Measurement Year 2016 Data Tables

For the Office of the Patient Advocate's Annual Health Care Complaint Data Report

Section 3 – Statewide Data Tables

A. Overview

Figure 3.1 2016 Reporting Entity Complaints, Plans, and Enrollment

Reporting Entity	Number of Complaints	Number of Plans with at Least 1 Complaint	Total Number of Enrollees
DMHC	25,884	79	56,062,035
DHCS	6,770	87	13,656,586
CDI	2,871	113	2,041,819
Covered California	20,398	Not applicable	1,384,640

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. In addition, direct comparisons across reporting entities are imprecise due to variances in department functions, complaint systems, and data availability.

B. Statewide Consumer Assistance Centers

Figure 3.2 Consumer Assistance Service Centers by Reporting Entity
See complete report for service center hours and contact information.

Figure 3.3 Statewide Requests for Assistance Volumes

Reporting Entity	2014 Volume	2015 Volume	2016 Volume
DMHC	109,760	171,597	189,482
DHCS	1,377,057	1,463,131	1,353,223
CDI	36,986	45,882	43,097
Covered California	4,428,436	5,397,086	6,058,978

Figure 3.4 Statewide Complaints as Percent of Requests for Assistance

Reporting Entity	2014 Percentage	2015 Percentage	2016 Percentage
DMHC	12.7%	10.3%	13.7%
DHCS	0.3%	0.5%	0.5%
CDI	11.0%	7.0%	6.7%
Covered California	0.1%	0.1%	0.3%

C. Statewide Health Care Complaint Data

Figure 3.5 Statewide Complaint Volumes

Reporting Entity	2014 Volume	2015 Volume	2016 Volume
DMHC	13,994	17,737	25,884
DHCS	4,589	6,740	6,770
CDI	4,079	3,209	2,871
Covered California	4,366	6,150	20,398

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.

Figure 3.6 Statewide Volume of Complaints Closed by Month

Month	2014 Volume	2015 Volume	2016 Volume
January	1,652	2,056	3,658
February	1,784	2,480	4,128
March	1,940	3,446	5,486
April	2,388	3,026	5,471
May	2,340	2,173	5,307
June	2,337	2,347	5,734
July	2,526	2,474	4,121
August	2,458	2,740	4,813
September	2,224	3,134	4,981
October	2,624	3,474	4,411
November	2,212	3,109	3,603
December	2,543	3,377	4,210

Figure 3.7 Statewide 2016 Top Five Complaint Reasons Compared to Prior Years

Complaint Reason	2014 Percentage	2015 Percentage	2016 Percentage
Denial of Coverage	13.0%	12.1%	23.4%
Cancellation	5.5%	9.7%	13.6%
Medical Necessity Denial	9.8%	12.1%	9.9%
Experimental/Investigational Denial	2.9%	3.2%	8.5%
Eligibility Determination	2.0%	3.0%	6.9%

Note: Experimental/Investigational Denial includes complaints that CDI reported under the complaint reason category Experimental.

Figure 3.8 Statewide 2016 Complaints by Source of Coverage

Source of Coverage	Percent of Complaints
Covered California/Exchange	45.8%
Group	23.7%
Medi-Cal	16.5%
Individual/Commercial	9.4%
Unknown	3.1%
Medicare	1.2%
Medi-Cal/Medicare	0.1%
COBRA	0.1%

Note: Due to differences in complaint reporting methodologies used by the reporting entities, complaint comparisons across sources of coverage should be interpreted with caution.

Figure 3.9 Statewide 2016 Complaints by Language

Language	Percent of Complaints
English	79%
Spanish	5%
Other	3%
Refused/Unknown	13%

Note: OPA combined language categories with low reported complaint volumes for analysis. The languages included in Other are: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

Figure 3.10 Statewide 2016 Top Five Complaint Reasons by Primary Language

	English	Spanish	Other Languages	Refused/Unknown
1	Denial of Coverage (22%)	Denial of Coverage (36%)	Denial of Coverage (40%)	Denial of Coverage (26%)
2	Cancellation (15%)	Cancellation (18%)	Cancellation (10%)	Claim Denial (18%)
3	Medical Necessity Denial (11%)	Eligibility Determination (12%)	Eligibility Determination (10%)	Eligibility Determination (12%)
4	Experimental/ Investigational Denial (10%)	Medical Necessity Denial (9%)	Dis/Enrollment (7%)	Pharmacy Benefits (9%)
5	Co-Pay, Deductible, and Co-Insurance Issues (6%)	Dis/Enrollment (5%)	Medical Necessity Denial (7%)	Medical Necessity Denial (7%)

Figure 3.11 Statewide 2016 Top 10 Complaint Results Compared to Prior Years

Complaint Result	2014 Percentage	2015 Percentage	2016 Percentage
Upheld/Company Position Substantiated	14%	28%	24%
Withdrawn/Complaint Withdrawn	19%	15%	18%
Compromise Settlement/Resolution	24%	12%	13%
Overturned/Company Position Overturned	7%	8%	11%
Consumer Received Requested Service	0%	6%	9%
No Action Requested/Required	6%	6%	8%
Insufficient Information	9%	10%	8%
Referred to Other Division for Possible Disciplinary Action	1%	4%	5%
Recovery	3%	3%	1%
Question of Fact/Contract/Provision/Legal Issue	1%	2%	1%

Figure 3.12 Resolution Times by Reporting Entity

Reporting Entity	Minimum Number of Days to Resolve a Complaint	Maximum Number of Days to Resolve a Complaint	Average Resolution Time
DMHC	0	1,298	28 days
DHCS	0	411	80 days
CDI	0	669	90 days
Covered California	0	262	66 days

Figure 3.13 Statewide 2016 Average Resolution Time by Complaint Type

Complaint Type	Average Resolution Time
DSS State Fair Hearing	83 days
DSS State Fair Hearing: Informal Resolution	59 days
Complaint/Standard Complaint	36 days
Independent Medical Review	31 days
Urgent Nurse Case	14 days
Quick Resolution	7 days

Section 4 – Department of Managed Health Care Data Tables

A. Overview

Figure 4.1 DMHC Volume of Requests for Assistance

Month	2014 Volume	2015 Volume	2016 Volume
January	9,429	15,805	17,483
February	8,524	17,068	19,123
March	9,055	17,497	19,217
April	11,500	16,065	16,890
May	10,280	13,087	15,414
June	9,310	14,457	15,140
July	10,457	14,149	15,199
August	8,931	13,181	16,900
September	8,938	12,433	13,949
October	8,788	12,841	15,469
November	6,251	12,333	12,286
December	8,297	12,681	12,412

Note: This chart displays the DMHC Help Center's 2014, 2015, and 2016 consumer assistance volumes by month. The Help Center received 189,482 requests for assistance in 2016, 171,597 in 2015, and 109,760 in 2014.

Figure 4.2 DMHC Volume of Complaints by Month Closed

Month	2014 Volume	2015 Volume	2016 Volume
January	947	1,327	1,804
February	1,014	1,309	1,803
March	1,086	1,331	2,112
April	1,294	1,549	2,239
May	1,112	1,410	2,151
June	1,149	1,323	2,309
July	1,295	1,409	2,228
August	1,350	1,523	2,780
September	1,080	1,483	2,389
October	1,275	1,457	1,915
November	1,165	1,812	1,791
December	1,227	1,804	2,363

Note: This chart displays annual complaint volumes distributed by the month the complaint reviews ended. There were 25,884 complaints closed in 2016, 17,737 complaints closed in 2015, and 13,994 complaints closed in 2014.

