2003

ANNUAL REPORT

DEPARTMENT OF MANAGED HEALTH CARE

Sacramento – Downtown

Sacramento – Folsom Blvd.

Los Angeles

Your RIGHTS as a 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 5 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 Department of Managed Health Care's California 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 Our HMO Plans, Physicians and Other Providers:

As Director of the Department of Managed Health Care, it is my pleasure to present our 2003 Annual Report. During 2003, we assisted more than 135,000 Californians in resolving their HMO problems, educated consumers on health care rights and responsibilities, and worked closely with the HMO plans we regulate to ensure a better, more solvent and stable managed health care system.

We are dedicated to working with all those involved in managed health care to realize a healthier California. From straightening out a simple paperwork mix-up to ensuring that independent doctors have the final word on HMO care, we are ready to resolve any Californian's HMO problem. Today's HMO patients can be assured that they have an advocate on their side, ready to assist them in obtaining the health care services to which they are entitled. When you are sick, and in need of medical care, we ensure that your health care services are available and responsive.

Today, our Help Center works with our team of enforcers, our Patient Advocate and our entire leadership team to root out systemic problems before harm is done to a patient. We will continue to coordinate our efforts with the HMO plans to ensure such issues are resolved at the earliest possible opportunity.

In 2004 we will focus on ensuring doctor's groups are financially sound and that HMOs pay providers on time, streamlining existing processes to encourage more efficient transactions between our Department and the HMO plans, ensuring that our call center continues to provide the best in customer service to our consumers, and increasing our communication and interaction with all stakeholders.

We are rolling up our sleeves to implement the best solutions to today's health care issues, so Californians can enjoy many healthier tomorrows.

Cindy Ehnes

Lucinda "Cindy" Ehnes
DIRECTOR
Department of Managed Health Care

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This report and more information about the HMO Help Center, the Department of Managed Health Care, the Business, Transportation and Housing Agency, our Patient Advocate, and your HMO rights and responsibilities are available at www.hmohelp.ca.gov or by calling 1-888-HMO-2219.

The Statistics section contains an aggregate summary of grievances against plans filed with the director by enrollees or subscribers as mandated by the Knox-Keene Act, Section 1397.5 and the annual audit of the independent medical review system mandated by the Knox-Keene Act, Section 1374.34(e).

About The Department

Mission

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

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

Our Vision

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

Who We Are & What We Do

The Department of Managed Health Care, a first-in-the-nation consumer rights program, helps Californians resolve problems with their Health Maintenance Organization (HMO aka "Health Plans") to ease 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 precious health care 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 (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.

Our Philosophy

The Department of Managed Health Care serves the HMO consumer and all California consumers by promoting an accessible and affordable healthcare system. Each response to a request for assistance, each business practice performed, each decision made, reflects our commitment to providing our consumers with 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 our consumers 24 hours a day, 7 days a week through our HMO Help Center. The HMO Help Center provides services for both English and Spanish speaking consumers, in addition to telephonic translation services available in over 100 other languages and a TDD device for the hearing impaired
- We encourage consumer education regarding their health care rights and responsibilities and respond to their health care concerns
- We make every effort to expeditiously resolve issues with health plans, physicians and other providers at the lowest possible level. Complaints are typically reviewed and resolved within the 30-day mandate
- We promote open lines of communication within the Department and with health plans, hospitals, physicians, nurses, and other providers to assure early intervention for the resolution of patient/enrollee issues
- We develop partnerships with stakeholders in order to share health care issues, information and responsibilities with everyone in managed health care
- We continually evaluate our business processes looking for new ways to deliver services to all our "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 our consumers

Consumer Assistance

> "I applaud your office *(Governor's Office – ed.)* for developing a department that responds directly to the public in a prompt, professional, caring manner. This is so important, especially when one has often felt helpless and discouraged. In spite of economic strains and budget cutbacks, I hope that *(you)* will clearly see the need to retain this department which works directly with the consumer. As in my case, I am sure this type of response to the public creates positive feelings about government officials and workers caring about the public they serve."
>
> Carol C. Carrasco
> Carlsbad, California

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 2003, the HMO Help Center assisted 135,126 consumers in resolving their HMO problems via telephone assistance, quick resolutions, urgent case resolutions, complaint resolution or Independent Medical Review (IMR). With services ***available 24 hours a day, 7 days a week***, the HMO Help Center is readily available to assist the consumers we serve. Patients' rights advocates, health care professionals, and consumer service representatives are available to help consumers resolve a simple paperwork mix-up or a complex medical issue with their 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 2003 as a result of HMO Help Center intervention was $2,164,403.00***. 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, and then later authorized by the health plan.

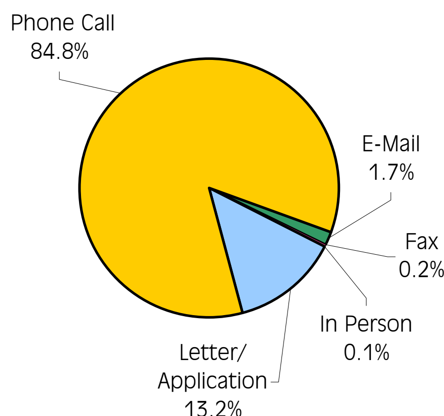
HMO Help Center Mission

The mission of the California HMO Help Center is to provide information to consumers regarding health care issues and to 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 based upon complaint data we collect and analyze, to improve the managed health care delivery system
- We make ourselves available to consumers by telephone, correspondence, e-mails, faxes, and walk-in visits from consumers

Consumer Method of Contact



In our continuing effort to provide efficient and timely consumer service, we noted a lax attitude from some health plans on responding timely to our requests for medical records required to resolve consumer complaints. HMOs are required to respond to HMO Help Center requests for medical information within five calendar days. Their timely cooperation is critical to our ability to respond to consumer complaints within thirty days. In 2003, we achieved significant improvement in the timeliness of these responses through enforcement actions.

Information Requests

In 2003, the HMO Help Center received over 13,000 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 website at www.hmohelp.ca.gov.

Requests for Information by Type	Volume
Complaint Packet	7,571
Phone Number	3,369
Supplemental Materials	573
IMR Packet	443
COBRA Packet	252
Patient Guides	118
Knox-Keene Act	110
Department Brochure	34
Other	1,414
Total Requests for 2003	13,884

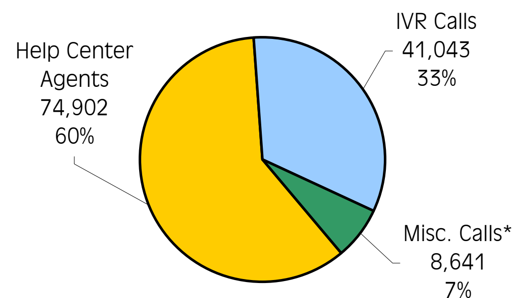
Telephone Assistance

The HMO Help Center's first priority is customer service. In addition to responding to formal complaints and requests for Independent Medical Review (IMR), the HMO Help Center responds to thousands of calls from consumers, requesting general information or assistance. The HMO Help Center receives from 8,000 to 15,000 calls each month from consumers, about seven percent of which result in a formal complaint or Independent Medical Review. In 2003, the HMO Help Center was able to provide telephone support services in more than twenty-one different languages.

Over 3,300 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 assist consumers in understanding their health care rights and responsibilities.

Calls Answered by the HMO Help Center in 2003
Total Calls Answered 124,586



**The total number of calls that were answered on the Provider Line, the TDD Line, or abandoned by the caller.*

Consumers Require 24/7 Availability

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

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. However, consumers initially receive immediate assistance from the Interactive Voice Response (IVR) system and may opt to speak with the staff of the HMO Help Center. The HMO Help Center's automated 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 website address for additional information

Almost 33% of all calls to the HMO Help Center are resolved by this digital interactive voice response system. During 2003, 41,043 calls were resolved through this system.

Consumer Complaint Resolution Options

The HMO Help Center resolves consumer issues at the lowest possible level in the shortest amount of time possible. There are three resolution options for consumers:

1. Quick Resolution option is an ***informal*** process that resolves consumers concerns within hours.
2. Urgent Case Resolution option is an ***informal*** process and resolves urgent issues that cannot wait 30 days to complete the formal complaint process.
3. Complaint Resolution is a ***formal*** process and complaints are generally resolved within 30 days.

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 line with the consumer in a three-way call to expedite the 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 2003, 304 calls were resolved through the Quick Resolution process.

Quick Resolution Issues	Number of Issues	% of Issues
Claim Payment	92	30%
Disenrollment	47	15%
Medical Appointment	37	12%
Health Plan Provider List	25	8%
Rx Issues	23	8%
Change Provider	16	5%
Coverage/Benefit	14	5%
Medical Record Access	9	3%
HIPAA	1	1%
Other	40	13%
Total	304	100%

Urgent Case Resolutions

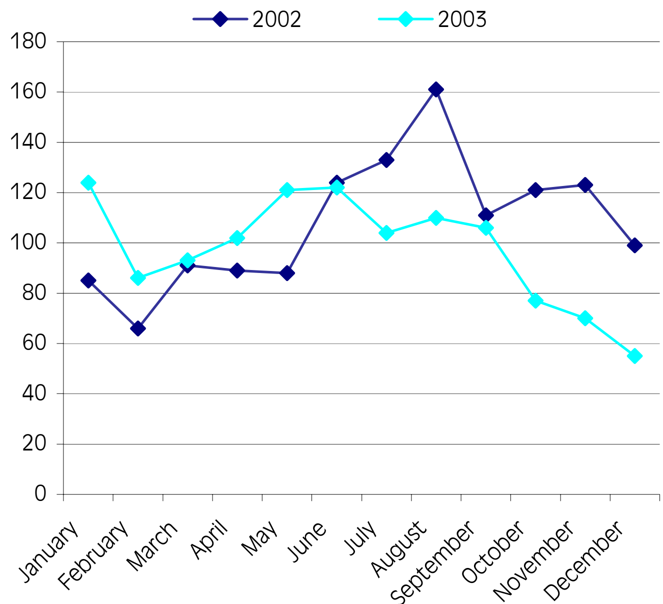
Consumers often call the HMO Help Center with issues that cannot wait 30 days to complete the formal complaint process. These complaints may involve issues of delays or denials in re-filling prescription medications, delays in obtaining appointments or surgery for pressing health care issues, premature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

In 2003 there were 1,170 urgent complaints that required an immediate resolution. Urgent complaints are generally referred to our clinical nurses who work with the consumer and the health plan to resolve the issue.

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

2-Year Comparison of Urgent Cases

The Department received 1,170 urgent requests during 2003, compared to 1,291 received in 2002.



If the HMO Help Center's nurse determines that the consumer does not require urgent assistance, the consumer's dispute is then referred to the Complaint Resolution or IMR process for resolution.

Urgent Complaints Received

Urgent Complaint Type	Volume
Access/Referral Issue	487
Benefit Issue	174
Rx/Medication Supply	165
Treatment Denied	86
Diagnostic Test Access	38
Early Discharge - Facility	31
Durable Medical Equipment	23
Mental Health	18
Experimental Treatment	16
Acute Pain	13
Poor Health Plan Communication	12
Chronic Pain Management	8
Medical Group Closure	1
Other	98
Total Volume for 2003	**1,170**

Complaint Resolution

Consumers file 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 Independent Medical Review, which is defined in the next section. The HMO Help Center has developed the infrastructure necessary to ensure that complaints are resolved and that we are responsive to all California HMO patients.

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 by the HMO Help Center, the HMO, through its own grievance and appeals process, must have had 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, or by completing a Consumer Complaint Form, which is 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 does facilitate 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 generally resolved by the HMO Help Center within 30 days. ***There is no charge to the consumer associated with filing a complaint with the HMO Help Center for resolution.***

If a consumer is involved in a time-sensitive dispute that requires intervention prior to the 30-day mandate, legal staff will perform an early review of the case. 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 Department determinations

If research determines that the issue is not critically time sensitive, it will be resolved through the standard 30 day complaint process.

The HMO Help Center issues 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).

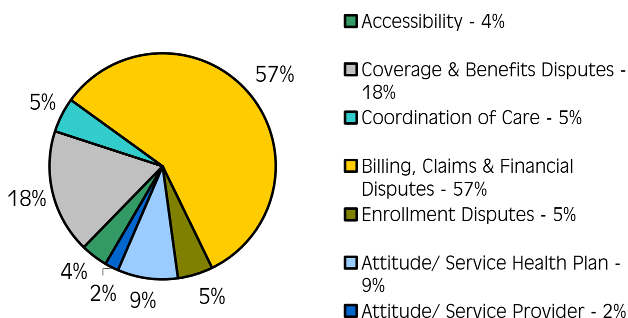
A significant number of requests for assistance are outside the Department's jurisdiction. If we can't assist the consumer, we will connect them with someone who can. As a result, our staff are required to have full knowledge and understanding of programs sponsored by other state and federal agencies and advocacy groups in order to refer the requests to the appropriate organizations. HMO Help Center staff consistently refer consumers to organizations such as: Health Rights Hot Line; 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, is entered into the HMO Help Center's automated case

management system. We ensure accurate data collection and maintenance of the automated case management system. This is done so that significant issues and trends can be analyzed and tracked and emerging issues discovered.

