help You Get the Care You Need" and "Problems and Complaints". In addition, health plans and medical providers will be able to find all of the information they need to comply with the regulatory and consumer requirements contained in California's strict patient protection laws.

Regulatory Activities

In addition to our commitment to consumer assistance, the Department is also charged with ensuring a better, more solvent and stable managed health care system.

As California's HMO regulator, the Department works with the health plans to achieve better accountability of patient premium dollars and improved financial stability of HMOs and medical groups. We are committed to ensuring that physicians, hospitals and other providers are willing to participate in managed care by vigorously enforcing prompt pay laws for contracted providers. We also strive to return the industry back to its roots of better preventive health care so that Californians are healthier and precious resources are preserved for those who are ill.

Among the Department's efforts for a stable, affordable managed health care system, we:

- Ensure HMO accountability through enforcing access and quality of care laws.
- Provide consumer outreach and promote the benefits of managed care.
- Provide an Annual Report Card on quality of care measures of HMOs and provider organizations.
- Ensure fiscal accountability for consumer premium dollars and co-payments throughout the HMO system.
- Ensure prompt payment of health care providers participating in managed care.

Industry Changes

The Knox-Keene Act was drafted with the traditional HMO model of managed health care in mind. Over the past three decades, the managed care industry has undergone major changes. The traditional HMO model – once the dominant model for managed care in California – is being challenged by newer and perhaps more flexible health care delivery formats. As the cost of health care continues to rise and the

"Regulations...You Rock! Keep up the great job. Many thanks."

Cleopatra Bullard
Rialto, California

demand for more flexibility increases, the preferred provider model (PPO) is becoming increasingly popular. In response to increasing health care costs, the consumer-driven model for health care delivery has been introduced. The rising numbers of the uninsured have fueled an interest in discount health plans. Unfortunately, legislative and regulatory changes have not kept pace with the rapid change in the health care marketplace and industry. As a result, the existing regulatory mechanisms being used by the Department must be revised to meet these new challenges. Therefore, the Office of Legal Services, Regulatory Division, continues to study industry and marketplace trends to assure that the Department's regulatory initiatives foster better and more cost-effective health outcomes for Californians.

Discount Health Plans

The oversight of discount health plans to ensure that consumers purchasing these products receive real benefits remains a priority to the Department. These discount health plans have not traditionally been directly regulated by any State agency. In conjunction with other divisions, the Office of Legal Services has studied and helped to develop mechanisms by which the Department is able to regulate these entities in a way that will protect California consumers.

Information regarding specific enforcement actions against discount health plan entities can be found on page 23.

Regulatory Revision

As noted above, the existing system for regulating managed care in California has become outdated in the past three decades since the adoption of many regulations implementing the Knox-Keene

Act. The Office of Legal Services is spearheading an incremental revision and reorganization of the Department's regulatory program to more appropriately regulate the managed care industry in California.

Establishing Expertise

As the policy arm of the Department, the Office of Legal Services continues to maintain a level of expertise that allows flexible and appropriate analysis of emerging critical issues. The Office of Legal Services also supports development of internal leadership to ensure that the Department is fostering the next generation of leadership.

Issues and Challenges

Mental Health Parity

The Division of Plan Surveys (DPS) began a series of focused reviews related to Mental Health Parity to both assess health plan compliance with the requirements of Health and Safety Code Section 1374.72 and its accompanying regulation, Rule 1300.74.72, and to gather information from the plans about challenges that they have faced or are facing in implementing Mental Health Parity. In the first half of 2005, the DPS conducted focused reviews on the seven largest Knox-Keene Act licensed full-service health plans and their behavioral health plan delegates. As a result, individual plan parity reports were issued for PacifiCare, Blue Shield, Aetna Health Plan, Kaiser, Health Net, CIGNA, and Blue Cross. These reports captured and summarized the results of the surveys and an analysis of the findings, and provided recommendations based on those findings.

Dental Plans/Denti-Cal

The HMO Help Center staff and the Department of Health Services (DHS) Dental Unit formed a joint work group to collaborate on future oversight of the Denti-Cal plans. The group will begin addressing dental survey audit requirements and assignment

of responsible parties. This joint effort will help to ensure regular surveys of Denti-Cal programs.

Health Plan Surveys

Section 1380 of the Knox-Keene Act requires the Department to conduct a medical survey of each licensed health plan at least once every three years. The medical survey is a comprehensive evaluation of the health plan's compliance with the Knox-Keene Act. The Knox-Keene Act also mandates a follow-up review to be conducted and reported within 18 months of the final report.

The medical survey reviews the major areas of grievances and appeals, utilization management, quality management, and access and availability in the following specific categories:

Quality Management – Each plan is required to assess and improve the quality of care it provides to its members. Areas surveyed are:

- Design, implementation, and effectiveness of the internal quality of care review systems.
- Overall performance of the plan in providing health care benefits.

Grievances and Appeals – Each health plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner. The Department regards a health plan's grievances and appeals process as a core mechanism through which members can exercise their rights should there be a need to resolve problems with their health plans. Areas surveyed are:

- Design, implementation, and effectiveness of the Grievances and Appeals system.
- Procedures for addressing the linguistic and cultural needs of its member population as well as the needs of members with disabilities such as those with visual or other communicative impairment.

Access and Availability of Services – Each health plan is required to ensure that its services are accessible and available to members throughout

its service areas and that services are available without a delay that may be detrimental to members' health. Areas surveyed are:

- Procedures for obtaining health care services.
- Procedures for monitoring and ensuring geographic access and ensuring appointment availability.

Utilization Management – Each health plan manages the utilization of medically necessary services through a variety of cost containment mechanisms while ensuring access and quality care. Areas surveyed are:

- Procedures for reviewing authorization requests and regulating utilization of services and facilities.
- Compliance with notification and timeliness standards and use of appropriate criteria or clinical guidelines to guide authorization decisions.

In addition to the routine surveys and follow-up reviews, additional responsibilities for DPS staff include non-routine surveys and focused reviews, Enforcement referrals, filings reviews, and legislation and regulation reviews.

The following charts illustrate the review and survey activity during calendar year 2005:

Focused Reviews and Non-Routine Surveys During 2005		
Type	Reviews/Surveys Completed	Final Reports Issued
Focused Review	7	7
Non-Routine Surveys	2	1
Totals	9	8

Routine Surveys Completed and Reports Issued During 2005			
Plan Type	Surveys Completed	Final Reports Issued	Follow-up Reports Issued
Full Service	14	14	14
Dental	10	5	7
Vision	9	6	4
Behavioral Health	5	3	4
Chiropractic	1	1	2
Totals	39	29	31

Licensing

The Division of Licensing is responsible for the review and approval of a wide variety of proposed changes to a health plan's operations. It is here that all applications from health plans for licensure and any changes after licensure that the plans make in their operations, contracts or benefits are reviewed by counsel. These reviews cover the full range of a health plan's business organization, health care delivery system and benefit structures. Last year the division received a total of 3,024 electronic filings from health plans.

UnitedHealth Group/PacifiCare Merger

On December 19, 2005, the Department approved the purchase of PacifiCare Health Systems, Inc. by UnitedHealth Group Incorporated. This effectuated a change in control of three Knox-Keene Act licensees: PacifiCare of California, PacifiCare Dental, and PacifiCare Behavioral Health of California, Inc.

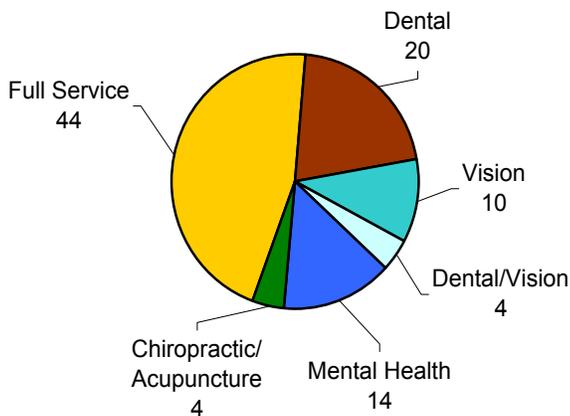
The Department reviewed the terms of the purchase for compliance with the Knox-Keene Act and applied several important consumer protection provisions as conditions to the approval. The most significant consumer financial protection guaranteed by the conditions was the requirement that California members of the three Knox-Keene Act licensed health plans would not fund any of the executive compensation payments. Furthermore, the companies were required to commit funds for improvements to California's health care system including: \$200 million in investments to improve health care information technology infrastructure and other community health initiatives; \$13 million in additional Pay-for-Performance payments to medical groups and Independent Practice Associations that help encourage positive health outcomes through disease management and efficient care delivery; \$1 million in additional marketing expenditures to support new commercial HMO products; and \$50 million for charitable activities including technology projects for safety net providers, medical education in underserved communities, preventive

health projects, and other health care related projects designed to serve low-income populations. Throughout the next four years, the Department will be regularly monitoring the companies' compliance with the conditions of the approval.

