Annual Health Care Complaint Data Report

Report to the Legislature

Measurement Year 2018

STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Mark Ghaly, Secretary

OFFICE OF THE PATIENT ADVOCATE
Monisha Avery, Acting Director

Statutory Requirement

Senate Bill 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014), added the following provision in law:

Health and Safety Code §136000.

(b)(1)(B) Produce a baseline review and annual report to be made publically available on the office's Internet Web site by July 1, 2015, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:

(i) The types of calls received and the number of calls.

(ii) The call center's role with regard to each type of call, question, complaint, or grievance.

(iii) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.

(iv) The protocol for referring or transferring calls outside the jurisdiction of the call center.

(v) The call center's methodology of tracking calls, complaints, grievances, or inquiries.

(C) (i) Collect, track, and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the office shall submit a report by July 1, 2015, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The format may be modified annually as needed based upon comments from the Legislature and stakeholders.

(ii) For the purpose of publically reporting information as required in subparagraph (B) and this subparagraph about the problems faced by consumers in obtaining care and coverage, the office shall analyze data on consumer complaints and grievances resolved by the agencies listed in subdivision (c), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.

This report is available online at
www.opa.ca.gov/ComplaintsReports/Documents/ComplaintDataReport-2018.pdf

Report data tables are available at
www.opa.ca.gov/ComplaintsReports/Documents/ComplaintDataTables-2018.pdf

Contents

(This Page Left Blank)

Section 1 – Executive Summary

The Office of the Patient Advocate (OPA) is statutorily required to develop and implement an annual multi-departmental Complaint Data Report. The authority and specifications for this public reporting initiative were originally established in AB 922 (Monning, Chapter 552, Statutes of 2011) and further detailed in SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014).

Statute specifies four state reporting entities that are required to provide data to OPA: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and California's state-based Health Benefit Exchange (Covered California).

Complaints in this report include written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer problem or dispute.

- DMHC and CDI reported complaint data from their respective consumer service center divisions.
- Covered California and DHCS reported complaint data from the California Department of Social Services (CDSS) State Fair Hearings Division.

This fifth annual Complaint Data Report catalogs 39,505 consumer health care complaints closed in 2018.

The combined statewide complaint volume from all four entities decreased for the third year (falling from 55,923 in 2016 and 45,375 in 2017).

- DMHC plan enrollment of 26,145,593 enrollees submitted 16,741 complaints, reflecting a decrease of nearly 13 percent from the number of 2017 complaints.
- DHCS program enrollment of 13,292,799 enrollees submitted 5,634 complaints, reflecting a decrease of nearly 15 percent from the number of 2017 complaints.
- CDI plan enrollment of 1,863,604 enrollees submitted 4,370 complaints, reflecting an increase of over 12 percent from the number of 2017 complaints.
    - CDI also submitted 4,493 non-jurisdictional complaints that resulted in a referral to an outside agency or department, an increase of 23 percent from the volume of non-jurisdictional complaints that CDI reported as referred in 2017.
- Covered California plan enrollment of 1,383,693 enrollees submitted 12,760 complaints, reflecting a decrease of nearly 19 percent from the number of 2017 complaints.

Enrollment volumes noted above likely include individuals who are counted more than once because they are enrolled in multiple plan types, such as dental, mental health, vision, and other plan types.

Top five statewide complaint reasons:

1. Denial of Coverage
2. Medical Necessity Denial
3. Cancellation
4. Co-Pay, Deductible, and Co-Insurance Issues
5. Claim Denial

Top five statewide complaint results:

1. Upheld/Health Plan Position Substantiated
2. Withdrawn/Complaint Withdrawn
3. Compromise Settlement/Resolution
4. Insufficient Information
5. Overturned/Health Plan Position Overturned

The order of the top results is not directly associated with order of the top reasons.

The range of time to resolve a complaint varied between reporting entities.

- DMHC – 0 to 167 days (25 days on average)
- DHCS – 0 to 693 days (62 days on average)
- CDI – 0 to 947 days (120 days on average)
- Covered California – 0 to 336 days (48 days on average)

OPA and the reporting entities continue to work to make improvements to standardize the data with fewer unknown data elements. Some of the differences between measurement years may be due to changes in data collection and reporting rather than actual differences in incidence or performance. In addition, differences in complaint systems make direct comparison between the reporting entities inexact for many complaint categories. Because of variances in data collection, analyses about many of the data elements are reported in the respective sections about each reporting entity, rather than aggregated statewide.

Both current and prior year reports are available through the OPA website: https://www.opa.ca.gov/ComplaintsReports/Pages/default.aspx.

Section 2 – Background and Methodology

OPA is statutorily charged under the California Health and Safety Code §136000 with implementation of a multi-departmental complaint data reporting initiative. OPA is required to annually report health care complaint data and related consumer assistance information from four state entities – the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California (collectively called "reporting entities").

This fifth year Complaint Data Report evaluates health care complaints closed January through December 2018 and other information collected from the four state reporting entities about their service centers' 2018 consumer assistance activities. For some categories, OPA also displays data from the 2016 and 2017 measurement years.

DMHC, DHCS, CDI, and Covered California submitted to OPA non-aggregated complaint data through an annual data submission process using standard data categories and elements. Overall consumer assistance volumes, protocols details, and other service center information were reported by the entities through an annual supplemental survey. The 2018 complaint types submitted were:

- **DMHC** – Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse Complaints
- **DHCS** – State Fair Hearings [conducted by the California Department of Social Services (CDSS)]
- **CDI** – Standard Complaints and Independent Medical Reviews
- **Covered California** – State Fair Hearings (conducted by CDSS) and State Fair Hearings: Informal Resolution (referred by CDSS for resolution by Covered California without a hearing)

Although OPA and the reporting entities continue to collaborate to standardize and enhance reporting, it is important to keep in mind that the data presented in this report may provide an imperfect comparison between measurement years, reporting entities, coverage types, and similar categories. Because of the differences in complaint systems, OPA has continued to display many data categories in separate reporting entity sections rather than aggregated statewide.

More information about the report methodology and the glossary of terms are available on the OPA website:
www.opa.ca.gov/ComplaintsReports/Pages/AbouttheComplaintDataReports.aspx.

Section 3 – Statewide Complaint Data

A. Overview

The Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and Covered California serve millions of Californians each year through health care coverage and regulatory oversight programs. These entities provided to OPA data about health care complaints and other information about their consumer assistance service centers, which are the help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by the entity.

This Statewide Complaint Data section provides an overview of the complaints reported to OPA for measurement year 2018. Sections 4-7 have additional information on the individual reporting entities.

It is important to note that the complaints reported by each entity differ significantly due to variances in entity functions, complaint systems, and data availability. OPA urges caution about drawing conclusions when comparing information across entities and coverage sources.

- DMHC reported jurisdictional complaints regarding health plan issues for care delivery and enrollment, as well as some non-jurisdictional complaints it resolved.
- DHCS reported formal State Fair Hearings about Medi-Cal eligibility and about some care delivery issues. Complaints about certain Medi-Cal health plans also were reported by DMHC. Most issues involving Medi-Cal eligibility are addressed at the county level rather than through a State Fair Hearing.
- CDI reported jurisdictional health care complaints about the companies and producers it regulates and non-jurisdictional complaints referred to other entities.
- Covered California reported formal and informal State Fair Hearings about its eligibility determinations and enrollment activities. Its complaints included dual agency appeals involving Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal. Complaints about Covered California health plans, including for health care delivery and certain enrollment issues, were reported by DMHC.

Figure 3.1

2018 Reporting Entity Complaints and Enrollment

Reporting Entity	Number of Complaints	Total Number of Enrollees
DMHC	16,741	26,145,593
DHCS	5,634	13,292,799
CDI	8,863	1,863,604
Covered California	12,760	1,383,693

Note: Due to differences in timing and reporting methodologies, the data in this table may not correspond to data published by the departments in other reports. Direct comparisons across reporting entities are imprecise due to variances in entity complaint and reporting systems. Enrollment volumes likely include individuals who are counted more than once because they are enrolled in multiple plans. CDI's complaint total includes non-jurisdictional case data not reported for years prior to 2017.

B. Statewide Consumer Assistance Centers

The following state service centers reported 2018 consumer assistance data to OPA:

- DMHC Help Center
- DHCS Medi-Cal Office of the Ombudsman
- DHCS Medi-Cal Telephone Service Center
- DHCS Medi-Cal Dental Telephone Service Center
- CDI Consumer Services Division
- Covered California Service Center

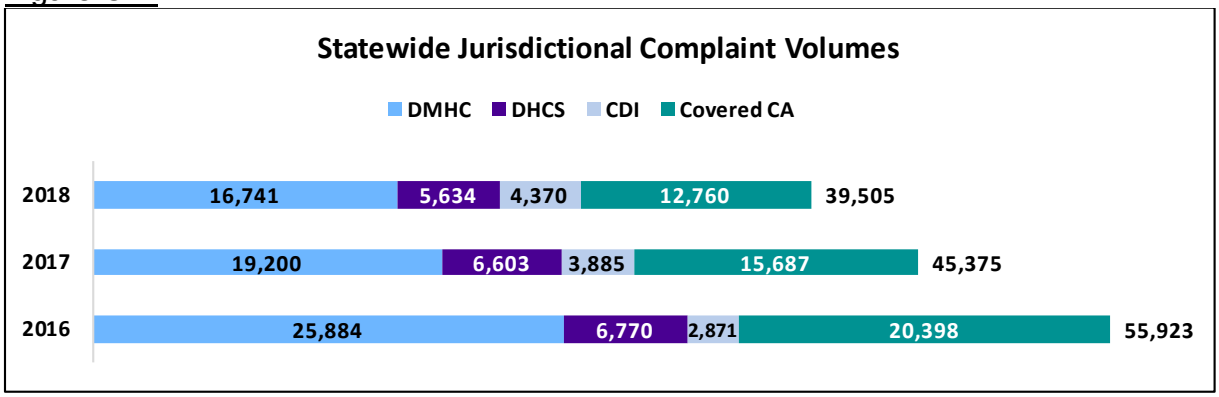
These reporting entity service centers received 6,593,190 requests for assistance from consumers in 2018, continuing a downward trend from the prior two reporting years (7,423,511 requests in 2017 and 7,644,780 in 2016). Most requests for assistance (99.4%) were inquiries from consumers who required information, referrals, or other assistance rather than contacts to initiate a complaint.

Sections 4-7 highlight additional service center data and protocols information. Unless otherwise noted, protocols outlined in prior reports are still applicable. Prior reports are online at www.opa.ca.gov/ComplaintsReports/Pages/AnnualComplaintReports.aspx.

C. Statewide Health Care Complaint Data

The four reporting entities submitted 43,998 consumer complaints to OPA for Measurement Year 2018 (including 4,493 non-jurisdictional complaint records). The statewide jurisdictional complaint volume of 39,505 was nearly a 13 percent decrease in volume from the prior year (45,372 in 2017).

Figure 3.2

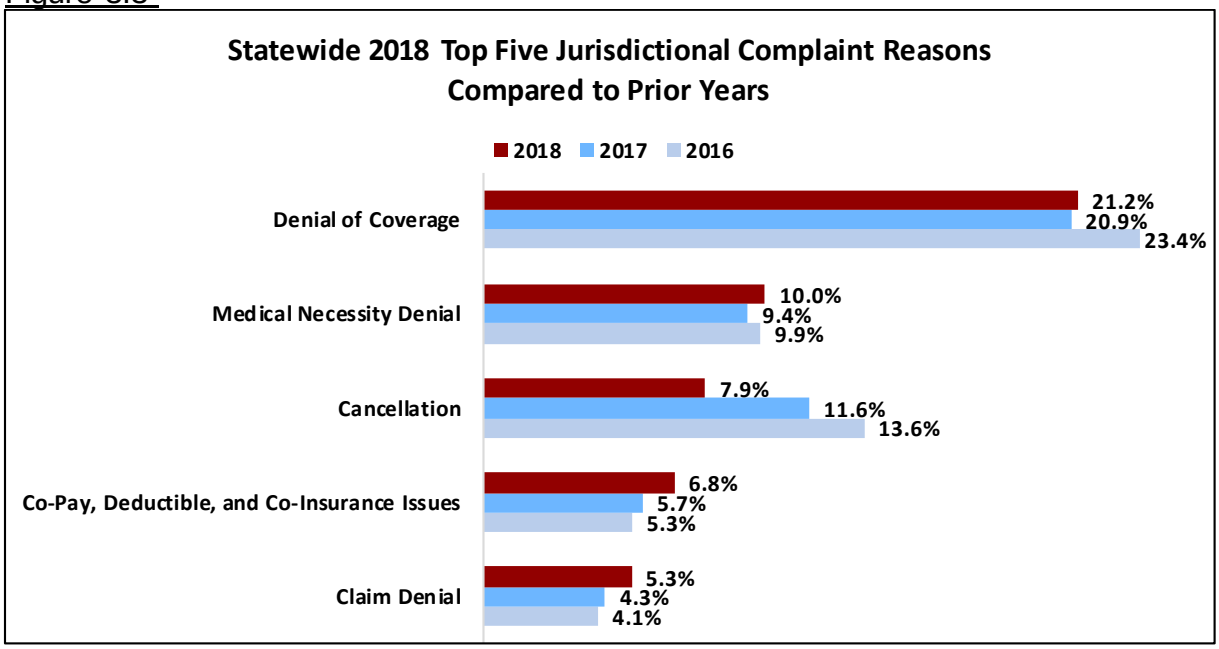


Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution. CDI's reported non-jurisdictional complaint data was excluded from the statewide three-year trend analysis, along with three cases referred by DMHC to outside agencies or departments in 2017.

Complaint Reasons

The following chart displays the most common jurisdictional complaint reasons for 2018, along with the 2016 and 2017 data for those same categories.

Figure 3.3

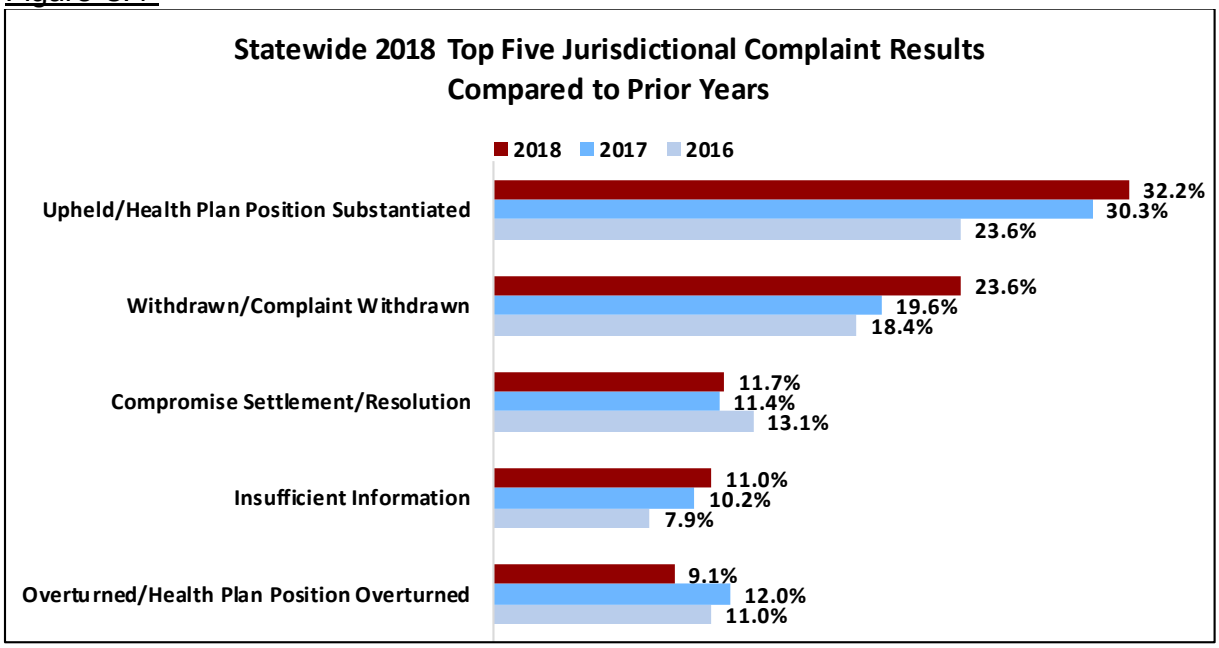


Note: The number of reasons exceeded the number of complaints because some cases had more than one reason (42,545 reasons from 39,505 complaints in 2018). Some differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Complaint Results

The following chart shows the most common jurisdictional complaints results for 2018, as well as the 2016 and 2017 data for the same results categories.

Figure 3.4



Note: The number of results exceeded the number of complaints because some cases had more than one result reported (43,321 results from 39,505 complaints in 2018). Differences between measurement years may be due in part to changes in data collection and reporting rather than incidence.

Resolution Time

The statewide average time to resolve a complaint was 48 days in 2018, two days fewer than the 2017 average. Resolution times are counted from the day a reporting entity opened a complaint from a consumer until the day the reporting entity closed the case.

Figure 3.5
2018 Complaint Resolution Times by Reporting Entity

Reporting Entity	Minimum Duration (in Days)	Maximum Duration (in Days)	Average Resolution Time (in Days)
DMHC	0	167	25
DHCS	0	693	62
CDI	0	947	120
Covered California	0	336	48

Note: The table analysis excludes CDI's non-jurisdictional complaints, which took four days on average to resolve with a referral.

It is important to note that meaningful conclusions about performance cannot be drawn when comparing entity resolution times due to differences in complaint review protocols and tracking systems. For example, a longer duration may be due to:

- A close date reflecting the date additional oversight or enforcement activities were completed rather than when the case was closed to the consumer.
- A tracking system that counts the open date of re-opened complaints as the initial filing date and not the date the case was re-opened.
- A case opened at the initial stage of an overall complaint process, which typically requires more time for gathering information pertinent to the complaint review from the involved parties.

CDI indicated that its 2018 data included a significant number of complaints with outlier durations from cases that were initiated in 2016 and held open during the department's discussions with a health plan, which resulted in a January 2019 settlement agreement.

Demographic and Other Complaint Categories

Sections 4-7 outline additional details about the demographic and other complaint elements submitted by each reporting entity.

Compared to the prior year:

- Statewide complaint volumes decreased for the main source of coverage categories of Group, Covered California/Exchange, Medi-Cal, and Individual/Commercial.
- Due to a decrease in complaints reported as Unknown or Refused, higher percentages of the statewide complaints identified known demographic elements.
- The average age of complainants fell slightly (age 46 in 2017 to age 45 in 2018). Under Age 18 was the only age group with an increase in statewide volume.

- English continued to be the primary language identified for most complainants (83.1%), followed by Spanish (5.3%) and Other Languages (3.1%). The remaining complaints did not have language identified (8.2% Refused or Unknown).

The following table shows the top complaint reasons reported by primary language, along with the percentage distribution among the specified language category.

Figure 3.6

Statewide 2018 Top Five Complaint Reasons by Primary Language

	English (% of English)	Spanish (% of Spanish)	Other Languages (% of Other)	Refused/Unknown (% of Refused/Unknown)
1	Denial of Coverage (21.7%)	Denial of Coverage (39.4%)	Denial of Coverage (28.8%)	Claim Denial (21.1%)
2	Medical Necessity Denial (10.4%)	Eligibility Determination (12.7%)	Cancellation (9.1%)	Pharmacy Benefits (20.2%)
3	Cancellation (8.6%)	Cancellation (9.2%)	Dis/Enrollment (8.5%)	Medical Necessity Denial (9.2%)
4	Co-Pay, Deductible, and Co-Insurance Issues (7.8%)	Medical Necessity Denial (8.6%)	Medical Necessity Denial (6.7%)	Rehabilitative/ Habilitative Care (6.5%)
5	Eligibility Determination (5.0%)	Dis/Enrollment (4.9%)	Scope of Benefits (6.3%)	Scope of Benefits (6.3%)

Section 4 – Department of Managed Health Care

A. Overview

The Department of Managed Health Care (DMHC) regulates 96 percent of enrollment in the commercial and public health care markets in California. DMHC's Help Center provides consumer assistance on health plan issues to ensure that managed care enrollees receive the medical care and services to which they are entitled.

- The Help Center received 147,674 requests for assistance from consumers in 2018, about a 10 percent decrease in volume from the prior year. Requests for assistance include jurisdictional and non-jurisdictional complaints and inquiries.
- DMHC reported 16,741 complaints closed in 2018, a nearly 13 percent decrease from the prior year (19,200 complaints). The 2018 volume includes 16,525 jurisdictional complaints.

