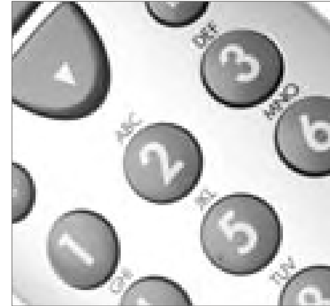
Annual Report 2004



Department of Managed Health Care

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:

The first full year of my tenure here at the Department of Managed Health Care has been full of changes and challenges. When it comes to access to health care, I believe we are not separated as much by wealth, race or party, as much as we are joined by our shared responsibility to ensure the well-being of our fellow Californians.

I am proud of the work we continue on behalf of consumers. During 2004, we assisted more than 119,000 Californians in resolving their HMO problems, educated consumers on health care rights and worked to ensure that enrollees have access to the right care at the right time.

Although enrollee protection remains the top priority here at the DMHC, we also recognize that we must foster a competitive marketplace to preserve important health care protections for all consumers. This year, we made significant strides to ensure a more solvent and stable managed health care system. Unlike past years, in 2004, there were no financial failures of full service or specialized health plans.

Some of our major accomplishments include:

- Aggressively acting on behalf of consumers to stop the operation of fraudulent discount health card companies.
- Implementing the Provider Complaint Unit within the HMO Help Center to ensure prompt and fair payment of claims.
- Reinventing the work of the licensing division to allow more choice for consumers in health plan products.
- Vigorously enforcing HMO laws and regulations.
- Providing leadership to consumer groups and industry leaders to help solve ongoing problems, such as payment and billing issues.

In 2005, we will be focusing on implementing several consumer-oriented regulatory packages such as new prescription drug protections, strengthening access to care standards and addressing cultural and linguistic barriers. We will also promote industry-wide efforts to build a secure, interoperable health IT system, will expand our role in ensuring timely provider payment, and will implement financial solvency standards for risk-bearing provider groups.

At the DMHC, we're continually working to solve today's health care problems, so all of us can lead healthy and productive lives.

Cindy Ehnes

Lucinda "Cindy" Ehnes
DIRECTOR

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About The Department

Mission

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

Through leadership and partnership, the Department ensures aggressive preventive care and high quality health care, as well as providing cost-effective regulatory oversight.

Vision

To be nationally recognized health care policy experts and establish national benchmarks for Health Maintenance Organization (HMO) regulation, policy development, patient advocacy and consumer empowerment.

Who We Are & What We Do

The Department of Managed Health Care (Department), 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 Department of Managed Health Care serves HMO and all California consumers by promoting an accessible and affordable healthcare system. Each business practice performed, each decision made, reflects our commitment to foster an accountable and viable managed care delivery system that provides patients with the medical care and services to which they are entitled.

- We are available to consumers 24 hours a day, seven 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. Complaints are typically reviewed and resolved within 30 days or faster if there is an urgent medical need.
- We develop partnerships with stakeholders in order to share health care concerns, information and responsibilities 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.

> "It's enough to make me believe in government again."
>
> Mildred Olson
> California

Consumer Assistance

HMO Help Center

The HMO Help Center is dedicated to ensuring that consumers understand their rights and receive prompt and effective responses to their HMO concerns. During 2004, the HMO Help Center assisted 119,404 consumers in resolving their HMO problems via telephone assistance, quick resolutions, early reviews, urgent case resolutions, complaint resolutions or Independent Medical Reviews. With services ***available 24 hours a day, seven days a week,*** the HMO Help Center is readily able to assist the consumers we serve. Patients' rights advocates, health care professionals and consumer service representatives are available to help resolve issues ranging from a simple paperwork mix-up to a complex medical issue with an HMO.

Consumers often contact the Department when they are being charged for services that they feel should be covered by their HMO. ***The amount of money consumers saved in 2004 as a result of HMO Help Center intervention was $1,191,020.*** This amount reflects claims disputes that expressly identified a dollar 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.

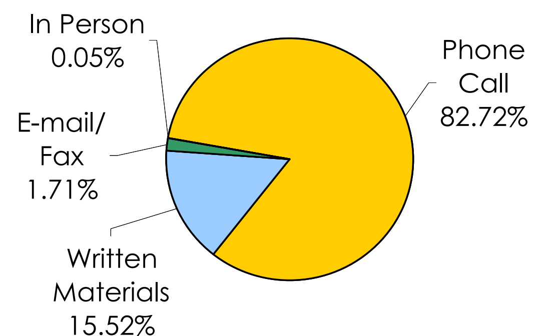
HMO Help Center Mission

The mission of the HMO Help Center is to provide information to consumers regarding health care issues, ensure that health plans are accountable to enrollees for providing required health care services and for appropriately addressing enrollee complaints.

How We Help

- We provide readily accessible assistance to health care consumers to resolve their health plan coverage concerns.
- We provide timely review of, and response to, complaints regarding HMOs and requests for information.
- We routinely monitor HMOs to ensure they comply with the law and fulfill their obligations to enrollees 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 and with health plans, hospitals, physicians, nurses and other providers to assure early intervention for the resolution of patient/enrollee issues.

Consumer Method of Contact in 2004



Information Requests

In 2004, the HMO Help Center received over 9,500 consumer requests for informational pamphlets, forms or specific sections of California's patients' rights laws. According to consumer need, 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 at www.hmohelp.ca.gov.

Requests for Information by Type	Number
Complaint Packet	5,187
Phone Numbers	1,158
IMR Packet	527
COBRA Packet	292
Supplemental Materials	287
HMO Guide	166
OPA Report Card	126
Knox-Keene Act	83
HMO Help Center Brochure	26
Patient Guides	2
Other	1,671
Total Number of Requests for 2004	9,525

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 from 8,000 to 12,000 calls each month from consumers, about eight percent of which resulted in a formal complaint or an Independent Medical Review. In 2004, the HMO Help Center provided telephone support services in 24 different languages.

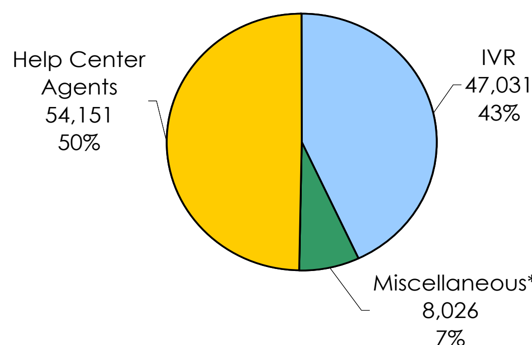
Over 5,500 individuals called with problems outside our jurisdiction and we connected them to the appropriate agency or patient organization to address their concerns. HMO Help Center agents also assisted consumers in understanding their health care rights and responsibilities.

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

Physicians and other medical professionals may use the toll-free Provider Line at (877) 525-1295 for assistance. The Provider Line received a total of 1,915 calls from providers during 2004 as compared to 1,749 calls received during 2003.

Calls Answered by HMO Help Center in 2004

Total Calls Answered = 109,208



**Includes the Provider Line, the TDD Line, or abandoned by the caller.*

Consumers Deserve 24/7 Availability

The HMO Help Center is available 24 hours a day, seven 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.

> "It is good to know that in this day and age of voicemail and passing the buck, someone (DMHC) had the knowledge and concern to sort out this mess, and take the insurance company to task for their mismanagement. Thank you for your help."
>
> Mrs. Gail Bunge
> Avery, 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 HMO and dental plans.
- General information regarding the HMO Help Center.
- Filing requirements for complaints and IMRs.
- COBRA, HIPAA, Medicare and Medi-Cal information.
- Recent changes in HMO or medical group services.
- The Department's Web site for additional information.

During 2004, 47,031 calls (nearly 43 percent of all calls) were resolved through the HMO Help Center's IVR system.

> "If you are ever looking for a 'poster child' to represent the best-case scenario of how your IMR process really works for real people, I would be happy to be that real person. Thanks for all your help."
>
> Mark Wilcox
> West Hills, California

Independent Medical Review (IMR)

An Independent Medical Review provides health plan members the opportunity to receive a second opinion from doctors and other health care professionals that are completely independent of the member's health plan.

In 2004, 839 individuals that had been denied health care services involving medical necessity, or the proven effectiveness of certain treatments, received Independent Medical Reviews. Thirty-nine 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.)

Sixteen percent of the 839 reviews were based on health plan denials of a service considered to be experimental or investigational. Forty percent of these were overturned. The remaining reviews were based on health plan denials of a service considered to be medically necessary. Thirty-nine percent of these were overturned.

The IMR Program has enabled consumers to receive treatment or medical care previously denied by their health plan. 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 therapy 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 patient for out-of-plan emergency or urgent medical services.

The Department determines whether a case involves an issue that is eligible for an IMR. Before an IMR application is eligible for review, the health plan must have an opportunity to assess and resolve the issue through its standard grievance process.

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

The Director 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.

Cases denied by a health plan and found to be eligible for an IMR generated a high incidence of health plans reversing their denials and asking the case to be withdrawn from the IMR process. The HMO Help Center held discussions with the health plans' medical and legal representatives

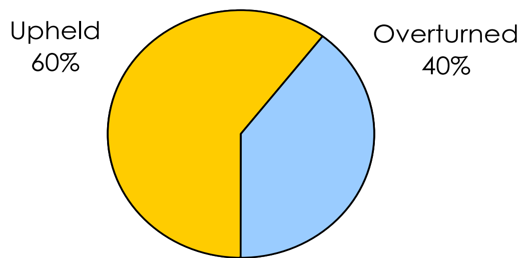
concerning the bases for the timing of these decisions. The HMO Help Center now asks health plans to document the reasons why the decision to provide the requested service was not made before the enrollee applied to the Department for a review, and for the specific treatment that the plan has authorized, to ensure that the dispute has been completely resolved to the enrollee's satisfaction.

The following charts provide information on the total number of IMRs in 2004 and identifies whether or not the review organization upheld or overturned the HMO's original denial. Results are provided separately for Experimental/Investigational reviews and Medical Necessity reviews.

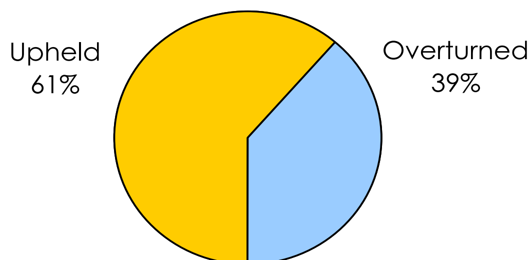
Upheld—The review organization upheld the HMO's original denial.

Overturned—The review organization overturned the HMO's original denial and the HMO is now required to provide the service to the patient.

138 Experimental/Investigational Cases Upheld vs. Overturned in 2004



701 Medical Necessity Cases Upheld vs. Overturned in 2004



IMR Resolutions: Upheld vs. Overturned

IMR Type	Upheld (Not Including Withdrawals)		Overturned (Not Including Withdrawals)		With-drawn	Total
Experimental / Investigational	81	60%	53	40%	4	138
Medical Necessity	401	61%	252	39%	48	701
Total Resolutions	**482**	**61%**	**305**	**39%**	**52**	**839**

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 therapy would be significantly less effective if not promptly initiated. 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.

The chart below provides information on the number of IMRs that were processed as standard versus expedited. Standard IMRs are resolved within 30 days of IMR application qualification. Expedited Experimental/Investigational IMRs are resolved within nine days of IMR application qualification. Expedited Medical Necessity IMRs are resolved within seven days of IMR application qualification.

Standard vs. Expedited Cases Closed Through IMR in 2004

IMR Type	Standard Resolved in 30 Days	Expedited Resolved in 7-9 Days	Total
Experimental/Investigational IMR	95	39	134
Medical Necessity IMR	617	36	653
Withdrawn IMR			52
Total	**712**	**75**	**839**

Continuing Care IMRs

IMR cases often involve "continuing care" where the 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 understandably 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. Our organization 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 salient factors used in analyzing the alternative treatments. Health plans have been advised to facilitate their interface between providers and enrollees in order to identify any changes in the patient's needs before implementing a post-IMR utilization review decision that might otherwise be construed as a violation of the Department's order.