The HMO Help Center researches and analyzes the following types of complaints:

Complaint Categories



Complaint Response

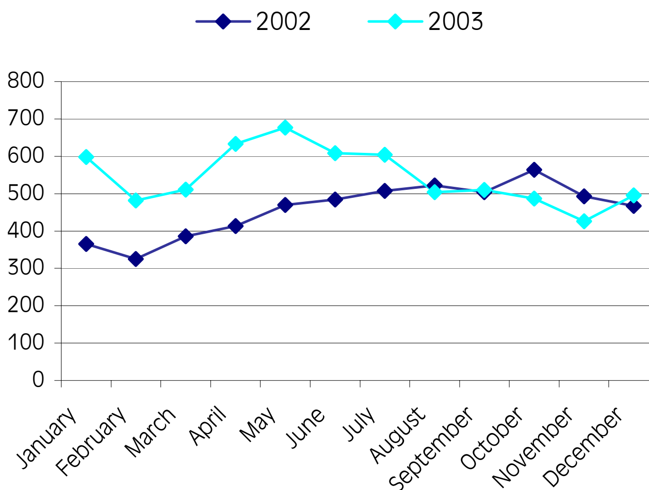
We focus on effectively resolving complaints. If systemic problems are discovered as a result of multiple complaints, the issues are referred to the appropriate office for further action. Please refer to Appendix A for Complaint Results By Category and HMO.

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, 2003 through December 31, 2003, consumers filed 6,535 formal complaints in comparison to the 5,500 filed in 2002. Below is a summary of the volume of complaints received, by month, excluding IMRs. Of the 6,535 complaints filed, 6,517 cases were resolved during 2003. Formal complaints with more complicated issues require detailed information such as medical records from patients and documentation from the HMOs. These are resolved within days or weeks.

2-Year Comparison
Volume of Complaints Received By Month
(This does not include IMRs)



"Thank you for the assistance that you provided in my recent complaint. The complaint has been resolved to my complete satisfaction. I would like to commend you and your Department for your advocacy of health care consumers in California. I am proud to live in a state that provides this level of service for its residents."

Mark Behm
San Francisco, California

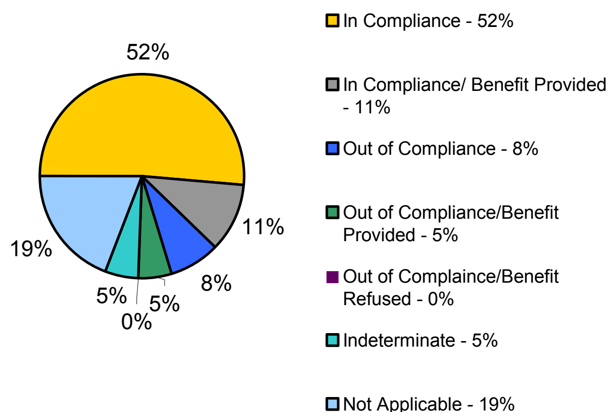
COMPLAINT TYPE DEFINITIONS
Accessibility - These complaints include: long wait times for appointments; lack of availability of primary care or specialty physicians; delay or failure to respond to patient requests for authorization or referrals; etc.
Attitude & Service of Health Plan - These include: complaints about health plan staff behavior (including attitude, communication, rudeness); complaints about slow responses to inquiries; etc.
Attitude & Service of Provider - These include: complaints about 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: disputes regarding complaints about 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: disputes regarding a 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 Compliance Determinations

California's patients' rights laws are embodied in the Knox-Keene Act of 1975. The following determinations were made 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. The facts and circumstances of the case still warrant a finding that the actions taken by the HMO comply with California's patients' rights laws.
- Out of Compliance – Based upon review of complaint documents (including the HMO's response to the complaint), staff has identified a specific violation of a section 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. The facts and circumstances of the case still warrant a finding that the actions taken by the HMO do not comply with California's patients' rights laws.
- Indeterminate – This determination is used in two scenarios: 1) there is insufficient evidence to indicate non-compliance on the part of the HMO, or 2) a compliance determination may not be applicable.
- Not Applicable – The subject matter does not reasonably relate to a matter of compliance 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 2003 since none of the Department's demands were refused.

Compliance with Patients' Rights Laws



Independent Medical Review (IMR)

> "I would like to take this opportunity to thank you for your support during the appeals process for my son. You have consistently been helpful. My phone calls to you are returned promptly and you always keep me informed about the status of his case. I hate to think what would happen to my son if the State did not have this program."
>
> Gayle Sharp
> Glendora, California

An Independent Medical Review allows doctors and other health care professionals, *outside* a consumer's HMO, to make an independent decision about the consumer's health care. For example, if a HMO denies a consumer health care services on the basis that the service is not medically necessary, the consumer can request an Independent Medical Review.

While every HMO must have their own system for handling their enrollee complaints, these ***internal*** systems are usually conducted by the HMO's own medical staff or one of their network providers.

The Department of Managed Health Care's Independent Medical Review process allows the consumer to bring problems regarding denial of treatment and medical care to health care professionals ***outside*** the consumer's HMO.

In 2003, independent physicians reviewed the cases of 800 individuals with especially difficult and subjective cases involving medical necessity or the proven effectiveness of certain treatments. Of the 800 cases where an HMO denied a service on the grounds that it was considered experimental or not medically necessary, 38% of the HMO decisions were overturned and consumers received services that otherwise would have been denied. Please refer to Appendix B for IMR Results by Health Plan.

Further, of the 800 Independent Medical Review cases heard before a panel of independent physicians, 18 percent were based on instances where an HMO denied a service on the grounds that it was experimental or investigational. Of these, 32 percent of the original denials were overturned. The remaining Independent Medical Review cases were based on instances where the HMO denied a service on the grounds that it wasn't medically necessary. Of these, 40 percent of the original denials were overturned.

The Independent Medical Review Program has enabled consumers to receive treatment or medical care previously denied by their HMOs. We believe that the success of this program has encouraged HMOs to resolve potential cases earlier.

Three types of disputes with HMOs 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 HMO, or one of its contracting medical providers, based on a finding that the service is not medically necessary; and
3. Disputes concerning an HMO'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 a medical necessity IMR. Before an IMR application is eligible for review, the HMO must have an opportunity to assess and resolve the issue through its standard grievance process within 30 days, or within 72 hours for expedited requests. The HMO's grievance process is not required when services are denied under an experimental/ investigational exclusion.

IMR requests are received and processed by an HMO Help Center team comprised of patients' rights experts, and legal and clinical staff. Because IMR cases may be received by telephone, e-mail, or correspondence, knowledge of the IMR system is a responsibility shared by a majority of HMO Help Center staff.

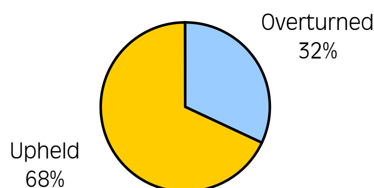
The HMO is assessed a fee for this service based on the type of case, the number of reviewers needed, and whether the determination must be expedited. ***There is no charge to the patient for the application, processing or resolution of an IMR.***

The IMR program is pivotal to the HMO Help Center's focus on resolving patient complaints with HMOs as expeditiously as possible through its clinical, legal and consumer assistance staff.

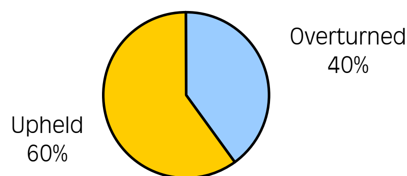
The Director must formally adopt the recommendation of the IMR contractor as the Department's decision. If the HMO's decision is overturned, the HMO is required to implement the findings within five days.

The following charts provide information on the total volume of IMRs 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.

147 Experimental/Investigational Cases
Upheld vs. Overturned



653 Medical Necessity Cases
Upheld vs. Overturned



IMR Resolutions: Upheld vs. Overturned

IMR Type	Upheld (Not Including Withdrawals)		Overturned (Not Including Withdrawals)		Withdrawn	Total
Experimental / Investigational IMR	98	68%	46	32%	3	**147**
Medical Necessity IMR	353	60%	234	40%	66	**653**
Total Resolutions	451	62%	280	38%	69	800

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 9 days of IMR application qualification. Expedited Medical Necessity IMRs are resolved within 7 days of IMR application qualification.

Cases Closed Through IMR in 2003

IMR Type	Standard Resolved in 30 Days	Expedited Resolved in 7-9 Days	Total
Experimental/ Investigational IMR	107	37	144
Medical Necessity IMR	517	70	587
Withdrawn IMR			69
TOTAL	624	108	800

Withdrawn IMRs

Cases denied by a health plan and found to be eligible for an Independent Medical Review generated an unexpectedly high incidence of health plans "reversing" their denials and asking to be withdrawn from the IMR process. The HMO Help Center held discussions with the health plans' medical and legal representatives concerning the basis for the timing of these decisions as there appeared to be no rapidly developing medical information between the time of the plan's decision on the member's grievance and the acceptance of the case for review. The HMO Help Center now asks health plans for substantiation of the reasons why the decision was not made before the enrollee applied to the Department for a review, as well as the specific treatment that the plan has authorized to ensure that the dispute has been completely resolved to the enrollee's satisfaction.

Mental Health IMRs

IMRs that involve mental health issues have been more challenging than most due to the enrollee's need for continuing treatment. When the Independent Medical Review Organization (IMRO) reaches a decision, the health plan will implement the decision but discontinue the treatment shortly thereafter. This confuses the enrollee, and can leave the enrollee without needed care. Additional information on the patient's status must be reviewed again in order for the plan to continue treatment.

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 IMRO 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.

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 has ensured that enrollees received continuity of care for ongoing treatment.

In 2003, Lifeguard Health Plan ceased to operate and the HMO Help Center faced the resulting problems associated with transitioning enrollees into new health plans. Staff also assisted with transitioning enrollees to new providers whenever a medical group withdrew from a service area or filed for bankruptcy.

Continuity of Care Legislation

Legislation in 2003 expanded the conditions for which a health plan must provide completion of covered services upon request of an enrollee. Formerly, this applied to enrollees receiving services from a terminated provider for a specified condition. The new law expanded applicability to newly covered enrollees who, at the time coverage became effective, were receiving services from a non-participating provider for a specified condition. Completion of covered services is now required for more conditions, most notably for the duration of pregnancy, terminal illness, or surgery authorized and scheduled to occur within 180 days. The HMO Help Center anticipates that medical group terminations will generate a substantial number of calls relating to this topic. In addition, the applicability of this statute depends on the terminated provider's willingness to continue care and accept the health plan's rates for currently contracting non-capitated providers. Additional information on Continuity of Care can be found in the "Regulation" section on page 20.

Duty Counsel

The Duty Counsel program provides a central forum to answer consumers' legal questions within a 24-hour time frame whenever possible. In 2003 the Office of Legal

Services responded to 1,223 calls and continued to refine this program to provide consistent, quality information to the public. Consumers may contact the Duty Counsel, toll free, at 1-888-HMO-2219.

Major Risk Medical Insurance Program (MRMIP)

The MRMIP Project deadlines were successfully met in September 2003 with information provided on the Department's public web site at www.dmhc.ca.gov/coverage/mrmip. Under this new pilot program, that will be in effect at least through September 1, 2007, individuals who will leave MRMIP following 36 months of coverage are eligible after September 1, 2003 for individual coverage on a guaranteed basis.

Conservatorship

A conservatorship may be instituted whenever it appears to the Director that a health plan has engaged, or is about to engage, in any act or practice constituting a violation of any provision of the Knox-Keene Act, or any order issued pursuant to the Act.

By placing health plans that are financially unstable into conservatorship, the Department has been able to maintain control over the fate of the health plans' enrollees, transitioning them in an orderly fashion that ensures continuity of care. The Department's involvement in this process has ensured that enrollees received continuity of care for ongoing treatment, including needed cancer chemotherapy and delivery at the intended hospitals. Further, by placing a conservator, the Department is able to facilitate the payment of pre-conservator claims ensuring an equitable reimbursement process. The Department tries to ensure continuity of care by transferring enrollees to plans that have the same or similar network of providers.

A conservatorship or a receivership can be instituted in one of two ways:

1) Pursuant to Health and Safety Code section 1392, the Director may bring an action in superior court to enjoin the acts or practices of the plan or to enforce compliance with the Knox-Keene Act or any order issued by the Director. Upon a proper showing in court, a receiver, monitor, conservator or other designated fiduciary may be appointed for the plan and/or its assets.

