

Section 8 – California Department of Insurance

A. Overview

The California Department of Insurance (CDI) oversees more than 1,300 insurance companies and licenses more than 360,000 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.

The CSD is staffed by state employees. Within the CSD:

- The Consumer Communications Bureau (also known as the Hotline) is responsible for managing the CDI toll-free telephone line, resolving consumer complaints that are time-sensitive in nature, responding to inquiries received through the Department's website, and assisting consumers at the public counter.
- The Health Claims Bureau is responsible for investigating complaints regarding the handling of claims by health insurance companies. The Bureau also administers CDI's Independent Medical Review (IMR) Program. If Bureau staff determine that a case meets the criteria for an IMR, a contractor (MAXIMUS) is responsible for conducting the external review and making a decision.
- The Rating and Underwriting Services Bureau is responsible for investigating all consumer rates and underwriting complaints.

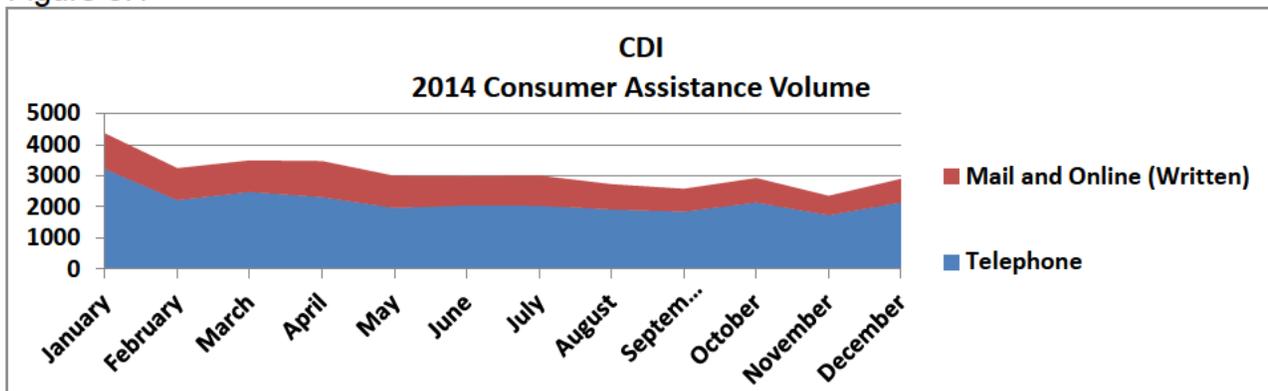
This report only includes CDI's health care coverage complaints, and not those related to other lines of business.

B. CDI Consumer Assistance

Consumer Assistance Volume by Month and Mode of Contact

CDI's service center received 36,986 requests for assistance in 2014, mostly by telephone. The following chart includes the volume of consumer contacts for all requests for assistance, including complaint and inquiry contacts.

Figure 8.1



Service Center Telephone Call Metrics

CDI's service center received 28,314 total telephone calls in 2014, of which 17,862 were related to a health care issue within CDI's jurisdiction. The following table shows the survey response from CDI regarding some of its service center telephone call metrics.

