Annual Health Care Complaint Data Report

Report to the Legislature for Measurement Year 2019

STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Mark Ghaly, Secretary

CENTER FOR DATA INSIGHTS AND INNOVATION
John Ohanian, Director

Statutory Requirement

Assembly Bill 172 (Chapter 696, Statutes of 2021) added the following provision in law: Health and Safety Code §130204 (requirements previously under §136000).

(b) The center shall produce an annual report to be made publicly available on the center's internet website by December 31, 2022, 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 State Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:

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

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

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

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

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

(c) (1) The center may collect 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, insurer or plan data, appeals, 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 center shall submit a report by December 31, 2022, 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.

(2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the center data concerning call centers to meet the reporting requirements in this section in the time, data elements, manner, and format requested by the center.

(3) For the purpose of publicly reporting information as required in paragraph (1) and this paragraph about the problems faced by consumers in obtaining care and coverage, the center shall analyze data on consumer complaints, appeals, and grievances resolved by the agencies listed in subdivision (b), 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 and associated data tables are available online at:
https://www.opa.ca.gov/ComplaintsReports/Pages/AnnualComplaintReports.aspx

Contents

Section 1 – Executive Summary

The Office of the Patient Advocate (OPA) was statutorily required to develop and implement an annual multi-departmental Complaint Data Report under the authority and specifications originally established by AB 922 (Chapter 552, Statutes of 2011) and SB 857 (Chapter 31, Statutes of 2014).

Per AB 172 (Chapter 696, Statutes of 2021) OPA's reporting requirements have transitioned to the Center for Data Insights and Innovation (CDII) at the California Health and Human Services Agency.

This Measurement Year 2019 report will be the final annual Complaint Data Report published on the OPA website. CDII will be responsible for future reports and posting associated publications on its website.

Statute specifies four state reporting entities that are required to provide data to CDII (previously 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 assistance service center divisions. DHCS and Covered California reported complaint data from the California Department of Social Services (CDSS) State Fair Hearings Division.

This sixth annual Complaint Data Report catalogs 35,470 consumer health care complaints closed in 2019. The statewide complaint volume from the four reporting entities decreased for the fourth year (55,923 in 2016; 45,375 in 2017; 39,505 in 2018). Compared to the prior year, the 2019 complaint volumes for:

- DMHC decreased by five percent, with 15,915 complaints from the 26,460,843 enrollees in DMHC-regulated health plans.
- DHCS decreased by 12 percent, with 4,978 complaints from the 12,911,521 enrollees in Medi-Cal and other DHCS programs.
- CDI increased by six percent, with 4,619 complaints from the 2,591,989 enrollees in CDI-regulated health insurance.
    - CDI also submitted 4,347 non-jurisdictional complaints that closed with a referral to an outside agency or department or similar result.
- Covered California decreased by 22 percent, with 9,958 complaints from the 1,338,882 enrollees in Covered California health plans.
- Enrollment volumes noted above likely include individuals who are counted more than once because they are enrolled in multiple plans.

The 2019 top five statewide complaint reasons:

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

The 2019 top five statewide complaint results:

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

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

The 2019 complaint resolution times:

- Statewide – 0 to 1,163 days (41 days on average)
- DMHC – 0 to 186 days (21 days on average)
- DHCS – 0 to 448 days (51 days on average)
- CDI – 0 to 1,163 days (103 days on average)
    - CDI's complaint resolution times include outlier cases initiated in 2016 and early 2017 but held open until 2019 for regulatory purposes.
- Covered California – 0 to 385 days (39 days on average)

Differences in complaint systems make direct comparisons between the reporting entities inexact for many of the complaint categories. Because of this, analyses about many of the categories are reported in the respective sections about each reporting entity rather than aggregated statewide. In addition, some of the differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence or performance.

Section 2 – Background and Methodology

The Center for Data Insights and Innovation (CDII) is statutorily charged under the California Health and Safety Code §130204, with implementation of a multi-departmental complaint data reporting initiative, taking over the requirement from the Office of the Patient Advocate (previously under §136000). OPA, now CDII, 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 sixth year Complaint Data Report evaluates health care complaints closed January through December 2019 and other information collected from the four state reporting entities about their service centers' 2019 consumer assistance activities. For some categories, CDII also displays data from the 2017 and 2018 measurement years.

DMHC, DHCS, CDI, and Covered California submitted to OPA (now CDII) 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 2019 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 (now CDII) and the reporting entities continued 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, many data categories are displayed in separate reporting entity sections rather than aggregated statewide.

More information about the report methodology and the glossary of terms are available online:
https://www.opa.ca.gov/ComplaintsReports/Pages/AnnualComplaintReports.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 (now CDII) 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.

Sections 4-7 have additional data and 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. CDII 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 addressed by its Help Center.
- DHCS reported formal State Fair Hearings about Medi-Cal eligibility and some care delivery issues. Complaints about certain Medi-Cal 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 complaints about the health insurance 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 include dual agency appeals involving Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal. Complaints about its health plans are reviewed by state regulators, DMHC or CDI, rather than through a State Fair Hearing. Most Covered California products are regulated by DMHC.

Figure 3.1 Reporting Entity 2019 Complaints and Enrollment

Reporting Entity	Number of Complaints	Total Number of Enrollees
DMHC	15,915	26,460,843
DHCS	4,978	12,911,521
CDI	8,966	2,591,989
Covered California	9,958	1,338,882

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 2019 consumer assistance data to OPA (now CDII):

- 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

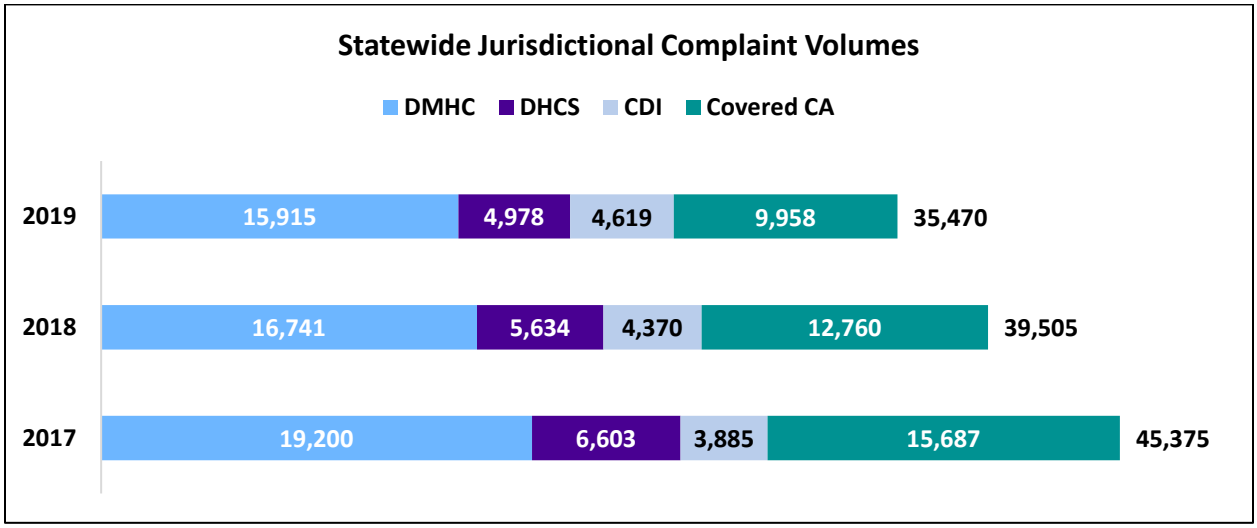
In 2019, these service centers received 6,458,041 consumer requests for assistance, continuing an annual decrease since 2016 (6,593,190 in 2018 and 7,423,511 in 2017). Nearly all (99%) of the requests for assistance were inquiries from consumers who required information, referrals, or other assistance rather than contacts to initiate a complaint.

Sections 4-7 include additional service center data and protocols information. Protocols outlined in prior reports are still applicable unless noted otherwise.

C. Statewide Health Care Complaint Data

The four reporting entities submitted 39,817 consumer complaints for Measurement Year 2019 (including 4,347 non-jurisdictional complaint cases). The 2019 statewide jurisdictional complaint volume was 35,470, continuing an annual decrease since 2016.

Figure 3.2

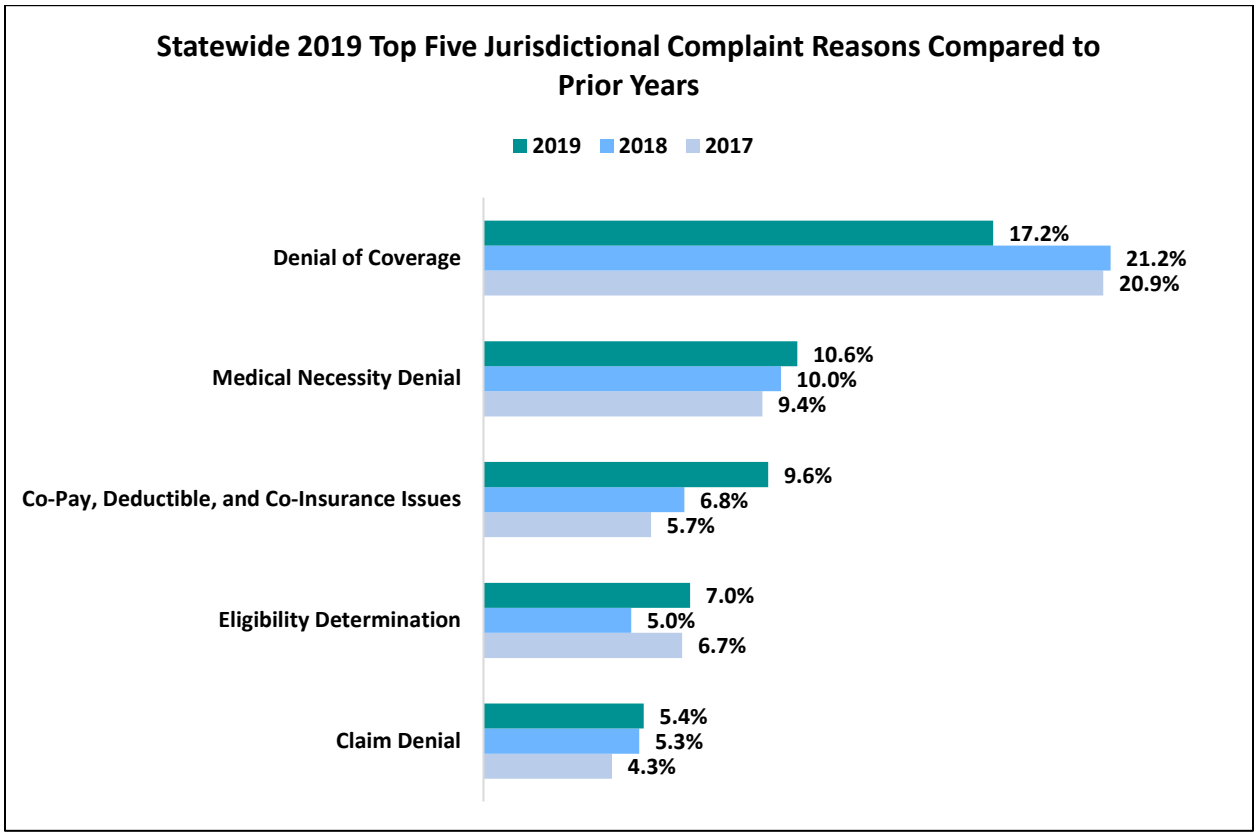


Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution.

Complaint Reasons

The following chart displays the most common reasons for the 35,470 jurisdictional complaints closed in 2019, along with the 2017 and 2018 data for those same categories.

Figure 3.3



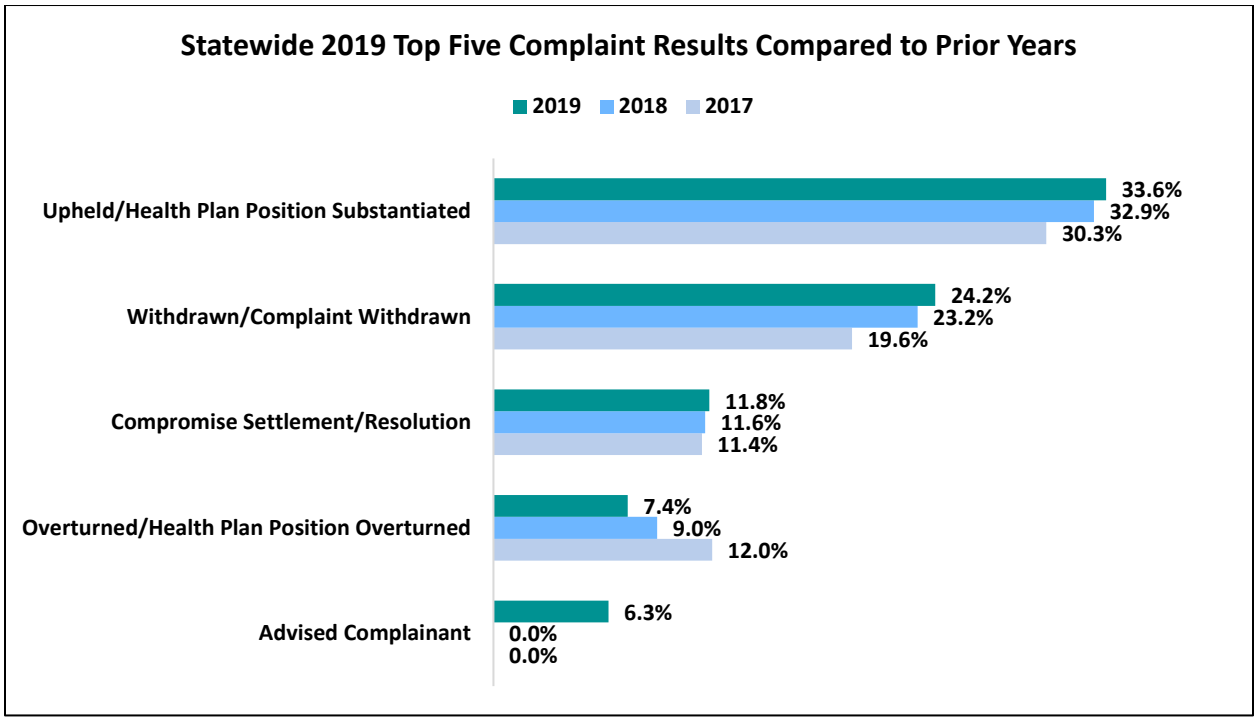
Note: The number of reasons exceeded the number of complaints because some cases had more than one reason submitted (44,473 reason entries for the 35,470 complaints in 2019). Some differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Complaint Results

The following chart shows the most common results for the 35,470 jurisdictional complaints closed in 2019, along with the 2017 and 2018 data for those same categories.

Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned 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.

Figure 3.4



Note: The number of results exceeded the number of complaints because some cases had more than one result reported (41,698 results entries from 35,470 complaints in 2019). Differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Resolution Time

The 2019 statewide average complaint resolution time was 41 days, a seven day decrease from the 2018 average. Resolution times are counted from the day a reporting entity opened a consumer complaint until the day the reporting entity closed the case.

Figure 3.5 2019 Complaint Resolution Times (in Days) by Reporting Entity

Reporting Entity	Minimum Duration	Maximum Duration	Average Resolution Time
DMHC	0	186	21
DHCS	0	448	51
CDI	0	1,163	103
Covered California	0	385	39

Note: The table analysis excludes CDI's non-jurisdictional complaints, which took three days on average to close.

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 of 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.

Demographic and Other Complaint Categories

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

- Complaint volumes continued to fall for the coverage sources of Covered California/Exchange (24% decrease between 2018 and 2019) and Medi-Cal (9% decrease). Complaint volumes regarding the Group and Medi-Cal/Medicare coverage sources increased slightly compared to the prior year.
- The 2019 statewide complaint distributions among most demographic categories were similar to the 2018 distributions.
- English continued to be the primary language identified for most complainants (84% of the 35,470 complaints in 2019), followed by Spanish (5%) and Other Languages (3%). Eight percent did not have a primary language identified.

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

Figure 3.6 Statewide 2019 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 (17.9%)	Denial of Coverage (28.2%)	Denial of Coverage (20.7%)	Pharmacy Benefits (25.6%)
2	Co-Pay, Deductible, and Co-Insurance Issues (10.7%)	Eligibility Determination (13.3%)	Eligibility Determination (9.7%)	Claim Denial (24.5%)
3	Medical Necessity Denial (10.3%)	Medical Necessity Denial (10.3%)	Co-Pay, Deductible, and Co-Insurance Issues (8.8%)	Medical Necessity Denial (15.5%)
4	Eligibility Determination (7.1%)	Co-Pay, Deductible, and Co-Insurance Issues (6.4%)	Scope of Benefits (7.6%)	Unsatisfactory Settlement/Offer (3.8%)
5	Out-of-Network Benefits (5.3%)	Quality of Care (6.1%)	Medical Necessity Denial (7.2%)	Rehabilitative/Habilitative Care (3.3%)

Section 4 – Department of Managed Health Care

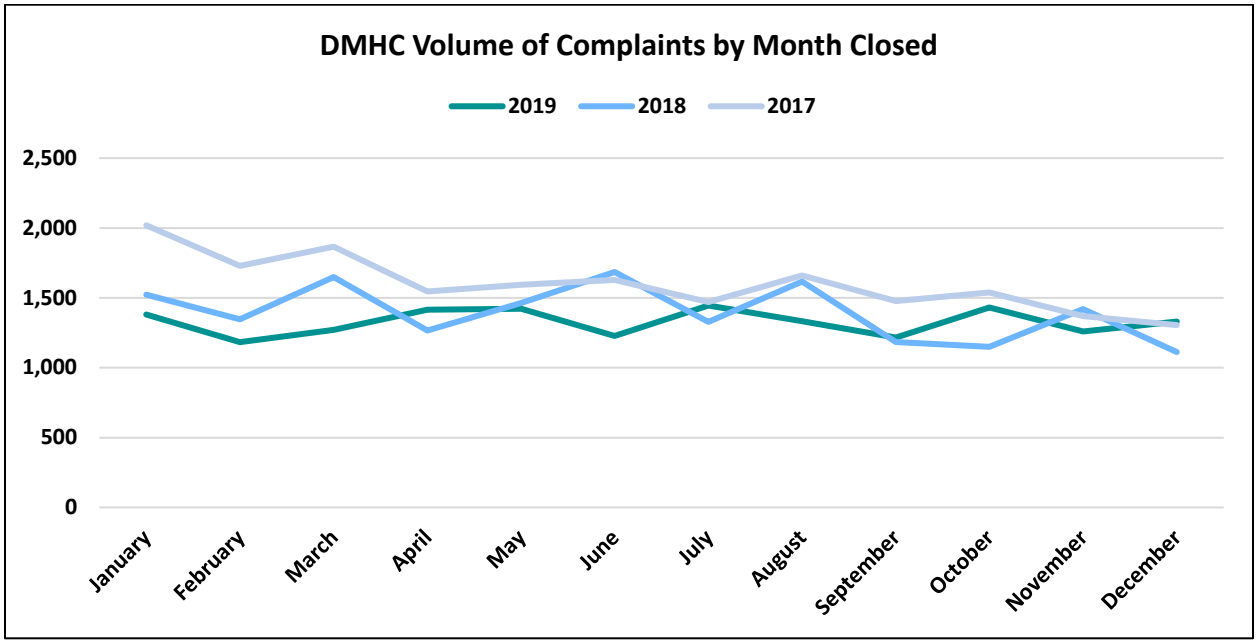
A. Overview

The Department of Managed Health Care (DMHC) regulates 96 percent of enrollment in state-regulated health plans. 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 138,804 requests for assistance from consumers in 2019, a six percent decrease in volume from the previous year. Requests for assistance include jurisdictional and non-jurisdictional complaints and inquiries.

With 15,915 complaints submitted for 2019, DMHC's complaint volume decreased for the third straight year (16,741 complaints in 2018, and 19,200 complaints in 2017).

Figure 4.1



The following figure outlines the DMHC complaint standards for its four reported complaint types.

Most of DMHC's 2019 complaints were the Standard Complaint type (71.9% of the 15,915 complaints), followed by Independent Medical Review (25.0%), Quick Resolution (2.6%), and Urgent Nurse Case (0.5%).