2) Pursuant to Health and Safety Code section 1393(a), upon the filing of a verified application showing any violation of section 1386, the superior court shall issue an order vesting title to all the assets of the plan in the Director. Alternatively, pursuant to section 1393(b), whenever it appears to the Director that irreparable loss and injury to the property and business of the health plan or the health plan's enrollees has, or may occur unless the Director takes immediate action, the Director, without notice and before applying to the superior court, may take possession of the assets of the plan.

Pursuant to Health and Safety Code section 1393(c), the Conservator of an insolvent health care service plan shall take possession of the property, business, and assets pending further disposition of its business. Once the Superior Court confirms the appointment of the Conservator, his/her administration of the insolvent health care service plan is defined by the Court Order and the scope of work established by the Department of Managed Health Care.

"I wanted to thank you and the California HMO Help Center for the help you gave me with my claim. For ten months, I wrote letters and called my HMO to no avail. It was not until after I contacted your organization did I actually feel my claim was reviewed. Even if the final decision went the other way, I would have felt good that I would have exhausted all my efforts. I am relieved to know there are government organizations protecting the citizens of California. I thank you for your time and help."

Li Chang
Redondo Beach, California

Stakeholder Synergy

This Department is accountable to its external stakeholders. These external stakeholders include, but are not limited to, enrollees and patients, health plans, physicians and other providers, advocacy groups, legislators, as well as federal, state, and county agencies. Our philosophy holds that distinct business entities can work together in a mutually beneficial relationship. That is, we all have a common goal: healthier Californians.

Plan & Provider Relations

The implementation of AB 1455 – 2000 is the culmination of extraordinary participation of stakeholders in the rule-making process. The standardization of claim payment procedures and dispute resolution processes raised uniquely complex issues impacting every participant in the health care delivery system. Responding to the caution echoed by all stakeholders, the Department commenced its implementation efforts by inviting all participants, in the later part of 2002, to express their concerns, problems and experiences with current claims payment practices. Following the Department's in-depth study of the issue, it commenced a year long effort to complete the formal rulemaking process.

AB 1455, the Claims Settlement Practices and Dispute Resolution Mechanisms regulation was promulgated and became effective on August 25, 2003. AB 1455 strengthened the Department's enforcement authority to ensure that health plans timely and accurately reimburse provider claims for health care services rendered to enrollees. Plans and capitated providers who pay claims were required to be fully compliant with these regulations by January 1, 2004. After AB 1455 was enacted, the FSSB provided over a dozen outreach and education seminars throughout the State to alert stakeholders of the new regulations and the implementation requirements The Department's outreach and informational seminars began in August of 2003 and continued through March of 2004.

Implementation of the AB 1455 regulations (CCR sections 13007.71 and 1300.71.38)

- Develop Quarterly and Annual Reporting Forms to facilitate plan reporting of claims payment timeliness and dispute resolution activities. The first Quarterly Claims reports from health plans will be due June 30, 2004.
- Establish a monthly "Open House" for invited stakeholder groups to visit the DMHC to discuss industry issues that are affecting the delivery of health care in California. In addition to receiving information on current market trends, these fact-gathering meetings will provide the DMHC the opportunity to work as a facilitator to encourage innovative solutions to payment and contracting issues that have historically deteriorated relationships between plans and providers. The California Medical Association (CMA) and Cal/ACEP attended the first Open House on April 22. The California Healthcare Association (CHA) attended the May 27 Open House.
- Design new processes to handle provider complaints patterned after the Help Center's approach in addressing consumer complaints. Providers can submit their complaints to the HMO Help Center's Providers/Physicians Line at (888) HMO -2219. The review process will focus on processing standards and systemic deficiencies. This review process will be completed within 45 working days. The Department has already assembled a team comprised of Help Center personnel, financial examiners and enforcement counsel who will focus their full time efforts to ensure that providers receive timely reimbursement of their claims.

- Update the Provider Complaint Form on the Department's website to align with the AB1455 standards. September 1, 2004 is the target date to commence the collection of more detailed claims complaint data through a web-based portal. The new portal will allow provider complaint information to be trended on a monthly basis. The new electronic submission will allow the Department to look at individual claims submissions to ensure that health plans

and their capitated providers have implemented AB 1455's claims processing standards, contract disclosures and dispute resolution mandates.

- Establish a more interactive Plan/Provider webpage to include:
  a. A listing for providers disclosing where they can access health plan and capitated providers' "Dispute Resolution" information including a link to the payer's website if available.
  b. A "Recent News Items" section to overview significant provider issues brought to the Department through the Open House Invitations and the DMHC's efforts to facilitate innovative solutions to systemic plan and provider issues.
  c. Post summaries of results of AB 1455 reporting results and claims payment enforcement actions.

Failure to Timely Pay Claims

- During the calendar year of 2003 through the end of April of 2004, the Department has taken enforcement action against 23 health plans and assessed a total of $789,500 in penalties for failure to timely pay claims, failure to pay interest on late paid claims, and, if applicable, failure to pay the $10 fee to providers for not automatically including interest in the late-paid claims payment
- These numbers include several repeat offenses by health plans. During the calendar year of 2003 through the end of April of 2004, the Department has assessed a total of $402,500 in penalties against 4 health plans for repeated violations of timely claims payment statutes
- Currently, the Department has pending enforcement referrals against 9 health plans for failing to timely pay claims, interest, or fees. Of these nine, we have collected $5,200 in penalties

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 public 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 ACMHC met twice during the 2002/03 fiscal year and provided input toward the development of the Access to Care regulations (AB 1282, stats. 2002; and AB 1279, stats. 2002). Over the next year, the ACMHC anticipates providing input for the development of regulations affecting cultural and linguistic appropriate services (SB 853, stats. 2003).

Clinical Advisory Panel

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

The CAP met twice during 2003. Agenda items at the May meeting included a facilitated discussion and overview of the IMR (independent medical review) system, the Department's outreach efforts to stakeholders, and a consultation with panel members to obtain comments regarding regulations providing for timely access to managed care services, pursuant to Health and Safety Code section 1367.03 (AB 2179). The November meeting featured an update of the IMR system, a presentation relating to cases involving medications for intractable pain, and a facilitated discussion on cancer clinical trial participation by managed care enrollees relating to Health and Safety Code section 1376.6 (SB 37).

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 plan operations, plan-affiliate operations and transactions, plan-provider contractual

relationships, and provider-affiliate operations and transactions. Additionally, the Board periodically monitors and reports on the implementation and results of the financial solvency requirements and standards and reviews proposed regulation changes.

Disputes regarding the reimbursement of health care claims is the most frequent and vocal issue brought to the Department by providers. During 2003, the FSSB directed most of its efforts toward the development of the AB 1455 regulations to improve claims settlement practices and to standardize dispute resolution processes.

The FSSB will also review and comment on SB 260 (stats. 2002) related to data collection, disclosure language, grading/reviewing and corrective action for risk-bearing organizations.

Stakeholder Outreach

We work with our stakeholder to form cooperative working relationships. In order to interact successfully together, stakeholders must communicate with each other regularly. The Department remains in contact with our stakeholder in a variety of ways:

HMO Help Center Health Plan Newsletter

We continue to publish our Health Plan Advisory Newsletter to promote better communication between the HMO Help Center and the 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.

Statewide Forums

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

- The HMO Help Center partnered with the InterAgency Coordinating Counsel that advises, counsels and makes recommendations related to the Early Start Program for children
- Staff participated in the development of the Strategic Plan for the Department of Disability and Health Project, which focuses on preventive health for the Disabled Community
- Staff participated in the California Cancer Dialogue's statewide plan for the early detection of all cancers
- The HMO Help Center's Assistant Chief Counsel, Robin Fried, was recognized by the Industry Collaboration Effort, (ICE), an organization of health plans, providers, associations and agencies. She received the ICE Leadership Award for outstanding leadership and collaboration
- 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
- The HMO Help Center participated in the second phase of The Institute of Medical Quality's survey and research of California's IMR system sponsored by the California Healthcare Foundation. The report published in May 2003 disclosed how participants in the first year (2001) of the HMO Help Center's IMR system viewed its resolution of enrollee-plan disputes. (The report is available at the Foundation's website under "Managed Care" at www.chcf.org.)
- Staff met with their counterparts at HMOs during the year to discuss consumer issues and industry challenges
- The Assistant Chief Counsel for the Office of Enforcement and the Deputy Director of Communications & Planning attended a town hall meeting in San Jose that assisted providers and enrollees in understanding issues involving the takeover of Lifeguard, Inc. and the failure of the San Jose Medical Group

> "I am so thankful for what your staff did for me and my family. Please keep doing this wonderful job, because by doing this you are saving lives; I am an example of your good work. Thank you again and God bless you and your families."
>
> Xiomara Douglas
> Los Angeles, California

Compliance Oversight

HMO Help Center staff worked with HMOs experiencing problems or deficiencies in their consumer grievance systems. The following areas were targeted:

- Staff reviewed all HMO web sites to ensure that consumers can file a grievance on-line with their health plan
- Staff worked with HMOs to ensure that their grievance process policies are in compliance with cultural and linguistic standards
- Staff initiated efforts to examine and remedy problems with consumer protection activities i.e., HMO complaint processes and consumer information materials
- Staff reviewed all health plan filings for compliance with the statutes and regulations pertaining to the grievance process and IMR arbitration. As a result, health plan grievance systems and the disclosure of the grievance process to enrollees were greatly improved
- Staff improved the oversight of health plan grievance systems by reviewing all complaint and IMR files for procedural violations of the Knox-Keene Act and regulations. All identified violations were referred to the Office of Enforcement for corrective action
- Staff improved Knox-Keene Act compliance of Medicare Supplement (Medigap) plans by assigning counsel to review all filings, attend conferences and act as a liaison with the Centers for Medicare and Medicaid Services (CMS) and other agencies involved in Medigap issues

Consumer Participation Program

In 2003, the Department implemented the Consumer Participation Program, a newly enacted program that is designed to increase consumer participation in rule making by awarding "reasonable advocacy and witness fees to any person or organization that 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 & Safety Code § 1348.9).

The Consumer Participation Program required the promulgation of new regulations and the implementation of the program. An interactive web application was deployed on the public website in July 2003 to provide information on this program and access to the participation form. For more information please visit www.dmhc.ca.gov/cpp/.

HMO Help Center Educational Outreach

The HMO Help Center had the opportunity to educate stakeholders on the Independent Medical Review process in 2003:

- Staff led an outreach effort by phone, by mail and by speaking before medical groups, associations, and consumer groups to raise public awareness of the Independent Medical Review program
- Radio ads were broadcast throughout northern California over a seven-week period, informing Californians of their right to an Independent Medical Review

Outreach To Health Care Community

The Department has worked with the California healthcare community to promote awareness of the Department and patients' rights. The following efforts were made during 2003:

- Providing newsletter articles for printing or electronic distribution
- Delivering on-site presentations
- Providing brochures and posters
- Establishing links to the Department website
- Producing Independent Medical Review radio ads
- Working with HMOs to incorporate IMR information on their websites
- Providing seminar training on access and continuity of care issues to California Association of Provider Groups and California Healthcare Association members
- Meeting with California Association of Health Plans staff and representatives to facilitate communication and understanding

Provider Line

The Department of Managed Health Care is 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.

Recognizing that it is important for hospitals, doctors and other providers to be paid promptly and accurately, the Department has posted a provider request for assistance tool available on our website at www.dmhc.ca.gov. This page provides information on how to resolve payment problems and, if necessary, how to report these problems to the Department.

Physicians and other medical professionals may also use the toll-free Provider Line at (877) 525-1295 to notify the HMO Help Center of complaints regarding a health plan or medical group. The majority of complaints (90%) received from providers concern claim payment delays and denials. Physicians may also call the Department on behalf of their patients. These calls are referred to the appropriate consumer dispute resolution process.

The HMO Help Center received a total of 1,749 calls from providers during 2003 as compared to 2,451 calls received during 2002.

New Product Advisories

New Product Advisories are publications of the Department's action taken on new products proposed by health plans in filings with the Department's Division of Licensing. These new products can either receive an approval, disapproval, postponement, or review concluded by the Department. Once an action is determined for a new product, it will be posted on the Department's public website at www.dmhc.ca.gov/library/reports/.

In 2003, the Office of Health Plan Oversight's Licensing Division posted 22 New Product Advisories (NPA) to the Department's website to communicate with the public and licensees the actions taken on "newsworthy" new products. The Licensing Division also updated the NPAs by deleting the name of the plan proposing the new product, to deter competitors from using a less-than-flattering NPA against a plan competitively.

Efficiency Through Technology

Quarterly Grievance Report

The Quarterly Health Plan Grievance interactive web application was deployed on the public web site on December 31, 2003 to provide an automated method for Health Plans to submit this report.

Electronic Filing

All health care service plans submit their filing via the electronic document management system (eFiling). The filings included: Material modifications, Amendments to Material Modifications, Amendments, and Report/Other.