Number of Licensed Health Care Service Plans

As of December 31, 2005, there were 44 full service plans and 52 specialized plans (24 dental, 10 vision, 14 mental health, and 4 chiropractic and/or acupuncture). Please refer to [Appendix C](#) for a listing of all health plans licensed with the Department in 2005.

Licensed Health Care Service Plans
as of December 31, 2005



Division of Licensing Functions

In 2005 the Division of Licensing completed review of:

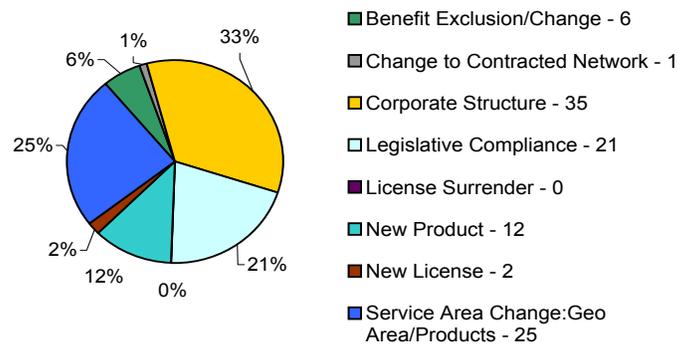
- Two new license applications
- 102 Material Modifications to an existing license
- 442 Evidence of Coverage Disclosure Agreement (§1352.1) amendments
- 496 advertisements
- 213 block transfer filings affecting 7,237,000 members

Material Modifications

By statute, a Notice of Material Modification is required to be filed, and the Department's approval secured, prior to implementing any material change

to a health plan or its operations. It is also required in certain specified situations (for example, should the health plan wish to exclude or limit a medically necessary prescription drug). The Licensing Division reviewed and closed (approved, disapproved, or concurred with plan withdrawal of filing) 102 material modifications in 2005. The following chart illustrates the number and types of material modifications:

Types of Material Modifications Closed in 2005



Technical Assistance Guides

The Division of Licensing has completed the development of Technical Assistance Guides (TAGs) for a variety of Licensing areas. These guides are used internally to ensure consistency in filing review and have been developed in conjunction with health plans to assist them in understanding the Act and preparing documents for submission. TAGs have been completed in the following areas: Evidence of Coverage, Provider Contracts, and Government Plan Products. Licensing expects to complete additional TAGs for specialized health plans, block transfer filings, and new applications during 2006.

Division of Financial Oversight

The Division of Financial Oversight (DFO) protects Californians who receive service from licensed health plans and their provider networks by ensuring that these entities are fiscally viable and comply with the financial provisions of the Knox-Keene Act and related rules. This is accomplished through the performance of on-site financial and compliance

examinations, analysis of regulatory filings and required necessary corrective actions. In 2005, the DFO accomplished the following:

- Met all statutory review deadlines.
- Performed 27 routine and orientation examinations and 29 provider dispute resolution examinations of health plans.
- Made 25 referrals to the Office of Enforcement for serious violations of the Knox-Keene Act.
- Reviewed 795 financial statements submitted by health plans.
- Implemented a survey for health plans to assess the performance of the financial examination staff at the end of each examination. The survey rates the DFO exam staff on their competency, knowledge, responsiveness, efficiency, and leadership.
- Reviewed 100 financial statements submitted by governmental entities that are exempt from licensure under 1349.2 of the Knox-Keene Act.
- Revised and updated the financial examination manual.

Financial Examinations

Financial examinations address appropriate internal controls, administrative capacity, claims payment problems, financial problems, financial viability, appropriate insurance and other compliance issues of a financial nature of health plans. There are five types of examinations:

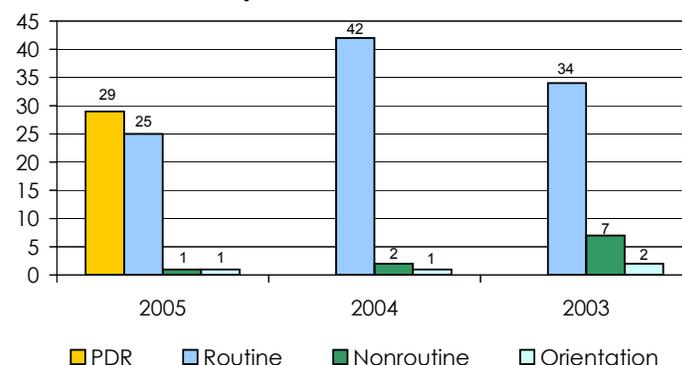
- 1) **Routine** financial examinations provide the Department with the opportunity to review the books and records relating to the fiscal and administrative affairs of the health plan. It is crucial that the books and records of the health plan accurately reflect the results of the health plans' operations to adequately evaluate its financial solvency.
- 2) **Nonroutine** examinations are performed when needed for issues regarding financial viability,

tangible net equity, claims payment, books and records, and financial statements.

- 3) **Special or Focused** examinations are performed as needed to verify implementation of corrective actions required as a result of a routine or nonroutine exam.
- 4) **Orientation** examinations are performed one year from the date of licensure. The purpose is to verify if the licensee is operating as represented in its license application.
- 5) **Provider Dispute Resolution (PDR)** examinations were performed in 2005 and were conducted as a limited examination of the health plans provider dispute resolution process.

Reports are issued that disclose the health plans' ability to comply with the financial viability, tangible net equity, claims payment, and other compliance requirements. Copies of examination reports can be viewed on the Department's Web site at www.dmhc.ca.gov/library/reports/hp_exam/rep_default.asp.

3-Year Comparison: Exams Performed*



*In 2005, PDR exams were performed to determine if health plans were complying with the new Provider Dispute regulation requirements. Future PDR exams will be conducted and reported as part of routine exams.

Financial Oversight Critical Measures

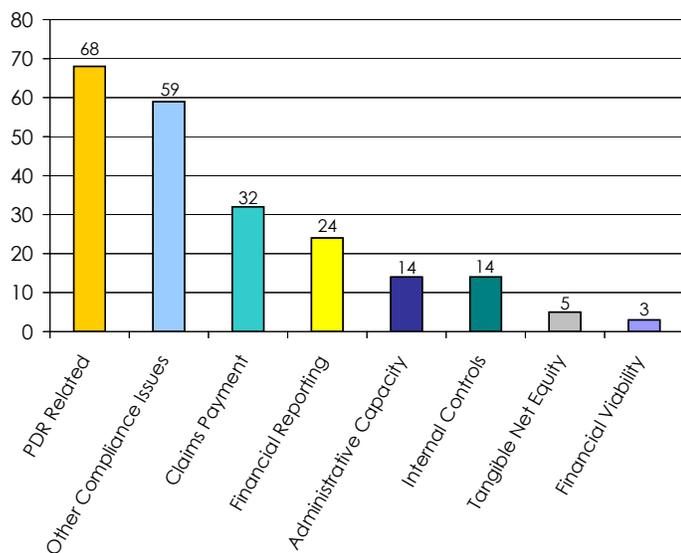
For a more efficient use of staff resources, the DOF developed an indicator model to highlight any potential financial issues with health plans. The

model uses the health plan's quarterly financial statements and compares the data to a group of indicators and related benchmarks. Each health plan is given an overall ranking from A to E. This model is intended to be the first-level of analysis and is used in conjunction with the total financial statement analysis performed by the division. The DFO is working to decrease the number of health plans with financial strength scores that fall below "C" for two consecutive quarters by identifying negative trends and working with the health plans.

Deficiencies Identified

In 2005, the majority of deficiencies in financial examinations were in the areas of financial reporting; tangible net equity, including maintaining the proper amount and calculation of the correct required amount; and claims payment issues.

