Annual Health Care Complaint Data Report

Report to the Legislature
Measurement Year 2015

STATE OF CALIFORNIA
Edmund G. Brown Jr., Governor

HEALTH AND HUMAN SERVICES AGENCY
Diana S. Dooley, Secretary

OFFICE OF THE PATIENT ADVOCATE
Elizabeth C. Abbott, Director

Statutory Requirement

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

Health and Safety Code §136000.

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

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

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

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

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

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

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

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

An electronic copy of this report is accessible at:
http://www.opa.ca.gov/Documents/ComplaintDataReport-2015Data.pdf

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Section 1 – Executive Summary

The Office of the Patient Advocate (OPA) is required to develop and implement a multi-departmental Complaint Data Analysis Report. The authority and specifications for this public reporting initiative were originally established in AB 922 (Monning, Chapter 552, Statutes of 2011) and further detailed in SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014). This legislation called for an annual report to collect, analyze, and publicly report health care complaint data from four state entities, specifically the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), the California Department of Insurance (CDI), and California's state-based Health Benefit Exchange called Covered California (collectively, "reporting entities").

This report constitutes the second annual report after last year's initial baseline review of California's health care complaint data. 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.

The Baseline Report for measurement year 2014 is available online at: http://www.opa.ca.gov/Documents/ComplaintDataReport-2014Data.pdf.

This Complaint Data Report catalogs 33,836 consumer health care complaints closed in 2015. Note that overall enrollment volumes attributed to each reporting entity likely include persons who are counted more than once because they are enrolled in multiple plan types, such as dental, mental health, vision, and other plan types. Highlights of the report include:

- DMHC plan enrollment of 55,925,968 enrollees submitted 17,737 complaints, reflecting an increase of 27 percent from the number of 2014 complaints.
- DHCS plan enrollment of 13,439,444 enrollees submitted 6,740 complaints, reflecting an increase of 47 percent from the number of 2014 complaints.
- CDI plan enrollment of 2,158,334 enrollees submitted 3,209 complaints, reflecting a decrease of 21 percent from the number of 2014 complaints.
- Covered California plan enrollment of 1,318,193 enrollees submitted 6,150 complaints, reflecting an increase of 41 percent from the number of 2014 complaints.
- CDI and DMHC complaint data comes from each of their respective call centers. Covered California and DHCS complaint data come from the California Department of Social Services (CDSS), State Fair Hearings Division.
- The reporting entities tracked many data elements (including: age, gender, race, ethnicity, language, county, health plan, mode of contact, product type, source of coverage, type and reason for the complaint, time to resolve the complaint, and the outcome of the complaint filed). It is important to note differences in the reporting entities' time standards and complaint review and tracking protocols which do not allow for meaningful comparison across entities. Because of variances in data

collection, analyses about many of these data elements are reported in the respective sections about each reporting entity, rather than aggregated statewide.

- Top five statewide complaint reasons:
    1. Medical Necessity Denial
    2. Denial of Coverage
    3. Cancellation
    4. Pharmacy Benefits
    5. Co-pay, Deductible, and Co-Insurance Issues
- Top five statewide complaint results:
    1. Upheld/Health Plan Position Substantiated
    2. Withdrawn/Complaint Withdrawn
    3. Compromise Settlement/Resolution
    4. Insufficient Information
    5. Overturned/Health Plan Position Overturned
- As shown in this report, the range of time to resolve a complaint varied between reporting entities.
    - DMHC 6 - 56 days
    - DHCS 0 - 200 days
    - CDI 68 - 95 days
    - Covered California 49 - 69 days
- To provide a better measure of health plan performance, OPA analyzed and displayed health plan complaints as ratios of complaints filed against a particular health plan divided by the health plan's enrollment. These ratios will enable policy makers, departmental managers, and health plans to more fairly gauge the complaints received not strictly by raw numbers of complaints, but in the context of the number of complaints received per covered lives.
- For this second year report, OPA reported new information or updates regarding service center protocols, procedures, and performance metrics. Unless otherwise noted, service center descriptions outlined in the previous year's report are still applicable.
- In this subsequent year's report, OPA and the reporting entities have been able to better standardize the data with fewer Unknown data elements. Therefore, some of the differences in data from 2014 to 2015 may be due to better data collection rather than actual differences in performance.
- Due to adjustments of the reporting of 2015 enrollment data, enrollment figures are not comparable between annual publications.

Section 2 – Background and Methodology

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

Enhancements and Changes for This Year's Report

- OPA conducted data analyses which compared 2015 data categories to the baseline 2014 data. In this report, tables, and charts display year-to-year trends for some data elements. The dark blue displays within the report identify data from 2015.
- OPA concentrated on or highlighted service center changes which feature new data and systems updates since the baseline report.
- All reporting entities showed improvement in data collection from 2014 to 2015. OPA continues to work with all of the reporting entities to improve standardization and streamline the collection of complaint data.
- Adjustments to enrollment data reporting were made to better align with reporting entities' usual collection processes. Some reporting entities reported enrollment for a different point in time in 2015 than used in 2014, making year to year enrollment comparisons inexact.
- The DHCS enrollment total for 2015 omits dental enrollment, which was included in the 2014 total.
- Complaint result definitions with corresponding consumer outcomes are located in Appendix B.
- **DMHC** did not report on race data in 2014 or 2015. In 2014, no ethnicity data was reported, however in 2015 DMHC submitted ethnicity data for all consumers who submitted complaints.
- **DHCS** requested to move categories Medi-Cal Managed Care, Medi-Cal Fee for Service, and Medi-Cal/Medicare (CCI) from reporting under "source of coverage" to reporting the data under "product type" and thus replacing all DHCS source of coverage data with the category Medi-Cal product type in 2015. Product types currently reported in 2015 include Medi-Cal Managed Care, Medi-Cal Fee for Service, Dental Managed Care, Dental Fee for Service, Medi-Cal/Medicare (CCI), Mental Health, and Long Term: SCAN. Product types from 2014 not reported in 2015 consist of Medi-Cal Managed Care: Two Plan Model, Medi-Cal Managed Care: COHS Model, Medi-Cal Managed Care: GMC Model, Medi-Cal Managed Care: Rural Model, Medi-Cal Managed Care: Imperial Model, Medi-Cal Managed Care: San Benito Model, and Long Term: PACE.
- **CDI** reported approximately 2 percent of race and ethnicity information for consumers who reported complaints in 2014 compared to 42 percent of race and 42 percent of ethnicity data for consumers in 2015.

- **Covered California** reported two categories of State Fair Hearing complaints in 2015. Complaints that were addressed through the formal CDSS State Fair Hearing process were differentiated from the State Fair Hearing requests that were referred by CDSS back to Covered California for complaint resolution. The complaints referred back to Covered California are identified by the new complaint type State Fair Hearing: Informal Resolution.

Methodology and Data Elements

This second year Complaint Data Report evaluates complaints closed January through December 2015, and provides comparisons to the Baseline Report of complaints closed in 2014 when possible.

The four reporting entities (DMHC, DHCS, CDI, and Covered California) are statutorily required to annually provide OPA with non-aggregated complaint data from their respective service centers. The complaint type of the records that were submitted to OPA for measurement year 2015 include:

- **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)]. DHCS did not submit complaint data from the DHCS Service Centers.
- **CDI** – Standard Complaints and Independent Medical Reviews
- **Covered California** – State Fair Hearings (conducted by CDSS) and State Fair Hearings: Informal Resolution. Covered California did not submit complaint data from the Covered California Service Center.

For purposes of this report "complaints" included written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer problem or dispute. OPA has also provided data about "inquiries" made by consumers to state service centers to the extent possible, encompassing the following:

- **Jurisdictional Inquiry** – Consumer requires guidance on a topic within the service center's purview (including a status update on an already filed complaint), or assistance with a regular business activity within the service center's authority that is unrelated to a complaint (e.g., initiating an application for coverage).
- **Non-Jurisdictional Inquiry/Complaint** – Consumer requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.

OPA analysis of complaints for measurement year 2015 does not include cases opened in previous years if they were closed before 2015 or cases opened in 2015 but closed in 2016 or later.

OPA determined complaint ratios across programs to provide a more equitable comparison of large versus small health plans. The complaint ratio is calculated by taking

the number of closed complaints and dividing it by the number of covered lives the insurer had in place in 2015. This number is standardized by dividing the ratio by 10,000.

OPA obtained enrollment figures from the reporting entities for the health plans. For 2015, DMHC and CDI provided December enrollment data and DHCS and Covered California provided March enrollment data. DHCS did not report dental enrollment in 2015. Due to timing and other reporting methodology differences, enrollment figures may not be comparable from year to year and may vary from other reporting entities' publications. OPA continues to adjust reporting to better align with the reporting entities' usual enrollment data collection timelines and reporting practices.

Overall enrollment volumes attributed to each reporting entity likely include persons who are counted more than once because they are enrolled in multiple plan types, such as dental, mental health, vision, and other plan types.

Additional information about the background, statutory requirements, and methodology used to produce this report is available on the OPA website at: www.opa.ca.gov/Pages/AbouttheComplaintDataReports.aspx.

Additional Guidance About the Complaint Data and Resulting Analysis

Before the baseline review of health care complaint data, California had never attempted the collection of health care consumer complaints across systems. One of the key challenges for the analysis of health care complaint data across reporting entities continues to be that complaint definitions and processes are not standardized in terms of definitions, coding, tracking, systems, or performance metrics. OPA has undertaken significant collaborative efforts to standardize and validate the data. However, because some data categories are not fully standardized, OPA urges caution on comparing these categories across reporting entities or aggregating data into a statewide metric.

When comparing plan ratios, a lower number of complaints per 10,000 enrollees in a plan indicates that fewer complaints were submitted per capita. A plan with a higher overall number of complaints submitted may still receive fewer complaints per 10,000 enrollees than another plan with fewer overall complaints.

A pattern of consumer complaints may indicate systemic problems regarding health care coverage and problems with access to care. However, complaint data results can be an imperfect measure, especially when conducting comparisons between reporting entities, coverage types, regulatory agencies, and similar categories.

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 are the primary components of California's state system for health care consumer assistance and serve millions of Californians each year. Their service centers are the help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by these four state reporting entities.

The following table displays by reporting entity the number of plans that had at least one complaint closed, total enrollment numbers, and corresponding number of complaints. The enrollment numbers likely include a person enrolled in multiple plans including dental, mental health, vision, and other plan types. The 2014 and 2015 enrollment figures are not comparable due to timing and other reporting methodology changes.

Figure. 3.1

Reporting Entity Plans, Enrollment, and Complaints			
Reporting Entity	**Number of Plans with at Least One Complaint**	**Total Number of Enrollees**	**Number of Complaints**
DMHC	**68**	**55,925,968**	**17,737**
DHCS	**89**	**13,439,444**	**6,740**
CDI	**112**	**2,158,334**	**3,209**
Covered CA	**N/A**	**1,318,193**	**6,150**

Note: DHCS has 22 health plan contracts. The health plans have 89 health plan service areas which had at least one complaint from the total of 13,439,444 enrollment in 2015. The data in this table may not reflect outcomes published by the DHCS. The 2015 DHCS enrollment total does not include dental enrollment.

B. Statewide Consumer Assistance Centers

The following table provides contact and other information about each of the reporting entity service centers that reported 2015 consumer complaints or inquiries to OPA.

Figure 3.2

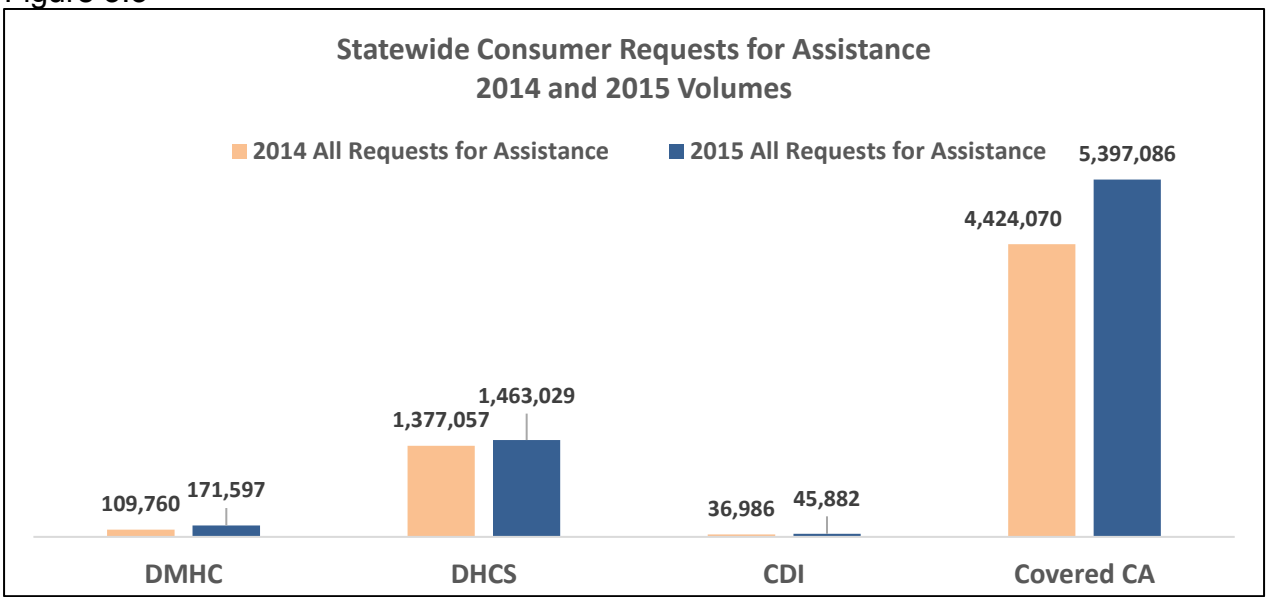
Consumer Assistance Service Centers Listed by Reporting Entity	
Department of Managed Health Care	
Help Center	
Main Phone Number	1-888-466-2219
TTY / TDD Line	1-877-688-9891
Days/Hours Open	Monday - Friday, 8:00 a.m. - 6:00 p.m. Service for urgent issues available after-hours and on state holidays
Service Center Website	www.healthhelp.ca.gov
Department of Health Care Services	

Medi-Cal Managed Care Office of the Ombudsman	
Main Phone Number	1-888-452-8609
TTY / TDD Line	Not available
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. (except state holidays)
Service Center Website	http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx
Mental Health Ombudsman	
Main Phone Number	1-800-896-4042
TTY / TDD Line	1-800-896-2512
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. (except state holidays)
Service Center Website	www.dhcs.ca.gov/services/MH/Pages/MH-Ombudsman.aspx
Medi-Cal Telephone Service Center (Contractor: Xerox)	
Main Phone Number	1-800-541-5555
TTY / TDD Line	916-635-6491
Days/Hours Open	Monday - Friday, 8:00 a.m. to 5:00 p.m. (beneficiary and provider assistance) Extended hours for provider technical assistance (365 days a year, 6:00 a.m. to Midnight)
Service Center Website	http://www.medi-cal.ca.gov
Denti-Cal Telephone Service Center (Contractor: Delta Dental)	
Main Phone Number	1-800-322-6384
TTY / TDD Line	1-800-735-2922
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. Some automated services available through the Interactive Voice Response system 7 days a week, 24 hours a day; Voicemail checked daily
Service Center Website	www.denti-cal.ca.gov
California Department of Insurance	
Consumer Services Division	
Main Phone Number	1-800-927-HELP (4357) or 213-897-8921 (Consumer Hotline)
TTY / TDD Line	1-800-482-4833
Other Phone Lines	1-800-967-9331 (Licensing Hotline)
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. After-hours message center
Service Center Website	www.insurance.ca.gov
Covered California	
Covered California Service Center (Rancho Cordova, Fresno, Contra Costa, and Faneuil Service Centers)	
Main Phone Number	1-800-300-1506
TTY / TDD Line	1-888-889-4500
Other Phone Lines	Arabic 1-800-826-6317; Հայերեն (Armenian) 1-800-996-1009; 中文 (Chinese) 1-800-300-1533; Español (Spanish) 1-800-300-0213; Farsi 1-800-921-8879; Hmoob (Hmong) 1-800-771-2156; Khmer 1-800-906-8528; 한국어 (Korean) 1-800-738-9116; Lao 1-800-357-7976; ру́сский (Russian) 1-800-778-7695; Tagalog (Filipino) 1-800-983-8816; Tiếng Việt (Vietnamese) 1-800-652-9528
Days/Hours Open	Monday - Friday, 8:00 a.m. to 6:00 p.m. (except state holidays)
Service Center Website	http://www.coveredca.com/

2015 Consumer Assistance Volumes

The reporting entity service centers that reported data to OPA received over seven million requests for assistance from consumers in 2015, a 19 percent increase over the previous year. Requests for assistance encompass the total volume of consumer contacts. Most consumers contacted the service centers by telephone. The vast majority of the requests for assistance received by state service centers were not to initiate a formal complaint, but were inquiries from consumers who required education, referrals, or other assistance.

Figure 3.3



Note: The DMHC utilizes criteria to determine request for assistance that does not closely match OPA. Therefore, the data in this table may not reflect outcomes published by the DMHC.

Figure 3.4

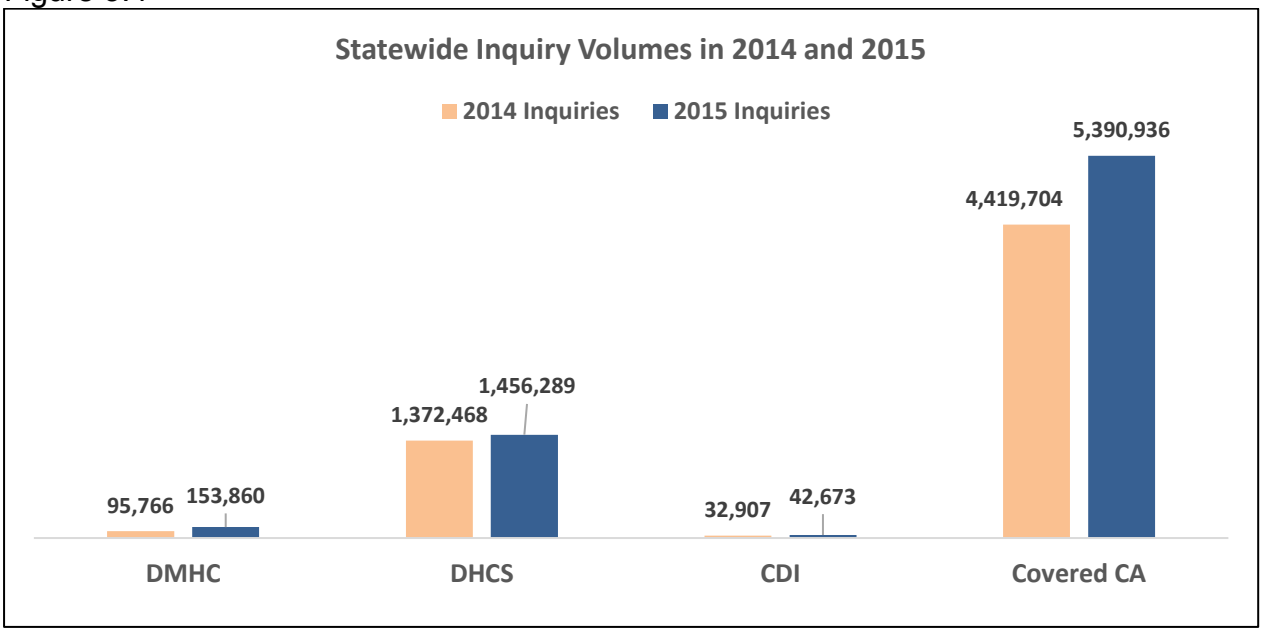
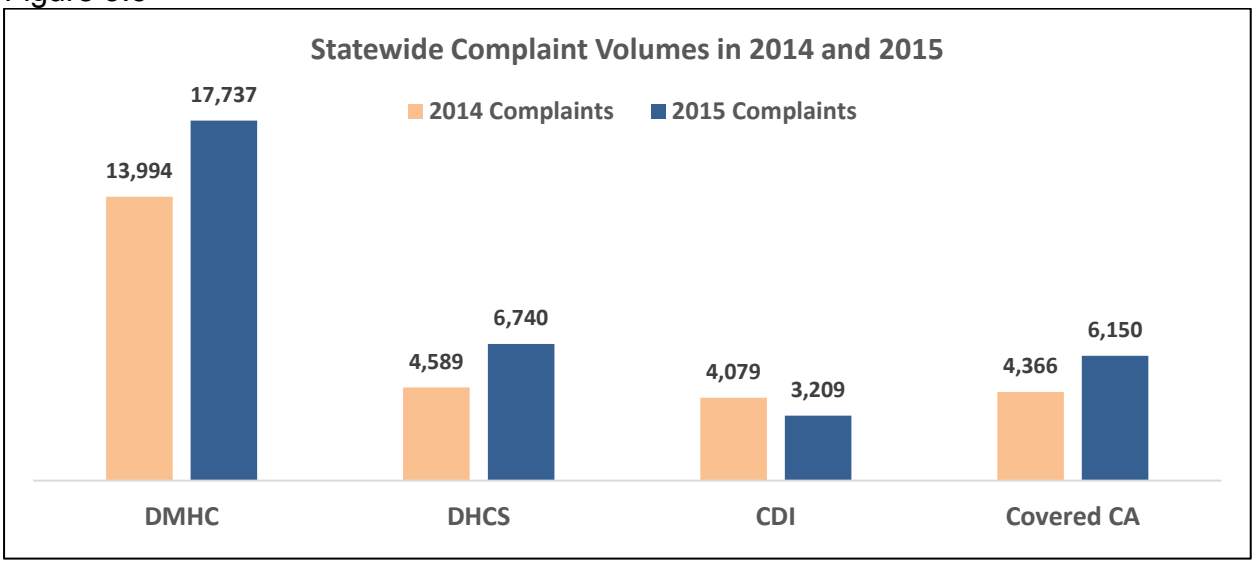


Figure 3.5



Note: The DMHC utilizes criteria to determine complaints that does not closely match OPA. Therefore, the data in this table may not reflect outcomes published by the DMHC.

Service Center Protocols

The reporting entities' service centers provided information about their protocols for handling consumer requests for assistance for the Baseline Report and submitted updates for 2015. Most service centers did not report significant changes in protocols or service centers systems for 2015. Any updates to service center systems are outlined further in Sections 4 - 7. Unless noted otherwise, service center descriptions outlined in the 2014 Complaint Data report are still applicable. The Baseline Report for measurement year 2014 is available online at http://www.opa.ca.gov/Documents/ComplaintDataReport-2014Data.pdf.

C. Statewide Health Care Complaint Data

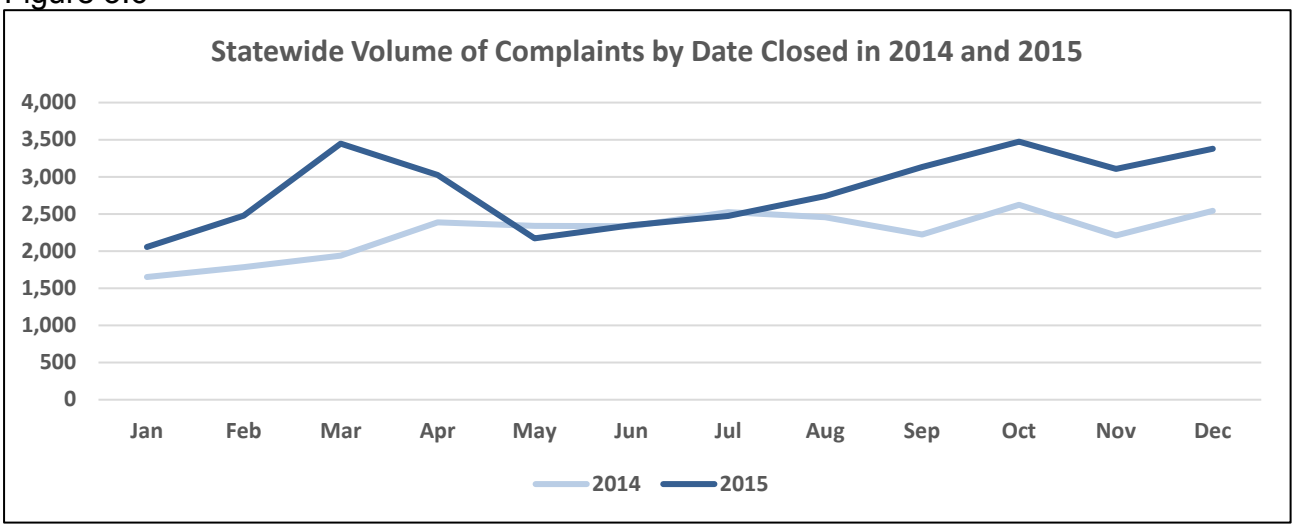
The four reporting entities submitted in total 33,836 consumer complaints to OPA for Measurement Year 2015: 52 percent of complaints were processed by DMHC, 20 percent by DHCS, 10 percent by CDI, and 18 percent by Covered California. The data represents complaints across 36 distinct product types from both commercial and public insurers. A large majority (42.32%) of complaint types were Standard Complaints, while 25.55 percent were CDSS State Fair Hearing, 16.46 percent were Independent Medical Reviews, 12.54 percent were CDSS State Fair Hearing: Informal Resolution, 2.80 percent were Quick Resolution Nurse, and 0.34 percent were Urgent Nurse Case complaints.

Volume of Closed Complaints

The statewide volume of complaints represents the total number of health care consumer complaints categorized by service center and CDSS State Fair Hearing submissions to

OPA from DMHC, DHCS, CDI, and Covered California. The chart below shows the monthly volume for complaints closed in 2014 (27,028) and 2015 (33,836).

Figure 3.6



Resolution Time

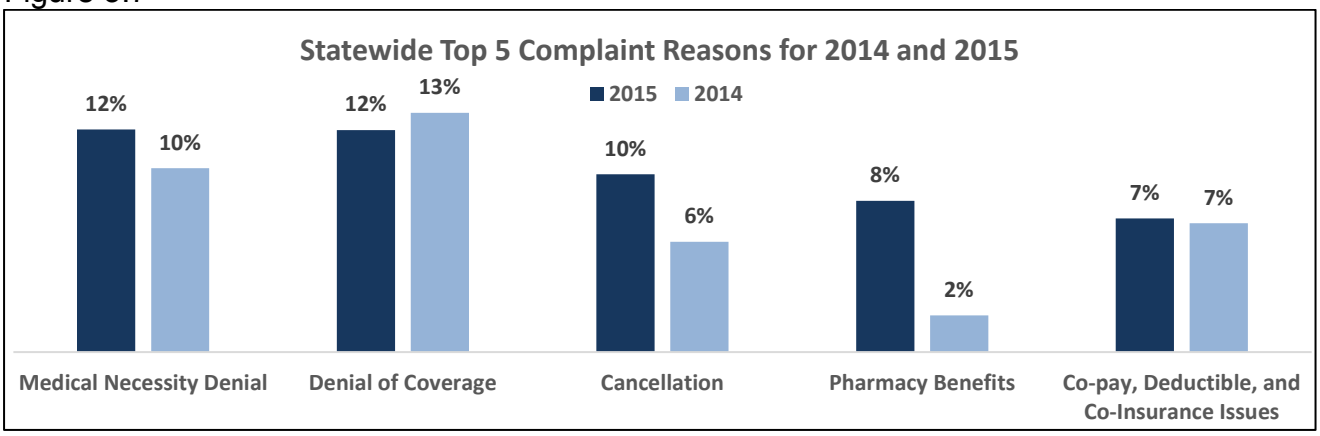
The average time to resolve or close a complaint is derived by calculating the number of days between the time a complaint was opened to the time it was closed and then computing the overall average for the total number of complaints processed by each reporting entity. The individual reporting entities resolution times are shown in their individual sections.

Complaint Reasons

Figure 3.7 presents the top five consumer complaint reasons statewide for 2014 and 2015. The top five complaint reasons represent 17,544 (49%) of all submitted complaint reasons for 2015. Medical Necessity Denial is the most reported complaint reason as reflected in the complaint data submitted by the reporting entities. The Baseline report combined Claim Denial and Denial of Covered California Coverage. In this and future reports, Denial of Covered California Coverage will be reported as Denial of Coverage.

It should be noted that the analyses conducted by the individual reporting entities revealed variations in the top complaints reasons. See Sections 4 through 7 for the individual entity rankings for top complaint reasons.

Figure 3.7

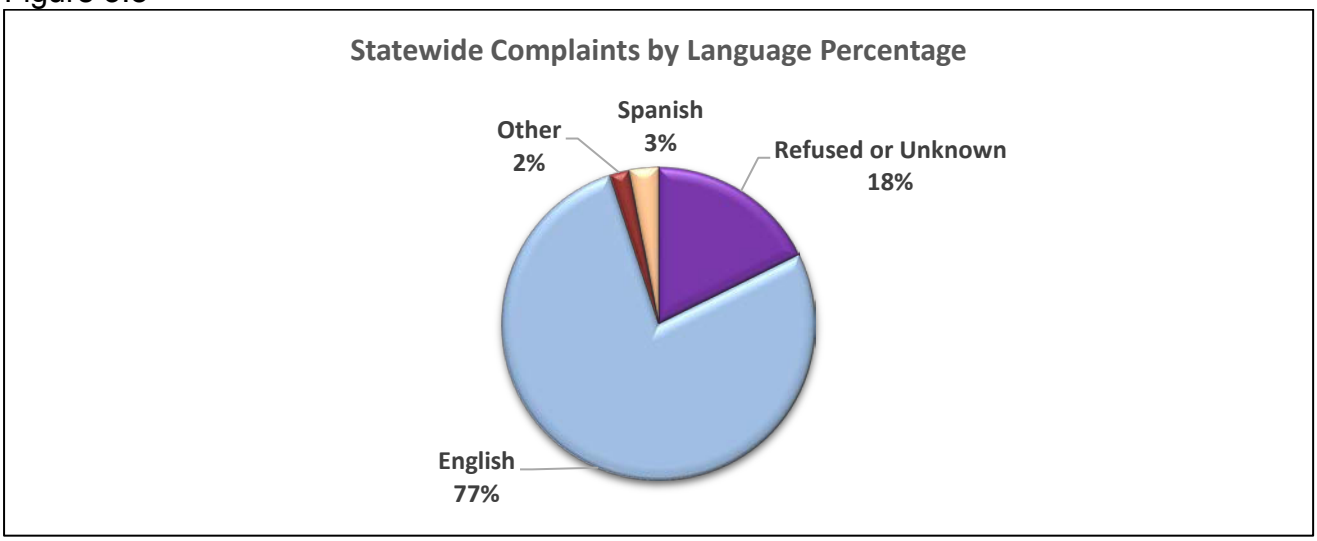


Note: The complaint reasons represented here are the top five complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data; they are not necessarily the top five complaint reasons in 2014.