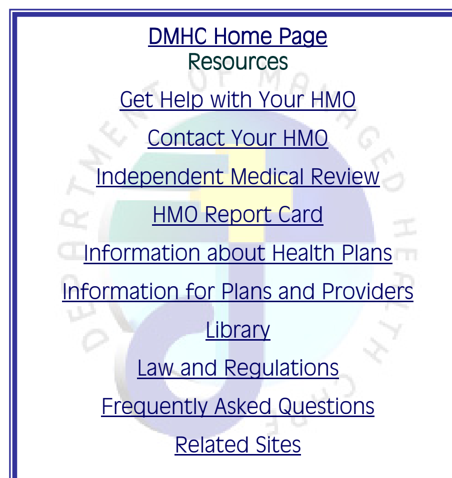
The first phase of the Electronic Document Management Project (e-File) was completed in early 2003. This application allows health plans to electronically file licensing documents with the Department. The documents are managed and stored by the automated system, which also supports DMHC staff review of the filings.

Service Area Application

An OTIS (DMHC intranet) Service Area application was developed to support a web portal that provides Health Plans the ability to submit service area information to the Department. Two new OTIS reports were developed for the Service Area application and were deployed to the Real Time Health Plan Project website: The "Health Plans by County Report" and the "Service Area Map".

Interactive public website

The cornerstone of successful stakeholder communication is our interactive website. All stakeholders may access a wide variety of information and services supported by the Department 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 the California 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 in the State's HMOs and provider organizations
- Ensure fiscal accountability for consumer premium dollars and co-payments throughout the HMO system
- Work to bring managed health care back to its roots of better preventive care that saves lives and preserves precious health dollars for those who become ill

"Fair HMO regulation ensures a stable market where services are available to consumers when needed, resulting, in healthier Californians."

Cindy Ehnes
Director

Emerging Issues

Conversion Coverage

A new law affecting plan group contracts issued, renewed or amended on or after January 1, 2003, requires health plans to offer enrollees guaranteed issue conversion coverage when group coverage is cancelled under certain specified conditions. This coverage is in addition to potential concurrent rights to COBRA, Cal COBRA and HIPAA coverage. Enrollees facing these choices present a challenge to the HMO Help Center in resolving complex complaints and answering inquiries. Further, these types of inquiries and complaints frequently require an urgent response since the enrollee must elect any continuation coverage within 63 days of termination.

Maternity Deductible

The law was amended to disallow plan contracts containing a co-payment or deductible for inpatient maternity services that exceeds the most common amount of the co-payment or deductible in the plan contract. The law previously expressly allowed such deductibles. One challenge relates to the law being applicable to plan contracts issued, amended, renewed or delivered on or after July 1, 2003. Often an enrollee is unaware of the renewal date of the plan contract and this requires additional inquiries by the HMO Help Center in order to resolve the complaint.

Retroactive Disenrollment

Retroactive disenrollment generally arises in the context of an employer failing to make payments on a group health plan, resulting in the plan disenrolling the employee members without their knowledge as of the last date the employer made the premium payment. This can result in an unsuspecting employee losing access to coverage and becoming liable for medical bills incurred during a time that he thought he had coverage. Recently, the Department issued a New Product Advisory approving a contract containing the ability to retroactively disenroll such employees if certain conditions are met, such as the offering of conversion coverage. This presents a challenge to the HMO Help Center in determining whether the conditions have been met for particular instances. However, the HMO Help Center counsel, by focusing on the plans' notice responsibilities as defined in regulation, do

have a high level of success in quickly resolving these types of complaints and getting consumers covered for services.

Mental Health IMRs

Through participation in surveys at behavioral plans, we found that many enrollees with serious mental health issues do not contact the HMO Help Center after taking part in their health plan's appeal process and being denied a service. Also, some health plans have a relatively small number of mental health grievances filed despite their large number of enrollees. Our challenge is to provide mental health associations with enough information to educate their members so that they do not give up on attaining services that may be covered, or medically necessary.

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.

The Knox-Keene Health Care Service Plan Act of 1975, Section 1380, 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 Plan's compliance with the Knox-Keene Act. The Act also mandates a follow up review to be conducted within 18 months of the final report.

The survey reviews the major areas of grievances and appeals, utilization management, access and availability, and quality management 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 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 Special Compliance Reviews, Review of Plan Filings, Arbitration Reviews, Enforcement Referrals, and Legislation and Regulation Reviews. The following chart illustrates the survey activity during calendar year 2003:

Surveys Completed and Reports Issued During 2003			
Plan Type	Surveys Completed	Final Reports Issued	Follow-up Reports Issued
Full Service	15	16	13
Dental	8	10	13
Vision	1	3	6
Behavioral Health	5	4	4
Chiropractic	1	0	0
Totals	30	33	36

Licensing

The Licensing Division provides timely legal review of new license applications, material modifications, and provider transitions and reviews those amendments that significantly impact the plan. Licensing reviews plan filings to require legally sufficient documentation and coordinates with plans and providers to ensure the smooth transition of patients to new provider groups. In 2003, Licensing:

- Reviewed 156 provider transition filings affecting 910,000 enrollees
- Made 7 referrals to Office of Enforcement for Knox-Keene Act violations
- For the Post MRMIP Graduate Product (AB 1401), reviewed material modifications for the seven plans participating in the individual commercial market; drafted a benefits matrix template per Section 1363.06, and compiled information from individual matrices and rate chart for 2003 on the website, and

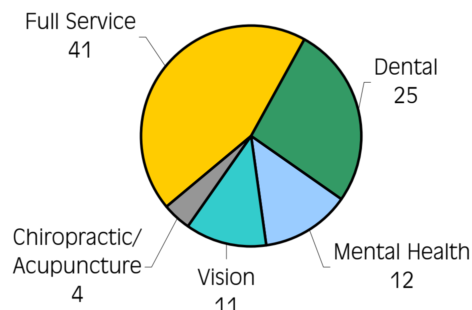
updated the information and Evidence of Coverage (EOC) changes for 2004

- For Individual Conversion (AB 1401) determined most popular individual HMO and PPO products, reviewed EOCs from 22 plans (including 11 plans with HIPAA products and 11 plans that mirror the most popular HMO product) for 2003, posted matrices and rates on our website, and updated theses matrices and rates and EOC changes for 2004
- Began compliance review of dental EOCs, including industry association input, to assure consumers of appropriate dental benefits and disclosure
- Issued temporary Order of Conditional Exemption to protect consumers from injurious retroactive termination practices
- Established expanded statutory standards for Continuity of Care for new enrollees and current enrollees with terminated providers under new legislation (AB 1286 and SB 244)
- Reviewed EOCs and one Material Modification for participation by eight plans in Access for Infant and Mothers (AIM) Program (starting in 2002)
- Provided project support to Office of Legal Services on various legislative matters, including AB 1286, and rule-making
- Expanded health plan compliance with filing hospital contract termination transfers over 2002
- Received 5,146 electronic filings during the year. This represents 175,336 pages that were processed through the system without paper
- Implemented SB 842, effective January 2, 2003, which requires plans to file as a material modification any desired exclusion or limitation to medically necessary prescriptions (seven filed and approved in 2003)

Number of Licensed Health Care Service Plans

As of December 31, 2003, there were 41 full service plans and 52 specialized plans (25 dental, 11 vision, 12 mental health and 4 chiropractic and/or acupuncture). Please refer to Appendix C for a listing of all Plans Licensed Through the Department of Managed Health Care in 2003.

Health Care Service Plans as of December 31, 2003



Licensing Functions

In 2003 the Licensing Division completed review of:

- 1 license application
- 70 material modifications
- 247 Evidence of Coverage Disclosure Agreement (§1352.1) amendments
- 320 Non-Evidence of Coverage Disclosure Agreement (non-§1352.1) amendments
- 476 advertisements
- 11 license surrenders
- 186 block transfer filings

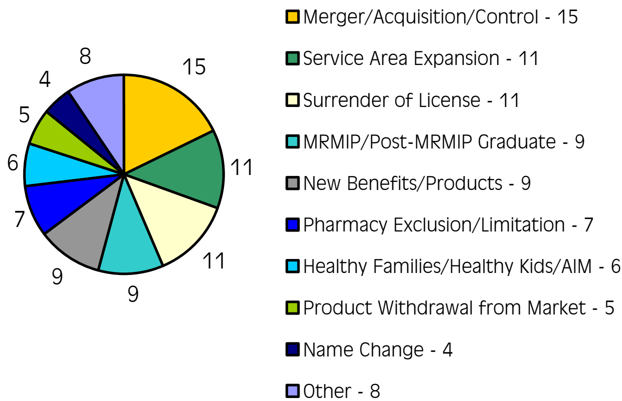
Licensing Activity

- New Licenses Issued: 1 (chiropractic)
- Licenses Surrendered: 11 (6 full service, 2 chiropractic, 1 dental, 1 vision, and 1 pharmacy)
- Under Review: 5 (3 full service and 2 mental health)

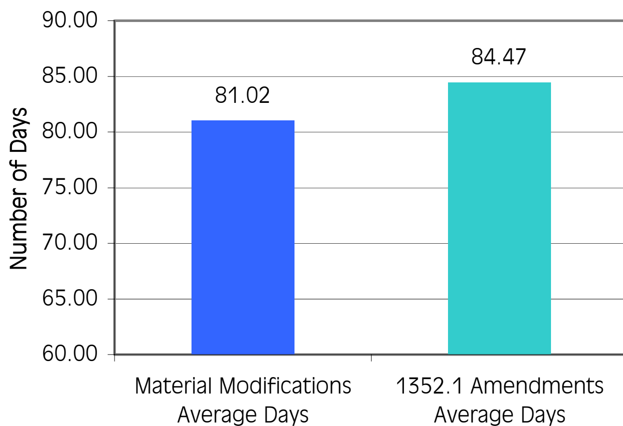
Material Modifications

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 and is also required in certain specified situations (for example, should the plan wish to exclude or limit a medically necessary prescription drug). The Licensing Division reviewed and closed (approved, disapproved, or concurred with plan withdrawal of filing) 70 material modifications in 2003. See the following charts regarding the number and types of material modifications:

Types of Material Modifications Closed in 2003



2003 Statistical Report



The above average days are calculated based on the accepted date for filings beginning January 1, 2003 to the end of December 31, 2003.

Pharmacy SB 842

Enacted in response to litigation that curtailed the Department's ability to protect consumers from clinically inappropriate pharmaceutical benefit terms, SB 842 (effective January 2, 2003) restored the Department's "authority to regulate the provision of [outpatient] medically necessary prescription drug benefits." SB 842 also upgraded the formality required when a plan wishes to exclude or limit a medically necessary drug, by requiring that such exclusions and limitations be filed as a material modification and approved by the Department to be effective and avoid independent medical review (to determine medical necessity) through the HMO Help Center, rather than as an amendment to a plan contract or evidence of coverage under Section 1352.1. Seven such material modifications were filed in 2003. All were approved.

Continuity of Care (AB 1286 and SB 244)

During the past three years, over 3 million Californians were affected by contract terminations that resulted in the block transfer of large groups of enrollees from a terminated medical group to new providers. In many instances, the provider group was insolvent and closed down abruptly. The Department provided critical guidance in more than 500 block transfers during the past 3 years, ensuring that patients received the care to which they were entitled.

In order to provide consumers with expanded rights to ensure a smooth transition to a new provider or to continue care with the same provider, the Department directed significant efforts last year toward writing AB 1286/SB 244, the continuity of care legislation. The Department met with consumer advocates, enrollees, health care lobbyists, provider groups and attorneys to craft this legislation that enhances the rights of Californians faced with a disruption of the provider network of their health care service plan. New protections under the law expand continuity of care rights to include the terminally ill, all pregnancies and surgeries or procedures scheduled to occur within 6 months of the contract termination date or date of new enrollment in a health care service plan. The law also provided for a new written continuity of care policy that clearly explains these rights to consumers.

Effective January 1, 2004, this legislation requires health care service plans to file a written continuity of care policy describing procedures for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital, including the notice it proposes to send affected enrollees, and its process to facilitate the completion of covered services for enrollees. It also requires that enrollees be informed in advance of contract termination, and provides for the uninterrupted care of pregnant patients, those who are terminally ill, and those who have a surgery or medical procedure scheduled within the next 180 days.

Financial Oversight

The Financial Oversight division 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 regulator examinations, analysis of regulatory filings, and requiring necessary corrective actions in coordination with other disciplines in the Department. In 2003, Financial Oversight:

- Met statutory review deadlines despite a severe reduction in staffing.
- Performed 43 routine, nonroutine, and orientation examinations of health plans.
- Made 23 referrals to the Office of Enforcement for serious violations of the Knox-Keene Act.

Financial Examinations

Financial examinations address exam findings, claims payment problems, financial problems, and financial viability. There are four types of examinations: Routine, Nonroutine, Follow up and Orientation.

