

**FOR IMMEDIATE RELEASE**  
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**DMHC announces nearly \$5 million in health plan fines for improper payment of provider claims**

*Settlements to require repayment in millions to health care providers*

**(Sacramento)** – California Department of Managed Health Care (DMHC) Director Cindy Ehnes has announced nearly \$5 million in fines against the seven largest health plans in the state for violations in paying claims to health care providers statewide. These fines, along with restitution to doctors and hospitals, cap an 18-month investigation of claims practices. In addition to penalties, the DMHC has ordered changes to health plans' payment practices.

“Our clear and consistent message is that California’s hospitals and physicians must be paid fairly and on time,” said Director Ehnes at a Los Angeles news conference. “Providers are struggling to stay afloat in a very difficult business environment. Improper payment of provider claims runs the risk that our health care delivery system could grind to a halt. Our audits have found that some health plans may consider their mistakes a ‘cost of doing business’, but public disclosure and penalties change that calculation.”

All seven plans were found to have violated the minimum legal threshold of paying 95 percent of their claims correctly. The audits found that not only did the plan not pay claims accurately, but the second-chance process of getting paid was also often flawed. Five of seven plans were found to violate provider dispute resolution procedures, which is the method that providers must use to protest an underpayment or claims denial and get a corrected payment. This unfairly puts the burden on the provider to fight for payment, either within the plan, through the DMHC or through the courts.

The health plans receiving fines are Anthem Blue Cross for \$900,000; Blue Shield of California for \$900,000; United/PacifiCare for \$800,000; HealthNet for \$750,000; Kaiser Foundation Health Plan for \$750,000; Cigna for \$450,000; and Aetna for \$300,000 for a total of \$4.85 million.

**(more)**

**Department of Managed Health Care**

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“Patients expect health plans to pay claims to doctors and hospitals fairly and promptly so they can get the care they need. Consumers would rather that the time and resources of health providers go to patient care, rather than in fighting to get insurers to pay correctly,” said Anthony Wright, executive director, Health Access California, the statewide health care consumer advocacy coalition. “It’s good the DMHC is using its existing authority to require prompt, fair payment of claims, and that the new federal health law will provide more tools for the overall oversight over insurers.”

The fines are the result of an initiative announced by Director Ehnes in 2009 in response to complaints by providers about unfair and untimely claims payment claims practices. Director Ehnes ordered DMHC financial oversight examiners to conduct simultaneous claims audits of the seven major health plans. Previously, claims payment practices were part of a larger financial examination conducted every three years.

In addition to the repayment of claims owed to providers, health plans are making changes in their payment processes, including dedicating additional staff and resources, providing additional management and oversight and re-vamping entire internal processes to avoid further violations of state law.

Getting the provider paid fairly and on time has been a long-standing priority of Director Ehnes, although not a legislatively-mandated activity of the DMHC. To date, the Provider Complaint Unit, which she established in 2004, has resulted in more than \$22 million in additional payments to providers throughout the state and identified systemic claims violations.

The California Department of Managed Health Care is the only stand-alone HMO watchdog agency in the nation, touching the lives of more than 21 million enrollees. The DMHC has assisted more than 1 million Californians resolve their health plan problems through its Help Center, educates consumers on health care rights and responsibilities, and works closely with health plans to ensure a solvent and stable managed health care system.

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