Language

The chart below displays the statewide language of complaint reasons by percentage.

Figure 3.8



Note: Other include: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

Figures 3.9 – 3.12 display all complaints for the top ten complaint reasons by primary language for the four reporting entities. English-language speakers represent the majority of consumers (77%) who submitted complaints to DMHC, DHCS, CDI, and Covered California.

For English speakers, Denial of Coverage replaced Claim Denial as the top complaint reason in 2015 compared to 2014. Pharmacy Benefits replaced Access to Care as a top ten statewide complaint reason in 2015 compared to 2014.

Figure 3.9

Statewide Top 10 Complaint Reasons for Primary Language: English	
Denial of Coverage	3,616
Medical Necessity Denial	3,593
Cancellation	3,037
Co-pay, Deductible, and Co-Insurance Issues	2,411
Dis/Enrollment	1,707
Pharmacy Benefits	1,340
Coverage Question	1,309
Out of Network Benefits	1,291
Provider Attitude and Service	979
Experimental/Investigational Denial	902
Total	20,185

Statewide, Cancellation replaced Claim Denial as the top complaint reason for Spanish speakers. Denial of Coverage and Dis/Enrollment replaced Eligibility Determination and Medical Necessity Denial as the second and third complaint reason for 2015. Several of the complaint reasons statewide for Spanish speakers tied in the top ten volume of complaint reasons.

Figure 3.10

Statewide Top 10 Complaint Reasons for Primary Language: Spanish	
Cancellation	193
Denial of Coverage	187
Dis/Enrollment	111
Quality of Care	102
Eligibility Determination	99
Pharmacy Benefits	49
Medical Necessity Denial	49
Out of Network Benefits	39
Co-pay, Deductible, and Co-Insurance Issues	39
Provider Attitude and Service	24
Claim Denial	22
Billing/Reimbursement Issue	22
Access to Care	15
Total	951

For the other language speakers, their top complaint reason was Denial of Coverage which replaced Claim Denial as the top complaint reason statewide. Dis/Enrollment and Quality of Care replaced Medical Necessity Denial and Co-pay, Deductible, and Co-Insurance Issues as the second and third complaint reason for 2015.

Figure 3.11

Statewide Top 10 Complaint Reasons for Primary Language: Other Languages	
Denial of Coverage	167
Dis/Enrollment	103
Quality of Care	96
Cancellation	53
Pharmacy Benefits	43
Claim Denial	39
Eligibility Determination	37
Medical Necessity Denial	30
Co-pay, Deductible, and Co-Insurance Issues	22
Out of Network Benefits	16
Total	606

Statewide, Pharmacy Benefits replaced Quality of Care as the top complaint reason for consumers where their language was Unknown or they refused to identify a language. In 2015, Scope of Benefits and Claim Denial replaced Claim Denial and Unknown as the second and third complaint reason.

Figure 3.12

Statewide Top 10 Complaint Reasons for Primary Language: Unknown or Refused	
Pharmacy Benefits	1,493
Scope of Benefits	1,194
Claim Denial	962
Medical Necessity Denial	632
Denial of Coverage	322
Unsatisfactory Settlement/Offer	271
Quality of Care	261
Dis/Enrollment	236
Out of Network Benefits	176
Experimental	162
Total	5,709

Product Type

The state reporting entities regulate and have contract oversight for different types of insurance products. The following table displays the jurisdictional and non-jurisdictional complaint product types submitted by each of the reporting entities in descending order of total volume of complaints per product type.

Figure 3.13

Statewide Descending Volume of Jurisdictional and Non-jurisdictional Complaint Product Types			
DMHC	DHCS	CDI	Covered California
HMO	Medi-Cal Managed Care	Health Only	Silver
PPO	Medi-Cal Fee for Service	Large Group	Unknown
Medi-Cal Managed Care	Dental	Small Group	Bronze
EPO	Medi-Cal Coordinated Care (CCI)	Stand Alone Dental	Gold
Unknown	Mental Health	Grandfathered	Platinum
POS	Long Term Care: SCAN	Mental Health	Catastrophic
Medi-Cal Fee for Service	Unknown	Medicare Supplement	
		Pharmacy Benefits	
		Exchange	
		Bronze	
		Limited Benefits	
		Dental	
		Autism/PDD	
		Silver	
		Platinum	
		Student Health	
		Gold	
		Cancer/Dread Disease	
		Vision	
		Hospital Indemnity	
		Short Term Limited Duration Policy	
		Catastrophic	
		Child Only	
		Home Health Care	
		Chiropractic	
		Other	

D. Complaint Data Results

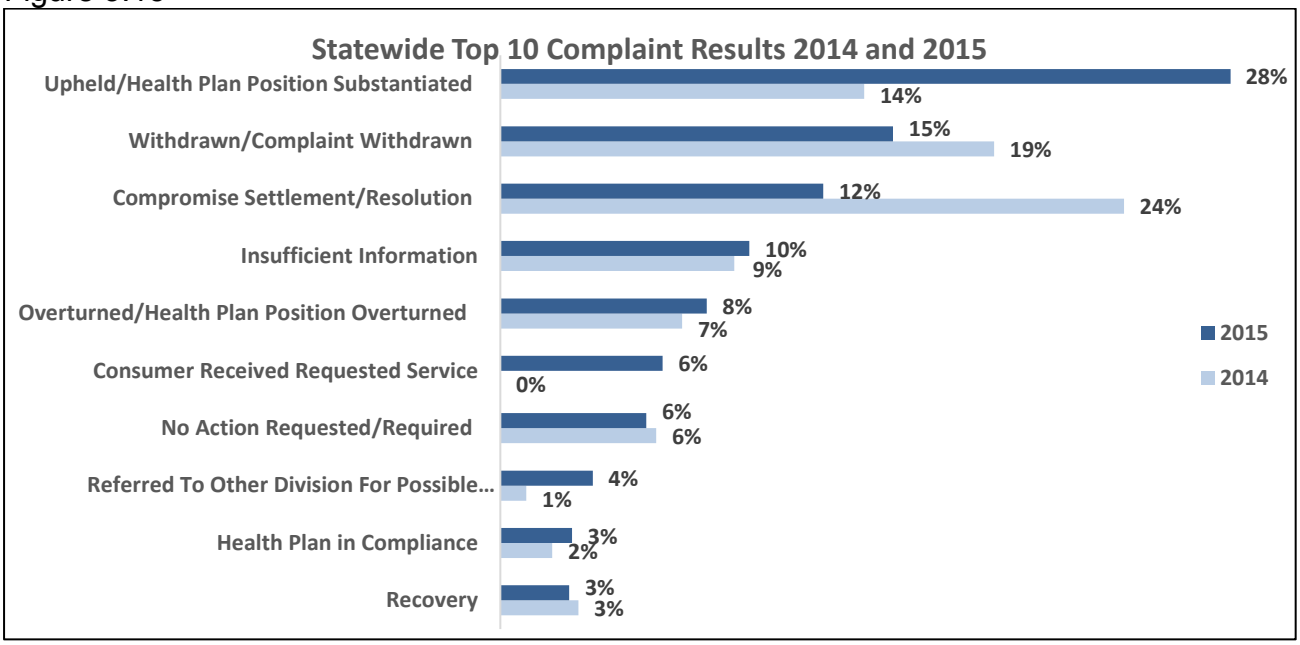
The following table shows the statewide top ten complaint results for 2015, which reflect 94 percent of 2015 complaint results. Some complaint cases submitted had more than one complaint result which is why the total number of results in 2015 (39,673) exceeds the total number of complaints (33,836). There were 81 complaints with an Unknown complaint result.

Figure 3.14

Statewide Top 10 Complaint Results	
Upheld/Health Plan Position Substantiated	**11,149**
Withdrawn/Complaint Withdrawn	**5,994**
Compromise Settlement/Resolution	**4,929**
Insufficient Information	**3,802**
Overturned/Health Plan Position Overturned	**3,149**
Consumer Received Requested Service	**2,475**
No Action Requested/Required	**2,227**
Referred To Other Division For Possible Disciplinary Action	**1,411**
Health Plan in Compliance	**1,094**
Recovery	**1,050**

The chart below shows the percentage of the statewide top ten complaint results for 2014 and 2015. For 2015, these ten complaint results represent 94 percent of the total complaint results for that year.

Figure 3.15



Note: New complaint results in 2015 is due to addition and standardization of complaint results in 2015. The complaint reasons represented here are the top ten complaint results for 2015 and the distribution of those same complaint results in the 2014 data; they are not necessarily the top ten complaint results in 2014.

Section 4 – Department of Managed Health Care

A. Overview

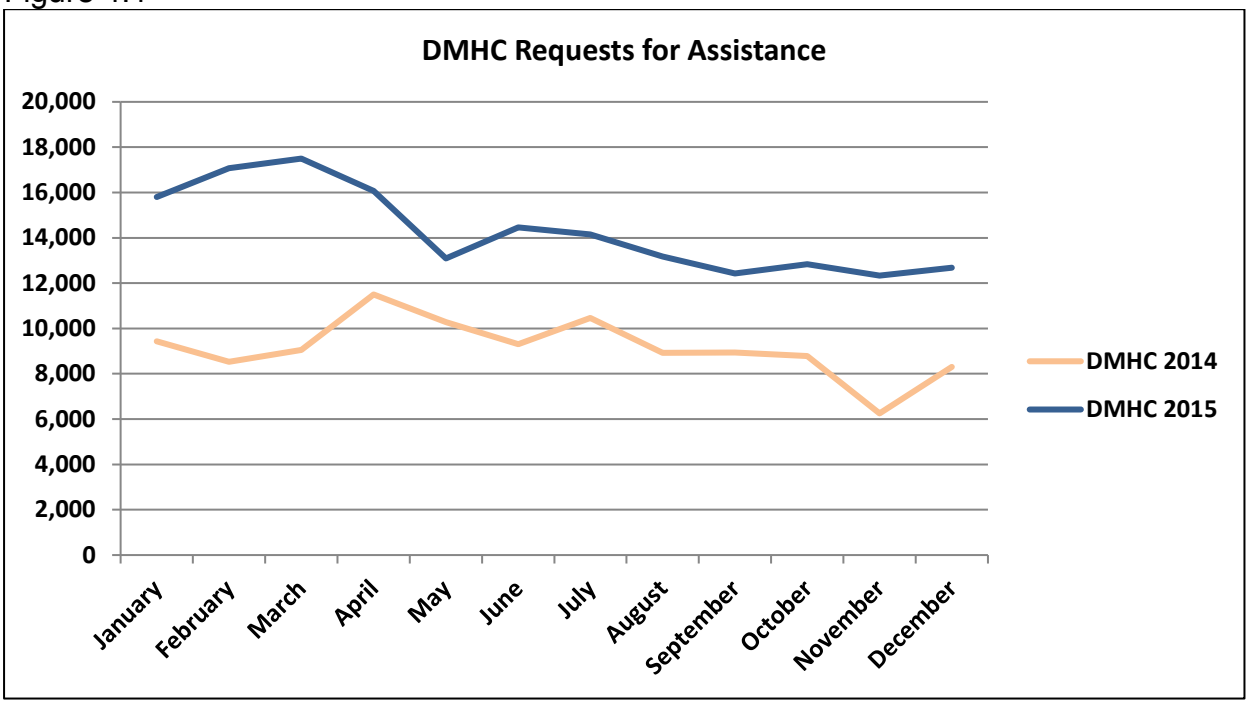
The Department of Managed Health Care (DMHC) regulates 95 percent of the commercial and public health care markets in California, including managed care plans that serve Medi-Cal and Covered California enrollees. DMHC's Help Center provides consumer assistance on health plan issues to ensure that managed health care enrollees receive the medical care and services to which they are entitled.

B. DMHC Consumer Assistance Center

Number of Requests for Assistance by Month

The DMHC Help Center received 171,597 requests for assistance from consumers in 2015, mostly (90%) by telephone. This volume was a 56 percent increase from 2014 (109,760). The following chart compares 2014 and 2015 consumer assistance volumes by month and includes both complaint and inquiry contacts.

Figure 4.1



Service Center Telephone Call Metrics

The DMHC Help Center received 154,635 total telephone calls from consumers in 2015. The following table shows the response from DMHC regarding some of its telephone call metrics.

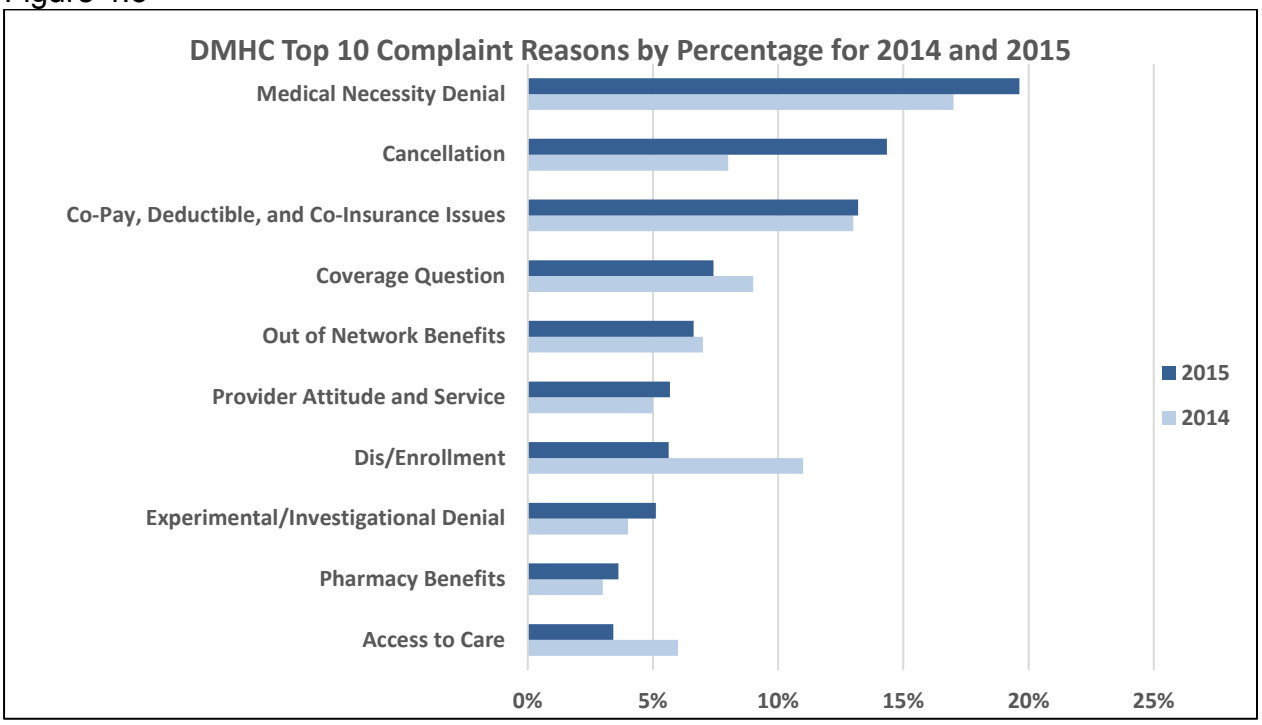
Figure 4.2

DMHC Help Center - 2015 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR) Abandoned Calls are the ones that abandon after being Queued. These do not include calls contained in the IVR.	16,946	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	70,822	Data
Number of jurisdictional inquiry calls	53,372	Data
Number of non-jurisdictional calls	14,183	Data
Average number of calls received per jurisdictional complaint case	0.27 status check calls per complaint case	Data
Average wait time to reach a CSR	10:53	Data
Average length of talk time (time between a CSR answering and completing a call)	5:59	Data
Average number of CSRs available to answer calls (during Service Center hours)	on average 15.5 agents (full-time equivalent)	Estimate

Top Ten Reasons for Jurisdictional Complaints

The top ten complaint reasons shown in the following chart accounted for 15,021 (85%) of all complaint cases closed by DMHC in 2015. The chart displays the complaint reasons from 2014 and 2015.

Figure 4.3



Note: The complaint reasons represented here are the top ten complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data; they are not necessarily the top ten complaint reasons in 2014.

Top Ten Topics for Non-Jurisdictional Inquiries

In 2015, the DMHC Help Center staff responded to 14,183 calls from consumers on topics outside of DMHC's authority to address or resolve, an 86 percent increase in non-jurisdictional calls from the previous year. The most common non-jurisdictional inquiries DMHC addressed in 2015 were the same as the previous year, with the top seven topics remaining in the same rank order.

Figure 4.4

DMHC Help Center Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	General Inquiry/Info	Department of Health Care Services (DHCS) Centers for Medicare and Medicaid Services (CMS) Covered California California Department of Insurance (CDI)
2	Covered California	Covered California
3	Enrollment Disputes	DHCS Covered California CMS U.S. Department of Labor (DOL)
4	Claims/Financial	CDI CMS DHCS DOL Out of State Department of Insurance (DOI)
5	Coverage/Benefits Disputes	DHCS CMS Covered California CDI
6	Access Complaints	DHCS CMS
7	Coordination of Care	CMS DHCS
8	Provider Service/Attitude	Department of Consumer Affairs California Department of Public Health (CDPH) CMS DHCS
9	Plan Service/Attitude	CMS DHCS
10	Appeal of Denial - IMR	CDI DOL

Note: Ranking by DMHC based on data.

Consumer Assistance Protocols

DMHC reported that there were not any significant changes to its consumer assistance protocols or systems since last year's Baseline Report. The complaint time standards and resolution times noted below are not comparable between reporting entities because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 4.5

DMHC Help Center Complaint Standards			
Complaint Process	**Primary Unit(s) Responsible and Role**	**Time Standard (if applicable)**	**Average Resolution Time in 2015**
Standard Complaint	*Call Center and Initial Review Branches:* Intake and routing *Complaint Resolution Branch:* Casework *Legal Review and Liaison Branch:* Legal review if needed	30 days from receipt of a completed complaint application	39 days Calculation includes time prior to the completion of the complaint application
Independent Medical Review (IMR)	*Call Center and Initial Review Branches:* Intake and routing *Independent Medical and Clinical Review Branch:* Casework *IMR contractor (MAXIMUS):* External Review decision *Legal Review and Liaison Branch:* Legal review if needed	30 days from receipt of a completed IMR application	26 days Calculation includes time prior to the completion of the IMR application
Urgent Clinical	*Call Center:* Intake and routing *DMHC clinical staff:* Casework	7 days from receipt of a completed complaint/IMR application	9 days* Calculation includes time prior to the completion of the complaint/ IMR application
Quick Resolution	*Call Center:* Intake and routing *DMHC clinical staff:* Casework	Standard Complaint or IMR process used if the quick resolution is not possible	6 days

Note: The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Resolution times were counted from the date that any initial information was received from a consumer. Figures detailing average resolution times are counted from the date that any initial information is received from a consumer.
** DMHC's average resolution time for Urgent Clinical is for reported Urgent Nurse complaints.*

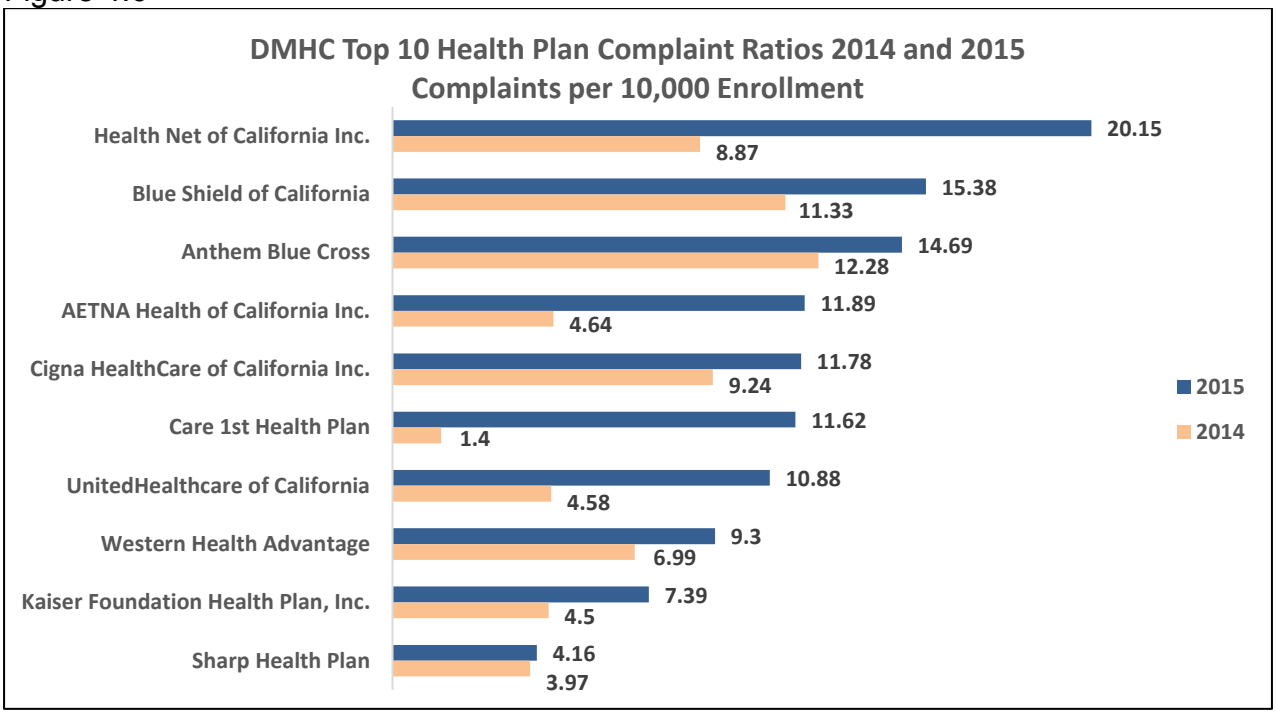
C. DMHC Complaint Data

Complaint Ratios

The following chart displays the top ten health plan complaint ratios under DMHC's jurisdiction with enrollment exceeding 70,000 covered lives in 2014 and 2015. There were 68 health plans with at least one complaint from the total of 55,925,968 enrollment

in 2015. This enrollment number likely includes a person enrolled in multiple plans including dental, mental health, vision, and other plan types.

Figure 4.6

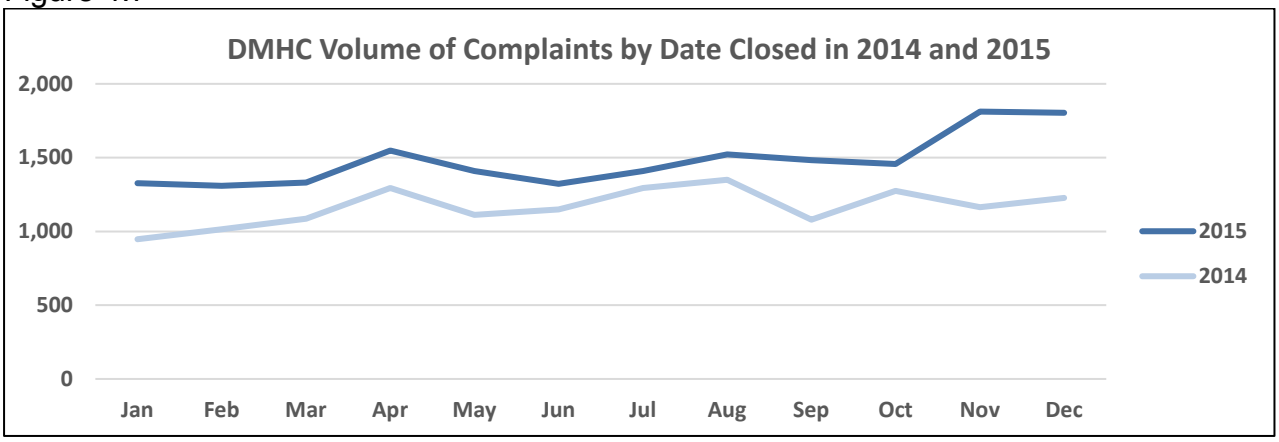


Note: Health Net of California, Inc. includes complaints regarding Health Net Community Solutions and cannot be separated for reporting. The complaint ratios represented here are the top ten complaint ratios for 2015 and the distribution of those same complaint ratios in the 2014 data; they are not necessarily the top ten complaint ratios in 2014.

Volume of Closed Complaints

The chart below displays by month the number of 13,994 complaints closed in 2014 and 17,737 complaints closed in 2015. The data captures complaints against health plans that serve commercial and public health plan members, including coverage through Covered California and DHCS.

Figure 4.7

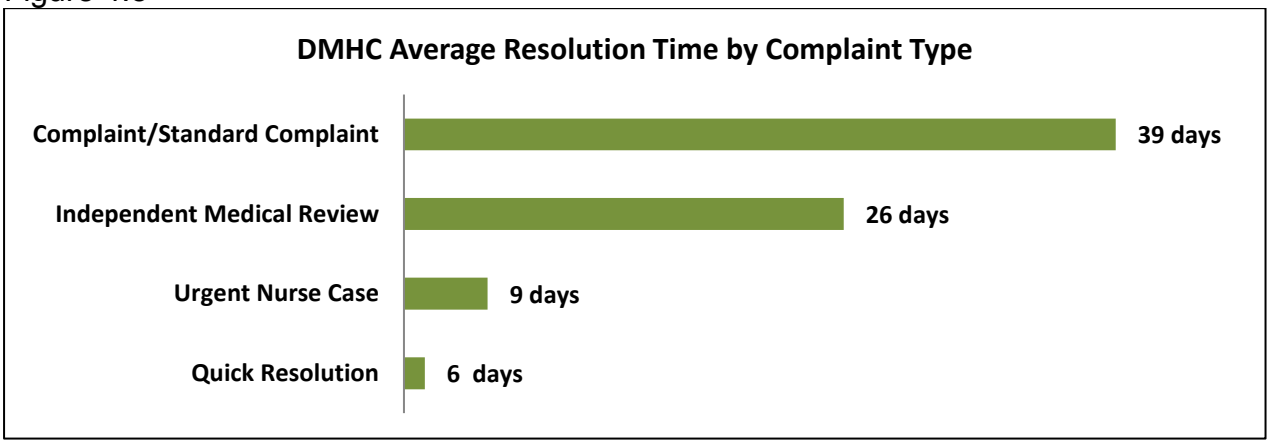


Resolution Time

The following three charts display DMHC's average lengths of time to resolve closed complaints in 2015. The resolution time of complaints is calculated by subtracting the date that the complaint was opened from the date the complaint was closed.

The average resolution time for all complaints in 2014 was 27 days and 33 days in 2015.

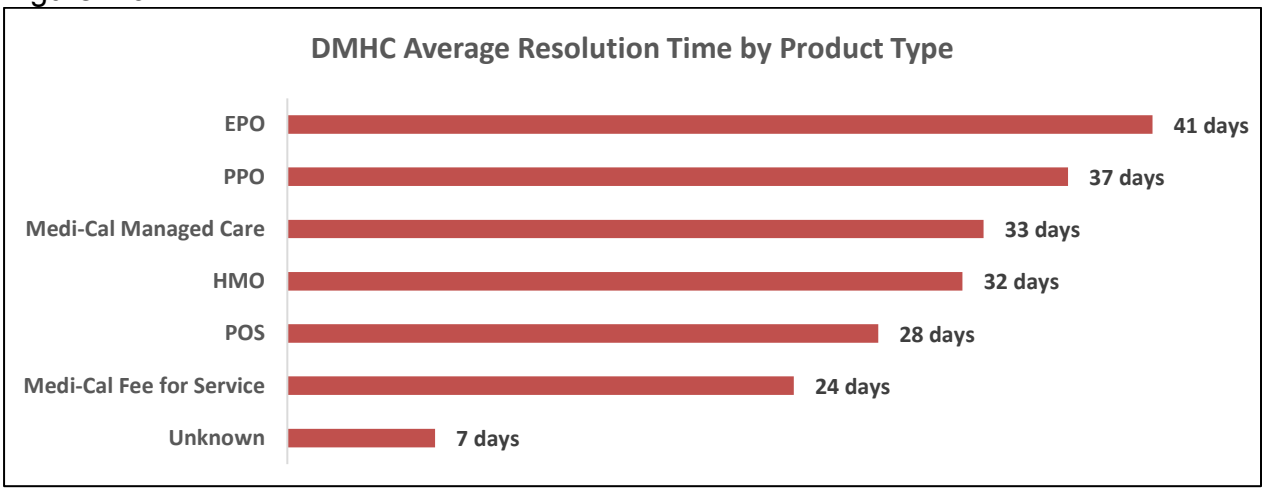
Figure 4.8



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

The following chart shows the average length of time to resolve complaints based on the Product Types: Point of Sale (POS), Exclusive Provider Organization (EPO), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Medi-Cal Managed Care, and Medi-Cal Fee for Service.