Figure 4.3 DMHC Help Center Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
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	30 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 Expedited IMR cases	24 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, open an IMR if needed	10 calendar days from receipt of a request for assistance	14 days
Quick Resolution	*Contact Center:* Intake and casework resolution	10 days	7 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. DMHC clarified its Urgent Nurse time standard as 10 calendar days, rather than 7 business days as reported for measurement year 2015.

B. Complaint Ratios, Reasons, and Results

Figure 4.4 DMHC 2016 Top Ten Highest Health Plan Complaint Ratios (Complaints per 10,000 Members)

Health Plan	2014 Ratio	2015 Ratio	2016 Ratio
Anthem Blue Cross	12.28	14.69	24.69
Blue Shield of California	11.33	15.38	22.37
Cigna HealthCare of California, Inc.	9.24	11.78	17.29
UnitedHealthcare of California	4.58	10.88	16.54
Care 1st Health Plan	1.40	11.62	15.24
Western Health Advantage	6.99	9.30	13.16
Aetna Health of California, Inc.	4.64	11.89	12.90
Kaiser Permanente	4.50	7.39	10.15
Health Net of California, Inc.	8.87	20.15	7.38
Sharp Health Plan	3.97	4.16	7.05

Note: The chart above displays the full-service health plans with the highest complaint ratios for 2016 among plans with at least 70,000 members. The display also shows the 2014 and 2015 complaint ratios for the health plans represented. Health Net of California, Inc.'s 2015 and 2016 complaint ratios include complaints regarding Health Net Community Solutions, which cannot be separated for reporting.

Figure 4.5 DMHC 2016 Top Ten Complaint Reasons Compared to Prior Years

Complaint Reason	2014 Percentage	2015 Percentage	2016 Percentage
Cancellation	8.4%	14.4%	18.2%
Experimental/Investigational Denial	4.4%	5.1%	17.3%
Medical Necessity Denial	17.2%	19.6%	14.3%
Co-Pay, Deductible, and Co-Insurance Issues	13.0%	13.2%	11.1%
Coverage Question	9.3%	7.4%	7.3%
Provider Attitude and Service	5.4%	5.7%	4.8%
Out of Network Benefits	6.7%	6.6%	4.7%
Other Violation of Insurance Law/Regulation	1.6%	2.8%	3.8%
Dis/Enrollment	11.0%	5.6%	3.8%
Pharmacy Benefits	3.0%	3.6%	2.9%

Note: The complaint reason categories represented in this chart are the top reasons for 2016 and the distribution of those same reason categories in the 2014 and 2015 data. The reasons displayed may not have been the same as the top ten reasons for 2014 and 2015.

Figure 4.6 DMHC Help Center 2016 Top Ten Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	General Inquiry/Info	Department of Health Care Services (DHCS) Covered California Centers for Medicare and Medicaid Services (CMS) California Department of Insurance (CDI) Health Insurance Counseling & Advocacy Program (HICAP) Health Consumer Alliance (HCA) Partners Department of Labor (DOL)
2	Covered California	Covered California DHCS HCA Partners
3	Enrollment Disputes	DHCS Covered California HCA Partners
4	Claims/Financial	CDI Covered California CMS DHCS
5	Coverage/Benefits Disputes	DHCS CMS HICAP CDI
6	Access to Care	DHCS CMS HICAP
7	Quality of Care	CMS HICAP DHCS
8	Provider Customer Service	California Department of Consumer Affairs CMS DHCS
9	Wrong Number	DHCS Covered California
10	Appeal of Denial / Independent Medical Review	CMS DHCS CDI DOL

Note: DMHC ranking was based on data.

Figure 4.7 DMHC 2016 Complaint Results

Complaint Result	Volume
Upheld/Health Plan Position Substantiated	10,275
Consumer Received Requested Service	5,315
Insufficient Information	4,762
Compromise Settlement/Resolution	3,819
Overturned/Health Plan Position Overturned	3,316
Referred to Other Division for Possible Disciplinary Action	3,042
Unknown	137
No Jurisdiction	19
No Action Requested/Required	14
Claim Settled	7

Note: DMHC uses criteria to determine complaint outcomes that does not closely match the standardized, NAIC-based results categories. Therefore, the data in this table may not directly correspond to complaint outcomes published by DMHC in other reports. Results categories considered favorable to the complainant include: Consumer Received Requested Service, Compromise Settlement/Resolution, Overturned/Health Plan Position Overturned, 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 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 4.8 DMHC 2016 Complaint Results Compared to Prior Years

Result	2014 Percentage	2015 Percentage	2016 Percentage
Upheld/Health Plan Position Substantiated	6.3%	38.0%	33.5%
Consumer Received Requested Service	0.0%	11.5%	17.3%
Insufficient Information	18.9%	17.4%	15.5%
Compromise Settlement/Resolution	44.6%	17.0%	12.4%
Overturned/Health Plan Position Overturned	4.0%	8.9%	10.8%
Referred to Other Division for Possible Disciplinary Action	2.0%	6.5%	9.9%
Unknown	0.0%	0.3%	0.4%
No Jurisdiction	0.5%	0.3%	0.1%
No Action Requested/Required	0.3%	0.1%	0.0%
Claim Settled	10.9%	0.1%	0.0%

Note: The chart displays the 2016 complaint results and the percentage distributions for the same ten complaint results categories in 2014 and 2015. DMHC reported all of its 21,583 complaint results in 2015 among the same categories. The 13,994 complaint results in 2014 were reported among eight of the same categories and one category not displayed (Withdrawn/Complaint Withdrawn).

Figure 4.9 DMHC 2016 Results for Cancellation Complaints

Complaint Result	Percentage of Cancellation Complaints
Two Results: Referred to Other Division for Possible Disciplinary Action and Overturned/Health Plan Position Overturned	32.13%
Upheld/Health Plan Position Substantiated	23.38%
Two Results: Upheld/Health Plan Position Substantiated and Compromise Settlement/Resolution	20.54%
Insufficient Information	13.02%
Referred to Other Division for Possible Disciplinary Action	10.15%
Compromise Settlement/Resolution	0.42%
Unknown	0.34%
Claim Settled	0.02%

Figure 4.10 DMHC 2016 Results for Experimental/Investigational Denial Complaints

Complaint Result	Percentage of Experimental/ Investigational Denial Complaints
Consumer Received Requested Service	72.69%
Overturned/Health Plan Position Overturned	17.98%
Upheld/Health Plan Position Substantiated	9.33%

Figure 4.11 DMHC 2016 Results for Medical Necessity Denial Complaints

Complaint Result	Percentage of Medical Necessity Denial Complaints
Consumer Received Requested Service	52.08%
Overturned/Health Plan Position Overturned	23.98%
Upheld/Health Plan Position Substantiated	23.93%

Figure 4.12 DMHC Average Resolution Time by Complaint Type

Complaint Type	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Complaint/Standard Complaint	30 days	39 days	30 days
Independent Medical Review	27 days	26 days	24 days
Urgent Nurse Case	9 days	9 days	14 days
Quick Resolution	7 days	6 days	7 days

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.