Consumer Complaint Resolution Options

The HMO Help Center strives to resolve consumer issues at the first possible level in the shortest amount of time. There are four resolution options for consumers:

1. Quick Resolution—An ***informal*** process that resolves consumer concerns within hours.
2. Urgent Case Resolution—An ***informal*** process that resolves urgent issues that cannot wait 30 days to go through the formal complaint process.
3. Early Review—A ***formal*** process that resolves time-sensitive issues prior to participation in the health plan's 30-day grievance and appeal process.
4. Complaint Resolution—A ***formal*** process that resolves complaints, usually within 30 days. This follows the enrollee'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. 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.

The Quick Resolution process is completely voluntary for both health plans and consumers. If either 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 alternative formal dispute resolution process. In 2004, 357 calls were resolved through the Quick Resolution process.

Quick Resolution Issues	No. of Issues	% of Issues
Disenrollment	56	16%
Medical Appointment	44	12%
Claim Payment	39	11%
Health Plan Provider List	15	4%
Rx Issues	10	3%
Medical Record Access	9	3%
Provider Change	8	2%
Coverage/Benefit	4	1%
HIPAA	3	1%
Other (Includes Blue Shield Narrow Network calls)	169	47%
Total	357	100%

Urgent Case Resolutions

Consumers often call the HMO Help Center with issues that cannot wait 30 days to complete the 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.

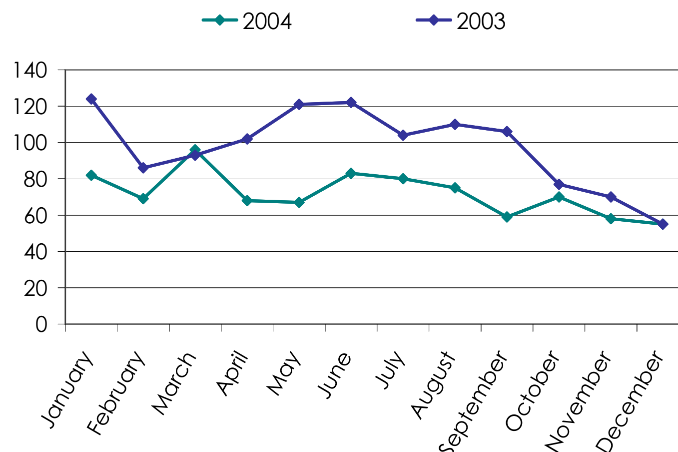
In 2004, there were 862 urgent complaints that required an immediate resolution. Urgent complaints were generally referred to our clinical nurses who worked with the consumer and the health plan to resolve the issue. The overall number of urgent complaints dropped from 2002 to 2003, and again from 2003 to 2004. As the health plans gained greater experience with the Department, adherence to the Knox-Keene Act and collaboration with HMO Help Center clinical staff, they became more likely to resolve clinical matters in favor of the enrollee without HMO Help Center intervention. In addition, in 2004, the urgent review screening process was redefined and cases were more thoroughly reviewed before being sent through the urgent review process, further decreasing the number of cases.

Urgent Complaints Received in 2004

Urgent Complaint Type	Number
Access/Referral Issue	360
Denied Treatment	161
Rx/Medication Supply	116
Benefit Issue	65
Early Dishcarge - Facility	28
Mental Health Services	18
Diagnostic Test Access	15
Problems with Pregnancy	11
Durable Medical Equipment	10
Acute Pain	8
Experimental Treatment	7
Chronic Pain Management	6
Medical Group Closure	2
Poor Health Plan Communication	1
Other	54
Total Number for 2004	862

2-Year Comparison of Urgent Cases

The Department received 862 urgent requests during 2004, compared to 1,170 received in 2003



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

Early Review

If a consumer is involved in a time-sensitive (non-clinical) dispute requiring intervention prior to the health plan's 30-day grievance and appeal process, staff performs an early review of the case. During 2004, the early review process was applied to 200 cases. Examples of these types of reviews include:

- HIPAA, Cal-COBRA, or Senior COBRA deadline issues.
- Cancellation of coverage deadline issues.
- Continuity of care issues involving a severe medical condition that requires the consumer to receive care from the same physician or medical group for a specified period of time.
- HMO delays in implementing a Department decision or agreed upon resolution.

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, etc.
Attitude & Service of Health Plan - These complaints include: health plan staff behavior (including attitude, communication, rudeness), complaints about slow responses to inquiries, etc.
Attitude & Service of Provider - These complaints include: physician or office staff behavior (including attitude, communication, rudeness), the physical condition of a hospital or physician office, complaints about inappropriate care by a hospital or physician (failure to diagnose or treat), complaints about slow responses to inquiries, etc.
Billing, Claims & Financial Disputes - These complaints include: false or misleading marketing information, claims disputes (including slow payment and insufficient payment), premium disputes (including refund requests and premium increases), refusals to pay for medical services or durable medical equipment, denials of payment for emergency or urgent services received, etc.
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.
Coverage & Benefits Disputes - These complaints include: disagreement about whether a service is covered under the member's evidence of coverage, refusal to refer to a specialist or out of network provider, a denial of ancillary services on the basis that benefit maximums have been reached, etc.
Enrollment Disputes - These complaints include disputes regarding disenrollment or termination of coverage.

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 HMO consumers.

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 HMO, 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 grievances).

A consumer 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 at: 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 consumer and the health plan, including relevant medical records if necessary. Complaints are almost always resolved by the HMO Help Center within 30 days. ***There is no charge to the consumer 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. Time sensitive issues are resolved through our early review process.

The HMO Help Center will then issue a written explanation of the complaint decision. If the complaint is resolved in the consumer's favor, the health plan is required to provide and pay for the disputed service or take other appropriate action as defined by the Department. If the complaint is not resolved in the consumer's favor, the consumer may pursue other remedies, as defined in the health plan's Evidence of Coverage (EOC).

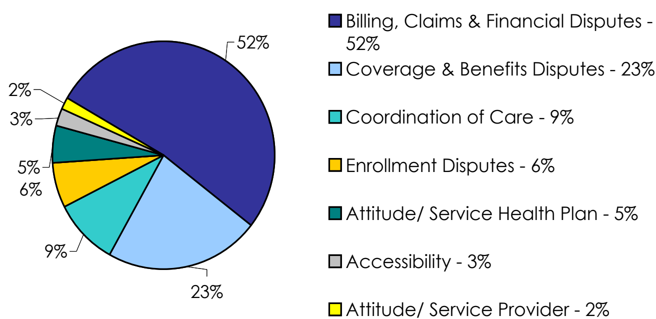
A significant number of requests for assistance are outside the Department's jurisdiction. If we can't assist the consumer, we will connect them with someone who can. As a result, our staff are required to have

full knowledge and understanding of programs sponsored by other state and federal agencies and advocacy groups in order to refer requests to the appropriate organization. HMO Help Center staff consistently refer consumers to organizations such as: Health Rights Hotline, Health Insurance Counseling and Advocacy Program, Major Risk Medical Insurance Board, Department of Health Services, Department of Insurance, Department of Consumer Affairs, CalPERS and the Center for Health Dispute Resolution.

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 2004, the HMO Help Center researched and analyzed the following types of complaints:

Complaint Categories



Complaint Response

We focus on effectively resolving complaints. If systemic problems are discovered as a result of multiple complaints, the issues are referred to the appropriate Department office for further action. (Please refer to Appendix B for complaint results by category and HMO.)

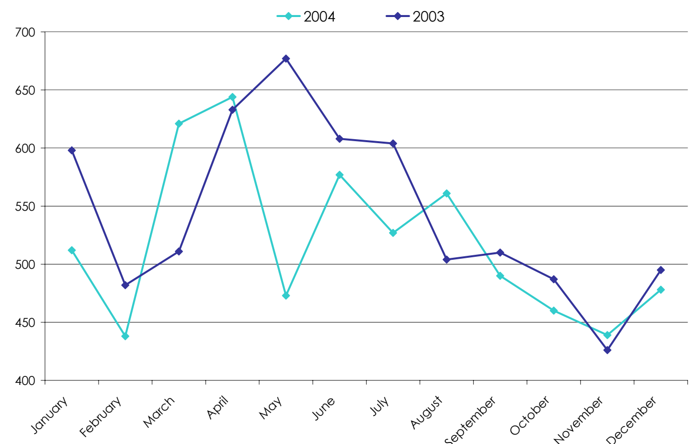
Written complaints received by the HMO Help Center are reviewed by a complaint analyst, who gathers the relevant facts and supporting documentation and then informs the consumer of the Department's intended action. The analyst coordinates efforts between health plan administrators and HMO Help Center 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 consumer is notified of the Department's decision in writing.

Volume of Formal Complaints Received

From January 1 through December 31, 2004, consumers filed 6,220 formal complaints in comparison to 6,535 filed in 2003. The following chart is a summary of the number of complaints received by month, excluding IMRs. Of the complaints filed in 2004, and those carried over from 2003, 6,353 cases were resolved during 2004. Formal complaints with more complicated issues require detailed information such as medical records from patients and documentation from HMOs.

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

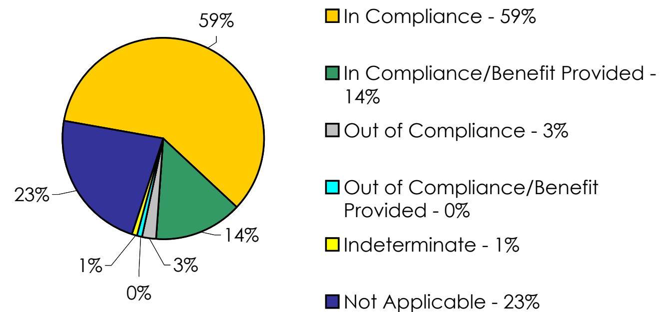


Complaint Compliance Determinations

California's patients' rights laws are embodied in the Knox-Keene Act. The 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 HMO's response to the complaint), no violation of California's patients' rights laws was found.
- In Compliance/Benefit Provided—The HMO initially denied a service or benefit and then reversed its position by providing the service or benefit after the enrollee accessed the HMO'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 HMO complied with California's patients' rights laws.
- Out of Compliance—Based upon review of complaint documents (including the HMO's response to the complaint), staff identified a specific violation of California's patients' rights laws.
- Out of Compliance/Benefit Provided—The HMO initially denied a service or benefit and then reversed its position by providing the service or benefit after the enrollee accessed the HMO'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 HMO did not comply with California's patients' rights laws.
- Out of Compliance/Demand Refused—The HMO refused to provide a benefit or service after being directed to do so by the Department. This determination was not assigned to any complaints during 2004. However, if a demand were refused the Department would still have other enforcement actions at its disposal.
- Indeterminate—This determination is used in two scenarios: (1) there was insufficient evidence to indicate non-compliance on the part of the HMO; or (2) a compliance determination may not have been applicable.
- Not Applicable—The subject matter did not reasonably relate to a matter of compliance with California's patients' rights laws.

Compliance with Patients' Rights Laws - 2004



Provider Complaints

In January of 2001, the State Legislature enacted amendments to the Knox-Keene Act through the passage of AB 1455 (stats. 2000). This legislation set legal requirements for prompt payment of provider claims by health care service plans, with interest, and, in some cases, penalties for delayed payments. It also directed the Department to promulgate regulations to streamline provider claims payment and to establish a Dispute Resolution Mechanism. The law required the Department to develop a definition of unfair payment patterns and a system of responding to them. Regulations were finalized on August 24, 2003, and became effective on January 1, 2004.

These changes led the Department to establish a new provider complaint process, which was implemented on September 20, 2004. Provider complaints are tracked to determine whether any health plan is engaged in "demonstrable and unjust payment patterns" prohibited by law or it's implementing regulations.

This new process is intended to create a "payor payment practice analysis," which is one step of

determining whether any plan is engaged in an unfair payment practice.

Provider Complaint Improvements

A major challenge being addressed by the new provider complaint process is to allow providers to submit multiple "like" claim disputes. The Department is finalizing changes to the Web-based system and database, so that multiple claims can be submitted. The proposed changes will allow providers, or their representatives, the option of submitting multiple "like" claims under one provider complaint form. This system will save 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.

Continuity of Care

Staff provided assistance to consumers affected by health plan bankruptcies or failed contract negotiations by informing them of the status of their particular plan or group. The HMO Help Center's involvement in this process ensured that enrollees received continuity of care for ongoing treatment.

The new completion of covered services legislation (AB 1286/SB 244, stats. 2003) that became effective in 2004 was applied to the CalPERS/Blue Shield narrow network filing that eliminated some provider groups from its network. The HMO Help Center anticipated and helped resolve a number of complaints on denials of requests to continue care with the terminated provider groups. The Division of Plan Surveys proactively conducted a focused survey of Blue Shield's handling of requests for continuity of care and the HMO Help Center handled complaints, with clinical input where appropriate. The HMO Help Center is poised to assist any California enrollee affected by any other situation arising due to health plans narrowing their networks.