Figure 4.1

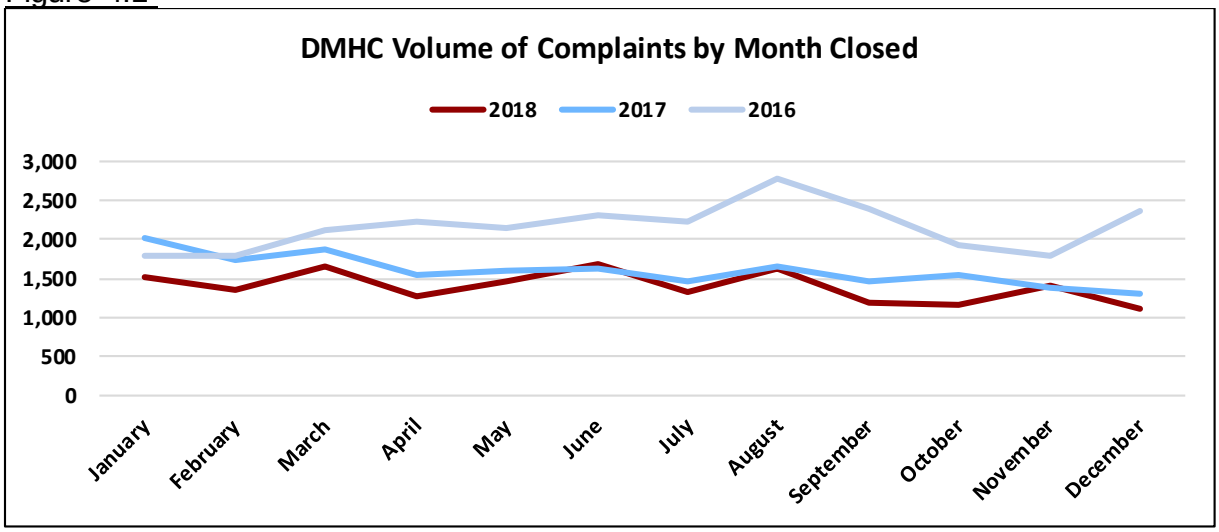
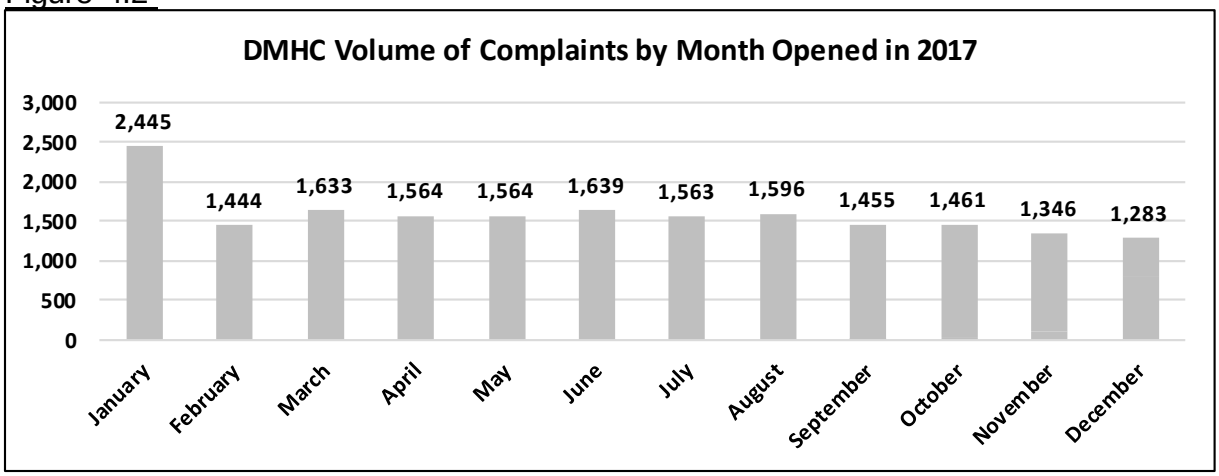


Figure 4.2



Note: A two-year analysis was necessary to capture complaint volumes for cases opened in the winter months of 2017 and closed in the following year (reported in the Measurement Year 2018 dataset).

Most of DMHC's 16,741 complaints closed in 2018 were the Standard Complaint type (72.0%), followed by Independent Medical Review (24.0%), Quick Resolution (3.4%), and Urgent Nurse Case (0.6%).

Figure 4.3
DMHC Help Center Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2018
Standard Complaint	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework Legal Branch: Casework for more complex legal cases	30 days from receipt of a completed complaint application	23 days
Independent Medical Review (IMR)	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework IMR Contractor (MAXIMUS): External Review decision Legal Branch: Legal review if needed	30 days from receipt of a completed IMR application 7 days for cases that qualify for an expedited IMR	32 days Calculation includes time prior to the completion of the IMR application
Urgent Nurse	Contact Center: Intake, initial casework, and routing Independent Medical Review/Complaint Branch: Casework, opens an IMR if an external review is needed	10 calendar days from the receipt of a request for assistance	9 days
Quick Resolution	Contact Center: Intake and casework resolution	10 days	4 days

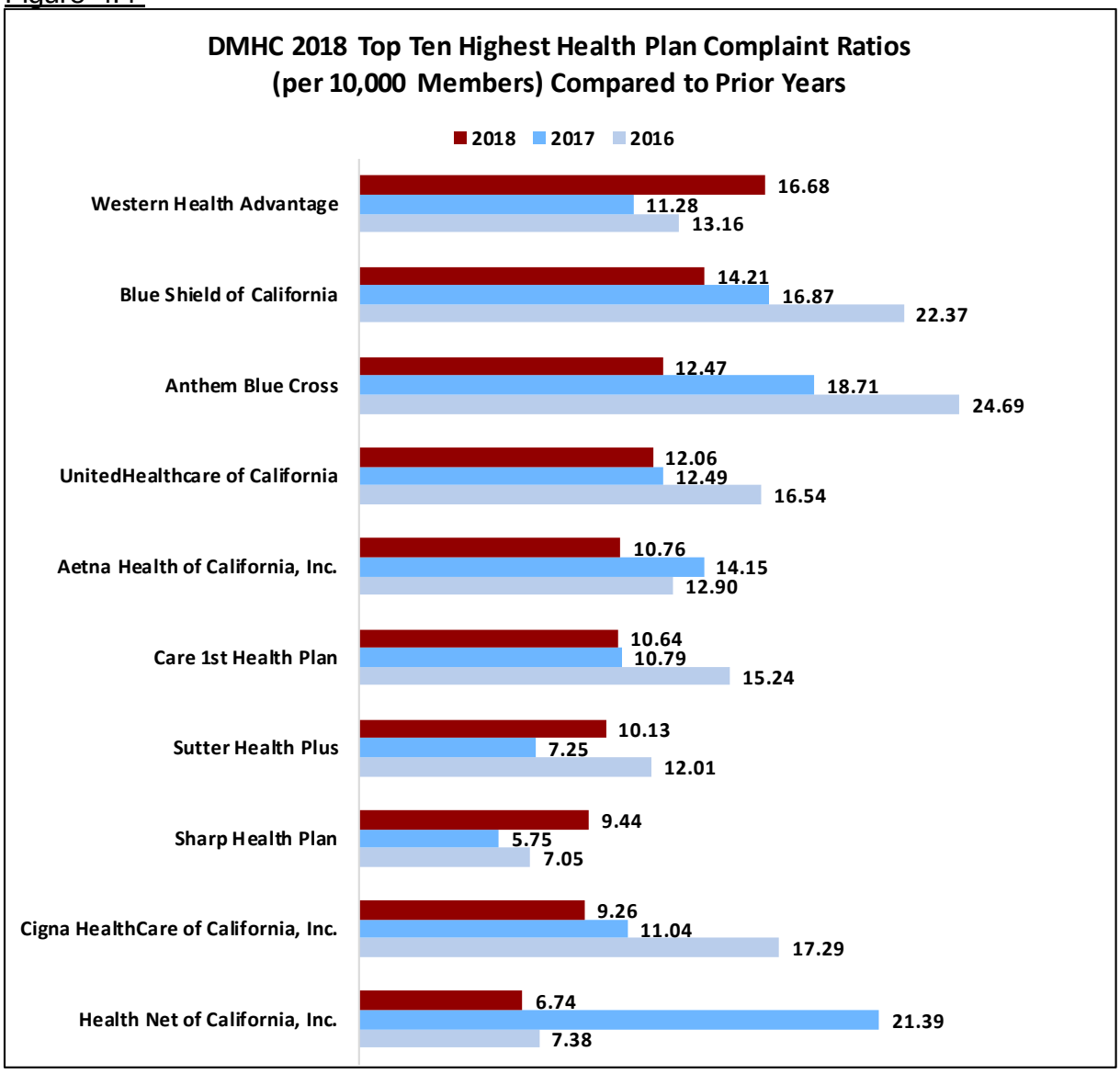
Note: The timeframes for DMHC's time standards are based on the date that DMHC receives a completed complaint/IMR application. Resolution times were counted from the date that any initial information was received from a consumer. DMHC may review complaints involving consumers with urgent clinical issues as Urgent Nurse Case complaints, or through expedited IMR and Standard Complaint processes.

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart shows the full-service health plans regulated by DMHC with the highest complaint ratios in 2018 among plans with enrollment over 70,000 members.

Figure 4.4



Note: Health Net of California, Inc.'s complaint ratios include complaints regarding Health Net Community Solutions.

Complaint Reasons

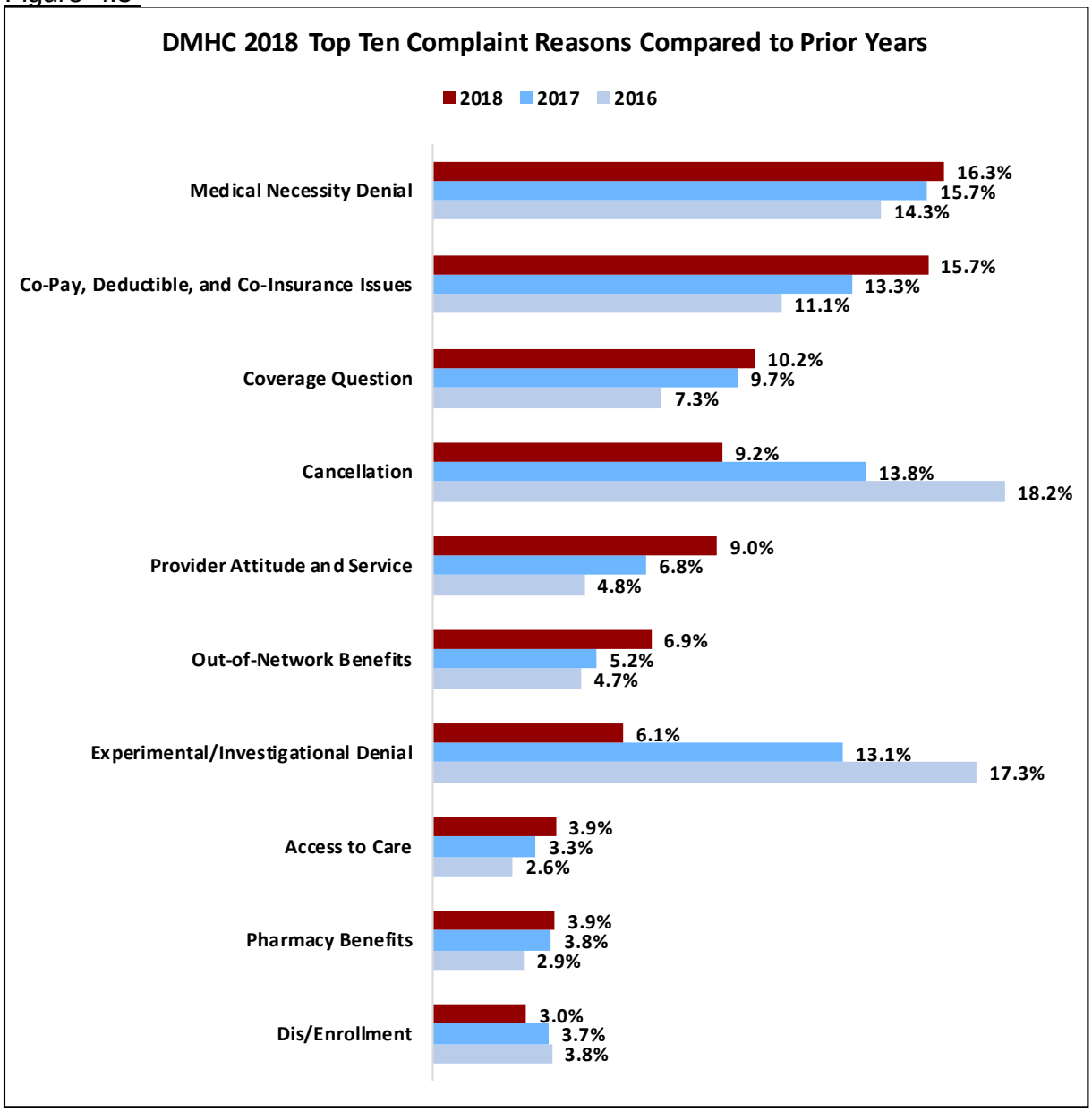
The following chart displays the most common reasons for DMHC complaints in 2018 as well as the 2016 and 2017 data for those same reason categories. The top ten reason categories account for 84 percent of the reported reasons in 2018. Some 2018 cases had multiple reasons reported (17,508 reasons reported from 16,741 complaints).

Some differences between reporting years may be due in part to changes in data collection and reporting rather than changes in incidence.

- Medical Necessity Denial and Pharmacy Benefits decreased in volume compared to the prior year, but showed increases in percentage distribution because other categories had more significant decreases.

- Experimental/Investigational Denial complaints decreased in volume by nearly 58 percent and Cancellation decreased by 39 percent compared to 2017.

Figure 4.5



Inquiry Topics and Referrals

The following table shows the most common topics of inquiries and complaints in 2018 that were outside of DMHC's jurisdiction to address. For each inquiry topic, referral organizations are listed in order of most common referral to least common referral. The volumes shown are only those addressed by DMHC service center staff and do not include certain common calls addressed within DMHC's Interactive Voice Response system, such as automated referrals to particular health plans, Health Care Options, and Covered California.

Figure 4.6

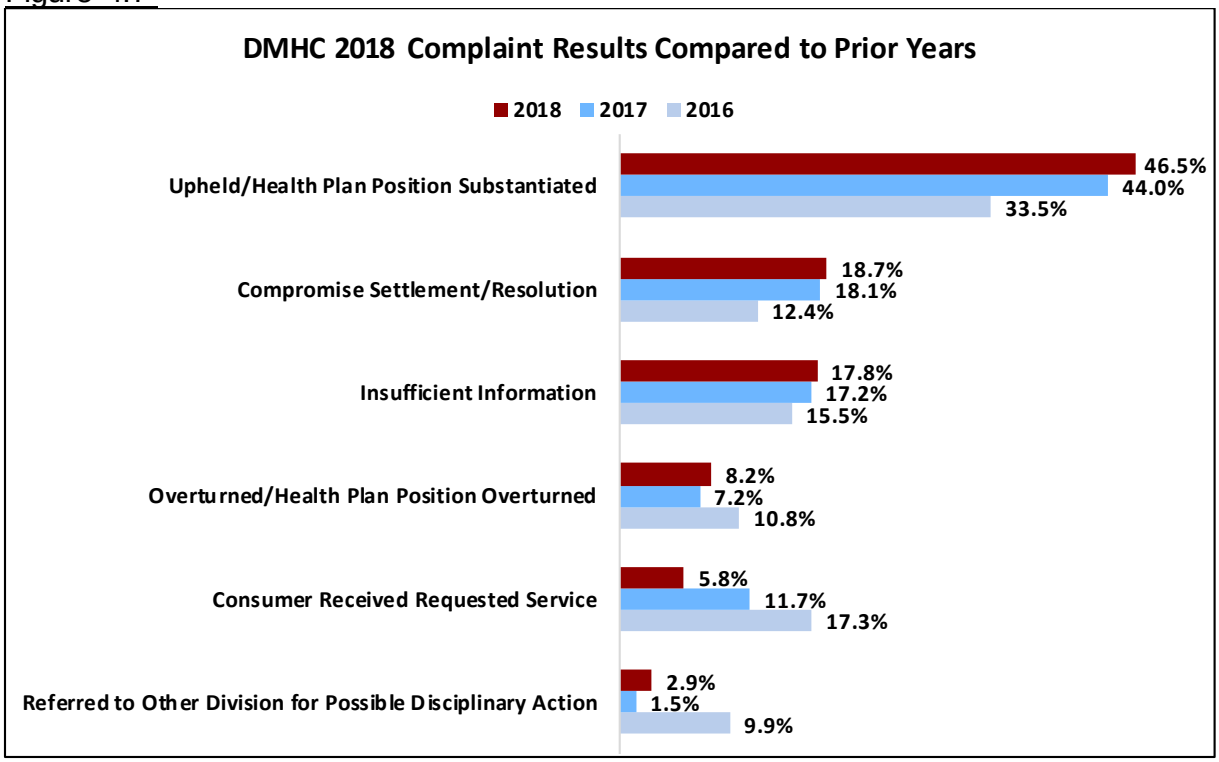
DMHC Help Center 2018 Top Ten Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Volume	Referred To
1 (Most Common)	General Inquiry/ Information	3,666	Department of Health Care Services (DHCS) Covered California Centers for Medicare and Medicaid Services (CMS) Health Insurance Counseling and Advocacy Program (HICAP) California Department of Insurance (CDI) U.S. Department of Labor (DOL) Health Consumer Alliance Partners Out-of-State Department of Insurance (DOI) Department of Consumer Affairs (DCA) Department of Social Services (DSS)
2	Claims/ Financial	383	CDI CMS Out-of-State DOI DHCS HICAP DOL
3	Enrollment Disputes	377	Covered California DHCS CDI
4	Provider Service/ Attitude	240	CMS DCA DHCS
5	Access Complaints	185	DHCS HICAP CMS
6	Coverage/ Benefits Disputes	174	DHCS CMS HICAP CDI
7	Coordination of Care	128	CMS HICAP DHCS
8	Wrong Number	86	Other
9	Plan Service/ Attitude	81	CMS DHCS HICAP
10	Appeal of Denial/ IMR	36	CDI Out-of-State DOI CMS

Complaint Results

The following chart displays DMHC's complaint results in 2018, along with the 2016 and 2017 data for those same results categories.

Figure 4.7



Note: Two results categories with low volumes were excluded from the display. Results categories considered to be favorable to the consumer complainant include: Overturned/Health Plan Position Overturned; Consumer Received Requested Service; Compromise Settlement/Resolution; and Referred to Other Division for Possible Disciplinary Action. Results considered to be favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories shown is neutral or cannot be determined.

The following figures show the 2018 results for DMHC's top three complaint reasons.

Figure 4.8

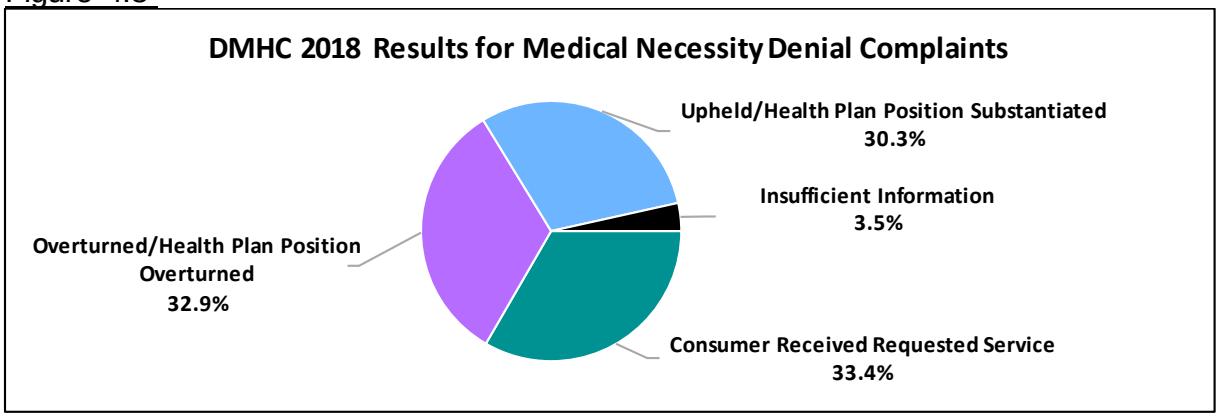


Figure 4.9

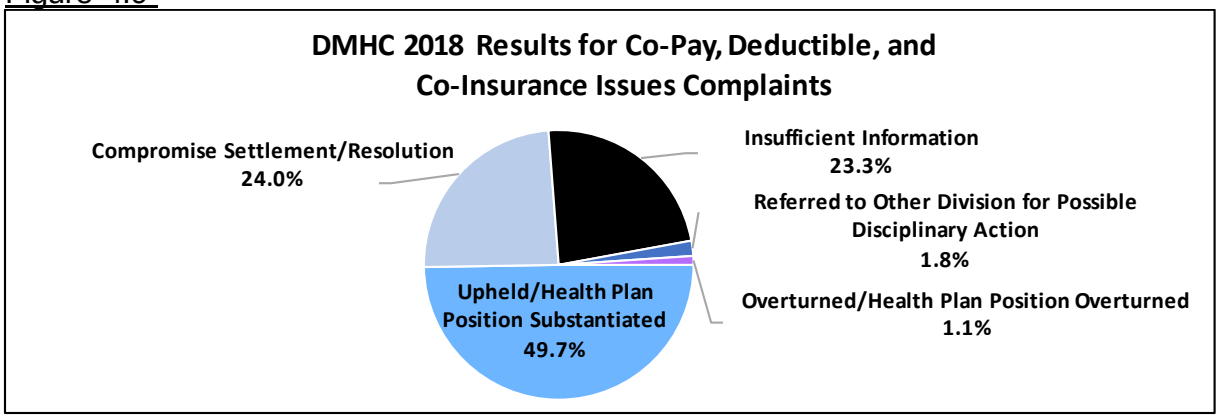
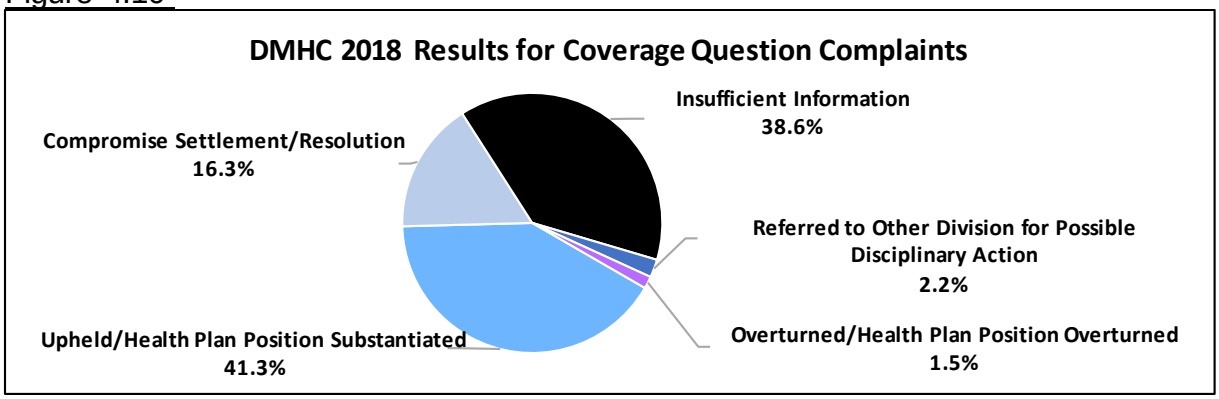


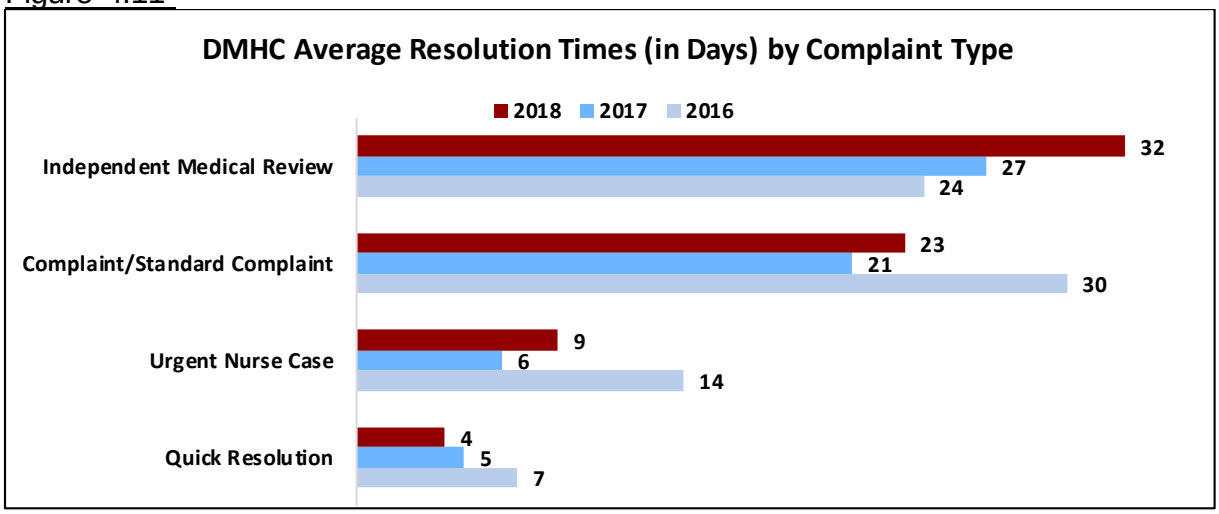
Figure 4.10



Resolution Time

DMHC's average resolution time for its 2018 complaints was 25 days, a three day increase from 2017's average but still below the 2016 average of 28 days.