Types of Deficiencies Identified in 2005

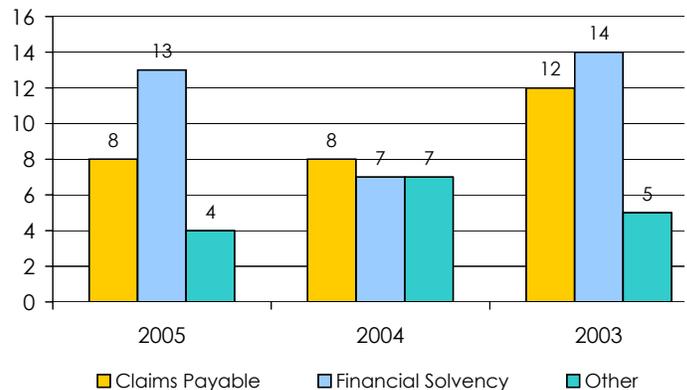


Referrals To Enforcement

When serious violations of the law or regulations are discovered through a financial examination, violations are referred to the Office of Enforcement. In 2005, 19 of the 25 referrals resulted from issues identified as part of the financial examination. As a result of these referrals, Enforcement opened 25 investigatory cases. When multiple violations are identified in the examination report, they will be

combined and included as one referral to the Office of Enforcement.

3-Year Comparison: Referrals to Enforcement



Financial Statement Review

All health plans are required to file quarterly and annual financial statements although, in some instances, a health plan may be required to file a monthly statement. When the health plan is dependent on a sister or parent company for administrative or financial support, the affiliate or parent company may also be required to file periodic financial statements. The financial statements are reviewed in order to identify potential negative trends that might be occurring with the health plan. The examiners may require either a corrective action plan from the health plan or perform a nonroutine examination to proactively address financial issues and avert larger negative consequences, such as a health plan failure.

Health plans file financial statements electronically to the Department and they are placed on the Department's Web site <www.dmhca.gov>.

Quality Assurance

This year the DFO began the practice of conducting a post financial examination survey. This survey is completed by the health plan at the conclusion of the examination and it rates the DFO exam staff on their competency, knowledge, responsiveness, efficiency, and leadership. The DFO also completed an internal quality control self-assessment of its financial examination program. This self-assessment was

designed to ensure the DFO's financial examinations were conducted effectively and provide assurance that the established policies, procedures, and applicable audit standards are being followed.

Examiner Manual

In 2005, the examiner manual and exam program were revised and updated. The examiner's manual sets the guidance, objectives, and the specific procedures to be performed in order for the examiner to conduct an examination of a health plan. The manual is posted on the Department's Web site <www.dmhc.ca.gov> to offer information that health plans may find useful when they have questions about the examination process.

Enforcement

During 2005, the Office of Enforcement (OE) continued to investigate and monitor discount health plan entities in the State. We continue to take an active role in stopping fraudulent discount health plan entities from operating, and to license legitimate discount health plan entities under the Knox-Keene Act. The OE has issued seven Cease and Desist Orders, 26 subpoenas and seven Orders regarding Licensure. The Department has received 337 complaints regarding these entities and the OE has opened 42 cases as a result of our investigations into discount health plans. Six of the seven discount health plan entities that were issued Orders regarding Licensure have pending applications for a Knox-Keene license with the Department.

In the past year, Enforcement staff investigated complaints made by health care providers regarding the unfair payment of claims made by plans. The division has successfully enforced AB 1455 regulations upon plans that were found to have violated the Knox-Keene Act by arranging health care services without a license. This has led to the plans re-evaluating their provider payment practices and implementing new policies and procedures.

The Office of Enforcement represents the Department in litigation initiated against it.

During the past year, the courts have ruled in favor of the Department in two cases:

- *Viola v. DMHC*: The court held that the Department does not violate constitutional rights to a civil jury trial by approving health plan/subscriber contracts containing arbitration clauses.
- *VSP v. DMHC*: The court held that the Department supplied proper notification and levied special assessments on health plans. In addition, the Department filed an amicus brief, ultimately adopted by the appellate court, in *Bell v. Blue Cross* advancing the position that providers can seek reimbursement through a statutory (Unfair Claims Practices) claim as well as through a common law claim based on implied-in-law contracts. This decision ensures that emergency physicians have the right to recover the reasonable and customary value of their services in a court of law.

The OE opened a total of 344 cases, including 21 cases regarding discount health plans. (Please refer to [Appendix D](#) for a breakdown of caseload, hours to close cases, enforcement actions and case aging.)

During 2005, the OE accomplished the following through its regulatory function:

- Collected a total of \$1,497,144 in fines from health plans that violated the Act compared to \$723,700 in 2004.
- Collected a total of \$1,704 in special assessments from health plans that failed to timely pay their assessments.
- Collected a total of \$5,650 in court sanctions.

(Please refer to [Appendix E](#) for fines associated with violation trends during 2005 and a two-year comparative summary of fines associated with specific Health and Safety Code violations.)

Legal Services

Regulations

In 2005, twelve regulation packages were initiated. However, not all have completed the drafting stage and the formal rulemaking process. Currently, four regulatory packages are going through the formal rulemaking process, two of which are of particular importance: (1) *Access to Language Assistance*; and (2) *Outpatient Prescription Drug Co-payments, Coinsurance, Deductibles, Limitations, and Exclusions*. It is anticipated that both of these rulemaking actions will be completed and implemented in 2006.

While each component of the managed health care regulatory scheme is important in the overall picture, of the six packages that completed the formal process during the 2005 calendar year, the two most notable are: (1) *Block Transfer Filings*, which address health plan policies and procedures relating to continuity of care, particularly block transfers of members from a terminated provider group or hospital to a new provider group or hospital; and (2) *Financial Solvency Regulations*, which provide guidelines for financial solvency data collection and disclosure, and methods for grading the financial solvency of risk bearing organizations.

Health Plan Assessments

The Department is funded from the Managed Care Fund, supported primarily by an annual assessment of each HMO. A minor portion of the fund's revenue is derived through penalties and fines imposed on HMOs. Up to \$2 million may be assessed to fund the review of legislatively mandated health care benefits by the University of California (UC). By law, this assessment will end in 2006.

HMOs were assessed \$35 million to fund the Department's operations and \$1.4 million to fund the UC Legislative mandate reviews for FY

2005/06. This assessment was, on the average, .046 percent of HMO "Total Revenue" and .589 percent of HMO "Total Administrative Expenses". (Please refer to [Appendix F](#) for assessment process information and [Appendix G](#) for assessment by type information.)

Innovation

At the Department, we know that success depends on continually seeking out business process improvements. In 2005, two divisions undertook key improvement programs.

HMO Help Center Process Improvements

- The HMO Help Center's Call Center implemented the following changes/improvements in the Quick Resolution process:
 - Expanded the Quick Resolution process to the Division of Complaint Management and Clinical Review within the HMO Help Center to expedite resolution of consumer complaints.
 - Provided additional training to staff.
 - Changed and distributed new guidelines and triggers.
 - Changed the automated case management system to accurately capture and record the completion of Quick Resolutions.
- Upgraded the Call Center's management information system in June 2005. The upgraded monitoring system has the capability to record calls for quality as well as for emergency purposes (i.e., record member calls that are threatening in nature).
- Held training sessions for health plans in Sacramento and Los Angeles focusing on improving the quality of health plans' grievance resolutions and utilization management better prepare the health plans for upcoming surveys.
- Educated staff on Medicare Supplement issues by providing extensive training and developing a collaborative relationship with the Center for Medicare and Medicaid Services to better serve consumers.
- Revised the HMO Help Center's consumer letter templates to meet suggested "health literacy

guidelines" so that members are able to easily understand them.

- Initiated outreach with consumer groups to discuss the Department's role and how we may be able to assist them concerning certain medical services and treatments.
- Designed a training program on the Knox-Keene Act compliance requirements relating to grievances and IMRs.
- Increased health plan compliance with grievance system requirements by implementing a structured review of every complaint and referral for imposition of penalties on a consistent basis.
- Focused on improving our timely response to consumers: 99 percent of the standard complaints and the IMRs were reviewed and resolved within 30 days.

Division of Licensing Process Improvements

The initial need for systemic changes to the licensing of health plans was identified in the Performance Improvement Initiative conducted by the Business, Transportation and Housing Agency in 2004. Recommendations resulted from input provided by both industry stakeholders and Department staff. Subsequently, the Department initiated a business process analysis to develop best practices for review of licensing filings. The goals for this process were to reduce the number of documents received from health plans and to improve the quality, consistency, predictability and timeliness of the review process. The other proposed outcomes include:

- Streamlining filing review through the use of performance metrics, a more transparent process, training for health plan compliance staff and filing guidelines and checklists.
- Enhancing the data collection system from health plan filings to help ensure consistency in review.

- A review process that balances the scope of prospective review, utilizes metrics as indicators of market conduct and eliminates duplicative effort.