Figure 4.2 DMHC Help Center Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2019
Standard Complaint	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework Legal Affairs Branch: Casework for more complex legal cases	30 days, from receipt of a completed complaint application	21 days
Independent Medical Review (IMR)	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework IMR Contractor (MAXIMUS or IPRO): External Review decision Legal Affairs Branch: Legal review if needed	45 days, from receipt of a completed IMR application 7 days for cases that qualify for an expedited IMR	25 days Calculation includes time prior to the completion of the IMR application and time for the adoption of the determination
Urgent Nurse	Contact Center: Intake, initial casework, and routing Independent Medical Review/Complaint Branch: Casework, opens an IMR if an external review is needed	N/A	12 days Calculation includes time after the case is closed to the consumer while services received are confirmed
Quick Resolution	Contact Center: Intake and casework resolution	N/A	3 days

Note: The timeframes for DMHC's time standards are based on the date the DMHC receives a completed complaint/IMR application. DMHC may review complaints involving consumers with urgent clinical issues as Urgent Nurse Case complaints, or through expedited IMR and Standard Complaint processes.

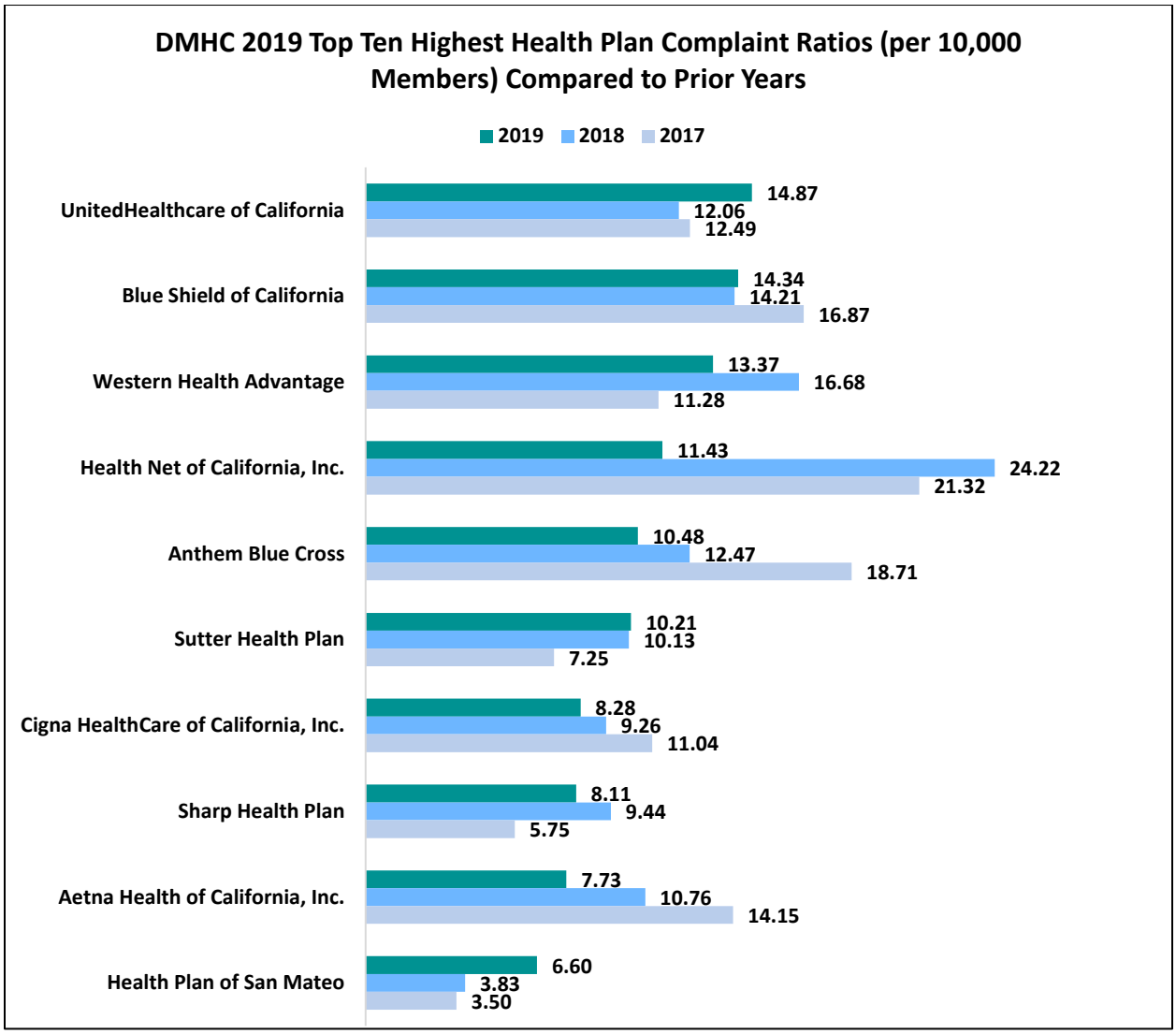
B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays the DMHC-regulated full-service health plans with the highest complaint ratios in 2019 among plans with enrollment over 70,000 members.

- Measurement Year 2019 was the first year that data for Health Net of California, Inc. and Health Net Community Solutions could be separated for the three-year trend analysis. Health Net of California, Inc.'s complaint ratios vary from prior year report displays because they were recalculated to remove the Health Net Community Solutions complaint volumes.

Figure 4.3



Note: The display excludes health plans with enrollment under 70,000 members in 2019. Health Net figures vary from prior reports due to a methodology change to separate data for the Health Net licenses.

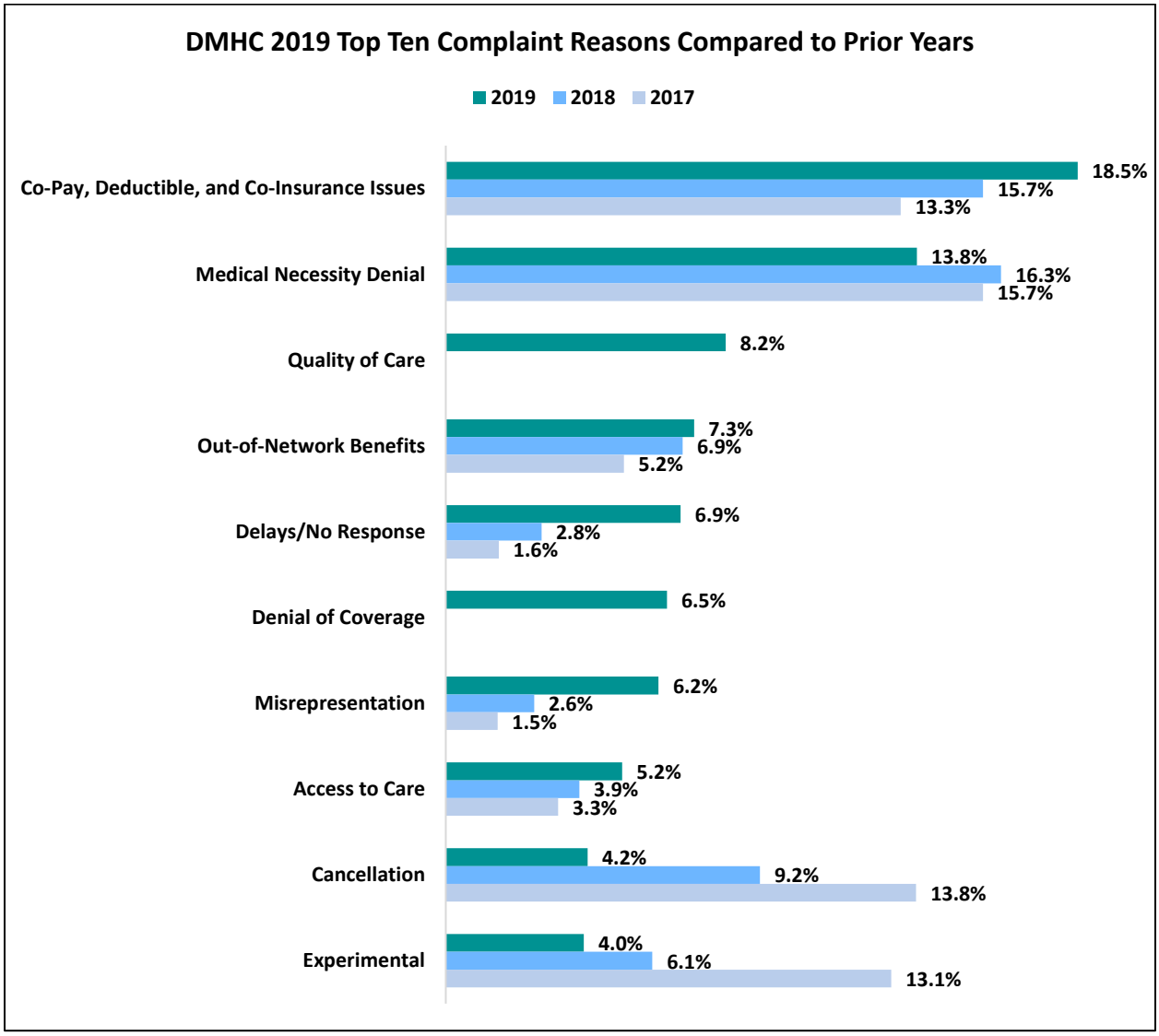
Complaint Reasons

The following chart displays the most common complaint reasons reported by DMHC in 2019, as well as the 2017 and 2018 data for those same reason categories. Some differences between measurement years may be due in part to reporting changes rather than changes in incidence. DMHC noted that some of its 2019 collection categories were reported under different OPA standard data elements than used in prior years. For example, some 2019 complaints:

- Previously submitted as Provider Attitude and Service were reported as Quality of Care.
- Previously submitted as Coordination of Benefits or Coverage Question were reported as Denial of Coverage.

- Previously submitted as Experimental/Investigational Denial were reported as Experimental.

Figure 4.4



Note: Some differences between measurement years may be due in part to reporting changes rather than changes in incidence. The 2017 and 2018 data for Experimental were displayed in prior reports as Experimental/Investigational Denial.

Inquiry Topics and Referrals

The following table shows the most common topics of inquiries and complaints in 2019 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 Help Center staff and do not include certain common calls addressed within DMHC's Interactive Voice Response system, such as for automated referrals to Covered California, Health Care Options, and particular health plans.

Figure 4.5

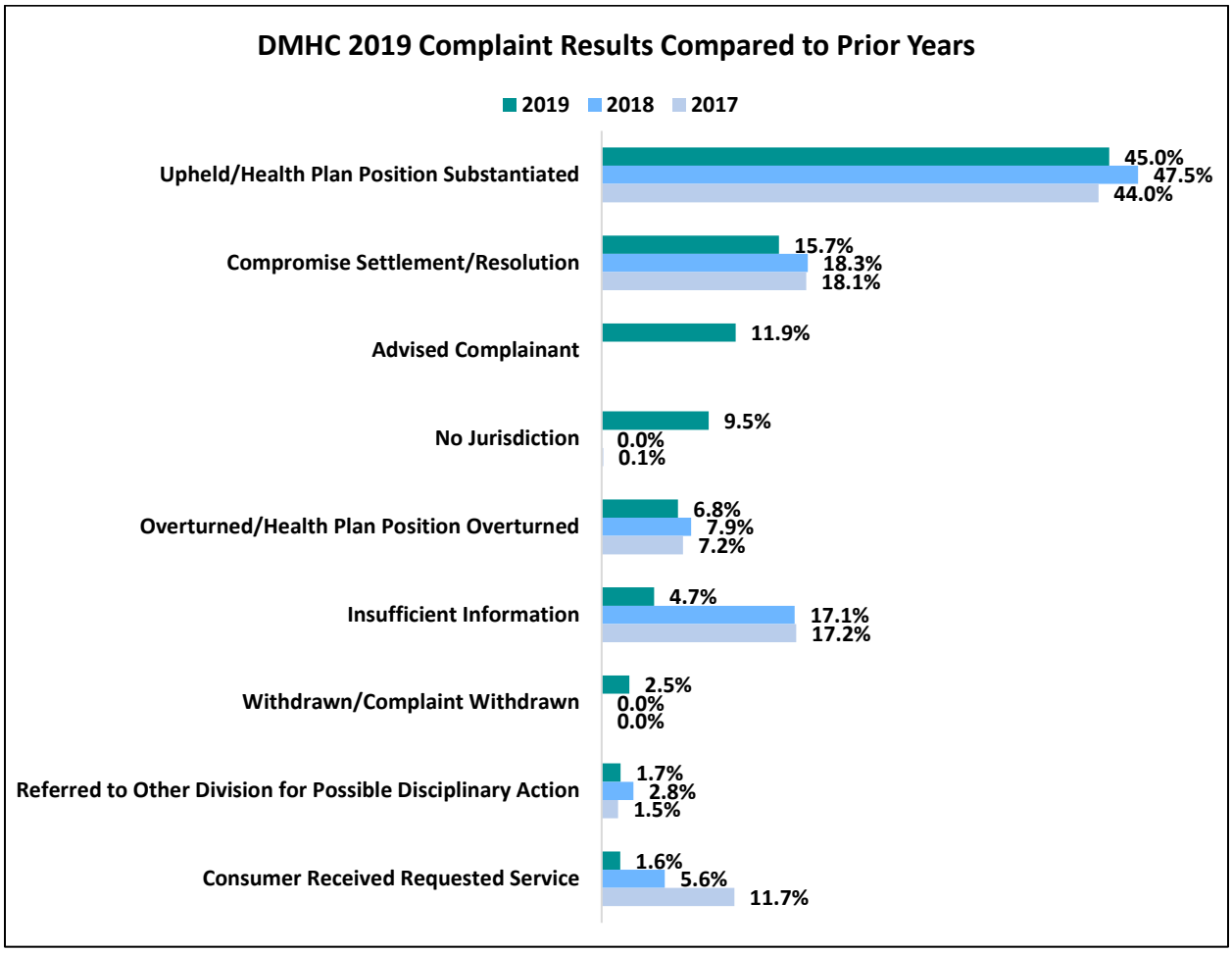
Ranking	Inquiry Topic	2019 Volume	Organization(s) Referred to
1 (most common)	General Inquiry/Info	4,278	Department of Health Care Services (DHCS) Covered California Centers for Medicare and Medicaid Services (CMS) Health Insurance Counseling and Advocacy Program (HICAP) California Department of Insurance (CDI) U.S. Department of Labor (DOL) Health Consumer Alliance partners (HCA) Various Departments of Insurance (DOIs) Department of Consumer Affairs (DCA) Department of Social Services (CDSS)
2	Claims/Financial	712	CDI CMS DOIs DHCS HICAP DOL
3	Provider Service/Attitude	650	CMS DCA DHCS
4	Enrollment Disputes	483	Covered California DHCS CDI
5	Access Complaints	338	DHCS HICAP CMS
6	Coverage/Benefits Dispute	324	DHCS CMS HICAP CDI
7	Coordination of Care	169	CMS HICAP DHCS
8	Plan Service/Attitude	113	CMS DHCS HICAP
9	Appeal of Denial – IMR	50	CDI DOIs CMS
10	Wrong Number	46	Other

Complaint Results

The following chart displays DMHC's 2019 complaint results, along with the 2017 and 2018 data for those same results categories. DMHC noted that some of its 2019 collection categories were reported under different OPA standard data elements than used in prior years. For example, some 2019 complaints:

- Previously submitted as Insufficient Information were reported as Advised Complainant or No Jurisdiction.
- Previously submitted as Consumer Received Requested Service were reported as No Jurisdiction.
- Previously submitted as Insufficient Information were reported as Withdrawn/Complaint Withdrawn.

Figure 4.6



Note: Some differences between measurement years may be due to changes in data collection and reporting rather than changes in incidence. Two results categories with low volumes were excluded from the display: Claim Settled and Policy Not in Force. 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 three figures show the 2019 results for DMHC's most commonly reported complaint reasons.

Figure 4.7

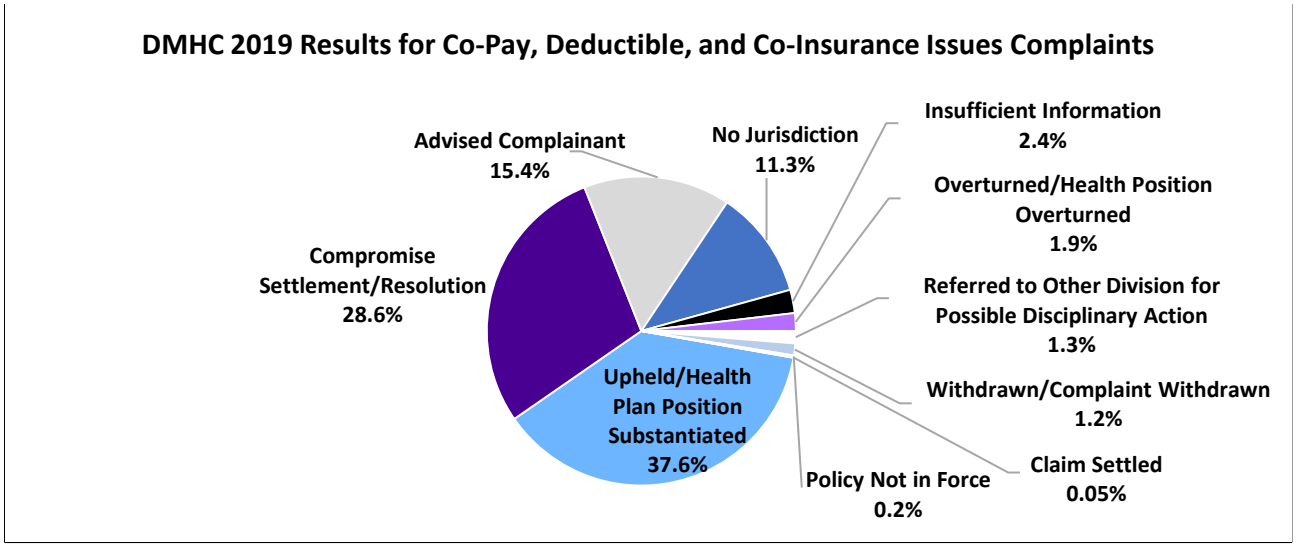


Figure 4.8

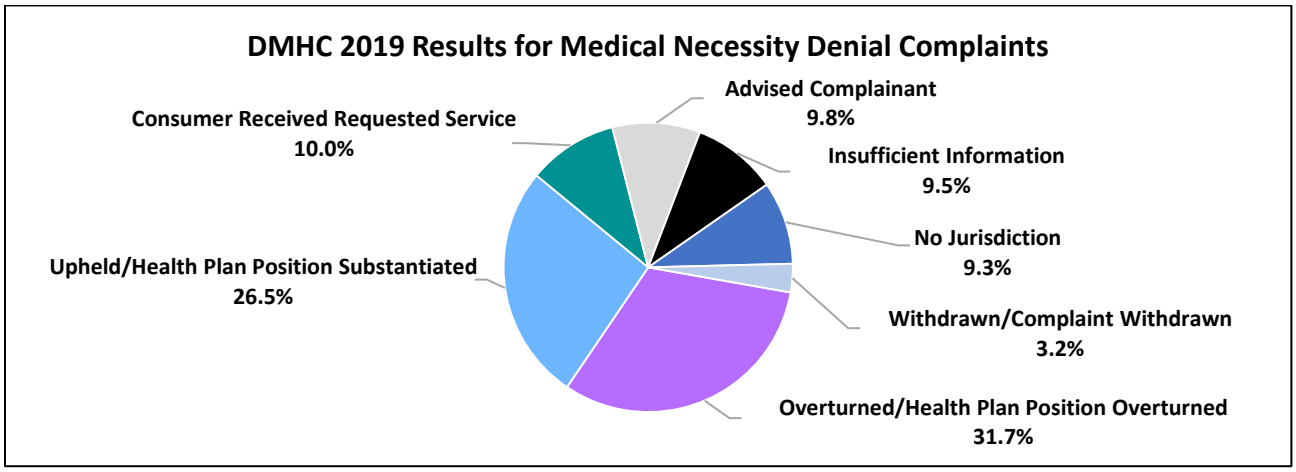
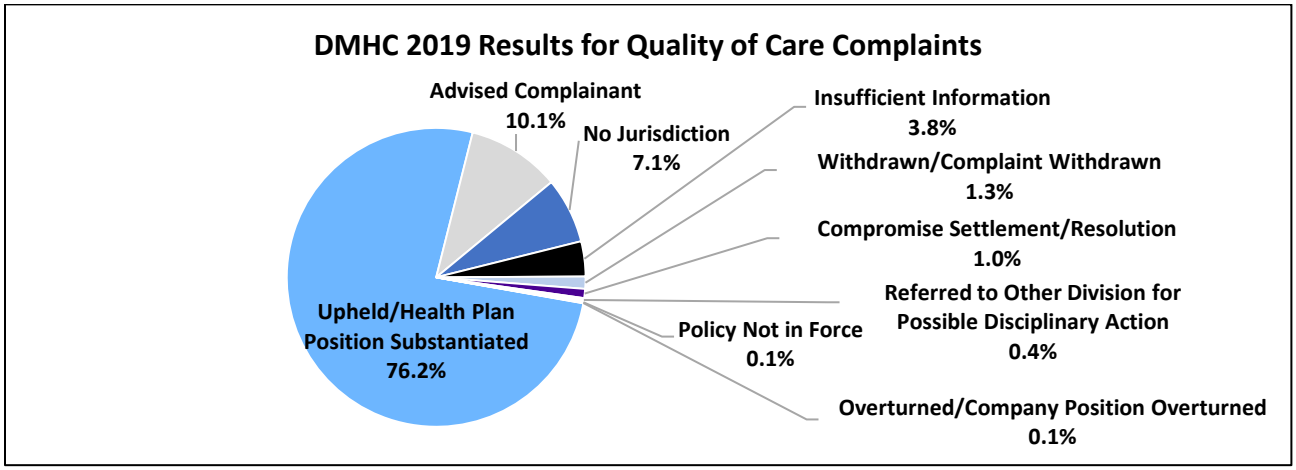