Figure 4.11



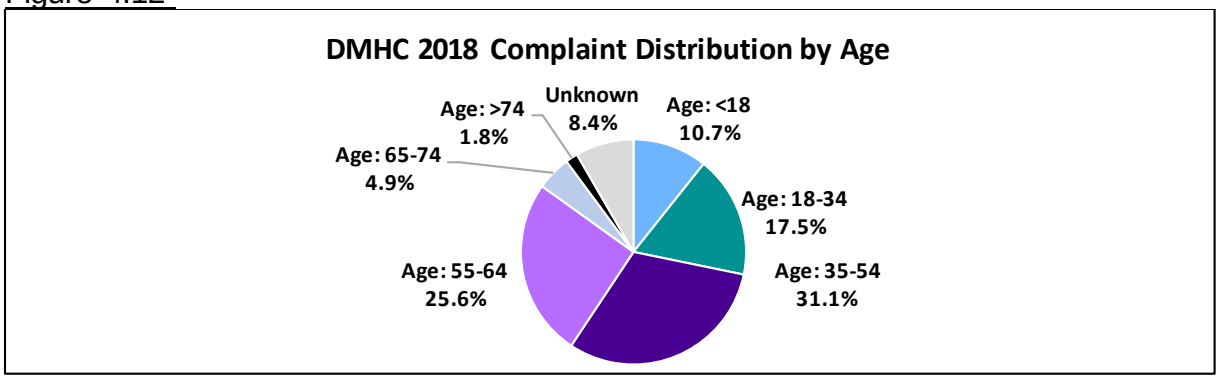
Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint. The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Figures detailing average resolution times include case durations with time prior to the completion of the complaint/IMR application.

C. Demographics and Other Complaint Elements

Age

The average age of DMHC complainants decreased to 44 years in 2018, compared to 46 years in 2017 and 45 years in 2016. All age groups decreased in volume from the prior year except for Under 18 (1,557 complaints in 2017 to 1,792 complaints in 2018).

Figure 4.12



Gender

The complainant's gender was identified as Female for most of DMHC's complaints in 2018 (56.4% of 16,741), followed by Male (42.3%), Unknown (1.1%), and Other (0.2%).

Race and Ethnicity

The number of DMHC complaints with race and ethnicity reported as Refused significantly decreased from the prior year. It is unknown the extent this change affected other known categories. Refused remained the most commonly reported race category (38.3% of the 16,741 complaints in 2018), followed by White (36.8%); Unknown (9.1%); Asian (5.2%); Other (5.2%); Black or African American (3.5%); Other Pacific Islander (1.2%); American Indian or Alaska Native (0.5%); and Native Hawaiian (Under 0.1%). Not Hispanic or Latino remained the most commonly reported ethnicity category (52.6%), followed by Refused (38.3%); Hispanic or Latino (7.1%); and Unknown (2.0%).

Language

DMHC's distribution of complaints by primary language was similar to the prior year, with English identified for most complaints (96.0% of the 16,741 complaints in 2018). Spanish was identified for 2.3 percent of complaints, followed by Mandarin (0.36%) and Other (0.31%). Ten other language categories had at least one complaint reported (each category had low volumes under 0.2%).

Mode of Contact

Nearly half of the complaints were initiated Online (48%), followed by Mail (32%); Fax (15%); Telephone (4%); and Email (2%).

Regulator

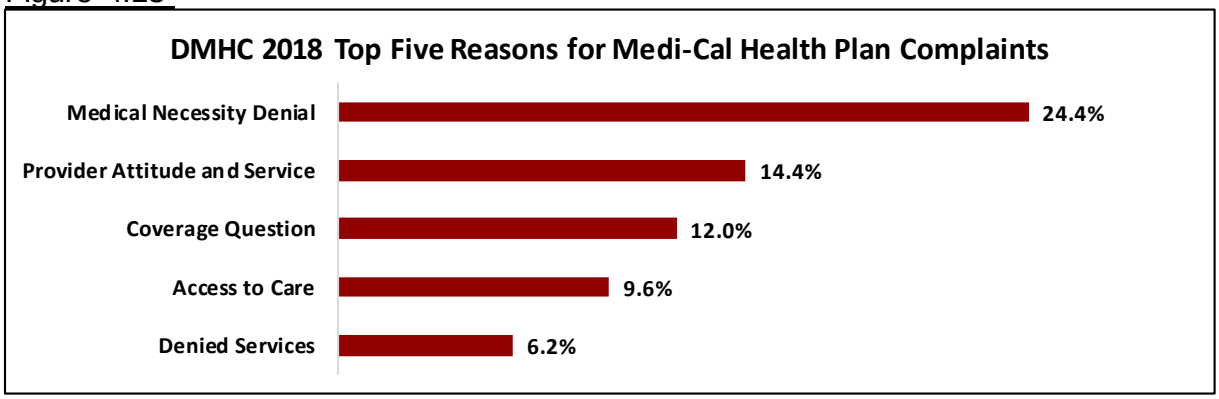
DMHC continued to be the identified regulator for most of its complaints (99% in 2018).

Source of Coverage

DMHC's 2018 distribution of complaints by source of coverage was similar to the prior year. Group was the most common category (46.9% of the 16,741 complaints), followed by Individual/Commercial (19.5%); Medi-Cal (15.0%); Covered California/Exchange (12.4%); Medicare (2.3%); CalPERS (1.6%); and Medi-Cal/Medicare (1.0%). Four other categories reported each had low complaint volumes below one percent.

The following figure shows the most common reasons for Medi-Cal health plan complaints that DMHC closed in 2018. DMHC reported 2,513 complaints with Medi-Cal identified as the source of coverage.

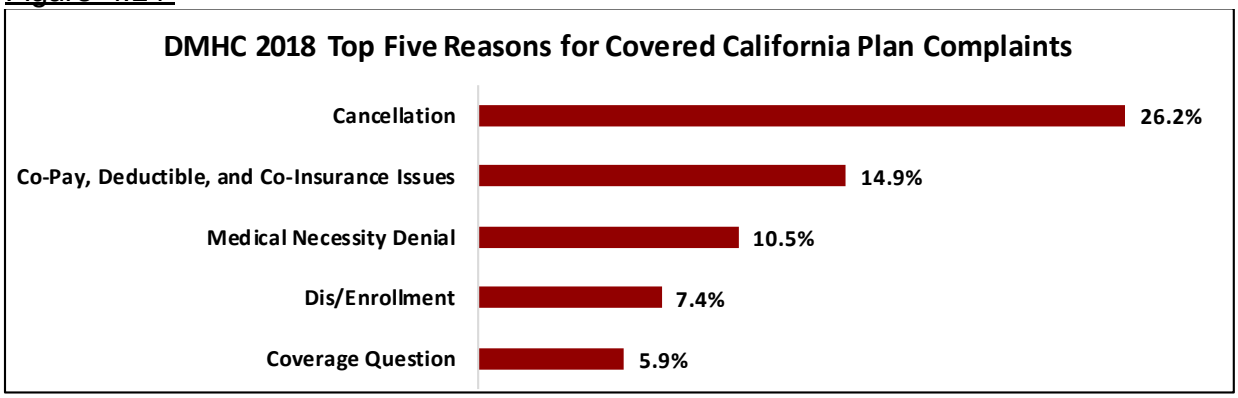
Figure 4.13



Note: The number of reasons exceeded the number of complaints because some Med-Cal plan complaints had more than one reason (2,639 reason entries from the 2,513 complaints in 2018).

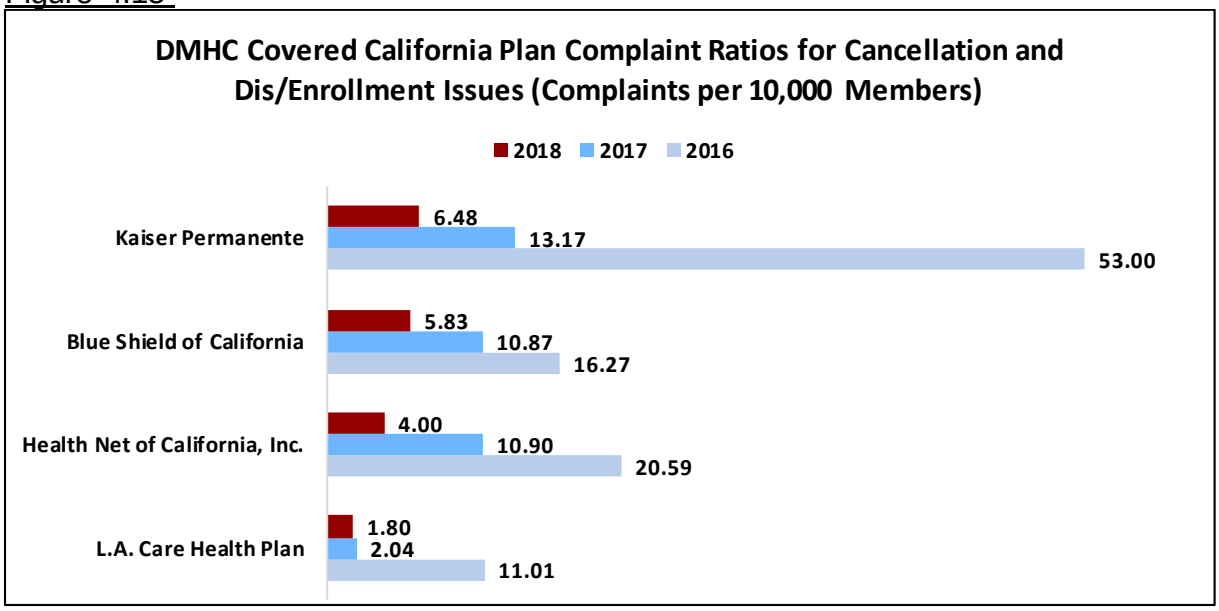
Figures 4.14-4.16 address the complaints DMHC reported with the source of coverage identified as Covered California/Exchange. DMHC regulates most of the health plans offered through the Covered California marketplace. DMHC submitted 2,076 Covered California plan complaints in 2018, a nearly 25 percent decrease from the 2017 volume.

Figure 4.14



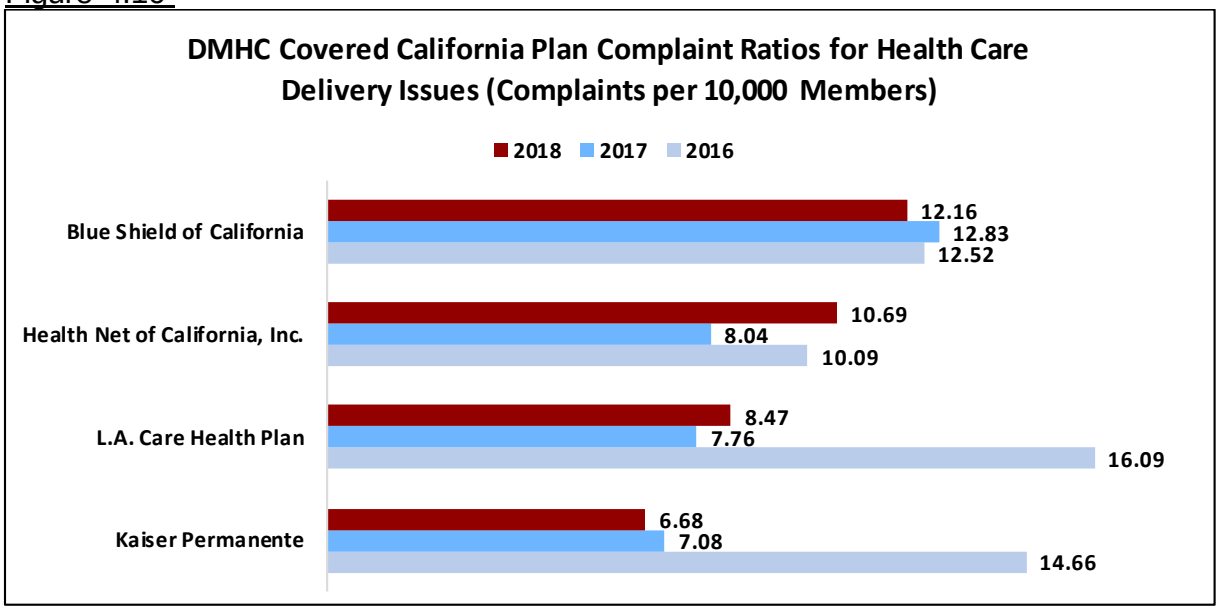
Note: The number of reasons exceeded the number of complaints because some Covered California plan complaints had more than one reason (2,150 reason entries from the 2,076 complaints in 2018).

Figure 4.15



Note: The display excludes health plans with Covered California enrollment under 70,000 members. The ratio was calculated based on the volume of Cancellation and Dis/Enrollment complaints, and excludes complaints for other reported reasons.

Figure 4.16



Note: The display excludes health plans with Covered California enrollment under 70,000 members. Cancellation and Dis/Enrollment complaint reason volumes were excluded from the complaint ratio calculations.

Product Type

DMHC reports health plan models under the product type category. HMO continued to be DMHC's most common product type (61.8% of 16,741 complaints in 2018), followed by PPO (32.7%), EPO (3.4%), POS (1.1%), Unknown (0.5%), and Other (0.5%).

D. Consumer Assistance Center Details

The DMHC Help Center received 147,674 requests for assistance from consumers in 2018, including 125,407 telephone calls.

Figure 4.17

DMHC Help Center 2018 Telephone Metrics

Metric	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative - CSR)	698
Number of Calls Resolved by the IVR/Phone System (caller's needs addressed without involving a CSR)	90,160
Number of Jurisdictional Inquiry Calls	20,651
Number of Non-Jurisdictional Calls	5,357
Average Number of Calls Received per Jurisdictional Complaint Case	0.044 status check calls per complaint case
Average Wait Time to Reach a CSR	0:00:36
Average Length of Talk Time (time between a CSR answering and completing a call)	0:08:31
Average Number of CSRs Available to Answer Calls (during Service Center hours)	13 full-time equivalent agents on average

Note: DMHC's abandoned calls are those that abandon after being queued for a Help Center agent and do not include calls contained within the IVR system.

DMHC noted that the Help Center's IVR phone system provided consumers new options for self-service rather than waiting for an agent to assist, which lead to nearly 75 percent of calls being resolved within the IVR and fewer calls queued for agents in 2018. Implemented in late 2017, the new self-service options contributed to shorter wait times in 2018 (average wait time dropped by one minute 42 seconds) and fewer abandoned calls (nearly 90% decrease from 2017).

Consumer Assistance Protocols

DMHC reported the following updates to Help Center systems, protocols, and standards since 2017.

DMHC's Help Center launched a new Customer Relationship Management system in October 2018 to upgrade and modernize its handling of consumer complaints. The updated system:

- Enhanced technology compatibility and user interfaces.
- Added integrated email messaging tied to complaint cases to reduce the need for faxing and printing and allow the department to go paperless.
- Improved data capture capacity to provide for a more complete view of consumer issues.

Section 5 – Department of Health Care Services

A. Overview

The Department of Health Care Services (DHCS) provides health care coverage and services to Californians with low incomes and disabilities. More than 13 million people receive health care financed or organized by DHCS through the Medi-Cal program.

For this report, DHCS provided complaint data for Medi-Cal issues addressed through State Fair Hearings, a dispute resolution process conducted by the California Department of Social Services (CDSS) State Hearings Division. DHCS also reported data on consumer inquiries made to three consumer assistance service centers: Office of the Ombudsman; Medi-Cal Telephone Service Center; and Medi-Cal Dental Telephone Service Center.

DHCS reported 1,470,325 requests for assistance from consumers in 2018, including 5,634 State Fair Hearings and 1,464,691 inquiries to its three consumer assistance service centers. The 2018 complaint total of 5,634 was the lowest in the last four reporting years and nearly 15 percent lower than the prior year (6,603 in 2017).

Figure 5.1

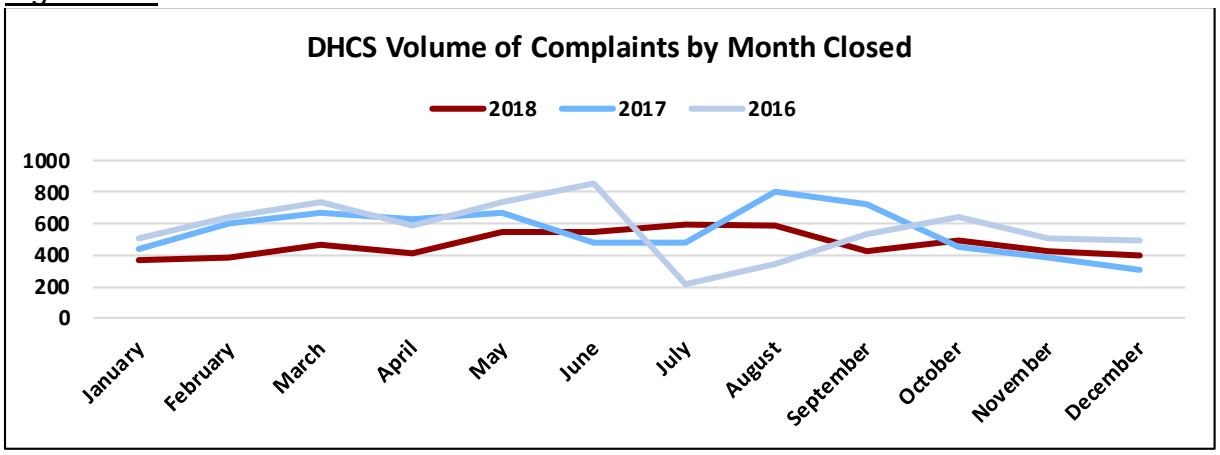
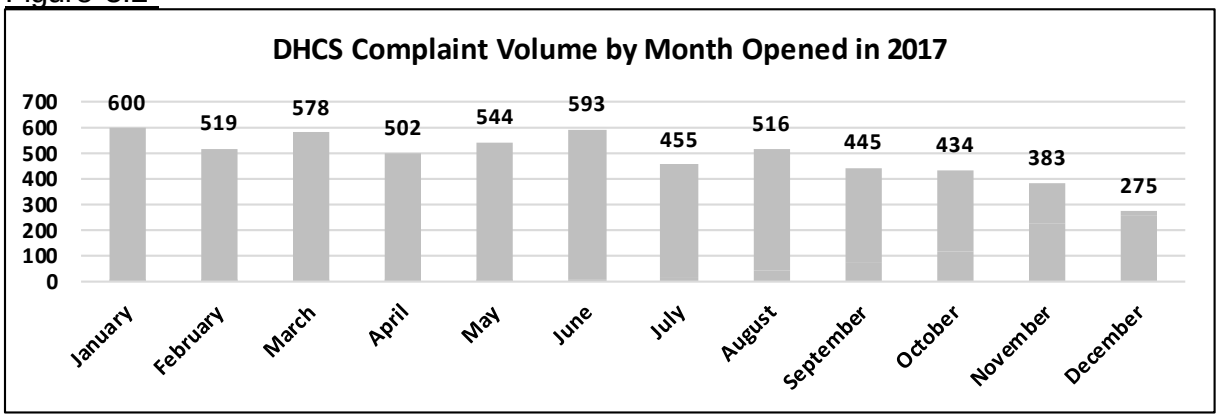


Figure 5.2



Note: A two-year analysis was necessary to capture complaint volumes for cases opened in the winter months of 2017 and closed in the following year (reported in the Measurement Year 2018 dataset).

The following table displays information about the State Fair Hearing process, the complaint type reported by DHCS.

Figure 5.3

Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2018
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions. Urgent clinical issues may qualify for an expedited hearing process.	90 days from the hearing request date	62 days

Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14.