New Product Development

During 2005, Division of Licensing staff engaged in active dialogue with the health plans regarding concepts for new products to help keep the industry competitive. A new product template was created in conjunction with the California Association of Health Plans (CAHP) to facilitate filing of health plan product features. Significant research was conducted by the Department into the newly emerging concept of Consumer Directed Health Care. The Division of Licensing approved two products for Kaiser Foundation Health Plan including one which satisfies federal Health Savings Account requirements and an employer-sponsored health reimbursement account. As health plans seek to bring new products to the marketplace, the Licensing Division is working to actively engage with them to approve new health plan product designs that are compliant with the Knox-Keene Act.

Technological Solutions

Office of Enforcement Process Improvements

In cooperation with the OTI, the Office of Enforcement now posts all orders, accusations, stipulations, settlement agreements and letters of agreement to the Department's Web site <www.dmhc.ca.gov> making them available for public view.

The Office of Enforcement also upgraded its file management software, Prolaw, to a more recent version enabling staff to accomplish more functions in document management.

Office of Legal Services Process Improvements

In early 2005, the Office of Legal Services upgraded public access to allow stakeholders early vetting opportunities in anticipated and proposed regulations on the Web site <www.dmhc.ca.gov>.

Stakeholder participation in the regulatory process makes the rulemaking procedures more efficient and effective.

Provider Complaint Online "Bulk" Submission

On June 1, 2005, the Provider Complaint System was enhanced to enable providers to submit bulk complaints electronically through a secured Department Web portal. The changes allow providers the option of submitting "multiple like" claims using one provider complaint form that will save time for providers. Multiple complaints are defined as a group of individual case payment claims submitted to the same plan or payor that were refused or delayed for very similar reasons.

The system allows the Department to review electronically submitted provider complaints, to ensure that health plans and their capitated providers have implemented complaint processing standards, contract disclosures and the dispute resolution mandates of the Knox-Keene Act contained in AB 1455.

Physicians and other medical professionals have a designated toll-free Provider Line at (877) 525-1295 to use for assistance. The Provider Line received a total of 1,861 calls from providers during 2005 as compared to 1,915 calls received during 2004.

Financial Solvency (SB 260)

The Department implemented SB 260 regulations, which require the collection of key financial data from risk-bearing organizations, and the establishment of grading criteria for their financial solvency.

On October 1, 2005, in response to the approved SB 260 regulations, the Financial Solvency on-line system was enhanced to allow the risk-bearing organizations to submit their quarterly financial information and corrective action plans to the Department through a secured Web portal.

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Independent Medical Review Results By Health Plan

Report Definition

The Summary of 2005 Independent Medical Reviews (IMRs) by Health Plan:

- Details the number and types of IMRs closed with a determination during the 2005 calendar year. The total number of IMRs resolved (989) includes 31 cases that were withdrawn during the review process; a total of 958 cases completed the review process.
- Lists health plans licensed during the 2005 calendar year, the health plan's average enrollment during the year, the number of IMRs closed for each health plan, the upheld and overturned determinations, and the number of IMR withdrawals. Enrollment data is provided for comparison purposes.
- Health plans are listed according to the name they were doing business as (dba) during 2005. In instances where a health plan is known by more than one name, the dba name is shown first with additional name(s) in parentheses.

Enrollment Information Definition

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2005. Because Medicare Advantage members are not eligible for IMR, the enrollment figures exclude them.

Total enrollment in this report excludes those in behavioral health and chiropractic health plans because a substantial number of their members are accounted for in the enrollment figures for full service health plans.

Report statistics on following page.

Independent Medical Review Results By Health Plan

Plan Type and Name	Members	Total IMRs Resolved	Experimental/Investigational IMR				Medical Necessity IMR			
			Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn	Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
Full Service - Enrollment Over 400,000										
Blue Cross of California	4,548,397	217	93	70	20	3	124	78	42	4
Blue Shield of California (California Physicians' Services)	2,661,387	372	64	45	18	1	308	185	113	10
Health Net of California Inc.	1,986,113	107	27	19	8	0	80	50	28	2
Kaiser (Foundation Health Plan)	5,851,177	91	3	2	1	0	88	68	15	5
PacifiCare of California	1,306,000	67	7	6	1	0	60	43	14	3
Universal Care	462,583	6	0	0	0	0	6	3	3	0
Subtotal	16,815,657	860	194	142	48	4	666	427	215	24
Full Service- Enrollment Under 400,000										
AETNA Health of California Inc.	260,496	21	6	5	1	0	15	5	10	0
Alameda Alliance for Health	92,984	2	0	0	0	0	2	2	0	0
Care 1st Health Plan	159,724	6	0	0	0	0	6	4	2	0
Cigna HealthCare of CA, Inc.	352,060	33	11	8	3	0	22	11	9	2
Community Health Group	99,492	6	0	0	0	0	6	2	4	0
Health Plan of San Joaquin (San Joaquin County Health Commission)	74,873	1	0	0	0	0	1	1	0	0
IEHP (Inland Empire Health Plan)	283,917	6	0	0	0	0	6	4	2	0
Kern Health Systems, Inc.	95,113	2	0	0	0	0	2	2	0	0
Molina Medical Center (Molina Healthcare of California)	308,059	5	0	0	0	0	5	5	0	0
One Health Plan (Great-West Healthcare of California, Inc.)	58,336	3	1	0	1	0	2	1	1	0
Sharp Health Plan	75,963	7	1	1	0	0	6	0	5	1
Western Health Advantage	79,707	6	3	2	1	0	3	3	0	0
Subtotal	1,940,724	98	22	16	6	0	76	40	33	3
Behavioral Health										
Cigna Behavioral Health of California, Inc.	266,314	1	0	0	0	0	1	1	0	0
Managed Health Network	3,019,032	3	0	0	0	0	3	3	0	0
PacifiCare Behavioral Health of California Inc.	1,538,311	21	0	0	0	0	21	11	10	0
U.S. Behavioral Health Plan of California	2,577,433	5	0	0	0	0	5	4	1	0
Subtotal	7,401,090	30	0	0	0	0	30	19	11	0
Chiropractic										
Landmark Healthplan of CA, Inc.	154,672	1	0	0	0	0	1	1	0	0
Subtotal	154,672	1	0	0	0	0	1	1	0	0
Total	18,756,381	989	216	158	54	4	773	487	259	27

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Complaint Results by Category & Health Plan

Report Definition

The Summary of 2005 Formal Member Complaints:

- Details the number and types of complaints closed by the Department during the 2005 calendar year. A patient's complaint can include more than one issue, such as: claim reimbursement; quality of care; access to care; etc. However, a consumer complaint resulting in multiple distinct issues is counted as only one against the health plan.
- Lists health plans licensed during the 2005 calendar year, the number of complaints closed for each health plan, the health plan's average enrollment during the year, the number of complaints per 10,000 members, and the number of issues for each complaint category. Enrollment data is provided for comparison purposes.
- Health plans are listed according to the name they were doing business as (dba) during 2005. In instances where a health plan is known by more than one name, the dba name is shown first with additional names in parentheses.
- Complaints are classified in seven categories: Access; Benefits/Coverage; Claims/Financial; Enrollment; Coordination of Care; Attitude/Service of the Health Plan; and Attitude/Service of the Provider.

Enrollment Information Definition

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2005. Because Medicare Advantage members are not eligible for the complaint process, the enrollment figures exclude them.

Total enrollment in this report excludes those in behavioral health, chiropractic, dental, and vision health plans because a substantial number of their members are accounted for in the enrollment figures for full service health plans.

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 COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

Report statistics on following page.