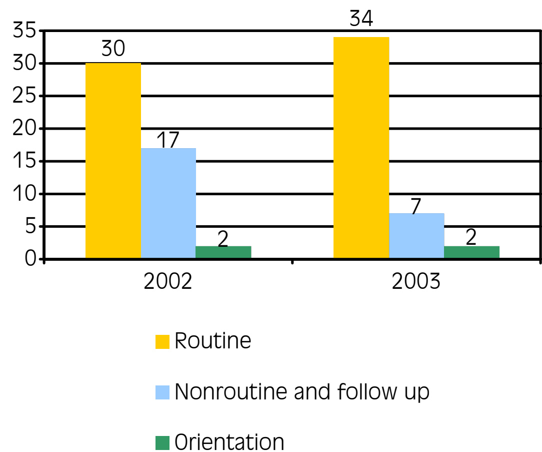
Routine financial examinations provide the Department with the opportunity to review the books and records relating to the fiscal and administrative affairs of the plan. It is crucial that the books and records of the plan accurately reflect the results of the plan's operations to adequately evaluate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

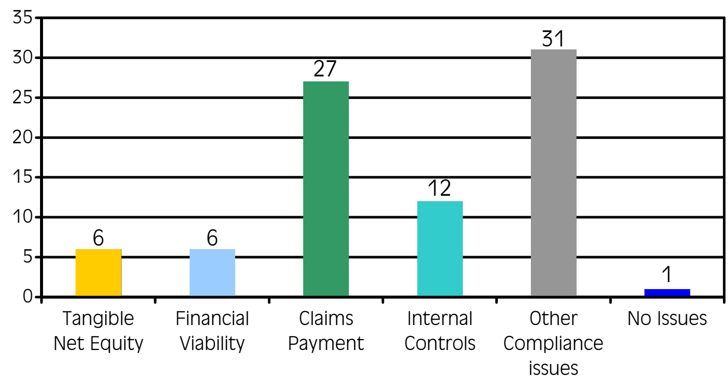
Nonroutine examinations are performed when needed for financial viability issues, tangible net equity, claims payment, books and records, financial statements, written instructions from the Department.

Follow-up exams are performed as needed to verify implementation of corrective actions required as a result of a routine or nonroutine exam.

Orientation examinations are performed one year from the date of licensure. The purpose is to verify if the licensee is operating as represented in the 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 website at www.dmhc.ca.gov/library/reports/hp_exam/.





When serious violations of the law or regulations are discovered, violations will be referred to the Office of Enforcement.

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, strong and fair enforcement of the Act. Please refer to Appendix D for Enforcement Case Load Tracking. In 2003, the Office of Enforcement:

- Received 300 case referrals, from the HMO Help Center, for action on grievance violations and non-compliance issues
- Collected a total of $849,000.00 in fines from health plans that violated the Act
- Collected special assessments from several health plans that had failed to pay their special assessments on time. The assessment amounts totaled $609,727.82
- Opened a total of 423 cases of which 253 were alleged grievance violations by the health plans. The number of grievance issue cases has declined considerably because of the assessment of fines where grievance procedures are violated
- Undertook responsibility for reviewing anti-fraud plans and annual anti-fraud reports required under Health and Safety Code section 1348. The investigators reviewed four anti-fraud plans submitted as part of the initial licensure process for several entities seeking Knox-Keene licenses. In addition, the investigators ensured that all 93 plans submitted their annual anti-fraud reports and reviewed those reports
- Ensured compliance by health plans with the Health Insurance Portability Accountability Act ("HIPAA") and provided significant input into the writing of the regulations that ensure compliance with HIPAA
- Received and responded to six subpoenas on behalf of enrollees involved in civil litigation during 2003
- Assisted a number of physicians and other providers in obtaining payment of their claims from various health plans

Enforcement of the Knox-Keene Act

The Office of Enforcement settled multiple cases for significant penalty amounts in the past year. A majority of cases are now settled without resorting to formal litigation. A "Letter of Agreement" is an informal resolution.

- Health Net of California, Inc. signed a Letter of Agreement regarding grievances, and $140,000.00 was paid by the plan for failure to timely implement Independent Medical Review (IMR) decisions
- Managed Health Network paid a fine of $80,000.00 for financial violations and untimely payment of claims
- Kaiser Foundation Health Plan, Inc. signed a Letter of Agreement and paid a fine of $50,000.00 for failure to respond to grievance issues within 30 days
- Sharp Health Plan signed a Letter of Agreement and paid a fine of $50,000.00 for failure to maintain Tangible Net Equity (TNE)
- Kaiser Foundation Health Plan, Inc. signed a Letter of Agreement and paid a fine of $40,000.00 for failure to file arbitration decisions with the Department within 30 days and failure to include required language in the arbitration decision
- Sharp Health Plan signed a Letter of Agreement and paid a fine of $35,000.00 for failure to include required information in their Independent Medical Review (IMR) notice of denial
- Blue Cross of California signed a Letter of Agreement and paid a fine of $30,000.00 for failure to respond to grievance issues within the required 30 days
- Holman Professional Counseling Centers signed a Letter of Agreement and paid a fine of $25,000.00 for failure to respond to grievance issues
- Cigna HealthCare of California, Inc. signed a Letter of Agreement and paid a fine of $30,000.00 for failure to pay claims in a timely manner
- PacifiCare of California signed a Letter of Agreement and paid a fine of $30,000.00 regarding access to care and various grievance issues
- Safeguard Health Plans, Inc. signed a Letter of Agreement and paid a fine of $30,000.00 for failing to pay claims in a timely manner

- Inter Valley Health Plan signed a Letter of Agreement and paid a fine of $27,500.00 for failure to maintain required Tangible Net Equity (TNE). In 2002, the Department had originally fined the plan $55,000.00 for this offense. However, the Department suspended half of the original fine if the plan remained compliant with the statute for a twelve-month period. The plan failed to remain compliant and the remainder of the original fine was reinstated
- Dental Health Services signed a Letter of Agreement and paid a fine of $20,000.00 for failure to maintain proper books and records as required by the Knox-Keene Act
- Health Net of California, Inc. signed a Letter of Agreement and paid a fine of $17,500.00 for failure to respond to various grievance issues and failure to respond to the Department for expedited review
- Vista Behavioral Health Plans signed a Letter of Agreement and paid a fine of $15,000.00 for failure to pay interest to providers on late claims
- Blue Cross of California signed a Letter of Agreement and paid a fine of $15,000.00 for six separate cases in which the plan failed to acknowledge the receipt of a grievance in writing within five calendar days
- One Health Plan of California, Inc. signed a Letter of Agreement and paid a fine of $15,000.00 for failure to pay claims in a timely manner
- The Office of Enforcement ordered 114,018 claims to be paid and a total of $746,565.54 in interest to be paid on those claims. Additionally, a total of $166,780.00 was paid by health plans resulting from ten-dollar fines imposed on each claim for failing to automatically pay interest on untimely paid claims. The Department assessed a total of $207,000.00 against the plans for failing to pay claims timely
- WATTSHealth Foundation, Inc. was re-organized by the Department through a Conservatorship and returned to the status of a viable company in 2003
- The Office of Enforcement appeared in Bankruptcy Court and successfully sought a delay in closing Health Plan of the Redwoods for the time necessary to allocate its enrollees to other health plans
- Overall in 2003, the Office of Enforcement opened a total of 423 cases, of which 193 remain open and 230 were closed. In addition, the Office of Enforcement opens an average of 35 cases each month. During 2003, the average time to investigate and resolve a case required 30 hours

Please refer to Appendix E for 2-year Comparative Summary of Enforcement Actions Taken and Health & Safety Code Violations and Appendix F for Enforcement Statistics on Claims Payment Cases in 2003.

Violation Trends and Issues

The following is a list of the total number and percentage of Enforcement actions, per specific Health and Safety Code sections, filed most frequently by the Office of Enforcement:

Health & Safety Code	Number Of Actions	Percentage Of Total
§1368: (Grievance)	32	37%
§1371/1371.35:(Untimely claims payment)	12	14%
§1375.1: (Fiscal Soundness)	9	10%
§1367/1300.67: (Continuity of care)	6	7%
§1376/1300.76:(TNE Deficiencies)	3	3%
All Other Health and Safety code sections	24	29%
Total	86	100%

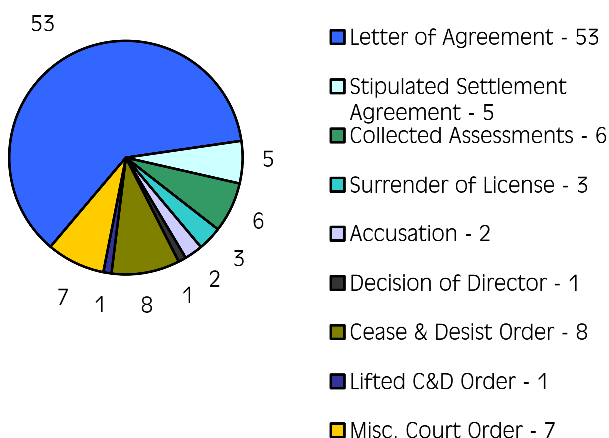
In 2003, there was an increase in grievance violations because the Office of Enforcement and the HMO Help Center have improved processes that allow for the identification and referral of these cases. Additionally, the Office of Enforcement has improved its process for expediting the resolution of these cases.

The trend in violations of the financial sections of the Health and Safety Code show a large decrease in the number of plans that fail to meet their tangible net equity requirements (§1376). This appears to be attributable to the decrease in time between financial examinations, as well as the number of enforcement actions, which has included placing plans in conservatorships. There was a slight increase in the number of plans alleged to be fiscally unsound (§1375). This may be attributable to the

frequency of the financial examinations. The number of plans failing to timely pay claims (§1371) remained constant. This may be attributed to the pattern and practice of claims processing.

Continuity of Care (§1367) has also decreased dramatically from calendar year 2002 to 2003. This may be explained by a number of factors: less plans were placed in conservatorship, more plans are meeting their financial requirements, and, possibly, fewer complaints were filed with the Department that rose to the level requiring enforcement action. A continuing issue for the Office of Enforcement is the continuity of care provided to enrollees from plans placed in conservatorship due to insolvency.

The following chart expresses the types of enforcement actions taken by the Office of Enforcement in 2003.



Legal Services

Department Advice

The Department issues advice on various issues related to managed health care plans. In 2003 Department Advice was issued on the following subjects:

03-01 Required Disclosures and Conditions of Binding Arbitration

03-02 Exclusion of Coverage for Certain Pharmaceuticals

03-03 Unilateral Amendments to Contracts

03-04 Signature Requirements for Reports

03-05 Unilateral Amendments to Contracts: Manual Policy or Procedure Documents

03-06 Cancellation of Enrollment

03-07 Implementation of the Claim Settlement Practices and Dispute Mechanisms Regulations

03-08 Compliance with Section 1366.35(i): Disclosure of the Availability of HIPAA Coverage; Model Language for Use in Evidences of Coverage

Regulations

The Office of Legal Services finalized the following eleven regulation packages in 2003:

- Interpretive Opinion – Filed with Secretary of State on 10/27/03, currently suspended by Executive Order S-02-03
- Record Retention – Filed with Secretary of State on 10/29/03, currently suspended by Executive Order S-02-03
- Waiting Room Notices – Filed with Secretary of State on 11/20/03, currently suspended by Executive Order S-02-03
- Ambulance Plan Exemption Amendment – Filed with Secretary of State on 7/24/03
- Conflict of Interest Amendment – Filed with Secretary of State on 7/21/03
- Claim Settlement Practices – Filed with Secretary of State on 7/24/03
- Consumer Participation Program – Filed with Secretary of State on 6/20/03
- IMR Grievance Regulations – Filed with Secretary of State on 2/18/03
- Mental Health Parity – Filed with Secretary of State on 9/23/03
- Out of Area Maternity Service – Filed with Secretary of State on 9/16/03
- Per Day Civil Penalty – Filed with Secretary of State on 9/18/03

You may find additional information on Departmental Advice and Regulations by visiting our website at www.dmhc.ca.gov. Select "Library" to review Departmental Advice and select "Law and Regulation" to review existing and proposed regulations.

Legislation

During the 2003 legislative session, ten bills were introduced on the subject of universal and expanded health care coverage. There were also several bills regarding health plans contracts and provider issues. Rising health care costs and the fiscal solvency of health care entities are likely to continue to be a catalyst for legislation.

The Department followed 61 bills in 2003. Of these, 25 were chaptered, 3 vetoed, 16 dropped, 8 are moving forward in the 2004 session, and 9 were deferred to other departments.

Legislation enacted effective January 2, 2003, regarding Prescription Drug Standards, restores the historic authority of the Department to regulate plans' pharmaceutical benefits, terms and conditions. Assuring that patients receive medically necessary prescriptions without "breaking the bank" is the goal of the Department. The Department is developing regulations outlining standards to be used in reviewing a health care service plan's prescription drug benefits.

Significant Health Plan Legal Actions

On October 27, 2003, it was announced publicly that WellPoint Health Networks, Inc. agreed to merge with Anthem, Inc. Neither Anthem nor WellPoint are licensees of the Department of Managed Health Care. However, Blue Cross of California, a for-profit corporation owned by WellPoint, is a licensee of the Department. Blue Cross filed a notice of material modification to their license to secure the Department's approval prior to the change being implemented.