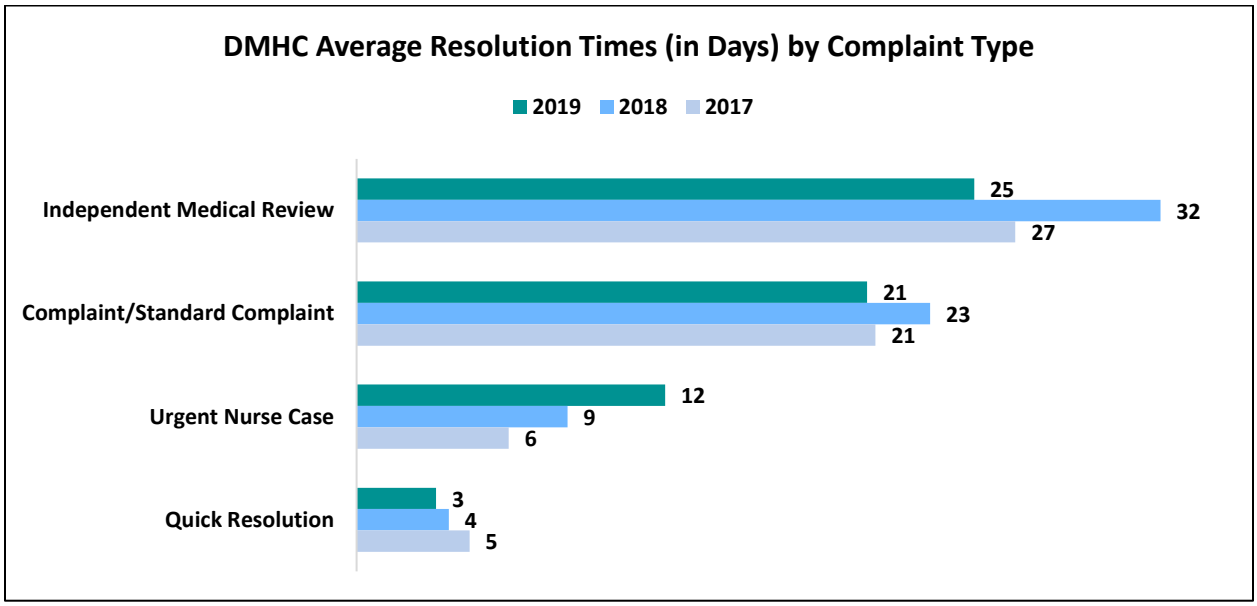
Figure 4.9



Resolution Time

DMHC's average resolution time for its 2019 complaints was 21 days, a four-day decrease from the prior year average.

Figure 4.10



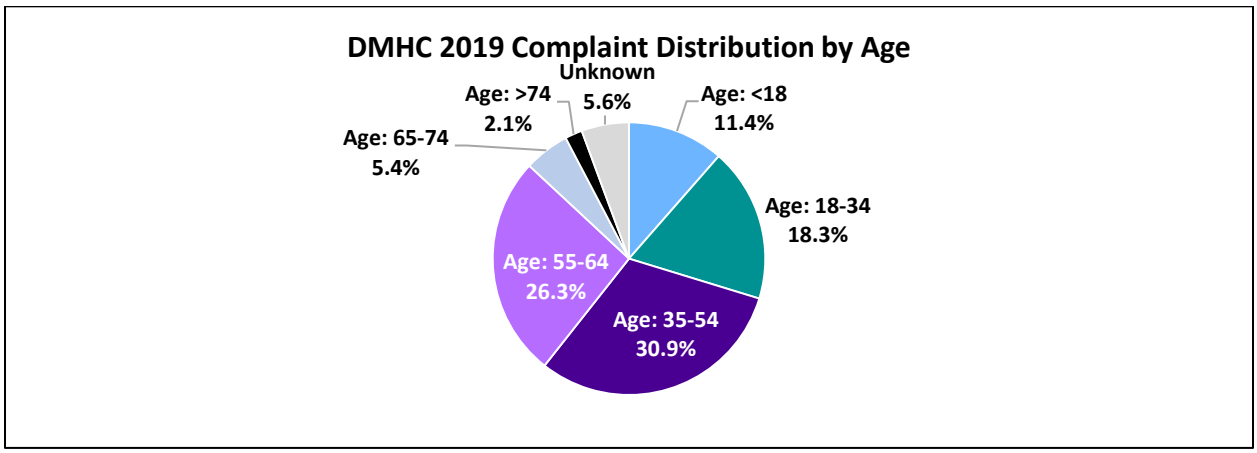
Note: The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Figures detailing average resolution times include case durations with time prior to the completion of the complaint/IMR application.

C. Demographics and Other Complaint Elements

Age

The average age of DMHC complainants in 2019 was 43 years old. Complaint volumes increased slightly compared to the prior year for age group categories of Under 18, Age 65-74, and Age 75 and Older.

Figure 4.11



Gender

Female continued to be the most commonly reported gender of DMHC's complainants (57.2% of the 15,915 complaints in 2019). DMHC also submitted complaints with Male (42.3%) or Other (0.6%) identified.

Race

White was the most commonly reported Race category (37.6% of the complaints in 2019), followed by Refused (36.4%), Unknown (10.3%), Asian (5.9%), Other (4.9%), Black or African American (4.3%), American Indian or Alaska Native (0.5%), Other Pacific Islander (0.2%), and Native Hawaiian (Under 0.1%).

Ethnicity

Not Hispanic or Latino was the most commonly reported Ethnicity category (53.3% of the complaints in 2019), followed by Refused (36.4%) and Hispanic or Latino (10.3%).

Language

The percentage distributions and volumes of complaints with Spanish or Other combined languages identified as the complainant's primary language increased slightly in 2019 compared to the prior year. English (94.3% of the complaints in 2019) continued to account for most of the DMHC complaints. Spanish accounted for 3.4 percent and Other languages (12 languages, each 0.4% or less) for 2.3 percent.

Mode of Contact

DMHC's 2019 percentage distributions by initial mode of contact did not vary much from the prior year. The Online mode (47.5% of the complaints in 2019) accounted for the greatest number of complaint initiations, followed by Mail (31.4%), Fax (16.7%), Telephone (3.2%), and Email (1.2%).

Regulator

DMHC continued to be the identified regulator for most of its submitted complaints (90.5% in 2019). The other reported regulators were the U.S. Department of Labor (2.9%), Centers for Medicare and Medicaid Services (1.9%), California Department of Insurance (1.6%), Other (1.3%), Out-of-State Department of Insurance (0.6%), and U.S. Office of Personnel Management (0.3%). Nearly one percent of complaints (0.8%) involved health coverage without a regulator.

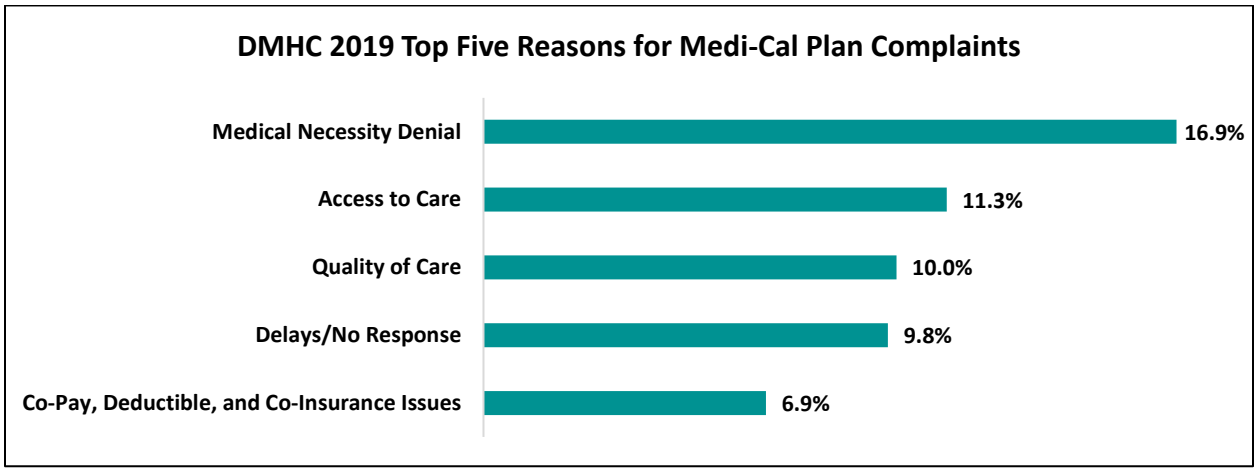
Source of Coverage

Group (49.4% of the complaints in 2019) continued to be DMHC's highest-volume coverage source. Medi-Cal was the next-most common (15.5%), followed by Individual/Commercial (13.6%), Covered California/Exchange (13.3%), CalPERS (2.8%), Medicare (2.2%), Medi-Cal/Medicare (1.2%), COBRA (0.6%), and Uninsured (0.1%). Around one percent were Unknown.

The following chart displays DMHC's top reasons for Medi-Cal plan complaints in 2019.

DMHC submitted 2,460 complaints with Medi-Cal identified as the coverage source.

Figure 4.12

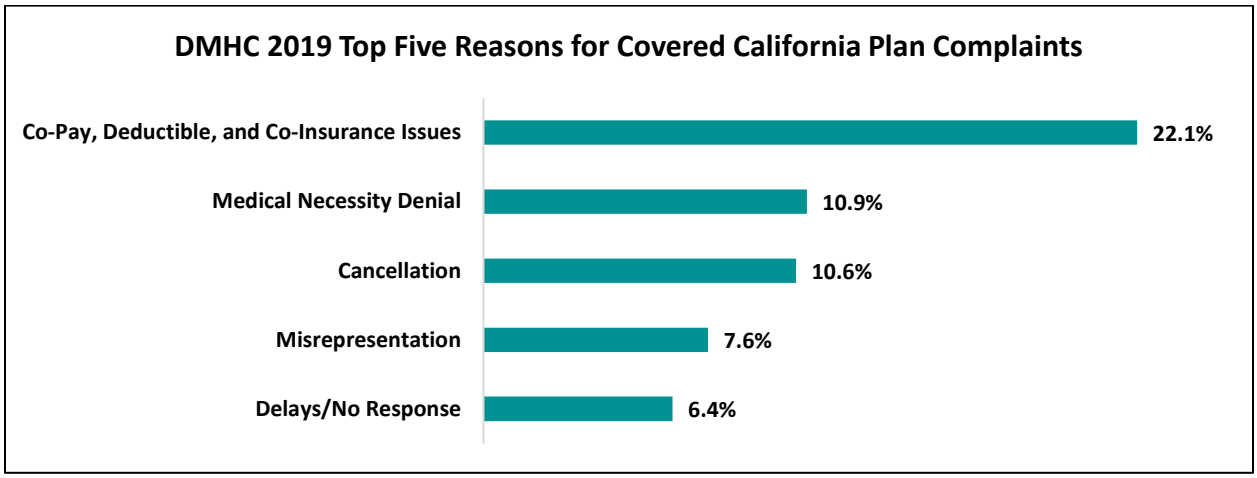


Note: Some differences between measurement years may be due in part to changes in reporting rather than changes in incidence. The number of Medi-Cal plan complaint reasons (3,436) exceeded the number of complaints (2,460) because some cases had more than one reason reported.

Figures 4.13-4.12 address the DMHC complaints with the coverage source submitted as Covered California/Exchange. DMHC regulates most of the health plans offered through the Covered California marketplace.

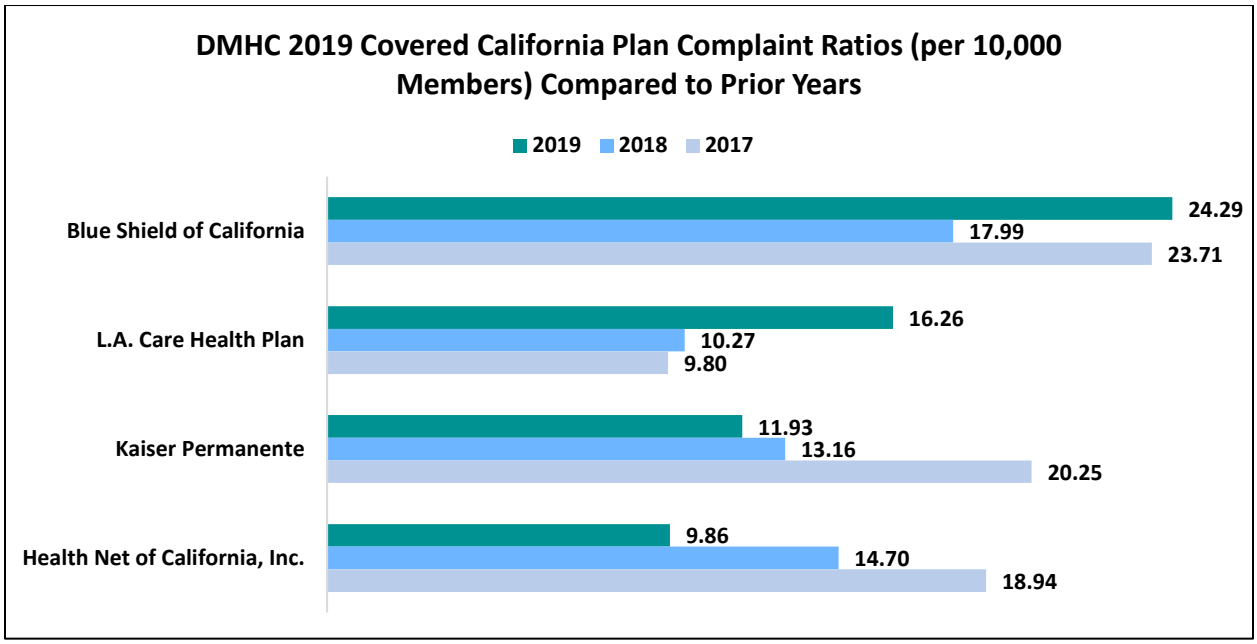
For 2019, DMHC submitted 2,116 Covered California plan complaints.

Figure 4.13



Note: Some differences between measurement years may be due in part to changes in reporting rather than changes in incidence. The number of reasons (2,994) exceeded the number of complaints (2,116) because some cases had more than one reason reported.

Figure 4.14



Note: The display excludes plans with Covered California enrollment under 70,000 members in 2019.

Product Type

DMHC reported health plan models under the product type category. HMO continued to be DMHC's most common product type (63.5% of the 15,915 complaints in 2019), followed by PPO (31.5%), EPO (2.4%), POS (1.1%), and Other (0.2%). One percent did not have a product type identified (1.4% Unknown)

D. Consumer Assistance Center Details

The DMHC Help Center received 138,804 requests for assistance from consumers in 2019, including 117,306 requests by telephone.

Figure 4.15 DMHC Help Center - 2019 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	2,063
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	81,304
Number of Jurisdictional Inquiry Calls	17,101
Number of Non-Jurisdictional Calls	7,001
Average Wait Time to Reach a CSR	0:02:03
Average Length of Talk Time (time between a CSR answering and completing a call)	0:09:16
Average Number of CSRs Available to Answer Calls (during Service Center hours)	9 full-time equivalent staff on average

Consumer Assistance Protocols

DMHC reported the following updates to Help Center systems, protocols, and standards since 2018.

- DMHC contracted with a second review organization, Island Peer Review Organization, Inc. (IPRO), to provide case analysis for Independent Medical Reviews (IMRs) starting in April 2019.
- DMHC's complaint system also was updated to help the department track the work with multiple review organizations and achieve better efficiency and quality of IMRs.

Section 5 – Department of Health Care Services

A. Overview

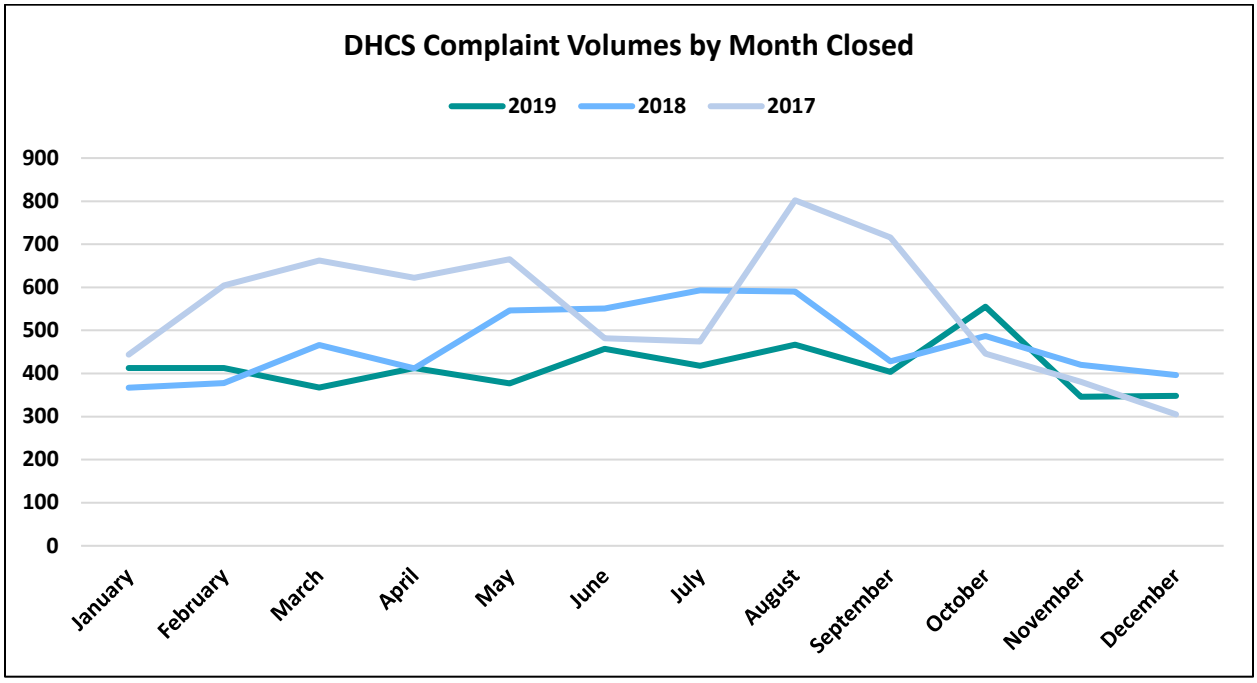
The Department of Health Care Services (DHCS) operates the Medi-Cal program, which is a public health care program that provides comprehensive health care services at no or low-cost for low-income Californians. In 2019, around 13 million people received from the Medi-Cal program. At the time of this report publication, this number is around 14 million.

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 1,246,505 requests for assistance from consumers in 2019, a 15 percent decrease from the prior year. These requests include 4,978 State Fair Hearings and 1,241,527 inquiries to the three DHCS service centers.

The following chart displays the monthly volumes for the 4,978 complaints in 2019, the 5,634 complaints in 2018, and the 6,603 complaints in 2017.