Complaint Results by Category & Health Plan

Plan Type and Name	Complaints Resolved	Members	Complaints		Access Issues		Benefits/Coverage Issues	
			Per 10,000		Count	Per 10,000	Count	Per 10,000
Full Service - Enrollment Over 400,000								
Blue Cross of California	735	4,548,397	1.62		21	0.05	271	0.60
Blue Shield of California	686	2,661,387	2.58		16	0.06	332	1.25
Health Net of California Inc.	369	1,986,113	1.86		16	0.08	168	0.85
Kaiser (Foundation Health Plan)	1,517	5,851,177	2.59		92	0.16	358	0.61
L.A. Care Health Plan	0	795,953	0.00		0	0.00	0	0.00
PacifiCare of California	342	1,306,000	2.62		10	0.08	188	1.44
Universal Care	19	462,583	0.41		1	0.02	7	0.15
Subtotal	3,668	17,611,610	2.08		156	0.09	1,324	0.75
Full Service- Enrollment Under 400,000								
AETNA Health of California, Inc.	91	260,496	3.49		7	0.27	37	1.42
Alameda Alliance for Health	3	92,984	0.32		0	0.00	1	0.11
CalOptima (Orange County Health Authority)	0	224,202	0.00		0	0.00	0	0.00
California Health Plan (Aids Healthcare Foundation)	0	0	0.00		0	0.00	0	0.00
Care 1st Health Plan	4	159,724	0.25		2	0.13	1	0.06
Central Coast Alliance for Health (Santa Cruz/Monterey Managed Medical Care)	0	85,308	0.00		0	0.00	0	0.00
Central Health Plan of California, Inc.	0	0	0.00		0	0.00	0	0.00
Chinese Community Health Plan	0	6,683	0.00		0	0.00	0	0.00
Cigna HealthCare of California, Inc.	50	352,060	1.42		0	0.00	26	0.74
Community Health Group	3	99,492	0.30		0	0.00	2	0.20
Contra Costa Health Plan (Contra Costa County Medical Services)	2	63,408	0.32		0	0.00	0	0.00
Health Plan of San Joaquin (San Joaquin County Health Commission)	3	74,873	0.40		1	0.13	2	0.27
Health Plan of San Mateo (San Mateo Health Commission)	0	56,671	0.00		0	0.00	0	0.00
Heritage Medical Systems (Heritage Provider Network, Inc.)	0	197,513	0.00		0	0.00	0	0.00
Honored Citizens Choice Health Plan, Inc.	0	0	0.00		0	0.00	0	0.00
IEHP (Inland Empire Health Plan)	2	283,917	0.07		1	0.04	0	0.00
Inter Valley Health Plan	0	0	0.00		0	0.00	0	0.00
Kern Health Systems, Inc.	1	95,113	0.11		1	0.11	0	0.00
Medcore	0	0	0.00		0	0.00	0	0.00
Molina Medical Center (Molina Healthcare of California)	0	308,059	0.00		0	0.00	0	0.00
On Lok Senior Health Services	0	924	0.00		0	0.00	0	0.00
One Health Plan (Great-West Healthcare of California, Inc.)	12	58,336	2.06		0	0.00	3	0.51
Partnership HealthPlan of California (Solano-Napa/Yolo Commission on Medical Care)	0	0	0.00		0	0.00	0	0.00
Positive Healthcare - California Health Plan (Aids Healthcare Foundation)	0	0	0.00		0	0.00	0	0.00
Primecare Medical Network, Inc.	0	209,133	0.00		0	0.00	0	0.00
San Francisco Health Authority	1	49,871	0.20		0	0.00	1	0.20

Claims/Financial Issues		Enrollment Issues		Coordination of Care Issues		Attitude/Service of Health Plan		Attitude/Service of Provider	
Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
328	0.72	72	0.16	30	0.07	30	0.07	5	0.01
239	0.90	59	0.22	37	0.14	23	0.09	3	0.01
153	0.77	27	0.14	8	0.04	15	0.08	3	0.02
560	0.96	81	0.14	403	0.69	72	0.12	102	0.17
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
115	0.88	16	0.12	11	0.08	11	0.08	2	0.02
9	0.19	1	0.02	1	0.02	2	0.04	0	0.00
1,404	0.80	256	0.15	490	0.28	153	0.09	115	0.07
26	1.00	4	0.15	16	0.61	3	0.12	4	0.15
0	0.00	1	0.11	0	0.00	1	0.11	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	1	0.06	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
18	0.51	1	0.03	2	0.06	5	0.14	0	0.00
1	0.10	0	0.00	0	0.00	0	0.00	0	0.00
1	0.16	0	0.00	1	0.16	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	0.04	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
8	1.37	2	0.34	2	0.34	1	0.17	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

Plan Type and Name	Complaints Resolved	Members	Complaints		Access Issues		Benefits/Coverage Issues	
			Per 10,000		Count	Per 10,000	Count	Per 10,000
Santa Barbara Regional Health Authority	0	56,662	0.00		0	0.00	0	0.00
Santa Clara Family Health Plan (Santa Clara County Health Authority)	3	95,458	0.31		0	0.00	1	0.10
SCAN Health Plan	2	3,479	5.75		0	0.00	1	2.87
Scripps Clinic Health Plan Services, Inc.	0	23,743	0.00		0	0.00	0	0.00
Sharp Health Plan	12	75,963	1.58		1	0.13	4	0.53
Simnsa Health Care (Sistemas Medicos Nacionales S.A. de C.V.)	1	14,502	0.69		0	0.00	0	0.00
UCSD (UC San Diego) Senior Health Plan (Regents of the University of California)	0	0	0.00		0	0.00	0	0.00
UHP Healthcare (WATTHealth Foundation, Inc.)	4	77,055	0.52		0	0.00	4	0.52
Valley Health Plan (Santa Clara County)	0	57,222	0.00		0	0.00	0	0.00
Ventura County Health Care Plan (County of Ventura)	2	9,963	2.01		0	0.00	1	1.00
Western Health Advantage	22	79,707	2.76		2	0.25	11	1.38
Subtotal	218	3,172,521	0.90		15	0.06	95	0.39
Chiropractic								
ACN (American Chiropractic Network, Inc.) (American Specialty Health Plans)	2	3,865,689	0.01		0	0.00	1	0.00
ACN Group of California, Inc.	0	2,709	0.00		0	0.00	0	0.00
Basic Chiropractic Health Plan	0	323	0.00		0	0.00	0	0.00
Landmark Healthplan of California, Inc.	0	154,672	0.00		0	0.00	0	0.00
Subtotal	2	4,023,393	0.00		0	0.00	1	0.00
Dental								
Access Dental Plan	1	246,503	0.04		0	0.00	0	0.00
AETNA Dental of California, Inc.	5	284,590	0.18		0	0.00	0	0.00
California Benefits Dental Plan	0	22,421	0.00		0	0.00	0	0.00
California Dental Network, Inc.	3	36,193	0.83		0	0.00	0	0.00
CENTAGUARD Dental Plan (American Healthguard Corporation)	0	20,009	0.00		0	0.00	0	0.00
Cigna Dental Health of California, Inc.	15	285,566	0.53		2	0.07	5	0.18
DDS, Inc./DDSI (Dedicated Dental Systems, Inc.)	7	27,954	2.50		0	0.00	0	0.00
Delta Dental Plan of California	88	14,608,666	0.06		1	0.00	35	0.02
Dental Choice of California, Inc. (Dental Benefit Providers of California, Inc.)	1	202,259	0.05		0	0.00	1	0.05
Healthdent of California, Inc. (Jaimini Health, Inc.)	0	7,456	0.00		0	0.00	0	0.00
Managed Dental Care	2	117,390	0.17		0	0.00	1	0.09
Mida Dental (United Concordia Dental Plans of CA, Inc.)	2	256,968	0.08		0	0.00	0	0.00
Newport Dental Centers (ConsumerHealth Inc.)	0	63,869	0.00		0	0.00	0	0.00
Pacific Union Dental, Inc.	4	237,479	0.17		0	0.00	1	0.04
PacifiCare Dental	3	275,498	0.11		0	0.00	1	0.04
Preferred Dental Plan (Liberty Dental Plan of California, Inc.)	2	36,808	0.54		0	0.00	0	0.00
SmileCare (Community Dental Services)	1	264,652	0.04		0	0.00	0	0.00

Claims/Financial Issues		Enrollment Issues		Coordination of Care Issues		Attitude/Service of Health Plan		Attitude/Service of Provider	
Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
2	0.21	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	1	2.87	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
4	0.53	0	0.00	2	0.26	1	0.13	0	0.00
1	0.69	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
2	0.26	0	0.00	1	0.13	1	0.13	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	1.00	0	0.00	0	0.00	0	0.00	0	0.00
5	0.63	1	0.13	2	0.25	2	0.25	0	0.00
70	0.29	9	0.04	28	0.12	14	0.06	4	0.02
0	0.00	1	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	1	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	1	0.04	0	0.00	0	0.00
4	0.14	0	0.00	1	0.04	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
2	0.55	0	0.00	0	0.00	0	0.00	1	0.28
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
7	0.25	0	0.00	4	0.14	2	0.07	1	0.04
3	1.07	1	0.36	2	0.72	3	1.07	0	0.00
44	0.03	3	0.00	7	0.00	1	0.00	3	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	0.09	0	0.00	0	0.00	0	0.00	0	0.00
2	0.08	0	0.00	0	0.00	0	0.00	1	0.04
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	0.04	1	0.04	1	0.04	0	0.00	0	0.00
1	0.04	0	0.00	1	0.04	0	0.00	1	0.04
2	0.54	0	0.00	0	0.00	0	0.00	0	0.00
1	0.04	0	0.00	0	0.00	1	0.04	0	0.00