"When it comes to access to health care, we are not separated as much by wealth, race or party, as much as we are joined by our shared responsibility to ensure the well-being of all Californians."

Cindy Ehnes
Director

Stakeholder Interaction

The Department is accountable to its external stakeholders which include, but are not limited to: enrollees 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 believe that all have a common goal: healthier Californians.

Advisory Boards & Committees

Three advisory groups provide input to the Department in order to ensure that the voices of everyone affected by managed health care are heard.

Advisory Committee on Managed Health Care

The Advisory Committee on Managed Health Care (ACMHC) is composed of 22 people and includes the Department Director, members appointed by the Governor, and members appointed by the Assembly and the Senate. The purpose of the ACMHC is to assist and advise the Director on aspects of the Director's duties under the Knox-Keene Act and to make recommendations as to how the Department may best serve Californians.

The committee met in October 2004 and addressed five agenda topics -- the Quality of Care Report Card, the preliminary draft of a regulation to implement SB 842 regarding prescription drugs, a discussion of racial disparities in medical outcomes, a discussion of cost-sharing, and a discussion of recommendations for the Director. Public comment was taken on each agenda item.

In addition, four public hearings were held in 2004. Various committee members attended or submitted comments. Hearing topics were the Anthem/WellPoint merger, the proposed access-to-care regulation, an open forum public hearing, and the proposed regulations for block filings.

Clinical Advisory Panel

The purpose of the Clinical Advisory Panel (CAP) is to provide expert assistance to the Director to ensure that the external IMR system meets the quality standards necessary to protect the public interest. Additionally, the CAP assists the Director with other clinical issues as needed. More important, the CAP reviews the decisions made in the external review process to ensure that they are consistent with best practices and to make recommendations for improvements where necessary.

CAP is composed of five medical professors, four of whom are currently practicing. The CAP met twice during 2004. The agenda at the March meeting included a facilitated discussion and overview of the IMR system; issues arising from IMRs involving a pain management medication frequently prescribed for non-FDA-approved uses; and a proposed Department/University of California, San Francisco study on health plan medical policy development. The September meeting featured an update of the IMR system, a presentation concerning the epidemiology and treatment issues of autism in California, and a forum regarding referrals and access to specialists in the treatment and management of HIV/AIDS under the Department's regulation (28.C.C.R. 1300.67.30).

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 and to develop and recommend 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 Department by providers.

The main order of business for the FSSB in 2004 was to review and comment on the Department's revised SB 260 regulations prior to the formal rulemaking process. The regulations seek to restore financial data collections for risk-bearing provider groups and to establish the criteria for corrective action plans for organizations that are financially deficient. The FSSB also considered managed care participation in the delivery of workers' compensation services and unfair billing patterns by providers.

Stakeholder Outreach

We work with our stakeholders to form cooperative working relationships. In order to interact successfully together, stakeholders must be held accountable to develop concensus-based solutions.

HMO Help Center Health Plan Newsletter

The Department publishes a Health Plan Advisory Newsletter to promote better communication between the HMO Help Center and HMOs. 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 complaint processes, the HMO Help Center's referral process and requirements of the Independent Medical Review process.

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

> *Making Managed Care Work*, sponsored by the Western Center on Law and Poverty.
>
> *Avoiding Managed Care Pitfalls*, an inter-agency forum sponsored by the U.S. Department of Labor.
>
> *Obesity Seminar*, sponsored by the California Association of Health Plans.

HMO Help Center Compliance Oversight

HMO Help Center staff dedicated resources toward the following efforts:

- Staff reviewed health plan filings relating to Quality of Care Review Systems, in addition to continuing the review of filings pertaining to grievance, IMR and arbitration. Staff also developed tools to effectuate a more streamlined and efficient review of health plan filings.
- Staff conducted joint surveys of Medi-Cal managed care plans with the Department of Health Services' Medi-Cal Managed Care Division and Medical Review Branch.
- Staff reviewed all complaint and IMR files to identify procedural violations of the Knox-Keene Act for referral to the Office of Enforcement. This review has resulted in improved quality of grievance correspondence to health plan enrollees.

HMO Help Center Educational Outreach

Through a contract with California State University, Sacramento, Media Services, the HMO Help Center

updated its informational brochures and generated print copies in English and Spanish. Staff distributed 86,000 brochures to libraries across California. In addition, this outreach project focused on compliance with the Americans with Disabilities Act (ADA) regulations for low-vision consumers, which led to audiotape, diskette (.pdf format), large print and Braille versions of the brochures.

HMO Help Center Health Literacy Project

The HMO Help Center has been working with the California Health Communication Project from the University of California, Berkeley, Center for Community Wellness to improve the health literacy of staff. Staff participated in an interactive training session led by trainers from the Center to learn techniques for improving the readability and usability of written materials, such as letters, forms and brochures. The training was tailored specifically to the HMO Help Center consumer materials and resulted in letters and forms that are easy to read and easy to use.

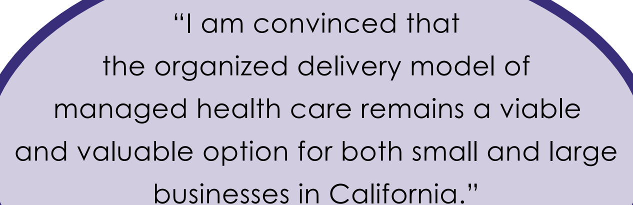
HMO Help Center Outreach to the Health Care Community

The Department has worked with the California health care community to promote awareness of the Department's mission and patients' rights. The following efforts were made during 2004:

- Staff provided representation in the Industry Collaboration Effort, Inc. (ICE) leadership group, and gave a presentation at the ICE annual conference concerning the Department's priorities. Staff participated in the successful completion of its Physician Group Oversight project that streamlined procedures involving regulatory requirements for providers.
- HMO Help Center staff participated in the *KCRA-TV* Health Fair at Cal Expo in Sacramento by assisting Office of the Patient Advocate (OPA) staff in answering HMO questions.
- Staff met with the Department of Health Services' Office of Disability and Health to review a draft of their strategic plan for *Living Healthy with a Disability*. In addition, staff participated on a subcommittee on *Improving Access to Health Care and Health Promotion Systems via Provider Education and Training.*

HMO Help Center Duty Counsel/Information Line

The Duty Counsel program, which provides a forum to answer legal questions from consumers and the general public, was transitioned into the general information assistance already in place at the HMO Help Center. The same staff that have assisted consumers through the toll-free telephone number now provide assistance to callers requesting general information. A Liaison Counsel was designated to assist in responses to these inquiries.



Office of Enforcement Outreach

The Office of Enforcement Assistant Deputy Director attends weekly *Reasonable and Customary Rate* meetings with two representatives from each of the California Medical Association, California Hospital Association, California Association of Health Plans and California Association of Provider Groups. These weekly meetings generate discussions regarding the improvement of the methodology, already in law, to be used to determine reasonable and customary rates to be paid for non-contracted provider services.

Additionally, Office of Enforcement staff has been working with the Provider Complaint Unit to help with provider non-payment issues.

Office of Legal Services Outreach

Due to a previous Executive Order placing a moratorium on regulations, meetings with stakeholders did not commence until May 2004. Thereafter, Legal Services conducted 14 separate meetings with stakeholders, including one in conjunction with the ACMHC and one with the FSSB. Subject matter ranged from the Consumer Participation Program; access to needed health care services; language assistance; and outpatient prescription drug co-payments, co-insurance, deductibles, limitations and exclusions. Legal Services has also worked in conjunction with the Office of Technology and Innovation to develop a process that will allow the public to submit comments on the Department's Web site about significant issues that may mature into regulations. The Department expects to make this innovation available for public use during 2005.

In addition to stakeholder meetings, the Office of Legal Services solicited public comments on the following proposed regulations:

- Geographic Accessibility Standards.
- Assessment for University of California Analysis of Proposed Mandate Legislation.
- Access to Needed Health Care Services.
- Assessment of Administrative Penalties.
- Block Transfer Filings.
- Execution Pages.
- Conflict of Interest Amendments.
- Outpatient Prescription Drug Co-payments, Co-insurance, Deductibles, Limitations and Exclusions.

The Office of Legal Services is dedicated to supporting the Department's efforts to work with all stakeholders in managed health care to achieve a healthier California by:

- Partnering for the development of innovative strategies that ensure access to essential, cost-effective, quality health care services for every Californian.
- Empowering Californians to make healthy choices to improve their health by increasing the transparency of health care costs and services.
- Encouraging the use of disease management, wellness, prevention and other innovative programs to deal with California's key public health concerns.
- Consolidating and partnering with existing state programs to achieve efficiencies in health care access and delivery.
- Supporting the achievement of maximum efficiencies through health information technology, including electronic health care records to ensure instant computer access to medical records and information, while maintaining security and patient confidentiality.

As the pace of change in managed health care continues to accelerate, the Office of Legal Services is committed to carefully studying industry and marketplace trends to ensure that the Department's regulatory initiatives foster better and more cost-effective health outcomes for Californians.

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 that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees (Health and Safety Code section 1348.9).

The Consumer Participation Program relies on three interactive, Web-based applications available on the

Department's Web site: (1) Request for Finding of Eligibility to Participate and Seek Compensation; (2) Petition to Participate in a Proceeding; and, (3) Award of Fees.

The Department has approved five applications for Request for Finding of Eligibility to Participate and Seek Compensation and 19 applications for Petition to Participate in a Proceeding. No applications were received for the Award of Fees. In order to receive the award, an applicant must complete the three applications and receive approval on each. As no applicant met the criteria, the Department did not award any advocacy and witness fees during 2004.

Efficiency Through Technology

Electronic Filing

Applications for licensure and proposed changes to a health plan's operations must be filed with the Department for review. All health plans submit their filings via the electronic document management system (eFiling). This application allows health plans to electronically file licensing documents with the Department. The documents are managed and stored by the automated system, which also supports Department staff review of the filings.

Interactive Public Web Site

The cornerstone of successful public and stakeholder communication is our interactive Web site. The public and stakeholders may access a wide variety of information and services supported by the Department at www.dmhc.ca.gov. The Web site is under review to improve it's easy accessibility to consumers. The following page shows a snapshot of our interactive Web site.

Welcome to California

DMHC Home Page

Resources

Get Help with Your HMO

Contact Your HMO

Independent Medical Review

HMO Report Card

Information about Health Plans

Enforcement Actions

Information for Plans and Providers

Claims Settlement Practices Information

Submit a Provider Complaint

Library

Law and Regulations

Frequently Asked Questions

Request for Public Information

Related Sites

The Department

About the DMHC

Advisory Boards

Office of the Patient Advocate

Small Business Advocate Program

Press Room

Subscribe to Updates

How Are We Doing?

Evaluate our Site

Contact Us

Site Map

Department of Managed Health Care

What's New

- **DMHC approves restructuring of Sharp Health Plan's government programs.**
  - Press Release
  - Order I
  - Order II
  - Order III
- **DMHC rescinds order for Blue Cross to continue providing care at Pomona Valley Hospital Medical Center due to new contract signing.**
  - Order
- **DMHC Fines Health Net for Failing to Correctly Reimburse Emergency Room and Hospital-based Doctors.**
  - Press Release
  - Consent Agreement
- **DMHC issues new cease and desist order against Platinum Health Plus from doing business in California.**
  - Order
- **Other discount health plans information.**
  - Consumer Alert
  - *Alerta Al Consumidor*
  - Cease and Desist Orders
- **New on-line Provider Complaint System available to assist California providers with health plan and/or payor complaints, including payment of claim issues.** This system is designed to accept complaints relating to services on or after January 1, 2004.

Upcoming Meetings

- No public meetings scheduled at this time.

Highlights

Search

My CA   This Site

GOVERNOR Schwarzenegger Click To Visit His Home Page

Agency Secretary Sunne Wright McPeak

Director Lucinda "Cindy" Ehnes

Flex your Power

GET HMO HELP NOW

Snapshot of our interactive Web site at www.dmhc.ca.gov

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.

