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 new 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 first annual report and as such it is considered a 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.

This Baseline Review of Health Care Complaint Data catalogs 27,028 consumer health care complaints closed in 2014. Highlights of the report include:

- DMHC plan enrollment of 61,813,050 enrollees submitted 13,994 complaints
- DHCS plan enrollment of 21,376,642 enrollees submitted 4,589 complaints
- CDI plan enrollment of 2,574,181 enrollees submitted 4,079 complaints
- Covered California plan enrollment of 1,395,929 enrollees submitted 4,366 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 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 5 statewide complaint reasons:
  - Claim Denial (18%)
  - Quality of Care (11%)
  - Medical Necessity Denial (10%)
  - Co-pay, Deductible, and Co-Insurance Issues (7%)
  - Dis/enrollment (6%)
- Top 5 statewide complaint results:
  - Compromise Settlement/Resolution (24%)
  - Complaint Withdrawn (19%)
  - Health Plan Position Substantiated (14%)

  - Insufficient Information (9%)
  - Health Plan Position Overturned (7%)
- The range of time to resolve a complaint varied between reporting entities.
  - DMHC 6 – 37 days
  - DHCS 12 – 150 days
  - CDI 21 – 157 days
  - Covered California 39 – 50 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.
- In addition to complaint data, this report includes information submitted by each reporting entity regarding their customer assistance service centers, such as their business hours, staffing, training, protocols, performance standards, overall consumer assistance volumes, average telephone call wait times and call duration. The differences in protocols, procedures, and performance metrics are reflective of the variance in each respective reporting entity's missions and programs.

This inaugural report has identified gaps in data that is due in part to the reporting entities not having previously collected some of the requested data elements. OPA found that performing a comparative analysis across the reporting entities was further limited because the reporting entities did not use common complaint codes and each entity used their own tracking mechanisms. OPA has and will continue to work with each reporting entity to standardize where appropriate the data collection and enable additional analysis in subsequent reports.