Figure 4.13 DMHC 2016 Top Ten Complaint Reasons and Corresponding Average Resolution Times

Complaint Reason	Percentage	Average Resolution Time
Cancellation	18.2%	30 days
Experimental/Investigational Denial	17.3%	23 days
Medical Necessity Denial	14.3%	25 days
Co-Pay, Deductible, and Co-Insurance Issues	11.1%	21 days
Coverage Question	7.3%	22 days
Provider Attitude and Service	4.8%	20 days
Out of Network Benefits	4.7%	27 days
Other Violation of Insurance Law/Regulation	3.8%	124 days
Dis/Enrollment	3.8%	20 days
Pharmacy Benefits	2.9%	22 days

Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

C. Demographic and Other Complaint Elements

Figure 4.14 DMHC 2016 Distribution of Complaints by Age

Age	Percent of Complaints
Under 18 Years Old	9%
18-34 Years Old	14%
35-54 Years Old	32%
55-64 Years Old	27%
65-74 Years Old	5%
Over 74 Years Old	1%
Unknown Age	12%

Figure 4.15 DMHC 2016 Distribution of Complaints by Race

Race	Percent of Complaints
American Indian or Alaska Native	0.4%
Asian	3.6%
Black or African American	1.6%
Other	1.1%
Refused	65.7%
Unknown	6.9%
White	20.8%

Figure 4.16 DMHC Volume of Complaints by Source of Coverage

Source of Coverage	2014 Volume	2015 Volume	2016 Volume
Group	8,119	7,883	11,421
Covered California/Exchange	1,076	3,179	5,206
Individual/Commercial	3,035	3,191	4,250
Medi-Cal	859	1,949	2,464
Unknown	629	868	1,737
Medicare	193	497	671
COBRA	78	67	72
Medi-Cal/Medicare	5	103	63

Note: Prior year reports displayed source of coverage categories for Medi-Cal Fee-for-Service and Medi-Cal Managed Care. This differentiation is now by product types rather than source of coverage.

Figure 4.17 DMHC Average Resolution Time by Source of Coverage

Source of Coverage	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Individual/Commercial	30 days	37 days	31 days
Group	26 days	31 days	29 days
Medi-Cal	27 days	32 days	28 days
Covered California/Exchange	32 days	42 days	27 days
Medi-Cal/Medicare	26 days	38 days	23 days
Unknown	13 days	24 days	19 days
Medicare	28 days	21 days	16 days
COBRA	16 days	42 days	13 days

Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

Figure 4.18 DMHC 2016 Top Ten Most Common Reasons for Covered California Health Plan Complaints About Health Care Delivery Issues

Complaint Reason	2016 Percentage
Co-Pay, Deductible, and Co-Insurance Issues	9.5%
Experimental/Investigational Denial	4.8%
Medical Necessity Denial	2.7%
Coverage Question	2.4%
Out of Network Benefits	2.1%
Provider Attitude and Service	2.0%
Other Violation of Insurance Law/Regulation	2.0%
Misrepresentation	1.5%
Access to Care	1.4%
Pharmacy Benefits	1.2%

Note: Eligibility and enrollment related complaint reasons, Cancellation and Dis/Enrollment, were excluded from the display due to the analysis focus on health care delivery issues.

Figure 4.19 DMHC 2016 Covered California Health Plan Complaint Ratios for Cancellation and Dis/Enrollment Issues

Health Plan	Complaint Ratio
Kaiser Permanente	53.00
Health Net of California, Inc.	20.59
Anthem Blue Cross	16.85
Blue Shield of California	16.27
Molina Healthcare of California	3.10

Note: The display shows health plans with Covered California enrollment over 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 4.20 DMHC 2016 Covered California Health Plan Complaint Ratios for Health Care Delivery Issues (Complaints per 10,000 Members)

Health Plan	Complaint Ratio
Anthem Blue Cross	16.08
Kaiser Permanente	14.66
Blue Shield of California	12.52
Health Net of California, Inc.	10.09
Molina Healthcare of California	4.17

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

Figure 4.21 DMHC Complaint Distribution by Product Type

Product Type	2014 Percentage	2015 Percentage	2016 Percentage
HMO	67.5%	65.9%	59.5%
PPO	25.6%	28.0%	36.0%
Unknown	3.0%	1.4%	2.3%
EPO	3.3%	3.6%	1.3%
POS	0.6%	1.2%	0.9%

Note: Some figures in this chart differ from prior year reports due to the inclusion of Medi-Cal source of coverage complaints in this year's analysis. HMO includes complaints reported under the HMO with Deductible product type category. PPO includes complaints reported under the PPO with Deductible product type category.

Figure 4.22 DMHC 2016 Complaint Volume by Source of Coverage and Product Type

Source of Coverage and Product Type	2016 Volume
Group HMO	7,667
Group PPO	3,487
Covered California HMO	2,991
Individual/Commercial PPO	2,904
Medi-Cal Managed Care	2,394
Covered California PPO	2,100
Individual/Commercial HMO	1,181
Medicare All Product Types	671
Group Other	267
Individual/Commercial Other	165
Covered California Other	115
COBRA All Product Types	72
Medi-Cal Fee-for-Service and Unknown Product Type	70
Medi-Cal/Medicare All Product Types	63

Note: Some categories with low complaint volumes were combined for analysis. Other includes Exclusive Provider Organization, Point-of-Sale (POS), and Unknown product type categories. HMO and PPO include complaints reported as HMO with Deductible and PPO with Deductible, respectively. The chart displays secondary product types reported for Medi-Cal. The Medi-Cal Fee-for-Service and Unknown Product Type category combines Medi-Cal source of coverage complaints that were reported with low volumes under the secondary product types of Fee-for-Service and Unknown.

Figure 4.23 DMHC 2016 Average Resolution Time by Product Type

Product Type	Average Resolution Time
EPO	38 days
PPO with Deductible	29 days
HMO with Deductible	28 days
HMO	27 days
PPO	25 days
POS	25 days
Unknown	17 days

Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

D. Consumer Assistance Center Details

Figure 4.24 DMHC Help Center – 2016 Telephone Metrics

Metric	Measurement	Based on
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	14,191*	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	81,088	Data
Number of jurisdictional inquiry calls	55,215**	Data
Number of non-jurisdictional calls	15,725**	Data
Average number of calls received per jurisdictional complaint case	0.28 status check calls per complaint case	Data
Average wait time to reach a CSR	0:03:53	Data
Average length of talk time (time between a CSR answering and completing a call)	0:06:23	Data
Average number of CSRs available to answer calls (during Service Center hours)	On average 15 agents (full-time equivalent)	Data

*Note: * DMHC's abandoned calls are those that abandon after being queued. These do not include calls contained in the IVR.*
*** DMHC reported two inquiry metrics from its case management database showing a combined volume of 70,940 calls, which is more than its phone system records of calls handled by its Contact Center agents (69,294). DMHC indicated that this difference may be due to inquiry calls by providers calling to check on the status of multiple cases at one time.*