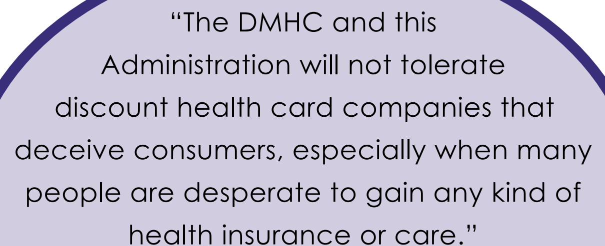
As California's HMO regulator, the Department works with the health plans to achieve better accountability of patient premium dollars and improved financial stability of HMOs and medical groups. We are committed to ensuring that physicians, hospitals and other providers are willing to participate in 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.
- Develop and launch public education and awareness efforts.
- 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.

Industry Changes

The Knox-Keene Act was drafted in 1975 with the traditional HMO model of managed health care in mind. In the ensuing quarter century, the managed health care industry has undergone significant changes. The traditional HMO model – once the dominant model for managed health care in California – is being challenged by newer and perhaps more flexible health care delivery formats. As the demand for more flexibility in the choice of health care providers has increased, the Preferred Provider Organization (PPO) model has become more popular. In response to increasing health care costs, the consumer-driven model for health care delivery has been introduced. Also, increasing numbers of uninsured have fueled an interest in discount health entities. Unfortunately, legislative and regulatory changes have not kept pace with the rapid change in the health care industry. As a result, the existing regulatory mechanisms being used by the Department will be revised to meet these new challenges.



Discount Health Entities

The regulation of discount health entities has increasingly become a challenge to the Department. These companies target low-income and ethnically diverse communities — requiring large enrollment and monthly fees and giving little or no benefit.

The Department has taken tough enforcement actions against fraudulent discount health card companies. To date, we have issued cease-and-desist orders against out-of-state companies doing business in California. A "Consumer Alert" has been issued and the HMO Help Center has assisted more than 150 consumers on problems with discount health cards.

Regulatory Revision

As noted above, the existing system for regulating managed care in California has become outdated in the quarter century since the adoption of many

regulations implementing the Knox-Keene Act. The Office of Legal Services has undertaken the task of recommending a revision and reorganization of the Department's regulations to more appropriately regulate the managed-care industry in California.

Establishing Expertise

As the policy arm of the Department, it is imperative for the Office of Legal Services to maintain a level of expertise that will allow flexible and appropriate analysis of critical issues as they arise. The Office of Legal Services has established, and is further developing, a broad range of expertise among its staff by capitalizing on existing knowledge, and providing additional training and mentoring. Legal Services' staff presented at seven seminars relating to current health plan issues, three seminars on labor law, three seminars dealing with health information technology, and eight seminars covering rule making legislation, analysis and supervision.

Issues and Challenges

Bariatric Surgery

The HMO Help Center will continue to address issues dealing with access to weight loss surgery, particularly as involves the criteria for authorization of procedures and pre-operative protocols.

Asthma Treatment Care

Under a new law (AB 2185, stats. 2004), HMOs are required to cover outpatient prescription drug benefits to provide coverage for inhaler spacers, nebulizers and peak flow meters when medically necessary, for the management and treatment of pediatric asthma, as well as education of pediatric asthma conditions. This coverage must be provided under the same general terms and conditions as all other benefits provided by the plan. The HMO Help Center anticipates consumer inquiries regarding the level of coverage required, the effective date and inquiries regarding equipment that is not specifically listed in the legislation.

Domestic Partners

The California Domestic Partner Rights and Responsibilities Act of 2003 (AB 205, stats. 2003), requires health plans to provide coverage on or after January 2, 2005, to the registered domestic partner of an employee, subscriber, insured or policyholder that is equal to the coverage provided to a spouse. Health plans can ask for proof of domestic partner status, but only if they also ask for proof of marital status. Many group plans operate on a calendar year basis, renewing on January 1 of each year. For those health plans, this law is not effective until January 1, 2006. The HMO Help Center is prepared to answer inquiries from enrollees who are unaware of their renewal date, and other questions or complaints about this new requirement.

Autism

HMO Help Center counsel is addressing the issue of Applied Behavioral Analysis (ABA) therapy for autistic children. An issue of coverage of ABA has risen where the health plan excluded coverage of services performed by unlicensed providers.

Health Plan Surveys

The Division of Plan Surveys became part of the HMO Help Center on July 1, 2003. This move was intended to provide a more efficient and effective way of reporting on efforts by licensed HMOs in California to comply with statutory and regulatory requirements.

Section 1380 of the Act requires the Department to conduct a Medical Survey of each licensed health care service plan at least once every three years. The Medical Survey is a comprehensive evaluation of the health plan's compliance with the Act. The Act also mandates a follow up review to be conducted and reported on 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:

- Procedures for obtaining health care services.
- Procedures for reviewing and regulating utilization of services and facilities.
- Procedures to review and control costs.
- Peer review mechanisms.
- Design, implementation and effectiveness of the internal quality of care review systems.
- Overall performance of the plan in providing health care benefits.
- Overall performance of the plan in meeting the health care needs of enrollees.

In addition to the Routine Surveys and Follow-up Reviews, additional responsibilities for the Division of Plan Surveys staff include Non-Routine Surveys and Focused Reviews, Enforcement Referrals, and Legislation and Regulation Reviews.

The following chart illustrates the survey activity during calendar year 2004:

Surveys Completed and Reports Issued During 2004			
Plan Type	Surveys Completed	Final Reports Issued	Follow-up Reports Issued
Full Service	12	11	13
Dental	10	11	13
Vision	5	5	6
Behavioral Health	4	5	3
Chiropractic	1	2	1
Totals	**32**	**34**	**36**

Medical Surveys and Mental Health Parity

The HMO Help Center responded to concerns from mental health advocates, patients and providers about plan compliance with Section 1374.72 (AB 88, stats. 2000) of the Act. The section requires plans to provide the same terms and conditions of coverage for specified mental illnesses and serious emotional disturbances as for other medical conditions. Together with the Office of Legal Services and the Division of Licensing, HMO Help Center staff and the Division of Plan Surveys developed a schedule to conduct an overview of behavioral services in early 2005. The Department worked with staff from the Department of Mental Health on a report on mental health parity under SB 1103 (stats. 2004), and helped plan a public meeting through the Clinical Advisory Panel (CAP). The Department's focused survey of full-service plans' implementation and oversight of mental health parity under Section 1374.72 will occur between March and June 2005. The HMO Help Center also became involved in targeted outreach efforts to address the special needs and concerns of patients, advocates, providers and family members relating to access, availability and coverage for medically necessary behavioral health services.

Licensing

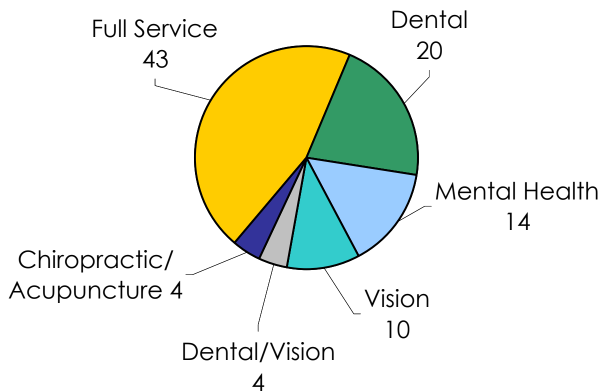
The Division of Licensing is responsible for the review and approval of a wide variety of proposed changes to a health plan's operations. It is here that all applications of health plans for licensure and any changes after licensure that the health plans make in their operations, contracts or benefits are reviewed. These reviews cover the full range of a health plan's business organization, health care delivery system and benefit structures. Last year, Licensing received a total of 3,635 electronic filings from health plans that totaled over 135,000 pages.

Wellpoint-Anthem Merger

In 2004, the Department reviewed the proposed merger of Wellpoint and Anthem Corporations, clearing the way for a change in control of Blue Cross of California. The review process was thorough, structured and deliberative. As a result of this review the Department was able to achieve concessions through extensive negotiations to improve the quality and accessibility of health care for Californians, retain administrative oversight activities in California, hold down administrative costs, maintain current levels of products available for low-income consumers, and provide investments in important health programs, such as the Healthy Families program.

Number of Licensed Health Care Service Plans

As of December 31, 2004, there were 43 full service plans and 52 specialized plans (20 dental, 10 vision, 14 mental health, four dental/vision and four chiropractic and/or acupuncture). (Please refer to Appendix D for a listing of all health plans licensed through the Department of Managed Health Care in 2004.)



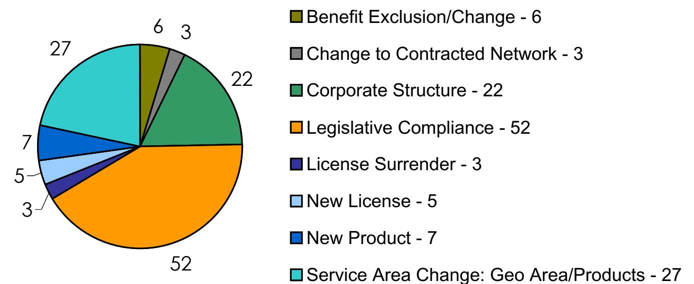
Licensing Functions

In 2004 the Division of Licensing completed review of:

- Five license applications.
- 120 Material Modifications to an existing license.
- 192 Evidence of Coverage Disclosure Agreement (non-§1352.1) amendments.
- 216 Non-Evidence of Coverage Disclosure Agreement (non-§1352.1) amendments.
- 168 advertisements.
- Three license surrenders.
- 160 block transfer of enrollee filings affecting 713,000 enrollees.

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 plan or its operations. It is also required in certain specified situations such as if a health plan wishes to exclude or limit a medically necessary prescription drug. Licensing reviewed and closed (approved, disapproved, or concurred with plan withdrawal of filing) 125 material modifications in 2004. The following chart shows the number and types of Material Modifications:



Blue Shield/CalPERS Narrow Provider Network

In July of 2004, Blue Shield filed a Material Modification for approval of a new narrow network for CalPERS enrollees. The Blue Shield proposal was significant because it offered a vastly different approach to cost savings. Usually employers utilize increased co-payments, deductible or cost sharing as the mechanism to control premium increases. In this case, CalPERS and Blue Shield developed a narrower network as the cost savings mechanism, an approach not previously presented to the Department. The Department was concerned with verifying that the new narrower network would adequately serve Blue Shield's enrollees, and approved and denied portions of the proposed network changes. In approving certain portions of the network, the Department imposed specific performance conditions (undertakings) on Blue Shield concerning continued access to providers. In this way, the Department allowed Blue Shield and CalPERS to implement this cost savings mechanism while ensuring that enrollee access to care will not be adversely affected.

The Department took additional steps after its decision on the Blue Shield narrow provider network to ensure that CalPERS enrollees were smoothly transitioned. The Department began monitoring all enrollee complaints to identify problems with the transition, including any problems enrollees had selecting a new provider. The Department communicated with Blue Shield representatives regularly to discuss and resolve any identified concerns. This also led the Department to conduct an audit of all continuity of care denials for serious and chronic conditions and a requirement that Blue Shield submit bi-weekly reports on continuity of care requests. The Department intends to continue monitoring this filing closely in 2005 to determine whether narrower network achieves the goal of cost containment without inappropriately restricting access. Lessons learned from this filing will be incorporated into new recommended procedures for reviewing similar filings.

Continuity of Care

In order to provide consumers with expanded rights and to ensure a smooth transition to a new provider or to continue care with the same provider, the Department directed significant efforts toward writing AB 1286/SB 244 (stats. 2003). This legislation, which took effect on January 1, 2004, provided new protections under the law and expanded continuity of care rights to include the terminally ill, pregnant women and surgeries or procedures scheduled to occur within six months of the contract termination date or date of new enrollment in a health care service plan.

The law also requires health plans to file a written continuity of care policy describing procedures for transferring enrollees from terminated provider groups or hospitals to new groups or hospitals. In 2004, the Department reviewed 63 continuity of care policies which were required by the Department. As a result of these regulations, enrollees will now receive advance notice of contract terminations.

Retroactive Termination

In addition to Pacificare, the Department has granted conditional exemptions to four other plans allowing for retroactive termination for non-payment of premiums. The Department has also issued a plan advisory containing instructions on the information that should be submitted by health plans who are requesting the conditional exemption. The Department is actively working on developing regulations in this area and expects to have them implemented by July 1, 2006.