Figure 5.1



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

Figure 5.2 Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2019
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.	90 days from the hearing request date	51 days

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

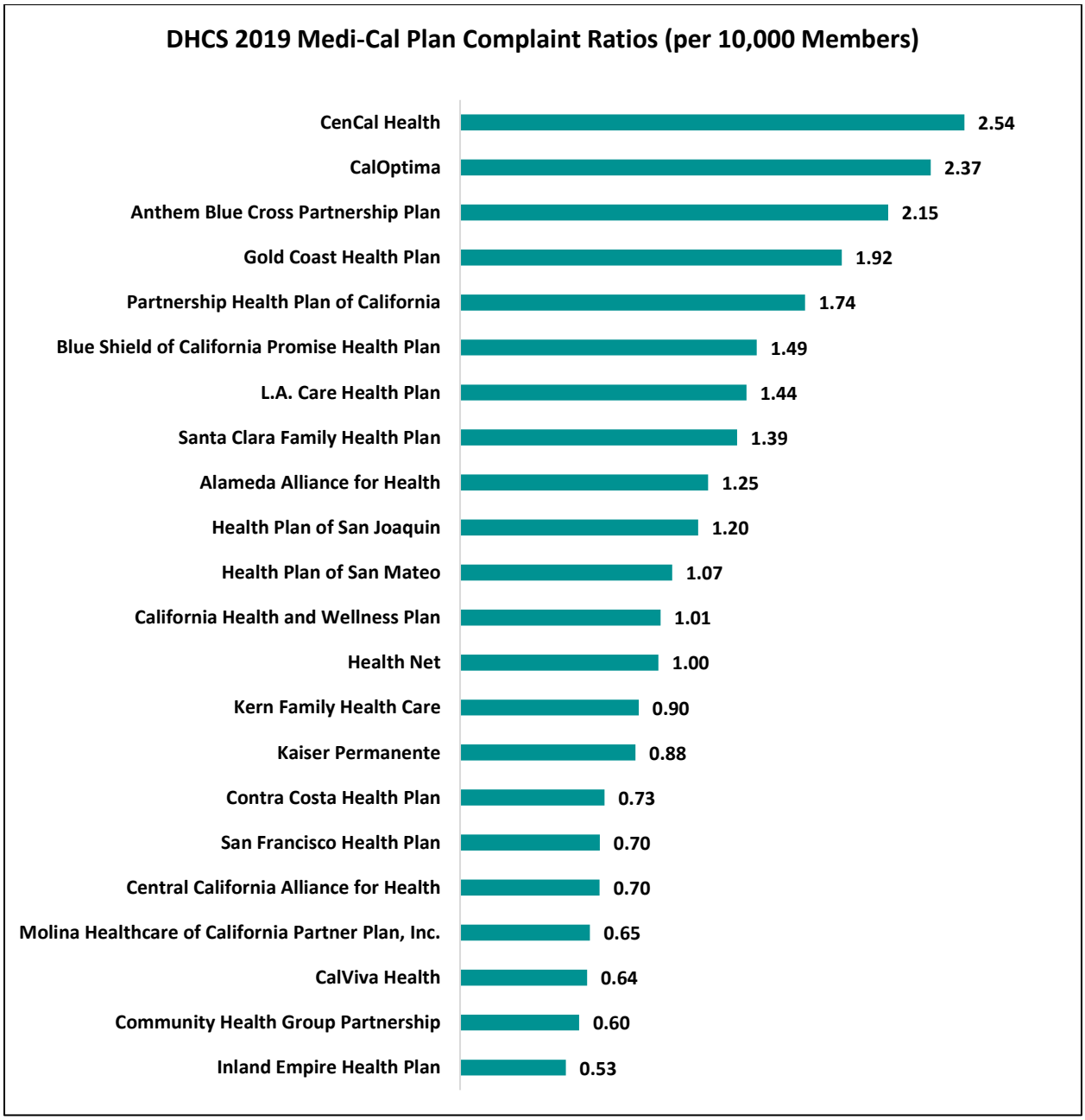
B. Complaint Ratios, Reasons, and Results

Of the 4,978 complaints reported by DHCS for 2019, over 40 percent was for Medi-Cal's dental delivery system, nearly 30 percent involved Fee-for-Service Medi-Cal, and slightly over 27 percent was for Medi-Cal managed care plans. Other reported delivery systems combined accounted for nearly two percent of the DHCS complaints.

Health Plan Complaint Ratios

The following chart displays ratios of the Medi-Cal managed care plans' statewide complaints per 10,000 plan members.

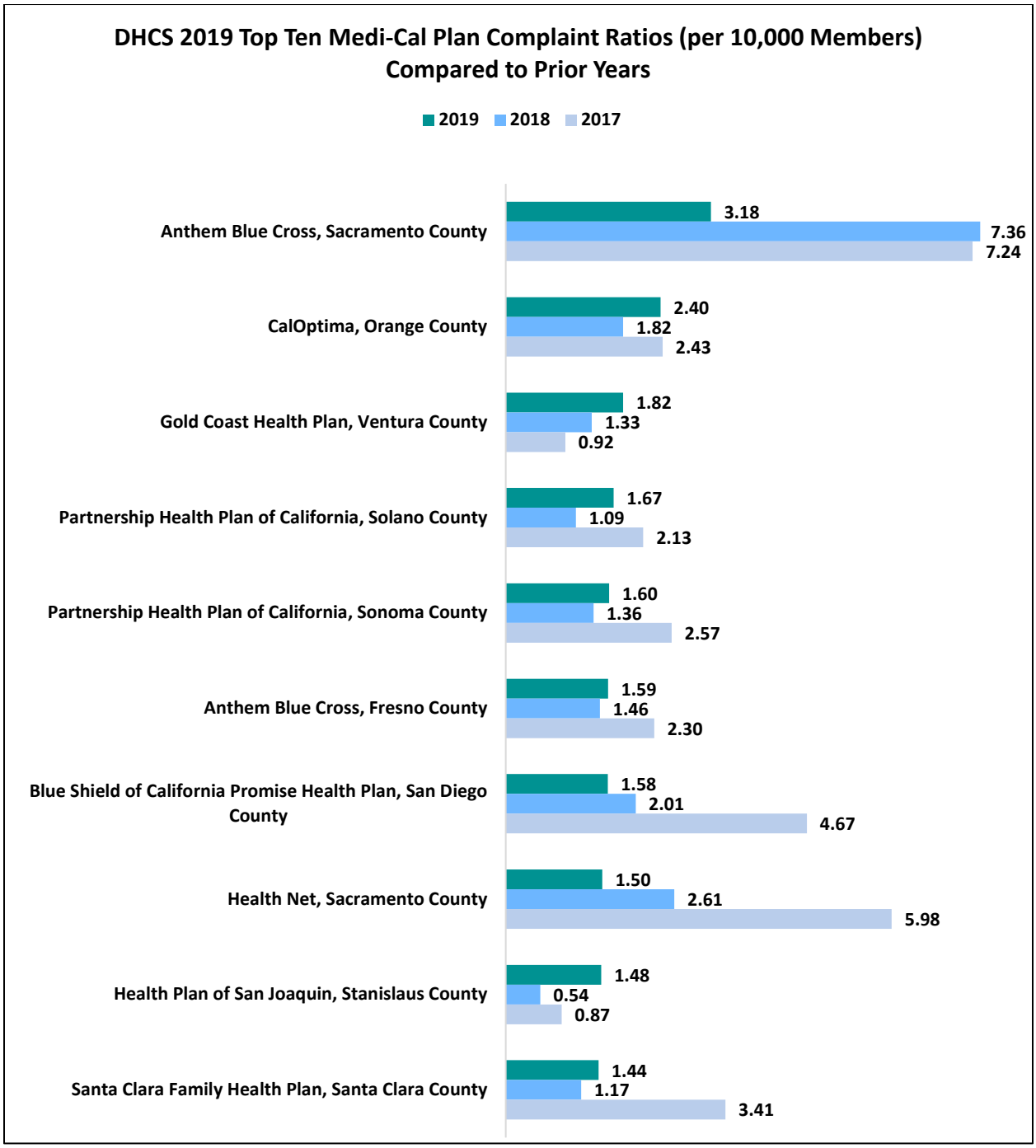
Figure 5.3



Note: The above display excludes Medi-Cal plans with 2019 statewide enrollment under 70,000 members. Many of the health plans shown serve multiple counties, including under different Medi-Cal contracting models. DHCS typically monitors quality issues by county contract. Because OPA has combined data, the analysis will not directly correlate with DHCS-produced reports. Blue Shield of California Promise Health Plan was previously reported under the name Care 1st Partner Plan.

The following chart displays the Medi-Cal plans with the highest complaint ratios in 2019 among plans with county Medi-Cal enrollment over 70,000 members. The complaint ratio is the total number of plan complaints by county residents per the plan's county enrollment.

Figure 5.4



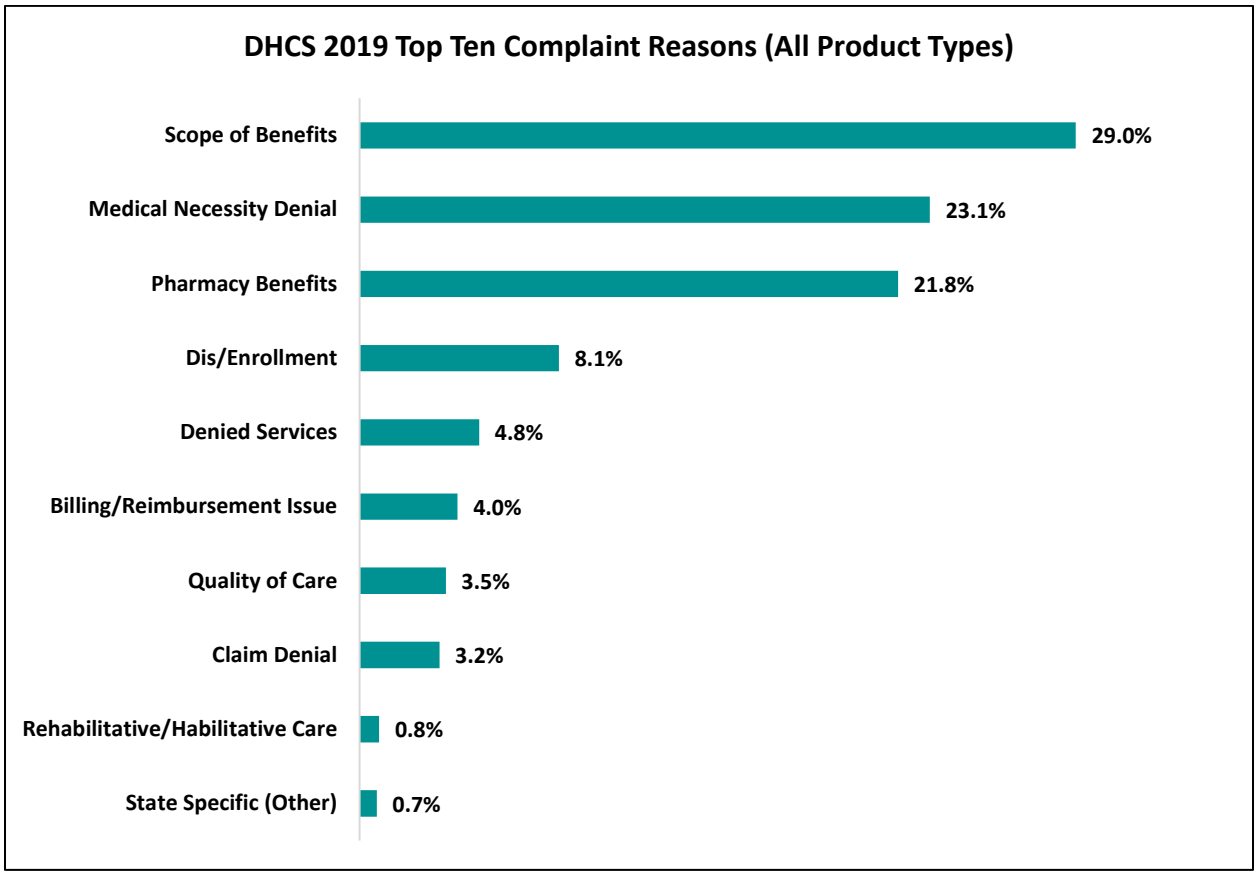
Note: The above display excludes plans with 2019 county Medi-Cal enrollment under 70,000 members. Blue Shield of California Promise Health Plan was previously reported under the name Care 1st Partner Plan.

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 shows the top complaint reasons in 2019 for all DHCS delivery systems (reported as product types). The total number of submitted complaint reasons (5,039) exceeded the number of complaints (4,978) because some cases had more than one reason reported.

Figure 5.5

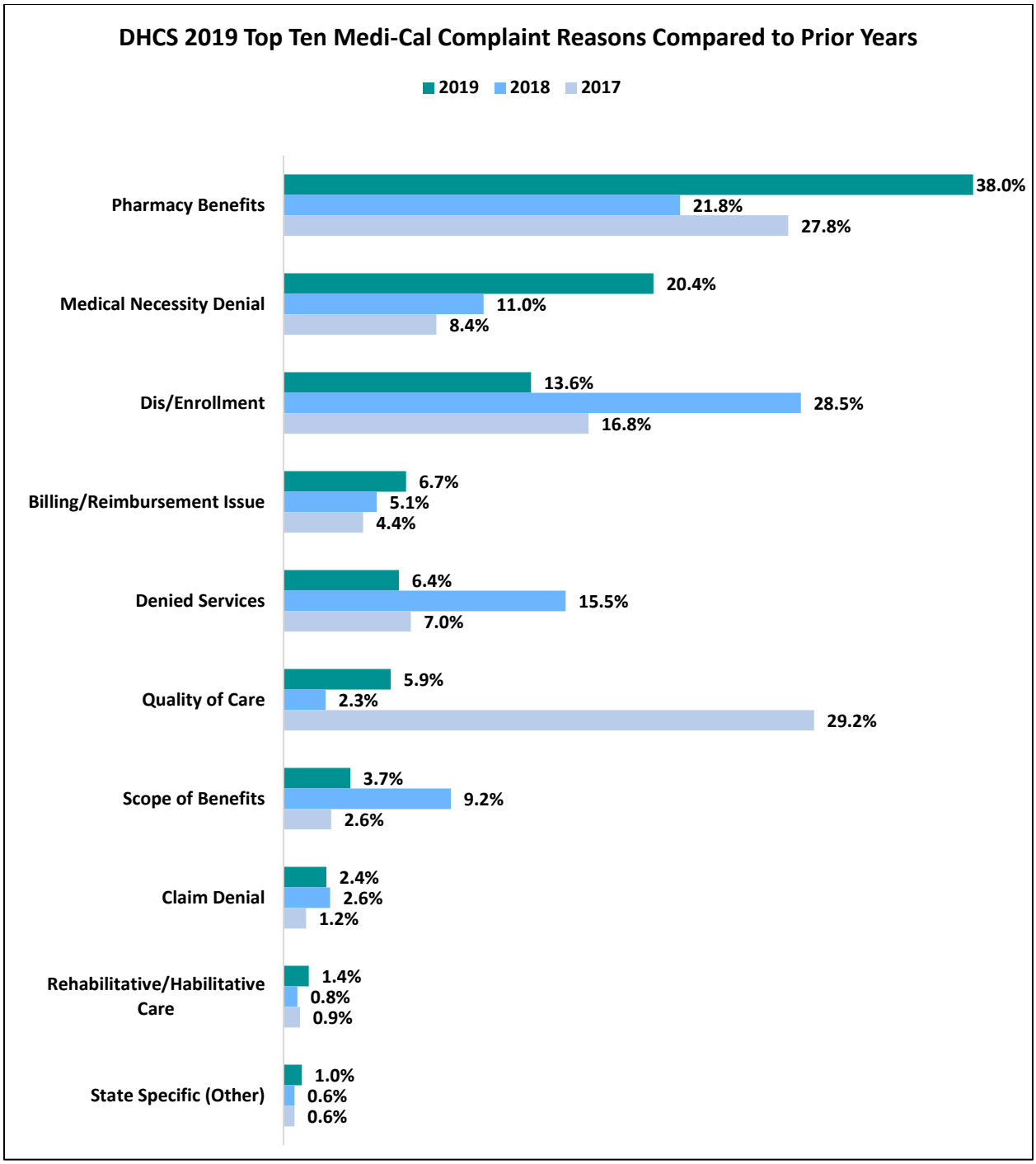


The top complaint reasons by DHCS delivery system (with each reason's distribution among the specified delivery system):

- Managed Care – Dis/Enrollment (23.8%)
- Fee-for-Service – Pharmacy Benefits (60.6%)
- Dental – Scope of Benefits (66.9%)
- Mental Health – Denied Services (51.1%)
- Long Term Care – Denied Services (50.0%)
- Medi-Cal Coordinated Care – Denied Services (25.8%)

The following chart displays the top complaint reasons in 2019 for Medi-Cal Managed Care and Fee-for-Service, as well as the 2017 and 2018 data for those same reasons.

Figure 5.6



Note: Differences between measurement years may be due in part to reporting changes rather than changes in incidence.

Inquiry Topics and Referrals

The following figures display the most common inquiry topics consumers contacted DHCS's services centers about in 2019, as well as the department or other service center the consumers were referred to about each topic.

Figure 5.7 Office of the Ombudsman 2019 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2019 Volume	Organization(s) Referred to
1 (most common)	Medi-Cal Eligibility	43,151	County Medi-Cal Office
2	Fee-for-Service	8,060	DHCS Fee-for-Service Help Line (Medi-Cal Telephone Service Center)
3	Health Care Options	5,283	Health Care Options
4	Medicare	3,771	Medicare
5	Covered California	3,000	Covered California
6	Mental Health	1,962	County Mental Health
7	Medi-Cal Dental	1,662	Medi-Cal Dental Program
8	State Fair Hearings	1,160	California Department of Social Services

Figure 5.8 Medi-Cal Telephone Service Center 2019 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Organization(s) Referred to
1 (most common)	Beneficiary Inquiry/Eligibility	County Medi-Cal 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	Beneficiary Inquiry/Coverage	Low Income Subsidy

Note: The Medi-Cal Telephone Service Center ranking was estimated by DHCS and so does not have reported volumes.

Figure 5.9 Medi-Cal Dental Telephone Service Center 2019 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2019 Volume	Organization(s) Referred to
1 (most common)	Complaints about care or treatment performed	1,219	California Dental Board
2	Share of Cost	1,020	Department of Social Services
3	Complaints against office (non-treatment)	364	California Dental Board
4	Miscellaneous	81	California Dental Board County Medi-Cal Office

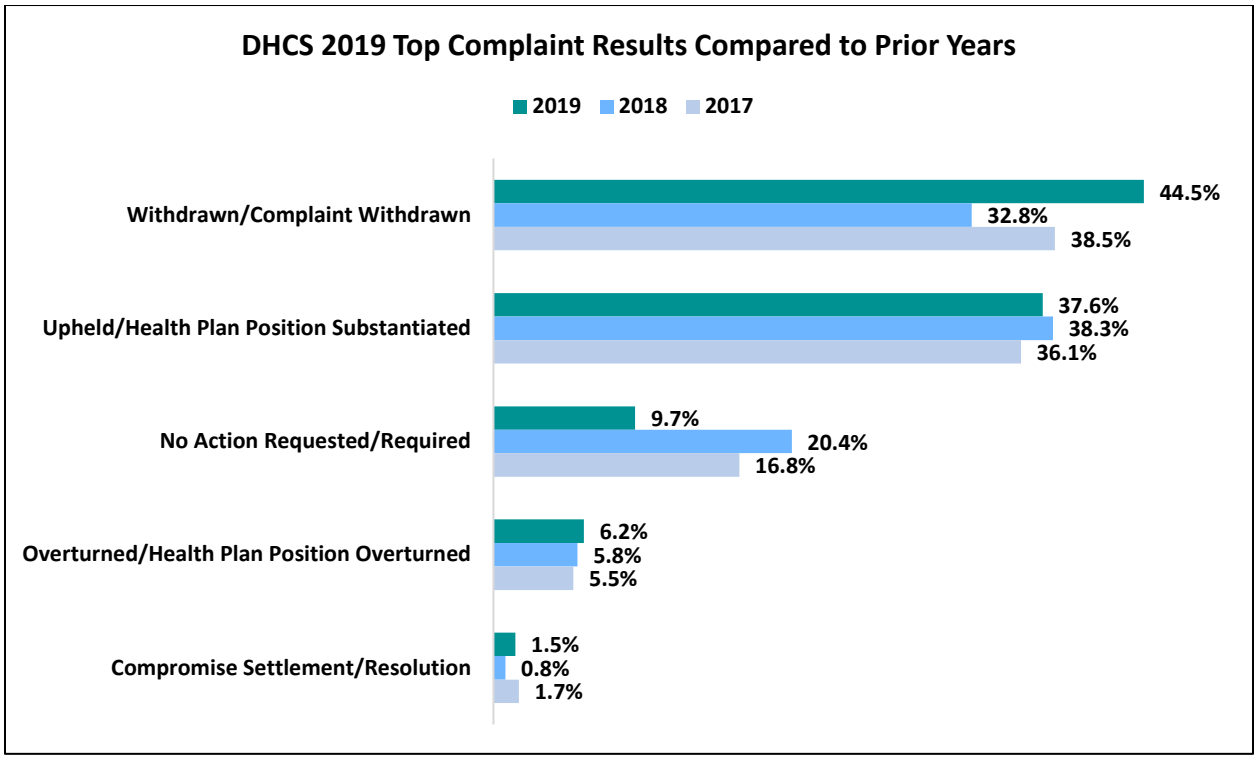
Note: DHCS indicated that the 2019 data for first two ranked topics were captured through the Service Center's Customer Relationship Management system.