B. Complaint Ratios, Reasons, and Results

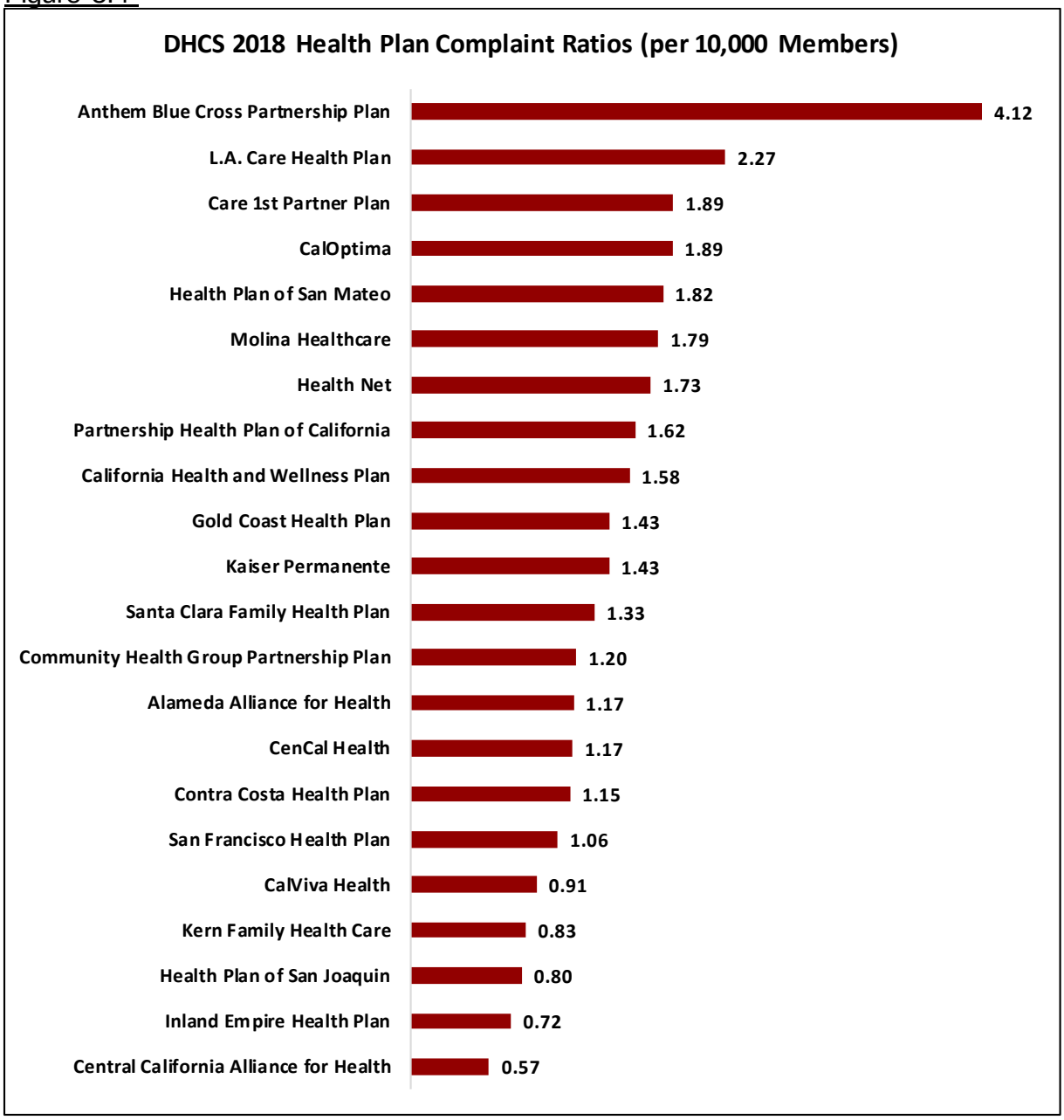
Of the 5,634 complaints reported by DHCS for 2018, nearly 34 percent was for Medi-Cal's dental delivery system, nearly 33 percent involved Medi-Cal managed care health plans, and slightly over 31 percent was for Fee-for-Service Medi-Cal. Other reported delivery systems each accounted for less than one percent of the DHCS complaints. Most Medi-Cal members are in managed care health plans.

Health Plan Complaint Ratios

The following chart displays statewide ratios for Medi-Cal managed care plans of complaints per 10,000 plan members. Each ratio was calculated using the number of plan complaints reported statewide for 2018 and the plan's statewide Medi-Cal enrollment.

Nearly all Medi-Cal managed care plans had lower statewide complaint ratios of State Fair Hearings per member compared to the prior year. DHCS attributes the lower ratios to the change in complaint protocols to require plan grievances prior to a State Fair Hearing. These requirements are outlined in All Plan Letter 17-006, issued by DHCS on May 17, 2017. A plan grievance provides the managed care plan the opportunity to resolve issues before they are elevated to a state-level complaint.

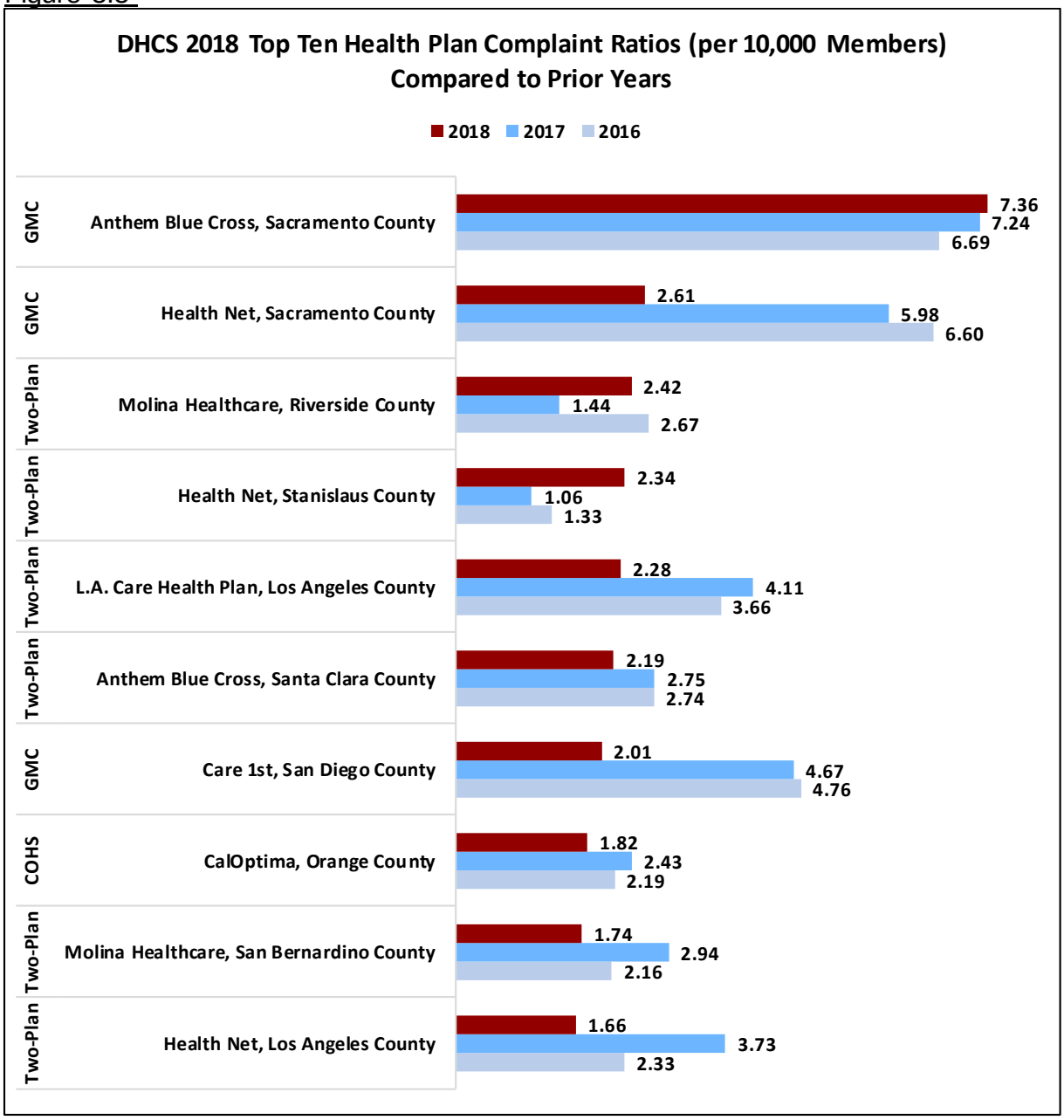
Figure 5.4



Note: Plans with Medi-Cal enrollment under 70,000 members statewide were excluded from the display. Many of the health plans shown on the chart serve multiple counties, including under different Medi-Cal contracting models. DHCS typically monitors quality issues by county contract. Because OPA has used different methodologies and combined data for analysis, the figures in this chart will not directly correlate with reports produced by DHCS.

The following chart displays the Medi-Cal plans with the highest complaint ratios in 2018 per county among those with enrollment over 70,000. The chart also shows the associated Medi-Cal contracting model, including County Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan models. The complaint ratio was calculated using the total number of complaints by county residents against a health plan. This complaint total was divided by 1/10,000 of the health plan's county enrollment for 2018.

Figure 5.5



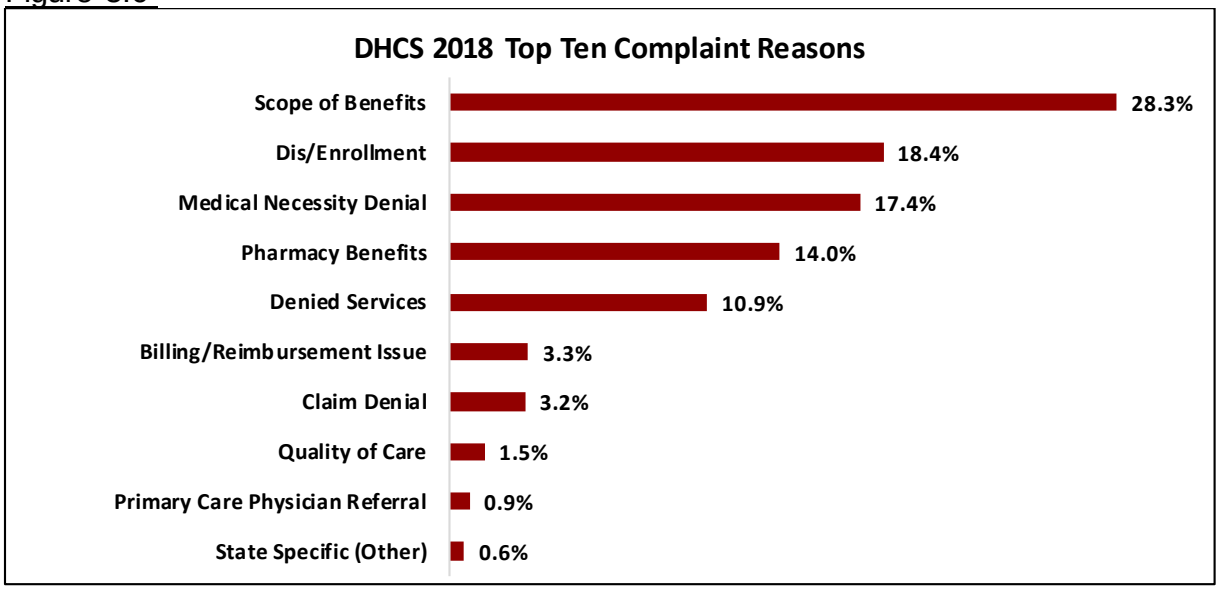
Note: This chart shows the health plans with the highest complaint ratios among plans with county enrollment over 70,000 members in 2018, as well as the ratios for the same plans in 2016 and 2017. The health plans displayed were not necessarily the plans with the highest complaint ratios in the prior years.

Complaint Reasons

Differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence. For example, some issues DHCS reported under Quality of Care in 2017 were categorized under other complaint reasons in other years.

The following chart displays the top complaint reasons in 2018 for all DHCS delivery systems. The total number of complaint reasons reported by DHCS exceeded the number of complaint cases because some cases had more than one reason reported.

Figure 5.6



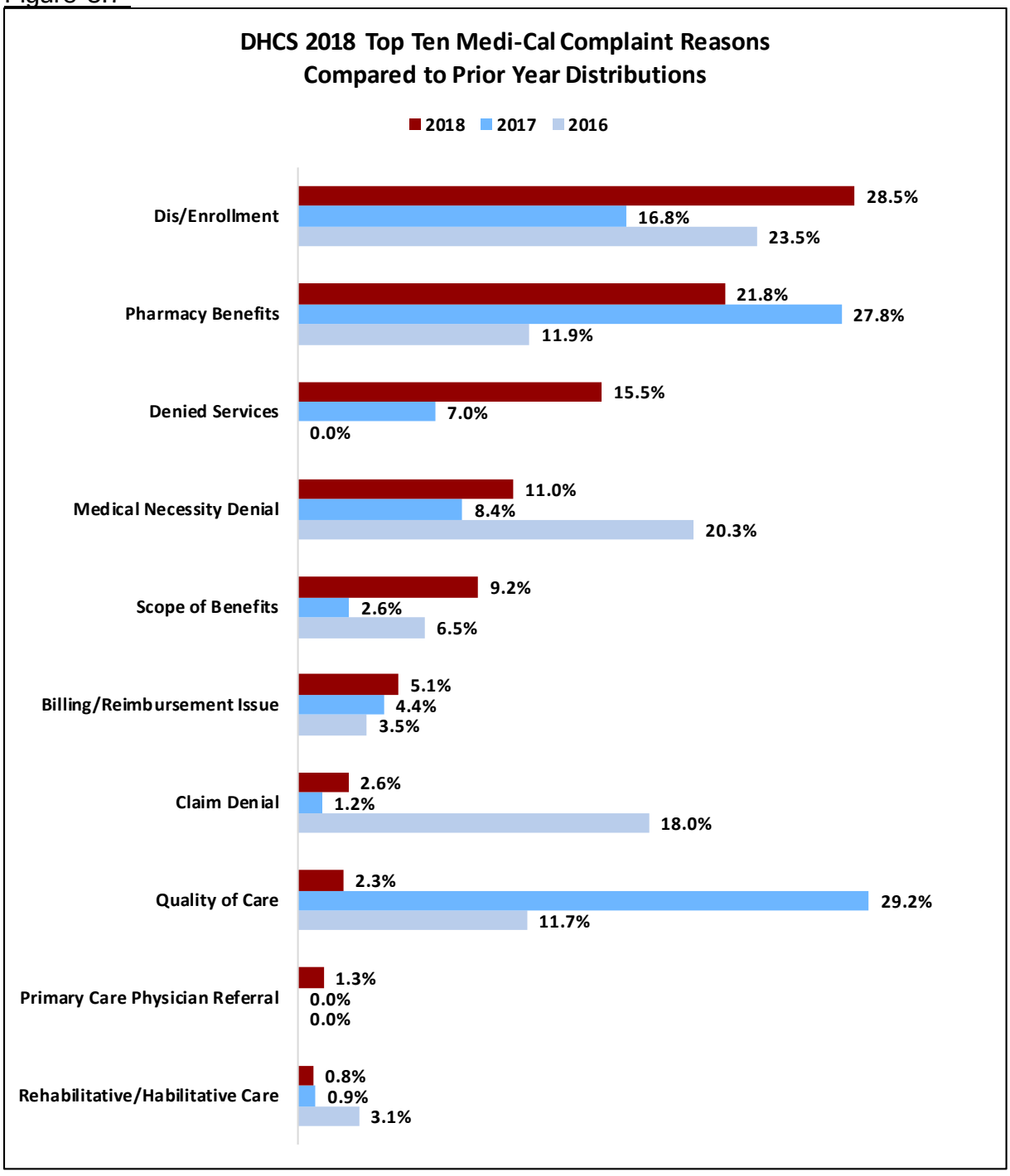
The top complaint reasons by DHCS delivery system (with each top reason's distribution among the specified delivery system):

- **Managed Care** – Dis/Enrollment (33.2%)
- **Fee-for-Service** – Pharmacy Benefits (44.9%)
- **Dental** – Scope of Benefits (66.1%)
- **Mental Health** – Denied Services (66.7%)
- **Long Term Care** – Claim Denial (32.1%)
- **Medi-Cal Coordinated Care** – Denied Services (53.1%)
- **Breast and Cervical Cancer Program** – Scope of Benefits (100%)

DHCS noted that an increase in Denied Services complaints is associated with quality improvement efforts and the March 2018 issuance of Mental Health and Substance Use Disorder Services Information Notice No. 18-10E, which outlined grievance and appeals processing requirements. This affected issuance of Notices of Action and grievance and appeals rights information provided to beneficiaries receiving mental health plan services. DHCS indicated that the vast majority of associated hearing requests were withdrawn by the complainant or referred to the Mental Health Plan under new grievance and appeals requirements.

The following chart shows the 2018 top complaint reasons for Medi-Cal Managed Care and Fee-for-Service, as well as the 2016 and 2017 data for those same reasons.

Figure 5.7



Inquiry Topics and Referrals

The following figure displays the most common inquiry topics consumers contacted DHCS's service centers about in 2018, as well as the department or other service center the consumers were referred to about each topic.

Figure 5.8

DHCS 2018 Service Centers' Top Topics for Non-Jurisdictional Inquiries

Office of the Ombudsman Ranking	Inquiry Topic	Referred To	Volume
1 (most common)	Medi-Cal Eligibility	County Social Services Office	52,310
2	Fee-for-Service	DHCS Medi-Cal Telephone Service Center	8,425
3	Health Care Options	Health Care Options	6,005
4	Medicare	1-800 Medicare	4,479
5	Covered California	Covered California	3,349
6	Mental Health	County Mental Health	2,127
7	Dental	Medi-Cal Dental Program	1,745
8	State Fair Hearings	California Department of Social Services	1,406

Note: The Office of the Ombudsman table includes inquiry volumes because its ranking was based on collected data.

Medi-Cal Telephone Service Center Ranking	Inquiry Topic	Referred To
1 (most common)	Beneficiary Inquiry/Eligibility	County Social Services Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Medi-Cal Dental Program
4	Beneficiary Inquiry/Eligibility	Medicare
5	Beneficiary Inquiry/Coverage	Pharmacy
6	Beneficiary Inquiry/Coverage	Medicare Part D
7	Beneficiary Inquiry/Coverage	Other Coverage
8	Provider Application Status	Provider Enrollment
9	Beneficiary Inquiry/Coverage	Low Income Subsidy
10	Technical Issue	Vendor

Note: The Medi-Cal Telephone Service Center ranking was estimated by DHCS.

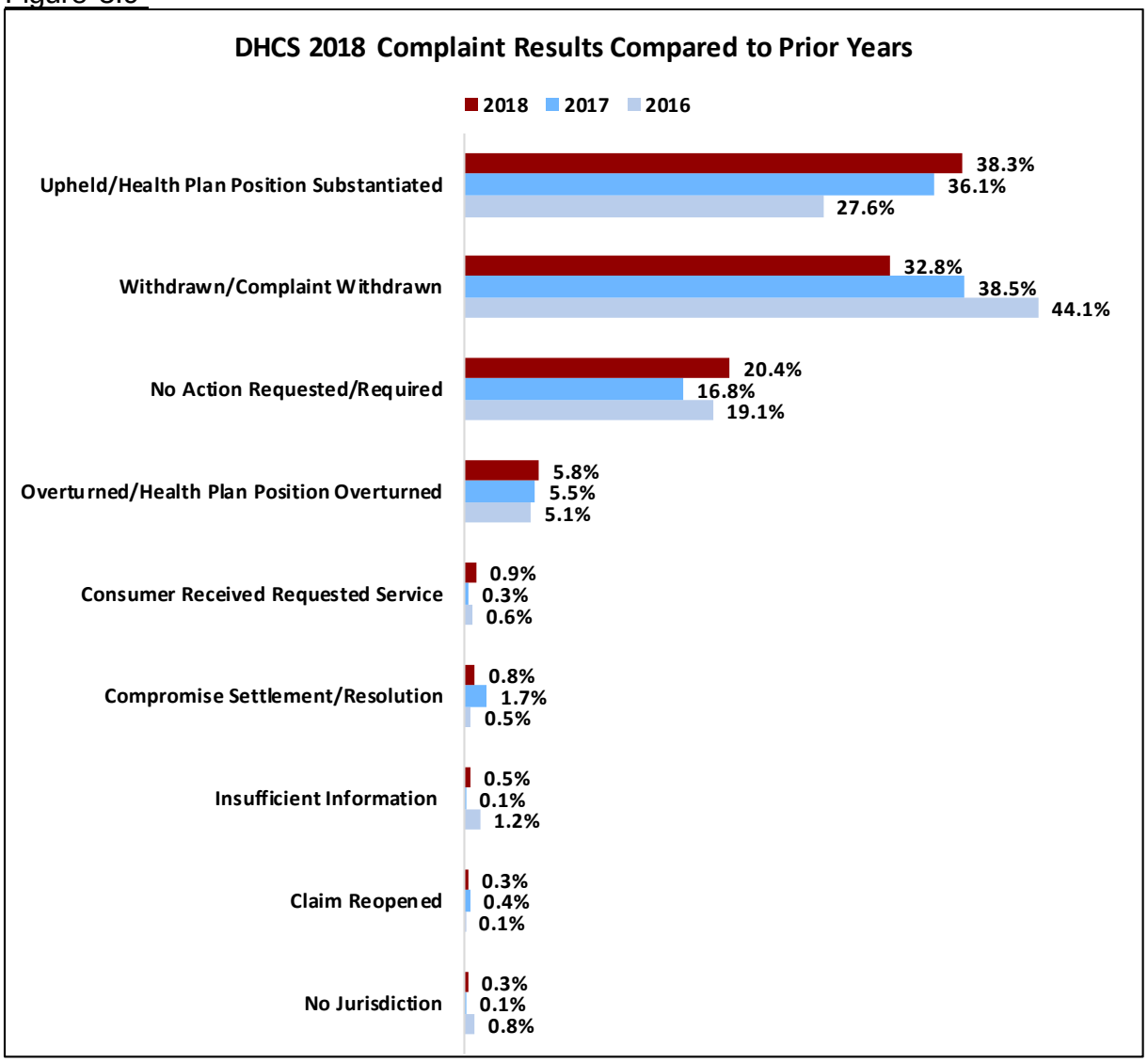
Medi-Cal Dental Telephone Service Center Ranking	Inquiry Topic	Referred To	Volume
1 (most common)	Complaints against office (non-treatment)	California Dental Board	1,244
2	Share of Cost or ID Card	County Social Services Office	612
3	Eligibility	County Social Services Office	195
4	Benefits	County Social Services Office	31
5	Referrals	Managed Care Plan of Record Health Care Options	N/A
6	Other Health Coverage	County Social Services Office	N/A

Note: The Medi-Cal Dental Telephone Service Center's top four inquiry topics were determined based on data collected through a new Customer Relationship Management system. The other topics were estimated based on service center staff feedback.