Technical Assistance Guides

The Division of Licensing developed an Evidence of Coverage (EOC) Technical Assistance Guide (TAG) for the review of EOC filings. This guide will be used internally to insure consistency in filing review and will be shared with the health plans to assist them in understanding the Act and preparing documents for submission. Another TAG is in development for provider contract filings and additional TAGs are planned for block transfer filings, new licensure applications and specialized health plans.

Specialized Plans Project

The Division of Licensing began a specialized plans project in 2004 with the goal of developing recommendations for the purpose of development of new regulations for these health plans. Licensing staff created presentations regarding specialized health plans for the purpose of educating staff on issues unique to service plans such as Dental.

Financial Oversight

The Division of Financial Oversight protects Californians who receive service from licensed health care service plans and their provider networks by ensuring that they 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 2004, the Division of Financial Oversight:

- Met all statutory review deadlines.
- Performed 45 routine and orientation examinations of health plans.
- Made 22 referrals to the Office of Enforcement for serious violations of the Knox-Keene Act.
- Reviewed 1,015 financial statements submitted by health plans.
- Reviewed 505 Material Modifications, amendments and license applications submitted by health plans.
- Reviewed 121 financial statements submitted by exempt health plans operated by city, county and public entities.

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 four types of examinations:

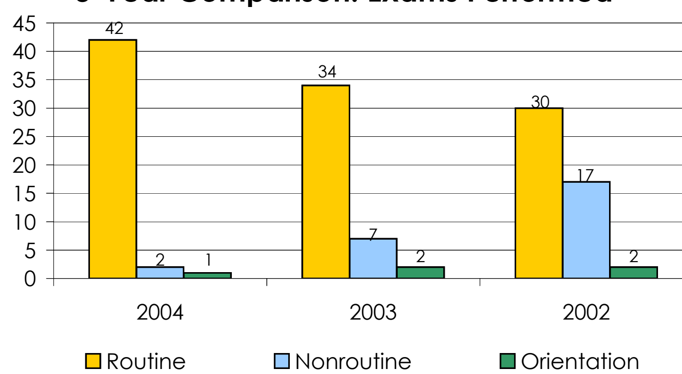
1) ***Routine*** financial examinations provide the Department with the opportunity to review the books and records relating to the fiscal and administrative affairs of the health plan. It is crucial that the books and records of the health plan accurately reflect the results of the plan's operations to adequately evaluate its financial solvency.

2) ***Nonroutine*** examinations are performed when needed for financial viability issues, tangible net equity, claims payment, books and records, financial statements and written instructions from the Department.

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.

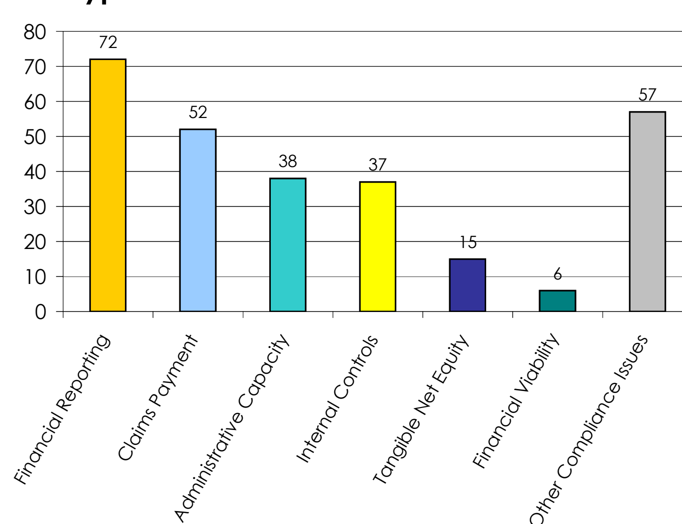
4) ***Orientation*** examinations are performed one year from the date of licensure. The purpose is to verify if the licensee is operating as represented in its license application.

Reports are issued that disclose the health plans' ability to comply with 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/.



Deficiencies Identified

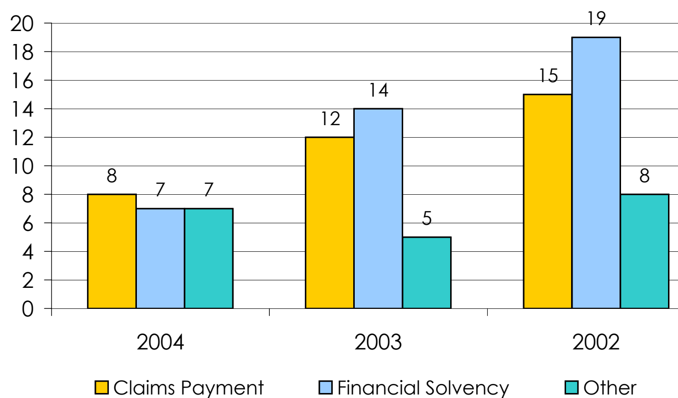
In 2004, the majority of deficiences in financial examinations were in the areas of financial reporting; tangible net equity including maintaining the proper amount and calculation of the correct required amount; and claims payment issues.



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 2004, 20 of the 22 referrals resulted from issues identified as part of the financial examination. 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 financial 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 health plan failure.

Health plans electronically submit financial statements to the Department and they are placed on the Department's Web site.

Enforcement

The Office of Enforcement is mandated by the Knox-Keene Act to ensure health plans comply with the requirements of the Act through timely, aggressive and fair enforcement. It is responsible for handling the litigation needs of the Department, representing it in actions to enforce managed health care laws and defend the Department and its representatives against incoming litigation.

During 2004, the Office of Enforcement:

- Opened a total of 251 cases as a result of grievance violations by health plans.
- Collected a total of $26,578 in special assessments from health plans that failed to pay their assessments in a timely manner.
- Collected a total of $723,700 in fines from health plans that violated the Act.

Currently, the Office of Enforcement is investigating a number of discount health entities. These entities are arranging for health care services and, therefore, fall within the definition of health care service plan under the Knox-Keene Act. However, they do not have a license to provide these services. Further, their advertising is often deceptive and the language utilized violates the Act. Finally, many discount health entities are being investigated to ensure that the actual discounts advertised are, in fact, provided.

Increased Caseload

In 2004, the Office of Enforcement opened a total of 458 cases, of which 232 remain open and 266 were closed. (Please refer to Appendix C for a further breakdown of caseload, hours to close cases, enforcement actions and case aging.)

Violation Trends and Issues

In 2004, the Office of Enforcement concentrated on grievance-related problems. Grievance procedures are the first opportunity for the enrollees to express their discontent with the decisions made by health plans. Thus, health plans were penalized if they

violated statutes ensuring prompt investigations, prompt responses and clear explanations to enrollees. (Please refer to Appendix E for fines associated with violation trends during 2004 and a two-year comparitive summary of fines associated with specific Health and Safety Code violations.)

Legal Services

Regulations

Seventeen regulatory packages were initiated in 2004. While not all have completed the drafting stage and the notice requirements of the Office of Administrative Law, six regulatory packages are currently going through the formal rulemaking process. Three of these are of particular importance: Continuity of Care; Access to Needed Health Care Services; and Outpatient Prescription Drug Co-payments, Co-insurance, Deductibles, Limitations and Exclusions. It is anticipated that these packages will be completed and implemented in 2005.

While each piece of the managed health care regulatory scheme is important in the overall picture, of the seven packages that completed the formal process during 2004, Geographic Accessibility Standards is the most noteworthy. This regulation became effective on July 10, 2004, and established an extended geographic accessibility standard to apply to plans in counties with a population of 500,000 or less. Enrollees in these counties have historically had difficulty gaining access to managed health care coverage. This regulation addresses this problem by clarifying procedures for health plans to request alternative accessibility requirements appropriate to a particular rural area, and by requiring a health plan that proposes to withdraw from such an area to hold a well-publicized public meeting, and possibly a hearing, in the affected county regarding the plan's proposal.

Additional information on Departmental Advice and Regulations can be found on our Web site at www.dmhc.ca.gov. Select "Library" to review Departmental Advice and select "Law and Regulation" to review existing and proposed regulations.

Health Plan Assessments

The Department is funded entirely 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 $2.0 million, until 2006, may be assessed to fund the review of legislatively mandated health care benefits by the University of California (UC). After the Department makes the assessment of these costs the funds are then transferred to the UC budget for expenditure.

HMOs were assessed $33.5 million to fund the Department's operations and $0.9 million to fund the UC Legislative mandate reviews for FY 2004/05. This assessment was, on the average, .047 percent of HMO "Total Revenue" and .554 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 is not stationary. We are continually in motion, seeking out business process improvements.

HMO Help Center Process Improvements

- Staff received customized training in customer service, reviewing telephone etiquette and handling of difficult calls. The Call Center implemented a new system called, "Take Back and Transfer", a functionality that enables redirection of calls to Department staff for more comprehensive service.
- The Department improved oversight of Medicare supplement plans through review of health plan filings by HMO Help Center counsel, and referral of rate filings and other financial issues to examiners. Communication was improved with Medicare supplement issuers by encouraging direct contact between plan counsel and issuers' counsel, prior to filings or in connection with responses to comment letters.
- HMO Help Center staff participated in the Evidence of Coverage Technical Assistance Guide (TAG) project. When implemented, a TAG will standardize the review of "Evidences of Coverage." This will result in internal streamlining and consistency as well as improved disclosure to enrollees, particularly in the areas of health plan grievance systems and the IMR process.
- In September 2004, the HMO Help Center initiated a project to address provider complaints. Staff is tracking provider complaints to determine whether any payors are engaging in demonstrable and unjust payment patterns prohibited by law.
- The Department formed a working group with representatives from consumer and provider stakeholders, and the Departments of Mental Health and Developmental Services, to gather information on mental health parity pursuant to SB 1103 (stats. 2004). The Department is conducting focused surveys of health plan efforts (through the CAP and in conjunction with the Department of Mental Health) to provide information on whether health plans have achieved mental health parity.
- Staff provided legal analysis of applicable statutes, comparing the Insurance Code and the Health and Safety Code in the following areas: Grievance, Arbitration, IMR and Benefit Disclosure. The Department facilitated Joint Work Group meetings with the California Department of Insurance through 2004, and completed a *Year 2 Report*. The report highlights accomplishments in improving complaint processes, consumer outreach and the IMR program.
- Staff developed new complaint forms and Call Center questions to obtain additional information concerning enrollee access to linguistic services. Staff participated in the Office of the Patient Advocate's Cultural and Linguistic Work Group regarding language services, and met with Pan-Ethnic Health Network's Policy Director and consumer advocates regarding upcoming cultural and linguistic regulations.
- Counsel addressed the interpretation of complex language regarding grievance system requirements in several sections of the Knox-Keene Act and regulations. In particular, the issue of whether a health plan is required to include an IMR application in coverage denials was analyzed and discussed in an interdivisional meeting with the Office of Enforcement. This requirement was reinforced with the health plans in the HMO Help Center Newsletter of March 2004.
- Counsel was presented with an application for IMR for denial of speech therapy. The health plan alleged that speech therapy was not covered for a child with apraxia, which is classified as

an articulation disorder. With assistance from Licensing counsel, the HMO Help Center determined that the health plan was using outdated language to deny coverage of speech therapy for articulation disorder. The health plan was referred to the Office of Enforcement for operating materially outside the documents it had filed with the Department and for other various grievance violations.

Grievance Violation Tracking System

The reporting function of the grievance violation tracking system was finalized. A demonstration was provided and HMO Help Center staff began using the new reporting function to track files identified and refer them to the Office of Enforcement. This enhancement will allow us to track improvements and analyze trends regarding health plan compliance with grievance requirements, which will improve our oversight of these requirements.

Licensing Process Improvements

The Performance Improvement Initiative undertaken by the Business, Transportation and Housing Agency offered a number of recommendations, which the Division of Licensing is implementing to improve business processes. Licensing is streamlining the process for health plans to file licensing-related documents; developing new performance measures, protocols, and technical assistance guides; and standardizing Evidence of Coverage language. Licensing recently reorganized its staff into teams around functional areas of licensing review. This change was implemented in order to improve the quality and consistency of the review process. Goals for these improvements are:

- Faster review of licensing filings.
- Enhanced staff training, including a more comprehensive understanding of industry business models.
- Routine training offered to health plan compliance staff to improve their understanding of filing requirements and changes in the law.

Subsequently, the Department developed best practices in the review of licensing filings. The goals for this process are to reduce the number of documents received from health plans by 50 percent while significantly improving the quality and timeliness of the review process.