Figure 8.2

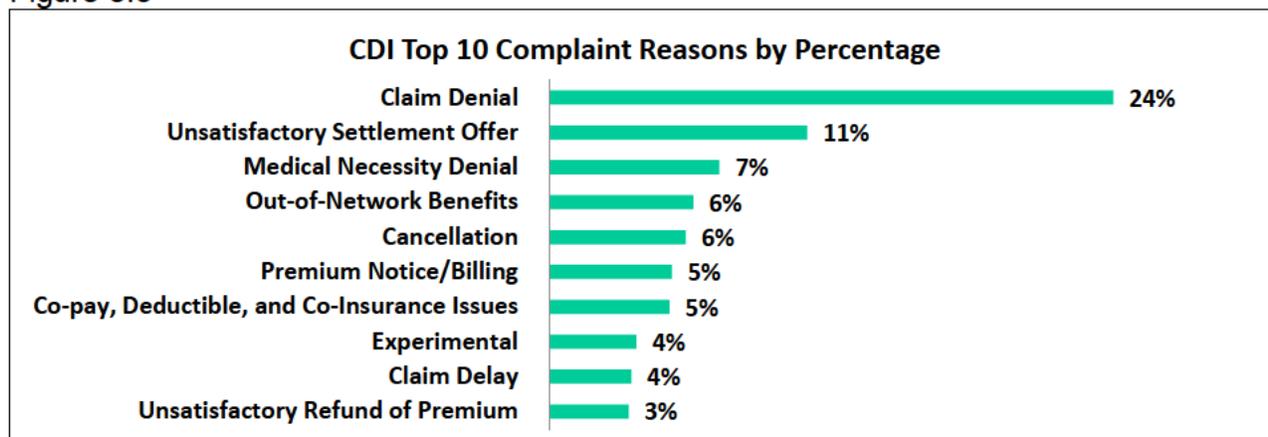
CDI Consumer Services Division - 2014 Telephone Metrics		Reporting Entity Estimated Metric or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	1,177 Introductory message recording filters out calls intended for insurers and provides information to callers that often makes talking to a CSR unnecessary. These are considered abandoned calls.	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,403	Data
Number of non-jurisdictional inquiry calls answered by a CSR	7,872	Data
Average wait time to reach a CSR	0:15	Data
Average length of talk time (time between a CSR answering and completing a call)		
	Jurisdictional complaint: 5:06 (*)	Data
	Non-jurisdictional inquiry: 5:06 (*)	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 10 complaint reasons shown in the following chart account for 75 percent of all complaint reasons associated with the complaint cases closed by CDI in 2014. In the remaining 25 percent of complaint reasons there are 61 complaint reasons.

Figure 8.3



Note: Many consumer complaints involve more than one issue, possibly resulting in higher percentages.

Top Ten Topics for Non-Jurisdictional Inquiries

In 2014, CDI's service center staff answered 7,872 non-jurisdictional calls. CDI's most common referrals include inquiries that were referred to the Department of Managed Health Care, Covered California, and the U.S. Department of Labor (DOL).

Figure 8.4

CDI 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) Centers for Medicare and Medicaid Services (CMS) California Public Employees' Retirement System (CalPERS) Medi-Cal Various Departments of Insurance (DOIs)
2	Copay/Out-of-Pocket Charges	DMHC DOL CMS
3	Out-of-Network Benefits/Usual, Customary, and Reasonable Charges	DMHC
4	Cancellation	Covered California DMHC
5	Enrollment	Covered California CMS DMHC

Figure 8.4 Continued

6	Premium/Billing	DMHC Various DOIs
7	Claim Handling Delays	DMHC DOL CMS Various DOIs
8	Policyholder Service	Covered California DMHC
9	Preventive Care	DMHC DOL Various DOIs
10	Provider Directory	Covered California DMHC

Note: Ranking estimated by CDI.

Consumer Assistance Protocols

The CDI Division of Consumer Services has established protocols and performance standards for providing consumer assistance on jurisdictional complaints and for non-jurisdictional referrals. Information is disseminated to CDI compliance officers through an internal, centralized web-based information repository, staff training, and other tools. Standard complaint and Independent Medical Review processes have time standards established in state statute.

Complaint Protocols

Throughout this report, OPA summarizes complaint protocols based on documentation submitted by the reporting entities. Each reporting entity has different time standards established for completing their complaint review processes, which are determined by applicable statutory and regulatory requirements, as well as internal department policies and procedures. 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. CDI's time standards include an average of 30 days regulatory review period.

Figure 8.5

CDI Complaint Standards			
Complaint Process	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2014
Standard Complaint	<i>Consumer Communications Bureau: Assistance to callers</i> <i>Health Claims Bureau and Rating and Underwriting Services Bureau: Compliance officers respond to written complaints</i> <i>Consumer Law Unit: Legal review (if needed)</i>	30 working days, or 60 days (if reviewed concurrently with health plan level review)	73 days Calculation includes time for regulatory review (average 30 days) after the case is closed to the consumer complainant

Figure 8.5 Continued

Independent Medical Review (IMR)	<i>Consumer Communications Bureau: Assistance to callers</i> <i>Health Claims Bureau: Intake and casework</i> <i>IMR Organization (contractor-MAXIMUS): Case review and decision</i> <i>Consumer Law Unit: Legal review (if needed)</i>	30 working days, or 60 days (if reviewed concurrently with health plan level review)	68 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 <i>IMR Organization (contractor-MAXIMUS): Case review and decision</i>	IMR: 3 days	Not available