Complaint Results

The following chart displays the most common complaint results for DHCS in 2019, as well as the 2017 and 2018 data for the same categories. The number of results (4,986) exceeded the number of complaints (4,978) because some cases had more than one result reported.

DHCS noted that the reduction in No Action Requested/Required and the increase in Withdrawn/Complaint Withdrawn are associated with a collaborative effort by DHCS and CDSS to reduce the number of cases closed with a Non-Appearance Dismissal Ruling by increasing the use of CDSS's formal fair hearing withdrawal process.

Figure 5.10



Note: Nine results categories with low volumes were excluded from display. Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned 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.

The following figures display the 2019 results for the three top complaint reasons reported by DHCS.

Figure 5.11

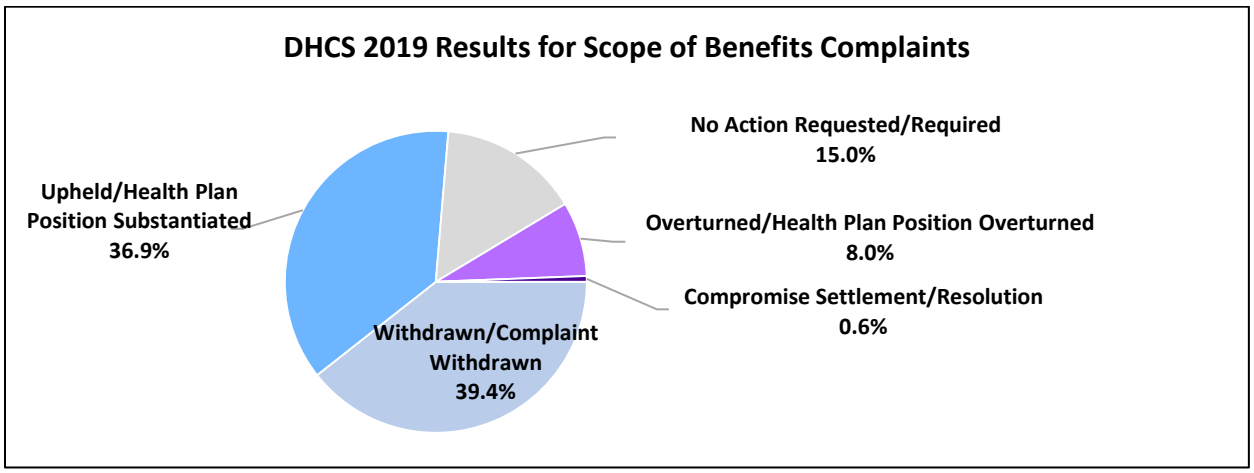


Figure 5.12

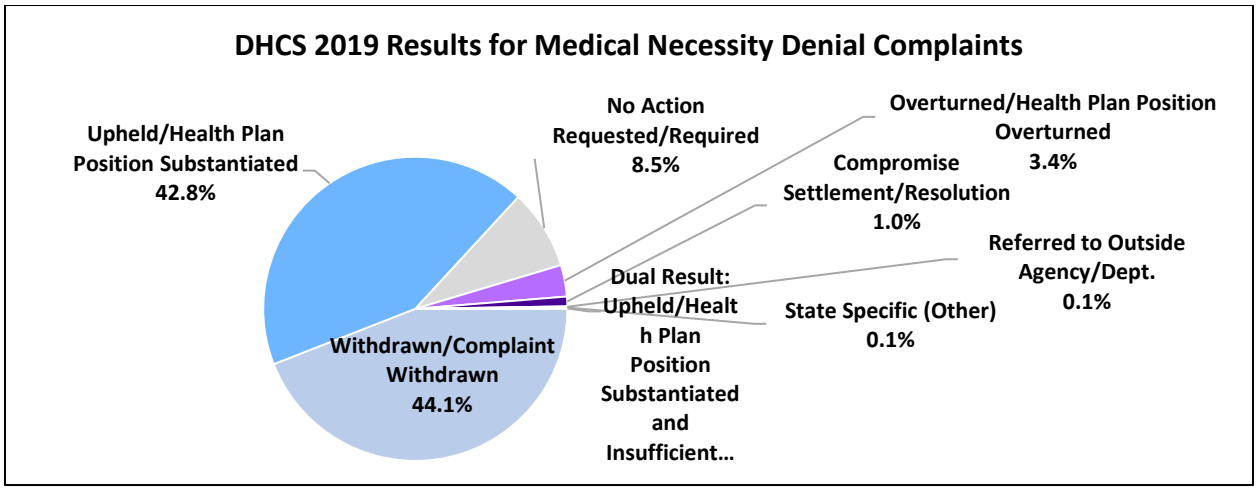
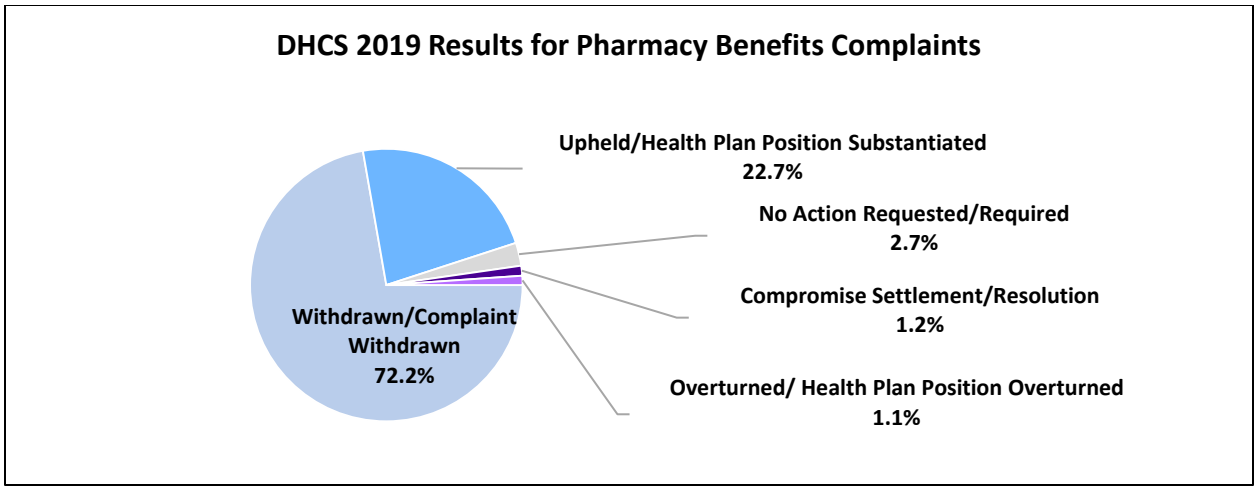


Figure 5.13



DHCS indicated that, in addition to the collaborative effort that increased Withdrawn/Complaint Withdrawn results in general, Pharmacy Benefits complaints often were withdrawn after patient services were authorized or a change in therapy met medical needs.

Resolution Time

The 2019 State Fair Hearings submitted by DHCS took 51 days on average to resolve, 11 days fewer than the prior year and continuing an annual decrease each year since 2015. The 2019 average resolution times by DHCS delivery system:

- Managed Care – 79 days
- Medi-Cal Coordinated Care – 71 days
- Mental Health – 72 days
- Long Term Care – 69 days
- Fee-for-Service – 48 days
- Dental – 33 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.

Age

The average age of the DHCS complainant for 2019 complaints was 44 years old. For the 4,978 complaints reported by DHCS, Age Under 18 accounted for 13.4 percent, Age 18-34 for 14.4 percent, Age 35-54 for 20.3 percent, Age 55-64 for 18.9 percent, Age 65-74 for 6.3 percent, and Age 75 and Older for 4.1 percent. Nearly 23 percent did not have age identified. Compared to the prior year, all age groups except for Age 75 and Older had a decrease in complaint volume.

Gender

DHCS and CDSS do not collect gender data as part of the Medi-Cal enrollment process or for State Fair Hearing filings. The data reported to OPA under gender represents data collected about sex. For the 4,978 DHCS complaints in 2019, the complainant's sex was identified as Female for nearly 43 percent (42.9%) and as Male for slightly over 30 percent (30.4%). Sex was unknown for over 26 percent (26.7%).

Race

Over 40 percent of the DHCS 2019 complaints did not have the complainant's race identified (41.8% Refused/Unknown). Among the known categories, White was the most commonly reported (37.3%), followed by Black or African American (9.7%), Other (6.0%), and Asian (4.0%). American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander categories each accounted for less than one percent.

Ethnicity

Most of the DHCS 2019 complaints did not have the complainant's ethnicity identified (55.4% Refused/Unknown). Not Hispanic or Latino accounted for over a fourth of the complaints (26.2%). Over 18 percent were Hispanic or Latino (18.4%). It is undetermined how the increase in Refused/Unknown volumes compared to the prior year affected distributions among the known categories.

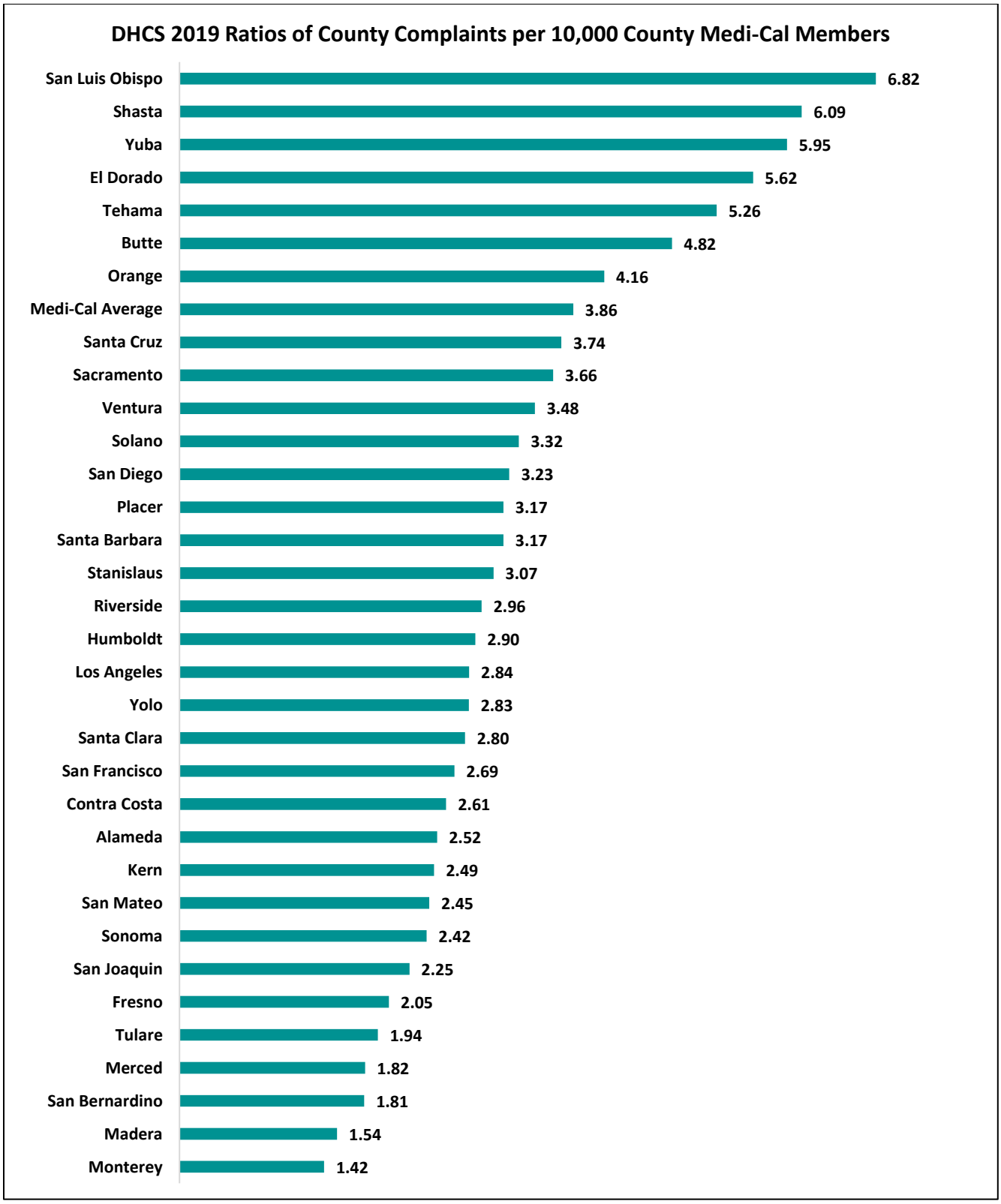
Language

Most of the DHCS complaints indicated that the complainant's primary language was English (60.7% of the 4,978 complaints in 2019). Spanish accounted for nearly eight percent (7.8%) and 12 language categories combined accounted for over four percent (4.6% Other languages combined, each under 1 percent). Over a fourth of the complaints did not identify a primary language (27.0% Refused/Unknown).

County of Residence

The following chart displays county ratios based on each county's 2019 volume of complaints divided by the number of Medi-Cal beneficiaries who reside in the county.

Figure 5.14



Note: The above display excludes counties with fewer than 10,000 Medi-Cal beneficiaries and/or 10 or fewer complaints in 2019.

Mode of Contact

Telephone was the most commonly identified known initial mode of contact for the DHCS 2019 complaints (35.5% of the 4,978 complaints), closely followed by Mail (34.3%). Under a half-percent of complaints were Online or Counter/In-Person. Approximately 30 percent of the complaints were reported as Unknown.

Regulator

Most of the DHCS 2019 complaints were reported with Other as the Regulator (71.2% of the 4,978 complaints). DMHC was the other identified Regulator (28.6%). A small number (0.1%) were Unknown.

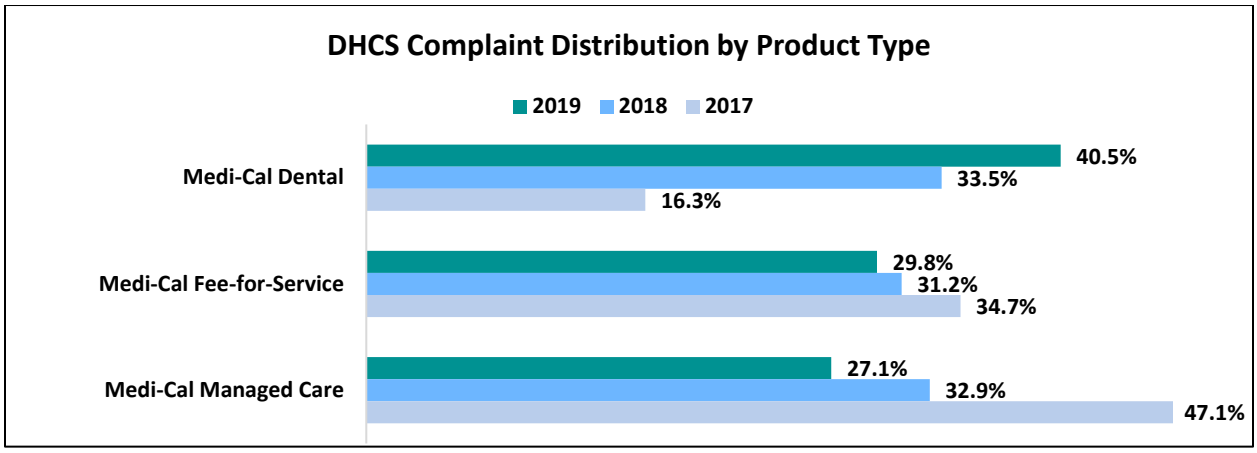
Source of Coverage

Nearly all of the 2019 DHCS complaints were associated with the Medi-Cal Source of Coverage (99.1% of the 4,978 complaints). Two other categories were identified with distributions under one percent (Medi-Cal/Medicare and Covered California/Exchange).

Product Type

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

Figure 5.15



Note: The chart excludes product types with low reported volumes (under 1% distribution) in 2019: Mental Health, Long Term Care, Medi-Cal Coordinated Care, and Unknown.

The decrease in managed care complaints from 2017 to 2019 coincides with federal Final Rule changes that went into effect July 1, 2017, requiring Medi-Cal managed care plan (MCP) members to first exhaust the MCP's internal appeal process prior to requesting a State Fair Hearing. DHCS implemented these changes via All Plan Letter 17-006 issued May 9, 2017.

While the overall distribution of complaints shifted between 2018 and 2019 to the majority related to Medi-Cal Dental, in terms of volume, there was not a marked increase in Medi Cal Dental complaints.

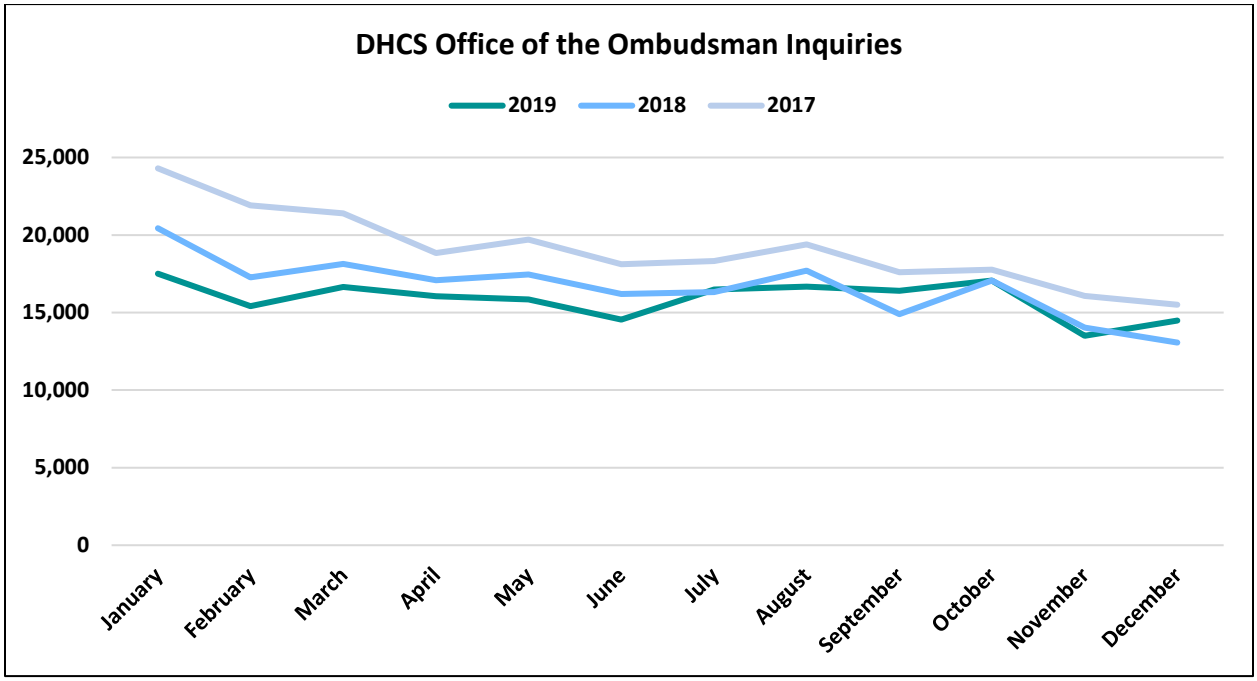
D. Consumer Assistance Center Details

DHCS reported 1,241,527 inquiries in 2019 for its three service centers. All of the consumer requests for assistance to the DHCS service centers are categorized as inquiries because these service centers do not make determinations for the complaints submitted by DHCS for this report.