Section 5 – California Department of Health Care Services Data Tables

A. Overview

Figure 5.1 DHCS Medi-Cal Volume of Complaints

Month	2014 Volume	2015 Volume	2016 Volume
January	218	357	509
February	286	553	635
March	294	583	740
April	406	620	580
May	329	519	729
June	340	686	854
July	433	579	214
August	409	549	346
September	514	497	528
October	503	531	634
November	357	499	510
December	500	767	491

Figure 5.2 Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
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	80 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

Figure 5.3 DHCS 2016 Complaint Ratios for Medi-Cal Managed Care Plans (Complaints per 10,000 Members)

Health Plan	Complaint Ratio
Care 1st Partner Plan	5.18
Molina Healthcare	4.32
Anthem Blue Cross Partnership Plan	3.77
L.A. Care Health Plan	3.66
California Health and Wellness Plan	3.65
Partnership Health Plan of California	3.57
Kaiser Permanente	3.57
Santa Clara Family Health Plan	3.26
Health Net	2.66
CalOptima	2.38
Inland Empire Health Plan	2.13
Central California Alliance for Health	2.04
Kern Family Health Care	2.03
San Francisco Health Plan	2.01
Alameda Alliance for Health	1.83
Contra Costa Health Plan	1.81
Community Health Group Partnership Plan	1.52
CenCal Health	1.41
Health Plan of San Mateo	1.08
CalViva Health	1.01
Gold Coast Health Plan	0.79
Health Plan of San Joaquin	0.58

Note: 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.

Figure 5.4 DHCS 2016 Top Ten Health Plan Complaint Ratios Compared to Prior Years (Complaints per 10,000 Members)

Health Plan and County	Model	2014 Ratio	2015 Ratio	2016 Ratio
Anthem Blue Cross, Sacramento County	GMC	6.76	6.19	6.69
Health Net, Sacramento County	GMC	6.17	9.82	6.60
Molina Healthcare, San Diego County	GMC	10.03	8.82	4.98
Care 1st, San Diego County	GMC	7.74	1.04	4.76
Partnership Health Plan of California, Solano County	COHS	3.27	3.95	3.96
L.A. Care Health Plan, Los Angeles County	Two-Plan	4.91	4.04	3.66
Santa Clara Family Health Plan, Santa Clara County	Two-Plan	4.22	3.07	3.22
Health Net, San Diego County	GMC	4.87	5.01	3.06
Anthem Blue Cross, Santa Clara County	Two-Plan	3.55	4.28	2.74
Kaiser Permanente, Sacramento County	GMC	2.45	3.74	2.72

Note: This chart shows the health plans with the highest complaint ratios among plans with county enrollment over 70,000 members in 2016, as well as the ratios for the same plans in 2014 and 2015. The health plans displayed were not necessarily the plans with the highest complaint ratios in 2014 and 2015.

Figure 5.5 DHCS 2016 Top Ten Medi-Cal Complaint Reasons Compared to Prior Years

Complaint Reason	2014 Percentage	2015 Percentage	2016 Percentage
Dis/Enrollment	2.30%	22.00%	23.48%
Medical Necessity Denial	0.00%	3.51%	20.25%
Claim Denial	0.00%	1.12%	17.95%
Pharmacy Benefits	0.00%	39.89%	11.87%
Quality of Care	90.64%	24.92%	11.72%
Scope of Benefits	0.00%	0.00%	6.48%
Billing/Reimbursement Issue	0.00%	4.35%	3.52%
Rehabilitative/Habilitative Care	0.00%	2.18%	3.10%
Utilization Review	0.00%	0.08%	1.06%
Hospitalization	0.00%	0.00%	0.35%

Figure 5.6 DHCS Service Centers' Top Topics for Non-Jurisdictional Inquiries

Managed Care Ombudsman Ranking	Inquiry Topic	Referred to
1 (most common)	Medi-Cal Eligibility	County Medi-Cal Office
2	Fee-For-Service	DHCS FFS Help Line (Medi-Cal Telephone Service Center)
3	Health Care Options	Health Care Options
4	Covered CA	Covered CA
5	Medicare	1-800 Medicare
6	Denti-Cal	Denti-Cal
7	State Fair Hearings	California Department of Social Services
8	Mental Health	County Mental Health

Note: Managed Care Ombudsman ranking was based on data.

Mental Health Ombudsman Ranking	Inquiry Topic	Referred to
1	Accessing Managed Care	Managed Care Plan
2	Status of Medi-Cal Application	County Medi-Cal Office
3	Disenrollment	County Medi-Cal Office
4	Remove Hold	Managed Care Division
5	Enrollment	Health Care Options
6	Replace Beneficiary ID Card	County Medi-Cal Office
7	Conservatorship	County Public Guardian Office
8	Substance Use Disorders	County Social Services
9	Housing	County Social Services
10	Treatment Authorization Request	Xerox (Fiscal Intermediary)

Note: Mental Health Ombudsman ranking was estimated by DHCS. As of 2017, Xerox reorganized and the FI became Conduent.*

Medi-Cal Telephone Service Center Ranking	Inquiry Topic	Referred to
1	Beneficiary Inquiry/Eligibility	County Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Denti-Cal
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	Vendor

Note: Medi-Cal Telephone Service Center ranking was based on data.

Denti-Cal Telephone Service Center Ranking	Inquiry Topic	Referred to
1	Referrals	Managed Care Plan & Health Care Options
2	Benefits Identification Card	County Social Services Office
3	Eligibility	County Social Services Office
4	Other Health Coverage addition or removal	County Social Services Office or Medi-Cal
5	Share of Cost	County Social Services Office
6	Complaint against Office (non-treatment)	Dental Board
7	Non-Covered Services	DHCS Medi-Cal Dental Division and CDSS State Fair Hearing Division

Note: Denti-Cal Beneficiary Telephone Service Center ranking was estimated by DHCS.

Figure 5.7 DHCS 2016 Top Ten Complaint Results

Complaint Result	Complaint Volume
Withdrawn/Complaint Withdrawn	3,043
Upheld/Health Plan Position Substantiated	1,902
No Action Requested/Required	1,318
Overturned/Health Plan Position Overturned	353
Insufficient Information	83
No Jurisdiction	54
Consumer Received Requested Service	43
Health Plan in Compliance	38
Compromise Settlement/Resolution	35
Unknown	20

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 and Health Plan in Compliance. 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 5.8 DHCS 2016 Top Ten Complaint Results Compared to Prior Years

Complaint Result	2014 Percentage	2015 Percentage	2016 Percentage
Withdrawn/Complaint Withdrawn	38.1%	48.0%	44.1%
Upheld/Health Plan Position Substantiated	24.8%	23.0%	27.6%
No Action Requested/Required	22.2%	18.2%	19.1%
Overturned/Health Plan Position Overturned	14.2%	3.1%	5.1%
Insufficient Information	0.0%	0.0%	1.2%
No Jurisdiction	0.0%	0.0%	0.8%
Consumer Received Requested Service	0.0%	0.0%	0.6%
Health Plan in Compliance	0.0%	4.9%	0.6%
Compromise Settlement/Resolution	0.2%	0.9%	0.5%
Unknown	0.6%	0.4%	0.3%

Note: The complaint results represented are the top complaint results for 2016 and the distribution of the same complaint results in the 2014 and 2015 data. Percentages shown for 2014 differ from previous year report displays, which did not include Mental Health or Dental in the calculation.