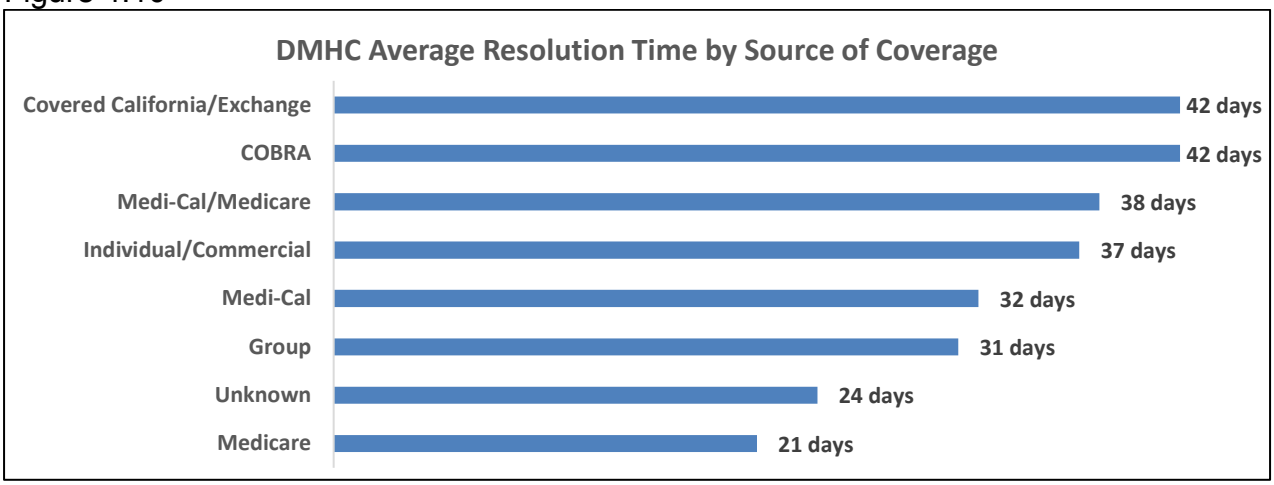
Figure 4.9



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

The following chart shows the average length of time for DMHC to resolve complaints based on the source of coverage in 2015.

Figure 4.10



Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer. The DMHC utilizes criteria to determine the above numbers that does not closely match OPA. Therefore, the data in this table may not reflect outcomes published by the DMHC.

Complaint Type

All 17,737 complaints were submitted with a complaint type. The most common complaint type was Standard Complaint at 12,130 (68%), followed by Independent Medical Review at 4,547 (26%), Quick Resolution at 946 (5%), and Urgent Nurse Case at 114 (1%).

Age

Of the 17,737 complaint cases submitted, 1,956 (11%) were Unknown with respect to age. Complaint reasons did not significantly differ among age groups, for example, Medical Necessity Denial ranked as the top complaint reason across all age groups. Among consumers for which age data was either Unknown or not disclosed, Cancellation ranked as the top complaint reason.

Complaint reasons that frequently appeared among the top five reasons include: Co-Pay, Deductible, and Co-Insurance Issues, Coverage Question, Out of Network Benefits, and Cancellation.

Gender

Of the 17,737 complaints closed, 7,747 (43.68%) were made by males, 9,923 (55.95%) were made by females, and 67 (.38%) were gender Unknown.

Race and Ethnicity

DMHC did not capture information about race in 2015.

The large majority (98%) of consumers who submitted complaints identified their ethnicity as non-Hispanic or Latino. Two percent of consumers identified as Hispanic or Latino as their ethnicity.

In January 2016, DMHC implemented changes in their consumer complaint form and department database to capture race and ethnicity categories. DMHC's future reporting of these categories will likely have more detailed data.

Language

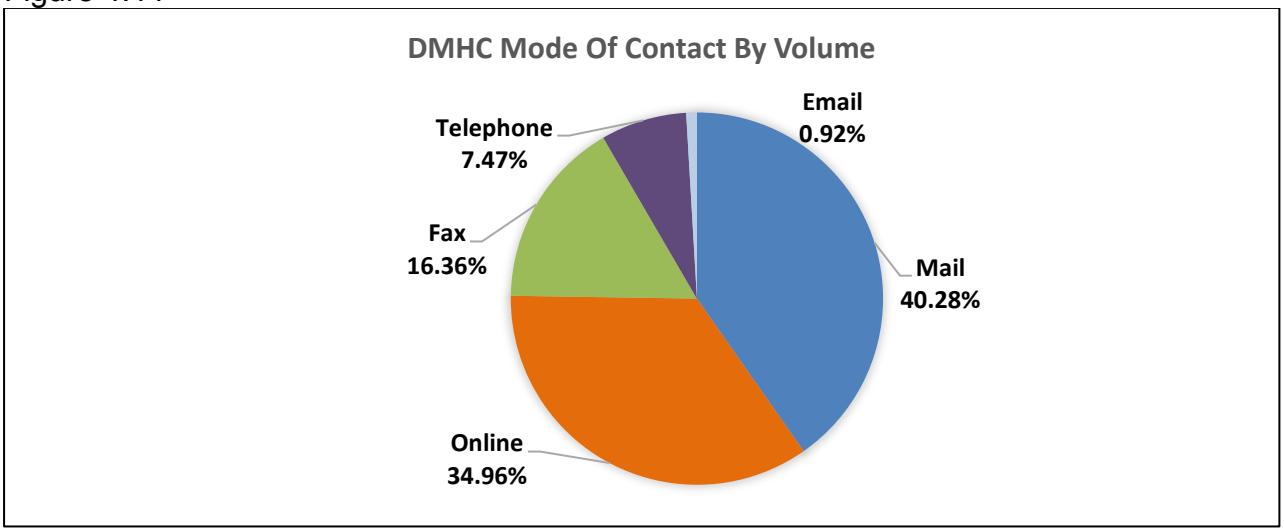
All 17,737 complaints except four (.02%) included language information. A total of 17,312 (97.60%) complaints identified English as their primary language, 313 (1.76%) identified Spanish as their primary language, and 108 (.61%) identified a language other than English or Spanish as their primary language.

Medical Necessity Denial ranked as the top complaint reason followed by Cancellation for consumers who identified either English or Other as their primary language. Cancellation was the top complaint reason followed by Medical Necessity Denial for consumers who identified Spanish as their primary language.

Mode of Contact

All 17,737complaints included information about the initial mode of contact. Consumers most frequently initiated a complaint with DMHC by mail. Contact by telephone decreased by five percent while contact by mail and online showed an increase by two percent and six percent respectively compared to 2014.

Figure 4.11



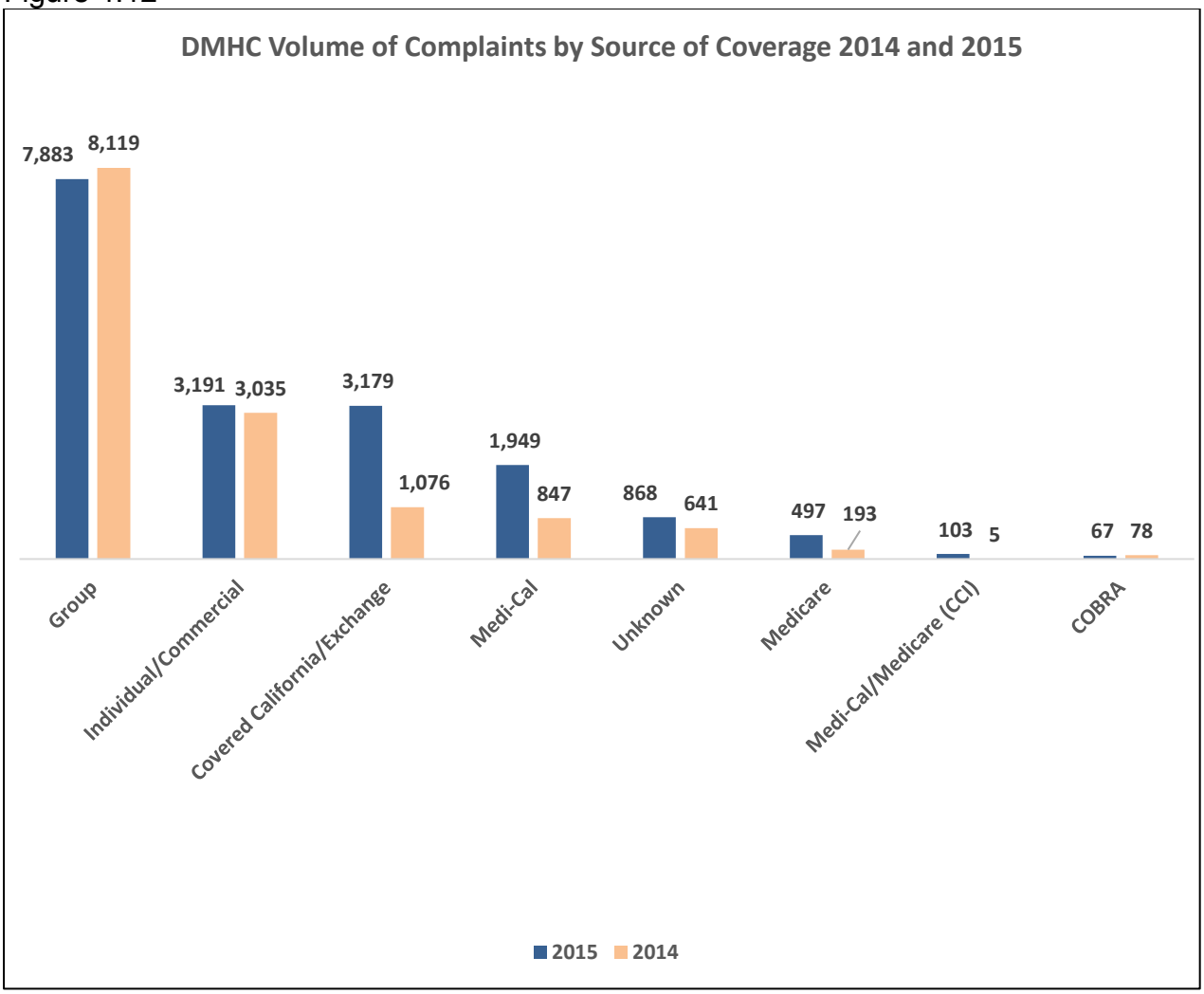
Regulator

All 17,737 DMHC complaints included health plan regulator information. DMHC was the state regulator for 93 percent of the complaints it handled, three percent were for coverage regulated by CDI, two percent were regulated by the federal Department of Labor, and two percent were regulated by Other.

Source of Coverage

The following chart shows source of coverage for the 17,737 complaints closed in 2015 compared to 2014. In 2015, Group accounted for 44 percent, followed by Individual/Commercial (18%), Covered California (18%), and Medi-Cal (11%). The remaining nine percent of complaints were Unknown, Medicare, COBRA, and Medi-Cal/Medicare (CCI).

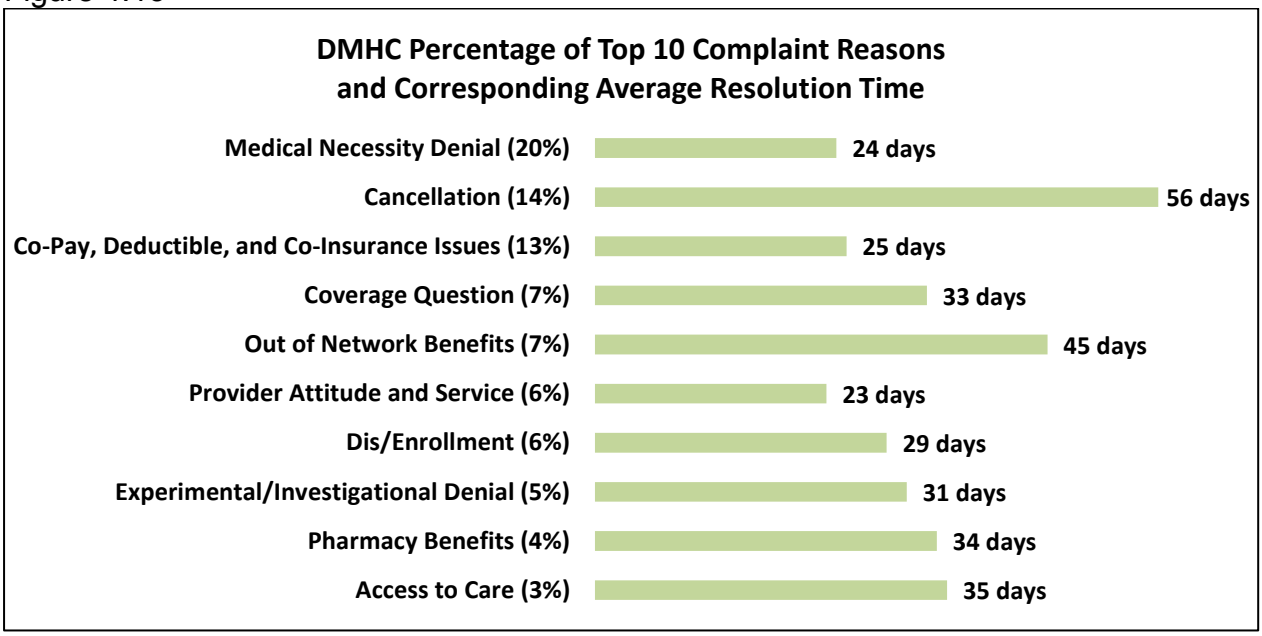
Figure 4.12



Complaint Reasons

The following chart shows the percentages for the ten most frequent complaints reasons and the average number of days for DMHC to close these complaints. Although Medical Necessity Denial was the number one complaint reason in 2014 and 2015, Cancellation went from the fifth highest complaint reason in 2014 to the second complaint reason in 2015. Access to Care moved from the seventh complaint reason in 2014 to tenth in 2015.

Figure 4.13



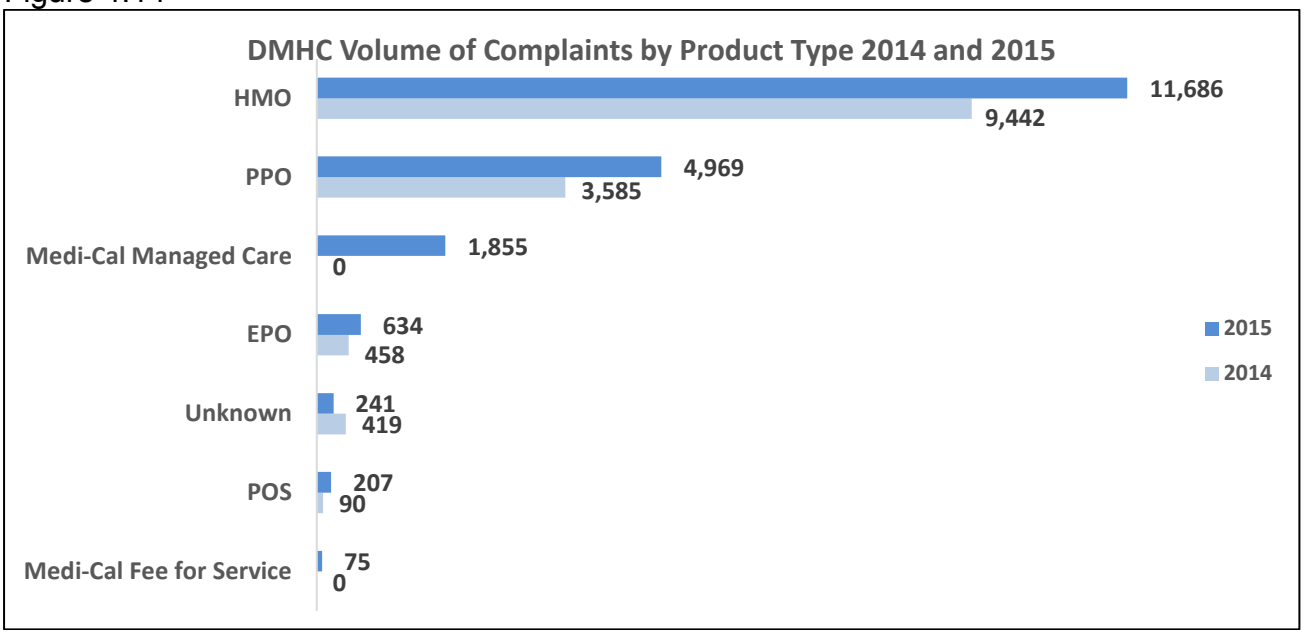
Note: These figures detailing average resolution times are counted from the date that any initial information is received from a consumer.

Product Type

Consumer complaints submitted to DMHC in 2015 are categorized into seven distinct product types including Unknown. Many consumers identified more than one product type when submitting a claim, which explains the difference between the total number of complaints (17,737) and the total number of reported product types (19,667). Product types in 2014 that show zero are new categories added in 2015 due to standardization of product types in 2015.

HMO accounts for 59.42 percent of the product types identified among the consumer complaints. PPO 25.27 percent, Managed Care 9.43 percent, EPO 3.22 percent, POS 1.05 percent, and Fee for Service 0.38 percent, while the remaining 1.23 percent were identified as Unknown.

Figure 4.14



Note: The product types represented here are the product types for 2015 and the distribution of those same product types in the 2014 data.

D. DMHC Complaint Data Results

The following table shows the 21,583 complaint results submitted by DMHC. Some consumer complaints result in more than one outcome, which explains the difference between the total number of complaints (17,737) and the total number of reported complaint results (21,583).

Figure 4.15

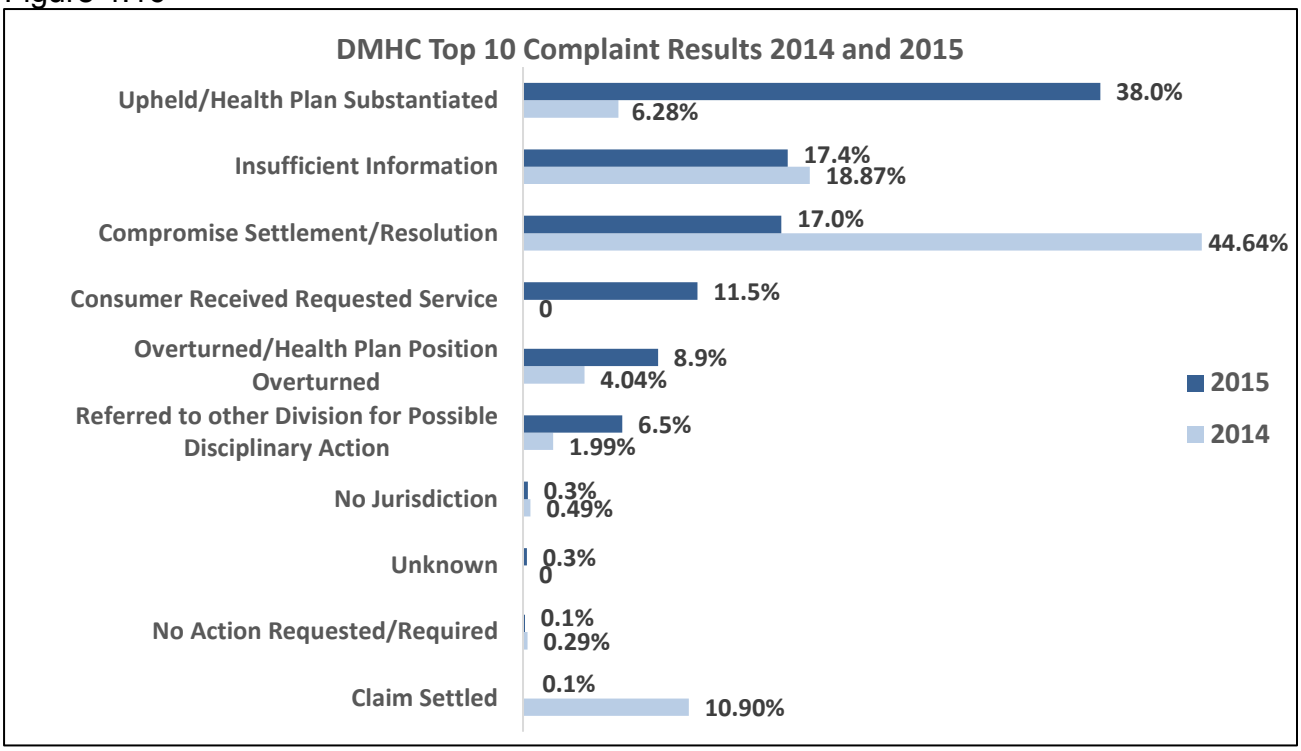
DMHC Top 10 Complaint Results	
Upheld/Health Plan Position Substantiated	**8,195**
Insufficient Information	**3,759**
Compromise Settlement/Resolution	**3,668**
Consumer Received Requested Service	**2,475**
Overturned/Health Plan Position Overturned	**1,917**
Referred to other Division for Possible Disciplinary Action	**1,410**
No Jurisdiction	**67**
Unknown	**54**
No Action Requested/Required	**27**
Claim Settled	**11**

Note: The DMHC utilizes criteria to determine complaint outcomes that does not closely match the NAIC choices. Therefore, the data in this table may not accurately reflect complaint outcomes published by the DMHC.

The following chart shows the percentage of the 21,583 complaint results submitted by DMHC in 2015 along with the complaint results from 2014 . Some consumer complaints result in more than one outcome, which explains the difference between the total number

of complaints (17,737) and the total number of reported complaint results (21,583). The top complaint result in 2014, Compromise Settlement/Resolution moved to the third complaint result in 2015. The top complaint result Upheld/Health Plan Position Substantiated (2015) was the fifth complaint result in 2014.

Figure 4.16



Note: The complaint results represented here are the top ten complaint results for 2015 and the distribution of those same complaint results in the 2014 data; they are not necessarily the top ten complaint results in 2014.

Section 5 – California Department of Health Care Services

A. Overview

The California Department of Health Care Services (DHCS) provides low-income and disabled Californians with access to medical, dental, mental health, and substance use treatment services, as well as long-term care. About one-third of Californians receive health care services financed or organized by DHCS. Multiple service centers operated or contracted by DHCS provide consumer assistance to beneficiaries in Medi-Cal and other DHCS programs.

DHCS submitted complaint data on Medi-Cal State Fair Hearings, a dispute resolution process conducted through the California Department of Social Services (CDSS) State Hearings Division. DHCS also reported data on consumer inquiries made to the following service centers:

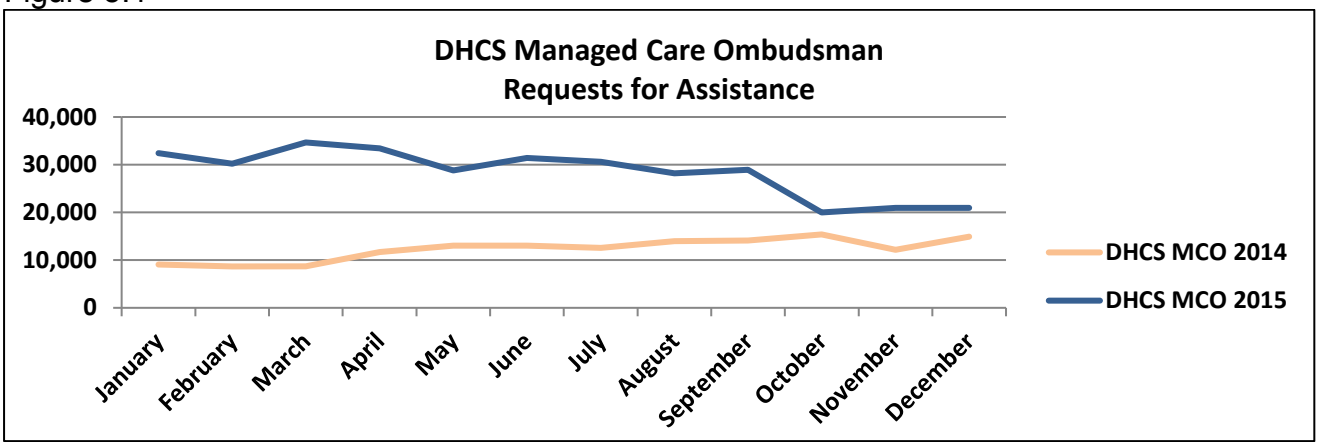
- ***Medi-Cal Managed Care Office of the Ombudsman*** - The Managed Care Ombudsman helps Medi-Cal managed care plan members receive all medically necessary covered services for which plans are contractually responsible by providing information and referrals.
- ***Mental Health Ombudsman*** - The Mental Health Ombudsman helps Medi-Cal members in need of mental health services navigate through the mental health plan system by providing information and referrals.
- ***Medi-Cal Telephone Service Center*** - Operated by the Fiscal Intermediary (FI) contractor that administers the California Medicaid Management Information System (CA-MMIS), the Medi-Cal Telephone Service Center assists Medi-Cal beneficiaries and medical and pharmacy providers regarding program billing and related systems and policies issues.
- ***Denti-Cal Beneficiary Telephone Service Center*** - Operated by the dental FI contractor that administers the California Dental Medicaid Management Information System (CD-MMIS), the Denti-Cal Beneficiary Telephone Service Center provides guidance to beneficiaries regarding dental providers who accept Medi-Cal, clinical screening appointments, dental share-of-cost and co-payments, Treatment Authorization Requests, covered services, and filing complaints.

B. I. DHCS Managed Care Ombudsman Consumer Assistance

Requests for Assistance by Month

DHCS reported all 340,434 requests for assistance made by Medi-Cal beneficiaries in 2015 to the Managed Care Ombudsman as inquiries. This was a 131 percent increase from 2014, some of which may be attributed to an increase in the number of Medi-Cal beneficiaries enrolled in Managed Care plans. The following chart compares 2014 and 2015 consumer assistance volumes by month.

Figure 5.1



Service Center Telephone Call Metrics

DHCS reported that a new phone system was implemented by the Managed Care Ombudsman at the end of September 2015 and changed the way some of its data was captured. The new phone system enabled callers to reach the Ombudsman on their first attempted call. DHCS estimated that 83 percent (284,127) of the inquiries the Managed Care Ombudsman received from Medi-Cal beneficiaries in 2015 were made by telephone. DHCS indicated that it was unable to separate some phone call and email data. The following table shows the response from DHCS regarding the Managed Care Ombudsman's telephone call metrics.

Figure 5.2

DHCS Managed Care Ombudsman – 2015 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	Unable to provide this information at this time	N/A
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	9,243 (during 11/2015-12/2015) Data regarding calls resolved by IVR from 1/2015-10/2015 is not available.	Data
Number of jurisdictional inquiry calls	269,117	Data
Number of non-jurisdictional calls	15,010	Data
Average number of calls received per jurisdictional complaint case	N/A	N/A
Average wait time to reach a CSR	12 minutes (during 10/2015-12/2015) Data regarding average wait time from 1/2015-9/2015 is not available.	Data
Average length of talk time (time between a CSR answering and completing a call)	20-25 minutes (from 1/2015-9/2015); 8.6 minutes (from 10/2015-12/2015)	Estimate; Data
Average number of CSRs available to answer calls (during Service Center hours)	6 permanent staff; 9 limited-term staff; 5 temporary staff	Data

Note: N/A is not available.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Managed Care Ombudsman that were referred to other organizations or DHCS entities to address or resolve. Although Medi-Cal eligibility inquiries remained the most common topic for referral, there were significant changes to the rest of the rankings compared to the previous year. Two new topics appeared: Health Care Options (ranked third) and Audits, Investigations, and Fraud (ranked tenth). Complaint related topics dropped in rank, with State Fair Hearings dropping from second to fifth and Independent Medical Review dropping off the top ten list. Estate Recovery also dropped off the top ten list.

Figure 5.3

DHCS Managed Care Ombudsman Top Ten Topics for Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	Medi-Cal Eligibility	County Medi-Cal Office
2	Fee-For-Service	DHCS Fee-For-Service Help Line
3	Health Care Options	Health Care Options
4	Other Health Coverage	DHCS Other Health Coverage website
5	State Fair Hearings	California Department of Social Services
6	Social Security/Medicare	Social Security Administration/ 1-800-Medicare
7	Denti-Cal	Denti-Cal
8	Mental Health	County Mental Health Office
9	Covered CA	Covered CA
10	Audits, Investigations, and Fraud	DHCS Audits & Investigations

Note: Ranking estimated by DHCS.

Consumer Assistance Protocols

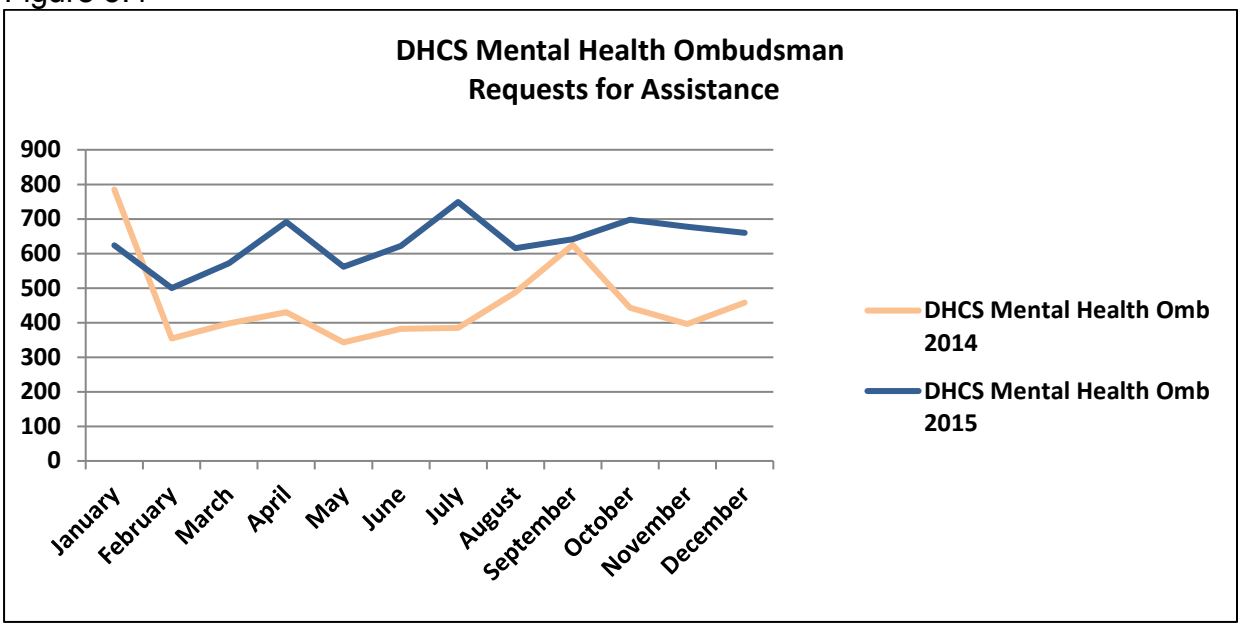
The Managed Care Ombudsman implemented a new phone system at the end of September 2015 with new features, such as call-routing, and real-time quality management, and a callback messaging option for callers. DHCS indicated that this system change affected telephone metrics tracking. DHCS reported that there were not any other significant changes to the Managed Care Ombudsman's consumer assistance protocols or systems since last year's Baseline Report.