Consumer Assistance Volumes by Service Center

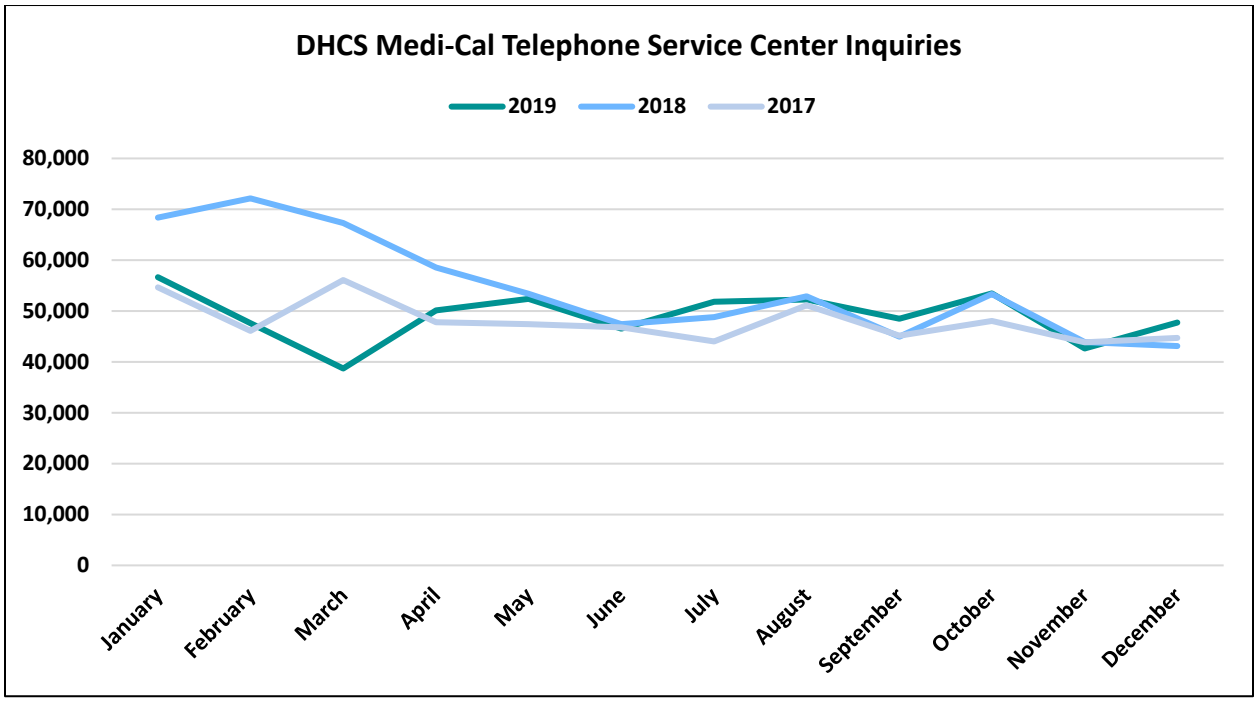
The Office of the Ombudsman's inquiry volume continued to decrease, with 190,651 inquiries reported for 2019, compared to 199,709 in 2018 and 228,946 in 2017. Most of the consumer inquiries were made by telephone (96.8% of the inquiries in 2019), with email accounting for the rest.

Figure 5.16



The Medi-Cal Telephone Service Center's inquiry volume decreased by 10 percent from 2018 to 2019, but remained higher than earlier annual totals. All reported inquiries were by telephone. The following chart represents 588,496 inquiries in 2019, 654,156 in 2018, and 575,819 in 2017.

Figure 5.17



The Medi-Cal Dental Telephone Service Center's inquiry volume decreased by 24 percent from 2018 to 2019. Nearly all of the inquiries were made by telephone (98.9% in 2019), with a small volume reported for mail. The following chart accounts for 462,380 inquiries in 2019, 610,826 in 2018, and 514,710 in 2017.

Figure 5.18

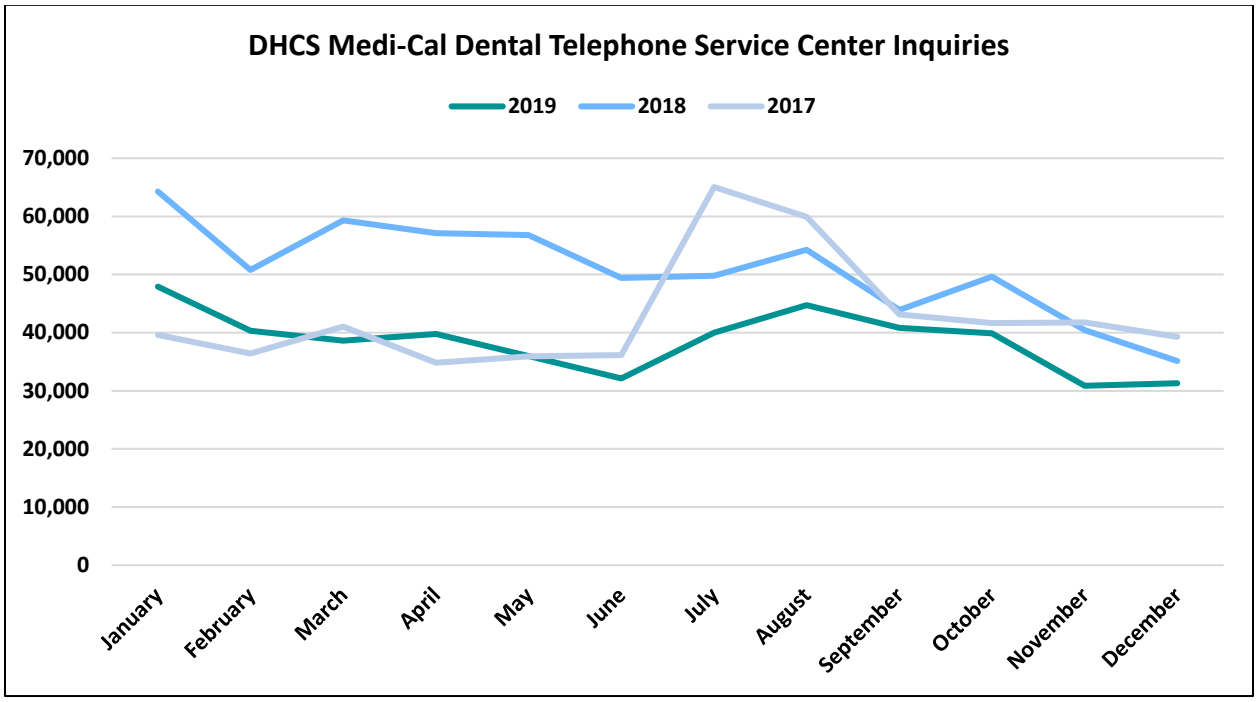


Figure 5.19 DHCS Service Centers' 2019 Telephone Metrics

Metric	Office of the Ombudsman	Medi-Cal Telephone Service Center	Medi-Cal Dental Telephone Service Center
Telephone call volume	184,530	588,496	457,247
Number of Abandoned Calls (incoming calls ended by callers prior to reaching a Customer Service Representative-CSR)	10,968	36,606	42,561
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System	105,513	2,664,076*	172,926
Number of Jurisdictional Inquiry Calls	68,049	588,496	455,863
Number of Non-Jurisdictional Calls	Considered the same as calls resolved by IVR	N/A	1,384
Average Wait Time to Reach a CSR	0:05:00	0:01:56	0:02:14
Average Length of Talk Time (Between a CSR answering and completing a call)	0:08:00	0:04:57 estimated	0:06:36
Average Number of CSRs Available to Answer Calls (during service center hours)	21 full-time equivalent staff	77 estimated	96

**The indicated category includes 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 reported the following updates to its service centers' systems.

- The Medi-Cal Telephone Service Center's Business Operations Fiscal Intermediary changed to a new vendor as of October 2019. Gainwell Technologies is the new vendor.
- The Dental Telephone Service Center's Administrative Services Organization contractor:
    - Established a new Care Coordination Team to help address Medi-Cal member complaints by working out issues between the member and the provider.
        - DHCS noted that this new team helped to address both jurisdictional and non-jurisdictional issues and reduced the number of non-jurisdictional inquiries previously referred to the Dental Board of California.
    - Changed to a new Genesys Platform for its customer service.

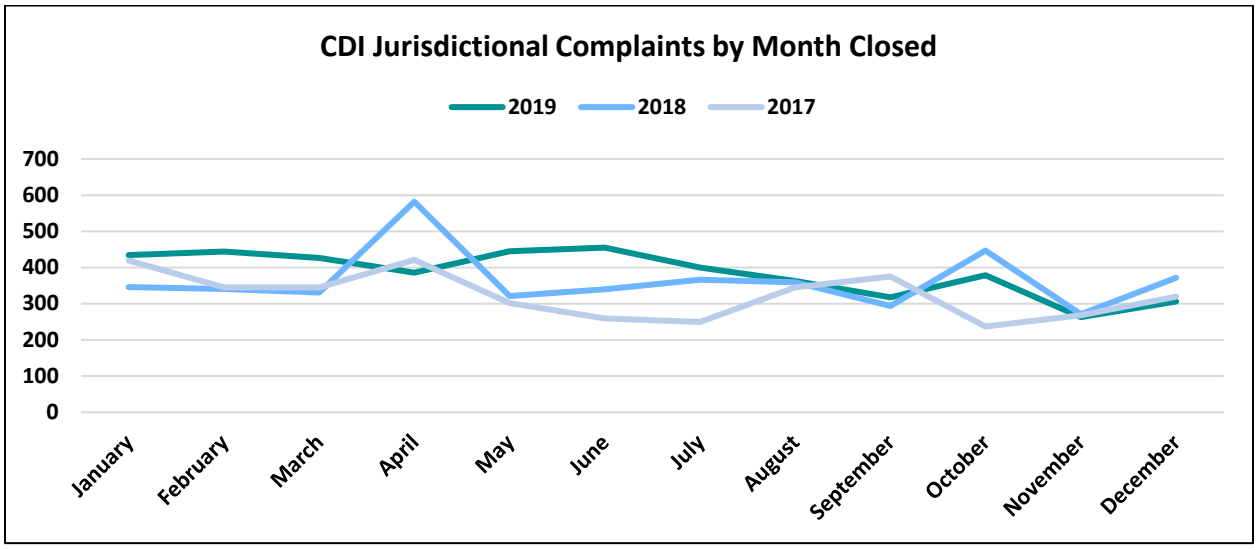
Section 6 – California Department of Insurance

A. Overview

The California Department of Insurance (CDI) licenses and regulates more than 1,400 insurance companies and more than 425,000 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 received fewer overall requests for assistance from consumers in 2019 compared to the prior year (38,494 in 2018 to 37,628 in 2019). However, its jurisdictional complaint volume increased by nearly six percent from 2018 to 2019. CDI submitted 8,966 complaints for 2019, including 4,619 jurisdictional complaints resolved by CDI and 4,347 non-jurisdictional complaints.

Figure 6.1



CDI reported two different complaint types: Standard Complaint and Independent Medical Review (IMR). The average resolutions times noted in Figure 6.2 were based on durations of jurisdictional complaints closed in 2019.

- 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 average resolution times continue to be affected by a significant number of complaints initiated in 2016 and 2017 that were held open for regulatory purposes.

Figure 6.2 CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2019
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	110 days Calculation includes time for regulatory review after the case is 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	68 days Calculation includes time for regulatory review after the case is closed to the complainant

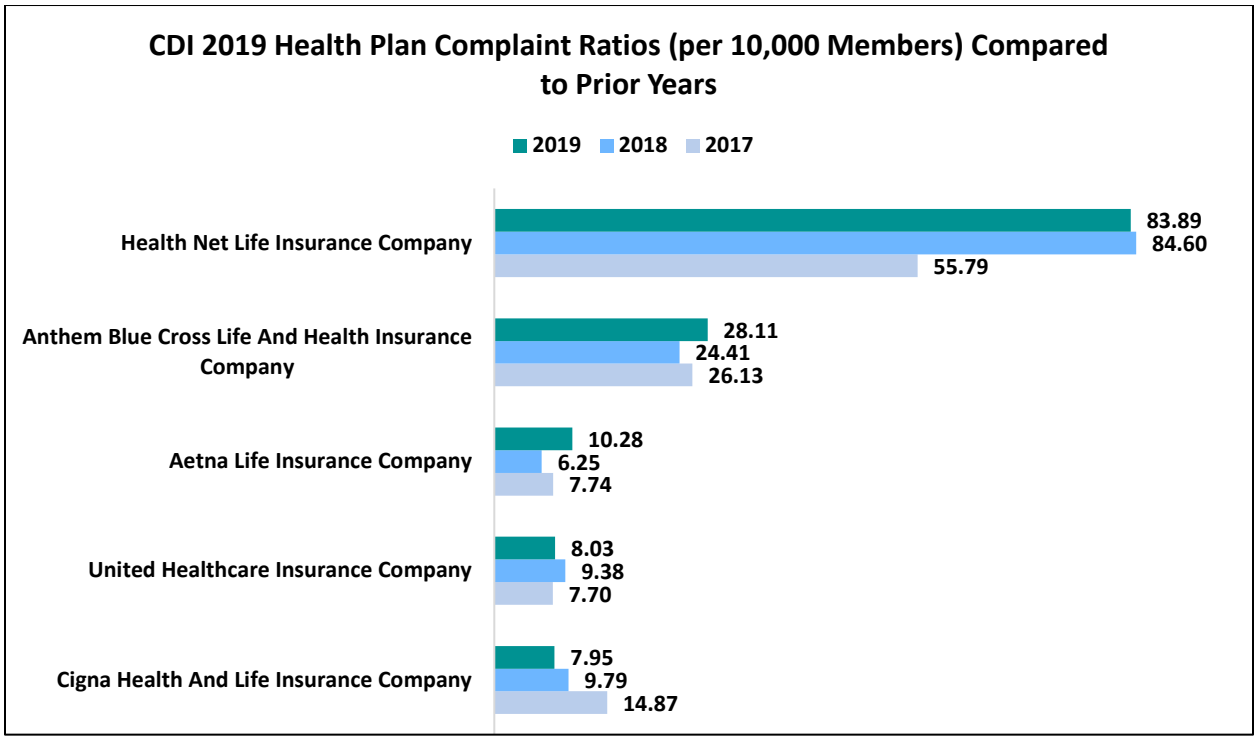
Note: CDI leaves cases open even if the case requires more time for gathering information pertinent to the complaint review from the involved parties. This time is included in the resolution time calculation.

B. Complaint Ratios, Reasons, and Results

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 2019. The ratio shown is each plan's jurisdictional complaint volume per 10,000 plan enrollees.

Figure 6.3

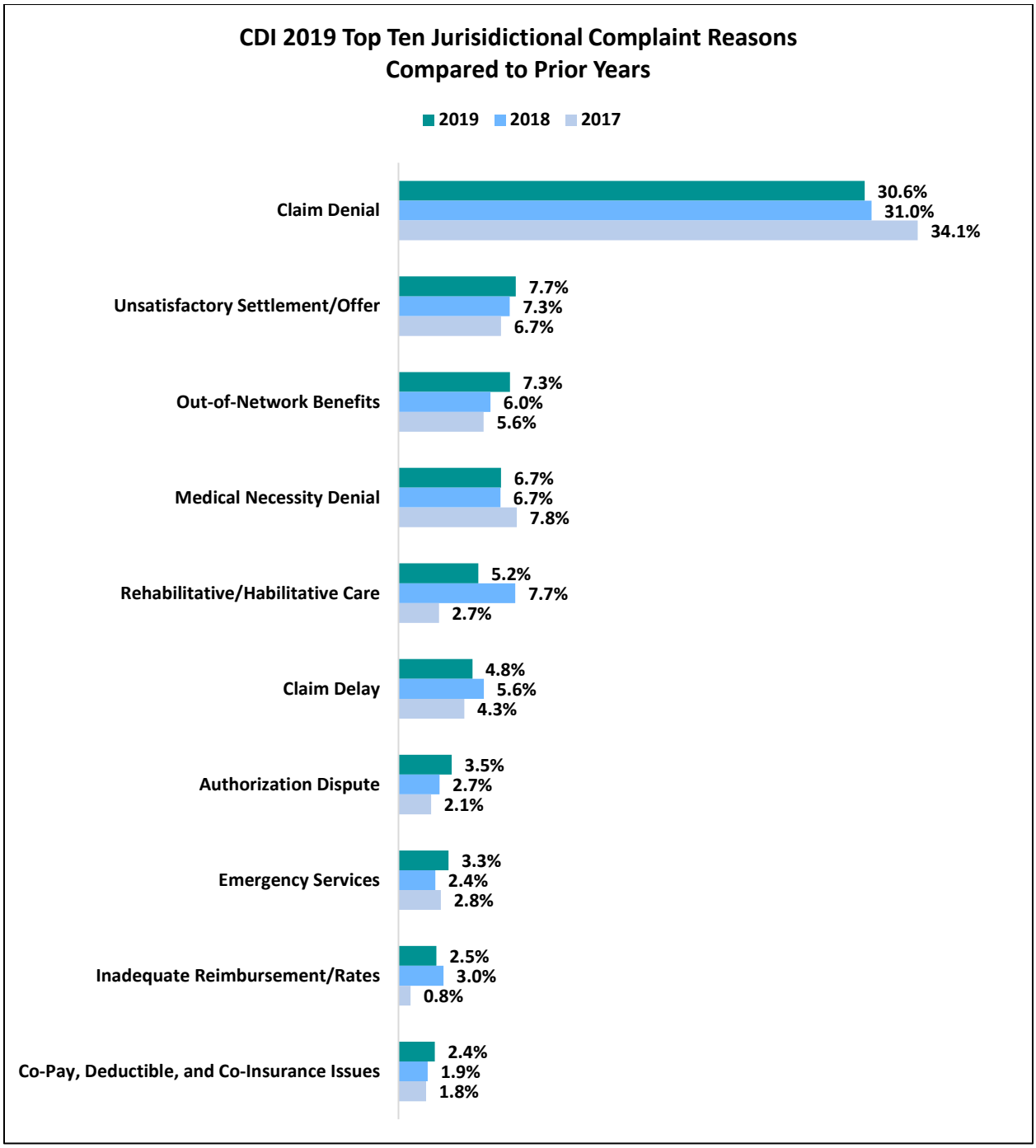


Note: Health Net Life Insurance Company's 2018 and 2019 complaint ratio calculations included a significant number of cases initiated in 2016 and 2017 that were held open for regulatory purposes. This may affect comparisons with prior years.

Complaint Reasons

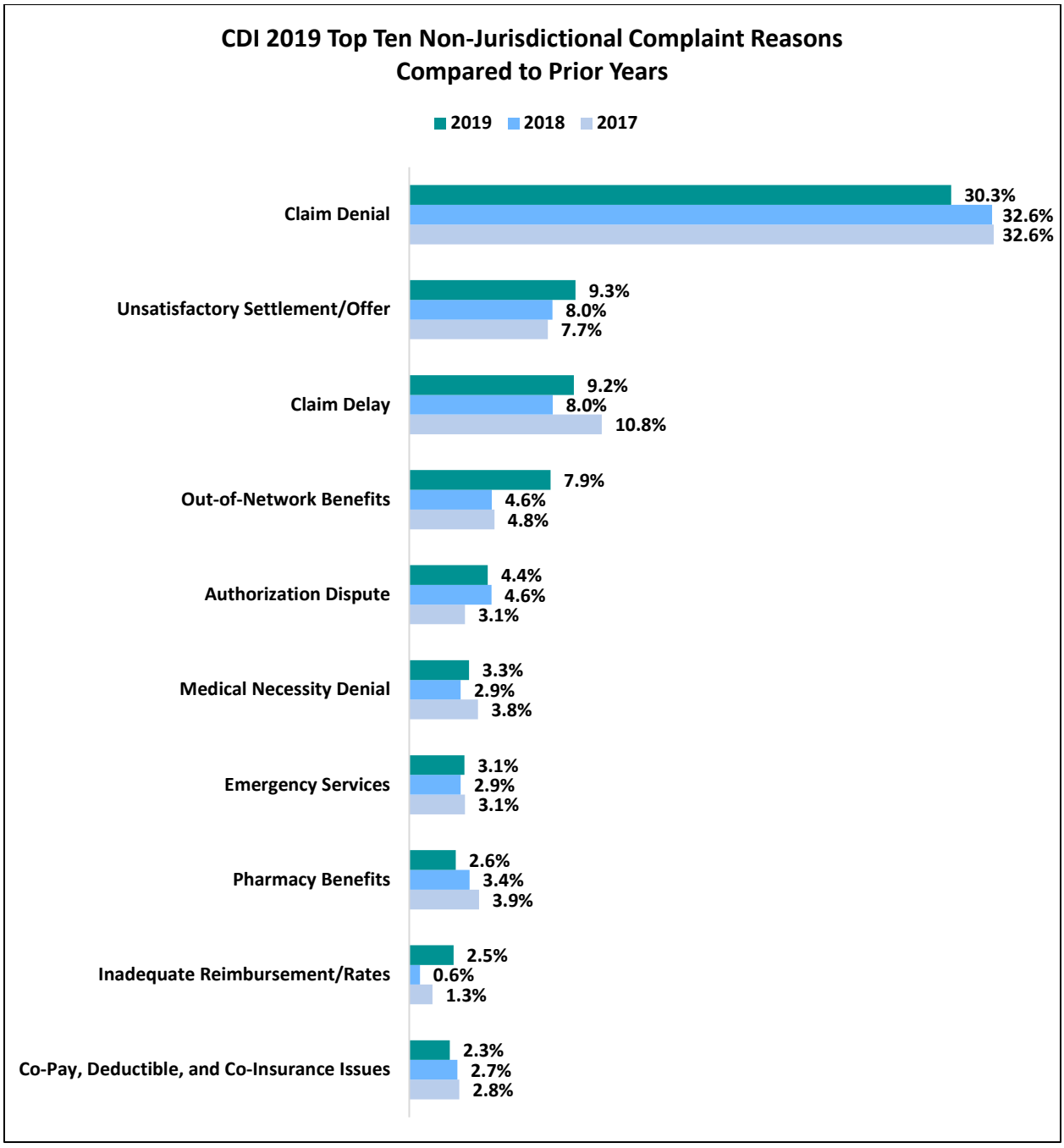
The following chart displays the 2019 top reasons for CDI's jurisdictional complaints, as well as the 2017 and 2018 data for the same categories. Many complaint cases had more than one reason submitted. There were 7,341 reasons reported for the 4,619 jurisdictional complaints closed in 2019.