Figure 5.9 DHCS 2016 Top Ten Medi-Cal Complaint Reasons and Average Resolution Times

Complaint Reason	Percent of Complaints	Average Resolution Time
Dis/Enrollment	23.48%	91 days
Medical Necessity Denial	20.25%	82 days
Claim Denial	17.95%	173 days
Pharmacy Benefits	11.87%	50 days
Quality of Care	11.72%	57 days
Scope of Benefits	6.48%	44 days
Billing/Reimbursement Issue	3.52%	79 days
Rehabilitative/Habilitative Care	3.10%	63 days
Utilization Review	1.06%	50 days
Hospitalization	0.35%	51 days

Figure 5.10 DHCS 2016 Dental Complaint Reasons and Average Resolution Times

Complaint Reason	Percent of Complaints	Average Resolution Time
Scope of Benefits	54.2%	33 days
Medical Necessity Denial	39.6%	38 days
Claim Denial	5.5%	43 days
Co-pay, Deductible, and Co-Insurance Issues	0.2%	21 days
Quality of Care	0.2%	46 days
Other	0.2%	19 days

Figure 5.11 DHCS 2016 Top Five Mental Health Complaints and Average Resolution Times

Complaint Reason	Percent of Complaints	Average Resolution Time
Denied Services	19.7%	36 days
Medical Necessity Denial	18.2%	52 days
Unknown	15.2%	25 days
Participating Provider Availability/Timely Access to Care	7.6%	59 days
Waiting Periods	6.1%	29 days

C. Demographics and Other Complaint Elements

Figure 5.12 DHCS 2016 Distribution of Complaints by Age

Age	Percent of Complaints
Age: <18	11%
Age: 18-34	12%
Age: 35-54	19%
Age: 55-64	18%
Age: 65-74	5%
Age: >74	3%
Unknown	32%

Figure 5.13 DHCS 2016 Distribution of Complaints by Race

Race	Percent of Complaints
American Indian or Alaska Native	0.2%
Asian	4.2%
Black or African American	8.8%
Native Hawaiian or Other Pacific Islander	0.4%
Other	2.2%
Refused/Unknown	59.1%
White	25.2%

Figure 5.14 DHCS 2016 Complaint Distribution by Ethnicity

Ethnicity	Percent of Complaints
Hispanic or Latino	20%
Not Hispanic or Latino	21%
Refused/Unknown	59%

Figure 5.15 DHCS 2016 Distribution of Complaints by Primary Language

Primary Language	Percent of Complaints
English	44%
Refused/Unknown	43%
Spanish	8%
Other	5%

Note: Other combines language categories with low volumes reported, including Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

Figure 5.16 DHCS 2016 Volume of Complaints by County of Residence

County	Complaint Volume
Los Angeles County	1,810
Sacramento County	541
San Diego County	458
Riverside County	367
San Bernardino County	324
Orange County	318
Alameda County	198
Santa Clara County	174
Kern County	140
Fresno County	121
Contra Costa County	102
San Francisco County	99
Placer County	83
Stanislaus County	72
Tulare County	70
San Joaquin County	68
Solano County	61
Butte County	55
El Dorado County	49
Monterey County	43
Shasta County	42
Merced County	41
Santa Cruz County	39
San Mateo County	38
Santa Barbara County	38
Sonoma County	37
Ventura County	37
San Luis Obispo County	30
Yolo County	28
Marin County	27
Imperial County	26
Nevada County	25
Yuba County	24

County	Complaint Volume
Humboldt County	22
Lake County	15
Napa County	15
Sutter County	14
Calaveras County	13
Madera County	13
San Benito County	13
Mendocino County	12
Tehama County	12

Note: Counties not shown that had at least one complaint but ten or fewer: Amador, Colusa, Del Norte, Glenn, Inyo, Kings, Lassen, Mariposa, Modoc, Plumas, Siskiyou, Trinity, and Tuolumne. Alpine, Mono, and Sierra Counties did not have any complaints reported.

Figure 5.17 DHCS 2016 Complaint Distribution by Product Type

Product Type	Percent of Complaints
Medi-Cal Managed Care	41.46%
Medi-Cal Fee-for-Service	39.20%
Dental	17.89%
Mental Health	0.93%
Long Term Care	0.37%
Cancer/Dread Disease	0.10%
Unknown	0.04%

Figure 5.18 DHCS 2016 Complaint Reasons for Medi-Cal Managed Care

Complaint Reason	Percent of Complaints
Medical Necessity Denial	37.5%
Dis/Enrollment	27.3%
Quality of Care	22.9%
Billing/Reimbursement Issue	6.4%
Rehabilitative/Habilitative Care	5.6%
Other	0.2%
Participating Provider Availability/Timely Access to Care	0.1%

Figure 5.19 DHCS 2016 Complaint Reasons for Medi-Cal Fee-for-Service

Complaint Reason	Percent of Complaints
Claim Denial	36.83%
Pharmacy Benefits	24.35%
Dis/Enrollment	19.45%
Scope of Benefits	13.30%
Utilization Review	2.17%
Medical Necessity Denial	2.14%
Hospitalization	0.71%
Rehabilitative/Habilitative Care	0.49%
Billing/Reimbursement Issue	0.45%
Eligibility Determination	0.04%
Documentation Requests/Disputes	0.04%
Emergency Services	0.04%

Note: The number of Fee-for-Service complaint reasons (2,669) exceeded the number of Fee-for-Service complaints (2,654) reported by DHCS because some complaints had more than one reason.

Figure 5.20 DHCS 2016 Dental Complaint Reasons

Complaint Reason	Percent of Complaints
Scope of Benefits	54.2%
Medical Necessity Denial	39.6%
Claim Denial	5.5%
Co-pay, Deductible, and Co-Insurance Issues	0.2%
Quality of Care	0.2%
Other	0.2%

Figure 5.21 DHCS 2016 Top Five Mental Health Complaint Reasons

Complaint Reason	Percent of Complaints
Denied Services	19.7%
Medical Necessity Denial	18.2%
Unknown	15.2%
Participating Provider Availability/Timely Access to Care	7.6%
Waiting Periods	6.1%

Note: The number of Mental Health complaint reasons (66) exceeded the number of Mental Health complaints (63) reported by DHCS because some complaints had more than one reason.