B. II. DHCS Mental Health Ombudsman Consumer Assistance

Requests for Assistance by Month

DHCS reported all consumer requests for assistance made to the Mental Health Ombudsman as inquiries, because this service center's primary role is to educate consumers and refer them to other complaint resolution resources. The Mental Health Ombudsman received 7,509 inquiries in 2015, a 36 percent increase from 2014. The following chart compares 2014 and 2015 consumer assistance volumes by month.

Figure 5.4



Service Center Telephone Call Metrics

Consumers contacted (5,036 calls) the Mental Health Ombudsman mostly (67%) by telephone in 2015. The following table shows the DHCS response regarding the Mental Health Ombudsman's telephone metrics.

Figure 5.5

DHCS Mental Health Ombudsman – 2015 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	307	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	0	0
Number of jurisdictional inquiry calls	1,157	Data
Number of non-jurisdictional calls	6,454	Data
Average number of calls received per jurisdictional complaint case	N/A	N/A
Average wait time to reach a CSR	None	None
Average length of talk time (time between a CSR answering and completing a call) Jurisdictional Inquiry Non-Jurisdictional Inquiry	 1.5 minutes 3.0 minutes	 Estimate Estimate
Average number of CSRs available to answer calls (during Service Center hours)	3	Data

Note: N/A is not applicable.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Mental Health Ombudsman that were referred to other organizations or DHCS entities to address or resolve. This order remained unchanged from 2014.

Figure 5.6

DHCS Mental Health Ombudsman Top Ten Topics for Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	Status of Medi-Cal application	County Medi-Cal Office
2	Disenrollment	County Medi-Cal Office
3	Remove Hold	Managed Care Division
4	Enrollment	Health Care Options
5	Replace Beneficiary Identification Card	County Medi-Cal Office
6	Substance Use Disorders	County Social Services
7	Conservatorship	County Public Guardian Office
8	Prescriptions	Provider
9	Housing	County Social Services
10	Treatment Authorization Request (TAR)	Xerox

Note: Ranking by DHCS based on data.

Consumer Assistance Protocols

DHCS provided new Policy & Procedure Manual documentation regarding the Mental Health Ombudsman's consumer assistance protocols, procedures, and referral tools. The following table summarizes protocols outlined in the excerpts submitted to OPA.

Figure 5.7

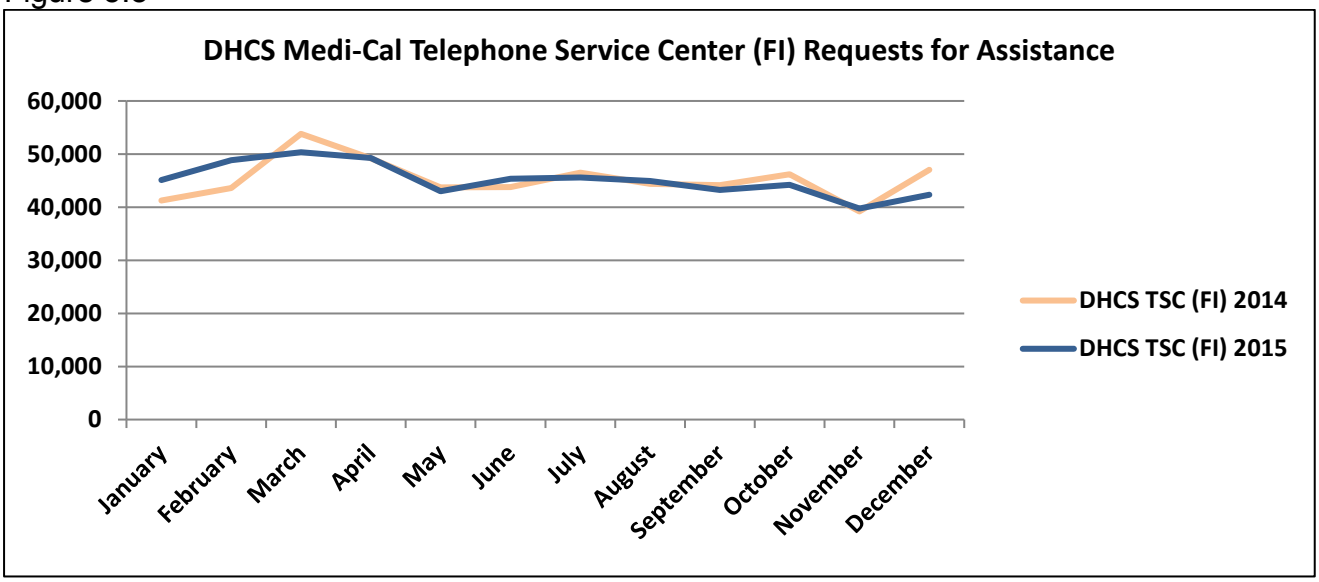
DHCS Mental Health Ombudsman Consumer Assistance Protocols	
Type of Protocol	**Process**
Referrals	Ombudsman staff use established protocols and scripted responses for making referrals based on the inquiry topic and assessed level of need. Crisis Call Protocol: Ombudsman staff attempt to complete a warm transfer of the caller to the appropriate county mental health crisis line or suicide hotline and remain on the telephone line to relay information to crisis line staff.
After-Hours Assistance	Callers reach a voicemail system after hours. Voicemails are returned by Ombudsman staff by the end of the next business day.

B. III. DHCS Medi-Cal Telephone Service Center Consumer Assistance

Requests for Assistance by Month

DHCS reported all consumer requests for assistance made to the Medi-Cal Telephone Service Center as inquiries. This service center answered 541,982 telephone inquiries from beneficiaries in 2015, a slight decrease (0.01%) from 2014. The following chart compares 2014 and 2015 consumer assistance volumes by month.

Figure 5.8



Service Center Telephone Call Metrics

All 541,982 inquiries in 2015 reported by DHCS were telephone calls from beneficiaries. The following table shows the response from DHCS regarding the Medi-Cal Telephone Service Center's telephone metrics.

Figure 5.9

DHCS Medi-Cal Telephone Service Center - 2015 Telephone Metrics *(FI Contractor: Xerox)*		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	61,647*	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	2,939,565*	Data
Number of jurisdictional inquiry calls	541,982	Data
Number of non-jurisdictional calls	N/A	N/A
Average number of calls received per jurisdictional complaint case	N/A	N/A
Average wait time to reach a CSR	1:58	Data
Average length of talk time (time between a CSR answering and completing a call)	4:46	Data
Average number of CSRs available to answer calls (during Service Center hours)	72	Data

Note: N/A is not applicable.
**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.*

Top Ten Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Medi-Cal Telephone Service Center that are outside its authority and referred to other organizations or DHCS entities. The rankings remained mostly unchanged from 2014, with the exception of a switch in places between the ninth and tenth ranked inquiries.

Figure 5.10

DHCS Medi-Cal Telephone Service Center Top Ten Topics for Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	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	Technical	Vendor
10	Beneficiary Inquiry/Coverage	Low-Income Subsidy

Note: Ranking by DHCS based on data.

Consumer Assistance Protocols

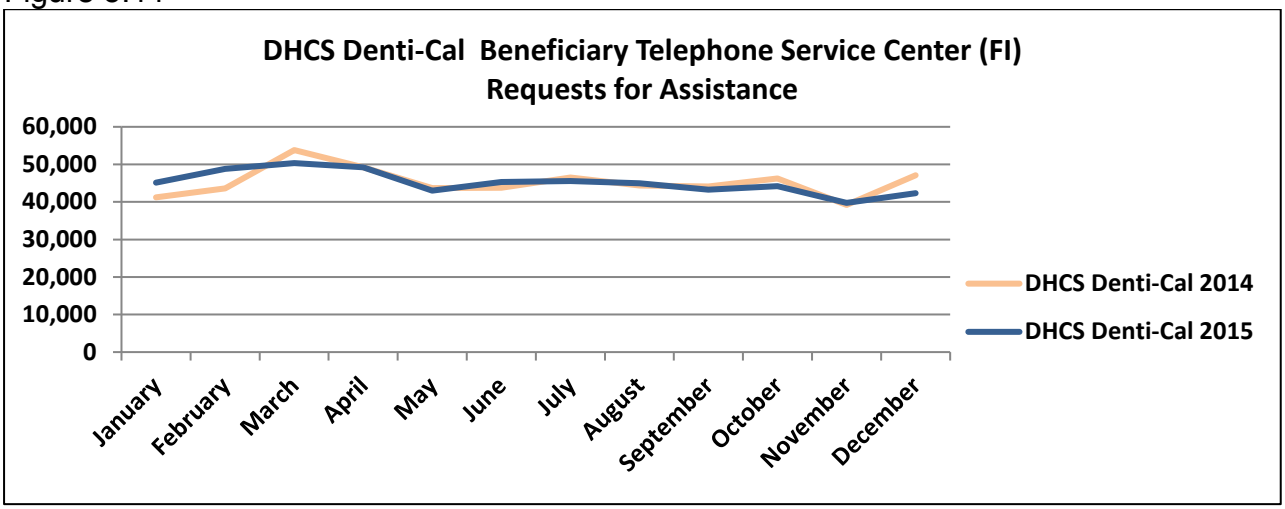
The Medi-Cal Telephone Service Center did not report information on its protocols or performance standards.

B. IV. Denti-Cal Beneficiary Telephone Service Center Consumer Assistance

Requests for Assistance by Month

DHCS reported all consumer requests for assistance made to the Denti-Cal Beneficiary Telephone Service Center as inquiries. This service center received 566,364 inquiries in 2015, a 16 percent decrease from 2014. The following chart compares 2014 and 2015 consumer assistance volumes by month.

Figure 5.11



Service Center Telephone Call Metrics

Nearly all of the Denti-Cal Beneficiary Telephone Service Center's 2015 inquiries from consumers were received by telephone (564,068 calls). The following table shows the response from DHCS regarding some of this service center's telephone metrics. There was a significant decline in average wait time to reach a customer service representative, dropping from 3:54 minutes in 2014 to under a minute in 2015.

Figure 5.12

DHCS Denti-Cal Beneficiary Telephone Service Center - 2015 Telephone Metrics *(Dental FI Contractor: Delta Dental)*		**Reporting Entity Estimated Metric or Based on Data**
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	21,987	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	290,614	Data
Number of jurisdictional inquiry calls	542,081	Data
Number of non-jurisdictional calls	N/A	Data
Average number of calls received per jurisdictional complaint case	N/A	Data
Average wait time to reach a CSR	0:00:43	Data
Average length of talk time (time between a CSR answering and completing a call)	0:06:53	Data
Average number of CSRs available to answer calls (during Service Center hours)	77	Data

Note: N/A is not applicable.

Top Topics for Non-Jurisdictional Inquiries

The following table lists the most common consumer inquiries received by the Denti-Cal Beneficiary Telephone Service Center in 2015.

Figure 5.13

DHCS Denti-Cal Beneficiary Telephone Service Center Top Ten Topics for Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	Referrals	Provider or Dental Managed Care (DMC) Plan
2	Covered Services	Provider or DMC Plan
3	Eligibility	County Office or Medi-Cal Eligibility Division
4	Benefits Identification Card (BIC)	County Office or Medi-Cal Eligibility Division
5	Inquiring on request status	Provider or DMC Plan or Medical Plan
6	Complaints on provided services	Oversight board of the dental professional (i.e., Dental Board or Hygienist Committee)
7	Share of Cost Inquiry	County Office or Medi-Cal Eligibility Division
8	Complaint about provider refusing to perform services covered by plan	Provider or DMC Plan or Medical Plan
9	Open Conlan Case	Department of Social Services for Non-Jurisdictional Inquiries
10	Title 22 Billing Issues (improper direct billing by provider)	County Medi-Cal Office or State Dental Board

Note: Rankings estimated by DHCS.

Consumer Assistance Protocols

DHCS reported that there were not any significant changes to the Denti-Cal Beneficiary Telephone Service Center's consumer assistance protocols or systems since last year's Baseline Report.

B. V. Medi-Cal Fair Hearing through CDSS

Complaint Protocols

Time standards and resolution times noted in this report are not comparable because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 5.14

Medi-Cal Fair Hearing Standards			
Complaint Process	**Primary Unit(s) Responsible and Role**	**Time Standard (if applicable)**	**Average Resolution Time in 2015**
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions.	90 days from the hearing request date	153 days (Fee-for-Service) 87 days (Mental Health) 82 days (Dental) 79 days (Managed Care)
Urgent Clinical	Cases involving urgent clinical issues may qualify for an expedited Fair Hearing process.	Not reported	Not reported

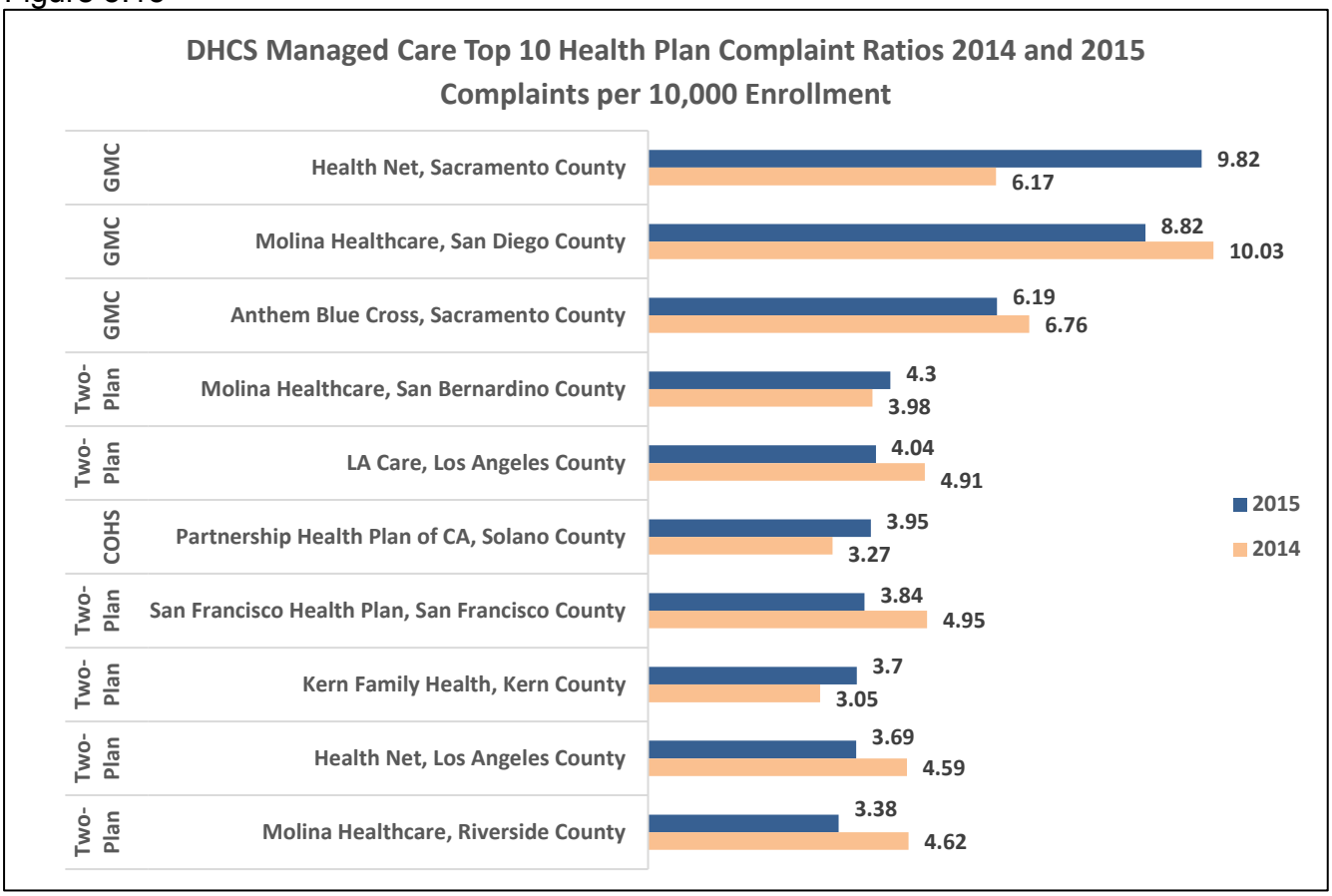
Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14.

C. DHCS Complaint Data

Complaint Ratios

In the following chart, the DHCS Managed Care complaint ratios are displayed by the top ten health plans exceeding 70,000 covered lives for 2015 and the ratios for those same plans in 2014. DHCS has 22 health plan contracts. The health plans have 89 health plan service areas which had at least one complaint from the total of 13,439,444 enrollment in 2015. The data in the following chart may not reflect outcomes published by the DHCS.

Figure 5.15



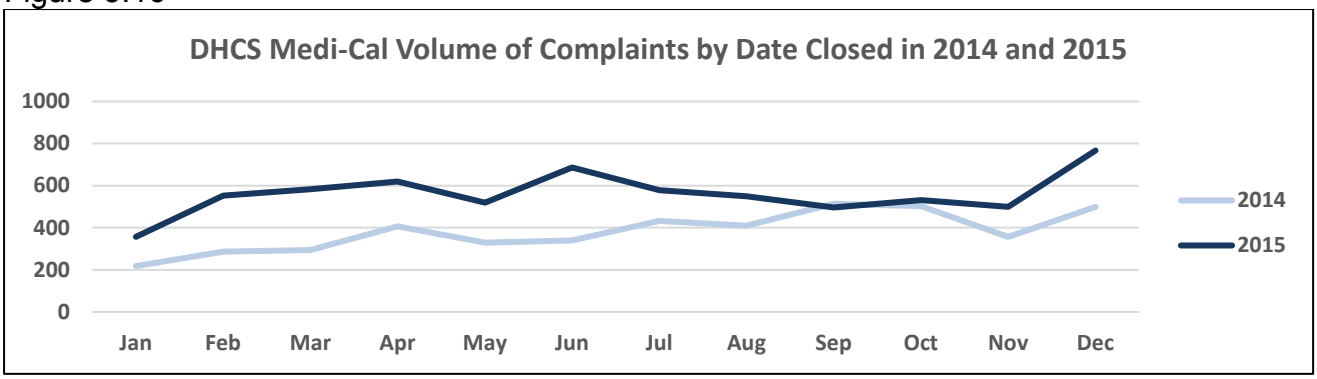
Note: Displayed health plans have over 70,000 enrollees. The complaint ratios represented here are the top ten complaint ratios for 2015 and the distribution of those same complaint ratios in the 2014 data; they are not necessarily the top ten complaint ratios in 2014.

DHCS did not associate dental plans with the dental complaints for 2015. Subsequently no dental plan enrollment figures were reported and no complaint ratios were calculated for 2015.

Volume of Closed Complaints

The chart below displays the total of 6,603 closed complaints distributed by month for 2014 and 6,740 closed complaints distributed by month for 2015.

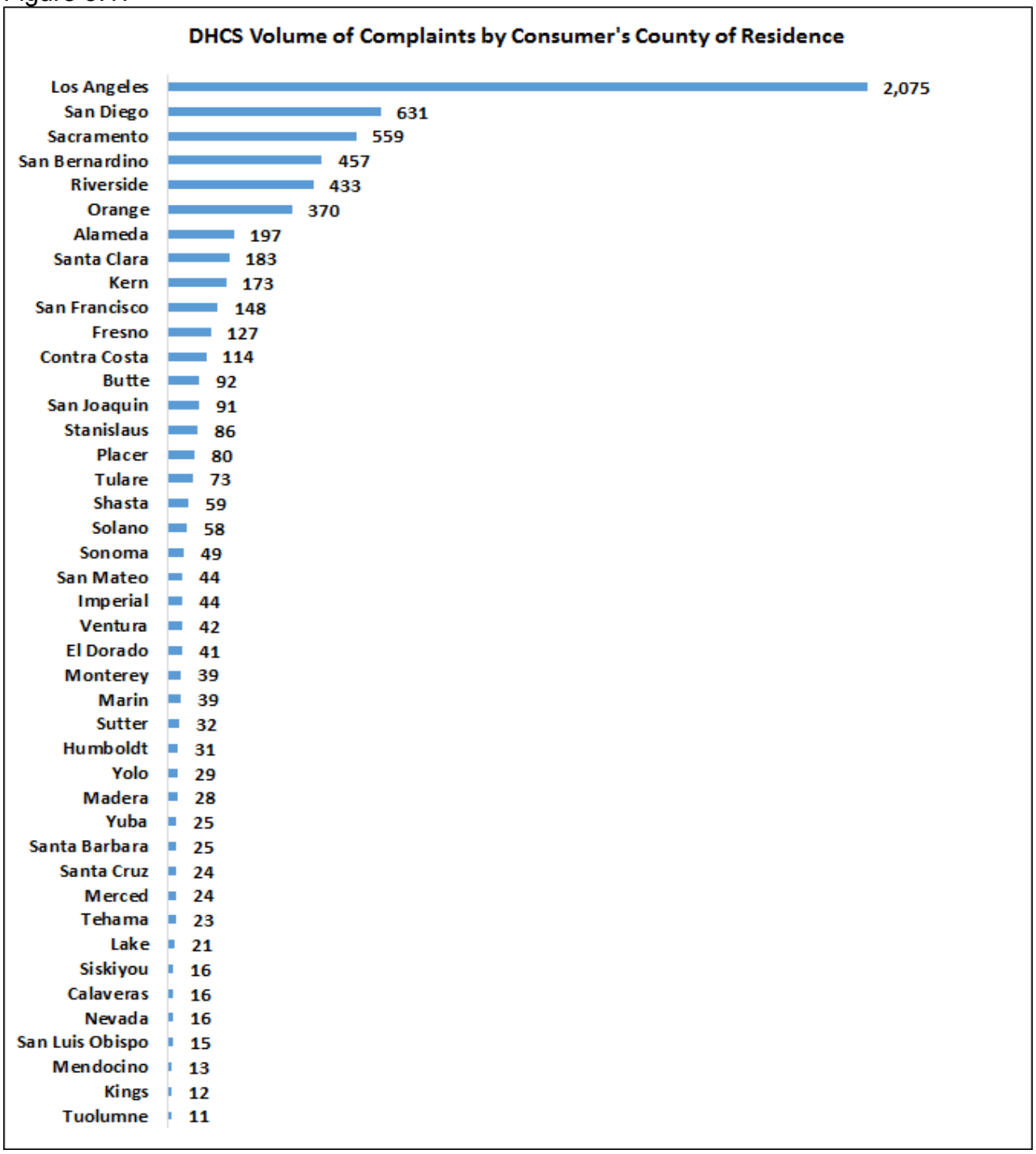
Figure 5.16



Volume of Complaints by County

The following chart displays the volume of complaints by consumer's county of residence. The counties not shown each have fewer than ten complaints. There were four complaints with an Unknown county.

Figure 5.17



Note: Counties not shown are those that received fewer than ten complaints: Amador, Colusa, Del Norte, Glenn, Lassen, Mariposa, Modoc, Mono, Napa, Plumas, San Benito, Sierra, and Trinity.

Complaint Type

All of the DHCS complaints submitted had the complaint type of DSS State Fair Hearing. The average length of time for DHCS complaints to be resolved in 2015 is 102 days and 77 days in 2014.

Age

DHCS submitted 5,224 Medi-Cal complaints with an age identified. Twenty-one percent of complaints are from consumers aged 35 – 54. There were 1,516 (23%) Unknown age complaints.

The average age of consumers who submitted complaints to DHCS was 44. Approximately 26 percent of complaints came from consumers 34 years of age or under. Forty-two percent of consumers were between the ages of 35 and 64, and ten percent of consumers were 65 and older.

For ages under 18 and ages 65 to over 74, the top complaint reason was Scope of Benefits. Consumers that were 18 – 34 identified Disenrollment/Enrollment as the top complaint reason. For age groups 35 through 64 the top complaint reason was Quality of Care. The number one complaint reason for consumers that did not identify an age was Pharmacy Benefit.

Gender

DHCS submitted complaints identifying 39 percent as female and 29 percent as male with Scope of Benefits as the top complaint reason for both females and males. The remaining 32 percent of consumers were Unknown as to gender with Pharmacy Benefits as the top complaint reason.

Race

DHCS submitted complaints where 19 percent of consumers identified as White and six percent identified as Black or African American with the same top complaint reason Quality of Care. Quality of Care was also the same top complaint reason for eight percent of consumers that identified as of one of the following races: American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, or Other. The remaining 68 percent of consumers were Unknown as to race or refused to identify race with Pharmacy Benefits as the top complaint reason.

Ethnicity

The majority (90%) of complaints submitted by DHCS were from consumers who refused to disclose or did not identify their ethnicity with the top complaint reason as Pharmacy Benefits. Ten percent of consumers identified as Hispanic or Latino with Disenrollment/Enrollment as the top complaint reason.

Language

Of the 6,740 complaints submitted by DHCS, 2,502 (37%) identified English as their primary language, 270 (4%) identified Spanish as their primary language, and another 262 (4%) identified a language other than English or Spanish as their primary language. The remaining 3,706 (55%) of consumers either refused to disclose or did not identify a primary language.

The top complaint reason for both English and Spanish speakers was Quality of Care. Disenrollment/Enrollment was the top complaint reason for consumers who identified as Other as their primary language.

Mode of Contact

All of the 6,740 complaints submitted by DHCS were indicated as Unknown for the mode of contact.

Regulator

DMHC served as the regulator for 2,776 (41%) of consumer complaints submitted by DHCS. The remaining 3,964 (59%) of complaints list Other as the regulator.

Source of Coverage

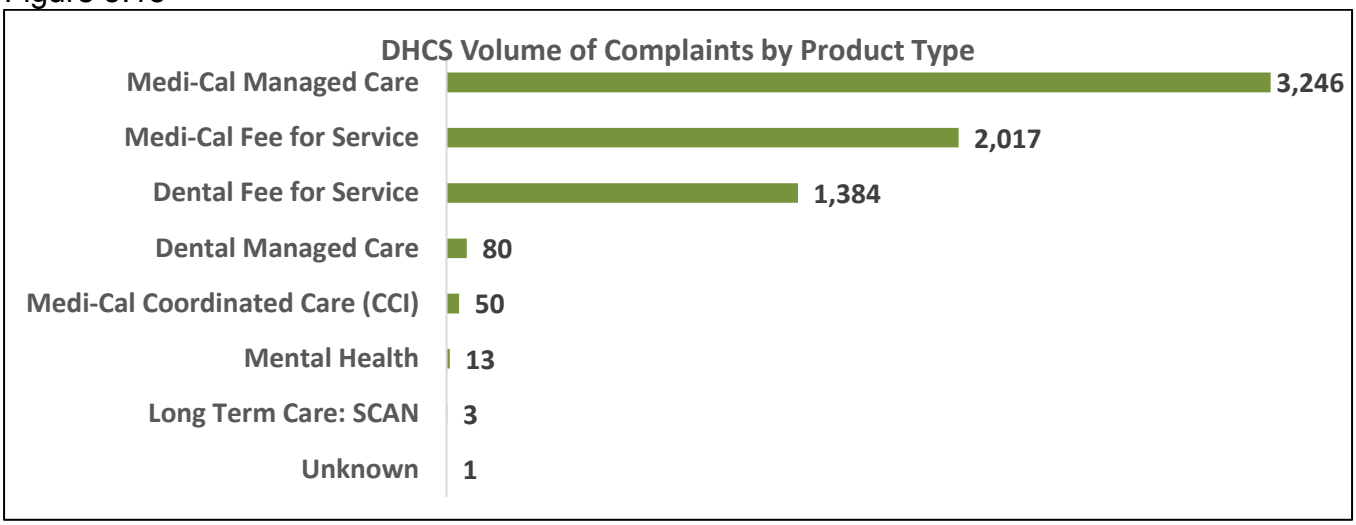
All of the 6,740 complaint's submitted by DHCS in 2015 identified Medi-Cal as the source of coverage. In 2014, DHCS identified four sources of coverage (Medi-Cal Managed Care, Medi-Cal Fee for Service, Medi-Cal/Medicare, and Unknown). These have been categorized as product types by DHCS in 2015.

Product Type

Consumer complaints submitted by DHCS are categorized into eight distinct product types and an unclassified category, identified as Unknown. Many complaints identified more than one product type, which explains the difference between the total number of complaints (6,740) and the total number of product types reported (6,794).

Medi-Cal Managed Care represents 3,246 (47.78%) of the product types identified among the consumer complaints. Medi-Cal Fee for Service accounts for 29.69 percent of the product types, Dental Fee for Service represents 20.37 percent, Dental Managed Care represents 1.18 percent. Medi-Cal Coordinated Care (CCI) (0.74%), Mental Health (0.19%), Long Term Care: SCAN (0.04%), and Unknown (0.1%) all equal less than two percent of the remainder or product types.