Health Plan Assessments

The Department is funded 100% from the Managed Care Fund, supported by an annual assessment of the HMOs. A minor portion of the fund's revenue (2.5%) is derived through penalties and fines imposed on the HMOs. Up to $2.0 million of the fund until 2006 funds the review of legislatively mandated health care benefits by the University of California. The Department makes the assessment of these costs and the funds are transferred to the UC budget for expenditure.

The HMOs were assessed $31.7 million to fund the Department's operations in FY 03/04, and $1.2 million to fund the UC Legislative mandate reviews. This assessment was, on the average, .06% of HMO "Total Revenue," and .667% of HMO "Total Administrative Expenses."

Please refer to Appendix G for Assessment Process information and Appendix H for Assessment by Type information.

"After weeks of getting the "run-around", I contacted the Department of Managed Health Care and was immediately contacted. My problem (after I thought there was no hope) in regards to my two and a half year old son's orthopedic shoes was solved. Staff followed through and were always available to speak with if needed. I'm very glad to know there are still people in the work force who actually take pride in their job and follow through in a timely manner."

Tami Thomas
Alta Loma, California

Innovation

Standing still is not an option. Here at DMHC we know that success is not stationary. We are continually in motion, seeking out business process improvements.

Call Center Process Improvements

- Increased our effectiveness in assisting consumers through the maze of managed care through staff training. Our training plan involved experts from a variety of entities: HMOs, consumer advocacy groups, other state agencies, and the Department's survey and legal staff. The training program included, but was not limited to, the following topics: Workload Efficiency, Customer Service, New Legislation, Referral Resources, Independent Medical Review, and specialized computer application courses
- Conducted a review of all IMR operations, policies and procedures. The effort resulted in improved communication with consumers, consistency in clinical assessment of disputed services, and in better data obtained from health plans
- Continued the evaluation of correspondence and other communication with enrollees
- Identified and implemented new methods to provide cost effective and informative Medical Survey Reports while meeting statutory timeline requirements as well as the needs of the various internal and external stakeholder groups

Non-Jurisdictional and Cross-Jurisdictional Workload

State agencies often are unable to recognize the appropriate jurisdiction of complaints they receive and sometimes refer consumer complaints to the HMO Help Center that are outside our jurisdiction. In an effort to improve turnaround times for enrollees, the HMO Help Center established program-level management work groups with the California Department of Insurance and the Department of Consumer Affairs to address specific consumer issues, effective case referral between departments, and methods to track consumer complaints and referrals.

Licensing and Financial Oversight Process Improvements

- Established updated New Product Advisories postings available on our public website. Please visit www.dmhc.ca.gov/library/reports/ for more information
- Posted to our public website the matrices for Post MRMIP Graduate Products, Individual Conversion, HIPAA and Individual Commercial Contracts for full service plan licensees, please visit www.dmhc.ca.gov/coverage/mrmip and www.dmhc.ca.gov/coverage/conversion/ for more information
- Streamlined the financial statement review process
- Implemented the use of risk factors when scheduling routine examinations
- Developed improved tracking and review of major (300,000 enrollee+) potential provider and hospital contract terminations across the state, working with health plans, providers and hospitals to avoid mass enrollee block transfers
- Began analysis of inefficiencies with existing electronic filing and workload management system with our technology office, and a consultant, with a view to further improving service and process
- Provided project support for the creation of the department's service area web portal project to list plans within counties throughout California
- Achieved maximum efficiencies possible with existing electronic filing and workload management system (VisiFLOW) and necessary manual measures

- Ongoing improvements to Filing Clerk routing protocols to handle expanded exceptions
- Completed the reorganization of Licensing Division into operating teams to increase consistency and efficiency
- Implemented the Decision Tree Project to foster increased efficiency and consistency in Licensing
- Improved internal standards for handling emergency provider group closures
- Developed and improved standards for handling insolvent health plan allocation of enrollees to new plans
- Reorganized the division's filing process for finished documents from VisiFLOW to a common shared network drive
- Implemented Issues Library to foster increased efficiency and consistency

Enforcement Process Improvements

- Upgraded the case management database to ProLaw Version 9 with little to no disruption to users and undertook the massive data conversion from SYBASE to MSSQL
- During 2003, policies and procedures were developed for administrative, accounting, and Conservatorship processes for Enforcement personnel setting forth the standards and criteria
- The Office of Enforcement created a grievance issue database so the HMO Help Center could easily communicate with Enforcement and expedite the referral process
- The Office of Enforcement, together with Licensing established the Licensing and Enforcement Roundtable (LERT) to discuss topical issues, facing the Department, with other divisions within DMHC
- The Office of Enforcement instituted separate and customized presentations to the financial examiners, medical surveyors and licensing personnel about the enforcement tools the Office of Enforcement has available to assist each division with their individual functions

Office of Legal Services (OLS) Process Improvements

- During 2003, OLS implemented the Department defense litigation. The Department defense litigation function includes all litigation in which the Department of Managed Health Care, or any of its employees in the course and conduct of departmental business, is a defendant in a lawsuit no matter who initiates the action. While the OLS has provided representation in all personnel and employment matters since OLS' inception, defense of the Department is a new function
- Over the years the Department has been sued in its capacity as the managed health care industry regulator by various organizations and individuals. By placing the defense function in the OLS, the Department is represented by attorneys with complete knowledge of the Knox-Keene Health Care Service Plan Act, in that they promulgate the regulations, maintain the Department regulatory scheme, and manage the Department's Legislative program
- Implemented ProLaw, a computerized timekeeping/work management system, to more accurately track tasks and time
- Provided seminars led by outside experts to all department personnel
- Promulgated new or amended regulations in a record setting number
- Revamped the regulation tracking system
- Provided oversight and contributions to OTIS, the Department's intranet system
- Developed staff expertise in various health care areas, i.e., Open Meeting Act, HIPPA, COBRA, FPPC, etc., for the purpose of providing advice to DMHC and its ancillary committees
- Streamlined the Duty Counsel Program to provide, to the extent possible, a 24-hour response time; updated duty counsel scripts and information resource data
- Formalized legislative analysis procedures

- Developed Public Records Act and Information Practices Act electronic request forms for the Department's website

Technological Solutions

- Reformatted the Department's public website to meet the requirements of the new Governor's state standard in December 2003
- Developed the Consumer Participation application on OTIS (our intranet) that allows the Office of Legal Services to manage requests submitted through the Consumer Participation Program
- Implemented the Real Time Health Plan application, on OTIS, to provide current, consolidated information on health plans to Department management from multiple DMHC databases
- Significantly upgraded the health plan assessments application that generates and tracks the health plan assessments. This application allows the use of DMHC data to calculate and generate bills and track payments for each health plan by fiscal year. The upgrade allows variable assessment rates, adjustments to assessments and additional management reports
- Several enhancements were completed in the network environment to ensure IT security for all DMHC business units. Notable enhancements include creating a security initiative that identified and analyzed vulnerabilities in our network, and designing, procuring and installing systems to address them

STATISTICS

This statistics section contains an aggregate summary of grievances against plans filed with the director by enrollees or subscribers as mandated by the Knox-Keene Act, Section 1397.5 and the annual audit of the independent medical review system mandated by the Knox-Keene Act, Section 1374.34(e).

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.

COMPLAINT RESULTS BY CATEGORY & HMO

Report Definition

The *Summary of 2003 Enrollee Complaints:*

- Details the number and types of complaints closed by the Department during the 2003 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 2003 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 2003. 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 2003. Because Medicare + Choice enrollees are not eligible for the complaint process, the enrollment figures below 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.

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	Claims/Financial Issues Count	Claims/Financial Issues Per 10,000	Enrollment Issues Count	Enrollment Issues Per 10,000	Coord. Of Care Issues Count	Coord. Of Care Issues Per 10,000	Attitude/Service of Health Plan Count	Attitude/Service of Health Plan Per 10,000	Attitude/Service of Provider Count	Attitude/Service of Provider Per 10,000
Full Service – Enrollment Over 400,000																	
Blue Cross of California	828	4,731,646	1.75	25	0.05	138	0.29	564	1.19	59	0.12	13	0.03	126	0.27	7	0.01
Blue Shield of California	889	2,608,802	3.41	28	0.11	192	0.74	609	2.33	50	0.19	9	0.03	78	0.30	1	0.00
Cigna HealthCare of California Inc.	115	581,421	1.98	6	0.10	31	0.53	65	1.12	7	0.12	2	0.03	19	0.33	1	0.02
Health Net of California Inc.	468	2,145,796	2.18	32	0.15	117	0.55	283	1.32	24	0.11	7	0.03	57	0.27	0	0.00
Kaiser Permanente	1,075	5,880,908	1.83	65	0.11	182	0.31	577	0.98	98	0.17	122	0.21	90	0.15	64	0.11
L.A. Care Health Plan	2	827,765	0.02	0	0.00	1	0.01	1	0.01	0	0.00	0	0.00	2	0.02	0	0.00
PacifiCare of California	471	1,335,000	3.53	23	0.17	107	0.80	315	2.36	19	0.14	14	0.10	49	0.37	1	0.01
Total	3,848	18,111,338	2.12	179	0.10	768	0.42	2,414	1.33	257	0.14	167	0.09	421	0.23	74	0.04
Full Service – Enrollment Under 400,000																	
AETNA Health of California Inc.	88	356,769	2.47	3	0.08	16	0.45	64	1.79	3	0.08	3	0.08	23	0.64	1	0.03
Alameda Alliance for Health	1	91,995	0.11	0	0.00	1	0.11	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CalOptima	0	318,329	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Care 1st Health Plan	1	186,115	0.05	0	0.00	0	0.00	0	0.00	0	0.00	1	0.05	0	0.00	0	0.00
CareMore Insurance Services Inc.	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cedars-Sinai Provider Plan LLC	0	278	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Chinese Community Health Plan	0	6,387	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Health Group	4	94,377	0.42	0	0.00	3	0.32	1	0.11	0	0.00	0	0.00	0	0.00	0	0.00
Community Health Plan	1	185,904	0.05	0	0.00	0	0.00	0	0.00	0	0.00	1	0.05	0	0.00	1	0.05
Concentrated Care Inc.	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Contra Costa Health Plan	0	60,349	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Great-West Healthcare of California, Inc.	14	55,960	2.50	0	0.00	2	0.36	12	2.14	1	0.18	0	0.00	3	0.54	0	0.00
Health Plan of San Joaquin	2	65,052	0.31	0	0.00	0	0.00	2	0.31	0	0.00	0	0.00	0	0.00	0	0.00
Health Plan of San Mateo	0	50,540	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Plan of the Redwoods	10	0	0.00	0	0.00	0	0.00	9	0.00	1	0.00	0	0.00	0	0.00	0	0.00
Heritage Medical Systems	0	190,560	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
IEHP (Inland Empire Health Plan)	2	264,865	0.08	0	0.00	0	0.00	0	0.00	1	0.04	0	0.00	1	0.04	0	0.00
Kern Health Systems Inc.	0	77,830	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Lifeguard, Inc.	80	0	0.00	0	0.00	5	0.00	75	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Maxicare of California, Inc.	8	0	0.00	0	0.00	1	0.00	7	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medcore	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