Figure 5.22 DHCS 2016 Average Complaint Resolution Time by Product Type

Product Type	Average Resolution time
Long Term Care	205 days
Cancer/Dread Disease	205 days
Fee-for-Service	106 days
Managed Care	75 days
Unknown	74 days
Mental Health	45 days
Dental	35 days

D. Consumer Assistance Center Details

Figure 5.23 DHCS Volume of Managed Care Ombudsman Inquiries

Month	2014 Volume	2015 Volume	2016 Volume
January	9,072	32,389	23,001
February	8,709	30,210	23,611
March	8,700	34,664	24,945
April	11,678	33,423	25,321
May	13,052	28,817	24,180
June	13,031	31,382	22,089
July	12,564	30,577	24,101
August	13,946	28,162	30,323
September	14,118	28,955	25,906
October	15,385	19,991	22,726
November	12,191	20,934	20,510
December	14,906	20,930	23,576

Figure 5.24 DHCS Volume of Mental Health Ombudsman Inquiries

Month	2014 Volume	2015 Volume	2016 Volume
January	785	624	649
February	354	500	725
March	398	572	703
April	430	691	753
May	343	562	774
June	382	622	609
July	385	749	617
August	488	615	682
September	625	641	642
October	443	698	545
November	396	677	563
December	458	660	475

Figure 5.25 DHCS Volume of Medi-Cal Telephone Service Center (FI) Inquiries

Month	2014 Volume	2015 Volume	2016 Volume
January	41,234	45,099	51,689
February	43,583	48,836	50,744
March	53,808	50,342	49,636
April	49,231	49,264	46,536
May	43,703	43,027	47,485
June	43,761	45,345	46,806
July	46,476	45,589	44,353
August	44,393	44,948	57,182
September	44,143	43,226	50,351
October	46,202	44,205	46,490
November	39,197	39,746	46,956
December	47,061	42,355	48,707

Figure 5.26 DHCS Volume of Denti-Cal Inquiries

Month	2014 Volume	2015 Volume	2016 Volume
January	37,532	55,543	36,089
February	30,771	57,136	42,865
March	39,154	57,484	46,198
April	53,449	50,224	40,498
May	59,163	43,859	39,997
June	71,592	47,275	40,955
July	85,621	49,866	39,451
August	67,138	46,964	44,422
September	65,111	42,844	35,607
October	64,535	42,695	34,016
November	52,936	36,237	31,934
December	49,835	36,237	29,460

Figure 5.27 DHCS Service Centers' 2016 Telephone Metrics

Metric	Medi-Cal Managed Care Ombudsman	Medi-Cal Mental Health Ombudsman	Medi-Cal Telephone Service Center	Denti-Cal Telephone Service Center
Total telephone calls received	236,768	7,473	586,935	457,593
Percent of inquiries that were phone calls	82%	97%	100%	99%
Number of abandoned calls (Incoming calls ended by callers prior to reaching a Customer Service Representative – CSR)	53,325	365*	60,449**	25,668
Number of calls resolved by the IVR/phone system (Caller provided and/or received information without involving a CSR)	64,364	Not available (no IVR system)	2,789,063**	220,855
Number of jurisdictional inquiry calls	119,079	922	586,935	457,593
Number of non-jurisdictional calls	Indicated above in the calls resolved by the IVR, which provides contact information for non-jurisdictional issues.	6,551	Not available	Not available
Average number of calls received per jurisdictional complaint case	Not available	Not available	Not available	Not available
Average wait time to reach a CSR	0:19:00	None***	0:02:00	0:01:05
Average length of talk time Time between a CSR answering and completing a call Jurisdictional Inquiry Non-Jurisdictional Inquiry	0:0900 Not available	1.5 min*** 3.0 min***	0:04:40 Not available	0:06:22 Not available
Average number of CSRs available to answer calls (during Service Center hours)	7 permanent staff; 9 limited-term staff; 5 temporary staff	3	72	86

Note: Numbers here are based on data unless otherwise specified.

** Mental Health Ombudsman counts the number of hang ups on their voicemail system.*

*** The number of abandoned calls and the number of calls resolved by the IVR/phone system include calls from both Medi-Cal beneficiaries and Medi-Cal providers. The beneficiary data cannot be separated.*

**** Estimated by DHCS.*

Section 6 – California Department of Insurance

A. Overview

Figure 6.1 CDI Volume of Requests for Assistance

Month	2014 Volume	2015 Volume	2016 Volume
January	4,357	4,252	3,833
February	3,238	4,004	3,850
March	3,488	4,486	4,141
April	3,467	4,237	3,662
May	2,992	3,587	3,491
June	2,977	3,922	3,687
July	3,001	3,790	3,448
August	2,724	3,504	3,702
September	2,576	3,699	3,286
October	2,921	3,669	3,635
November	2,350	3,066	3,052
December	2,895	3,666	3,310

Figure 6.2 CDI Volume of Complaints

Month	2014 Volume	2015 Volume	2016 Volume
January	425	256	272
February	356	250	248
March	368	242	285
April	463	287	220
May	427	233	248
June	333	329	213
July	303	308	237
August	238	256	194
September	304	263	169
October	325	273	209
November	255	202	272
December	282	310	304

Figure 6.3 CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2016
Standard Complaint	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau and Rating 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 health plan level review)	88 days Calculation includes time for regulatory review after the case is closed to the consumer 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)	30 working days, or 60 days (if reviewed concurrently with health plan level review)	94 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.
Urgent Clinical	CDI compliance officers handle case intake and initiate expedited IMRs *IMR Organization (contractor–MAXIMUS):* Case review and decision	IMR: 3 days	Not available

B. Complaint Ratios, Reasons, and Results

Figure 6.4 CDI Health Plan Complaint Ratios (Complaints per 10,000 Members)

Health Plan and Source of Coverage	2014 Ratio	2015 Ratio	2016 Ratio
Health Net Life Insurance Company, Group	15.04	12.62	20.12
Anthem Blue Cross Life And Health Insurance Company, Individual/Commercial	47.64	24.13	20.06
UnitedHealthcare Insurance Company, Group	8.44	9.57	11.59
Aetna Life Insurance Company, Group	7.07	9.19	10.85
Cigna Health And Life Insurance Company, Group	2.68	4.8	9.14

Note: The chart above displays the complaint ratios for plans with at least one complaint in 2016 and enrollment exceeding 70,000 for either their Group or Individual/Commercial products.

Figure 6.5 CDI 2016 Top Ten Complaint Reasons Compared to Prior Years

Complaint Reason	2014 Percentage	2015 Percentage	2016 Percentage
Claim Denial	24.1%	28.7%	29.3%
Experimental	3.7%	4.5%	8.7%
Unsatisfactory Settlement/Offer	11.0%	9.8%	8.4%
Medical Necessity Denial	7.3%	9.3%	7.5%
Out-of-Network Benefits	6.2%	7.1%	6.5%
Co-pay, Deductible, and Co-Insurance Issues	5.1%	4.9%	3.8%
Claim Delay	3.5%	3.6%	3.4%
Pharmacy Benefits	0.9%	3.7%	3.3%
Emergency Services	1.7%	2.9%	3.3%
Cancellation	5.8%	2.3%	2.2%

Note: The complaint reasons represented in this chart are the top ten complaint reasons for 2016 and the distribution of those same complaint reasons in the 2014 and 2015 data. These reasons were not necessarily the top ten complaint reasons in 2014 and 2015.

Figure 6.6 CDI 2016 Top Ten Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC) Department of Labor (DOL) Centers for Medicare and Medicaid Services (CMS) Various Departments of Insurance (DOIs)
2	Subsidy/Enrollment	Covered California
3	Claim Handling Delay	DMHC DOL Various DOIs
4	Co-pay/Out-of-Pocket Charges	DMHC DOL
5	Out-of-Network Benefits	DMHC DOL
6	Medical Necessity	DMHC DOL
7	Premium/Billing	DMHC
8	Cancellation	DMHC
9	Pharmacy Benefits	DMHC
10	Policyholder Service	DMHC DOL Covered California

Note: Ranking estimated by CDI.