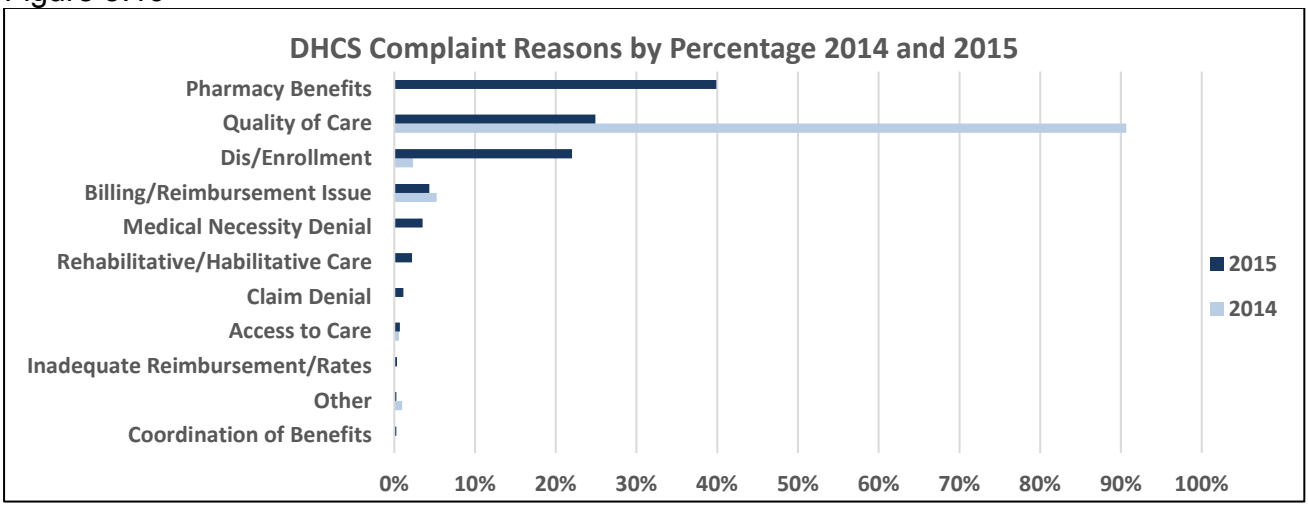
Figure 5.18



Complaint Reasons

The total number of complaints submitted by DHCS Medi-Cal is 5,262. The number of complaint reasons, 5,654, exceeds the total number of complaints because some consumer complaints involved more than one issue. The top ten complaint reasons account for 99.26 percent of all complaint reasons submitted. The remaining nine complaint reasons account for less than one percent of complaints reasons. The percentage of complaint reasons shown below include data from 2014 and 2015. Some of the complaint categories were not included in the 2014 complaint data due to more standardization of data in 2015. Complaint reason Other and Coordination of Benefits each had the same number of complaints tying for the tenth complaint reason.

Figure 5.19

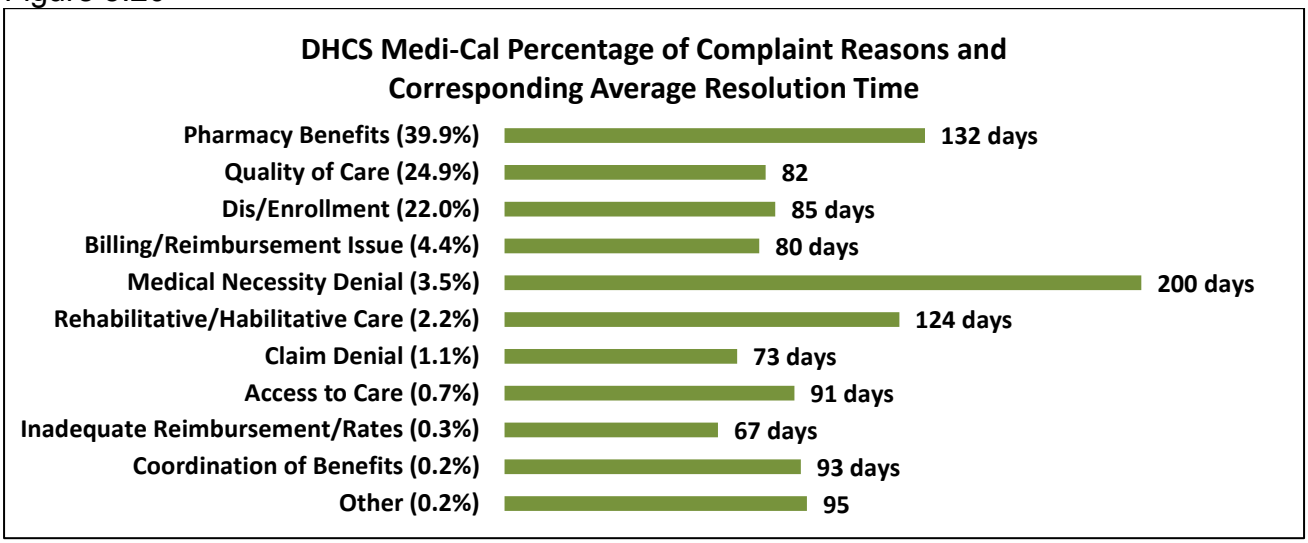


Note: The complaint reasons represented here are the top ten complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data.

The following charts display the percentage of complaint reasons with corresponding average resolution times.

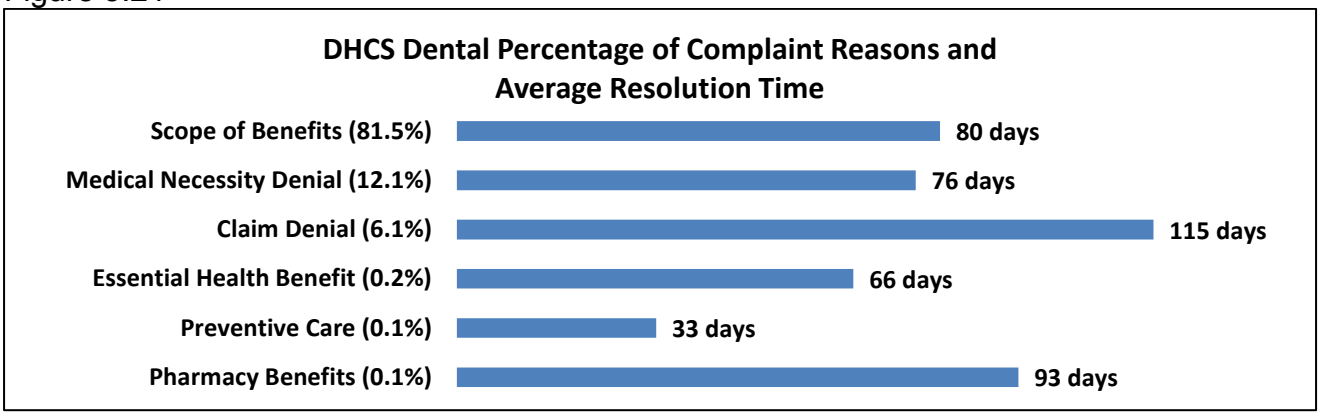
The figures 5.20 and 5.21 include both DHCS Managed Care and DHCS Fee for Service complaints.

Figure 5.20



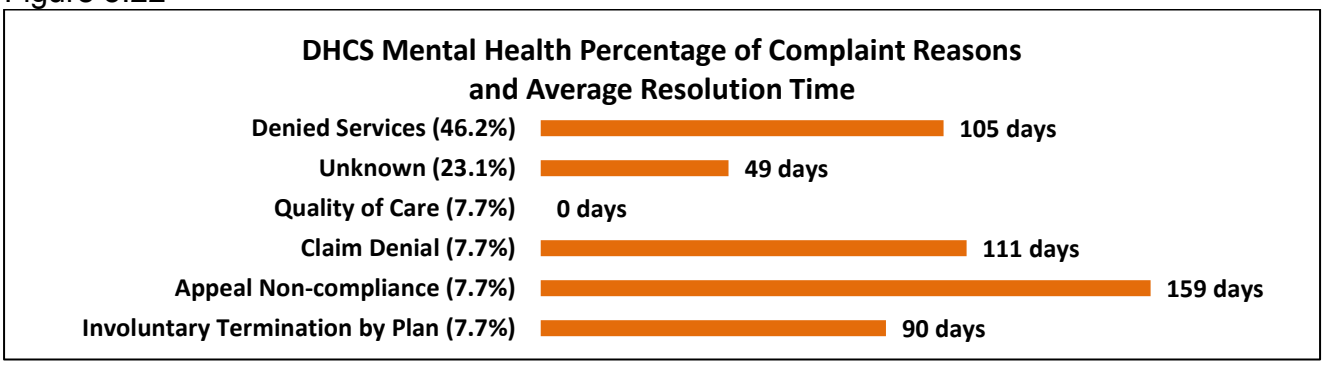
Note: The total number of complaints submitted by DHCS Medi-Cal is 5,262. The number of complaint reasons, 5,654, exceeds the total number of complaints because some consumer complaints involved more than one issue.

Figure 5.21



Note: The total number of complaints submitted by DHCS Dental is 1,465.

Figure 5.22

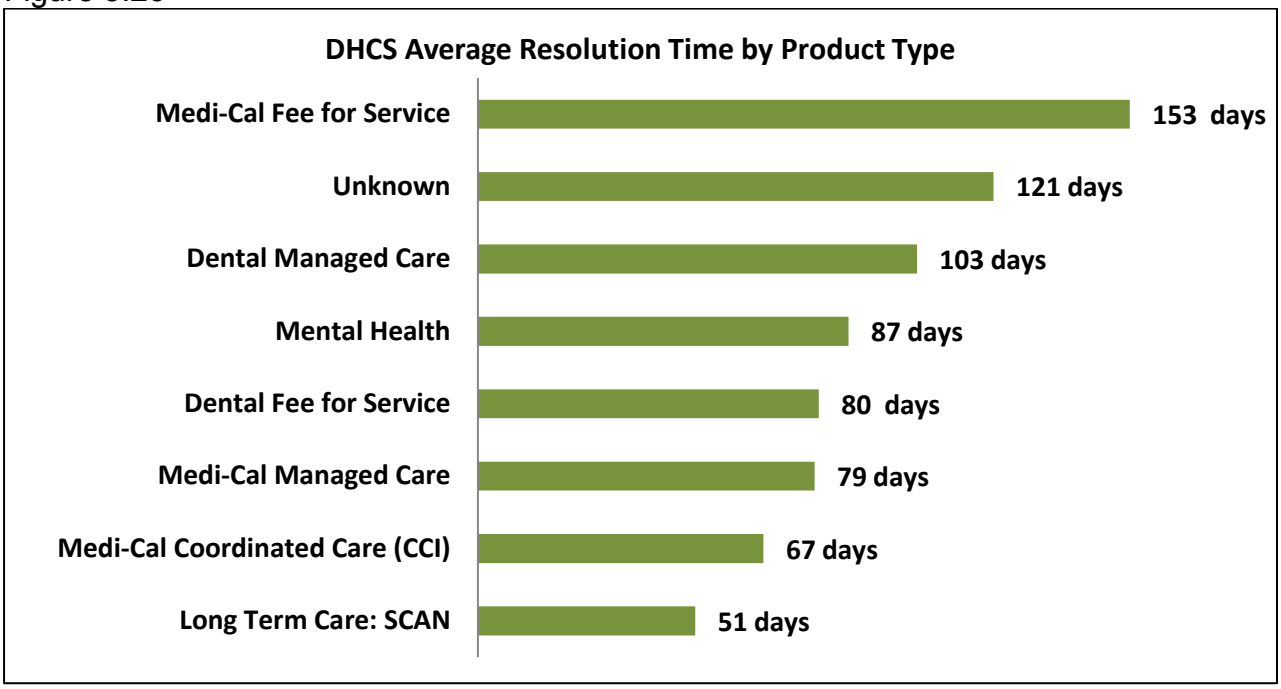


Note: The total number of complaints submitted by DHCS Mental Health is 13.

Resolution Time

The chart below shows the average length of time to resolve DHCS complaints in 2015 by product type. The resolution time of complaints is calculated by subtracting the date that the complaint was opened from the date the complaint was closed.

Figure 5.23



D. Complaint Results

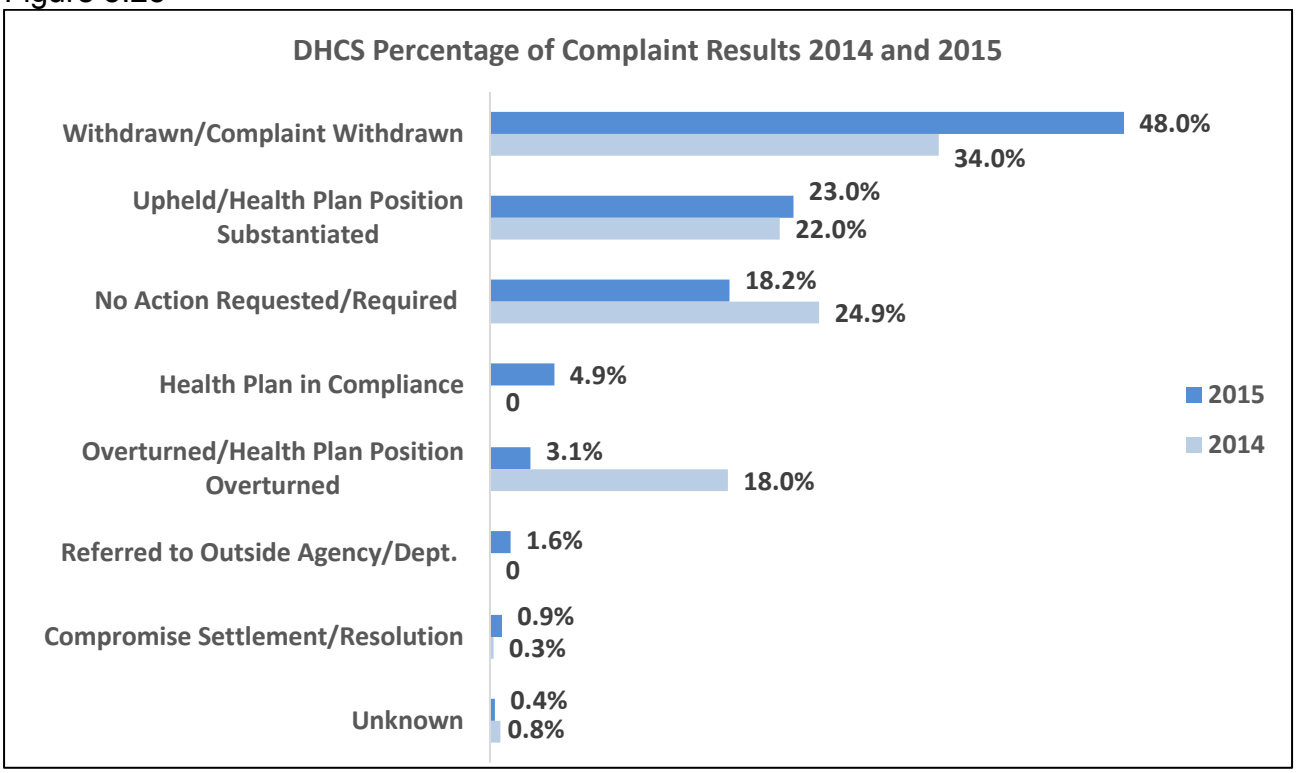
The following table displays the complaint results for all of the 6,740 submitted complaints by DHCS. The complaint result of Withdrawn/Complaint Withdrawn was the number one complaint in 2014 as well as 2015, while Upheld/Health Plan Position Substantiated moved from the third complaint result in 2014 to the second complaint result in 2015.

Figure 5.24

DHCS Complaint Results	
Withdrawn/Complaint Withdrawn	3,238
Upheld/Health Plan Position Substantiated	1,550
No Action Requested/Required	1,224
Health Plan in Compliance	329
Overturned/Health Plan Position Overturned	207
Referred to Outside Agency/Department	105
Compromise Settlement/Resolution	61
Unknown	26

The following chart shows the percentage of the 6,740 complaint results submitted by DHCS in 2015 along with the complaint results from 2014. The complaint results represented here are the complaint results for 2015 and the distribution of those same complaint results in the 2014 data.

Figure 5.25



Note: The complaint results represented here are the complaint results for 2015 and the distribution of those same complaint results in the 2014 data.

Section 6 – California Department of Insurance

A. Overview

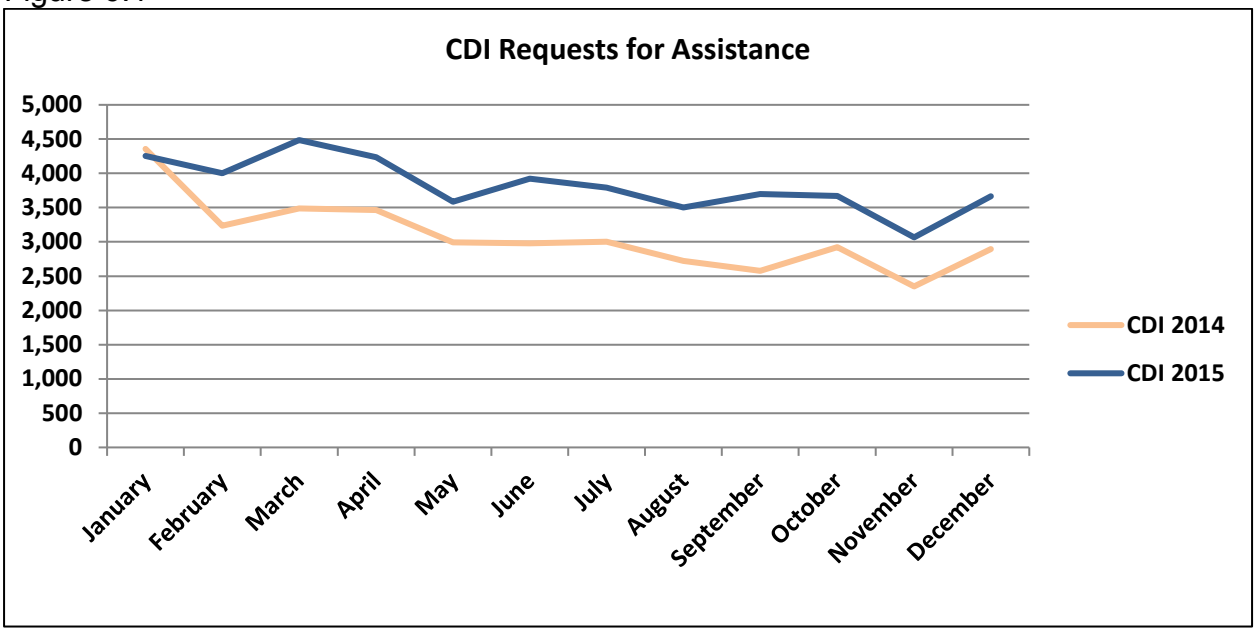
The California Department of Insurance (CDI) oversees more than 1,300 insurance companies and licenses more than 390,000 agents, brokers, adjusters, and business entities. CDI enforces the insurance laws of California and has authority over how insurers and licensees conduct business in California. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance company or producer activities. This report only includes CDI's health care coverage complaints, and not those related to other lines of business.

B. CDI Consumer Assistance

Consumer Assistance Volume by Month and Mode of Contact

CDI's service center received 45,882 requests for assistance in 2015, a 24 percent increase over the 2014 volume of 36,986. The following chart compares 2014 and 2015 consumer assistance volumes by month.

Figure 6.1



Service Center Telephone Call Metrics

Most (79%) of the requests for assistance received by CDI's service center in 2015 were made by telephone (36,097 calls). The following table shows the survey response from CDI regarding some of its service center telephone call metrics.

Figure 6.2

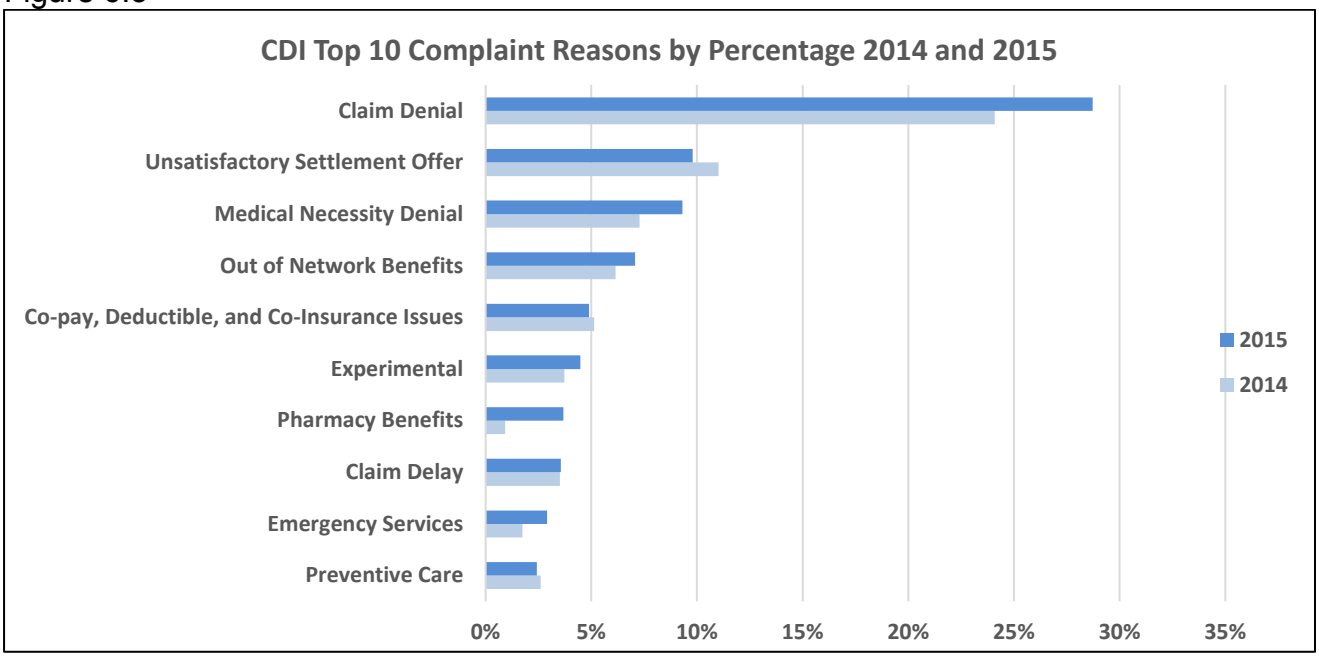
CDI Consumer Services Division - 2015 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	626	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,376	Data
Number of jurisdictional inquiry calls	27,144	Data
Number of non-jurisdictional calls	7,577	Data
Average number of calls received per jurisdictional complaint case	N/A	
Average wait time to reach a CSR	0.29	Data
Average length of talk time (time between a CSR answering and completing a call)	5.28*	Data
Average number of CSRs available to answer calls (during Service Center hours)	Varies based on need	

Note: (*) 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 reflect time of consumer initial contact only.

Top Ten Reasons for Jurisdictional Complaints

The top ten complaint reasons shown in the following chart account for 77 percent of all complaint reasons associated with the complaint cases closed by CDI in 2015. Many consumer complaints involve more than one issue, possibly resulting in higher percentages. The percentage of complaint reasons shown below includes the distribution of those same complaint reasons from 2014. The top five complaint reasons were the same for 2014 and 2015.

Figure 6.3



Note: The complaint reasons represented here are the top ten complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data; they are not necessarily the top ten complaint reasons in 2014.

Top Ten Topics for Non-Jurisdictional Inquiries

In 2015, the CDI responded to 7,577 calls from consumers on topics outside of CDI's authority to address or resolve. The top three most common non-jurisdictional inquiries remained unchanged from 2014. Inquiries regarding Cancellation, Policyholder Service, and Provider Directory topics dropped off the top ten list (previously ranked fourth, eighth, and tenth, respectively). New topics that appeared on the list are Medical Necessity, Pharmacy Benefits and Emergency Services.

Figure 6.4

CDI Top Ten Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC) U.S. Department of Labor (DOL) Various Departments of Insurance (DOIs)
2	Copay/Out-of-Pocket Charges	DMHC DOL Centers for Medicare and Medicaid Services (CMS)
3	Out-of-Network Benefits	DMHC
4	Enrollment/Subsidy	Covered California Medi-Cal CMS
5	Medical Necessity	DMHC
6	Premium/Billing	DMHC Various DOIs
7	Claim Handling Delays	DMHC DOL Various DOIs
8	Preventive Care	DMHC DOL Various DOIs
9	Pharmacy Benefits	DMHC
10	Emergency Services	DMHC

Note: Ranking estimated by CDI.

Consumer Assistance Protocols

CDI reported that there were not any significant changes to its consumer assistance protocols or systems since last year's Baseline Report.

The complaint time standards and resolution times noted below are not comparable between reporting entities because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases. CDI's time standards include an average of 30 day regulatory review period.

Figure 6.5

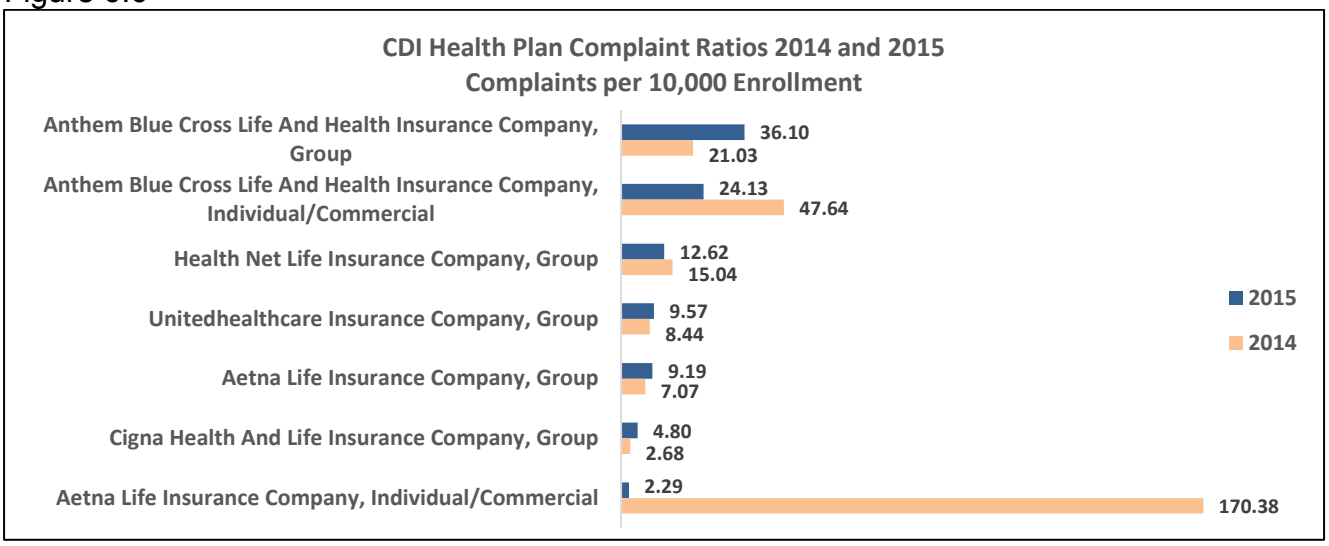
CDI Complaint Standards			
Complaint Process	**Primary Unit(s) Responsible and Roles**	**Time Standard (if applicable)**	**Average Resolution Time in 2015**
Standard Complaint	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau and Rating and Underwriting Services Bureau:* Compliance 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)	74 days Calculation includes time for regulatory review (average 30 days) 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)	78 days Calculation includes time for regulatory review (average 30 days) 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

C. CDI Complaint Data

Complaint Ratios

The following chart shows the complaint ratios for the largest health plans regulated by CDI with enrollment exceeding 70,000 covered lives in 2014 and 2015. These include complaints against health plans that serve commercial group and individual health plans, including coverage purchased through Covered California. Many consumer complaints involve more than one issue possibly resulting in higher complaint ratios. There were 112 plans with at least one complaint from the total of 2,158,334 enrollment in 2015. This enrollment number likely includes a person enrolled in multiple plans including dental, mental health, and other plan types.

Figure 6.6

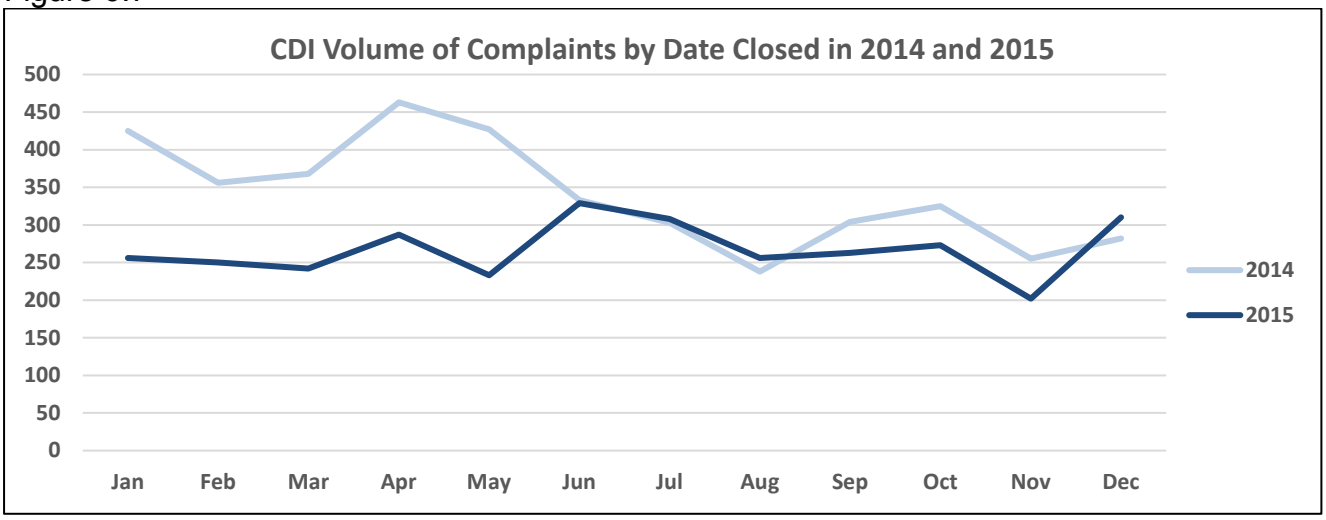


Note: Many consumer complaints involve more than one issue, possibly resulting in higher complaint ratios. The complaint ratios represented here are the complaint ratios for 2015 and the distribution of those same complaint ratios in the 2014 data.