Figure 6.4



The following chart shows the top reasons CDI reported for non-jurisdictional complaints in 2019, as well as the 2017 and 2019 data for the same reason categories. There were 5,652 reason entries reported for the 4,347 non-jurisdictional complaints in 2019.

Figure 6.5


CDI 2019 Top Ten Non-Jurisdictional Complaint Reasons
Compared to Prior Years
2019
2018
2017
Claim Denial
30.3%
32.6%
32.6%
Unsatisfactory Settlement/Offer
9.3%
8.0%
7.7%
Claim Delay
9.2%
8.0%
10.8%
Out-of-Network Benefits
7.9%
4.6%
4.8%
Authorization Dispute
4.4%
4.6%
3.1%
Medical Necessity Denial
3.3%
2.9%
3.8%
Emergency Services
3.1%
2.9%
3.1%
Pharmacy Benefits
2.6%
3.4%
3.9%
Inadequate Reimbursement/Rates
2.5%
0.6%
1.3%
Co-Pay, Deductible, and Co-Insurance Issues
2.3%
2.7%
2.8%

The following table displays CDI's top referral topics for consumer inquiries, as well as the entities to which those inquiries were referred. These estimated rankings exclude the non-jurisdictional complaints represented in Figure 6.5.

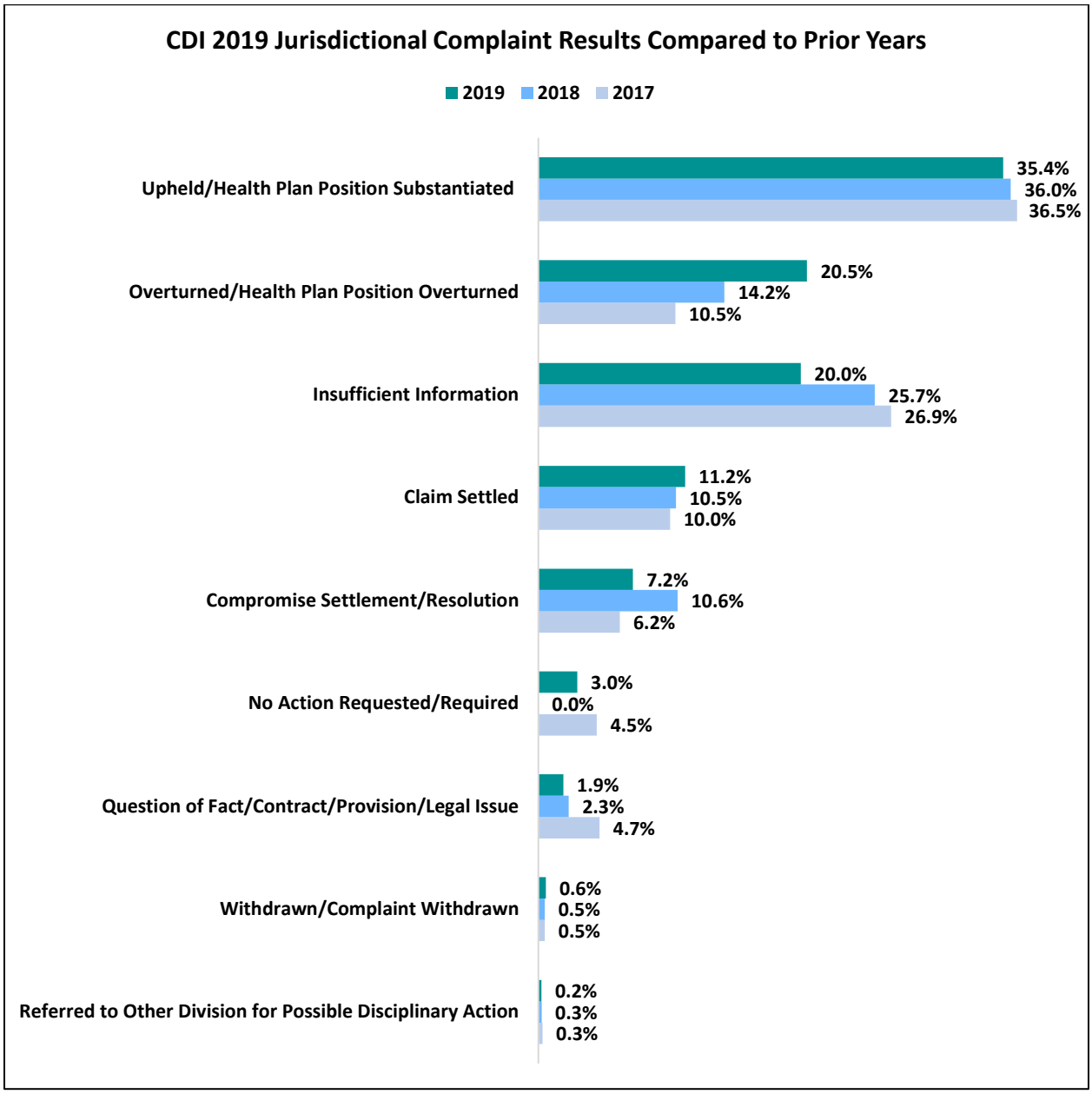
Figure 6.6 CDI Top Ten Topics for Non-Jurisdictional Inquiries

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	Unsatisfactory Settlement/Offer	DMHC DOL CMS DOIs
3	Claim Delay	DMHC DOL CMS DOIs
4	Out-of-Network Benefits	DMHC DOL CMS DOIs
5	Medical Necessity/Experimental	DMHC DOIs
6	Authorization Dispute	DMHC DOL DOIs
7	Cancellation	DMHC DOL CMS DOIs
8	Co-Pay/Deductible Issues	DMHC DOL DOIs
9	Inadequate Reimbursement	DMHC DOL
10	Premium Refund	DMHC CMS DOIs

Complaint Results

The following chart displays the 2019 results of CDI's 4,619 jurisdictional complaints. Some differences between measurement years may be due to reporting changes rather than changes in incidence.

Figure 6.7



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 2019 average resolution time for jurisdictional complaints decreased by 17 days from the prior year (120 days in 2018 to 103 days in 2019). The 2019 non-jurisdictional complaint reviews took three days on average, less time than prior years (4 days in 2017 and 2018).

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 2019 average duration was affected by a significant number of complaints initiated in 2016 that were held open for regulatory purposes until a January 2019 settlement agreement was reached.

C. Demographics and Other Complaint Elements

Age

The average age of complainants was 45 years old for CDI's 2019 jurisdictional complaints. Age Under 18 accounted for eight percent of the complaints; Age 18-34 for 22 percent; Age 35-54 for 30 percent; Age 55-64 for 23 percent; Age 65-74 for eight percent; Age 75 and Older for three percent; and Refused/Unknown for six percent.

Gender

Female complainants continued to account for most of the CDI jurisdictional complaints (55% in 2019), with Male complainants accounting for 45 percent. Compared to the prior year, the volume of 2019 jurisdictional complaints decreased by two percent for Male complainants and increased by 13 percent for Female complainants.

Race and Ethnicity

Approximately 45 percent of CDI's 2019 jurisdictional complaints did not have Race or Ethnicity identified.

- For Race categories, White was the most common reported (39.4%), followed by Other (6.3%); Asian (6.0%); Black or African American (2.1%); American Indian or Alaska Native (0.6%); and Native Hawaiian or Other Pacific Islander (0.4%).

- For Ethnicity categories, Not Hispanic or Latino accounted for nearly 49 percent (48.7%) and Hispanic or Latino accounted for more than six percent (6.4%).

Language

English continued to be the top reported primary language of complainants (66.1% of the 4,619 jurisdictional complaints in 2019). Spanish accounted for over one percent (1.3%) and Other Languages for over two percent (2.3%). Approximately 30 percent of the complaints did not identify a language (29.6% Refused and 0.7% Unknown).

Mode of Contact

Mail continued to be the most common initial mode of contact (48.2% in 2019) for CDI's jurisdictional complaints. Use of the online mode of contact (accounting for 47.0% in 2019) has increased each year since 2015. Nearly five percent (4.8%) of the 2019 complaints were initiated by telephone.

Regulator

CDI was the reported regulator for all of its submitted complaints for 2019.

Source of Coverage

CDI reported two coverage source categories for all of its 2019 complaints. The Group category accounted for 57 percent of the jurisdictional complaints and 68 percent of the non-jurisdictional complaints. Individual/Commercial accounted for 43 percent of the jurisdictional complaints and 32 percent of the non-jurisdictional complaints.

Product Type

CDI submitted 24 different product type categories for 2019. Because many complaints had more than one product type reported, the number of product type entries (8,359) exceeded the number of associated jurisdictional complaints (4,619) in 2019. Health Only continued to be the most common product type for jurisdictional complaints (33.2% in 2019), followed by Large Group (20.0%), Stand Alone Dental (12.8%), Small Group (9.0%), Grandfathered (4.9%), Mental Health (4.6%), Exchange (2.4%), Bronze (2.3%), Silver (2.2%), and Medicare Supplement (1.9%). The other 14 reported categories each had low volumes account for around or under one percent.

D. Consumer Assistance Center Details

CDI's Consumer Services Division received 37,628 requests for assistance from consumers in 2019, including 27,999 telephone calls. Most requests for assistance were consumer inquiries rather than a complaint initiation. The following table outlines the service center metrics for CDI's 2019 telephone calls.

Figure 6.8 CDI Consumer Services Division – 2019 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	724
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	1,094
Number of Jurisdictional Inquiry Calls	22,125
Number of Non-Jurisdictional Calls	4,430
Average Wait Time to Reach a CSR	0:00:28
Average Length of Talk Time (time between a CSR answering and completing a call)	0:05:25
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 changes to its consumer assistance protocols or systems.

Section 7 – Covered California

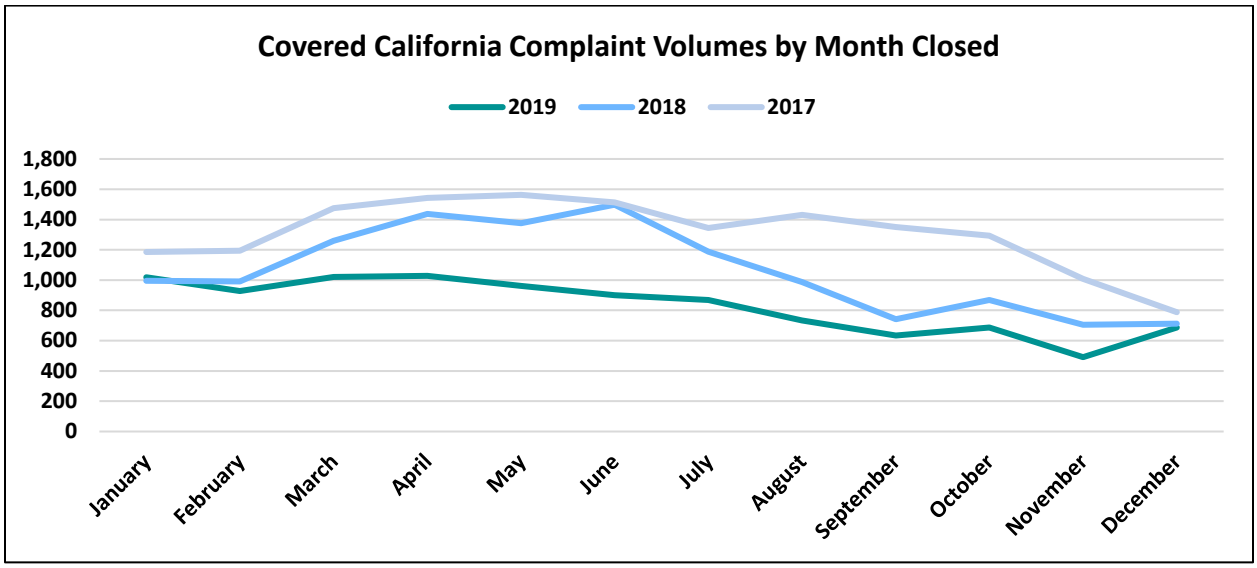
A. Overview

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.

Covered California received 5,035,104 requests for assistance from consumers in 2019, a two percent volume increase from the prior year (4,936,697 in 2018). The requests for assistance volume includes inquiries to the Covered California Service Center and complaints resolved formally and informally through a State Fair Hearing. Covered California reported 9,958 complaints in 2019 (26.7% were formal State Fair Hearings and 73.3% were informal resolutions to State Fair Hearing requests).

Figure 7.1



- Covered California's complaint volume has fallen each year since 2016.
- The volume of formal State Fair Hearings decreased by nearly 40% and the volume of informal resolutions decreased by nearly 13% from 2018 to 2019.

- Covered California noted that 52 percent of the complaints closed in 2019 were dual agency appeals to address eligibility determinations for Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal coverage.

Figure 7.2 Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2019
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving urgent health issues.	90 days from the date the hearing request was filed	68 days
State Fair Hearing: Informal Resolution	CDSS State Hearings Division: Reviews hearing request and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge	45 days from the date the appeal was filed	29 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

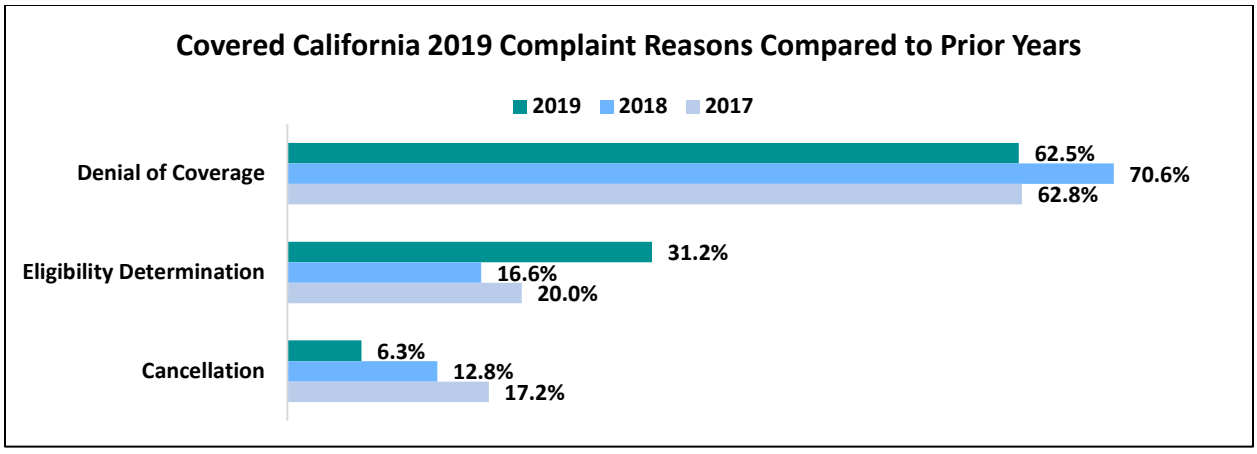
Health Plan Complaint Ratios

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

The following chart shows the complaint reason distribution for all 15,687 complaints in 2017, all 12,760 complaints in 2018, and all 9,958 complaints in 2019.

Figure 7.3

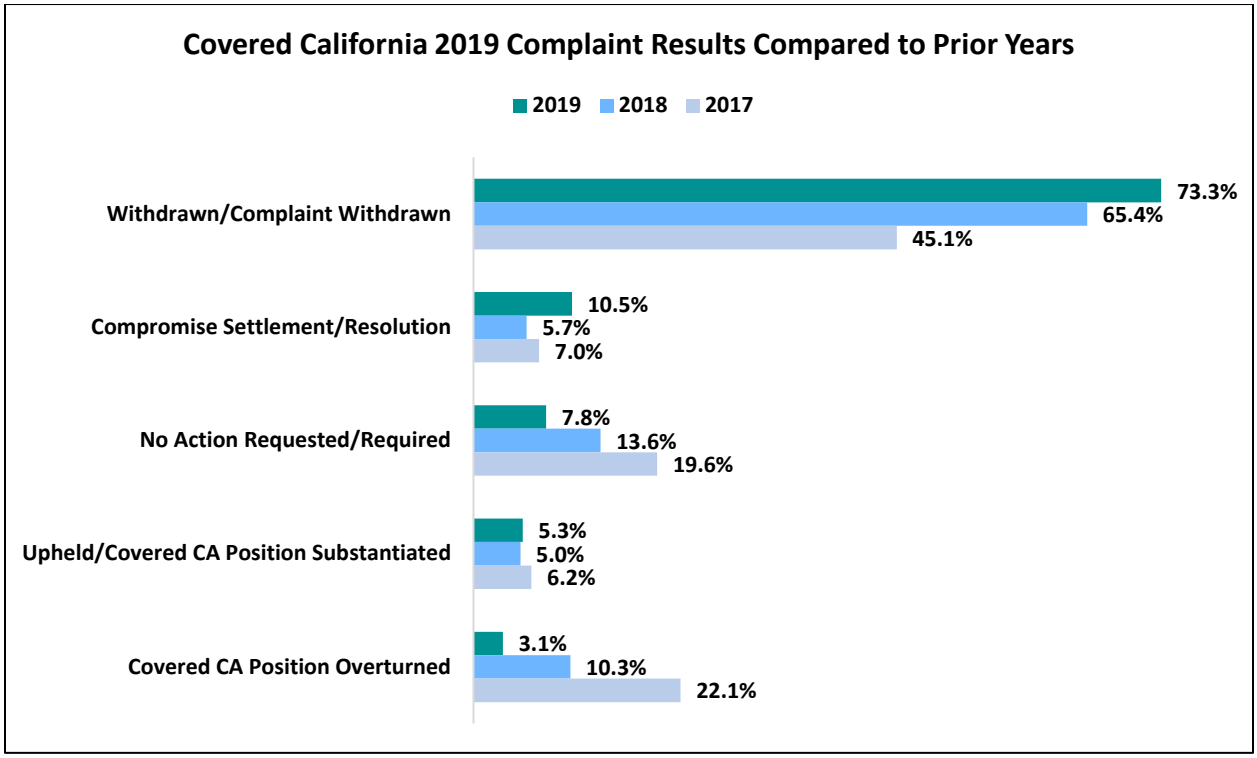


Complaint Results

The following chart accounts for all complaint results reported for the 15,687 complaints in 2017, all 12,760 complaints in 2018, and all 9,958 complaints in 2019.

Covered California noted that the increased Withdrawn/Complaint Withdrawn volumes in recent years are associated with its ongoing focus on informally resolving complaints in accordance with regulations and continuing goal of improving the consumer journey. The Withdrawn/Complaint Withdrawn category includes many cases where the complainant's issue was resolved prior to the completion of the State Fair Hearing.

Figure 7.4



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 display the 2019 results distributions for each of the three complaint reasons reported by Covered California.