New Product Development

Division of Licensing staff engaged in active dialogue with the health plans during 2004 regarding concepts for new product introductions. A new product template was created in conjunction with the California Association of Health Plans to facilitate filing of plan product features. Significant research was conducted by the Department into the newly emerging concept of Consumer Directed Health Care. As health plans seek to bring new products to the marketplace, the Division of Licensing is working to actively work with them to allow new product designs that are compliant with the Knox-Keene Act.

Technological Solutions

Enforcement Process Improvements

The Office of Enforcement is building an "Enforcement Action Database" that will be accessible on the public Web site. The database will be a user-friendly tool to access all enforcement actions taken against health plans.

Office of Legal Services Process Improvements

During 2004, the Office of Legal Services provided access on the public Web site to submit requests for public records and forms under the Information Practices Act. Instructions and forms are also now available for the Consumer Participation Program.

In 2005, the Office of Legal Services will launch its improved regulations access Web site that will allow the public and stakeholders early opportunities to

comment on anticipated and proposed regulations. Early participation in the regulatory process will make it more efficient and save time in implementing regulations.

Provider Complaint Online Submission and Tracking System

On September 20, 2004, the Provider Complaint System was deployed to enable providers to submit individual complaints electronically through a secured Department Web portal. This system allows electronically submitted provider complaints to be processed, tracked and examined for trends. The data generated by this system will allow the Department to look for systemic or recurring types of payment, payor or contract problems and to target follow-up investigations of the root causes of any problems identified.

It enables the Department to review individual complaint submissions to ensure providers have been appropriately reimbursed and that health plans and their capitated providers have implemented complaint processing standards, contract disclosures and the dispute resolution mandates.

The Provider Complaint Project Team is currently drafting requirements for enhancing the system to accept “bulk” complaints. The proposed changes will allow providers or their representatives the option of submitting “multiple like” claims under one provider complaint form and will save time for providers or their representatives.

Quarterly Claims Settlement Practices

The Quarterly Claims Settlement Practices (AB 1455, stats. 2000) interactive Web application was implemented in May 2004. The Web-based application allows health plans to report claims payments that failed to meet requirements less than 95 percent of the time. Health plans report specific information to the Department regarding their own and risk-bearing providers payment histories on a quarterly basis.

Annual Claims Settlement Practices

The Annual Claims Settlement Practices and Dispute Resolution (AB 1455, stats. 2000) interactive Web application was implemented in November 2004. Health plans use the application to report claims payments which failed to meet requirements less than 95 percent of the time and report dispute resolution information. Health plans report specific information to the Department regarding their own and risk-bearing providers payment and dispute resolution histories for each calendar year.

Independent Medical Review Results By HMO

Report Definition

The Summary of 2004 IMRs by HMO:

- Details the number and types of IMRs closed with a determination during the 2004 calendar year. The total number of IMRs resolved (839) includes 52 cases that were withdrawn during the review process; a total of 787 cases completed the review process.
- Lists HMOs licensed during the 2004 calendar year, the HMO's average enrollment during the year, the number of IMRs closed for each HMO, the associated uphold and overturn determinations, and the number of IMR withdrawals. Enrollment data is provided for comparison purposes.

Enrollment Information Definition

The HMO enrollment figures were provided to the Department by the HMOs in their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2004. Because Medicare + Choice enrollees are not eligible for IMR, the enrollment figures below exclude them.

Total Enrollment on this report excludes Managed Health Network and PacifiCare Behavioral Health Care of California, Inc., as they are specialized HMOs, not full service HMOs.

Report statistics on following page.

Independent Medical Review Results By HMO

Plan Type and Name	Enrollees	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	4,597,195	126	45	30	15	0	81	53	21	7
Blue Shield of California	2,643,159	278	39	23	13	3	239	139	87	13
Cigna HealthCare of California Inc.	442,938	62	7	2	5	0	55	21	32	2
Health Net of California Inc.	2,108,910	93	23	11	12	0	70	43	21	6
Kaiser Permanente	5,763,699	100	4	3	1	0	96	55	31	10
L.A. Care Health Plan	769,789	1	0	0	0	0	1	0	1	0
PacifiCare of California	1,372,667	96	15	8	7	0	81	47	27	7
Universal Care	476,053	8	0	0	0	0	8	3	5	0
Total	18,174,410	764	133	77	53	3	631	361	225	45
Full Service- Enrollment Under 400,000										
AETNA Health of California Inc.	286,732	17	2	2	0	0	15	7	6	2
Alameda Alliance for Health	96,723	2	0	0	0	0	2	2	0	0
Care 1st Health Plan	164,422	7	0	0	0	0	7	5	1	1
Community Health Group	102,317	1	0	0	0	0	1	1	0	0
IEHP (Inland Empire Health Plan)	277,606	4	0	0	0	0	4	3	1	0
Santa Clara Family Health Plan	97,341	1	0	0	0	0	1	0	1	0
Sharp Health Plan	124,623	8	0	0	0	0	8	6	2	0
UHP Healthcare	82,544	2	0	0	0	0	2	0	2	0
Western Health Advantage	68,430	12	3	2	0	1	9	5	4	0
Total	1,300,738	54	5	4	0	1	49	29	17	3
Psychological										
Cigna Behavioral Health of California, Inc.	352,184	1	0	0	0	0	1	1	0	0
Managed Health Network	2,544,139	2	0	0	0	0	2	1	1	0
PacifiCare Behavioral Health of California Inc.	1,890,356	14	0	0	0	0	14	8	6	0
U.S. Behavioral Health Plan California	2,342,612	3	0	0	0	0	3	0	3	0
Total	7,129,291	20	0	0	0	0	20	10	10	0
Chiropractic										
Landmark Healthplan of California, Inc.	142,159	1	0	0	0	0	1	1	0	0
Total	142,159									

COMPLAINT RESULTS BY CATEGORY & HMO

Report Definition

The Summary of 2004 Formal Enrollee Complaints:

- Details the number and types of complaints closed by the Department during the 2004 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 complaint against the HMO.
- Lists HMOs licensed during the 2004 calendar year, the number of complaints closed for each HMO, the HMO's average enrollment during the year, the number of complaints per 10,000 enrollees, and the number of issues for each complaint category. Enrollment data is provided for comparison purposes.
- HMOs are listed according to the name they were doing business as (dba) during 2004. In instances where an HMO is known by more than one name, the dba name is shown first with additional names in parentheses.
- Complaints are classified in five categories: Access to Care; Benefits/Coverage; Billing/Claims/Enrollment; Attitude/Service of the Health Plan; and Attitude/Service of the Provider.

Enrollment Information Definition

The HMO enrollment figures were provided to the Department by the HMOs in their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2004. Because Medicare + Choice enrollees are not eligible for the complaint process, the enrollment figures exclude them.

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 & HMO

Plan Type and Name	Complaints Resolved	Enrollees	Complaints Per 10,000	Access Issues Count	Access Issues Per 10,000	Benefits/Coverage Issues Count	Benefits/Coverage Issues Per 10,000
Full Service - Enrollment Over 400,000							
Blue Cross of California	777	4,597,195	1.69	19	0.04	195	0.42
Blue Shield of California	868	2,643,159	3.28	14	0.05	253	0.96
Cigna HealthCare of California Inc.	78	442,938	1.76	2	0.05	23	0.52
Health Net of California Inc.	474	2,108,910	2.25	9	0.04	135	0.64
Kaiser Permanente	1,402	5,763,699	2.43	59	0.10	236	0.41
L.A. Care Health Plan	4	769,789	0.05	0	0.00	1	0.01
PacifiCare of California	441	1,372,667	3.21	10	0.07	158	1.15
Universal Care	25	476,053	0.53	1	0.02	7	0.15
Total	4,069	18,174,410	2.24	114	0.06	1,008	0.55
Full Service- Enrollment Under 400,000							
AET Health Care Plan of California -INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
AETNA Health of California Inc.	89	286,732	3.10	4	0.14	18	0.63
Alameda Alliance for Health	4	96,723	0.41	0	0.00	1	0.10
CalOptima	0	325,276	0.00	0	0.00	0	0.00
Care 1st Health Plan	7	164,422	0.43	0	0.00	4	0.24
CareMore Insurance Services Inc.	0	0	0.00	0	0.00	0	0.00
Cedars-Sinai Provider Plan LLC - INACTIVE 2004	0	0	0.00	0	0.00	0	0.00
Central Coast Alliance for Health	0	83,681	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	1	6,505	1.54	0	0.00	1	1.54
Community Health Group	3	102,317	0.29	0	0.00	2	0.20
Community Health Plan	1	164,467	0.06	0	0.00	0	0.00
Concentrated Care Inc. - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
Contra Costa Health Plan	1	62,328	0.16	0	0.00	0	0.00
Great-West Healthcare of California, Inc.	7	55,494	1.26	0	0.00	1	0.18
Health Plan of San Joaquin	1	76,005	0.13	0	0.00	0	0.00
Health Plan of the Redwoods - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
Heritage Medical Systems	0	199,756	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	277,606	0.07	0	0.00	1	0.04
Inter Valley Health Plan	1	0	0.00	0	0.00	0	0.00
Kern Health Systems, Inc.	1	85,171	0.12	0	0.00	0	0.00
Maxicare of California, Inc. - INACTIVE 2002	0	0	0.00	0	0.00	0	0.00
Medcore	0	0	0.00	0	0.00	0	0.00
Molina Medical Center	1	248,413	0.04	0	0.00	0	0.00
National Health Plans - INACTIVE 2002	0	0	0.00	0	0.00	0	0.00
On Lok Senior Health Services	0	924	0.00	0	0.00	0	0.00
Primecare Medical Network, Inc.	0	216,070	0.00	0	0.00	0	0.00
ProMed HCA (Health Care Administrators)	0	0	0.00	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
437	0.95	78	0.17	28	0.06	62	0.13	9	0.02
495	1.87	85	0.32	17	0.06	35	0.13	0	0.00
42	0.95	2	0.05	5	0.11	12	0.27	1	0.02
275	1.30	22	0.10	17	0.08	49	0.23	2	0.01
702	1.22	117	0.20	305	0.53	67	0.12	67	0.12
3	0.04	0	0.00	0	0.00	1	0.01	0	0.00
242	1.76	12	0.09	14	0.10	35	0.25	1	0.01
13	0.27	4	0.08	0	0.00	2	0.04	0	0.00
2,209	1.22	320	0.18	386	0.21	263	0.14	80	0.04
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
61	2.13	2	0.07	2	0.07	14	0.49	1	0.03
0	0.00	2	0.21	1	0.10	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
3	0.18	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	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	0.10	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	1	0.16	0	0.00	0	0.00
5	0.90	1	0.18	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	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	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
1	0.00	0	0.00	0	0.00	1	0.00	0	0.00
1	0.12	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