Volume of Closed Complaints

The chart below displays the total of 4,079 closed complaints distributed by month for 2014 and 3,209 closed complaints distributed by month for 2015.

Figure 6.7



Resolution Time

The following charts display resolution time by complaint type and source of coverage.

The resolution time of complaints by complaint type is calculated by subtracting the date complaint opened from the date complaint closed. CDI's complaint duration period reflects the date from the initial receipt of the complaint through the final regulatory review

period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

The average resolution time by complaint type and source of coverage are shown below.

Figure 6.8

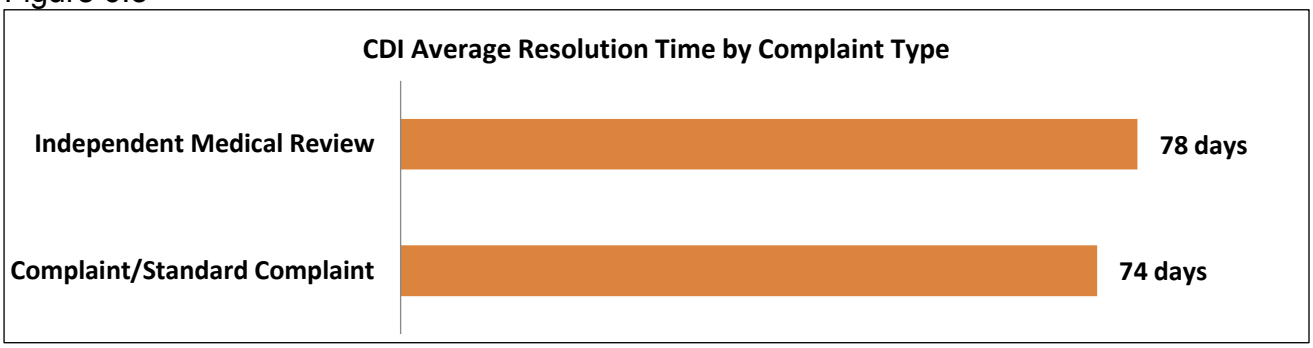
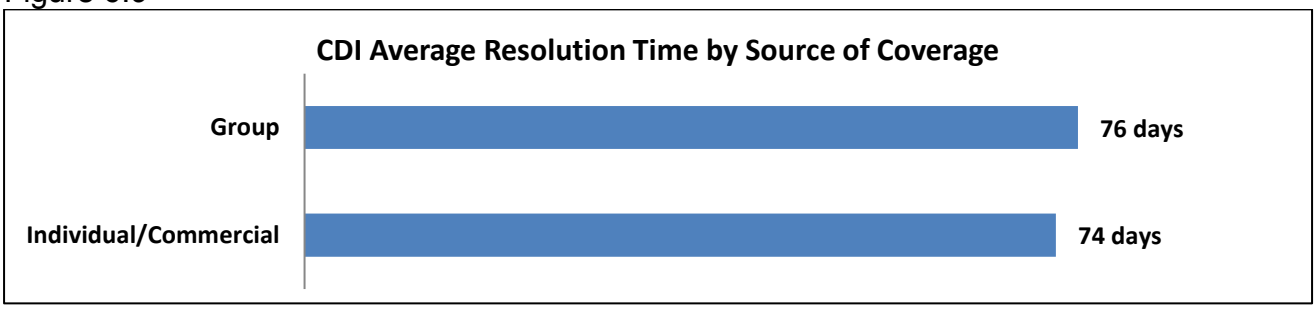


Figure 6.9



Age

Claim Denial ranked as the top complaint reason across all age groups and among consumers for which age data was either Unknown or not disclosed. Unsatisfactory Settlement Offer consistently appeared in the top five complaint reasons across all age groups and among consumers for which age data was either Unknown or not disclosed.

The top three complaint reasons for each age group are as follows:

- Age group under 18 - 34
  - Claim Denial
  - Medical Necessity Denial
  - Unsatisfactory Settlement/Offer
- Age group 35 - 54
  - Claim Denial
  - Unsatisfactory Settlement/Offer
  - Out of Network Benefits
- Age group 55 - 64
  - Claim Denial
  - Medical Necessity Denial
  - Unsatisfactory Settlement/Offer

- Age group 65 - 74
    - Claim Denial
    - Unsatisfactory Settlement/Offer
    - Claim Delay
- Age group Over 74
    - Claim Denial
    - Unsatisfactory Refund of Premium
    - Cancellation

Gender

All of the 3,209 complaints identified a gender. Claim Denial was the top complaint reason for both males and females.

The top five complaint reasons for males are as follows:

1. Claim Denial
2. Unsatisfactory Settlement/Offer
3. Medical Necessity Denial
4. Out of Network Benefits
5. Co-pay, Deductible, and Co-Insurance Issues

The top five complaint reasons for females are as follows:

1. Claim Denial
2. Medical Necessity Denial
3. Unsatisfactory Settlement/Offer
4. Out of Network Benefits
5. Experimental

Race

Fifty-eight percent (1,861) of CDI's complaint records for 2015 do not include data for race. CDI has improved the consumer complaint form for demographic categories and launched a consumer portal for the electronic submission of consumer complaints. Future reporting of this category will likely have more detailed data.

Claim Denial ranked as the top complaint reason across all race categories. Unsatisfactory Settlement/Offer and Out of Network Benefits consistently appeared in the top five complaint reasons among consumers who identify as White, consumers who did not disclose their race, and consumers who identified as Other or one of the following races: Asian, Black or African American, Multi-Racial, Native Hawaiian or Other Pacific Islander, Other and American Indian or Alaska Native.

Ethnicity

Fifty-eight percent (1,849) of CDI's complaint records did not include data for ethnicity.

Claim Denial ranked as the top complaint reason among consumers who identified as Hispanic or Latino, for consumers who identified as non-Hispanic or Latino, and for consumers who did not disclose their ethnicity. Unsatisfactory Settlement/Offer was the second most frequently cited complaint reason among consumers who identified as Hispanic or Latino and for consumers who identified as non-Hispanic or Latino. Medical Necessity Denial was the second most frequently cited complaint reason among consumers who did not disclose their ethnicity.

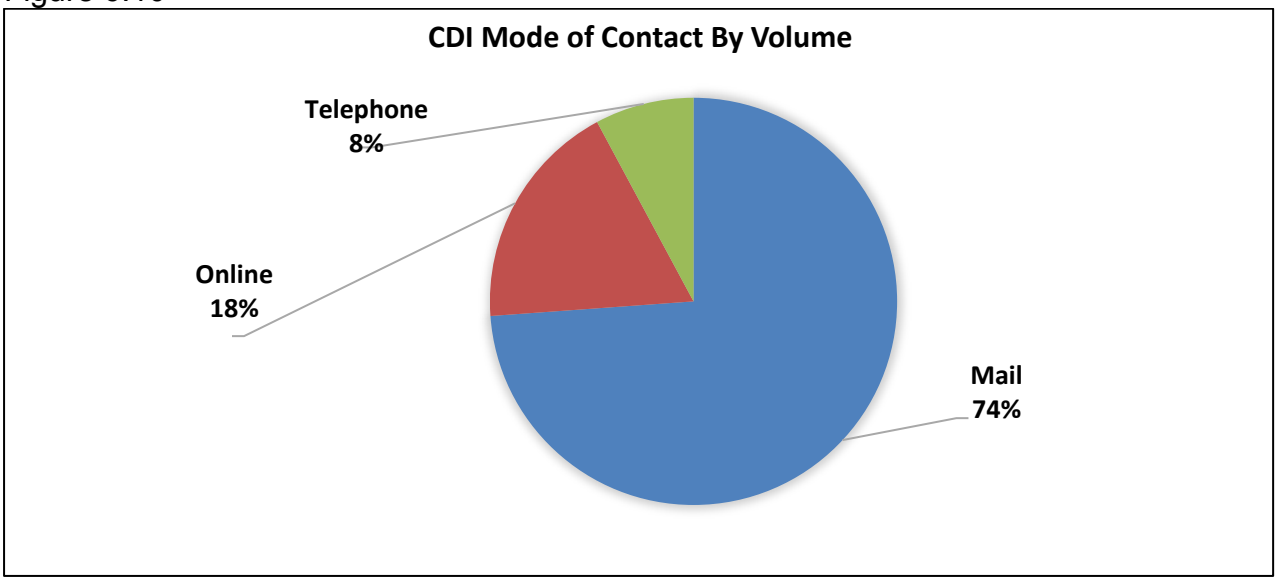
Language

Of the 3,209 consumers who submitted complaints, 1,348 (42%) identified English as their primary language, while 107 (3%) identified a language other than English. The remaining 1,754 (55%) of consumers either refused to disclose or did not identify a primary language when submitting a complaint.

Mode of Contact

All of the 3,209 complaints submitted identified the initial mode of contact. Consumers most often used mail when filing a complaint.

Figure 6.10



Regulator

All of the 3,209 complaints submitted identified CDI as the regulator.

Source of Coverage

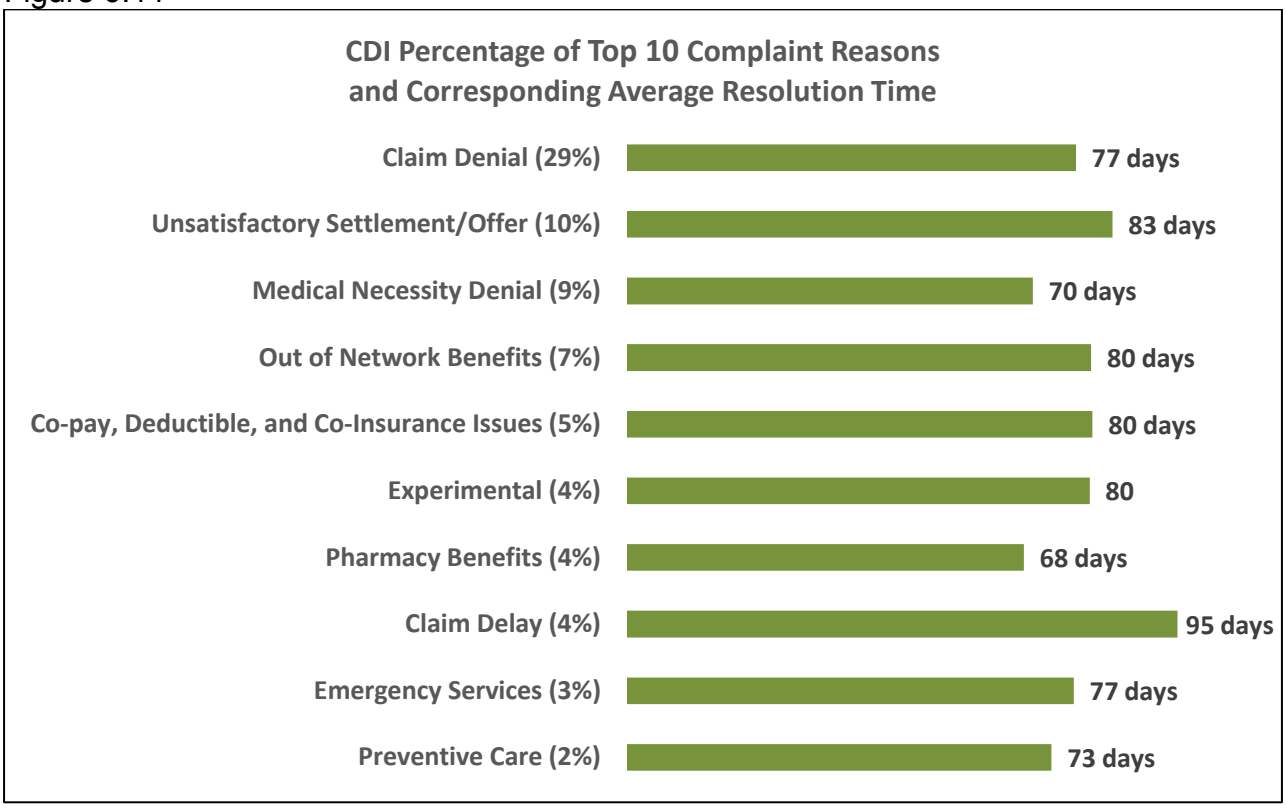
CDI identified two sources of coverage: Group and Individual/Commercial. Of the total 3,209 complaints submitted, Group had 1,951 (61%) complaints and Individual/Commercial had 1,258 (39%).

Complaint Reasons

There were 4,927 complaint reasons derived from the 3,209 complaint records submitted. Many consumer complaints involved more than one complaint reason.

The following chart displays 77 percent of complaint reasons submitted by CDI. The chart contains both the type and percentages of the top ten complaint reasons and the average number of days that CDI took to resolve those complaints. The CDI complaint duration period reflects the date from initial receipt of complaint through the final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

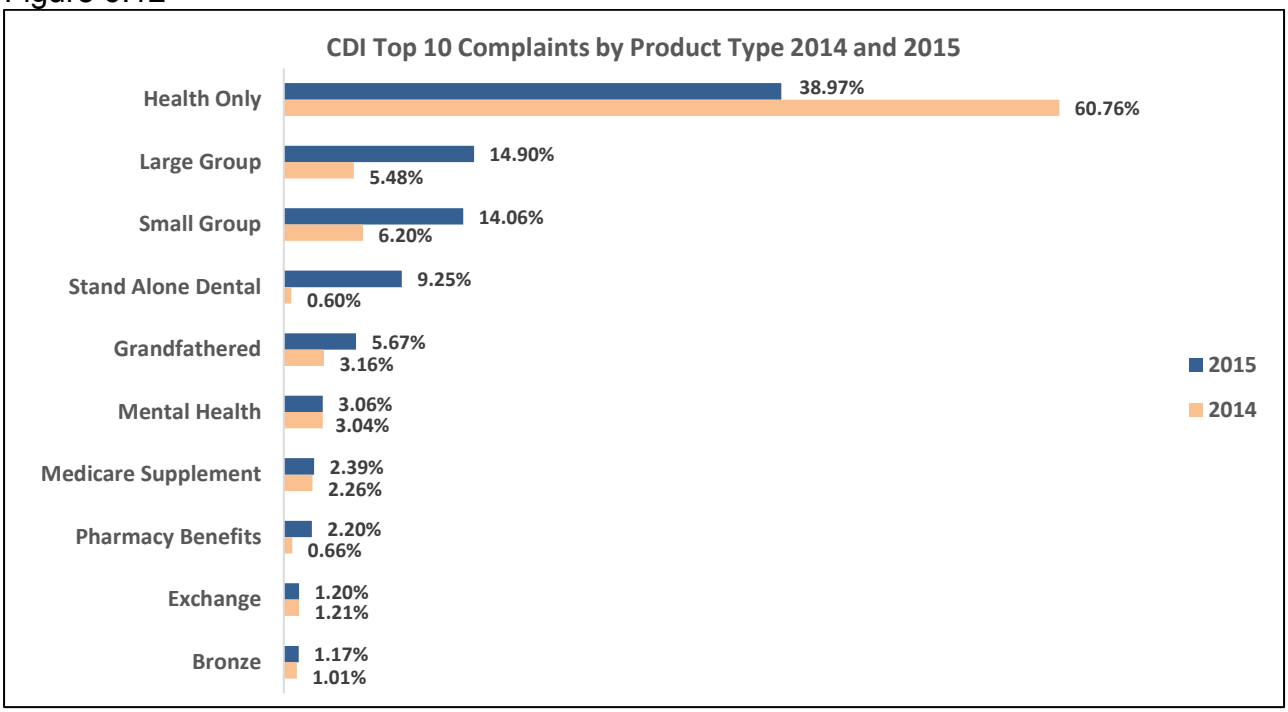
Figure 6.11



Note: Many consumer complaints involve more than one issue, possibly resulting in higher percentages. CDI complaint duration period reflects the date from initial receipt of complaint to final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory review after the case is closed to the complainant.

The following chart displays the top ten complaints by product type. The product type of Health Only continued to be the number one product type with complaints in 2014 and 2015.

Figure 6.12



Note: Consumer complaints submitted to CDI in 2015 are categorized into 26 distinct product types and an unclassified category, identified as Other. The product types represented here are the top ten product types for 2015 and the distribution of those same product types in the 2014 data; they are not necessarily the top ten product types in 2014.

D. CDI Complaint Data Results

The table below shows the top ten complaint results submitted by CDI for the 3,209 total consumer complaints in 2015. Many consumer complaints include more than one complaint result. The top ten total complaint result categories constituted 95 percent of all submitted complaint results. The remainder of 271 complaints are not displayed. Complaint result Policy Issued/Restored was the only complaint result that did not show up in the top ten complaint results in 2014.

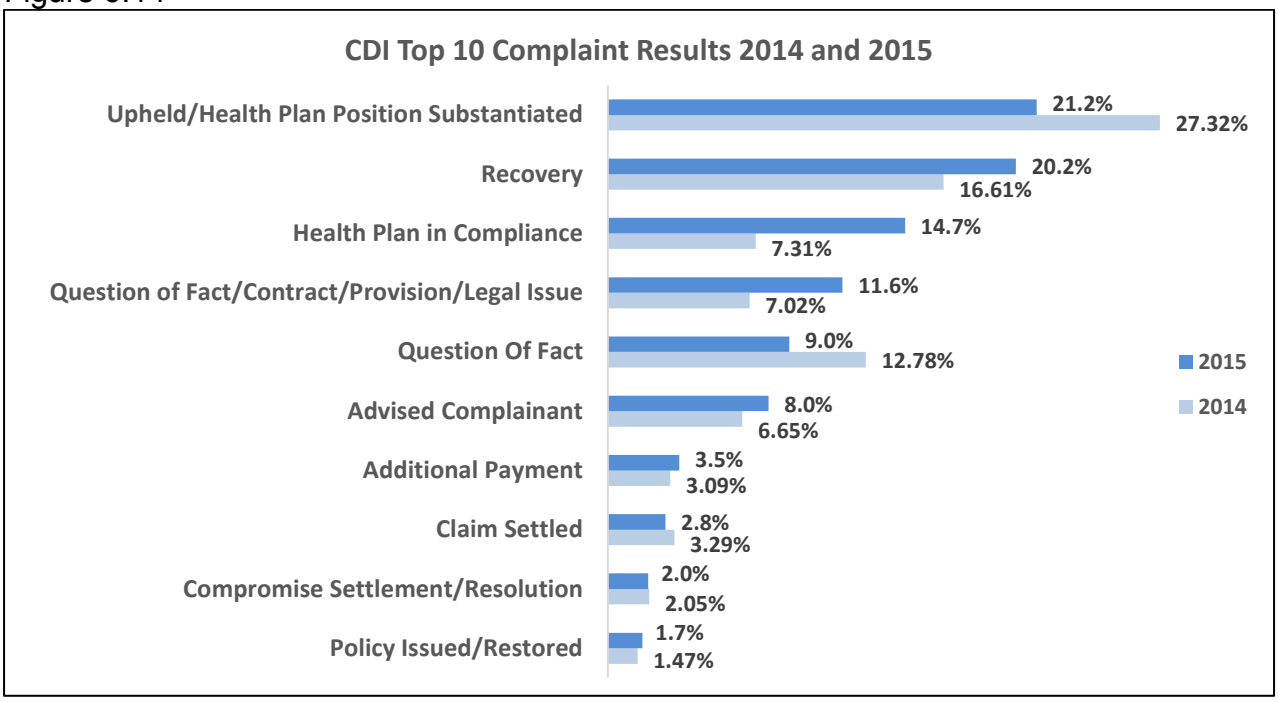
Figure 6.13

CDI Top 10 Complaint Results	
Upheld/Health Plan Position Substantiated	**1,104**
Recovery	**1,050**
Health Plan in Compliance	**765**
Question of Fact/Contract/Provision/Legal Issue	**604**
Question Of Fact	**467**
Advised Complainant	**414**
Additional Payment	**184**
Claim Settled	**148**
Compromise Settlement/Resolution	**104**
Policy Issued/Restored	**89**

Note: The table displays the top ten complaint results, which represent 95% of all results. Many consumer complaints involve more than one complaint result, which is why the total number of results (5,200) exceeds the total number of complaints (3,209).

The chart below shows the percentage of the top ten complaint results submitted by CDI for 2015 and the corresponding complaint results from 2014. Many consumer complaints include more than one complaint result. Complaint result Policy Issued/Restored was the only complaint result that did not show up in the top ten complaint results in 2014.

Figure 6.14



Note: The table displays the top ten complaint results, which represent 95% of all complaint results. The complaint results represented here are the top ten complaint results for 2015 and the distribution of those same complaint results in the 2014 data; they are not necessarily the top ten complaint results in 2014.

Section 7 – Covered California

A. Overview

Covered California (also known as the California Health Benefit Exchange) created a state-based health insurance marketplace to allow consumers to compare health insurance options and choose a health plan that best fits their needs and budget. Covered California serves as an active health care purchaser, selecting and establishing criteria for the health plans and insurance companies that can sell products on the Covered California marketplace.

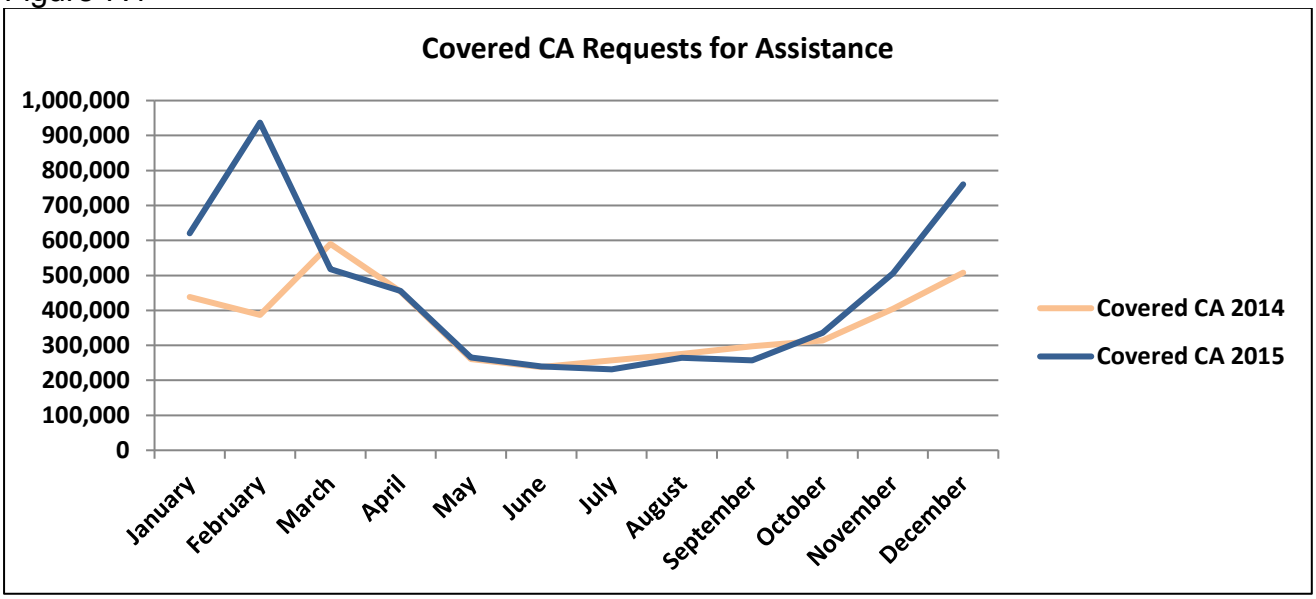
- The Covered California Service Center helps consumers understand coverage options and apply for health care coverage and associated financial assistance.
- Covered California appeals are adjudicated by the California Department of Social Services (CDSS) through the State Fair Hearing process that utilizes an Administrative Law Judge.

B. Covered California Consumer Assistance

Number of Requests for Assistance by Month

Covered California's Service Center received 5,390,936 requests for assistance from consumers via telephone and online chat in 2015, a 29 percent increase over the comparable 2014 volume (4,173,373 contacts). The following chart displays the 2014 and 2015 reported consumer assistance volumes by month. The 2014 reported volume of 4,24,070 includes 250,697 Small Business Health Options Program (SHOP) contacts. SHOP contacts were not reported for 2015.

Figure 7.1



Service Center Telephone Call Metrics

Most (95%) of the Covered California Service Center's inquiries in 2015 were received by telephone (5,124,146 calls). The following table shows the response from Covered California regarding some of its service center telephone call metrics. There was a significant reduction in the average wait time to reach a customer service representative (CSR), dropping from about 23 minutes in 2014 to about two and a half minutes in 2015. This was accomplished despite having over 400 fewer CSRs available on average to answer calls.

Figure 7.2

Covered California Service Center - 2015 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	287,782	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,851,433	Data
Number of jurisdictional inquiry calls	N/A	
Number of non-jurisdictional calls	N/A	
Average number of calls received per jurisdictional complaint case	N/A	
Average wait time to reach a CSR	0:02:38	Data
Average length of talk time (time between a CSR answering and completing a call)	0:16:06	Data
Average number of CSRs available to answer calls (during Service Center hours)	1,019	Estimated

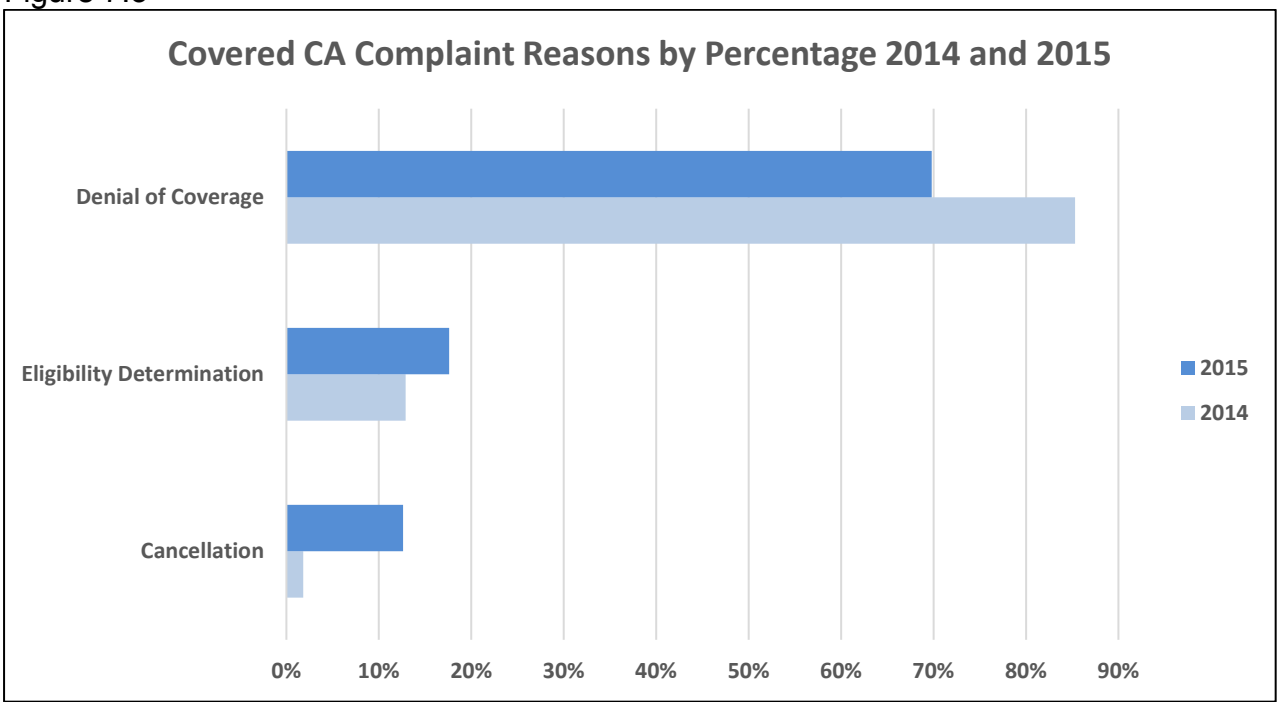
Note: N/A is not available.

Reasons for Jurisdictional Complaints

As shown in the following chart, three reasons account for all of the submitted Covered California complaints addressed through the CDSS State Fair Hearing process and those that were resolved informally before the State Fair Hearing took place in 2014 and 2015.

Denial of Coverage was still the top complaint reason for 2014 and 2015.

Figure 7.3



Note: The complaint reasons represented here are the complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data.

Top Non-Jurisdictional Inquiries

Covered California reported the top ten jurisdictional and non-jurisdictional inquiries made by consumers to its Service Center in 2015. The most common non-jurisdictional consumer referrals were regarding Medi-Cal topics.

Figure 7.4

Top Ten Covered California Jurisdictional and Non-Jurisdictional Inquiries		
Ranking	**Inquiry Topic**	**Referred to**
1 (most common)	Current Customer- Application/Case Status- Inquiry/Assistance	N/A
2	New Enrollment-Inquiry/Assistance	N/A
3	Current Customer- Renewal- Complete Enrollment	N/A
4	Current Customer- Renewal- Inquiry/Assistance	N/A
5	Medi-Cal- Provided County Contact/Number Info	Referred to Medi-Cal
6	Medi-Cal-Medi-Cal/Enrollment Inquiries	Referred to Medi-Cal
7	Current Customer- Disenrollment/Termination	N/A
8	Requesting to be Terminated	N/A
9	Current Customer- Consumers Online Account	N/A
10	Password Reset/Unlock	N/A

Note: Covered California ranked based on data.