Figure 7.5

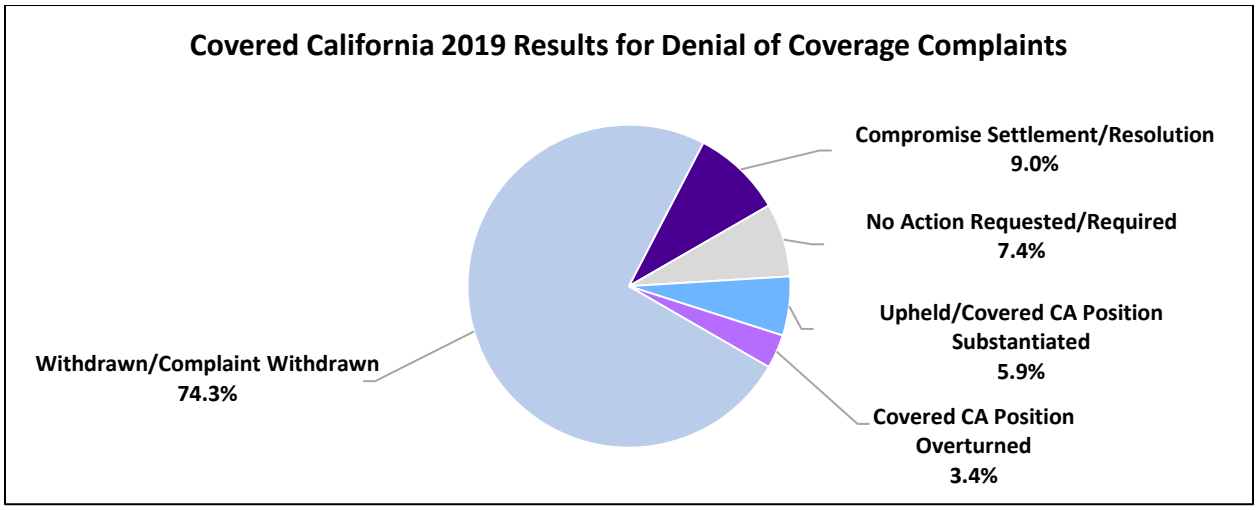


Figure 7.6

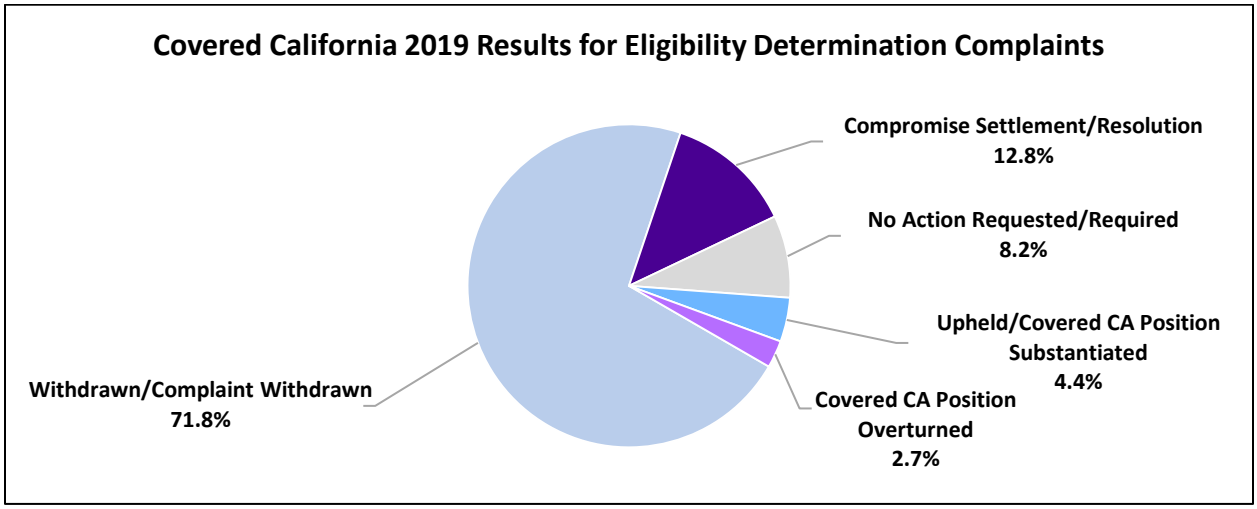
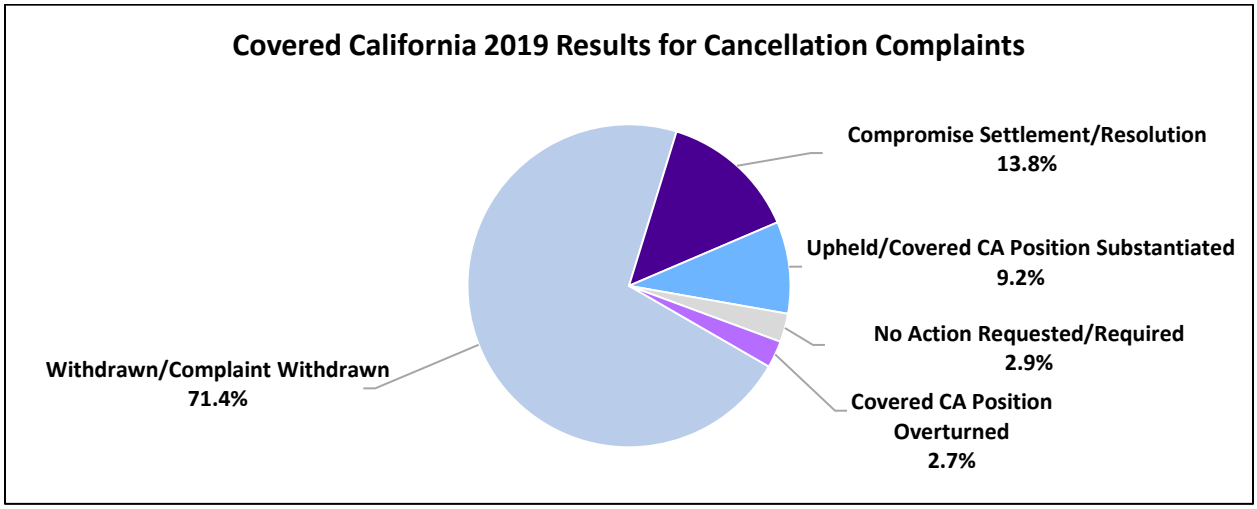


Figure 7.7



Resolution Time

Covered California's average resolution time for complaints closed in 2019 was 39 days, a decrease of 9 days from the 2018 average. The formal State Fair Hearing complaint type had an average duration of 68 days (one more day than the 2018 average). The informal resolution complaint type had an average duration of 29 days (9 days fewer than the 2018 average).

C. Demographics and Other Complaint Elements

Age

Covered California's 2019 distribution of complaints by age group was similar to prior years. The Age 35-54 group had the most complaints (40.3% of the 9,958 complaints in 2019), followed by Age 55-64 (27.4%), Age 18-34 (26.2%), Age 65-74 (5.3%), Age 75 and older (0.4%), and Under 18 (0.2%). Under one percent were Age Unknown (0.2%).

Gender

Female complainants continued to account for the majority of Covered California's complaints (56.2% of the 9,958 complaints in 2019), followed by Male (42.9%) and Unknown (0.9%).

Race and Ethnicity

Covered California's 2019 complaint distributions for the Race and Ethnicity categories were similar to prior years. White was the most commonly identified Race (37.8%), followed by Asian (10.8%), Other (10.2%), Black of African American (6.1%), American Indian or Alaska Native (0.5%), and Native Hawaiian or Other Pacific Islander (0.2%).

For Ethnicity, Not Hispanic or Latino accounted for nearly 69 percent (68.5%) and Hispanic or Latino for 23 percent (23.3%) of the 2019 complaints. Approximately one-third of Race entries and eight percent of Ethnicity entries had Unknown reported. Covered California noted that related demographic information is collected but optional for applicants seeking coverage to provide.

Language

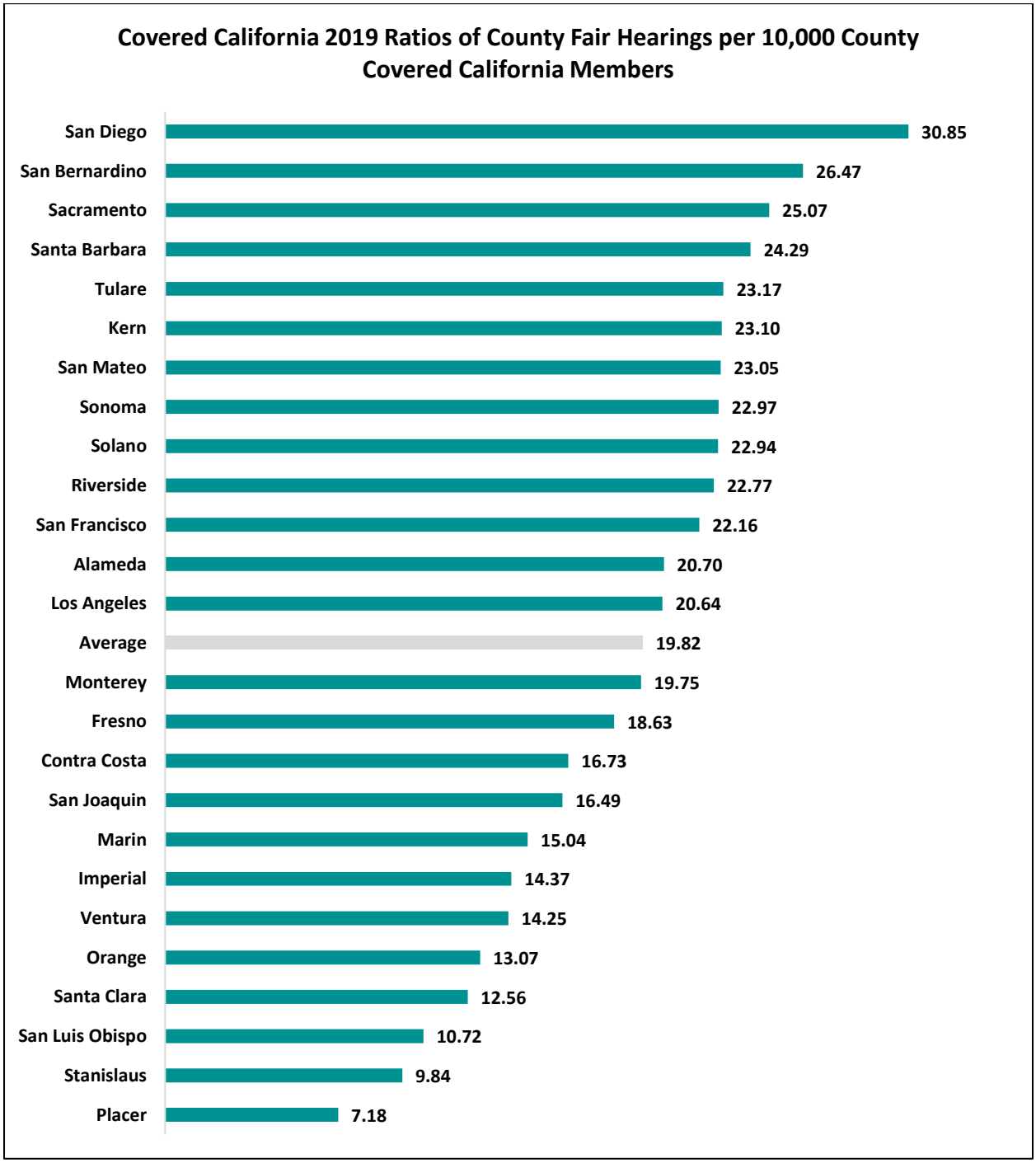
English continued to be the most commonly reported primary language of the Covered California's complainants (86.6% of the 2019 complaints) and Spanish second most commonly reported primary language (8.5%). Other languages accounted for more than three percent (3.6%). More than one percent did not have the primary language identified (1.3% Unknown).

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 State Fair Hearings per 10,000 county residents enrolled in a Covered California plan. The complaint volume does not

include the informal resolution hearing complaint type. Counties with ten or fewer complaints or Covered California enrollment under 10,000 are excluded from the display. The average county ratio has fallen each year since 2017.

Figure 7.8



Mode of Contact

Most of Covered California's complaints continued to be initiated by telephone (64.9% of the 2019 complaints). The volume of Email, the second most common initial mode of contact (33.5%), increased by 86 percent from the prior year. Online mode accounted for 1.5 percent. All other reported modes combined accounted for under one percent, with the volumes of the Fax, Counter/In-Person, and Mail modes significantly decreasing from the prior year.

Regulator

Covered California's complaints do not address health plan issues and so do not have attributed regulator information. Covered California noted that enrollment in CDI-regulated plans modestly increased to 3.2 percent of Covered California's total enrollment in 2019. Most Covered California members continued to be enrolled in plans regulated by DMHC (96.8% of the 2019 enrollment).

Source of Coverage

Most (55.3%) of Covered California's 2019 complaints identified Covered California as the source of coverage. Unknown (44.7%) was reported for cases where consumers had not selected a health plan when they filed an appeal.

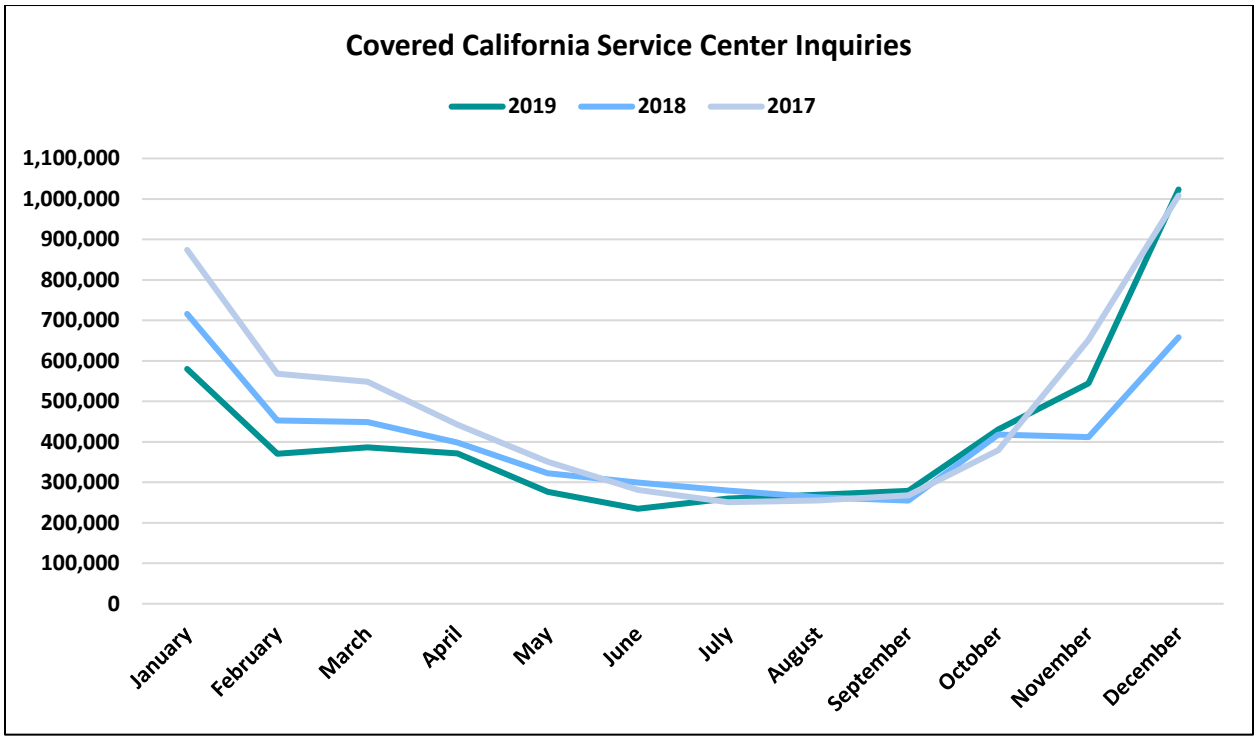
Product Type

Covered California submitted complaints with product types pertaining to the metal tier associated with the complainant's level of coverage. The most common submitted product type for 2019 was Unknown (44.7%), which was reported for cases where consumers had not selected a health plan when they filed an appeal. Among the identified categories, Silver accounted for nearly one-third (32.1%), followed by Bronze (14.0%), Gold (6.6%), Platinum (2.2%), and Catastrophic (0.4%).

D. Consumer Assistance Center Details

The Covered California Service Center received 5,025,136 inquiries from consumers in 2019, an increase (2.1%) from the prior year but not reaching 2015-2017 volumes.

Figure 7.9



The following table displays the top ten inquiries made to the Covered California Service Center in 2019 for both jurisdictional and non-jurisdictional topics. Covered California noted that a 2019 change to its Customer Relationship Management system may have affected inquiry reporting and trending with prior years.

Figure 7.10 Covered California Top Ten Topics for Inquiries

Ranking	Inquiry Topic	Organization(s) Referred to
1 (most common)	Inquiry/Assistance - Application/Case Status	Not Applicable
2	Case Status Inquiry	Not Applicable
3	Renewal Assistance	Not Applicable
4	Provided County Contact Information	Medi-Cal
5	Enrollment	Not Applicable
6	Online Account Assistance Inquiry	Not Applicable
7	1095-A Inquiry/Assistance	Not Applicable
8	Inquiry about Covered California	Not Applicable
9	Report a Change - Income Change	Not Applicable
10	Medi-Cal to Covered California	Medi-Cal

Most inquiries to the Covered California Service Center were made by telephone (4,391,534 calls). The table below outlines metrics for Covered California's 2019 telephone calls. The metrics were based on tracked data unless otherwise indicated.

Figure 7.11 Covered California Service Center – 2019 Telephone Metrics

Yearly Metrics	Measurement
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative – CSR)	162,433
Number of calls resolved by the Interactive Voice Response (IVR)/phone system (caller provided service without involving a CSR)	1,906,431
Average wait time to reach a CSR	0:03:33
Average length of talk time (time between a CSR answering and completing a call)	0:19:18
Average number of CSRs available to answer calls (during Service Center hours)	852 Full-Time Equivalent (estimated)

Consumer Assistance Protocols and Systems

Covered California reported that its Service Center replaced its Customer Relationship Management system and began using Salesforce in May 2019.

Section 8 – Conclusion

The Office of the Patient Advocate (OPA) programs have transferred to the Center for Data Insights and Innovation (CDII) as a result of the enactment of AB 172 (Chapter 696, Statutes of 2021). CDII will be responsible for producing future Annual Complaint Data Reports and will make the OPA publications available through the CDII website.

OPA (now CDII) reviewed the sixth 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 2019 data. Continue to use caution in making comparisons between reporting entities and measurement years due to complaint system differences and reporting changes.

Volume of Complaints

The statewide jurisdictional complaint volume decreased for the fourth straight year. The four reporting entities submitted 35,470 jurisdictional complaints that were closed in 2019, a nearly 20 percent decrease from the prior year volume. For the third year, CDI was the only reporting entity with an annual increase in complaint volume. The number of enrollees in health care coverage CDI oversees also increased.

Complaint Reasons

The most common complaint reason in 2019 was Denial of Coverage, the fourth-straight year as the top statewide reason.

Co-Pay, Deductible, and Co-Insurance Issues surpassed Medical Necessity Denial for the first time to become DMHC's top complaint reason.

- Co-Pay, Deductible, and Co-Insurance Issues also was the top reason for Covered California health plan complaints resolved by DMHC.
- Medi-Cal Necessity Denial remained the most common reason for Medi-Cal health plan complaints resolved by DMHC.

Scope of Benefits remained DHCS's most common reason.

- Most of the Scope of Benefits complaints were associated with the Dental delivery system.
- Dis/Enrollment was the top reason for the Managed Care delivery system.
- Pharmacy Benefits was the top reason for the Fee-for-Service delivery system.

Claim Denial has been CDI's top complaint reason since 2014.

Denial of Coverage has been Covered California's top complaint reason since 2014.

Complaint Results and Resolution Time

Upheld/Health Plan Position Substantiated has remained the most common reported complaint result since Measurement Year 2015. The result also has remained the top result for both DMHC and CDI. Withdrawn/Complaint Withdrawn has been the top result for DHCS and Covered California since Measurement Year 2014.

The 2019 average complaint resolution time was 41 days, seven days fewer than the 2018 average. All four reporting entities had decreases in average resolution times compared to the prior year. The average complaint durations in 2019:

- DMHC – 21 days (4-day decrease)
- DHCS – 51 days (11-day decrease, continuing an annual decrease since 2015)
- CDI – 103 days (17-day decrease)
- Covered California – 39 days (11-day decrease)

Complaint Ratios

Ratios of health plan complaints per 10,000 members were displayed for plans with enrollment over 70,000 members in 2019. Compared to 2018, in 2019:

- Six of the 10 DMHC-regulated plans with the highest ratios had a lower ratio.
- 15 of the 24 Medi-Cal plans with submitted State Fair Hearings had lower ratios.
- Three of the five submitted CDI plans had lower complaint ratios.
- Six of the 10 Covered California health plans with complaints reported by DMHC had higher ratios.

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 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.

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