Plan Type and Name	Complaints Resolved	Enrollees	Complaints Per 10,000	Access Issues Count	Access Issues Per 10,000	Benefits/Coverage Issues Count	Benefits/Coverage Issues Per 10,000
San Francisco Health Authority	1	46,928	0.21	0	0.00	0	0.00
Santa Barbara Regional Health Authority	0	55,819	0.00	0	0.00	0	0.00
Santa Clara Family Health Plan	1	97,341	0.10	0	0.00	1	0.10
Scripps Clinic Health Plan Services, Inc.	0	24,170	0.00	0	0.00	0	0.00
Sharp Health Plan	26	124,623	2.09	1	0.08	8	0.64
Simnsa Health Care	0	14,012	0.00	0	0.00	0	0.00
Smartcare Health Plan	1	2,641	3.79	0	0.00	0	0.00
Tower Health Services - INACTIVE 2002	0	0	0.00	0	0.00	0	0.00
UCSD (UC San Diego) Senior Health Plan	0	0	0.00	0	0.00	0	0.00
UHP Healthcare	7	82,544	0.85	1	0.12	1	0.12
Valley Health Plan	0	58,300	0.00	0	0.00	0	0.00
Ventura County Health Care Plan	4	10,642	3.76	0	0.00	2	1.88
Western Health Advantage	30	68,430	4.38	3	0.00	9	1.32
Total	189	3,037,340	0.62	9	0.03	49	0.16
Chiropractic							
ACN (American Chiropractic Network, Inc.)	1	3,758,302	0.00	0	0.00	0	0.00
ACN Group of California, Inc.	0	0	0.00	0	0.00	0	0.00
Avante Complementry Health Plan - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
Basic Chiropractic Health Plan	0	306	0.00	0	0.00	0	0.00
ChiroSave, Inc. - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
Landmark Healthplan of California, Inc.	1	142,159	0.07	0	0.00	0	0.00
Total	2	3,900,767	0.01	0	0.00	0	0.00
Dental							
AETNA Dental of California, Inc.	3	269,541	0.11	0	0.00	2	0.07
Ameritas Managed Dental Plan, Inc. - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
California Benefits Dental Plan	0	22,822	0.00	0	0.00	0	0.00
California Dental Network, Inc.	3	48,167	0.62	0	0.00	0	0.00
CENTAGUARD Dental Plan	0	19,545	0.00	0	0.00	0	0.00
Century Dental Health of California, Inc.	0	0	0.00	0	0.00	0	0.00
Cigna Dental Health of California, Inc.	24	334,630	0.72	0	0.00	6	0.18
Delta Dental Plan of California	92	15,158,333	0.06	1	0.00	18	0.01
Dental Choice of California, Inc.	1	165,760	0.06	0	0.00	1	0.06
Denticare of California, Inc. - INACTIVE 2004	5	403,099	0.12	0	0.00	2	0.05
Healthdent of California, Inc.	1	8,802	1.14	0	0.00	0	0.00
Ideal Dental Health Plan, Inc. - INACTIVE 2002	0	0	0.00	0	0.00	0	0.00
Managed Dental Care	4	104,349	0.38	0	0.00	0	0.00
Newport Dental Centers	0	65,280	0.00	0	0.00	0	0.00
Pacifiic Union Dental, Inc.	1	223,706	0.04	0	0.00	0	0.00
PacifiCare Dental	8	286,900	0.28	1	0.03	1	0.03
Preferred Dental Plan	0	15,534	0.00	0	0.00	0	0.00
Primecare Dental Plan, Inc. - INACTIVE 2001	0	0	0.00	0	0.00	0	0.00
SmileCare	4	125,276	0.32	0	0.00	2	0.16

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
1	0.21	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
13	1.04	0	0.00	2	0.16	2	0.16	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	3.79	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
4	0.48	0	0.00	0	0.00	2	0.24	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	0.94	0	0.00	1	0.94	0	0.00	0	0.00
15	2.19	0	0.00	1	0.15	1	0.15	1	0.15
108	0.36	6	0.02	8	0.03	23	0.08	3	0.01
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
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
1	0.07	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
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
1	0.21	1	0.21	0	0.00	0	0.00	1	0.21
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
11	0.33	0	0.00	10	0.30	1	0.03	0	0.00
65	0.04	1	0.00	10	0.01	3	0.00	1	0.00
0	0.00	0	0.00	0	0.00	1	0.06	0	0.00
3	0.07	0	0.00	1	0.02	2	0.05	0	0.00
1	1.14	0	0.00	0	0.00	1	1.14	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
3	0.29	0	0.00	2	0.19	0	0.00	1	0.10
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
4	0.14	1	0.03	1	0.03	0	0.00	1	0.03
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	0.08	0	0.00	1	0.08	0	0.00	0	0.00

Plan Type and Name	Complaints Resolved	Enrollees	Complaints Per 10,000	Access Issues Count	Access Issues Per 10,000	Benefits/Coverage Issues Count	Benefits/Coverage Issues Per 10,000
South Hills Dental Plan	1	80,741	0.12	0	0.00	0	0.00
United Dental Plan	0	27,055	0.00	0	0.00	0	0.00
Western Dental Plan	3	347,874	0.09	0	0.00	0	0.00
Total	150	17,707,414	0.08	2	0.00	32	0.02
Dental/Vision							
Golden West Vision-Dental Plan	7	221,426	0.32	0	0.00	1	0.05
PMI (Private Medical-Care, Inc.)	40	955,473	0.42	0	0.00	10	0.10
Safeguard Health Plans, Inc.	26	595,315	0.44	1	0.02	6	0.10
SmileSaver/Signature Vision	4	231,021	0.17	1	0.04	1	0.04
Total	77	2,003,235	0.38	2	0.01	18	0.09
Vision							
Eye Care Plan of America - California, Inc. - INACTIVE 2003	0	0	0.00	0	0.00	0	0.00
EYEXAM of California, Inc.	0	366,693	0.00	0	0.00	0	0.00
For Eyes Vision Plan	0	21,792	0.00	0	0.00	0	0.00
Health Net Vision, Inc. - INACTIVE 2004	1	82,547	0.12	0	0.00	0	0.00
Medical Eye Services, Inc.	0	86,277	0.00	0	0.00	0	0.00
NVAL Visioncare Systems of California, Inc.	0	164,017	0.00	0	0.00	0	0.00
Pearle Visioncare, Inc.	0	159,398	0.00	0	0.00	0	0.00
ProCare Eye Exam, Inc. - INACTIVE 2002	0	0	0.00	0	0.00	0	0.00
Spectera Vision Services of California, Inc.	0	112,773	0.00	0	0.00	0	0.00
Vision First Eye Care, Inc.	0	1,298	0.00	0	0.00	0	0.00
Vision Plan of America	0	33,646	0.00	0	0.00	0	0.00
Vision Service Plan	4	8,064,082	0.00	0	0.00	2	0.00
Total	5	9,092,523	0.01	0	0.00	2	0.00
Psychological							
Avante Behavioral Health Plan	0	2,854	0.00	0	0.00	0	0.00
Cigna Behavioral Health of California, Inc.	6	352,184	0.17	0	0.00	0	0.00
CONCERN: Employee Assistance Program	0	69,702	0.00	0	0.00	0	0.00
HAI-CA (Human Affairs International of Ca.)	0	988,276	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	184,274	0.00	0	0.00	0	0.00
Integrated Insights	0	225,102	0.00	0	0.00	0	0.00
Managed Health Network	11	2,544,139	0.04	0	0.00	2	0.01
Merit Behavioral Care of California, Inc.	1	569,287	0.02	0	0.00	0	0.00
PacifiCare Behavioral Health of California, Inc.	41	1,890,356	0.22	1	0.01	8	0.04
Robert T. Dorris & Associates	0	138	0.00	0	0.00	0	0.00
U.S. Behavioral Health Plan California	9	2,342,612	0.04	0	0.00	4	0.02
ValueOptions of California, Inc.	1	364,165	0.03	0	0.00	0	0.00
Vista Behavioral Health Plans	0	49,481	0.00	0	0.00	0	0.00
VMC Connect	0	57,704	0.00	0	0.00	0	0.00
Total	69	9,640,274	0.07	1	0.00	14	0.01

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
1	0.12	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	0.03	0	0.00	1	0.03	1	0.03	0	0.00
93	0.05	3	0.00	26	0.01	9	0.01	4	0.00
4	0.18	0	0.00	2	0.09	0	0.00	0	0.00
25	0.26	1	0.01	11	0.12	1	0.01	1	0.01
12	0.20	0	0.00	9	0.15	1	0.02	2	0.03
2	0.09	1	0.04	3	0.13	0	0.00	0	0.00
43	0.21	2	0.01	25	0.12	2	0.01	3	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	1	0.12	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	1	0.00	1	0.00	0	0.00
0	0.00	0	0.00	2	0.00	1	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
5	0.14	0	0.00	1	0.03	1	0.03	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	0.03	0	0.00	1	0.00	0	0.00	0	0.00
1	0.02	0	0.00	0	0.00	1	0.02	0	0.00
29	0.15	0	0.00	0	0.00	5	0.03	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
5	0.02	0	0.00	0	0.00	0	0.00	0	0.00
1	0.03	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
49	0.05	0	0.00	2	0.00	7	0.01	0	0.00

ENFORCEMENT CASE LOAD TRACKING

Case Activity	1ST QRT	2ND QRT	3RD QRT	4TH QRT	YTD TOTAL
Number of cases opened					
Number of Financial	43	30	41	40	154
Number of Health Plan Standards	58	39	23	82	202
Number of Anti-Fraud	65	3	26	4	98
Number of Other	2	2	0	0	4
Total	**168**	**74**	**90**	**126**	**458**
Number of cases closed					
Number of Financial cases closed	28	47	20	16	111
Number of Health Plan Standards closed	35	55	45	29	164
Number of Anti-Fraud	62	7	2	25	96
Number of Other	3	0	0	2	5
Total	**128**	**109**	**67**	**72**	**376**
Total number of hours to close cases					
Total number of hours to close all Financial cases	1928.40	1840.46	310.40	214.55	4,293.81
Total number of hours to close all HPS cases	1985.85	553.05	584.10	1034.75	4,157.75
Number of Anti-Fraud	699.75	36.70	2.00	6.40	744.85
Number of Other*	6054.70	0.00	0.00	74.55	6,129.25
Total	**10668.70**	**2430.21**	**896.50**	**1330.25**	**15,325.66**
Average number of hours to close cases					
Average number of hours to close one case	83.35	22.30	13.38	18.48	40.76
Average number of hours to close one Financial case	68.87	39.16	15.52	13.41	38.68
Average number of hours to close one HPS case	56.74	10.10	12.98	35.68	25.35
Number of Anti-Fraud	11.29	5.24	1.00	0.26	7.76
Number of Other	2018.23	0.00	0.00	37.28	1225.85
Enforcement Actions					
Number of Accusations Filed	1	0	0	0	1
Number of Assessments Collected	0	1	0	0	1
Number of Cease and Desist Orders	0	0	2	1	3
Number of Conservatorships	0	0	0	0	0
Number of Decisions of the Director	0	0	0	0	0
Number of Denial of Licenses	0	0	0	0	0
Number of Letters of Agreement	21	49	43	20	133
Number of Licenses Surrendered or Revoked	0	0	0	0	0
Number of Miscellaneous Orders	0	0	0	0	0
Number of Statements of Issues	0	0	0	0	0
Number of Stipulated Settlement Agreements	0	0	1	0	1
Number of Other	0	0	0	0	0
Total					**139**
Aging*					
Number of cases open less than 6 months	165	148	151	184	
Number of cases open more than 6 mths, but less than 1 yr	74	48	56	76	
Number of cases open more than 1 yr, but less than 2 yrs	15	22	33	32	
Number of cases open more than 2 years	17	18	19	21	
Total number of open cases	**271**	**236**	**259**	**313**	

*Other cases are matters open prior to the financial/health plan standards classification

Plans Licensed Through The Department of Managed Health Care

FULL SERVICE PLANS

Plan ID	Plan Name
933-0176	Aetna U.S. Healthcare of California, Inc.
933-0328	Alameda Alliance for Health
933-0303	Blue Cross of California
933-0415	Blue Cross of California Partnership Plan
933-0043	California Physicians' Service
933-0326	Care 1st Health Plan
933-0408	CareMore Insurance Services, Inc.
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
933-0248	County of Los Angeles-Dept. of Health Services
933-0344	County of Ventura
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
933-0151	Inter Valley Health Plan
933-0055	Kaiser Foundation Health Plan, Inc.
933-0335	Kern Health Systems
933-0355	Local Initiative Health Authority for L.A. Co.
933-0390	Medcore HP
933-0322	Molina Healthcare of California
933-0385	On Lok Senior Health Services
933-0394	Orange County Health Authority
933-0126	PacifiCare of California
933-0367	PRIMECARE Medical Network, Inc.
933-0349	San Francisco Health Authority
933-0338	San Joaquin County Health Commission
933-0358	San Mateo Health Commission
933-0400	Santa Barbara Regional Health Authority
933-0236	Santa Clara County
933-0351	Santa Clara County Health Authority
933-0401	Santa Cruz-Monterey Managed Medical Care Comm.
933-0212	Scan Health Plan
933-0377	Scripps Clinic Health Plan Services, Inc.
933-0310	Sharp Health Plan
933-0393	Sistemas Medicos Nacionales, S.A.de CV
933-0209	Universal Care
933-0008	WATTSHealth Foundation, Inc.
933-0348	Western Health Advantage

SPECIALIZED PLANS - DENTAL

Plan ID	Plan Name
933-0318	Access Dental Plan
933-0313	Aetna Dental of California, Inc.
933-0195	American Healthguard Corporation
933-308	California Benefits Dental Plan
933-0286	California Dental Network, Inc.
933-0258	Cigna Dental Health of California, Inc.
933-0170	Community Dental Services
933-0215	ConsumerHealth, Inc.
933-0244	Dedicated Dental Systems, Inc.
933-0092	Delta Dental of California
933-0255	Dental Benefit Providers of California, Inc.
933-0059	Dental Health Services
933-0136	GE Dental and Vision
933-0080	Golden West Health Plan, Inc.
933-0197	Jaimini Health Inc.
933-0052	Liberty Dental Plan of California, Inc.
933-0302	Managed Dental Care
933-0211	Pacific Union Dental, Inc.
933-0100	PacifiCare Dental
933-0079	Private Medical-Care, Inc.
933-0034	SafeGuard Health Plans, Inc.
933-0291	UDC Dental California, Inc.
933-0046	United Concordia Dental Plans of CA, Inc.
933-0224	Western Dental Services, Inc.