Consumer Assistance Protocols

Covered California reported that there were not any significant changes to its consumer assistance protocols or systems since last year's Baseline Report. The complaint time standards and resolution times noted below are not comparable between reporting entities because of differences in how the reporting entities review consumer complaints and track the initiation and closing of cases.

Figure 7.5

Covered California Complaint Standards			
Complaint Process	**Primary Unit(s) Responsible and Role**	**Time Standard (if applicable)**	**Average Resolution Time in 2015**
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	69 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	49 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.

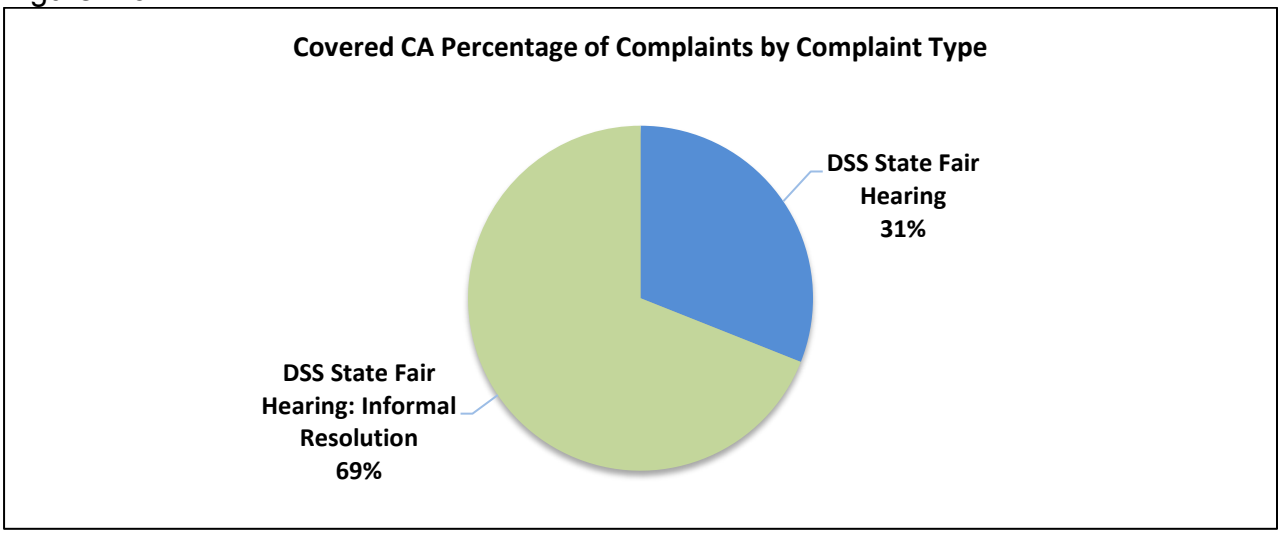
C. Covered California Complaint Data

The Covered California complaint data identifies two complaint types DSS State Fair Hearing and DSS State Fair Hearing: Informal Resolution. The complaints are processed by CDSS, which conducts State Fair Hearings on Covered California eligibility-related appeals. These complaints include both cases that were resolved informally before a hearing took place (4,242) and those that went through the full State Fair Hearing process (1,908).

The complaint types DSS State Fair Hearing took an average of 69 days and DSS State Fair Hearing: Informal Resolution took an average of 49 days.

The chart below displays the percentage of complaint types submitted by Covered California in 2015.

Figure 7.6



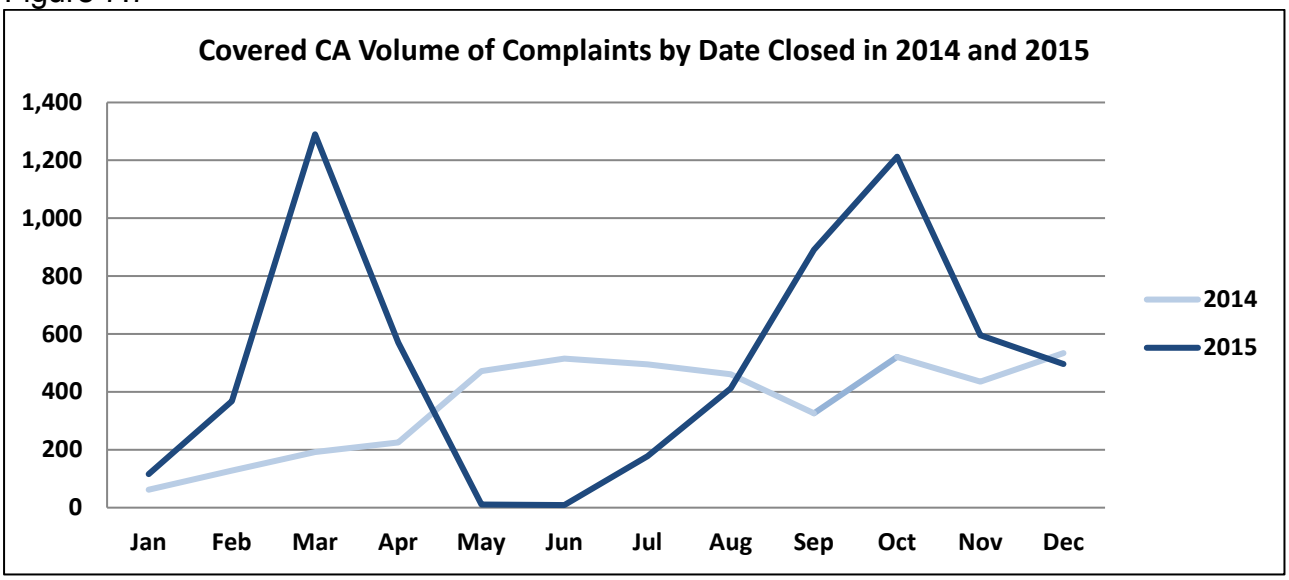
Complaint Ratios

No complaint ratios were calculated based on the eligibility-related complaints submitted by Covered California, because they did not report associated health plan information.

Volume of Closed Complaints

The following chart displays the total of 4,366 closed complaints distributed by month for 2014 and 6,150 closed complaints distributed by month for 2015.

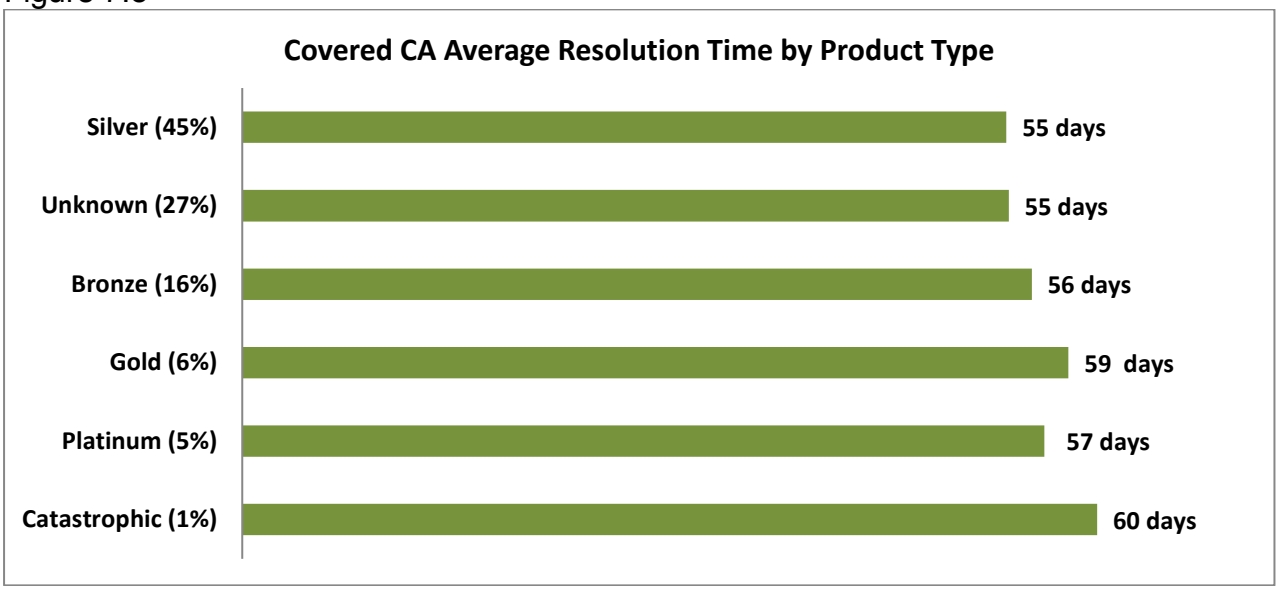
Figure 7.7



Resolution Time

The chart below displays the average length of time for Covered California to resolve complaints based on product type. It took 46 days in 2014 and 55 days in 2015.

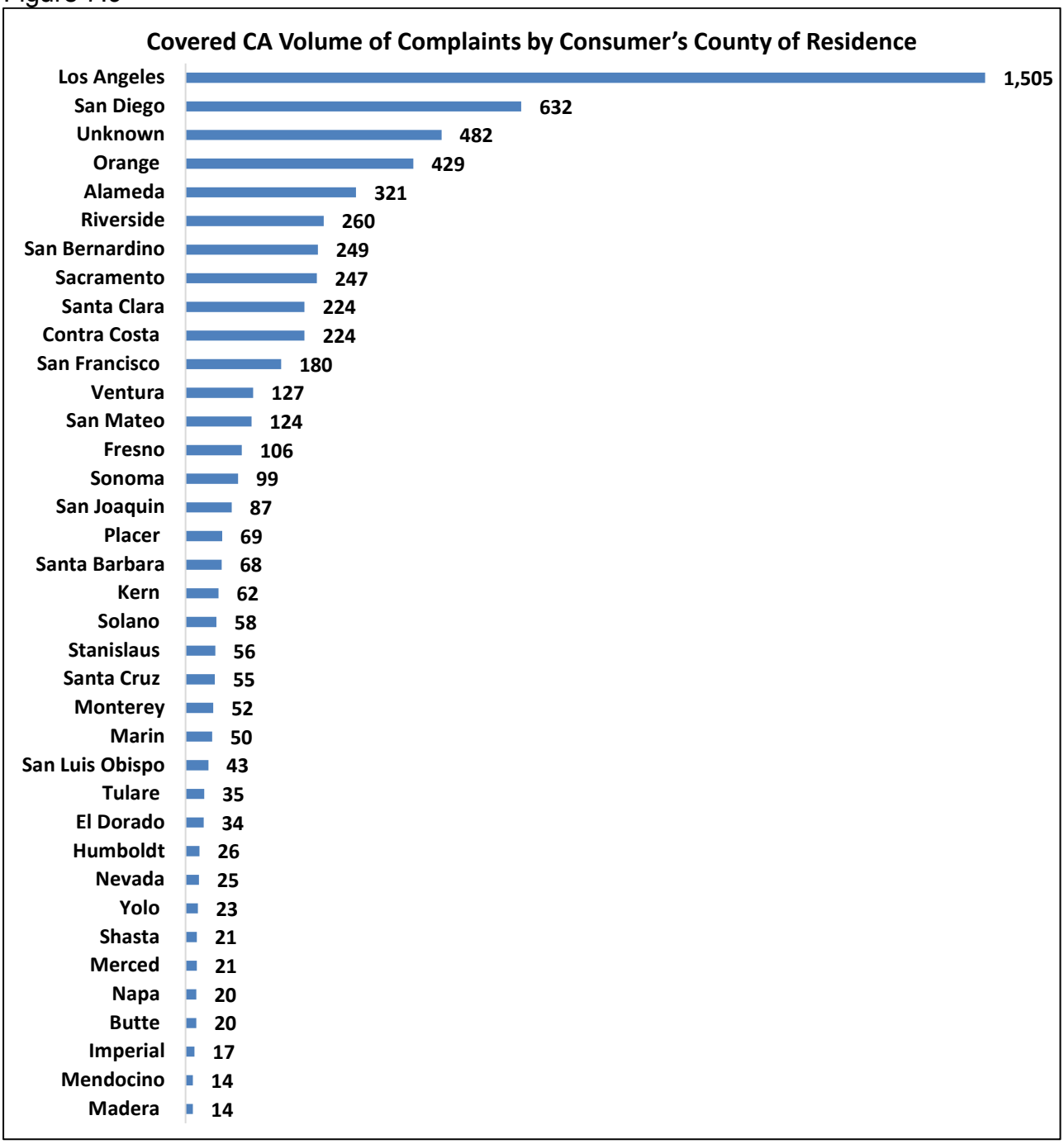
Figure 7.8



Volume of Complaints by County

The following chart displays the volume of complaints by consumer's county of residence. The counties not shown each have fewer than ten complaints. There were 482 complaints with an Unknown county.

Figure 7.9



Note: Counties not listed had less than ten complaints: Amador, Calaveras, Colusa, Glenn, Inyo, Kings, Lake, Lassen, Mariposa, Modoc, Mono, Plumas, San Benito, Sierra, Siskiyou, Sutter, Tuolumne, and Yuba.

Age

Covered California submitted 6,119 complaints with an age identified. Forty-two percent of complaints are from the age group of consumers 35 – 54. There were 31 complaints with an Unknown age.

The complaint reasons for age groups from under age 18 through 64 were identical in order of frequency as follows:

1. Denial of Coverage
2. Eligibility Determination
3. Cancellation

Consumers aged 65 - over age 74 were in order of frequency as follows:

1. Denial of Coverage
2. Cancellation
3. Eligibility Determination

The average age of consumers who submitted complaints to Covered California was 47. Complaints from consumers who were less than 18 or greater than 74 years of age accounted for only 0.8 percent of total complaints. Complaints from consumers aged 18-34 and 55-74 made up 22 percent and 35 percent of complaints, respectively. Less than 1 percent of consumers refused to disclose or did not identify their age.

Gender

Of the 5,668 complaints submitted by Covered California, just over half 3,137 (51%) of consumers identified as female, 2,531 (41%) identified as male, and 482 (8%) of consumers did not disclose their gender.

Race

Covered California submitted 4,176 complaints with race information. Consumers identified as White or Caucasian at 39 percent, Asian at 11 percent, Multi-Racial at five percent, Black or African-American at four percent, Native Hawaiian or Other Pacific Islander at one percent, and American Indian or Alaska Native at less than one percent. There were 1,974 (32%) complaints where race was Unknown.

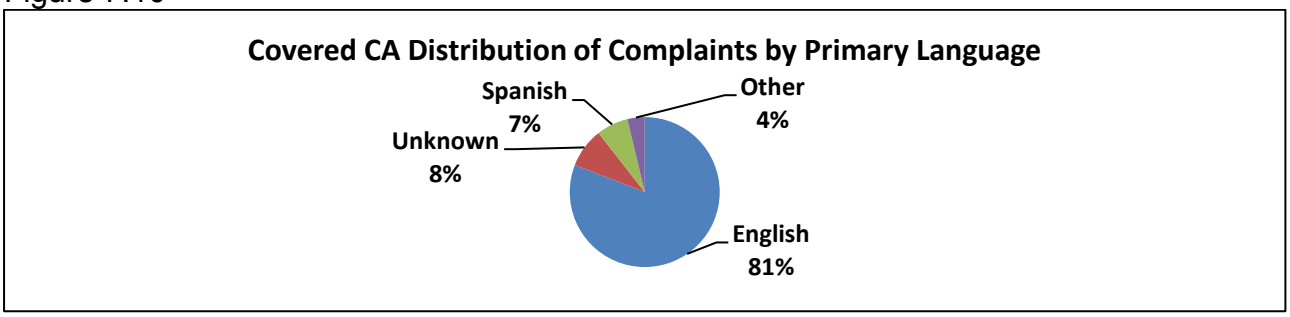
Ethnicity

Ethnicity was identified among 4,801 of the 6,150 submitted complaints. Sixty-one percent of consumers (3,769) identified as Not Hispanic or Latino consumers and 1,032 (17%) identified as Hispanic or Latino consumers. There were 1,349 (22%) Unknown complaints by ethnicity.

Language

Covered California submitted 5,975 complaints that identified a primary language. There were 526 (9%) complaints where the primary language was Unknown. The following chart displays the percentage of complaints by primary language.

Figure 7.10



Mode of Contact

Covered California submitted 6,124 complaints with an identified mode of contact. Consumers contacted Covered California by telephone 3,502 times (57%), followed by 984 emails (16%), 823 faxes (13%), 493 mail (8%), 223 counter/in-person (4%), and 99 Other contacts (2%). There were 26 complaints where an initial mode of contact was Unknown.

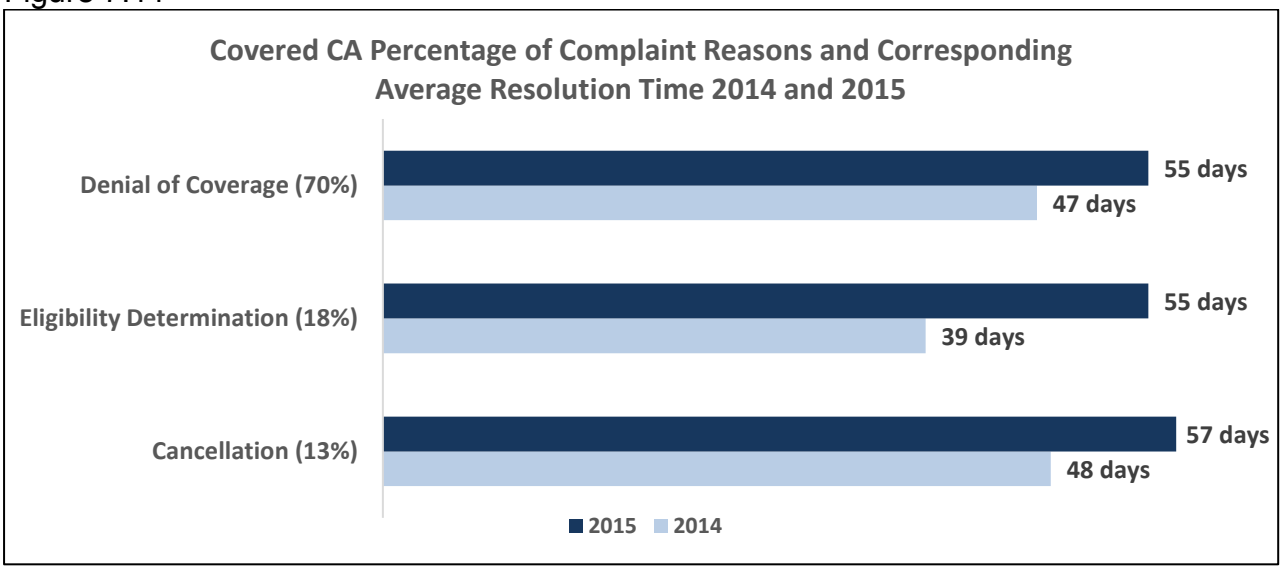
Regulator

Covered California did not report regulator information.

Complaint Reasons

All of the 6,150 complaints submitted by Covered California identified a complaint reason. The most frequent complaint reason (4,292) was Denial of Coverage. The chart below displays the percentage of complaint reasons in 2015 with corresponding average resolution times from 2014 and 2015.

Figure 7.11



Note: The complaint reasons represented here are the complaint reasons for 2015 and the distribution of those same complaint reasons in the 2014 data.

Source of Coverage

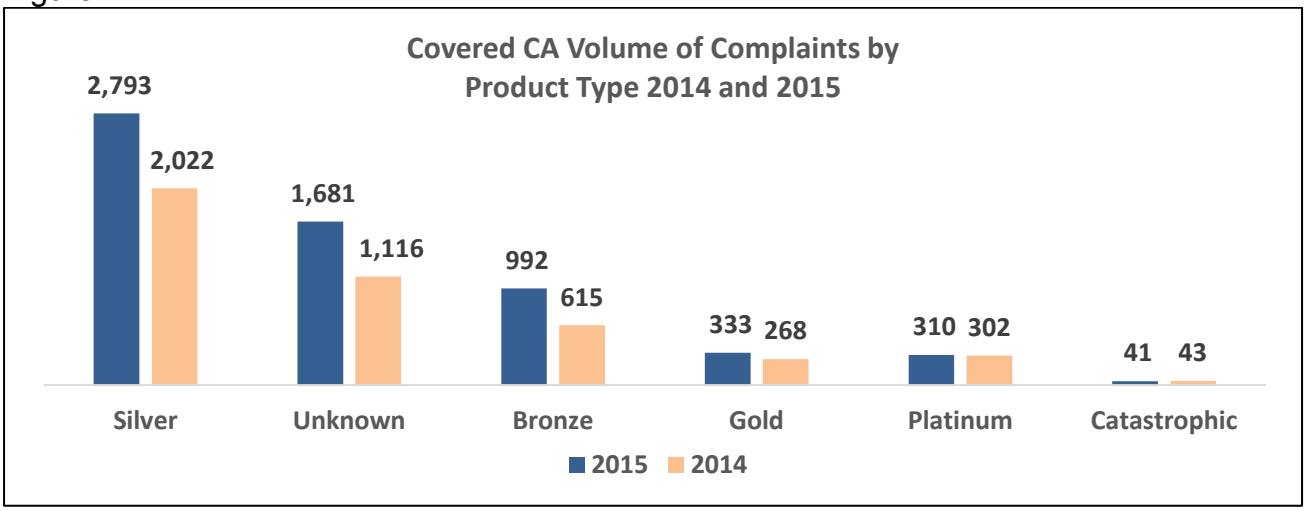
Source of coverage for all 6,150 Covered California complaints was identified as Covered California/Exchange.

Product Type

Covered California had a total volume of 6,150 complaints with five identified product types and 1,681 (27%) with an Unknown product type. The largest numbers of complaints, 2,793 (45%), were regarding Silver plans. The remaining complaints were regarding Bronze at 992 (16%), Platinum at 310 (5%), Gold at 333 (5%), and Catastrophic at 41 (1%).

The chart below displays the volume of complaints by product type in 2014 and 2015.

Figure 7.12



D. Complaint Data Results

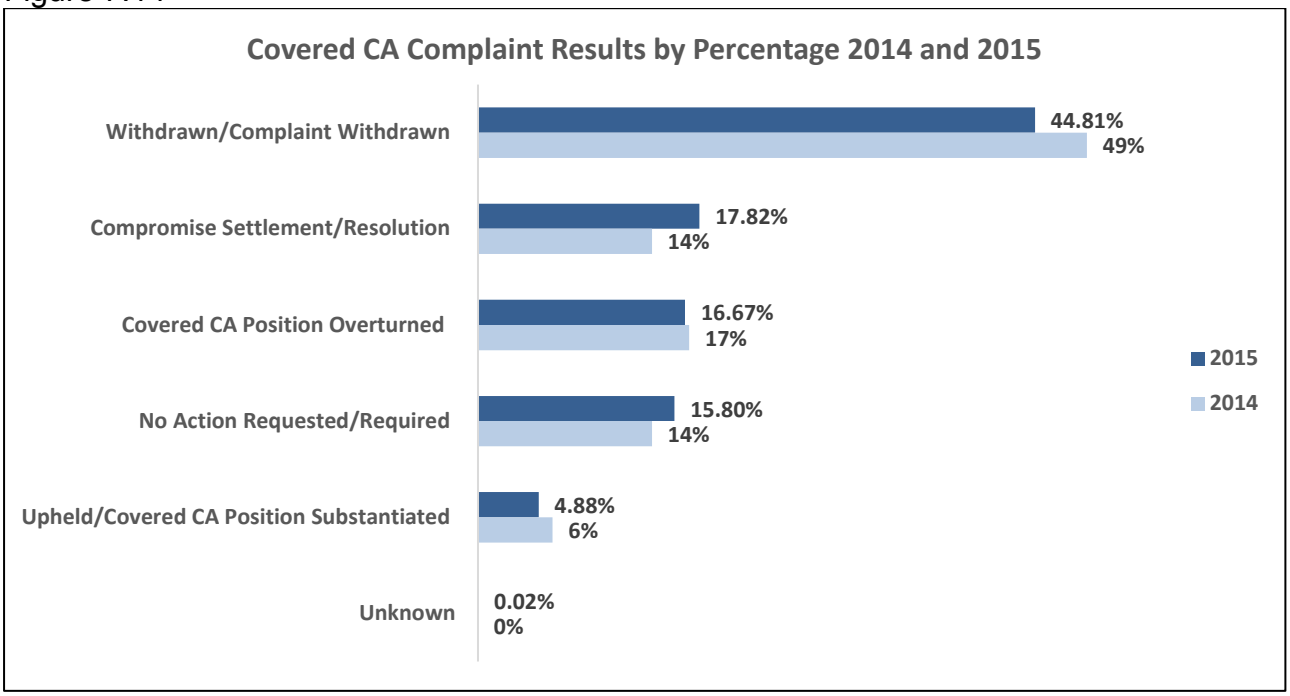
The following table shows that all of the 6,150 complaints submitted by Covered California had a complaint result. The complaint result Withdrawn/Complaint Withdrawn moved from the fifth complaint result in 2014 to the top complaint result in 2015. Compromise Settlement/Resolution was the second complaint result for both 2014 and 2015.

Figure 7.13

Covered CA Complaint Results	
Withdrawn/Complaint Withdrawn	2,756
Compromise Settlement/Resolution	1,096
Covered CA Position Overturned	1,025
No Action Requested/Required	972
Upheld/Covered CA Position Substantiated	300
Unknown	1

The below chart shows the corresponding percentage of each of the six complaint results in 2014 and 2015.

Figure 7.14



Note: The complaint results represented here are the complaint results for 2015 and the distribution of those same complaint reasons in the 2014 data. The complaint result Unknown was not included in 2014.

Section 8 – Conclusion

OPA reviewed the data collection process and analyzed the complaint data submitted by the four reporting entities: DMHC, DHCS, CDI, and Covered California. This section identifies some highlights where the 2015 complaint data shows noteworthy changes from the previous year's data. This report displays 2015 data along-side 2014 baseline data in some tables and charts. However, a second year of data is not enough to indicate a trend in data. OPA will include previous years' data in future reports for each reporting entity, so any trends or patterns can be easily identified. OPA also noted significant health care events in 2015 to give some context for changes in the data. However, changes from one year to the next does not imply causality and should not be assumed to account for the data results.

Volume of Complaints:
Three reporting entities, DMHC, DHCS, and Covered California, all showed an increase in the total number of complaints they received. (DMHC reported an increase of 27 percent, DHCS an increase of 47 percent, and Covered California an increase of 41 percent.) The increases may be in large part attributed to the increased efficiency with which the reporting entities are now collecting their data. CDI's reported decrease of 21 percent may reflect its decreased enrollment and the changes in marketplace.

Complaint Reason:
Pharmacy Benefits increased significantly as a complaint reason from 3.93 percent of all complaint reasons in 2014 to 47.9 percent of the complaint reasons in 2015. Complaints regarding pharmacy benefits did not appear in the Top 10 complaint reasons in the 2014 data for DHCS or CDI. In 2015, Pharmacy Benefits was the top complaint reason for DHCS, and the ninth and seventh most common reason for DMHC and CDI respectively. Covered California did not report Pharmacy Benefits complaints in 2014 or 2015.

Many different factors may have contributed to the reported increase in Pharmacy Benefits complaints. It is unknown to what extent the increase can be attributed to a rise in the incidence of pharmacy-related problems within the health care system. Improvements to complaint data collection categorizations, increased consumer awareness of related patient rights and complaint review processes, or other reporting factors may have also played a role. Media attention may serve to amplify consumer complaints and any response by policy makers and regulators on a particular issue. In reviewing the available data for these two years, OPA was unable to draw definitive conclusions about the cause of the increase in Pharmacy Benefits complaints.

Cancellation made the list of the Top 10 complaint reasons for DMHC, CDI, and Covered California in 2014; however, the percentage of complaints were low and as such it did not appear on the Statewide Top 5 complaint reasons table in 2014. The 2015 data shows an increase in Cancellation as the complaint reason. The Statewide Top 5 complaint reasons shows Cancellation among the three highest complaint reasons. Medical Necessity Denial and Denial of Coverage tied as the number one complaint reason.

DMHC indicated that the increase in Cancellation complaints was likely due to complaints involving cancellations for nonpayment of premiums.

Complaint Results:
The DMHC data show Upheld/Health Plan Position Substantiated complaint resolutions increased significantly from 2014 to 2015, moving from a rank of 5th among the top nine complaint results to the number one complaint result. The 2014 data for DMHC shows the top complaint result is Compromise Settlement/Resolution. DHCS shows a slight increase in Upheld/Health Plan Position Substantiated complaints, moving from a ranking of 3rd most often complaint result to the 2nd most often complaint result in 2015. Upheld/Health Plan Position Substantiated is the top complaint result for CDI in both 2014 and 2015. Covered California data show Upheld/Covered California Position Substantiated complaints ranked 5th among the five possible complaint result outcomes in 2015. This is a decrease from the 2014 data which ranked Upheld/Covered California Position Substantiated at third. It is unclear why there was an overall increase in the companies' position being upheld (as opposed to the consumer's complaint prevailing as it did in 2014). OPA will continue to gather data for 2016 and subsequent years to determine the reasons for this change and whether it represents a pattern.

Withdrawn/Complaint Withdrawn is the top complaint result for DHCS and Covered California in 2015 as it was in 2014.