Complaint Results

The following chart displays the percentage distributions of all complaint results reported for 2018 compared to prior years' distributions. There were more 2018 results (5,712) than complaint cases (5,634) because some cases had more than one result.

Figure 5.9



Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Consumer Received Requested Service, and Compromise Settlement/Resolution. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan, but indicates that the consumer received services or a similar positive outcome. For DHCS, the category No Action Requested/Required indicates that the case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.

Although its volume decreased by nearly nine percent from 2017 to 2018, Upheld/Health Plan Position Substantiated replaced Withdrawn/Complaint Withdrawn as the top complaint result. Withdrawn/Complaint Withdrawn decreased in volume by 27 percent over the same period.

The following charts display the results for the three most common complaint reasons reported for 2018: Scope of Benefits, Dis/Enrollment, and Medical Necessity Denial. The reason-to-result analysis counted dual results reported for a case as a single combined result category.

Figure 5.10

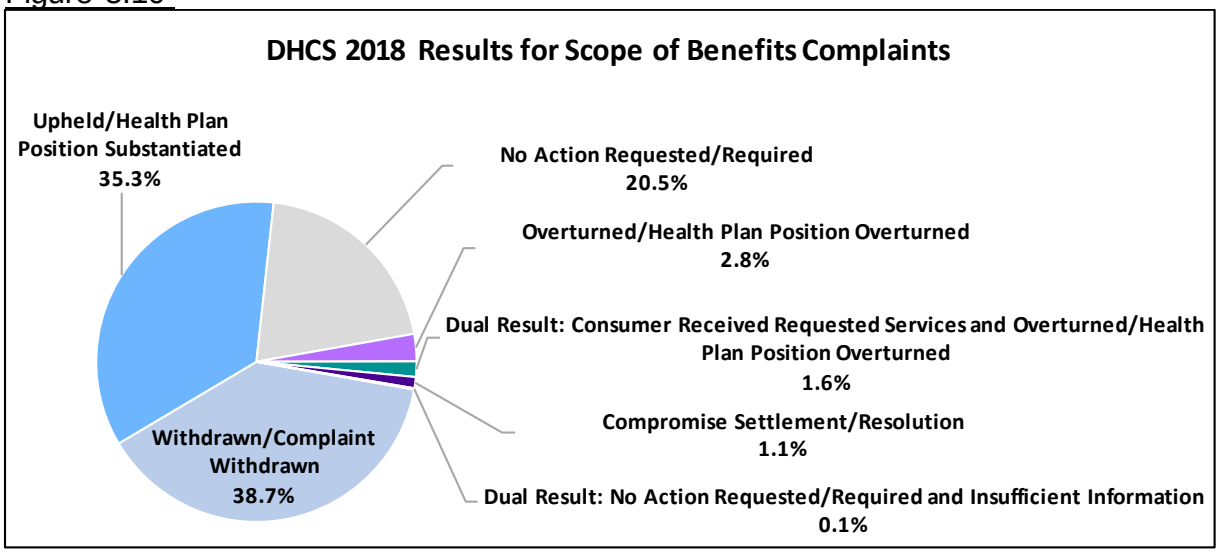


Figure 5.11

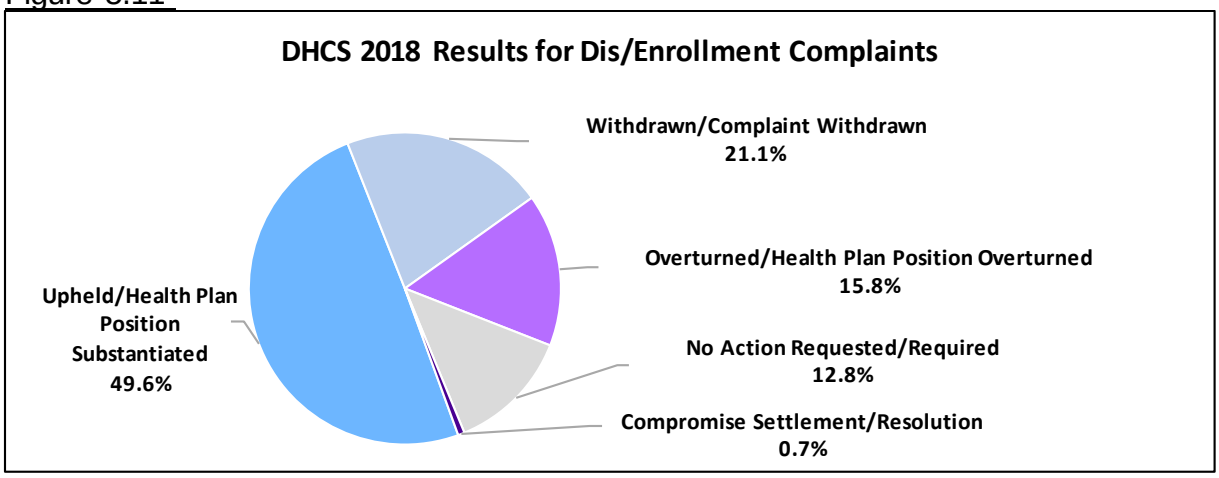
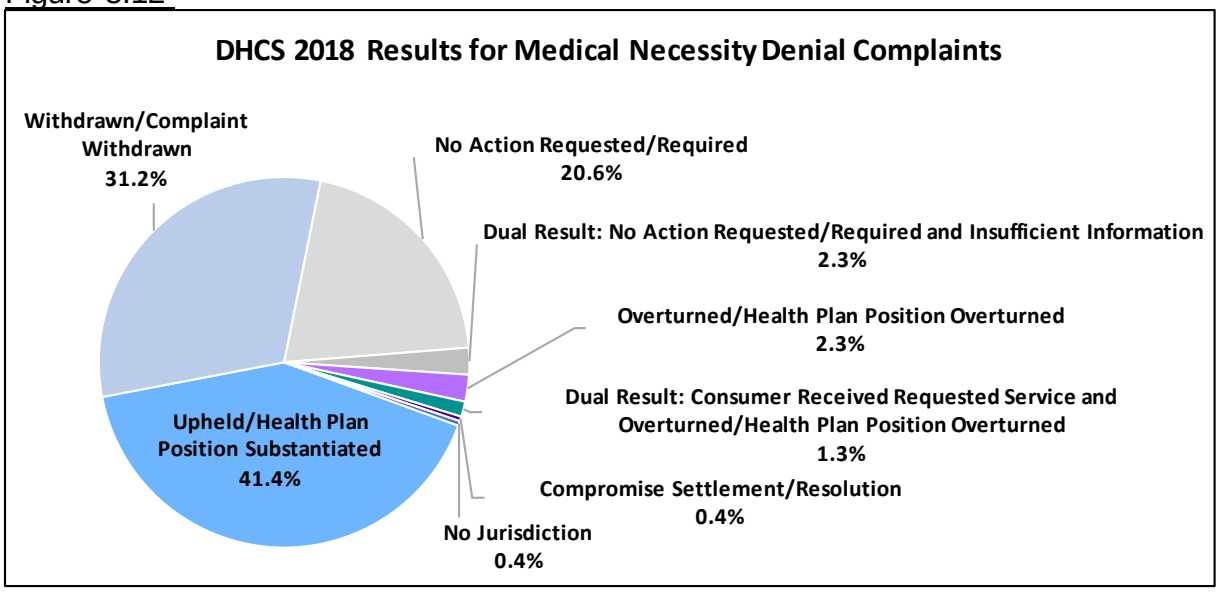


Figure 5.12



Resolution Time

The 2018 State Fair Hearings reported by DHCS took 62 days on average to resolve, a decrease of 17 days from the 2017 average. The overall annual average resolution time has dropped each year since 2015.

The 2018 average resolution times by DHCS delivery system:

- Mental Health - 89 days
- Managed Care - 78 days
- Medi-Cal Coordinated Care - 78 days
- Long Term Care - 72 days
- Fee-for-Service - 58 days
- Dental - 50 days

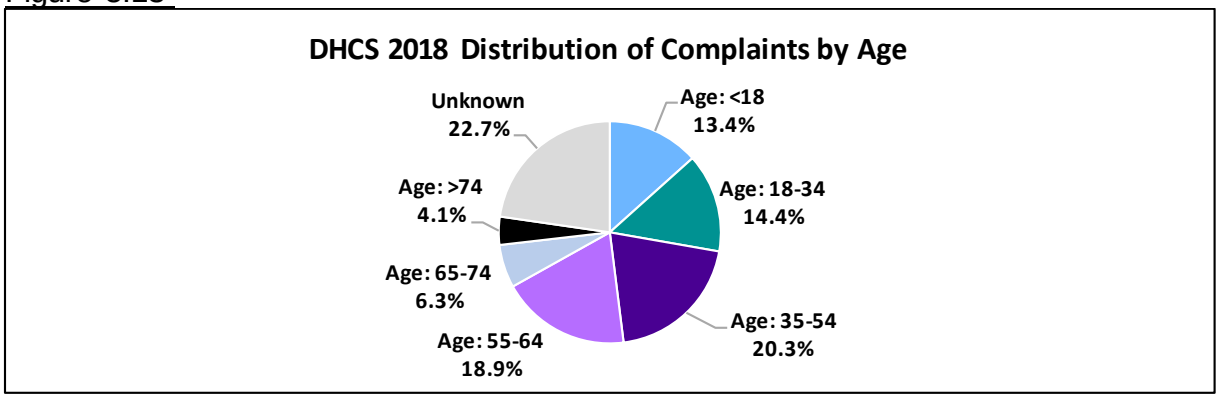
C. Demographics and Other Complaint Elements

Differences in findings between measurement years are likely due in part to changes in data collection and reporting rather than incidence. DHCS resumed reporting in 2018 of some categories of demographic data for complainants enrolled in Medi-Cal Managed Care that were not available for the 2017 report.

Age

The average age of complainants dropped slightly from 44 years in 2017 to 43 years in 2018. Complaint volumes decreased for most age groups, with the exception of the Under 18 (3% increase) and Age 75 and Older (14% increase) age groups.

Figure 5.13



Gender

The complainant's gender was identified as Female for over 46 percent and as Male for nearly 32 percent of the 5,634 complaints in 2018. Approximately 22 percent of cases were reported as gender Unknown. The distribution of complaints by gender was similar to the prior year.

Race and Ethnicity

Significantly more complaints had race and ethnicity identified than the prior year. It is unknown the extent that the increased identification affected increases in each of the known race and ethnicity categories.

- Refused/Unknown continued to be the most common reported race category (41.0% of the 5,634 complaints in 2018), followed by White (38.4%), Black or African American (10.8%), Other (4.7%), Asian (3.2%), Native Hawaiian or Other Pacific Islander (1.7%), and American Indian or Alaska Native (0.2%).
- Not Hispanic or Latino was the most common ethnicity category (42.5% of the 5,634 complaints in 2018), followed by Refused/Unknown (39.4%) and Hispanic or Latino (18.1%).

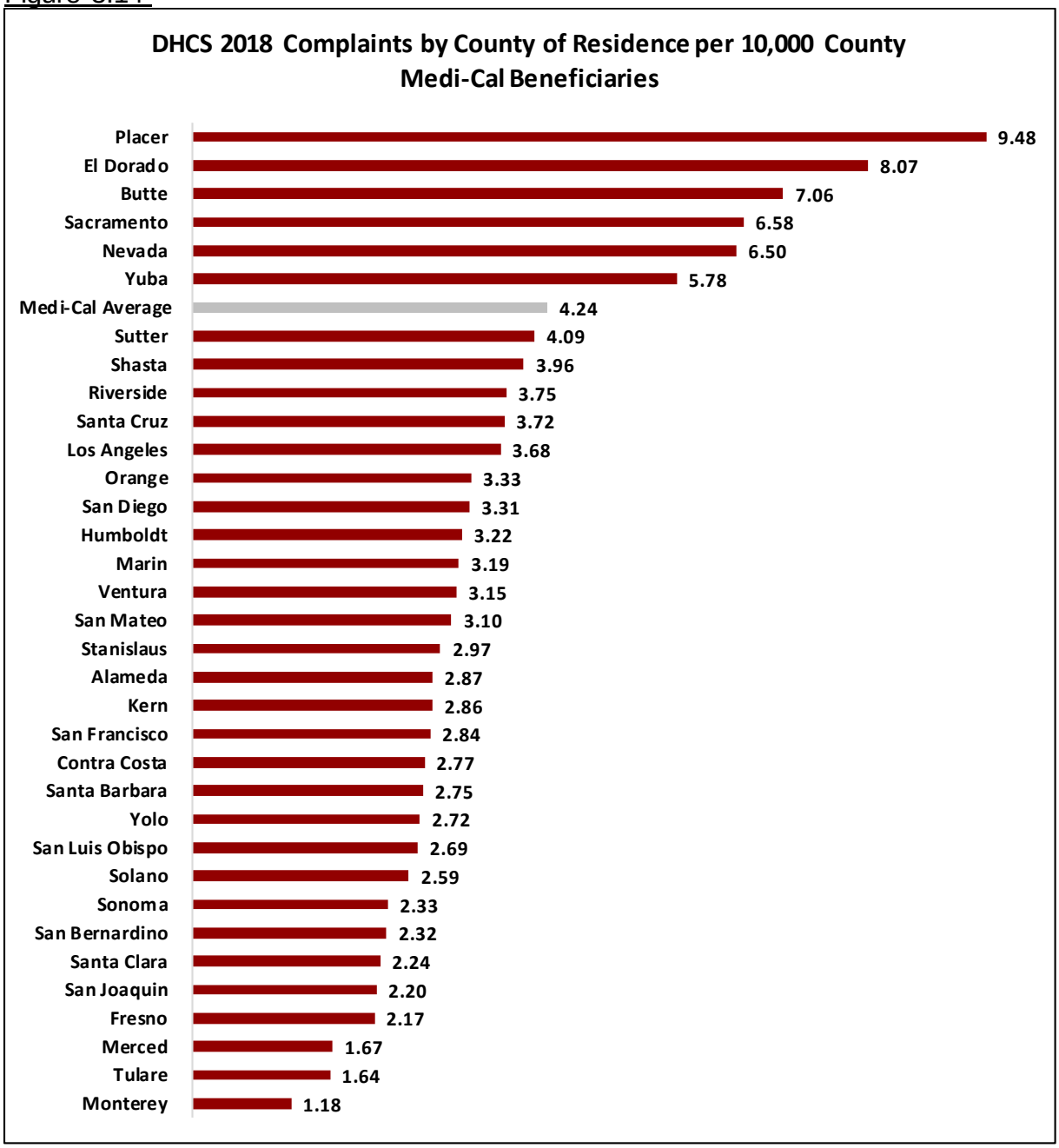
Language

Significantly more complaints had primary language identified than the prior year. It is unknown the extent that the increased identification affected increases in the known language categories. English was the most commonly reported language (62.4% of the 5,634 complaints in 2018, followed by Spanish (6.9%) and Other languages (5.4%). Approximately one-fourth of the complaints did not identify a language (25.5% Unknown/Refused).

County of Residence

The following chart displays ratios based on the county's 2018 volume of complaints divided by the number of Medi-Cal beneficiaries who reside in the county. The ratios were then calculated per 10,000 beneficiaries. Significantly more complaints had county of residence identified as Unknown than the prior year. It is unknown the extent that the decreased identification affected complaint volumes reported for each county.

Figure 5.14



Note: Twenty-four counties with complaint volumes under 11 and/or Medi-Cal enrollment under 10,000 were excluded from the display.

Mode of Contact

Mail was the most commonly identified known mode of contact to initiate a complaint (31.8% of the 5,634 complaints in 2018), followed by Telephone (26.3%) and other modes (under 1%). Approximately 42 percent of complaints were Unknown as to the initial mode of contact.

Regulator

Most (65.2%) of the 5,634 complaints in 2018 identified Other as the regulator. DMHC was identified for 34.5 percent. The remaining cases were Unknown.

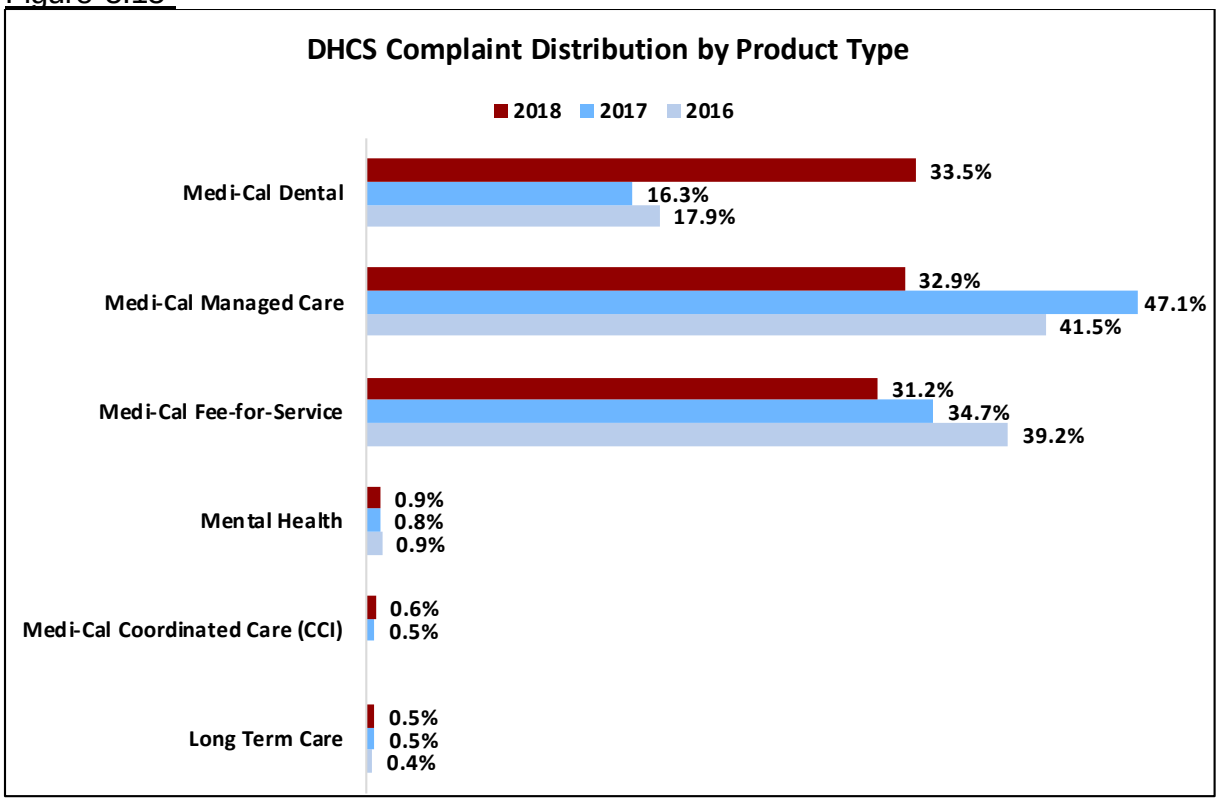
Source of Coverage

Medi-Cal continued to be the source of coverage identified for nearly all of the DHCS complaints (99.0% of the 5,634 complaints in 2018). One percent identified Medi-Cal/Medicare as the source of coverage.

Product Type

DHCS identified health care delivery systems under the product type category.

Figure 5.15



Note: The chart excludes the following categories with low reported volumes in 2018 (under 0.5%): Breast and Cervical Cancer Treatment Program and State Specific (Other).

D. Consumer Assistance Center Details

DHCS service centers' consumer requests for assistance are categorized as inquiries, as these service centers offer guidance and referrals rather than complaint resolution determinations. DHCS reported 1,464,691 inquiries to its three service centers in 2018.

Consumer Assistance Volumes by Service Center

- The Office of the Ombudsman continued to experience a decrease in annual inquiry volumes, with 199,709 consumer inquiries reported for 2018 (compared to 228,946 in 2017).
- The Medi-Cal Telephone Service Center volume increased nearly 14 percent from the prior year (575,819 inquiries in 2017 to 654,156 inquiries in 2018).
- The Medi-Cal Dental Telephone Service Center volume increased nearly 19 percent from the prior year (514,710 inquiries in 2017 to 610,826 inquiries in 2018). Effective January 1, 2018, DHCS fully restored adult optional dental benefits that had not been part of a May 2014 partial restoration for beneficiaries ages 21 and older with full-scope dental coverage. Communications to beneficiaries about this change likely contributed to increased inquiry numbers during 2018.