Plan Type and Name	Complaints Resolved	Members	Complaints Per 10,000	Access Issues		Benefits/Coverage Issues	
				Count	Per 10,000	Count	Per 10,000
South Hills Dental Plan (Dental Health Services)	0	74,172	0.00	0	0.00	0	0.00
United Dental Plan	1	24,662	0.41	0	0.00	1	0.41
Western Dental Plan (Western Dental Services, Inc.)	9	432,157	0.21	0	0.00	2	0.05
Subtotal	144	17,525,272	0.08	3	0.00	47	0.03
Dental/Vision							
Golden West Vision-Dental Plan (Golden West Health Plan, Inc.)	7	223,510	0.31	0	0.00	1	0.04
PMI (Private Medical-Care, Inc.)	36	940,136	0.38	1	0.01	12	0.13
Safeguard Health Plans, Inc.	50	953,087	0.52	1	0.01	22	0.23
SmileSaver/Signature Vision (GE Dental and Vision)	7	220,779	0.32	0	0.00	2	0.09
Subtotal	100	2,337,512	0.43	2	0.01	37	0.16
Vision							
EYEXAM of California, Inc.	0	363,961	0.00	0	0.00	0	0.00
FirstSight Vision Services, Inc.	0	179,621	0.00	0	0.00	0	0.00
For Eyes Vision Plan	0	21,230	0.00	0	0.00	0	0.00
Medical Eye Services, Inc.	0	82,336	0.00	0	0.00	0	0.00
Pearle Visioncare, Inc.	0	61,735	0.00	0	0.00	0	0.00
Spectera Vision Services of California, Inc.	0	105,559	0.00	0	0.00	0	0.00
Sterling Visioncare (VisionCare of California)	0	66,097	0.00	0	0.00	0	0.00
Vision First Eye Care, Inc.	0	1,679	0.00	0	0.00	0	0.00
Vision Plan of America	0	27,212	0.00	0	0.00	0	0.00
Vision Service Plan	4	8,239,884	0.00	0	0.00	1	0.00
Subtotal	4	9,149,314	0.00	0	0.00	1	0.00
Behavioral Health							
Avante Behavioral Health Plan	0	14,748	0.00	0	0.00	0	0.00
Cigna Behavioral Health of California, Inc.	3	266,314	0.11	0	0.00	0	0.00
CONCERN: Employee Assistance Program	0	88,838	0.00	0	0.00	0	0.00
HAI-CA (Human Affairs International of Ca.)	0	1,028,963	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	184,560	0.00	0	0.00	0	0.00
Integrated Insights (Health and Human Resource Center)	0	235,957	0.00	0	0.00	0	0.00
Managed Health Network	6	3,019,032	0.02	1	0.00	0	0.00
Merit Behavioral Care of California, Inc.	0	340,868	0.00	0	0.00	0	0.00
PacifiCare Behavioral Health of California, Inc.	34	1,538,311	0.22	1	0.01	25	0.16
Robert T. Dorris & Associates	0	1,943	0.00	0	0.00	0	0.00
U.S. Behavioral Health Plan California	5	2,577,433	0.02	0	0.00	3	0.01
ValueOptions of California, Inc.	2	405,342	0.05	1	0.02	1	0.02
Vista Behavioral Health Plans (Magellan Health Services of California)	0	157,269	0.00	0	0.00	0	0.00
VMC Connect (VMC Behavioral Health-care Services, Inc.)	0	58,233	0.00	0	0.00	0	0.00
Subtotal	50	9,917,811	0.05	3	0.00	29	0.03
TOTAL	4,186	20,784,131	0.67	179	0.03	1,534	0.24

Claims/Financial Issues		Enrollment Issues		Coordination of Care Issues		Attitude/Service of Health Plan		Attitude/Service of Provider	
Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
6	0.14	0	0.00	2	0.05	0	0.00	0	0.00
74	0.04	5	0.00	19	0.01	7	0.00	7	0.00
3	0.13	0	0.00	2	0.09	0	0.00	1	0.04
15	0.16	0	0.00	10	0.11	1	0.01	0	0.00
21	0.22	1	0.01	6	0.06	3	0.03	2	0.02
2	0.09	0	0.00	2	0.09	1	0.05	1	0.05
41	0.18	1	0.00	20	0.09	5	0.02	4	0.02
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
3	0.00	0	0.00	0	0.00	0	0.00	0	0.00
3	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
3	0.11	0	0.00	0	0.00	1	0.04	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
2	0.01	0	0.00	2	0.01	1	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
9	0.06	0	0.00	1	0.01	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
2	0.01	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
16	0.02	0	0.00	3	0.00	2	0.00	0	0.00
1,608	0.26	272	0.04	560	0.09	181	0.03	130	0.02

Plans Licensed Through The Department of Managed Health Care

FULL SERVICE PLANS

Plan ID	Plan Name	Doing Business As (DBA)
933-0176	Aetna U.S. Healthcare of California, Inc.	
933-0432	AIDS HealthCare Foundation	Positive Healthcare
933-0328	Alameda Alliance for Health	
933-0303	Blue Cross of California	
933-0408	California Health Plan	
933-0043	California Physicians' Service	Blue Shield of California
933-0326	Care 1st Health Plan	
933-0404	Central Health Plan of California, Inc.	
933-0278	Chinese Community Health Plan	
933-0152	Cigna HealthCare of California, Inc.	
933-0200	Community Health Group	
933-0054	Contra Costa County Medical Services	Contra Costa Health Plan
933-0248	County of Los Angeles-Dept. of Health Services	Community Health Plan
933-0344	County of Ventura	Ventura County Health Care Plan
933-0325	Great-West Healthcare of California, Inc.	
933-0300	Health Net of California, Inc.	
933-0357	Heritage Provider Network, Inc.	
933-0414	Honored Citizens Choice Health Plan, Inc.	
933-0346	Inland Empire Health Plan	IEHP
933-0151	Inter Valley Health Plan	
933-0055	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation/Permanente Medical Care Program
933-0335	Kern Health Systems	
933-0355	Local Initiative Health Authority for L.A. Co.	L.A. Care Health Plan
933-0390	Medcore HP	Medcore
933-0322	Molina Healthcare of California	American Family Care, Molina Medical Center
933-0385	On Lok Senior Health Services	
933-0394	Orange County Health Authority	Caloptima
933-0126	PacifiCare of California	Secure Horizons, Health Plan of America (HPA)
933-0367	PRIMECARE Medical Network, Inc.	
933-0349	San Francisco Health Authority	San Francisco Health Plan
933-0338	San Joaquin County Health Commission	The Health Plan of San Joaquin
933-0358	San Mateo Health Commission	Health Plan of San Mateo
933-0400	Santa Barbara Regional Health Authority	
933-0236	Santa Clara County	Valley Health Plan; Santa Clara Valley Medical Center
933-0351	Santa Clara County Health Authority	Santa Clara Family Health Plan
933-0401	Santa Cruz-Monterey Managed Med. Care Comm.	Central Coast Alliance for Health

Plans Licensed Through The Department of Managed Health Care

FULL SERVICE PLANS *continued*

Plan ID	Plan Name	Doing Business As (DBA)
933-0212	Scan Health Plan	Smartcare Health Plan
933-0377	Scripps Clinic Health Plan Services, Inc.	
933-0310	Sharp Health Plan	
933-0393	Sistemas Medicos Nacionales, S.A.de CV	Simnsa Health Care
933-0416	Solano-Napa-Yolo Commission on Medical Care	Partnership HealthPlan of California
933-0209	Universal Care	
933-0008	WATTHealth Foundation, Inc.	UHP Healthcare
933-0348	Western Health Advantage	

SPECIALIZED PLANS - DENTAL

Plan ID	Plan Name	Doing Business As (DBA)
933-0318	Access Dental Plan	
933-0313	Aetna Dental of California, Inc.	
933-0195	American Healthguard Corporation	Centaguard Dental Plan
933-0308	California Benefits Dental Plan	
933-0286	California Dental Network, Inc.	
933-0258	Cigna Dental Health of California, Inc.	
933-0170	Community Dental Services	Smilecare
933-0215	ConsumerHealth, Inc.	Newport Dental Plan, Newport Dental Centers
933-0244	Dedicated Dental Systems, Inc.	
933-0092	Delta Dental of California	
933-0255	Dental Benefit Providers of California, Inc.	Dental Choice of CA, Inc.
933-0059	Dental Health Services	South Hills Dental Plan
933-0136	GE Dental and Vision	Smilesaver
933-0080	Golden West Health Plan, Inc.	
933-0197	Jaimini Health Inc.	
933-0052	Liberty Dental Plan of California, Inc.	Personal Dental Services
933-0302	Managed Dental Care	
933-0211	Pacific Union Dental, Inc.	
933-0100	PacifiCare Dental	CDHP
933-0079	Private Medical-Care, Inc.	PMI
933-0034	SafeGuard Health Plans, Inc.	
933-0291	UDC Dental California, Inc.	United Dental Care of California, Inc.
933-0046	United Concordia Dental Plans of CA, Inc.	Mida Dental
933-0224	Western Dental Services, Inc.	Western Dental Plan, Beauchamp Family Dental