Other Protocols

Figure 8.6

CDI Other Protocols		
	Process	Timing (if applicable)
Non-Jurisdictional Referrals	Consumer Communications Bureau compliance officers try to establish jurisdiction during the initial phone contact and make an immediate referral if needed. For calls referred to DMHC (CDI's most common referral), CDI uses a warm transfer to connect the caller to the DMHC Help Center. If jurisdiction cannot be easily determined, compliance officers contact the insurance company to obtain information needed to review a complaint or make an appropriate referral.	As soon as possible after jurisdiction determined and appropriate referral identified
After-Hours Assistance	Interactive Voice Response system allows callers to leave a phone message. Complaints filed online anytime to initiate a Standard Complaint or IMR process.	Voicemails left by consumers returned next business day
Language Assistance	CDI utilizes bilingual staff and a contracted Language Line to provide interpreter services when needed.	CDI connects to the Language Line as needed

C. CDI Complaint Data

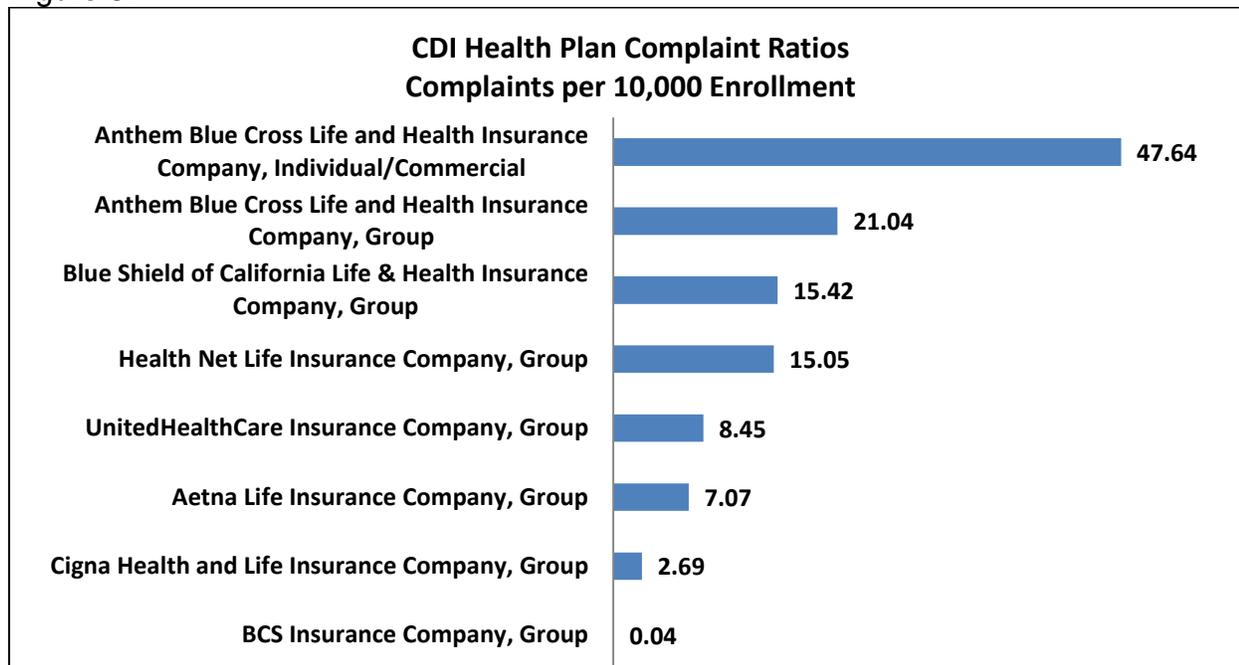
Complaint Ratios

The complaint data ratio is used as a performance indicator to compare health plans. Due to variance in the enrollment size among health plans and health programs in California, a complaint ratio allows for a more equitable comparison between small and large health plans and across programs.