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	Claims/Financial Issues Count	Claims/Financial Issues Per 10,000	Enrollment Issues Count	Enrollment Issues Per 10,000	Coord. Of Care Issues Count	Coord. Of Care Issues Per 10,000	Attitude/Service of Health Plan Count	Attitude/Service of Health Plan Per 10,000	Attitude/Service of Provider Count	Attitude/Service of Provider Per 10,000
On Lok Senior Health Services	0	907	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Primecare Medical Network Inc.	0	232,141	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ProMed HCA (Health Care Administrators)	0	8,531	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
San Francisco Health Authority	0	42,409	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Santa Barbara Regional Health Authority	0	54,104	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Santa Clara Family Health Plan	0	91,310	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scripps Clinic Health Plan Services Inc.	1	57,843	0.17	0	0.00	0	0.00	1	0.17	0	0.00	0	0.00	0	0.00	0	0.00
Sharp Health Plan	6	125,136	0.48	2	0.16	2	0.16	3	0.24	0	0.00	2	0.16	2	0.16	0	0.00
Simnsa Health Care	0	11,942	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Smartcare Health Plan	6	2,369	25.33	1	4.22	3	12.66	2	8.44	0	0.00	0	0.00	0	0.00	0	0.00
Tower Health Services	9	0	0.00	0	0.00	0	0.00	9	0.00	0	0.00	0	0.00	2	0.00	0	0.00
UCSD (UC San Diego) Senior Health Plan	0	13,007	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UHC Healthcare (United Healthcare of California) - INACTIVE 2001	6	0	0.00	0	0.00	0	0.00	6	0.00	0	0.00	0	0.00	3	0.00	0	0.00
UHP Healthcare	9	85,715	1.05	0	0.00	1	0.12	8	0.93	0	0.00	0	0.00	3	0.35	0	0.00
Universal Care	36	376,677	0.96	0	0.00	6	0.16	24	0.64	6	0.16	1	0.03	5	0.13	0	0.00
Ventura County Health Care Plan	1	10,714	0.93	0	0.00	0	0.00	0	0.00	1	0.93	0	0.00	0	0.00	0	0.00
Western Health Advantage	40	61,824	6.47	3	0.49	9	1.46	19	3.07	4	0.65	3	0.49	7	1.13	0	0.00
Total	**325**	**3,179,939**	**1.02**	**9**	**0.03**	**49**	**0.15**	**242**	**0.76**	**17**	**0.05**	**11**	**0.03**	**49**	**0.15**	**2**	**0.01**
Chiropractic																	
ACN (American Chiropractic Network Inc.)	1	3,590,450	0.00	0	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ACN Group of California, Inc.	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Avante Complementry Health Plan	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Basic Chiropractic Health Plan	0	305	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ChiroSave Inc.	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Landmark Healthplan of California Inc.	1	130,660	0.08	0	0.00	0	0.00	1	0.08	0	0.00	0	0.00	0	0.00	0	0.00
Total	**2**	**3,721,415**	**0.01**	**0**	**0.00**	**1**	**0.00**	**1**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
Dental																	
Access Dental Plan	1	207,631	0.05	0	0.00	0	0.00	1	0.05	0	0.00	0	0.00	0	0.00	0	0.00
AETNA Dental of California Inc.	4	277,235	0.14	0	0.00	1	0.04	4	0.14	0	0.00	0	0.00	2	0.07	0	0.00
Ameritas Managed Dental Plan Inc.	1	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00	0	0.00	1	0.00	0	0.00
California Benefits Dental Plan	2	24,929	0.80	0	0.00	1	0.40	2	0.80	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		Benefits/ Coverage Issues		Claims/Financial Issues		Enrollment Issues		Coord. 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	Count	Per 10,000	Count	Per 10,000
California Dental Network, Inc.	2	29,086	0.69	0	0.00	0	0.00	1	0.34	0	0.00	0	0.00	0	0.00	1	0.34
CENTAGUARD Dental Plan	0	22,019	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna Dental Health of California Inc.	12	392,177	0.31	0	0.00	2	0.05	8	0.20	0	0.00	3	0.08	5	0.13	1	0.03
DDS Inc./DDSI (Dedicated Dental Systems Inc.)	3	34,671	0.87	0	0.00	0	0.00	0	0.00	0	0.00	2	0.58	1	0.29	0	0.00
Delta Dental Plan of California	143	14,825,333	0.10	1	0.00	28	0.02	107	0.07	0	0.00	7	0.00	12	0.01	1	0.00
Denticare of California Inc.	15	399,873	0.38	1	0.03	2	0.05	10	0.25	0	0.00	2	0.05	2	0.05	1	0.03
Healthdent of California Inc.	1	10,482	0.95	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.95
Managed Dental Care	6	83,664	0.72	0	0.00	1	0.12	4	0.48	0	0.00	1	0.12	0	0.00	0	0.00
Mida Dental	3	275,095	0.11	0	0.00	0	0.00	3	0.11	0	0.00	0	0.00	1	0.04	0	0.00
Newport Dental Centers	0	55,771	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Pacific Union Dental, Inc.	1	242,017	0.04	0	0.00	1	0.04	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PacifiCare Dental	10	289,932	0.34	0	0.00	3	0.10	9	0.31	0	0.00	2	0.07	4	0.14	0	0.00
SmileCare	2	121,392	0.16	0	0.00	1	0.08	0	0.00	0	0.00	0	0.00	1	0.08	0	0.00
South Hills Dental Plan	3	84,162	0.36	0	0.00	0	0.00	1	0.12	0	0.00	1	0.12	0	0.00	1	0.12
United Dental Care	0	20,079	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Dental PLan	5	317,444	0.16	0	0.00	0	0.00	3	0.09	0	0.00	2	0.06	0	0.00	1	0.03
Total	**214**	**17,712,992**	**0.12**	**2**	**0.00**	**40**	**0.02**	**154**	**0.09**	**0**	**0.00**	**20**	**0.01**	**29**	**0.02**	**7**	**0.00**
Dental/Vision																	
Golden West Vision-Dental Plan	8	241,124	0.33	0	0.00	1	0.04	4	0.17	0	0.00	3	0.12	1	0.04	0	0.00
PMI (Private Medical-Care Inc.)	60	1,025,923	0.58	6	0.06	15	0.15	31	0.30	2	0.02	5	0.05	7	0.07	3	0.03
Safeguard Health Plans Inc.	18	278,699	0.65	2	0.07	4	0.14	9	0.32	0	0.00	1	0.04	2	0.07	2	0.07
SmileSaver/Signature Vision	13	259,613	0.50	2	0.08	1	0.04	8	0.31	1	0.04	2	0.08	1	0.04	0	0.00
Total	**99**	**1,805,359**	**0.55**	**10**	**0.06**	**21**	**0.12**	**52**	**0.29**	**3**	**0.02**	**11**	**0.06**	**11**	**0.06**	**5**	**0.03**
Vision																	
ESP (Eyecare Service Plan)	0	113,208	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Eye Care Plan of America - California Inc.	0	8,314	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
For Eyes Vision Plan	0	21,936	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Net Vision Inc.	0	316,030	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medical Eye Services Inc.	0	81,883	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
NVAL Visioncare Systems of Calirornia Inc.	0	103,360	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Pearle Visioncare Inc.	0	316,127	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		Benefits/ Coverage Issues		Claims/Financial Issues		Enrollment Issues		Coord. 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	Count	Per 10,000	Count	Per 10,000
Sterling Visioncare	0	74,426	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision First Eye Care Inc.	0	1,419	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Plan of America	0	44,134	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Service Plan	3	8,271,463	0.00	0	0.00	1	0.00	1	0.00	1	0.00	0	0.00	1	0.00	0	0.00
Total	3	9,352,300	0.00	0	0.00	1	0.00	1	0.00	1	0.00	0	0.00	1	0.00	0	0.00
Pharmacy																	
MedcoCal, Inc.	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total	0	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Psychological																	
Cigna Behavioral Health of California Inc.	3	481,374	0.06	0	0.00	3	0.06	1	0.02	0	0.00	0	0.00	2	0.04	0	0.00
CONCERN: Employee Assistance Program	0	57,028	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
HAI-CA (Human Affairs International of California)	0	919,890	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	198,979	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Integrated Insights	0	219,798	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Managed Health Network	31	2,427,833	0.13	1	0.00	4	0.02	23	0.09	1	0.00	1	0.00	8	0.03	0	0.00
Merit Behavioral Care of California Inc.	3	551,979	0.05	0	0.00	0	0.00	3	0.05	0	0.00	0	0.00	0	0.00	0	0.00
PacifiCare Behavioral Health of California Inc.	37	1,913,333	0.19	2	0.01	7	0.04	25	0.13	0	0.00	1	0.01	9	0.05	0	0.00
U.S. Behavioral Health Plan California	18	2,349,240	0.08	0	0.00	6	0.03	11	0.05	0	0.00	1	0.00	1	0.00	0	0.00
ValueOptions of California Inc.	1	278,606	0.04	0	0.00	0	0.00	1	0.04	0	0.00	0	0.00	0	0.00	0	0.00
Vista Behavioral Health Plans	0	84,603	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total	93	9,482,663	0.10	3	0.00	20	0.02	64	0.07	1	0.00	3	0.00	20	0.02	0	0.00
Grand Total	4,584	63,366,006	0.72	203	0.03	900	0.14	2,928	0.46	279	0.04	212	0.03	531	0.08	88	0.01

INDEPENDENT MEDICAL REVIEW RESULTS BY HMO

Report Definition

The *Summary of 2003 IMRs by HMO:*

- Details the number and types of IMRs closed with a determination during the 2003 calendar year. The total number of IMRs resolved (773) includes 84 cases that were withdrawn during the review process; a total of 689 cases completed the review process.
- Lists HMOs licensed during the 2003 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 2003. 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 PacfiCare Behavioral Health Care of California, Inc., as they are specialized HMOs, not full service HMOs.

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Plan Type and Name	Enrollees	Total IMRs Resolved	Experimental/Investigational IMR: Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn	Medical Necessity IMR: Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
Full Service - Enrollment Over 400,000										
Blue Cross of California	4,731,646	153	49	33	14	2	104	66	31	7
Blue Shield of California	2,608,802	198	34	26	7	1	164	82	52	30
Cigna HealthCare of California Inc.	581,421	64	8	6	2	0	56	25	29	2
Health Net of California Inc.	2,145,796	106	34	21	13	0	72	33	34	5
Kaiser Permanente	5,880,908	109	2	1	1	0	107	58	41	8
PacifiCare of California	1,335,000	105	17	10	7	0	88	59	16	13
Subtotals	**17,283,573**	**735**	**144**	**97**	**44**	**3**	**591**	**323**	**203**	**65**
Full Service- Enrollment Under 400,000										
AETNA Health of California Inc.	356,769	24	1	0	1	0	23	10	13	0
Community Health Group	94,377	1	0	0	0	0	1	0	1	0
IEHP (Inland Empire Health Plan)	264,865	4	0	0	0	0	4	3	1	0
Molina Medical Center	279,921	1	0	0	0	0	1	1	0	0
Sharp Health Plan	125,136	1	0	0	0	0	1	0	1	0
Universal Care	376,677	6	0	0	0	0	6	1	5	0
Valley Health Plan	55,414	1	0	0	0	0	1	0	1	0
Western Health Advantage	61,824	4	1	1	0	0	3	3	0	0
Subtotals	**1,614,983**	**42**	**2**	**1**	**1**	**0**	**40**	**18**	**22**	**0**
Psychological										
Managed Health Network	2,427,833	5	0	0	0	0	5	3	2	0
PacifiCare Behavioral Health of California Inc.	1,913,333	16	1	0	1	0	15	9	5	1
U.S. Behavioral Health Plan California	2,349,240	2	0	0	0	0	2	0	2	0
Subtotals	**6,690,406**	**23**	**1**	**0**	**1**	**0**	**22**	**12**	**9**	**1**
Totals		800	147	98	46	3	653	353	234	66

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
933-0043	California Physicians' Service
933-0326	Care 1st Health Plan
933-0408	CareMore Ins.
933-0366	Cedars-Sinai Provider Plan, LLC
933-0401	Central Coast Alliance for Health
933-0278	Chinese Community Health Plan
933-0152	Cigna HealthCare of California, Inc.
933-0200	Community Health Group
933-0054	Contra Costa Co. Medical Services
933-0248	County of Los Angeles-Dept of Hlth Svcs.
933-0344	County Of Ventura
933-0300	Health Net
933-0357	Heritage Provider Network, 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, Inc.
933-0355	Local Initiative Health Authority For LA Co.

Plan ID	Plan Name
933-0390	Medcore HP
933-0322	Molina Medical Centers
933-0394	Orange Prevention and Treatment
933-0385	On Lok Senior Health Services
933-0325	One Health Plan of California, Inc.
933-0126	Pacificare of California
933-0367	Primecare Medical Network, Inc.
933-0349	San Francisco Health Plan
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
933-0212	Scan Health Plan
933-0377	Scripps Clinic Health Plan Services, Inc.
933-0310	Sharp Health Plan
933-0393	Sistemas Medicos Nacionales, S.A. de C.V.
933-0209	Universal Care
933-0008	Watts Health Foundation, Inc.
933-0348	Western Health Advantage

SPECIALIZED PLANS

Dental

Plan ID	Plan Name
933-0318	Access Dental Plan
933-0313	Aetna US HealthCare Dental of California, Inc.
933-0195	American Healthguard Corporation
933-0308	California Benefits Dental Plan
933-0286	California Dental Network, Inc.
933-0258	Cigna Dental Health of CA, Inc.
933-0170	Community Dental Services
933-0215	Consumer Health, Inc.
933-0244	Dedicated Dental Systems, Inc.
933-0092	Delta Dental Plan
933-0255	Dental Benefit Providers of CA., Inc
933-0059	Dental Health Services
933-0171	Health Net Dental Inc./Denticare of California, Inc.

Plan ID	Plan Name
933-0080	Golden West Health Plan, Inc.
933-0136	Greater California Dental Plan/GE Wellness
933-0197	Jamini Health/Healthdent of California, Inc.
933-0302	Managed Dental Care
933-0100	Pacificare Dental and Vision
933-0211	Pacific Union Dental, Inc.
933-0052	Preferred Health Plan, Inc/Liberty Dental Plan
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 Calif.
933-0224	Western Dental Services, Inc.