Plans Licensed Through The Department of Managed Health Care

SPECIALIZED PLANS - VISION

Plan ID	Plan Name	Doing Business As (DBA)
933-0264	EYEXAM of California, Inc.	
933-0342	FirstSight Vision Services, Inc.	
933-0320	For Eyes Vision Plan, Inc.	
933-0359	Medical Eye Services, Inc.	
933-0263	Pearle Visioncare, Inc.	
933-0189	Spectera Vision Services of California, Inc.	ESP, Opica Familiar
933-0329	Vision First Eye Care, Inc.	
933-0268	Vision Plan of America	
933-0049	Vision Service Plan	
933-0287	VisionCare of California	Sterling Visioncare

SPECIALIZED PLANS - BEHAVIORAL HEALTH

Plan ID	Plan Name	Doing Business As (DBA)
933-0397	Avante Behavioral Health Plan	
933-0298	Cigna Behavioral Health of California, Inc.	
933-0402	CONCERN: Employee Assistance Program	
933-0319	Health and Human Resource Center	Horizon Health EAP - Behavioral Services
933-0231	Holman Professional Counseling Center	
933-0292	Human Affairs International of California	HAI, HAI-CA
933-0102	Magellan Health Services of California	
933-0196	Managed Health Network	
933-0288	Merit Behavioral Care of California, Inc.	
933-0301	PacificCare Behavioral Health of California Inc.	
933-0409	Robert T. Dorris & Associates	
933-0259	U.S. Behavioral Health Plan, California	
933-0293	ValueOptions of California, Inc.	
933-0411	VMC Behavioral Healthcare Services, Inc.	VMC Behavioral Healthcare Services; VMC Connect

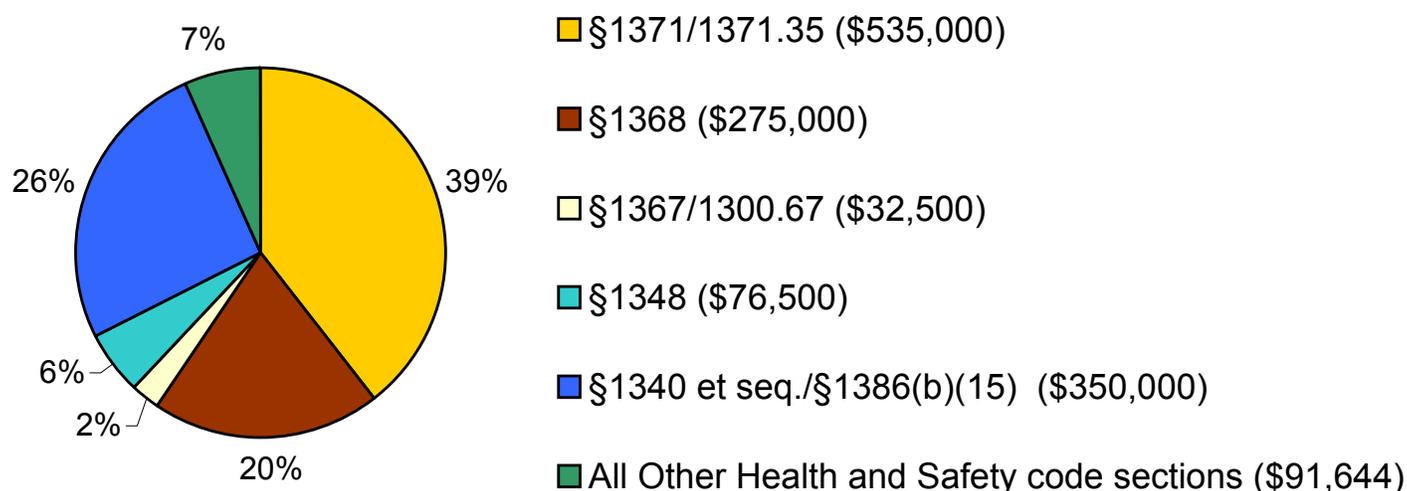
SPECIALIZED PLANS - CHIROPRACTIC/ACUPUNCTURE

Plan ID	Plan Name	Doing Business As (DBA)
933-0407	ACN Group of California, Inc.	
933-0315	American Specialty Health Plans, Inc.	ASHP
933-0399	Basic Chiropractic Health Plan	
933-0361	Landmark Healthplan of California, Inc.	

Enforcement Case Load Tracking

Case Activity	1ST QTR	2ND QTR	3RD QTR	4TH QTR	YTD TOTAL
Number of cases opened					
Number of Anti-Fraud	0	73	33	3	109
Number of Discount Health Plan	14	3	3	1	21
Number of Financial	9	5	10	3	27
Number of Grievance	37	37	21	19	114
Various Violations	31	21	9	12	73
Total	91	139	76	38	344
Number of cases closed					
Number of Anti-Fraud	4	72	10	18	104
Number of Discount Health Plan	0	0	1	0	1
Number of Financial	7	2	5	7	21
Number of Grievance	65	73	42	11	191
Various Violations	16	10	9	10	45
Total	92	157	67	46	362
Total number of hours to close cases					
Total number of hours to close Anti-Fraud cases	3.20	66.00	274.30	133.85	477.35
Total number of hours to close Discount Health Plan cases	0.00	0.00	121.85	0.00	121.85
Total number of hours to close Financial cases	352.20	37.35	232.20	152.65	774.40
Total number of hours to close Grievance cases	600.05	938.90	605.30	206.25	2350.50
Total number of hours to close Various Violations	7259.70	1183.65	1110.05	595.85	10149.25
Total	8215.15	2225.90	2343.70	1088.60	13873.35
Average number of hours to close cases					
Average number of hours to close one case	89.30	14.18	34.98	23.67	38.32
Average number of hours to close one Anti-Fraud case	0.80	0.92	27.43	7.44	4.59
Average number of hours to close one Discount Health Plan case	0.00	0.00	121.85	0.00	121.85
Average number of hours to close one Financial case	50.31	18.68	46.44	21.81	36.88
Average number of hours to close one Grievance case	9.23	12.86	14.41	18.75	12.31
Average number of hours to close Various Violations	453.73	118.37	123.34	59.59	225.54
Enforcement Actions					
Number of Accusations Filed	1	1	0	0	2
Number of Assessments Collected	1	0	0	0	1
Number of Cease and Desist Orders	1	0	3	0	4
Number of Cease and Desist Orders Suspended	2	0	0	0	2
Number of Conservatorships	0	0	0	0	0
Number of Decisions of the Director	0	0	0	0	0
Number of Letters of Agreement	33	55	28	28	144
Number of Licenses Surrendered or Revoked	0	0	0	0	0
Number of Miscellaneous Orders	1	2	0	0	3
Number of Miscellaneous Orders RE: Licensure	1	2	0	0	3
Number of Statements of Issues	0	0	0	0	0
Number of Stipulated Settlement Agreements	1	3	0	1	5
Number of Other	3	2	2	1	8
Total					172
Aging					
Number of cases open less than 6 months	181	123	105	82	
Number of cases open more than 6 months, but less than 1 yr	78	98	99	99	
Number of cases open more than 1 yr, but less than 2 yrs	31	49	55	90	
Number of cases open more than 2 years	22	25	22	26	
Total number of open cases	312	295	281	297	

Fines Associated With Violation Trends - 2005



2-Year Comparison: Amount of Fines Per Health & Safety Code

Health & Safety Code Section	2005	2004
§1340 et seq./§1386(b)(15): (Failure to protect consumers)	\$ 350,000	\$ -
§1348: (Failure to file Antifraud Annual Report)	76,500	-
§1367/1300.67: (Continuity of care)	32,500	5,000
§1368: (Grievance)	275,000	428,500
§1371/1371.35:(Untimely claims payment)	535,000	77,700
§1374.30 (IMR Notification Form to member)	-	82,500
§1376/1300.76:(TNE Deficiencies)	-	75,000
All other Health & Safety Code sections	91,644	55,000
Total Amount Collected	\$ 1,497,144	\$ 723,700

In 2005 no penalties were collected from health plans for violations of two Health and Safety Codes: (1) IMR Notification Form to member; and (2) Tangible Net Equity ("TNE") deficiencies. This was, in part, due to meeting the Department's goal of reducing the number of plans with TNE deficiencies. In some cases, fines were assessed but suspended when corrective action plans were implemented in order to resolve the financial instability of several health plans.