Figure 5.16

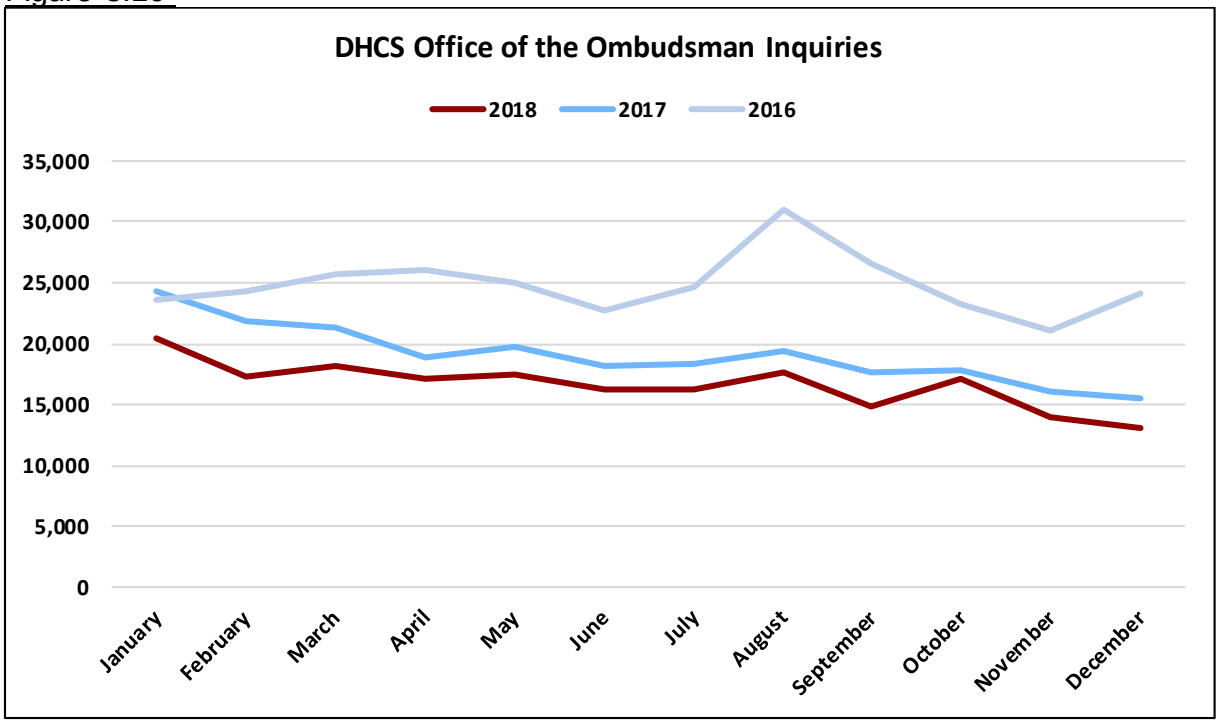


Figure 5.17

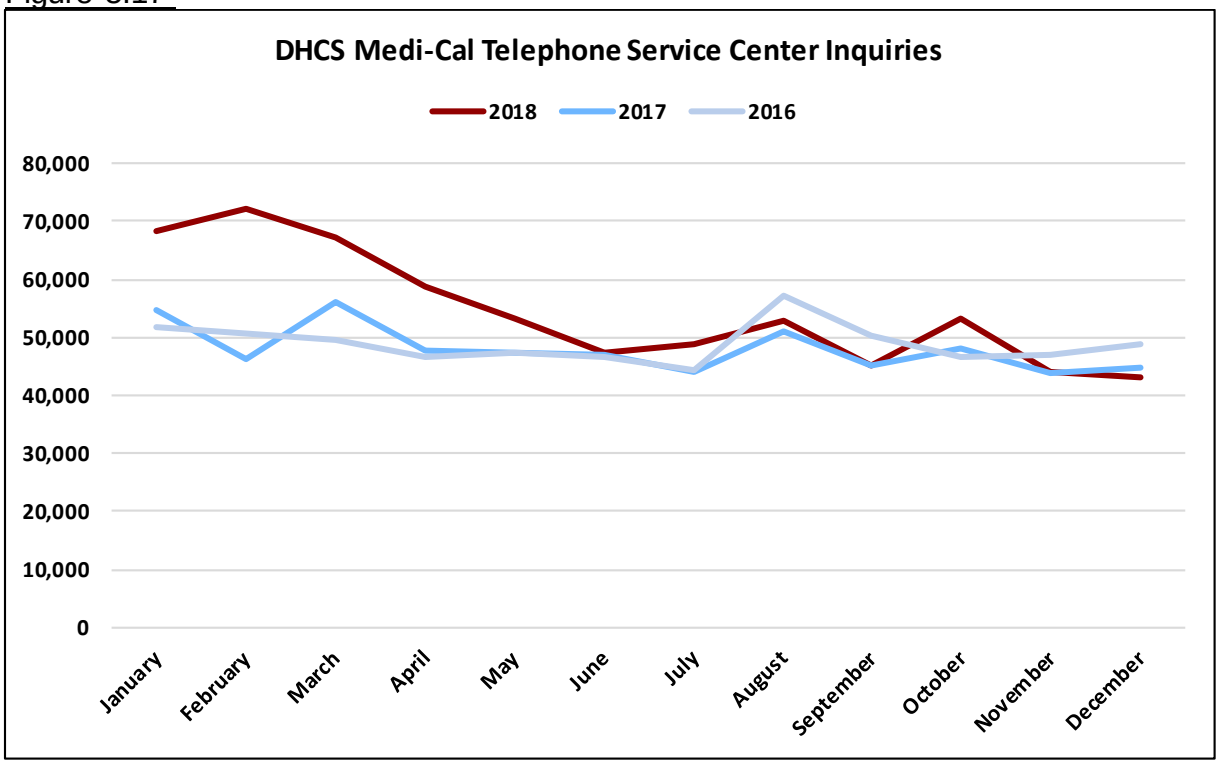


Figure 5.18

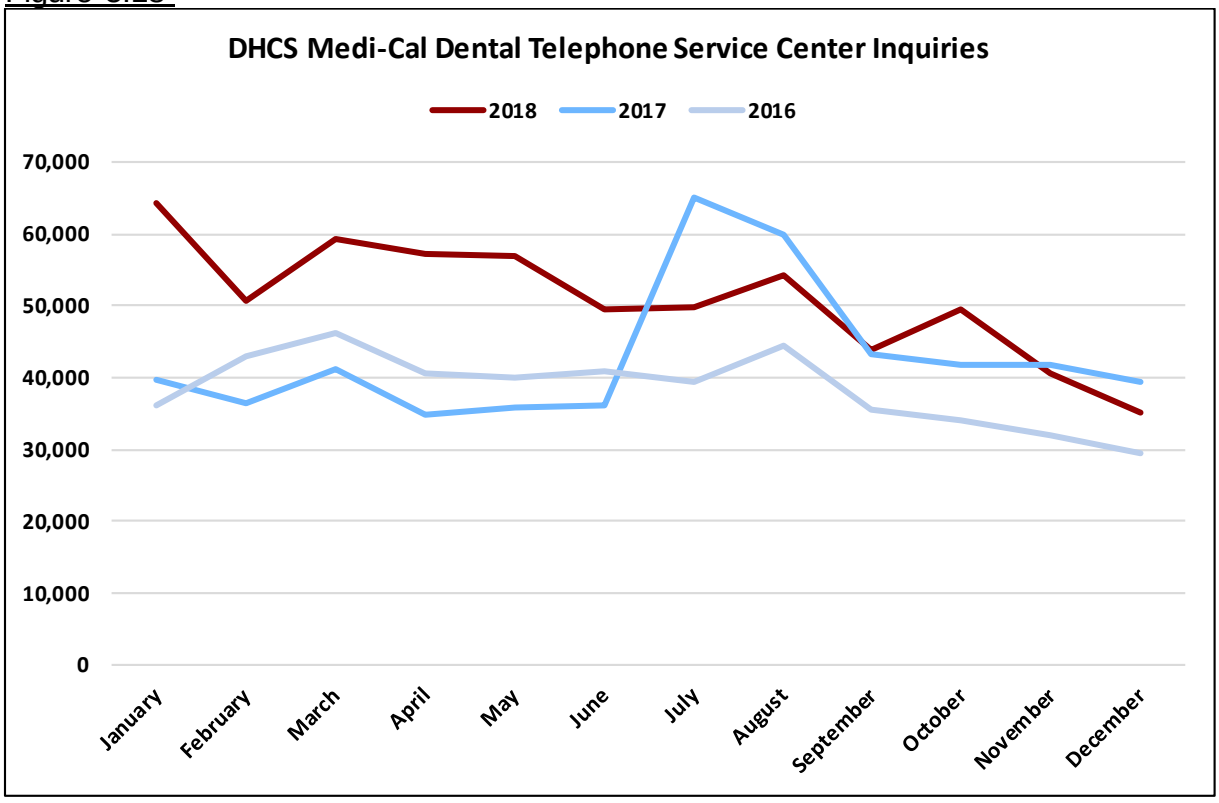


Figure 5.19

DHCS Service Centers' 2018 Telephone Metrics

Metric	Office of the Ombudsman	Medi-Cal Telephone Service Center	Medi-Cal Dental Telephone Service Center
Telephone Call Volume	194,292	654,156	604,921
Percent of Inquiries that Were Phone Calls	97%	100%	99%
Number of Abandoned Calls (Incoming calls ended by callers prior to reaching a Customer Service Representative –CSR)	9,866	58,996*	26,382
Number of Calls Resolved by the IVR/Phone System	110,998	2,563,713*	214,910
Number of Jurisdictional Inquiry Calls	73,428	654,156	602,839
Number of Non-Jurisdictional Calls	110,998 (considered same as calls resolved by IVR)	N/A	2,082
Average Wait Time to Reach a CSR	0:05:00	0:01:57	0:00:37
Average Length of Talk Time (Between a CSR answering and completing a call)	0:08:00	0:04:46	0:05:58
Average Number of CSRs Available to Answer Calls (During service center hours)	21 (Full-Time Equivalent)	80	86 (Estimated due to staffing fluctuations)

**The indicated categories reported by the Medi-Cal Telephone Service Center include calls from both Medi-Cal beneficiaries and Medi-Cal providers. The beneficiary data could not be separated for reporting.*

Service Center Protocols and Systems

DHCS did not report any changes to the DHCS service centers' systems for consumer assistance in 2018.

Section 6 – California Department of Insurance

A. Overview

The California Department of Insurance (CDI) licenses and regulates more than 1,300 insurance companies and more than 410,000 insurance agents, brokers, adjusters, and business entities. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance companies or producers. This report addresses CDI's health care coverage complaints, and not those related to life insurance, long term care, or other lines of business. For report standardization, OPA refers to the health insurance companies licensed by CDI as health plans.

CDI's 38,494 overall volume of consumer requests for assistance in 2018 was slightly higher than the prior year volume (38,316 in 2017), with a decrease in consumer inquiries offset by an increase in jurisdictional complaints. CDI reported 4,370 jurisdictional complaints closed in 2018, a 12 percent increase from the prior year.

Figure 6.1

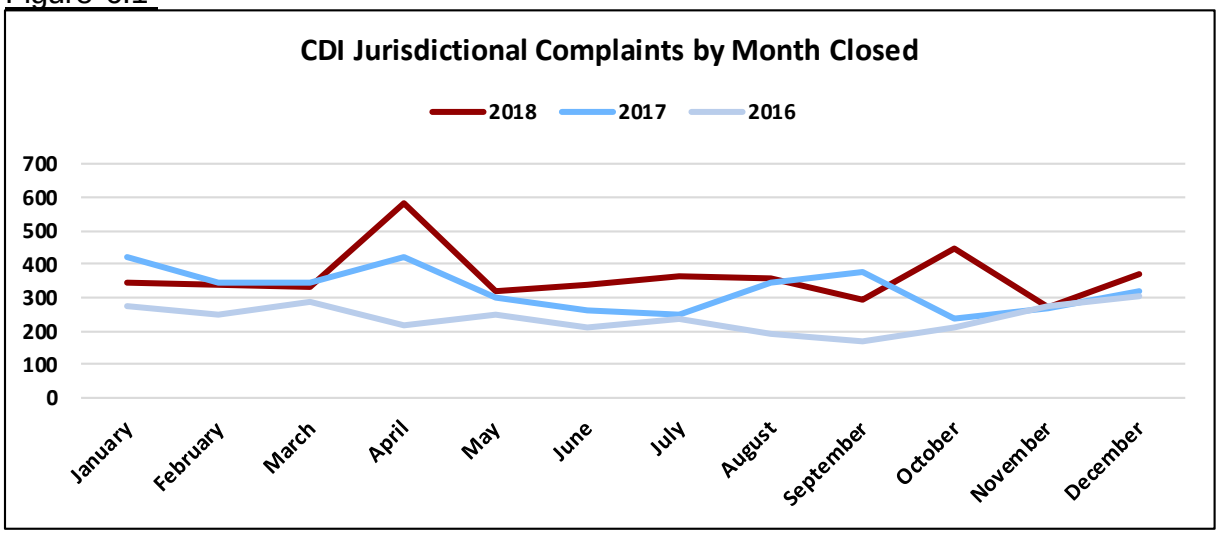
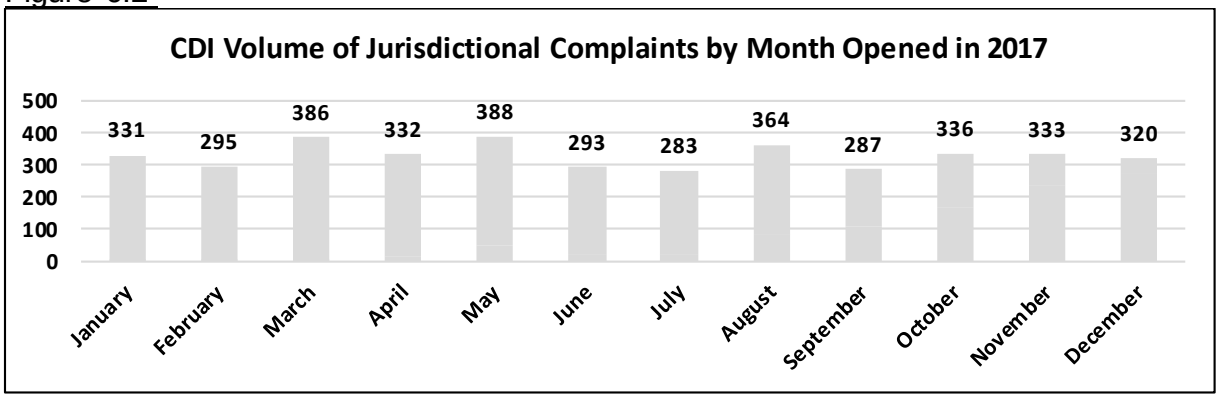


Figure 6.2



Note: A two-year analysis was necessary to capture complaint volumes for cases opened in the winter months of 2017 and closed in the following year (reported in the Measurement Year 2018 dataset).

CDI reported two different complaint types: Standard Complaint and Independent Medical Review (IMR). The average resolutions times noted in the figure below were based on durations of jurisdictional complaints closed in 2018.

- CDI's complaint duration reflects the date from initial receipt of the complaint to the date the complaint was closed after completion of the final regulatory review.
- CDI's resolution times were affected by a significant number of complaints initiated in 2016 that were held open until 2018 for regulatory purposes.

Figure 6.3

CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2018
Standard Complaint	Consumer Communications Bureau: Assistance to callers Health Claims Bureau and Underwriting Services Bureau: Compliance Officers respond to written complaints Consumer Law Unit: Legal review (if needed)	30 working days, or 60 days if reviewed concurrently with the health plan review	125 days Calculation includes time for regulatory review after the case in closed to the complainant
Independent Medical Review (IMR)	Consumer Communications Bureau: Assistance to callers Health Claims Bureau: Intake and casework IMR Organization (contractor- MAXIMUS): Case review and decision Consumer Law Unit: Legal review (if needed) Urgent clinical issues that qualify are addressed through an expedited IMR process	30 working days, or 60 days if reviewed concurrently with the health plan review	91 days Calculation includes time for regulatory review after the case is closed to the consumer complainant. Calculation also includes cases that met urgent clinical criteria.

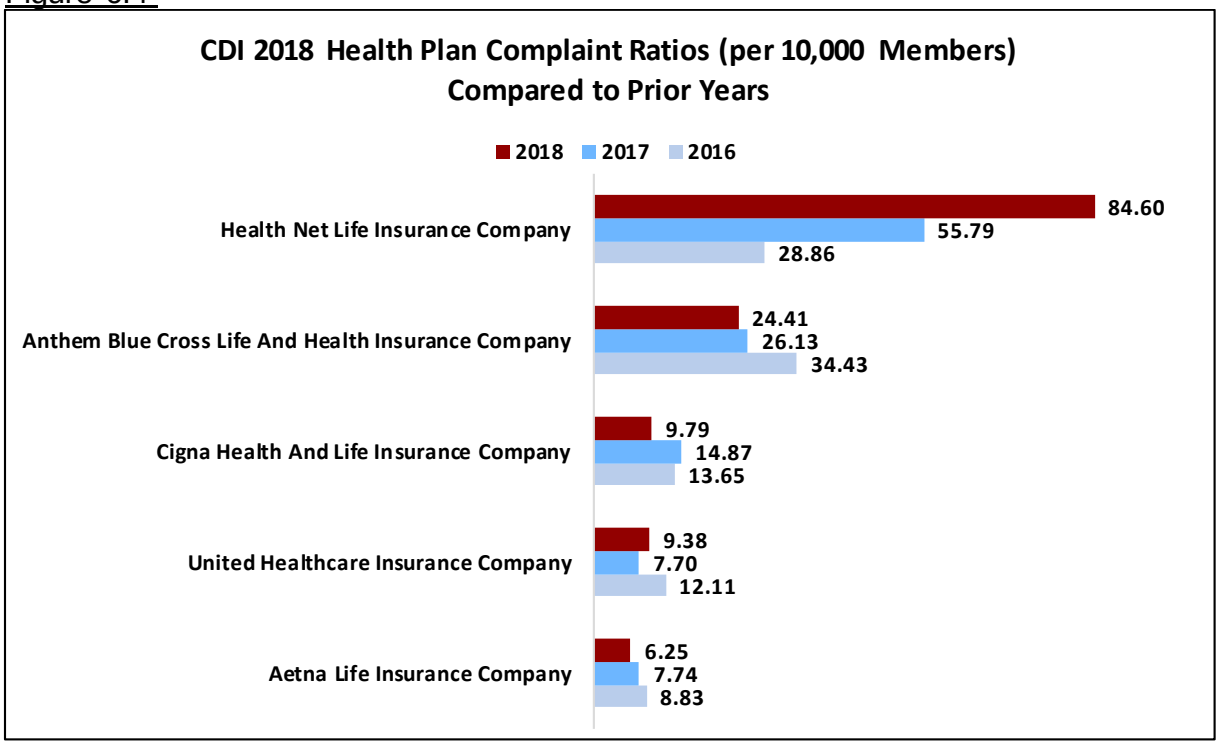
B. Complaint Ratios, Reasons, and Results

CDI submitted 8,863 complaints for 2018, including 4,370 jurisdictional complaints resolved by CDI and 4,493 non-jurisdictional complaints referred to other agencies or departments. Volumes increased compared to the prior year for both jurisdictional complaints (12% increase) and non-jurisdictional complaints (23% increase).

Health Plan Complaint Ratios

The following chart displays health plan complaint ratios for the plans with at least 25 complaints closed by CDI and with enrollment exceeding 70,000 members in 2018. The ratio shown is each plan's jurisdictional complaint volume divided by the number of the plan's enrollees. Ratios were calculated as complaints per 10,000 members.

Figure 6.4

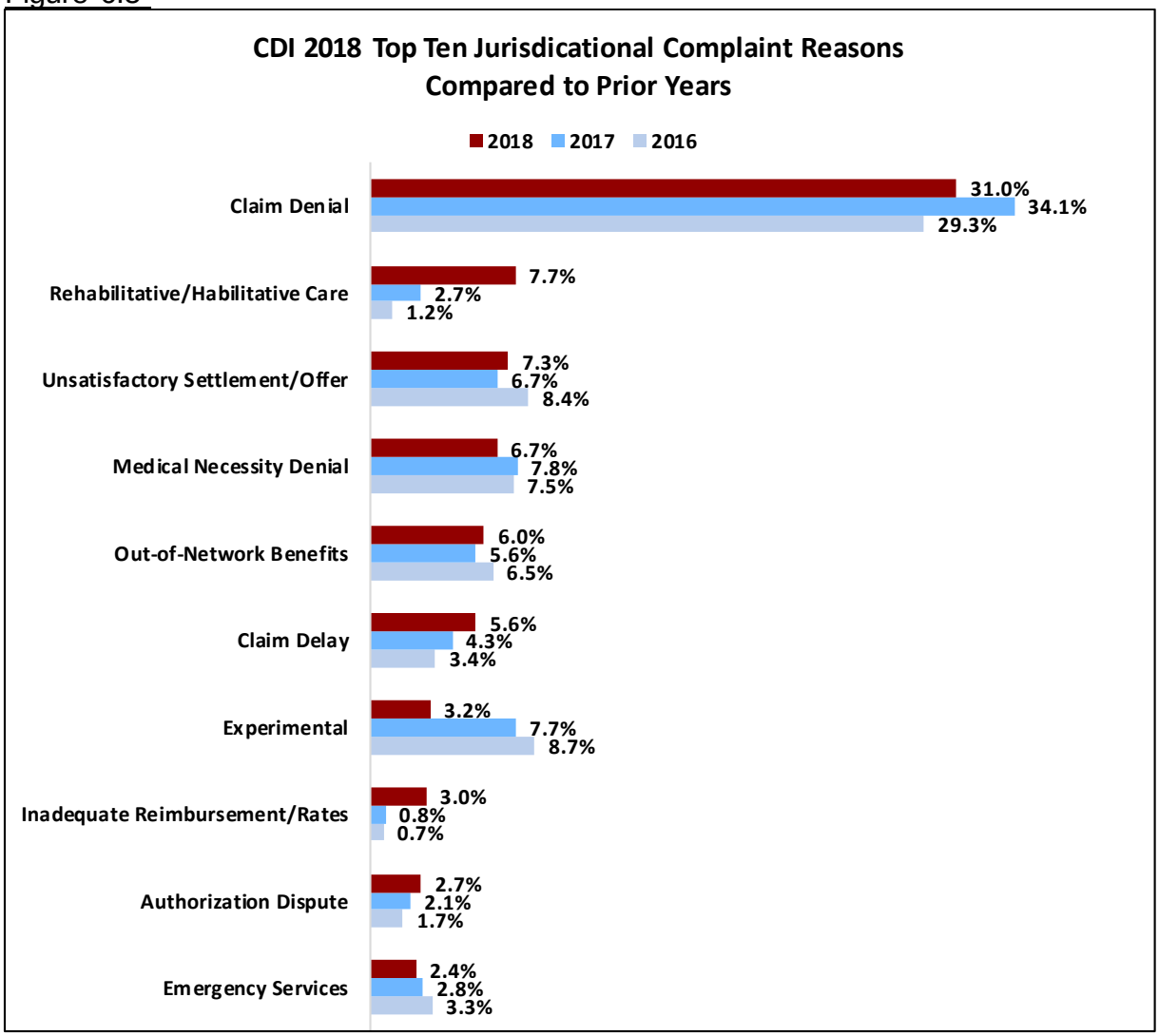


Note: Health Net's 2018 ratio increase is due in part to a significant volume of behavioral health complaints initiated in 2016 that CDI held open in its system during discussions prior to a settlement agreement reached in January 2019.