Vision

Plan ID	Plan Name	Plan ID	Plan Name
933-0189	Eyecare Service Plan, Inc./Spectera Vision	933-0263	Pearle Vision Care, Inc.
933-0264	Eyexam 2000 of California, Inc./Eyemed	933-0329	Vision First Eye Care, Inc.
933-0320	For Eyes Vision Plan, Inc.	933-0268	Vision Plan of America
933-0220	Health Net Vision/Foundation Health Vision Services	933-0049	Vision Service Plan
933-0359	Medical Eye Services Inc	933-0287	Visioncare of California
933-0342	NVAL Visioncare Systems Of California, Inc.		

Mental Health

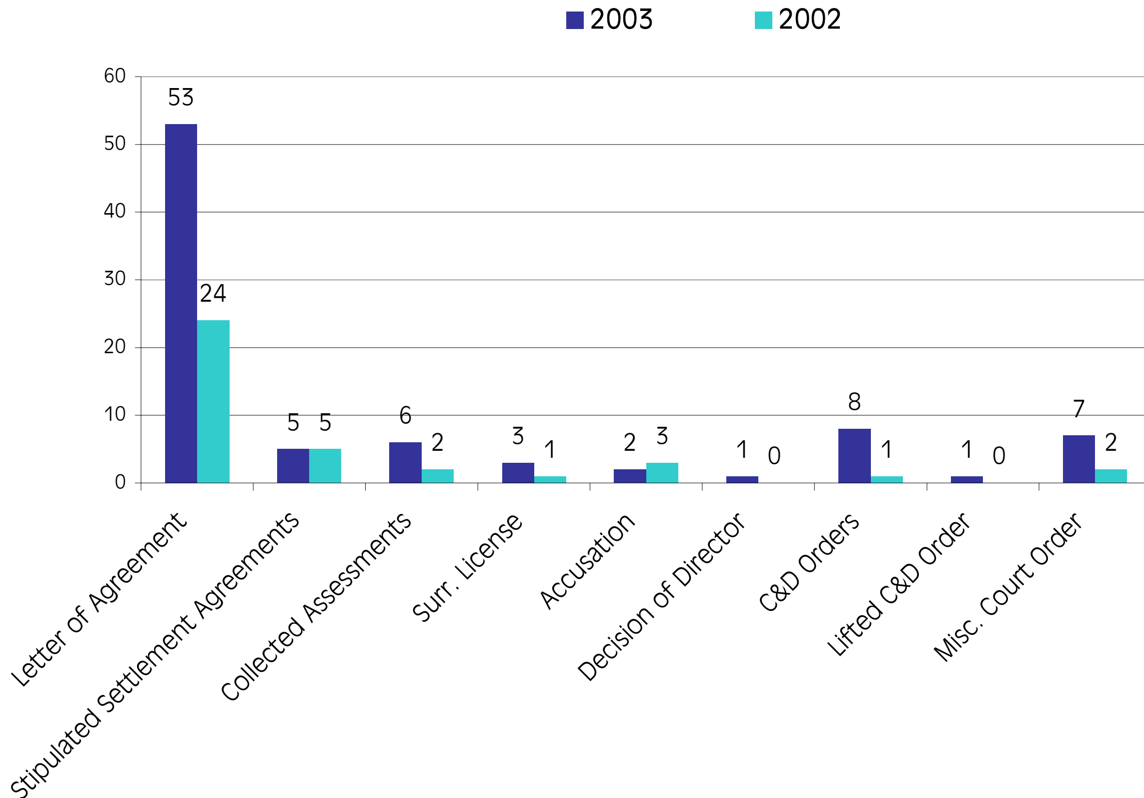
Plan ID	Plan Name	Plan ID	Plan Name
933-0397	Avante Behavioral Health Plan (ABHP)	933-0298	MCC Managed Behavioral Care of Calif., Inc.
933-0402	Concern Employee Assistance Program	933-0288	Merit Behavioral Care of Calif., Inc.
933-0319	Health and Human Resource Center	933-0301	Pacificare Behavioral Health of California
933-0231	Holman Professional Counseling Ctrs	933-0259	U.S. Behavioral Health Plan, California
933-0292	Human Affairs International of California	933-0293	Value Behavioral Health of California, Inc.
933-0196	Managed Health Network, Inc	933-0102	Vista Behavioral Health Plan

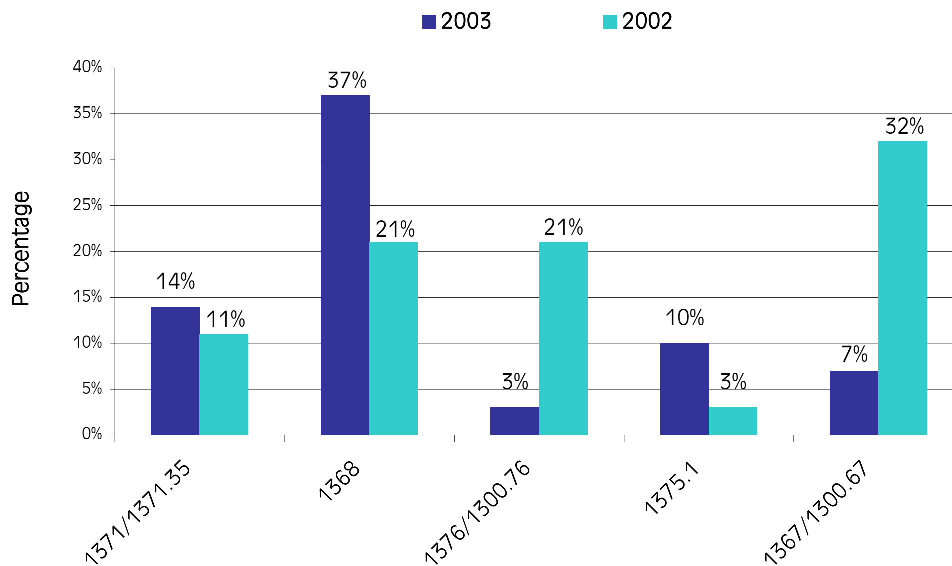
Chiropractic and/or Acupuncture

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

Case Activity	1ST QRT	2ND QRT	3RD QRT	4TH QRT	YTD TOTAL
Number of cases opened					
Number of Financial	12	31	56	9	108
Number of Health Plan Standards	13	37	78	73	201
Number of Anti-Fraud	91	6	6	7	110
Number of Other	2	1	0	1	4
Total	118	75	140	90	423
Number of cases closed					
Number of Financial cases closed	13	11	18	32	74
Number of Health Plan Standards closed	15	16	10	67	108
Number of Anti-Fraud	64	30	8	4	106
Number of Other	3	7	0	10	20
Total	95	64	36	113	308
Total number of hours to close cases					
Total number of hours to close all Financial cases	1,294.55	859.7	950.5	1,193.80	4,298.55
Total number of hours to close all HPS cases	1,254.35	996.15	691.85	1,146.75	4,089.10
Number of Anti-Fraud	91.95	135.6	27.4	7.25	262.2
Number of Other*	5,958.45	5,592.95	0.00	2,000.04	13,551.44
Total number of hours to close all cases	8,599.30	7,584.40	1,669.75	4,347.84	22,201.29
Average number of hours to close cases					
Average number of hours to close one case	90.52	118.51	46.38	38.48	72.08
Average number of hours to close one Financial case	99.58	78.15	52.81	37.31	58.09
Average number of hours to close one HPS case	83.62	62.26	69.19	17.12	37.86
Number of Anti-Fraud	1.44	4.52	3.43	1.81	2.47
Number of Other	1986.15	798.99	0	200	677.57
Enforcement Actions					
Number of Accusations Filed	2	1	0	0	3
Number of Assessments Collected	4	1	0	0	5
Number of Cease and Desist Orders	4	4	0	0	8
Number of Conservatorships	0	0	0	0	0
Number of Decisions of the Director	1	0	0	0	1
Number of Denial of Licenses	0	1	0	0	1
Number of Letters of Agreement	6	6	10	32	54
Number of Licenses Surrendered or Revoked	2	1	0	0	3
Number of Miscellaneous Orders	4	1	0	0	5
Number of Statements of Issues	1	0	0	0	1
Number of Stipulated Settlement Agreements	4	1	0	1	6
Number of Other	0	0	0	1	1
Total					88
Aging					
Number of cases open less than 6 months	66	91	182	158	
Number of cases open more than 6 mths, but less than 1 yr	25	15	26	43	
Number of cases open more than 1 yr, but less than 2 yrs	38	25	20	12	
Number of cases open more than 2 years	11	17	24	17	
Total number of open cases	140	148	244	230	

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





Health and Safety Code Sections:

§1371/1371.35: Untimely Claims Payment
§1368: Grievance
§1376/1300.76: Tangible Net Equity (TNE) Deficiencies
§1375.1: Fiscal Soundness
§1367/1300.67: Continuity of Care

Enforcement Statistics for Claims Payment Cases 2003

Health Plan	Fine Collected By Department*	Date Collected	Total Number of Late Paid Claims Paid To Provider**	Total Amount of Late Paid Claims Paid To Provider**	Total Amount of Interest Ordered Paid To Provider**
Cigna HealthCare of California, Inc.	$ 30,000.00	1/29/2003	2,119	$ 3,610,613.51	$ 65,396.94
Human Affairs International of California	$ 5,500.00	4/29/2003	5,042	$ 4,995,748.23	$ 51,281.69
Inter Valley Health Plan	$ 7,500.00	9/8/2003	9,108	$ 11,164,658.18	$ 34,378.12
Molina Healthcare of California	$ 5,000.00	9/16/2003	2,663	$ 174,137.91	$ 131,086.33
One Health Plan of California, Inc.	$ 15,000.00	1/31/2003	16,364	$ 10,863,248.86	$ 132,112.93
Access Dental Plan	$ 5,000.00	10/14/2003	61	$ 191,420.22	$ 1,678.36
Managed Health Network	$ 80,000.00	6/18/2003	66,355	$ 14,704,246.29	$ 248,791.87
Safeguard Health Plans, Inc.	$ 30,000.00	5/9/2003	2,053	$ 390,170.00	$ 27,565.00
ValueOptions of California, Inc.	$ 10,000.00	7/16/2003	4,408	$ 1,109,443.90	$ 30,335.51
Vista Behavorial Health Plans	$ 15,000.00	10/8/2003	5,845	$ 1,174,955.73	$ 20,023.79
Western Dental Services, Inc.	$ 4,000.00	7/25/2003	---***	$ 639,853.00	$ 3,915.00
TOTAL	$ 207,000.00		≅ 114,018	$ 49,018,495.83	$ 746,565.54

* Fines collected by the Department are placed into the Managed Care Fund. If the monies available in this fund exceed the Department's spending authority it will be "rolled over" into the next fiscal year and considered when formulating that year's assessments.
** Late claims paid and related interest are paid to the Provider, not the Department.
***Information unavailable

Assessment Process

For the 2002/03 fiscal year, the health plans were assessed a total of $31.6 million. This is comprised of $20.9 million and $10.7 million in annual and special assessments, respectively. The full-service plans were assessed approximately 51% and the specialized plans 49% of the total assessments.

For the 2003/04 fiscal year, the health plans were assessed a total of $32.9 million. This is 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% and specialized plans pay 35% of the Department's costs and expenses.

Revenue & Expenditures

In addition to the annual assessments of $31.6 million in 2002-03, fines, penalties and miscellaneous collections generated $3.2 million in revenues. Total expenditures were $32.6 million.

In 2003-04, annual assessments were $32.9 million, other revenues are expected to be $1.7 million, and total expenditures are forecast to be $35.8 million. Please see the charts below for additional detail.

Authorized Positions Chart

	2002-03 Fiscal Year	2003-04 Fiscal Year
Budgeted	314.0	274.0

Revenue/Expenditure Chart

	2002-03 Fiscal Year	2003-04 Fiscal Year
Beginning Fund Balance	$3,416,000	$4,052,000
Assessment of HMO	31,599,000	32,929,000
Fines & Penalties	2,116,000	764,000
Other Revenues	1,054,000	948,000
Transfers	-1,500,00	-1,248,000
Total, Resources	36,685,000	37,445,000
Total, Expenditures	32,633,000	35,795,000
Ending Fund Balance	4,052,000	1,650,000
Budget Allocations:		
▪ DMHC	28,115,000	30,366,000
▪ OPA	4,018,000	4,181,000
▪ UC Mandate	500,000	1,248,000
TOTAL	32,633,000	35,795,000

Assessments By Type

Plan Type	Enrollees	Regular	Special/ AB 1996 *	Total	Pct of Total
FY 2003-04	*@ 3/31/03*				
Full Service Plans	21,999,122	$20,559,627	$1,248,054	$21,807,681	66.3%
Specialized Plans	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 Plans	22,201,083	$10,971,576	$5,418,235	$16,389,811	50.9%
Specialized Plans	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 Plans	22,626,166	$11,213,578	$4,746,445	$15,960,023	51.6%
Specialized Plans	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 Plans	21,698,587	$10,812,274	$4,046,758	$14,859,032	53.5%
Specialized Plans	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).

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