Figure 6.7 CDI 2016 Top Ten Complaint Results

Complaint Result	2016 Volume
Upheld/Health Plan Position Substantiated	1,508
Recovery	881
Question of Fact/Contract/Provision/Legal Issue	605
Company in Compliance	316
Additional Payment	66
Insufficient Information	53
Claim Settled	52
Advised Complainant	43
State Specific (Other)	42
Policy Issued/Restored	40

Note: Results categories considered favorable to the complainant include: Recovery, Additional Payment, Claim Settled, and Policy Issued/Restored. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated and Health Plan in Compliance. The favorability of other categories shown is neutral or cannot be determined.

Figure 6.8 CDI 2016 Top Ten Complaint Results Compared to Prior Years

Complaint Result	2014 Percentage	2015 Percentage	2016 Percentage
Upheld/Health Plan Position Substantiated	27.3%	21.2%	40.1%
Recovery	16.6%	20.2%	23.4%
Question of Fact/Contract/Provision/Legal Issue	7.0%	11.6%	16.1%
Health Plan in Compliance	7.3%	14.7%	8.4%
Additional Payment	3.1%	3.5%	1.8%
Insufficient Information	0.5%	0.8%	1.4%
Claim Settled	3.3%	2.8%	1.4%
Advised Complainant	6.7%	8.0%	1.1%
State Specific (Other)	4.5%	1.0%	1.1%
Policy Issued/Restored	1.5%	1.7%	1.1%

Note: The complaint results displayed are the top ten complaint results for 2016 and the distribution of those same complaint results in the 2014 and 2015 data. The results categories shown were not necessarily the top ten for 2014 or 2015.

Figure 6.9 CDI Average Resolution Time by Complaint Type

Complaint Type	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Independent Medical Review	68 days	78 days	94 days
Complaint/Standard Complaint	73 days	74 days	88 days

Note: The CDI complaint duration reflects the date from initial receipt of the complaint to the end of the final regulatory review. The close date does not reflect the date when the complaint was closed to the complainant. Consumers can submit a complaint to CDI concurrent with the health plan's internal review period. For applicable complaints, the duration period may include the health plan's internal review period, the Independent Medical Review Organization's review time, as well as CDI's regulatory investigation period.

Figure 6.10 CDI 2016 Top Ten Complaint Reasons and Corresponding Average Resolution Time

Complaint Reason	Percent of Complaint Reasons	Average Resolution Time
Claim Denial	29%	92 days
Experimental	9%	94 days
Unsatisfactory Settlement/Offer	8%	96 days
Medical Necessity Denial	8%	96 days
Out-of-Network Benefits	6%	99 days
Co-pay, Deductible, and Co-Insurance Issues	4%	100 days
Claim Delay	3%	113 days
Pharmacy Benefits	3%	89 days
Emergency Services	3%	85 days
Cancellation	2%	65 days

Note: The CDI complaint duration reflects the date from initial receipt of the complaint to the end of the final regulatory review. The close date does not reflect the date when the complaint was closed to the complainant. Consumers can submit a complaint to CDI concurrent with the health plan's internal review period. For applicable complaints, the duration period may include the health plan's internal review period, the Independent Medical Review Organization's review time, as well as CDI's regulatory investigation period.

C. Demographics and Other Complaint Elements

Figure 6.11 CDI Average Resolution Time by Source of Coverage

Source of Coverage	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Group	70 days	76 days	92 days
Individual/Commercial	73 days	74 days	87 days

Note: The CDI complaint duration reflects the date from initial receipt of the complaint to the end of the final regulatory review. The close date does not reflect the date when the complaint was closed to the complainant. Consumers can submit a complaint to CDI concurrent with the health plan's internal review period. For applicable complaints, the duration period may include the health plan's internal review period, the Independent Medical Review Organization's review time, as well as CDI's regulatory investigation period.

Figure 6.12 CDI 2016 Top Ten Product Types Compared to Prior Years

Product Type	2014 Percentage	2015 Percentage	2016 Percentage
Health Only	60.8%	39.0%	38.1%
Large Group	5.5%	14.9%	17.6%
Small Group	6.2%	14.1%	14.2%
Stand Alone Dental	0.6%	9.3%	9.3%
Grandfathered	3.2%	5.7%	6.3%
Mental Health	3.0%	3.1%	2.8%
Pharmacy Benefits	0.7%	2.2%	2.1%
Medicare Supplement	2.3%	2.4%	1.9%
Limited Benefits	1.5%	1.1%	1.1%
Bronze	1.0%	1.2%	0.8%

Note: The product type categories displayed are the most common for 2016 and the distribution of those same categories in the 2014 and 2015 data. The categories shown were not necessarily the top ten for 2014 or 2015.

D. Consumer Assistance Center Details

Figure 6.13 CDI Consumers Services Division – 2016 Telephone Metrics

Metrics	Measurement	Based on
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	526	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,300	Data
Number of jurisdictional inquiry calls	25,451	Data
Number of non-jurisdictional calls	6,493	Data
Average number of calls received per jurisdictional complaint case	Not measured	
Average wait time to reach a CSR	0:00:27	Data
Average length of talk time (time between a CSR answering and completing a call)	0:05:38*	Data
Average number of CSRs available to answer calls (during Service Center hours)	Varies based on need	

** The CDI system does not differentiate the average talk time between jurisdictional and non-jurisdictional calls. In addition, in order to provide best practice customer service, secondary health officers are added to the health queue depending upon volume of calls received. The data also does not reflect time spent by officer to verify jurisdiction and return call to consumer. Stats only reflect time of consumers' initial contact.*

Section 7 – Covered California Data Tables

A. Overview

Figure 7.1 Covered California Volume of Requests for Assistance

Month	2014 Volume	2015 Volume	2016 Volume
January	438,175	620,060	812,430
February	387,192	936,924	642,637
March	590,138	517,711	639,586
April	453,552	455,796	479,181
May	260,660	265,224	314,083
June	238,010	239,435	292,400
July	256,813	231,415	259,484
August	275,635	264,498	283,615
September	297,510	257,341	275,268
October	314,026	335,727	425,371
November	404,780	506,039	546,304
December	507,579	760,766	1,068,221

Figure 7.2 Covered California Volume of Complaints

Month	2014 Volume	2015 Volume	2016 Volume
January	62	116	1,073
February	128	368	1,442
March	192	1,290	2,349
April	225	570	2,432
May	472	11	2,179
June	515	9	2,358
July	495	178	1,442
August	461	412	1,493
September	326	891	1,895
October	521	1,213	1,653
November	435	596	1,030
December	534	496	1,052

Figure 7.3 Covered California Percentage of Complaints by Complaint Type

Complaint Type	2014 Percentage	2015 Percentage	2016 Percentage
CDSS State Fair Hearing: Informal Resolution	0%	69%	72%
CDSS State Fair Hearing	100%	31%	28%