Complaint Reasons

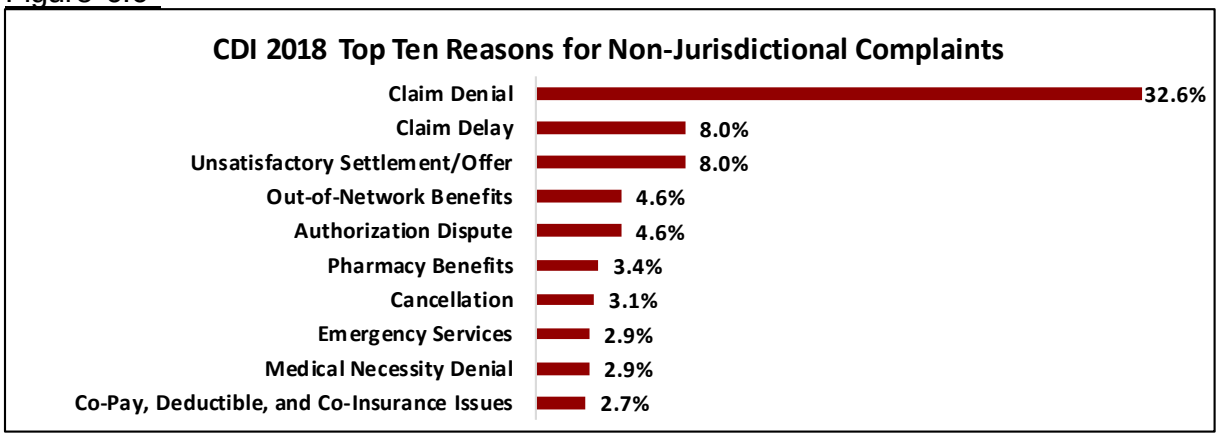
The following chart displays the 2018 top reasons for the jurisdictional complaints, and the 2016 and 2017 data for the same categories. There were 6,632 reasons reported for the 4,370 jurisdictional complaints closed in 2018.

Figure 6.5



The following chart displays the top reasons for the 4,493 non-jurisdictional complaints (5,840 reason entries) that CDI referred to an outside agency or department in 2018.

Figure 6.6



The following table displays CDI's 2018 top referral topics for consumer inquiries, as well as the entities to which those inquiries were referred. The estimated rankings exclude non-jurisdictional complaints represented in Figure 6.6.

Figure 6.7

CDI 2018 Top Ten Topics for Non-Jurisdictional Inquiries

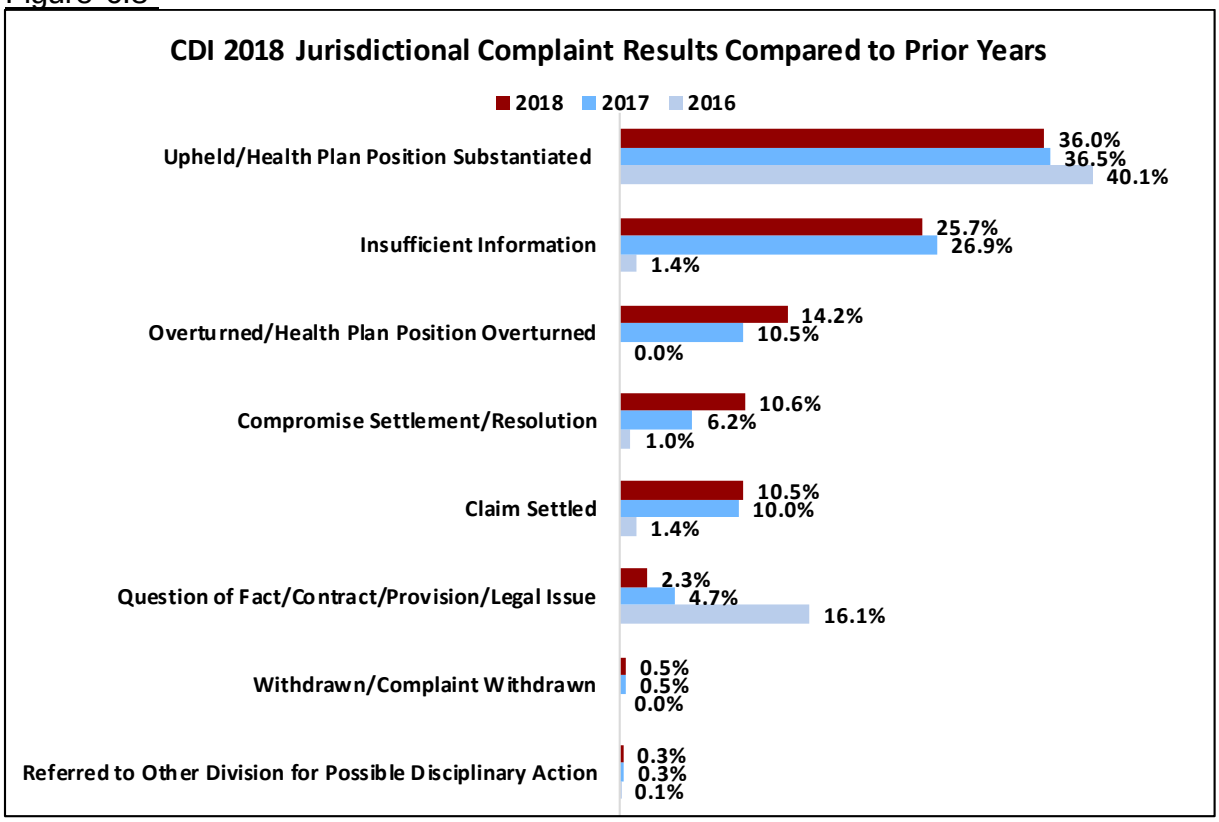
Ranking	Inquiry Topic	Organization(s) Referred to
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC) U.S. Department of Labor (DOL) Centers for Medicare and Medicaid Services (CMS) Various Departments of Insurance (DOIs)
2	Claim Delay	DMHC DOL CMS DOIs
3	Unsatisfactory Settlement/Offer	DMHC DOL CMS DOIs
4	Premium Notice/Billing	DMHC DOL CMS DOIs
5	Cancellation	DMHC DOIs
6	Out-of-Network Benefits	DMHC DOL DOIs
7	Medical Necessity/Experimental	DMHC DOL
8	Co-Pay/Deductible Issues	DMHC DOL DOIs
9	Provider Availability	DMHC
10	Pharmacy Benefits	DMHC CMS DOIs

Complaint Results

The following chart displays the 2018 results of CDI's 4,370 jurisdictional complaints.

Some differences between measurement years may be due to reporting changes rather than incidence. For example, CDI reported Overturned/Health Plan Position Overturned for the first time for 2017.

Figure 6.8



Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Claim Settled, Compromise Settlement/Resolution, and Referred to Other Division for Possible Disciplinary Action. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of other categories shown is neutral or cannot be determined.

Resolution Time

CDI's 2018 average resolution time was 120 days for jurisdictional complaints and four days for non-jurisdictional complaints. The overall average duration was 61 days for all 8,863 submitted complaints. Jurisdictional Standard Complaints took 125 days and IMRs took 91 days on average.

The CDI duration period for jurisdictional complaints reflects the open date when the department received the initial complaint through the close date when the department completed its final regulatory review.

- Since CDI allows for concurrent review, average resolution time calculations include complaints opened prior to the completion of the health plan internal complaint review period.
- The close date reported by CDI does not reflect the date the complaint was closed to the complainant, but rather the conclusion of the department's regulatory investigation period.
- CDI indicated that its final regulatory review period is 30 days on average.
- CDI's 2018 average duration was affected by a significant number of complaints initiated in 2016 that were held open for regulatory purposes prior to a January

2019 settlement agreement. OPA estimated that these outlier cases increased CDI's 2018 average resolution time for jurisdictional complaints by approximately 20 days. Without the outlier cases, the average resolution time was an estimated 91 days for Standard Complaints and an estimated 86 days for IMRs.

C. Demographics and Other Complaint Elements

Age

The average age of complainants was 45 years old for CDI's 2018 jurisdictional complaints. All known age groups had increased volumes of complaints compared to the prior year. Of the 4,370 jurisdictional complaints in 2018, Age Under 18 accounted for seven percent; Age 18-34 for 22 percent; Age 35-54 for 30 percent; Age 55-64 for 22 percent; Age 65-74 for nine percent; Age 75 and Older for four percent; and Refused/Unknown for seven percent.

Gender

Complaint volumes for both reported genders increased from the prior year (Male by 23% and Female by 4%). Of the 4,370 jurisdictional complaints in 2018, cases with Female complainants accounted for 51 percent and cases with Male complainants accounted for 49 percent.

Race and Ethnicity

CDI continued to have an ample volume of jurisdictional complaints reported as Refused for the race (46.2% in 2018) and ethnicity (44.6% in 2018) categories. One percent of the complaints were reported as race or ethnicity Unknown.

- White was the most common known race category (39.1%), followed by Asian (5.7%), Other (4.9%), Black or African American (2.0%), American Indian or Alaska Native (0.5%), and Native Hawaiian or Other Pacific Islander (0.3%).
- Not Hispanic or Latino was the most common known ethnicity category (49.0%). Hispanic or Latino was reported for slightly over five percent (5.1%).

Language

English continued to be the top reported primary language of complainants (60.9% of the 4,370 jurisdictional complaints in 2018). Spanish accounted for nearly one percent (0.9%) and Other Languages for over two percent (2.6%). Nearly 36 percent of the complaints did not identify a primary language (33.1% Refused and 2.5% Unknown).

Mode of Contact

More consumers used the Online mode of contact to initiate complaints than the prior year (50% of the 2017 complaints to 58% of the 2018's). Mail continued to be the most common mode for jurisdictional complaints (49%), followed by Online (46%) and Telephone (5%). Seventy percent of non-jurisdictional complaints were initiated online.

Regulator

CDI was the reported regulator for all of its submitted complaints for 2018.

Source of Coverage

CDI identified two source of coverage categories for all of its 2018 complaints: Group and Individual/Commercial. Most 2018 complaints involved Group coverage (58% of all complaints, including 56% of jurisdictional cases and 60% of non-jurisdictional cases).

Product Type

CDI identified 25 different product type categories for 2018. The product type volume exceeded the number of complaint cases because some cases had more than one product type reported. Health Only continued to be the most common product type for jurisdictional complaints (36.6% of the 7,027 entries in 2018), followed by Large Group (18.1%), Stand Alone Dental (12.8%), Small Group (10.0%), Mental Health (7.7%), Grandfathered (5.1%), Medicare Supplement (2.7%), Pharmacy Benefits (1.0%), Limited Benefits (0.9%), and Bronze (0.9%). The other 15 categories reported each had volumes under one percent.

D. Consumer Assistance Center Details

CDI's Consumer Services Division received 38,494 requests for assistance from consumers in 2018, slightly above the prior year volume (38,316 requests in 2017). Most requests for assistance were consumer inquiries (74% telephone and 3% written) rather than a request to initiate a complaint.

CDI reported that its service center received 28,642 telephone calls for 2018. The following table outlines metrics for its service center's 2018 calls.

Figure 6.9

CDI Consumer Services Division – 2018 Telephone Metrics

Metric	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative - CSR)	1,086
Number of Calls Resolved by the IVR/Phone System (caller's needs addressed without involving a CSR)	1,168
Number of Jurisdictional Inquiry Calls	22,199
Number of Non-Jurisdictional Calls	4,961
Average Wait Time to Reach a CSR	0:00:29
Average Length of Talk Time (time between a CSR answering and completing a call)	0:05:45
Average Number of CSRs Available to Answer Calls (during Service Center hours)	Varies based on need

Note: Secondary health officers may be added to the health queue depending upon volume of calls received. The data does not reflect time spent by the officer to verify jurisdiction and return a call to the consumer. Stats only reflect time of consumers' initial contacts.

Consumer Assistance Protocols and Systems

CDI did not report any 2018 changes to its consumer assistance protocols or systems.

Section 7 – Covered California

A. Overview

Covered California, the state's health benefit exchange, provides a state-based health insurance marketplace for consumers to buy health insurance and qualify for financial assistance to help pay their insurance costs. This report includes information reported by Covered California regarding:

- Covered California complaints that were adjudicated by the California Department of Social Services (CDSS) through the State Fair Hearing process with a decision from an Administrative Law Judge.
- State Fair Hearing requests that were resolved informally by Covered California without completing the hearing process.
- Consumer assistance provided by the Covered California Service Center to help Californians understand their health care coverage options and apply for coverage and associated financial assistance.

Complaints reported by Covered California include dual agency appeals to address eligibility determinations for Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal coverage. Covered California noted that 45 percent of the 12,760 complaints closed in 2018 were dual appeals.

Covered California received 4,936,697 requests for assistance from consumers in 2018, a 16 percent volume decrease from the prior year (5,894,358 in 2017). The requests for assistance volume includes inquiries to the Covered California Service Center and complaints resolved formally and informally through a State Fair Hearing.

The following chart compares Covered California complaint volumes by month closed over a three-year period. Covered California's annual complaint volume continued to decrease with 12,760 complaints in 2018 from 15,687 in 2017 and 20,398 in 2016.

Figure 7.1

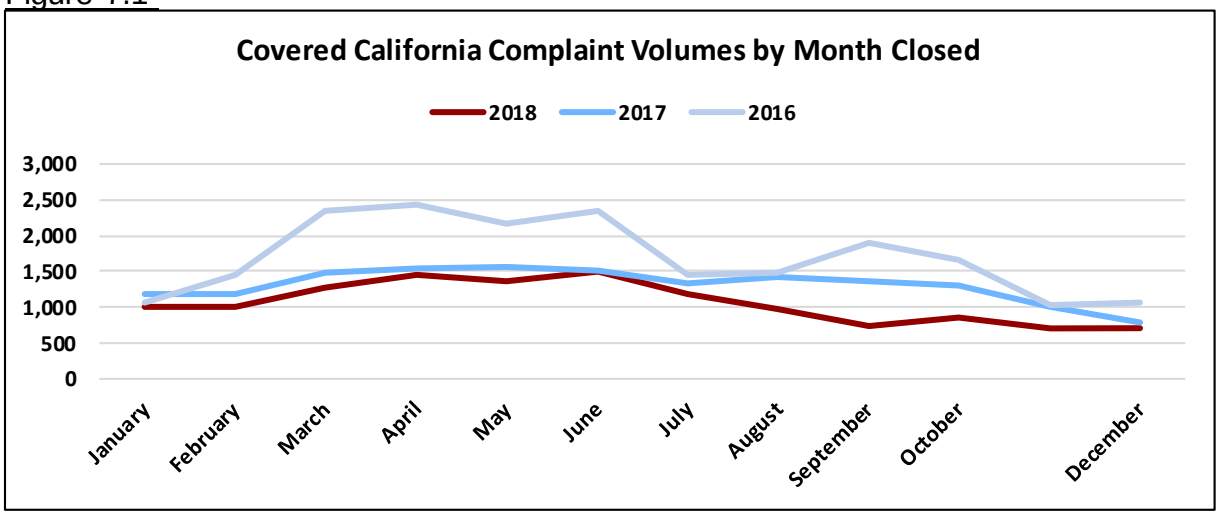
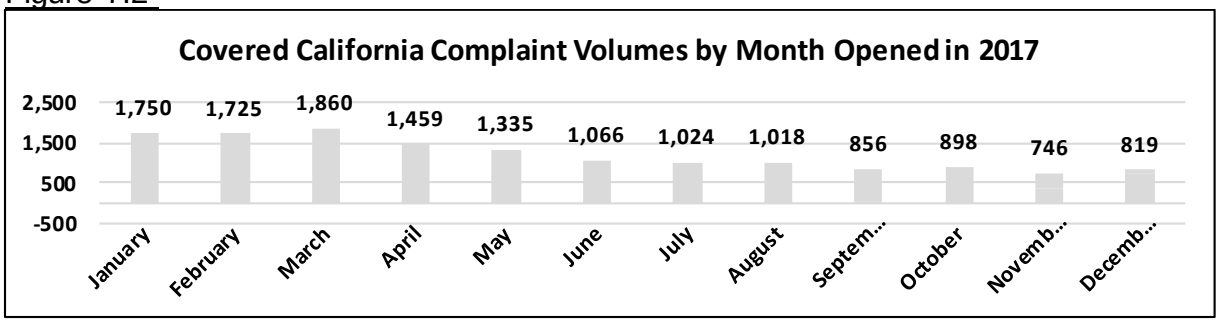


Figure 7.2



Note: A two-year analysis was necessary to capture complaint volumes for cases opened in the winter months of 2017 and closed in the following year (reported in the Measurement Year 2018 dataset).

Figure 7.3

Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2018
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on Covered California eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving consumers with urgent clinical issues.	90 days from the date the hearing request was filed	67 days
State Fair Hearing: Informal Resolution	CDSS State Hearings Division: Reviews requests for State Fair Hearings and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge. Covered California staff: Reviews complaint outlined in the State Fair Hearing request and conducts casework to resolve the complaint.	45 days from the date the appeal was filed	38 days

Note: State Fair Hearing time standard is from All County Letter 14-14 issued by CDSS on 2/7/14. The Covered California Service Center staff address Service Center complaints that are not State Fair Hearing appeals, and escalate issues to internal supervisors, subject matter experts, and customer resolution teams as needed. Covered California's External Coordination Unit addresses certain non-appeal issues escalated by the Service Center that involve consumers with urgent access to care issues.

B. Complaint Ratios, Reasons, and Results

Covered California's 12,760 complaints closed in 2018 were comprised of 4,410 formal State Fair Hearings and 8,350 State Fair Hearing: Informal Resolution complaint types. With a nearly 19 percent decrease in overall complaints, there were fewer complaints for both complaint types compared to the prior year. The number of formal State Fair Hearings decreased by 49 percent from 2017 to 2018. The volume of the Informal Resolution type decreased by 18 percent over the same period.

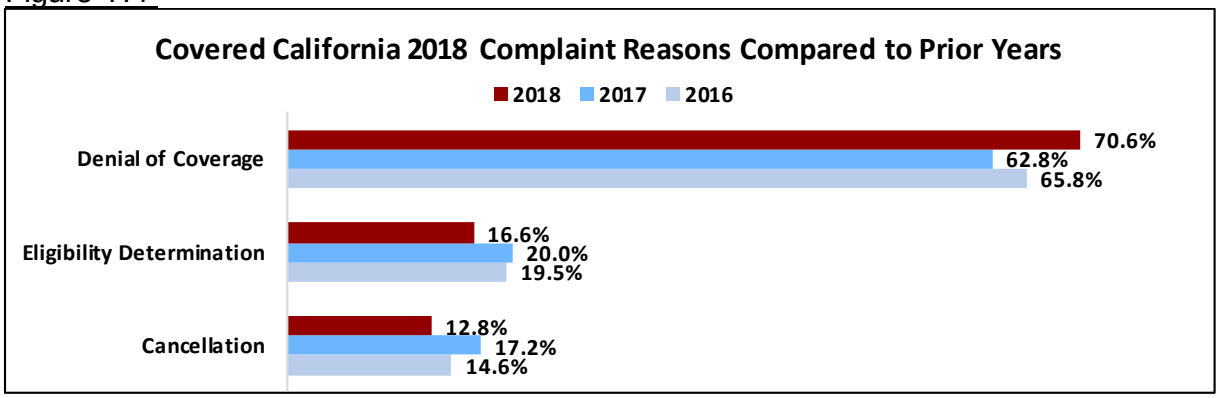
Health Plan Complaint Ratios

Covered California health plan complaints are addressed through health plan grievance and insurance regulator complaint review processes rather than through a State Fair Hearing. See Section 4.C for information about Covered California health plan complaints resolved by the Department of Managed Health Care.

Complaint Reasons

Covered California reported three complaint reason categories for program eligibility and enrollment issues. The following chart shows the complaint reason distribution for all 20,398 complaints in 2016, all 15,687 complaints in 2017, and all 12,760 complaints in 2018. Complaint volumes for all three reasons dropped from 2017 to 2018.

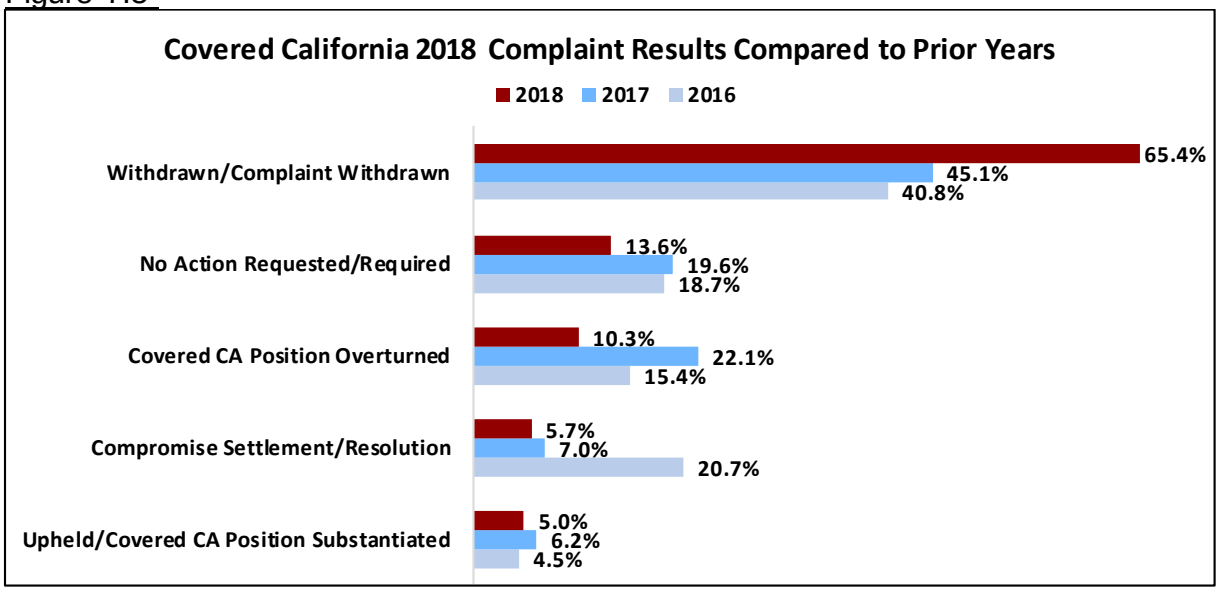
Figure 7.4



Complaint Results

The following chart compares the annual percentage distributions of the complaint results reported by Covered California over a three-year period (for all 20,398 complaints in 2016; all 15,687 in 2017; and all 12,760 in 2018). Withdrawn/Complaint Withdrawn was the only result that increased in volume from 2017 to 2018.