In 2005, two new categories of violations were added (1) Failure to File Anti-Fraud Annual Reports, and (2) Failure to Protect Consumers.

Assessment Process

For the 2004/05 fiscal year, the health plans were assessed a total of \$34.4 million. This is comprised of \$33.5 million for the Department's expenses and \$ 900,000 for funding health-mandated reviews, per AB 1996, by the University of California. The latter was applied only to the full-service plans as instructed by legislation.

For the 2005/06 fiscal year, the health plans were assessed a total of \$35 million. This is comprised of \$33.6 million for the Department's expenses and \$1.4 million for funding health-mandated reviews, per AB 1996, by the University of California. The latter was applied only to the full-service plans as instructed by legislation.

Revenue & Expenditures

In 2004/05, annual assessments of \$34.4 million and other revenues of \$2.3 million were collected. Total expenditures were \$35.8 million.

In 2005/06, annual assessments were \$35 million, other revenues are expected to be \$2 million, and total expenditures are forecast to be \$35.8 million. Please see the charts below for additional detail.

Authorized Positions Chart

	FY 2004/05	FY 2005/06
Budgeted	272.0	289.0

Revenue/Expenditure Chart

	FY 2004/05 Actual	FY 2005/06 Projected
Beginning Fund Balance	\$ 3,391,000	\$ 3,446,000
Assessments	34,437,000	34,989,000
Fines & Penalties	1,141,000	856,000
Other Revenues	1,168,000	1,149,000
Transfers	-906,000	-1,766,000
Total, Revenues	39,231,000	38,674,000
Total, Expenditures	35,785,000	35,817,000
Ending Fund Balance	3,446,000	2,857,000
Budget Allocations:		
• DMHC	31,576,000	31,547,000
• OPA	4,209,000	4,270,000
TOTAL	\$ 35,785,000	\$ 35,817,000

Assessments By Type

Health Plan Type	Members	Regular	Special/AB 1996 ^a	Total	% of Total
FY 2006-07 @ 3/31/06					
Full Service ^b	24,311,714	\$ 23,958,460	\$ 1,279,671	\$ 25,238,131	66.2%
Specialized	41,529,049	12,900,690		12,900,690	33.8%
Totals	65,840,763	\$ 36,859,150	\$ 1,279,671	\$ 38,138,821	100.0%
FY 2005-06 @ 3/31/05					
Full Service	21,498,496	\$ 21,787,352	\$ 1,385,299	\$ 23,172,651	66.4%
Specialized	40,107,873	11,731,634		11,731,634	33.6%
Totals	61,606,369	\$ 33,518,986	\$ 1,385,299	\$ 34,904,285	100.0%
FY 2004-05 @ 3/31/04					
Full Service	21,563,697	\$ 21,787,392	\$ 917,514	\$ 22,704,906	65.9%
Specialized	39,294,656	11,731,670		11,731,670	34.1%
Totals	60,858,353	\$ 33,519,062	\$ 917,514	\$ 34,436,576	100.0%
FY 2003-04 @ 3/31/03					
Full Service	21,999,122	\$ 20,559,627	\$ 1,248,054	\$ 21,807,681	66.3%
Specialized	39,470,531	11,070,566		11,070,566	33.7%
Plan Totals	61,469,653	\$ 31,630,193	\$ 1,248,054	\$ 32,878,247	100.0%
FY 2002-03 @ 3/31/02					
Full Service	22,201,083	\$ 10,971,576	\$ 5,418,235	\$ 16,389,811	50.9%
Specialized	39,152,996	10,556,648	5,274,747	15,831,395	49.1%
Totals	61,354,079	\$ 21,528,224	\$ 10,692,982	\$ 32,221,206	100.0%

^a Special assessment was in effect for three years through FY 2002-03. In FY 2003-04, SB 580 changed the assessment calculation method. Also, AB 1996 mandated the Department to fund a University of California Commission (directed to assess health care benefits legislation) beginning on 1/1/03 effective through 1/1/07. Currently, SB 1704 will extend this program through 1/1/2011.

^b Includes 15 QIF plans with 2,887,375 enrollees; these plans will be assessed \$3,074,954. (The amount includes \$151,980 for AB 1996.)

NOTE: This schedule reflects assessments invoiced, not assessments collected.

Comparison of Health Plan Revenue & Administrative Expenses to Annual Assessments

Top Health Plans in Each Type Identified - 4 Quarters Ending 9/30/05

Plan Name	FY 2005-06 Assessments	% Assess w/in Plan Type	Total Revenue 4 Qtrs 9/30/05	Assess: Revenue	Total Admin Exp 4 Qtrs 9/30/05	Assess: Adm Exp
Blue Cross of California	\$4,638,962	19.947%	\$11,107,380,000	0.042%	\$1,269,715,000	0.365%
California Physicians' Service Health Net	2,883,259	12.398%	7,315,867,000	0.039%	849,397,000	0.339%
Kaiser Foundation Health Plan, Inc.	2,237,468	9.621%	6,332,137,515	0.035%	622,821,309	0.359%
Pacificare of California	6,673,155	28.694%	30,631,772,000	0.022%	1,087,806,000	0.613%
All Others	1,782,131	7.663%	6,612,968,000	0.027%	600,337,000	0.297%
All Others	5,041,689	21.678%	9,872,706,318	0.051%	745,969,012	0.676%
FULL SERVICE PLAN TOTALS	\$23,256,664	100.000%	\$71,872,830,833	0.032%	\$5,176,045,321	0.449%
Delta Dental Plan	\$3,299,453	67.740%	\$2,433,051,000	0.136%	\$338,725,000	0.974%
Private Medical-Care, Inc.	271,389	5.572%	143,779,646	0.189%	43,695,988	0.621%
Safeguard Health Plans, Inc.	228,249	4.686%	96,905,000	0.236%	19,657,000	1.161%
All Others	1,071,638	22.002%	806,728,840	0.133%	154,408,479	0.694%
DENTAL PLAN TOTALS	\$4,870,729	100.000%	\$3,480,464,486	0.140%	\$556,486,467	0.875%
Vision Service Plan	\$2,258,020	84.218%	\$704,957,012	0.320%	\$70,825,955	3.188%
All Others	423,144	15.782%	86,205,280	0.491%	10,462,872	4.044%
VISION PLAN TOTALS	\$2,681,164	100.000%	\$791,162,292	0.339%	\$81,288,827	3.298%
Human Affairs Internat'l of California Managed Health Network, Inc.	\$299,539	10.387%	\$23,184,380	1.292%	\$5,197,099	5.764%
Pacificare Behavioral Health of California	870,739	30.195%	125,796,380	0.692%	18,552,434	4.693%
US Behavioral Health Plan, California	439,528	15.242%	157,456,009	0.279%	43,105,946	1.020%
All Others	726,666	25.199%	125,241,698	0.580%	8,418,822	8.631%
All Others	547,257	18.977%	64,122,470	0.853%	19,482,184	2.809%
PSYCHOLOGICAL PLAN TOTALS	\$2,883,729	100.000%	\$495,800,937	0.582%	\$94,756,485	3.043%
American Chiropractic Network Health Plan	\$1,188,985	93.728%	\$71,184,574	1.670%	\$26,891,773	4.421%
All Others	79,570	6.272%	4,808,009	1.655%	3,853,916	2.065%
OTHER PLAN TOTALS	\$1,268,555	100.000%	\$75,992,583	1.669%	\$30,745,689	4.126%
FULL SERVICE PLAN TOTALS	\$23,256,664	66.522%	\$71,872,830,833	0.032%	\$5,176,045,321	0.449%
DENTAL PLAN TOTALS	4,870,729	13.932%	3,480,464,486	0.140%	556,486,467	0.875%
VISION PLAN TOTALS	2,681,164	7.669%	791,162,292	0.339%	81,288,827	3.298%
PSYCHOLOGICAL PLAN TOTALS	2,883,729	8.248%	495,800,937	0.582%	94,756,485	3.043%
All Others	1,268,555	3.629%	75,992,583	1.669%	30,745,689	4.126%
PLAN TOTALS	\$34,960,841	100.000%	\$76,716,251,131	0.046%	\$5,939,322,789	0.589%

*Top health plans identified by enrollment. Health plans which lacked four quarters of financial data were omitted from analysis.

*Source: HMO Health Plan financial reports, Revenue & Administrative Expense data for 12/31/04 - 9/30/05 quarters. FY 2005-06 Assessments based on 3/31/05 members.



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