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 by the end of a specific month in the Spring of 2014. This number is standardized by dividing the ratio by 10,000. When comparing plans, a lower number of complaints per 10,000 enrollees in a plan indicate 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.

The following chart shows the complaint ratios for the largest health plans regulated by CDI with 2014 enrollment exceeding 70,000 covered lives. 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 103 plans with at least one complaint from the total of 2,574,574 enrollment. This enrollment number likely includes persons enrolled in multiple plans including dental, mental health, and other plan types.

Figure 8.7



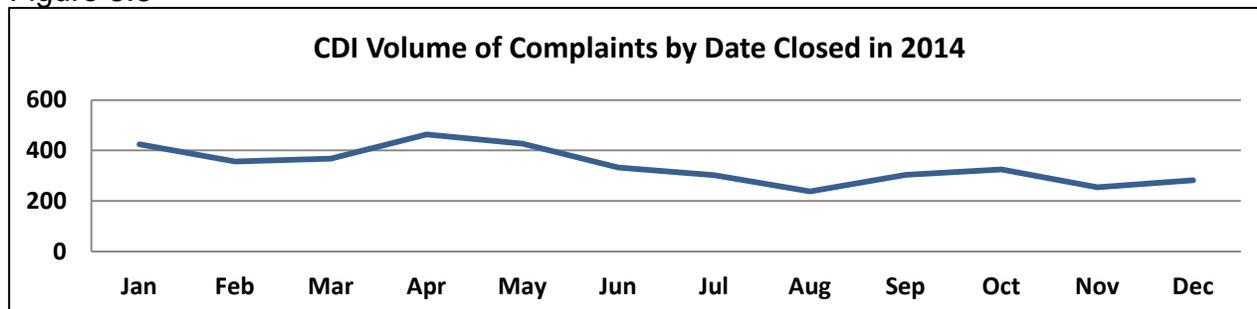
Note: Many consumer complaints involve more than one issue, possibly resulting in higher complaint ratios.

Volume of Closed Complaints

The volume of complaints is the total count of complaints submitted for the year. The below chart displays the total of 4,079 complaints distributed by month for 2014.

This chart reflects the only those cases closed in 2014 and does not include cases opened in previous years if they were closed before 2014 or cases opened in late 2014 but closed in 2015.

Figure 8.8



Resolution Time

The resolution time of complaints by Complaint Type is calculated by subtracting the date complaint opened from the date complaint closed. The averages are displayed in number of days. CDI’s complaint duration period reflects the date from the 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.

Figure 8.9

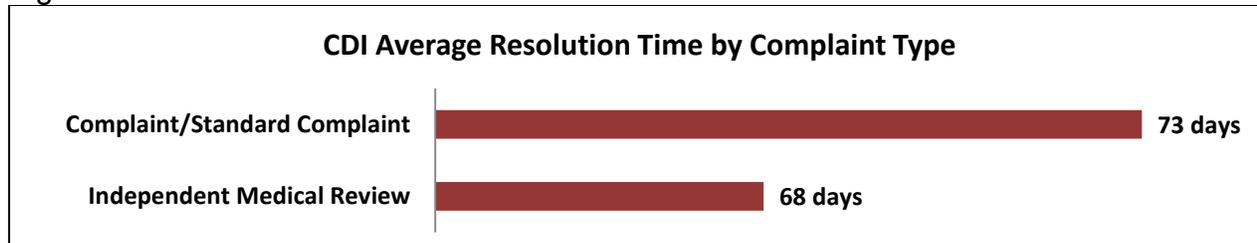
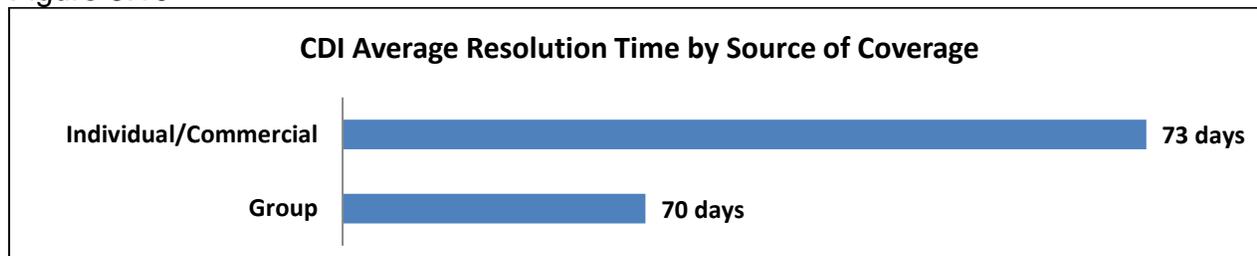


Figure 8.10



Age

The age group “Unknown” accounted for 3,311 complaints submitted. CDI started gathering demographic data in the last quarter of 2014. Therefore, 81 percent of records do not include age data.