Complaint Ratios:
The complaint ratios are calculated for the Top 10 health plans in each of the three reporting entities; DMHC, DHCS, and CDI. (Covered California does not provide health plan information to calculate ratios.) It is noted that the health plan ratios varied, in some cases quite significantly, from 2014 to 2015. For example: the 2015 DMHC data show Health Net of California, Inc. with a complaint ratio of 20.15 per 10,000 enrollees. In 2014, DMHC data show Health Net of California, Inc. with a complaint ratio of 8.87 per 10,000 enrollees. Another example: in the 2015 CDI data show Aetna Life Insurance Company, Individual/Commercial with a complaint ratio of 2.29 complaints per 10,000 enrollees. In 2014, CDI data show Aetna Life Insurance Company, Individual/Commercial with a complaint ratio of 170.38 complaints per 10,000 enrollees. These variances cannot be explained with the data that is provided. Future reports will show if these differences are one-time anomalies or if further analysis is required to explain.

Data Limitations:
OPA cannot make comparisons among health plans across reporting entities. Health plans with similar names do not represent identical health plan products or corporate affiliation. Additionally, the reporting entities that are regulators, DMHC and CDI, serve a different group of consumers with their consumer assistance centers; HMOs and PPOs respectively. DHCS and Covered California data come from the California Department of Social Services, State Fair Hearings Division rather than consumer assistance centers, ombudsman, or county offices.

The data shown in this report for each of the reporting entities may not match precisely to similar data as published by each reporting entity in their respective departmental reports. Differences in the data may occur due to variances in methodology or other criteria.

OPA will continue to work with the four reporting entities to improve and standardize data definitions and coding, where appropriate. Standardizing data will allow for better collection, tracking, and analyzing data on problems and complaints by consumers. OPA also believes this standardization will enable greater ability to compare data among the reporting entities and within the state of California.

OPA considers consumer participation in complaint processes to be vital for complaint data reports to accurately reflect consumers' problems experienced in the health care system. Consumers should be aware of their complaint rights and be able to easily access related consumer assistance resources. Barriers to this participation can hinder reporting and monitoring efforts and skew available data, making it more difficult for regulators and other oversight programs to identify and address systemic issues.

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Section 10 – Appendices

Appendix A. Glossary

The glossary includes terms defined by the National Association of Insurance Commissioners (NAIC), Office of the Patient Advocate, and other state entities. Most terms for complaint reasons and results use the NAIC definitions. For the purpose of this report, references within the NAIC definitions to "Department of Insurance," "insurer," and "insured" may also apply to other California reporting entities, health plans, and health plan enrollees, respectively.

Term	Explanation
Abusive Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior (other than "twisting" or "churning") by the insurer or its representative.
Access to Care	Complaint that needed care is inaccessible due to refusal of primary care doctor to authorize specialist care or due to inadequate provider network.
Accident Only	Health insurance pertaining to only accident coverage.
Additional Payment	The party complained against paid more money (i.e. claims payment) than was initially paid to the policyholder or claimant.
Advanced Premium Tax Credit	Financial assistance that eligible consumers may receive when enrolling in a Covered California health plan to assist them in paying their monthly premium costs. This tax credit is sometimes called premium assistance.
Advised Complainant	A complaint result indicating that the reporting entity informed the complainant of the state position, company status, agent status, or possible course of action.
Authorization Dispute	Complaint alleging that the insurer has improperly denied claim or assessed a penalty on the basis of required preauthorization not having been obtained.
Autism/PDD	Coverage provided for treatment of autism/persuasive developmental disorder in covered children under the age of 19.
BIC (Benefits Identification Card)	People who are eligible for Medi-Cal receive a Benefits Identification Card (BIC), which is used by Medi-Cal providers to check eligibility. Medi-Cal recipients enrolled in a Medi-Cal managed care health plan have both a BIC and a health plan member card.
Bronze	A Covered California health plan product type. Bronze tier indicates a level of coverage provided by a health plan with 60 percent of the total allowed costs of benefits paid by the health plan.
CalHEERS	The California Healthcare Enrollment, Eligibility and Retention System is a web-based system that streamlines the eligibility and enrollment process for all products and programs available through Covered California.
Cal MediConnect	A Department of Health Care Services, Medi-Cal Managed Care three-year demonstration program for dual Medi-Cal/Medicare eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system. See also Medi-Cal Coordinated Care Initiative.
Cancellation	Complaint alleging the insurer's improper cancellation of a policy and/or coverage before the expiration date.
Cancer/Dread Disease	An insurance product type that only pays benefits for the diagnosis and treatment of cancer and/or other specifically named serious disease or diseases.
Catastrophic	Health plans that meet all the requirements of a qualified health plan but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met.
Chiropractic	Coverage for care provided by a Chiropractor. Normally, not seen as regular health maintenance but as a term recovery plan.
Claim Delay	Complaint alleging that the insurer has unreasonably delayed the investigation and/or processing of a claim.
Claim Denial	Complaint alleging improper claim denial by insurer.
Claim Reopened	Regulated entity or individual has reopened claim for further investigation or settlement negotiation. A final resolution of the claim has not been determined.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate.

Closed Complaint	A complaint that has been investigated by the state insurance department and given a resolution code. A complaint that has completed a complaint review process by a reporting entity or its official affiliate.
Closed Network/ Provider Discrimination	Complaint regarding insurer's refusal to admit provider to network, due to lack of need.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	A U.S. statute which requires that employers sponsoring group health plans offer continuation of coverage under the group plan to employees and their dependents who have lost coverage because of the occurrence of a "qualifying event." Qualifying events include reduction in work hours, many types of termination of employment, death, and divorce.
Complaint	A written or oral complaint, grievance, appeal, independent medical review, hearing, or similar process to resolve a consumer problem or dispute.
Complaint Ratio	The number of complaints closed during the calendar year divided by the number of covered lives the insurer had in place by the end of a specific month. For this report the complaint ratio was calculated from complaints closed in 2015 divided by the number of covered lives from a single month in 2015 enrollment, and the resulting ratio was divided by 10,000.
Complaint Reason	A complaint data element indicating the primary reasons for the consumer complaint. For this report a single complaint case can have up to three reasons. Examples of complaint reasons include cancellation, medical necessity denial, and claim denial.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.
Compromise Settlement/Resolution	Complaint resolved voluntarily by an insurer or regulated entity, via additional payment, restored benefit or policy status, and/or other means. No finding by the insurance department that the regulated entity or individual was in violation or otherwise at fault.
Consumer's Money Returned	A return of money or benefits was made to the insured/complainant.
Continuation of Benefits	Complaint regarding COBRA (Comprehensive Omnibus Budget Reconciliation Act) enrollment and/or coverage after the insured no longer qualifies for group coverage.
Continuity of Care	Complaint regarding the transition plan of continuing care.
Coordination of Benefits	Complaint alleging one or both insurers' failure to properly coordinate benefits.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible or co-insurance amounts has been applied to a claim.
Cost Containment	Complaint alleging insurer's misapplication of cost-containment measures such as pre-certification, utilization review, concurrent review, managed care, second opinion, etc.
Coverage Question	Complaint alleging insurer's inadequate response to insured's request for information on policy status or coverages, or for interpretation of policy provisions.
Covered California/ Exchange/Marketplace	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Tile 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run exchange.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
CRM (Customer Relationship Management)	A call center technology system to manage and record interactions with people who contact the call center.
Customer Service Representative (CSR)	A person who answers telephone calls in a service center (or communicates with customers through other modes of contact, such as email).
Delay Resolved	A delay in provider service or information was resolved.
Delayed Authorization Decision	Complaint alleging insurer's delayed response to healthcare authorization request.
Delivery of Policy	Complaint alleging insurer's delayed delivery of, or failure to deliver, an insurance policy to the insured.
Denial of Coverage	Complaint that coverage through Covered California was improperly denied.
Dental Combined with Major Medical	A Product Type reported by CDI. See Dental Only and Major Medical definitions.
Dental Only	A line of business providing dental only coverage; coverage can be on a stand-alone basis or as a rider to a medical policy. If the coverage is as a rider, deductibles or out-of-pocket limits must be set separately from the medical coverage. Does not include self-insured business as well as FEHBP or Medicare and Medicaid programs.
Dental Stand Alone	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Eligibility Determination	Complaint is about a problem with eligibility for health care coverage, typically through a public program.

Emergency Services	Complaint regarding coverage, with respect to an emergency medical condition, arising out of a medical screening examination that is within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize a patient.
EPO (Exclusive Provider Organization)	An EPO is a kind of health plan that requires its members to use an exclusive network of contracted providers, but typically allows members to see network providers without a referral.
ERISA	The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most pension and health benefits voluntarily established by private industry employers to provide protection for individuals in these plans.
Ethnicity	A demographic data element consisting of categories Hispanic or Latino, Not Hispanic or Latino, Unknown, and Refused
Exchange	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Tile 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run Exchange.
Experimental	See definition for Experimental/Investigational Denial.
Experimental/ Investigational Denial	Complaint regarding denial of coverage for a treatment or service that the health plan has determined is experimental.
External review	Complaint alleging insurer's failure to comply with statutory process requirements for external review.
FI (Fiscal Intermediary)	A contracted company that serves as the government's agent for claims processing and managing related systems for administering a public health care program.
59 Hold	Refers to a status code in the Medi-Cal Eligibility Data System (MEDS) indicating that a health plan enrollment is on hold due to a change in the Medi-Cal recipient's status other than Medi-Cal eligibility (e.g., the recipient moved to a different county).
Fraud/Forgery	Complaint alleging some form of claim-related deception or unfair practice by a third party resulting in unfair financial or compensable gain.
Gold	A Covered California health plan product type. The gold tier indicates a level of coverage provided by a health plan with 80 percent of the total allowed costs of benefits paid by the health plan.
Grandfathered	Coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations).
Group Health Plan	Health insurance coverage policy purchased by an employer or other employee organization and offered to eligible employees as a benefit. Insurance that is issued to Insurance that is issued against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Benefit Exchange Board	The Exchange is an independent public entity within state government with a five-member board appointed by the Governor and the Legislature. Two members are appointed by the Governor; one by Senate Rules Committee; and one by Speaker of the Assembly. The Secretary of the Health and Human Services Agency or another designee serves as an ex-officio voting member of the Board. Appointed members serve four year terms.
Health Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), who provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments, deductibles, and a PPO (Preferred Providers Organization).
Health Plan/Health Insurer	A health plan or insurer is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members or policy holders for a fixed, prepaid premium. Health plans are licensed to operate in California by the Department of Managed Health Care. Health insurers are licensed by the California Department of Insurance. For this report, health plan may be used to refer to both health plans and health insurers.
Health Plan in Compliance	Complaint result category originally used by the NAIC to indicate that a company's tendencies comply with the state insurance regulations.
Health Plan Position Overturned	Complaint resolved by a regulated entity to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity to be in violation or otherwise at fault.
Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Health Privacy	Complaint regarding the protections (or lack thereof) to ensure privacy of health information.

HIPAA	Health Insurance Portability and Accountability Act. Includes provisions that guarantees that employers are not able to impose preexisting condition limitations in the insurance they offer to new employees who had insurance coverage for at least 12 months with their previous employer.
HMO (Health Maintenance Organization)	A kind of managed care health plan that requires its members to use a network of contracted providers to get health care services.
Home Health Care	Health care provided in the home of the patient, usually by a private nurse or a state-licensed home health care agency. Services are usually limited to part-time or intermittent nursing care and physical or occupational rehabilitation.
Hospital Indemnity	Coverage that provides a predetermined flat benefit for each day of hospitalization regardless of expenses incurred.
Hospitalization	Complaint regarding coverage for expenses arising out of services provided during confinement in a hospital as a patient for diagnostic study and/or treatment.
Independent Medical Review (IMR)	An Independent Medical Review is an external review process for addressing certain qualifying complaints about treatment or service denials or delays. Doctors who aren't part of the complainant's health plan or insurance company conduct the review and make a determination. Under law an IMR must be resolved within 30 days.
Individual Health Plan or Individual/Commercial	Insurance that is issued to an individual insuring one (and one's dependents if on the same policy) against sickness or injury.
Inquiry	A request for assistance made by a consumer to a consumer assistance service center that does not initiate a complaint with the associated reporting entity. For this report, the general category of inquiry is used to refer to jurisdictional inquiries and non-jurisdictional inquiries/complaints.
Insufficient Information for Further Investigation	Complainant failed to provide sufficient information/documentation to warrant further investigation.
Interactive Voice Response (IVR)	A technology system used by telephone service centers that interacts with callers by allowing them to input information using their phone keypad and/or their voice. IVR systems often are used to gather information needed to route the call to the right customer service representative or to provide appropriate pre-recorded information.
Involuntary Termination by Plan	Complaint alleging improper termination of provider contract by insurer.
Jurisdictional	Within the authority of a consumer assistance service center to address or resolve.
Jurisdictional Complaint	Complaint that falls under the authority of the service center to address or resolve.
Language Access	With regards to internal claims and appeals and external review processes and federal health reform requirements to provide relevant notices in a culturally and linguistically appropriate manner, a consumer complaint alleging (1) failure to provide language access or (2) inadequate/improper notice regarding language accessibility.
Language Assistance	Assistance to provide relevant information and services in a culturally and linguistically appropriate manner.
Large Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and sometimes their dependents) through a group health plan maintained by a large employer, unless otherwise provided under state law.
Limited Benefits	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary.
Long Term Care PACE	PACE stands for Program of All-Inclusive Care for the Elderly. PACE is a model of care provided through a DHCS program to coordinate health care, long term care, and other social services to help older adults who would otherwise reside in nursing facilities to remain in their own homes. A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).
Long Term Care SCAN	SCAN stands for Senior Care Action Network. A Medicare Advantage Special Needs Plan provided through a DHCS program to coordinate health care and long term care services for beneficiaries in three counties who are eligible for Medicare and Medi-Cal.
Major Medical	Coverage which, after the limits of coverage have been exhausted under a basic plan, medical expenses relating to room and board, physician fees, miscellaneous expenses such as bandages, operating room expenses, drugs, x-ray, and fluoroscopy, are then met under a major medical plan.

Maternity and Newborn Care	Complaint regarding coverage for expenses arising out of hospital length of stay in connection with childbirth for a mother or her newborn, as described in §146.130 and §148.170 of Title 45.
Medical Exemption Request	A DHCS process for a Medi-Cal beneficiary to request continued medical care from a regular Medi-Cal Fee-for-Service provider who is not a part of a Medi-Cal managed care plan network.
Medi-Cal	California's Medicaid program to provide health coverage to low-income individuals. The Medi-Cal program is administered and overseen by DHCS.
Medi-Cal County Organized Health System (COHS) Model	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the county. In a COHS county, everyone is in the same managed care plan.
Medi-Cal Coordinated Care Initiative (CCI)	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. CCI is a demonstration project in certain counties that promotes coordinated care models where seniors and disabled Medi-Cal beneficiaries receive all benefits in an organized delivery system. It includes medical services, long term support services and behavioral health services.
Medi-Cal Fee for Service	A health care delivery system of the Medi-Cal program. Under this model, providers render services to Medi-Cal beneficiaries and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
Medi-Cal Geographic Managed Care (GMC) Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In GMC counties, DHCS contracts with several commercial plans to provide more choices for beneficiaries. GMC serves Medi-Cal beneficiaries in two counties: Sacramento and San Diego.
Medi-Cal Managed Care	A health care delivery system of the Medi-Cal program. Under managed care models, the Medi-Cal program contracts with managed care plans to provide services to beneficiaries through established networks of organized systems of care.
Medi-Cal Managed Care Imperial Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there are two commercial plans that contract with DHCS. The Imperial model serves Medi-Cal beneficiaries in Imperial County.
Medi-Cal Managed Care San Benito Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this rural Medi-Cal managed care model, there is one commercial plan that contracts with DHCS. Beneficiaries can choose the managed care plan or regular (Fee-for-Service) Medi-Cal. The San Benito Model serves Medi-Cal beneficiaries in San Benito County.
Medi-Cal Managed Care Two Plan Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this Medi-Cal managed care model, DHCS contracts with a local initiative plan (county organized) and a commercial plan. The Two-Plan Model serves Medi-Cal beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medicare	A source of coverage indicating the consumer has Medicare, a federal government health insurance program for people age 65 years and older and for some people with disabilities.
Medicare Advantage	A source of coverage indicating the consumer has a type of Medicare health plan offered by a private company that contracts with Medicare to provide the consumer with his/her Part A and Part B benefits.
Medicare Prescription Drug/Part D	A source of coverage indicating a stand-alone drug plan that adds prescription drug coverage to Original Medicare and some other Medicare plans.
Medicare Supplement	Coverage that provides accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage.
Mental Health	Coverage for professional mental health services. Including psychologist, crisis centers, rehabilitative therapy, etc. An emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addition); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual. (American Psychiatric Association's Diagnostic and Statistical Manual).
Mental Health Parity	With respect to mental health and substance abuse disorder services essential health benefits, including behavioral health treatment services, a complaint regarding improper application of lifetime and annual dollar limits and out of pocket maximums. Mental health parity laws require that health plans and insurers cover benefits for mental health and substance abuse disorders similarly to other health conditions.
Misrepresentation	Complaint alleging that the insurer or representative made misleading or untrue statements about policy terms, benefits, or about insurance during the marketing/sales process.

Mode of Contact	A report data element indicating the communication platform used by a consumer to contact a consumer assistance service center. Examples of modes of contact include telephone, mail, email, chat, and fax.
Multi State	Coverage provided by a health plan that is offered under a contract between the U.S. Office of Personnel Management and the Multi State Plan Program issuer pursuant to section 1334 of the Affordable Care Act and that meets the requirements of Title 45.
No Action Requested/Required	Department of Insurance received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance.
No Jurisdiction	Complaint does not fall under the regulatory authority of the state's Insurance Department, and was not referred to any outside agency, Department or court system. Includes Action Suspended for litigation and/or formal arbitration.
Non-Jurisdictional	Not within the authority of a consumer assistance service center to address or resolve.
Non-Jurisdictional Inquiry/Complaint	A request for assistance to a consumer assistance service center from a consumer who requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.
Nonrenewal	Complaint alleging insurer's failure to (or decision not to) offer policy renewal, and/or insurer's.
Notice Requirements	Consumer complaint alleging non-issuance or improper issuance of notice of grandfathered status and notice of choice of primary care provider.
Other	Indicating a category not fitting into any specific standardized report category.
Other Violation of Insurance Law/Regulation	Complaint about a violation of a provision of law or regulation not specified in another category.
Out of Network Benefits	Complaint regarding dissatisfaction with the administration or determination of benefits on a claim for services that have been requested, received or determined to be out-of-network.
Overturned/Health Plan Position Overturned	Complaint resolved by a regulated entity or individual to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity or individual to be in violation or otherwise at fault.
Participating Provider Availability/Timely Access to Care	Complaint alleging that no in-network provider available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.
Personnel Year	The actual or estimated portion of a position expended for the performance of work. A personnel year is equal to 12 months full-time employment of one person, or 12 persons employed for one month, two persons employed for six months, or any similar combination equal to one personnel year.
Pharmacy Benefits	Complaint regarding coverage for expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician.
Platinum	A Covered California health plan product type. The platinum tier indicates a level of coverage provided by a health plan with 90 percent of the total allowed costs of benefits paid by the health plan.
Policyholder Service	A general complaint classification that includes multiple complaint reason categories associated with a failure by the insurer to provide adequate and/or timely services to the policyholder. Examples of Policyholder Service complaints include abusive service, inaccessible care, failure to send premium-related notices, and delays in responding to a policyholder request for information.
POS (Point of Service)	A POS plan is a kind of managed care health plan. It combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).
PPO (Preferred Provider Organization)	A PPO is a kind of managed care health plan. A PPO has a network of contracted providers but offers its members options to go outside of the network for care. In addition, members can see providers without prior approval from the plan.
Premium & Rating	Complaint regarding a disagreement, inquiry, or question about insurer's premium/rating structure, or manual rules (ratings). Includes complaints alleging that the insurer improperly classified the applicant as a higher risk than it should have, resulting in an improperly high premium.
Premium Notice/Billing	Complaints alleging insurer's failure to send notice regarding premium due date, premium increase/decrease, policy lapse, etc.
Preventive Care	Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, and other health problems. Most health plans must cover certain preventive services at no cost to the plan enrollee. Complaint regarding coverage for expenses arising out of preventive care/wellness services and/or chronic disease management, to include complaints about an insurer's assessment of cost-sharing (improper application of co-payments, deductibles, and co-insurance) for such services.

Product Type	A complaint data element used to identify details about specific areas of coverage, such as the health plan's model, structure, benefits, and/or other distinguishing characteristics. In this report, most product types align with NAIC's Type of Coverage/Accident & Health Second Level codes. Examples of product types include HMO, PPO, Silver, Platinum, Health Only, Dental, and Small Group.
Protocols	Performance standards, policies and procedures, and other system requirements that determine a service center's response to a consumer request for assistance.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Provider Directory	A list of doctors and other providers who participate in a health plan's network. A complaint about a provider directory alleges improper reflection of provider participation status in the insurer's directory (also see Provider Listing Dispute).
Provider Listing Dispute	Complaint alleging improper reflection of provider participation status in insurer's directory.
Quality of Care	Complaint alleging that the health care provided was not appropriate for their health needs or the provider did not possess sufficient competency.
Question of Fact/ Contract/ Provision/Law Fall Outside Regulator	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority of the Insurance Department.
Quick Resolution (QR)	A complaint type reported by DMHC. QR complaints meet DMHC's Urgent Nurse (see Urgent Nurse definition) screening triggers but a DMHC staff review determines that the issues can be resolved without standard complaint or urgent nurse processes. The QR process includes issues such as requests to file a grievance/appeal, expedited review of a grievance/appeal, access to providers, out of network referrals, second opinion consultation, quality of care complaints, or refill of medication(s).
Quick Sort Calculator	A computer application tool used by Covered California's Service Center staff to decide if a caller is likely eligible for Medi-Cal and should be transferred to the county for further assistance.
Race	A demographic data element consisting of categories White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Unknown, and Refused
Referral to Another State's Dept. of Insurance	Complaint falls under the regulatory jurisdiction of another state's insurance department.
Referred to Other Division for Possible Disciplinary Action	Complaint referred elsewhere within regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.
Referred to Outside Agency/Department	Complaint was referred to a different state agency/department.
Refund	A refund was made to the claimant.
Regulator	A government entity with the authority to oversee and enforce health insurance laws and regulations, including those related to licensing, product regulation, financial regulation, and market conduct. California has two state health insurance regulators, the Department of Insurance and the Department of Managed Health Care.
Reporting Entity	For this report, a state health care department or entity that is statutorily required to provide consumer complaint data and other consumer assistance information to the Office of the Patient Advocate (per Health and Safety Code section 136000). Reporting entities are the Department of Managed Health Care, Department of Health Care Services, Department of Insurance, and the Exchange (Covered California).
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Self-Funded/ERISA	Self-funded refers to the coverage purchaser making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses more than those estimated did. ERISA refers to the federal law establishing (a) the rights of pension plan participants, (b) standards for the investment of pension plan benefits, and (c) requirements for the disclosure of plan provisions and funding.

Service Center	Health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers. For this report, service centers refer to those operated or contracted by the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California.
Short Term Limited Duration Policy	A policy that is less than one year in duration and that is not guaranteed renewable.
Silver	A Covered California health plan product type. The Silver tier indicates a level of coverage provided by a health plan with 70 percent of the total allowed costs of benefits paid by the health plan.
Small Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.
Source of Coverage	A complaint data element used to identify a category of a health plan's contracting/purchasing mechanism, which is associated with an insurance market segment and related laws. Examples of coverage sources include Individual/Commercial, Group, Medi-Cal, and COBRA.
Standard Complaint	A complaint type category for complaints that undergo the reporting entity's typical complaint review process. Examples of issues that may be addressed as a Standard Complaint include billing problems, cancellation of coverage, and a provider's attitude. Complaints that are urgent or require the intervention of a health care provider may also be addressed as Standard Complaints.
State Fair Hearing	A formal complaint process to adjudicate appeals from California residents who have applied for, have received, or are currently receiving benefits or service from an assistance program administered by the State of California. The California Department of Social Services is authorized to conduct State Fair Hearings for appeals regarding Covered California applications and eligibility determinations, as well as for all Medi-Cal appeals. A State Fair Hearing is sometimes called a State Hearing, Fair Hearing, or Medi-Cal Fair Hearing.
State Fair Hearing: Informal Resolution	A complaint type used by Covered California that identifies a complaint that went as an appeal to The California Department of Social Services for a State Fair Hearing but was resolved before the State Fair Hearing took place.
State Specific (Other)	Complaint is about a state specific code: regulatory agency will use a further state-specific code to track data needed for a purpose not shared by other states or the NAIC.
Student Health	Coverage provided by a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents.
Summary of Benefits	Complaint regarding the improper issuance or non-issuance of a Summary of Benefits and Coverage/Uniform Glossary.
Unknown	A complaint data category indicating data was not identified. Data listed as Unknown were for fields submitted as Unknown or blank (without data), either because the data was not collected by a reporting entity (CDI, Covered California, DHCS, or DMHC) or because there were complainants who did not provide information to a reporting entity.
Unsatisfactory Refund of Premium	Complaint alleging insurer or their representative failed to properly refund an unearned premium.
Unsatisfactory Settlement/Offer	Complaint that insurer's payment or settlement offer is less than or below the amount expected by the insured or claimant.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Upheld/Covered California Position Substantiated	A complaint result reported by Covered California. See definition for Upheld/Health Plan Position Substantiated.
Urgent Clinical	An expedited complaint resolution protocol for addressing a complaint potentially involving an urgent medical issue or emergency that puts the complainant's health at risk.
Urgent Nurse Complaint	A complaint type reported by DMHC. DMHC's Urgent Nurse process identifies and addresses complaints involving a potential health risk to the complainant and that may need immediate attention and expedited resolution by DMHC clinical staff, who are experienced in both health care and managed care systems.
Usual, Customary, and Reasonable Charges	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. Complaint reason alleging that the insurer's "usual, customary and reasonable" reimbursement amounts are inadequate.
Vision	Health insurance coverage for eye examinations and eyeglasses or contact lens prescriptions.

Waiting Periods	Complaint alleging an insurer's improper application of waiting periods. A "waiting period" is defined as the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of a plan.
Warm Transfer	A process for transferring a call where the customer service representative who initially answered the call dials the referral phone number for the caller, helps to navigate phone system options, and speaks to the other customer service representative prior to completing the call transfer.
Willing Provider	Complaint alleging insurer's failure to comply with a state's any willing provider law.
Withdrawn/Complaint Withdrawn	Complainant requested that the complaint be withdrawn.

Appendix B. Complaint Results

The complaint results in this report are aligned with the NAIC definitions. OPA collaborated with the reporting entities in creating new complaint result categories that better fit their particular complaints.

Complaint Result	NAIC Definitions	Effect on Consumer
Additional Payment	**The party complained against paid more money (i.e. unearned premium, claims payment, cash surrender value) than was initially paid to the policyholder or claimant.**	**Neither Favorable or Unfavorable**
Advised Complainant	**Informed complainant of the state position, company status, agent status, or possible course of action.**	**Neither Favorable or Unfavorable**
Claim Settled	**Claim brought to conclusion, in whole or in part, and no other disposition is appropriate.**	**Neither Favorable or Unfavorable**
Compromise Settlement/Resolution	**Complaint resolved voluntarily by a regulated entity or individual, via additional payment, restored benefit or policy status, and/or other means. No finding by the Insurance Department that the regulated entity or individual was in violation or otherwise at fault.**	**Favorable to Consumer**
Consumer Received Requested Service	**A DMHC complaint result identifying the consumer received the requested service after the complaint was filed.**	**Favorable to Consumer**
Covered CA Position Overturned	**A Covered California complaint result identifying a complaint was resolved by Covered California to ensure compliance with applicable state law/requirement.**	**Favorable to Consumer**
Health Plan in Compliance	**Company's tendencies comply with the state insurance regulations.**	**Favorable to Health Plan**
Insufficient Information	**Complainant failed to provide sufficient information/documentation to warrant further investigation.**	**Neither Favorable or Unfavorable**
No Action Requested/Required	**Department of Insurance received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance.**	**Neither Favorable or Unfavorable**
No Jurisdiction	**Complaint does not fall under the regulatory authority of the state's Insurance Department, and was not referred to any outside agency, Department or court system. Includes Action Suspended for litigation and/or formal arbitration.**	**Neither Favorable or Unfavorable**

Complaint Result	NAIC Definitions	Effect on Consumer
Overturned/Health Plan Position Overturned	Complaint resolved by a regulated entity or individual to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Insurance Department found the regulated entity or individual to be in violation or otherwise at fault.	Favorable to Consumer
Policy Issued/Restored	Coverage was activated, reinstated, evidenced, etc. This may also apply to the reinstatement of a canceled policy with a lapse in coverage.	Favorable to Consumer
Question of Fact	The State Department of Insurance cannot adjudicate the facts. For resolution, a determination must be made by some other entity such as the courts.	Neither Favorable or Unfavorable
Question of Fact/Contract/Provision/Legal Issue	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority of the Insurance Department.	Neither Favorable or Unfavorable
Recovery	A return of money or benefits to the insured/complainant.	Favorable to Consumer
Referred To Other Division For Possible Disciplinary Action	Complaint referred elsewhere within Insurance Department (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.	Favorable to Consumer
Referred to Outside Agency/Department	Complaint referred to other state agency/department.	Neither Favorable or Unfavorable
Unknown	The complaint result was unknown.	Neither Favorable or Unfavorable
Upheld/Covered CA Position Substantiated	The regulated entity or individual upheld its original position, and appears to be in compliance with applicable statutes/regulations.	Favorable to Health Plan
Upheld/Health Plan Position Substantiated	The regulated entity or individual upheld its original position, and appears to be in compliance with applicable statutes/regulations.	Favorable to Health Plan
Withdrawn/Complaint Withdrawn	Complainant requested that the complaint be withdrawn.	Neither Favorable or Unfavorable

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