SPECIALIZED PLANS - VISION

Plan ID	Plan Name	Plan ID	Plan Name
933-0264	EYEXAM of California, Inc.	933-0189	Spectera Vision Services of California, Inc.
933-0320	For Eyes Vision Plan, Inc.	933-0329	Vision First Eye Care, Inc.
933-0359	Medical Eye Services, Inc.	933-0268	Vision Plan of America
933-0342	NVAL Visioncare Systems of California, Inc.	933-0049	Vision Service Plan
933-0263	Pearle Visioncare, Inc.	933-0287	VisionCare of America

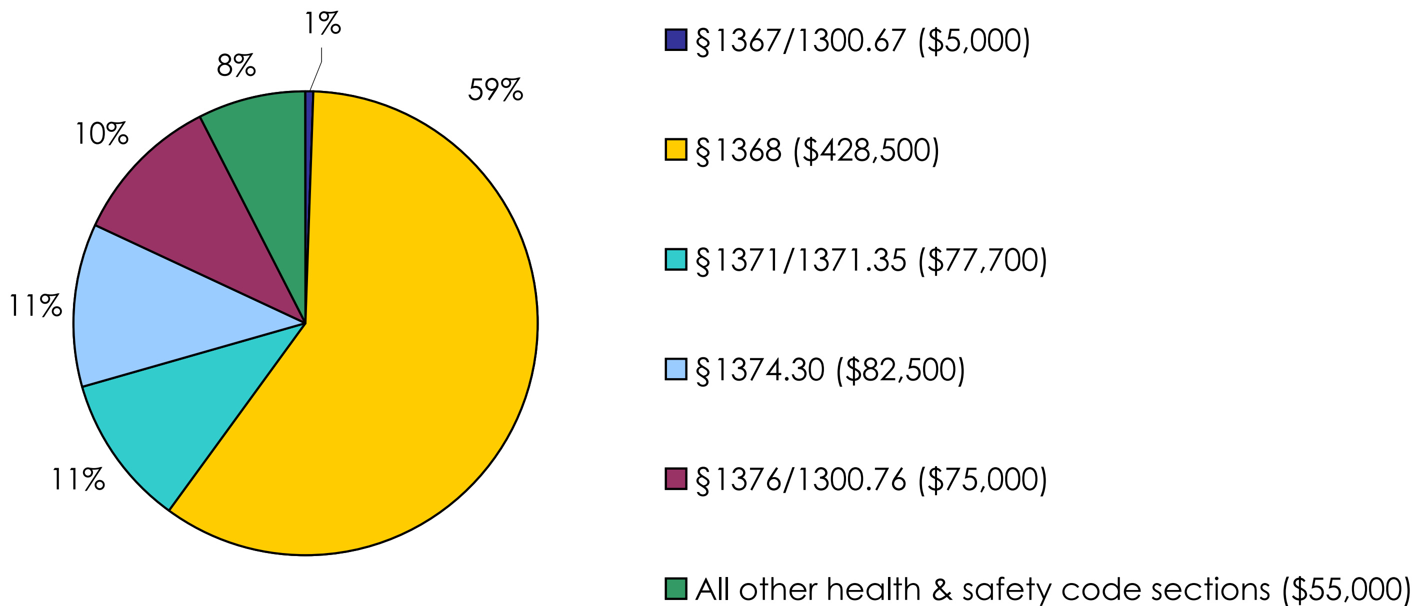
SPECIALIZED PLANS - MENTAL HEALTH

Plan ID	Plan Name	Plan ID	Plan Name
933-0397	Avante Behavioral Health Plan	933-0288	Merit Behavioral Care of California, Inc.
933-0298	Cigna Behavioral Health of California, Inc.	933-0301	PacifiCare Behavioral Health of California Inc.
933-0402	CONCERN: Employee Assistance Program	933-0409	Robert T. Dorris & Associates
933-0319	Health and Human Resource Center	933-0259	U.S. Behavioral Health Plan, California
933-0231	Holman Professional Counseling Center	933-0293	ValueOptions of California, Inc.
933-0292	Human Affairs International of California	933-0102	Vista Behavioral Health Plans
933-0196	Managed Health Network	933-0411	VMC Behavioral Healthcare Services, Inc.

SPECIALIZED PLANS - CHIROPRACTIC/ACUPUNCTURE

Plan ID	Plan Name	Plan ID	Plan Name
933-0407	ACN Group of California, Inc.	933-0399	Basic Chiropractic Health Plan
933-0315	American Specialty Health Plans, Inc.	933-0361	Landmark Healthplan of California, Inc.

FINES ASSOCIATED WITH VIOLATION TRENDS DURING 2004



2-YEAR COMPARISON: AMOUNT OF FINES PER HEALTH & SAFETY CODE

Health & Safety Code Section	2004	2003
§1367/1300.67: (Continuity of care)	$ 5,000	$ 8,000
§1368: (Grievance)	428,500	255,000
§1371/1371.35:(Untimely claims payment)	77,700	209,500
§1374.30 (IMR notification Form to EE)	82,500	175,000
§1376/1300.76:(TNE Deficiencies)	75,000	102,500
All other Health & Safety Code sections	55,000	99,000
Total Amount Collected	**$ 723,700**	**$ 849,000**

Assessment Process

For the 2003/04 fiscal year, the health plans were assessed a total of $32.9 million. This was comprised of $31.6 million for the Department's expenses and $1.3 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. Also, SB 580 became effective, which requires that non-specialized health care plans pay 65 percent and specialized plans pay 35 percent of the Department's costs and expenses.

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 $0.9 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. Also, SB 1103 authorized the use of up to $364,000 from the Managed Care Fund for the 2004/05 and 2005/06 fiscal years to support costs associated with the California Health Care Quality Improvement and Cost Containment Commission. No assessment of HMO's was made to cover these costs.

Revenue & Expenditures

In 2003-04, annual assessments of $32.8 million and other revenues of $1.9 million were collected. Total expenditures were $35.0 million.

In 2004-05, annual assessments were $34.4 million, other revenues are expected to be $1.5 million, and total expenditures forecast to be $36.3 million. Please see the charts below for additional detail.

Authorized Positions Chart

	FY 2003/04	FY 2004/05
Budgeted	274.0	272.0

Revenue/Expenditure Chart

	FY 2003/04 Actual	FY 2004/05 Projected
Beginning Fund Balance	$ 4,839,000	$ 2,776,000
Assessments	32,824,000	34,437,000
Fines & Penalties	779,000	584,000
Other Revenues	1,083,000	952,000
Transfers	-1,748,000	-1,287,000
Total, Resources	37,777,000	37,462,000
Total, Expenditures	35,001,000	36,251,000
Ending Fund Balance	2,776,000	1,211,000
Budget Allocations:		
• DMHC	30,820,000	32,017,000
• OPA	4,181,000	4,234,000
TOTAL	$ 35,001,000	$ 36,251,000

Assessments By Type

Plan Type	Enrollees	Regular	Special/AB 1996 *	Total	Pct of Total
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%
Plan 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%
Plan Totals	61,354,079	$21,528,224	$10,692,982	$ 32,221,206	100.0%
FY 2001-02	*@ 3/31/01*				
Full Service	22,626,166	$11,213,578	$ 4,746,445	$ 15,960,023	51.6%
Specialized	38,503,654	10,476,388	4,490,559	14,966,947	48.4%
Plan Totals	61,129,820	$21,689,966	$ 9,237,004	$ 30,926,970	100.0%
FY 2000-01	*@ 3/31/00*				
Full Service	21,698,587	$10,812,274	$ 4,046,758	$ 14,859,032	53.5%
Specialized	34,360,920	9,364,223	3,553,540	12,917,763	46.5%
Plan Totals	56,059,507	$20,176,497	$ 7,600,297	$ 27,776,795	100.0%

*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).

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

Comparison of HMO Health Plan Revenue & Administrative Expenses to Annual Assessments

Top Plans in Each Type Identified - 4 Quarters Ending 9/30/04

Plan Name	FY 2004-05 Assessments	% Assess w/in Plan Type	Total Revenue *4 Qtrs 9/30/04*	Assess: Revenue	Total Admin Exp *4 Qtrs 6/30/02*	Assess: Adm Exp
Blue Cross of California	$4,602,614	20.341%	$10,441,691,000	0.044%	$1,252,428,000	0.367%
California Physicians' Service	2,469,625	10.914%	6,667,423,000	0.037%	778,388,000	0.317%
Health Net	2,348,990	10.381%	6,132,251,252	0.038%	609,432,944	0.385%
Kaiser Foundation Health Plan, Inc.	6,414,261	28.347%	27,551,948,000	0.023%	966,888,000	0.663%
Pacificare of California	1,807,262	7.987%	6,185,090,902	0.029%	595,249,077	0.304%
All Others	4,984,838	22.030%	9,160,854,817	0.054%	796,091,936	0.626%
FULL SERVICE PLAN TOTALS	$22,627,590	100.000%	$66,139,258,971	0.034%	$4,998,477,957	0.453%
Delta Dental Plan	$3,299,719	67.675%	$3,332,352,000	0.099%	$299,852,000	1.100%
Private Medical-Care, Inc.	271,470	5.568%	142,579,923	0.190%	44,552,404	0.609%
Safeguard Health Plans, Inc.	237,467	4.870%	61,214,000		12,949,000	1.834%
All Others	1,067,181	21.887%	814,466,309	0.131%	141,758,497	0.753%
DENTAL PLAN TOTALS	$4,875,837	100.000%	$4,350,612,232	0.112%	$499,111,901	0.977%
Vision Service Plan	$2,333,319	93.896%	$668,239,890	0.349%	$70,637,792	3.303%
All Others	151,694	6.104%	19,397,302	0.782%	428,474,109	0.035%
VISION PLAN TOTALS	$2,485,013	100.000%	$687,637,192	0.361%	$499,111,901	0.498%
Managed Health Network, Inc.	$700,362	25.827%	$116,687,077	0.600%	$23,988,760	2.920%
Pacificare Behavioral Health of California	495,733	18.281%	152,649,774	0.325%	43,850,918	1.130%
US Behavioral Health Plan, California	672,849	24.813%	110,386,496	0.610%	7,317,983	9.194%
All Others	842,761	31.079%	88,433,647	0.953%	23,904,315	3.526%
PSYCHOLOGICAL PLAN TOTALS	$2,711,705	100.000%	$468,156,994	0.579%	$99,061,976	2.737%
American Chiropractic Network Health Plan	$1,180,848	93.814%	$65,554,460	1.801%	$26,401,434	4.473%
All Others	77,859	6.186%	3,975,720	1.958%	3,695,778	2.107%
OTHER PLAN TOTALS	$1,258,707	100.000%	$69,530,180	1.810%	$30,097,212	4.182%
FULL SERVICE PLAN TOTALS	$22,627,590	66.632%	$66,139,258,971	0.034%	$4,998,477,957	0.453%
DENTAL PLAN TOTALS	4,875,837	14.358%	4,350,612,232	0.112%	499,111,901	0.977%
VISION PLAN TOTALS	2,485,013	7.318%	687,637,192	0.361%	499,111,901	0.498%
PSYCHOLOGICAL PLAN TOTALS	2,711,705	7.985%	468,156,994	0.579%	99,061,976	2.737%
All Others	1,258,707	3.707%	69,530,180	1.810%	30,097,212	4.182%
PLAN TOTALS	$33,958,852	100.000%	$71,715,195,569	0.047%	$6,125,860,947	0.554%

* Top plans identified by enrollment. Some plans omitted because they lacked four quarters of financial data.
* Source: OTIS, HMO Health Plan financial reports, Revenue & Administrative Expense date for 12/1/03 - 9/30/04. Assessment Period: FY 2004-05 based on 3/31/04

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