Figure 7.4 Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Covered California eligibility appeals. Administrative Law Judges make decisions.	No later than 90 days from the date the hearing request was filed	86 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.	Up to 45 days from the date the appeal was filed	59 days
Service Center Complaint	*Covered California Service Center staff*: Phone representatives provide assistance to callers and escalate issues they cannot resolve to a supervisor. Service center staff or supervisors route calls as needed. *Covered California subject matter experts, customer resolution teams, or Back Office staff:* Casework and resolution of escalated issues that are not appeals.	Not reported	Not reported
Urgent Clinical	*Covered California staff:* The Service Center escalates certain non-appeal cases involving consumers with urgent access to care issues to the External Coordination Unit to address. *CDSS State Hearings Division:* For State Fair Hearing appeals, grants expedited appeal status on certain cases involving consumers with urgent clinical issues.	Not reported	Not reported

Note: State Fair Hearing time standard 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

Figure 7.5 Covered California Complaint Reasons by Percentage

Complaint Reason	2014 Percentage	2015 Percentage	2016 Percentage
Denial of Coverage	85.3%	69.8%	65.8%
Eligibility Determination	12.9%	17.6%	19.5%
Cancellation	1.8%	12.6%	14.6%

Figure 7.6 Covered California 2016 Top Ten Jurisdictional and Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	Inquiry/Assistance - Application/Case Status	Not Applicable
2	1095-A Inquiry/Assistance	Not Applicable
3	Current Customer- Renewal-Complete Enrollment	Not Applicable
4	Inquiry/Assistance - New Enrollment	Not Applicable
5	Requesting to be Terminated	Not Applicable
6	Provided County Contact/Number Info	Referred to Medi-Cal
7	Medi-Cal/Enrollment Inquiries	Referred to Medi-Cal
8	Password Reset/Unlock	Not Applicable
9	Inquiry/Assistance - Renewal	Not Applicable
10	Inquiry/Assistance - Payment Inquiry	Qualified Health or Dental Plan

Note: Covered California ranking is based on data. Not Applicable means the inquiry was handled by the Covered California Service Center, not referred to another agency.

7.7 Covered California 2016 Complaint Results

Complaint Result	Complaint Volume
Withdrawn/Complaint Withdrawn	8,315
Compromise Settlement/Resolution	4,213
No Action Requested/Required	3,824
Covered California Position Overturned	3,138
Upheld/Covered California Position Substantiated	908

Note: Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Covered CA Position Overturned. Results categories considered favorable to Covered CA 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.

Figure 7.8 Covered California 2016 Complaint Results Compared to Prior Years

Result	2014 Percentage	2015 Percentage	2016 Percentage
Withdrawn/Complaint Withdrawn	48.6%	44.8%	40.8%
Compromise Settlement/Resolution	13.9%	17.8%	20.7%
No Action Requested/Required	13.8%	15.8%	18.7%
Covered California Position Overturned	17.3%	16.7%	15.4%
Upheld/Covered California Position Substantiated	6.4%	4.9%	4.5%

Note: The chart accounts for all of the complaint results reported for 2014 and 2016. One unknown result from 2015 is not displayed.

Figure 7.9 Covered California 2016 Results for Denial of Coverage Complaints

Complaint Result	Percentage of Denial of Coverage Complaints
Withdrawn/Complaint Withdrawn	39.29%
Compromise Settlement/Resolution	22.02%
No Action Requested/Required	18.44%
Covered CA Position Overturned	15.70%
Upheld/Covered California Position Substantiated	4.54%

Figure 7.10 Covered California 2016 Results for Cancellation Complaints

Complaint Result	Percentage of Cancellation Complaints
Withdrawn/Complaint Withdrawn	40.62%
Compromise Settlement/Resolution	21.40%
No Action Requested/Required	17.62%
Covered California Position Overturned	15.74%
Upheld/Covered California Position Substantiated	4.62%

Figure 7.11 Covered California 2016 Results for Eligibility Determination Complaints

Complaint Result	Percentage of Eligibility Determination Complaints
Withdrawn/Complaint Withdrawn	45.83%
No Action Requested/Required	20.62%
Compromise Settlement/Resolution	15.49%
Covered California Position Overturned	14.04%
Upheld/Covered California Position Substantiated	4.02%

Figure 7.12 Covered California Percentage of Complaint Reasons and Corresponding Average Resolution Time

Complaint Reason	Percent of 2016 Complaints	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Denial of Coverage	66%	47 days	55 days	67 days
Eligibility Determination	20%	40 days	55 days	63 days
Cancellation	15%	48 days	57 days	66 days

C. Demographics and Other Complaint Elements

Figure 7.13 Covered California 2016 Distribution of Complaints by Primary Language

Language	Percent of Complaints
English	70.9%
Spanish	8.1%
Other	4.5%
Unknown	16.6%

Note: Language categories with low reported complaint volumes were combined for display. Other includes complaints with primary language identified as: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Tagalog, and Vietnamese.

Figure 7.14 Covered California 2016 Complaint Volume by County of Residence

County	Complaint Volume
Los Angeles	4,740
Unknown	3,279
San Diego	1,900
Orange	1,549
Alameda	874
Riverside	857
San Bernardino	781
Santa Clara	655
Sacramento	587
San Francisco	507
Contra Costa	479
Ventura	407
San Mateo	346
Sonoma	293
San Joaquin	272
Fresno	267
Santa Barbara	210
Kern	188
Stanislaus	175
Marin	166
Solano	165
Santa Cruz	156

County	Complaint Volume
San Luis Obispo	154
Placer	143
Monterey	126
Tulare	121
Humboldt	85
Merced	80
Butte	80
El Dorado	76
Shasta	76
Yolo	62
Nevada	62
Napa	57
Imperial	44
Mendocino	41
Tuolumne	37
Madera	33
Yuba	31
Lake	28
Sutter	22
Kings	21
Tehama	20
San Benito	17
Siskiyou	16
Calaveras	15
Colusa	12
Glenn	11
Plumas	11
Mariposa	11

Note: Counties not shown with ten or fewer complaints: Alpine, Amador, Del Norte, Inyo, Lassen, Modoc, Mono, Sierra, and Trinity.

Figure 7.15 Covered California Complaints by Product Type

Product Type	2014 Percentage	2015 Percentage	2016 Percentage
Unknown	26%	27%	42%
Silver	46%	45%	38%
Bronze	14%	16%	14%
Gold	6%	5%	3%
Platinum	7%	5%	3%
Catastrophic	1%	1%	0%

Figure 7.16 Covered California Average Resolution Time by Product Type

Product Type	2014 Average Resolution Time	2015 Average Resolution Time	2016 Average Resolution Time
Unknown	46 days	55 days	63 days
Silver	46 days	55 days	69 days
Bronze	47 days	56 days	71 days
Gold	49 days	59 days	68 days
Platinum	43 days	57 days	64 days
Catastrophic	50 days	60 days	76 days

D. Consumer Assistance Center Details

Figure 7.17 Covered California Service Center Metrics – 2016 Telephone Metrics

Metric	Measurement	Based on
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	303,793	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	2,538,248	Data
Number of jurisdictional inquiry calls	Not reported	
Number of non-jurisdictional calls	Not reported	
Average number of calls received per jurisdictional complaint case	Not reported	
Average wait time to reach a CSR	0:03:22	Data
Average length of talk time (time between a CSR answering and completing a call)	0:16:27	Data
Average number of CSRs available to answer calls (during Service Center hours)	899	Estimated