Figure 7.5



Note: Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Covered CA Position Overturned. Results categories considered favorable to Covered California include: Upheld/Covered CA Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against Covered California, but indicates that the consumer received services or a similar positive outcome.

The following figures show the 2018 results for each of the three complaint reasons reported by Covered California, including the 9,010 Denial of Coverage complaints, 2,114 Eligibility Determination complaints, and 1,636 Cancellation complaints.

Figure 7.6

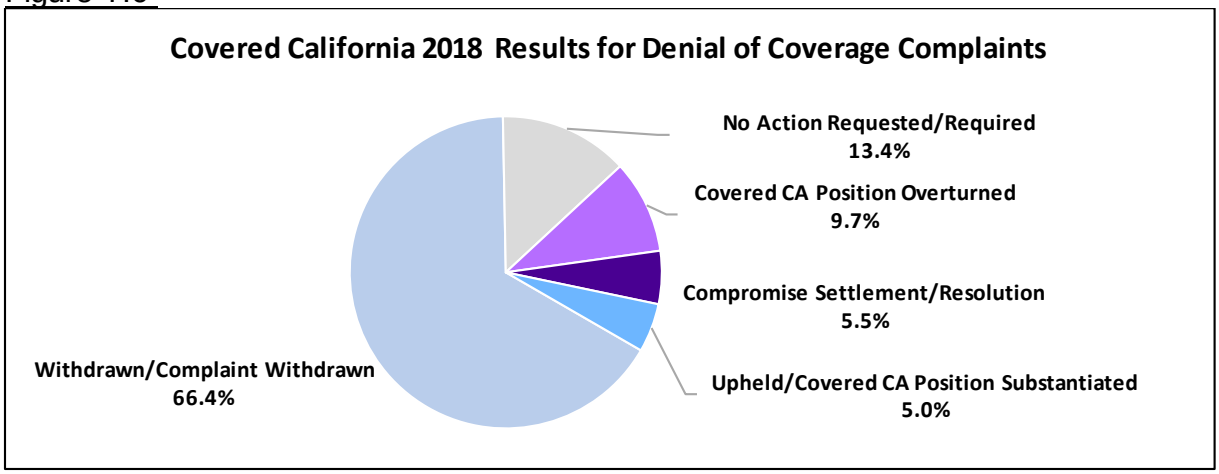


Figure 7.7

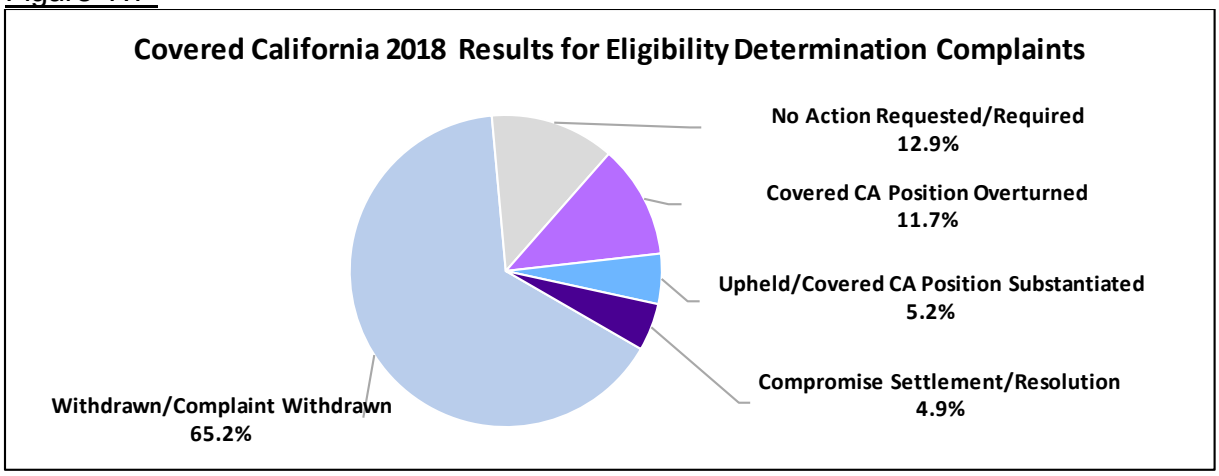
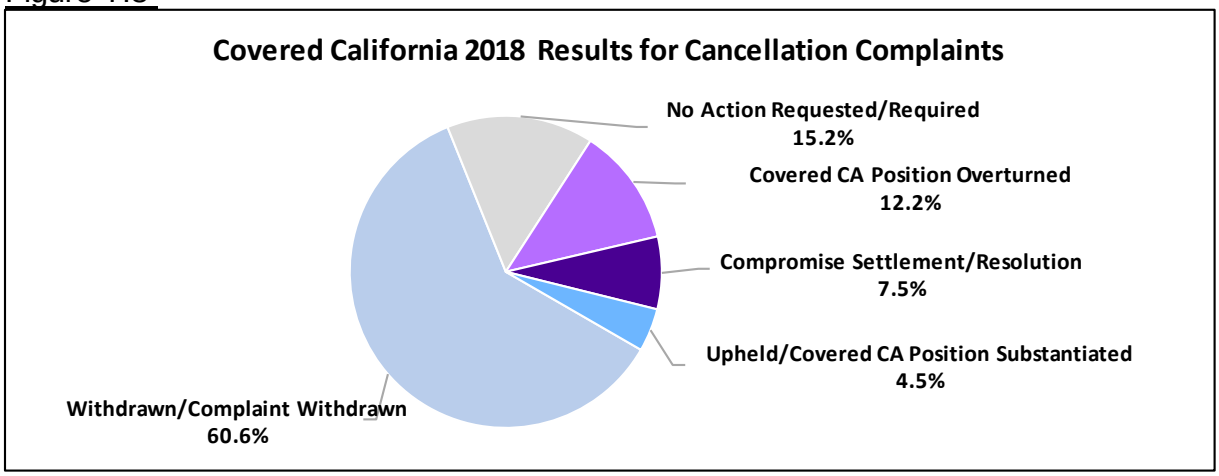


Figure 7.8



Resolution Time

Covered California complaints took on average 48 days to resolve in 2018, a decrease of 18 days from the prior year average resolution time.

- The formal State Fair Hearing complaint type had an average duration of 67 days (10 fewer days than the 2017 average).
- The Informal Resolution complaint type had an average duration of 38 days (14 fewer days than the 2017 average). Covered California indicated that case durations decreased due to its internal process improvements, including for training, reporting, and analysis.

C. Demographics and Other Complaint Elements

Covered California's percentage distributions of its 12,760 complaints in 2018 was similar to the prior year for complaint categories Age, Gender, Race, Ethnicity

Age

In 2018, Age 35-54 was the most commonly reported age group (41.1%), followed by Age 55-64 (27.6%); Age 18-34 (25.9%); Age 65-74 (4.9%); Ages 75 and Older (0.3%); Ages Under 18 (0.2%); and Unknown (0.1%).

Gender

Most 2018 complainants were identified as Female (55.4%), while Male (42.9%) and Unknown (1.7%) were the other two submitted gender categories.

Race and Ethnicity

White was the most commonly identified race of the 2018 complainants (37.0%), followed by Asian (11.1%), Other (10.0%), Black or African American (4.9%), American Indian or Alaska Native (0.4%), and Native Hawaiian or Other Pacific Islander (0.2%). The remaining cases were Unknown (36.3%).

Not Hispanic or Latino was the ethnicity category reported for most (65.0%) of the 2018 complaints. Hispanic or Latino was identified for nearly a quarter of the complaints (23.8%). The remaining cases did not identify ethnicity (11.1% Unknown).

Language

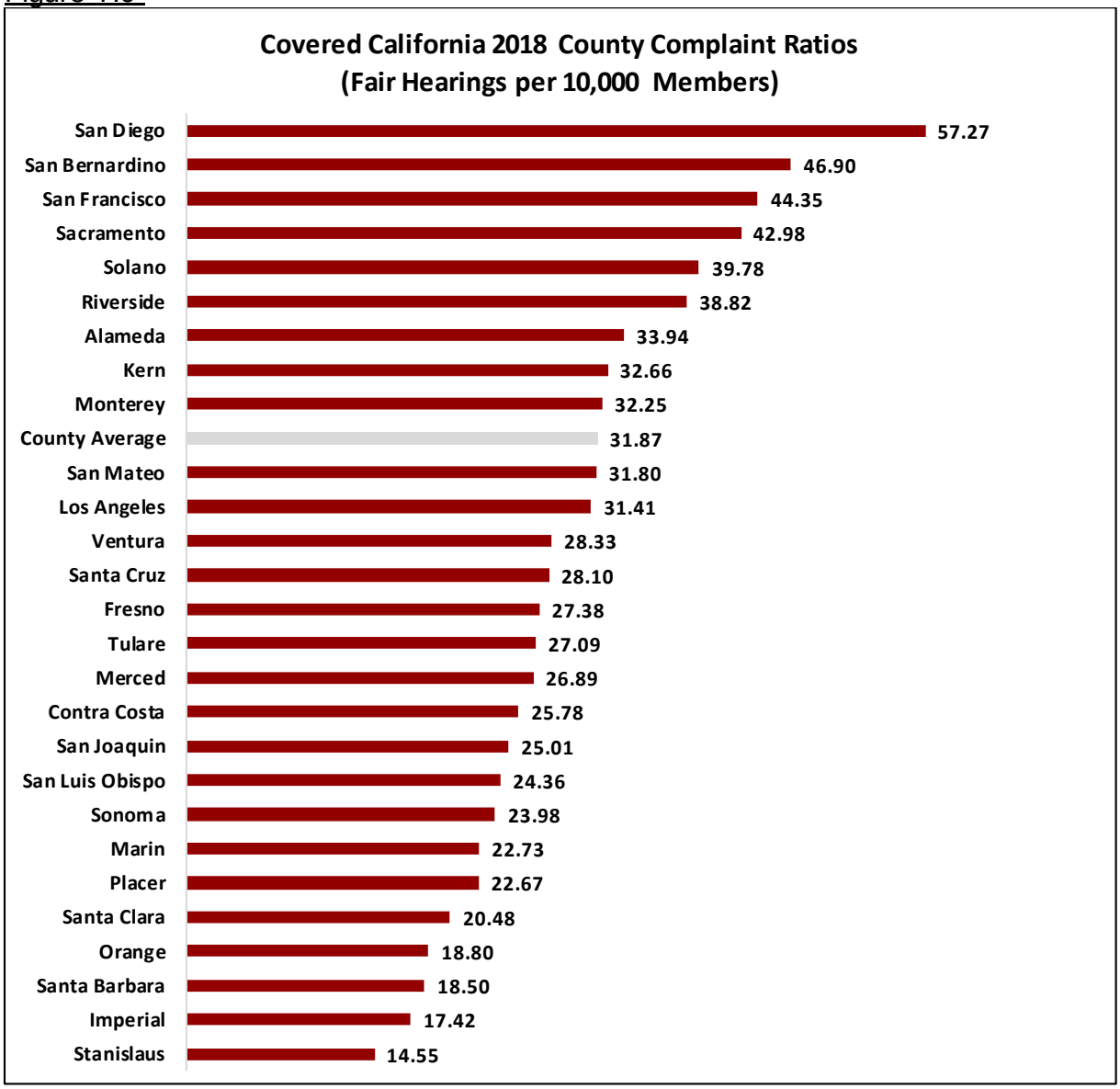
English was identified as the primary language for most 2018 complainants (83.7%), followed by Spanish (10.0%), Unknown (2.0%), and Mandarin (1.0%). The other reported languages each had volumes under one percent (3.2% combined).

County of Residence

The following chart displays complaint ratios by the county of residence identified for the complainant. The ratio is the county's volume of formal Covered California State Fair Hearings per 10,000 county residents enrolled in Covered California. The complaint volume does not include the informal resolution complaint type. Counties with ten or

fewer complaints or Covered California enrollment under 10,000 are not shown. The average county ratio dropped nearly in half from the prior year. Fifty-four counties had lower ratios than in 2017.

Figure 7.9



Mode of Contact

Most of Covered California's complaints continued to be initiated by Telephone (66.3% of the 12,760 complaints in 2018). Email was the next most common mode of contact (14.1%), followed by Fax (10.1%), Mail (6.7%), and Counter/In-Person (2.7%).

Regulator

Covered California's complaints do not address health plan issues and so do not have attributed regulator information. Covered California noted that additional CDI-regulated

plans were offered through the 2018 marketplace and enrollment in CDI-regulated plans modestly increased to 2.8 percent of Covered California's total enrollment. Most Covered California members continued to be enrolled in plans regulated by DMHC (97.3% of the 2018 enrollment).

Source of Coverage

Most (62.3%) of Covered California's 2018 complaints identified Covered California as the source of coverage. Due to a reporting change, Covered California submitted Unknown cases (37.7%) for the first time in this complaint category. Covered California indicated that Unknown was reported for cases where consumers had not selected a health plan when they filed an appeal.

Product Type

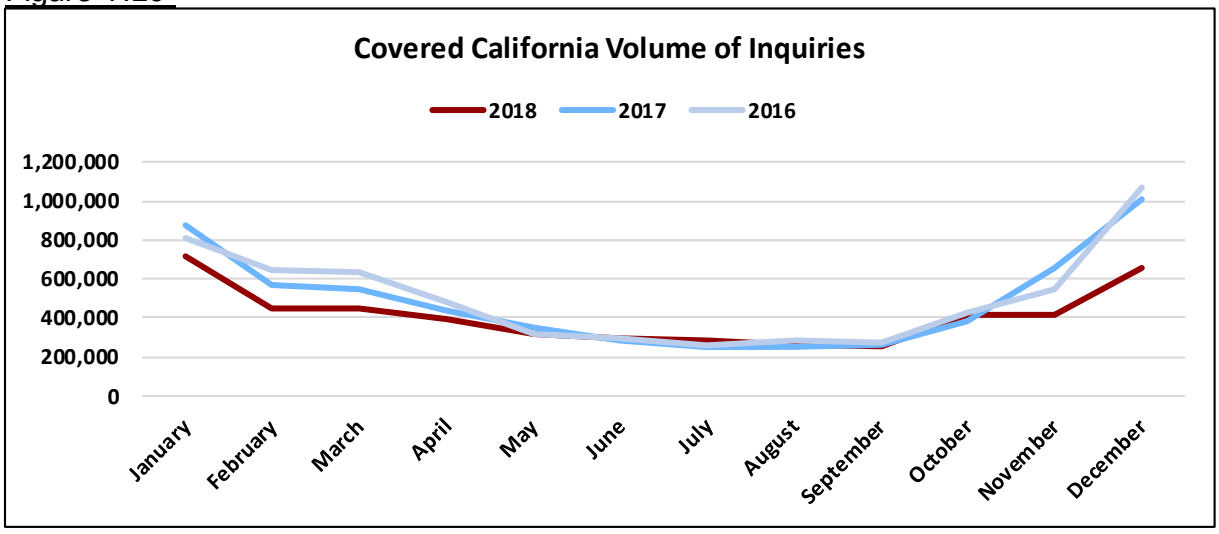
Covered California submitted complaints with product types pertaining to the metal tier associated with the complainant's level of coverage.

- Silver continued to be the most commonly identified product type (39.5% in 2018) despite a decrease in volume and percentage distribution compared to 2017.
- Bronze was the next most commonly identified product type (14.5%), followed by Gold (5.1%), Platinum (2.5%), and Catastrophic (0.7%).
- Unknown was submitted for nearly 38 percent of the complaints.
- Complaint volumes decreased for all product type categories except for Gold compared to the prior year.

D. Consumer Assistance Center Details

The following chart compares the monthly volumes of consumer inquiries to the Covered California Service Center for a three-year-period. The annual inquiry volumes were 4,923,937 in 2018; 5,878,671 in 2017; and 6,038,580 in 2016. The 2018 inquiry volume includes ChatBot sessions starting in October.

Figure 7.10



The following table displays the top ten inquiries made to the Covered California Service Center in 2018 for both jurisdictional and non-jurisdictional topics.

Figure 7.11

Covered California Top Ten Reasons for Inquiries

Ranking	Inquiry Topic	Organization Referred To
1 (most common)	Inquiry/Assistance - Application/Case Status	Not Applicable
2	Inquiry/Assistance - New Enrollment	Not Applicable
3	Current Customer - Disenrollment/Termination	Not Applicable
4	1095-A Inquiry/Assistance	Not Applicable
5	Current Customer - Report a Change	Not Applicable
6	Current Customer - Consumer's Online Account	Not Applicable
7	Current Customer - Renewal	Not Applicable
8	Provided County Contact/Number Information	Medi-Cal
9	Medi-Cal/Enrollment Inquiries	Medi-Cal
10	Inquiry/Assistance - Payment Inquiry	Qualified Health Plan or Dental Plan

Note: The Covered California ranking is based on data. Not Applicable means the inquiry was handled by Covered California and not referred to another entity.

Most inquiries (94% in 2018) to the Covered California Service Center were made by telephone. The table below outlines metrics reported by Covered California for its 2018 telephone calls. The metrics were based on tracked data unless otherwise indicated.

Figure 7.12

Covered California Service Center – 2018 Telephone Metrics

Metric	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative - CSR)	121,463
Number of Calls Resolved by the IVR/Phone System (caller's needs addressed without involving a CSR)	2,006,098
Average Wait Time to Reach a CSR	0:0:18
Average Length of Talk Time (time between a CSR answering and completing a call)	0:17:16
Average Number of CSRs Available to Answer Calls (during Service Center hours)	895 (Estimated)

Consumer Assistance Protocols and Systems

A new ChatBot application was implemented on the Covered California website in October 2018. The ChatBot is available 24 hours a day through an online chat platform and uses artificial intelligence software to help answer commonly asked questions without involving a Service Center agent.

Section 8 – Conclusion

The Office of the Patient Advocate (OPA) reviewed the fifth year of complaint data submitted by four reporting entities: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California. This section highlights issues that were noteworthy among the analysis of the Measurement Year 2018 data. OPA continues to urge caution in making comparisons between reporting entities and measurement years due to complaint system differences and reporting adjustments.

Volume of Complaints

The four reporting entities submitted 43,998 consumer complaints to OPA for Measurement Year 2018. The statewide jurisdictional complaint volume decreased for the third straight year, with the 2018 volume of 39,505 jurisdictional complaints decreasing by nearly 13 percent from the prior year (45,372 in 2017). For the second year, CDI was the only reporting entity that reported an increased number of complaints.

Complaint Reasons

Denial of Coverage remained the most common statewide complaint reason, as well as the top reason reported by Covered California.

- For DMHC, Medical Necessity Denial continued to be the most common complaint reason. Cancellation remained the top reason for Covered California health plan complaints resolved by DMHC despite a 13 percent decrease in volume from the prior year. Medical Necessity Denial remained the top reason for Medi-Cal health plan complaints resolved by DMHC.
- Scope of Benefits was DHCS's most common reason in 2018, largely due to the reported volume of its Dental delivery system complaints. Dis/Enrollment was the top reason reported for Medi-Cal Managed Care and Fee-for-Service delivery systems. Fluctuation between measurement years for the top reasons were due in part to reporting changes.
- Claim Denial continued to be CDI's top complaint reason.
- Complaint volumes for all three reason categories reported by Covered California (Denial of Coverage, Cancellation, and Eligibility Determination) decreased in volume for the second year.

Complaint Results and Resolution Time

Upheld/Health Plan Position Substantiated was the top result reported for the statewide complaints closed in 2018, as well as top result of complaints reported by DMHC, DHCS, and CDI. Covered California's top result continued to be Withdrawn/Complaint Withdrawn. The 2018 statewide average time to resolve a consumer health care complaint was 48 days, two days fewer than the 2017 average.

- DMHC's average resolution time was 25 days, a three-day increase from the prior year but still below the 2016 average.
- DHCS's 2018 average resolution time was 62 days, a 17-day decrease from the prior year. The average duration for DHCS-reported State Fair Hearings has dropped each year since 2015.
- CDI's 2018 average duration increased to 120 days due to a group of outlier cases initiated in 2016 and kept open during CDI's discussions with a health plan, which resulted in a January 2019 settlement agreement.
- Covered California's average duration decreased by 18 days to 48 days in 2018.

Complaint Ratios

Ratios of health plan complaints per 10,000 members were displayed for plans with enrollment over 70,000 members in 2018.

- Seven of the ten DMHC-regulated health plans with the highest complaint ratios in 2018 had a lower ratio in 2018 compared to 2017.
- Nearly all Medi-Cal managed care health plans had lower statewide complaint ratios of State Fair Hearings per member compared to the 2017. DHCS attributed the lower ratios in part due to a change in complaint protocols (outlined in All Plan Letter 17-006) to require a plan grievance prior to a State Fair Hearing. The grievance process provides the managed care plan the opportunity to resolve issues before they are elevated to a state-level complaint.
- Three of five CDI-regulated plans displayed had a lower complaint ratio in 2018 than the prior year.
- Based on data reported by DMHC, all four displayed Covered California plans had lower complaint ratios based on Cancellation and Dis/Enrollment issues. Two of these plans had higher ratios based on health care delivery issues in 2018 compared to 2017, but remained below or about the same as 2016 levels.

Data Limitations

Differences in coverage products and complaint and reporting systems make comparisons inexact between reporting entities and measurement years. The data from the four state entities only partially represents the various and differing levels of complaint outlets available to consumers. For example, Covered California reported a type of informal complaint resolved at the initial service center level (informal resolutions of State Fair Hearings) not represented for other coverage sources. Medicare, self-insured plans, and certain other coverage types are not fully represented as they are not overseen by the state entities that provide data for this report. Each reporting entity may use different methodologies and other criteria for similar subjects in their respective departmental reports.

The Office of the Patient Advocate
925 L Street, Suite 1275
Sacramento, CA 95814
(916) 324-6407

Published August 2020