The top two Complaint Reasons, Claim Denial and Medical Necessity Denial, were the same across all ages. The Top 3 Complaint Reasons for each age group are as follows:

- Age group Under 18 - 54
 - Claim Denial
 - Medical Necessity Denial
 - Unsatisfactory Settlement Offer
- Age group 55 - 74
 - Claim Denial
 - Medical Necessity Denial
 - Experimental
- Age group Over 74
 - Claim Denial
 - Medical Necessity Denial
 - Premium & Rating

Gender

CDI's demographic data collection started in the last quarter of 2014. Thus, 80 percent (3,278) of the complaint records submitted do not include gender data. Of the 801 Gender identified records submitted with complaint reasons, male and female had the same top three Complaint Reasons:

- 1) Claim Denial
- 2) Medical Necessity Denial
- 3) Unsatisfactory Settlement Offer

Race and Ethnicity

CDI started gathering demographic data in the last quarter of 2014. Therefore, approximately 98 percent of CDI's complaint records for 2014 do not include data for race or ethnicity.

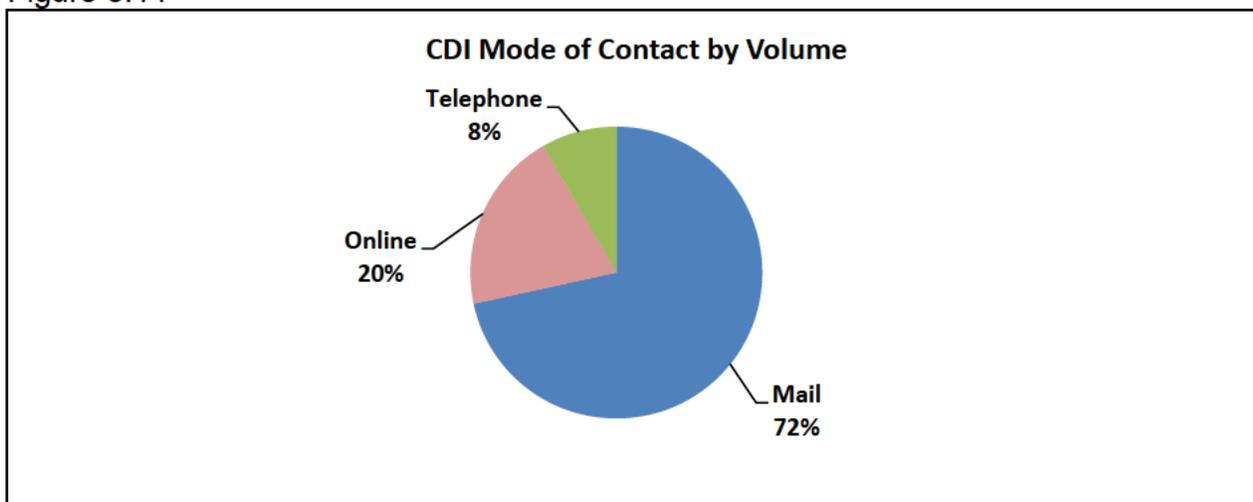
Language

Of the 4,079 complaints submitted, 4,010 did not identify a primary language. For the remaining 69 complaints, English was indicated 46 times, Other was indicated 5 times, and 18 refused to state a language.

Mode of Contact

Of the 4,079 complaints submitted with the Initial Mode of Contact information, consumers most often used mail, followed by online, and telephone.

Figure 8.11



Regulator

Of the 4,079 complaints submitted with regulator information, 99 percent were regulated by CDI while the remaining one percent of the complaints were Unknown.

Source of Coverage

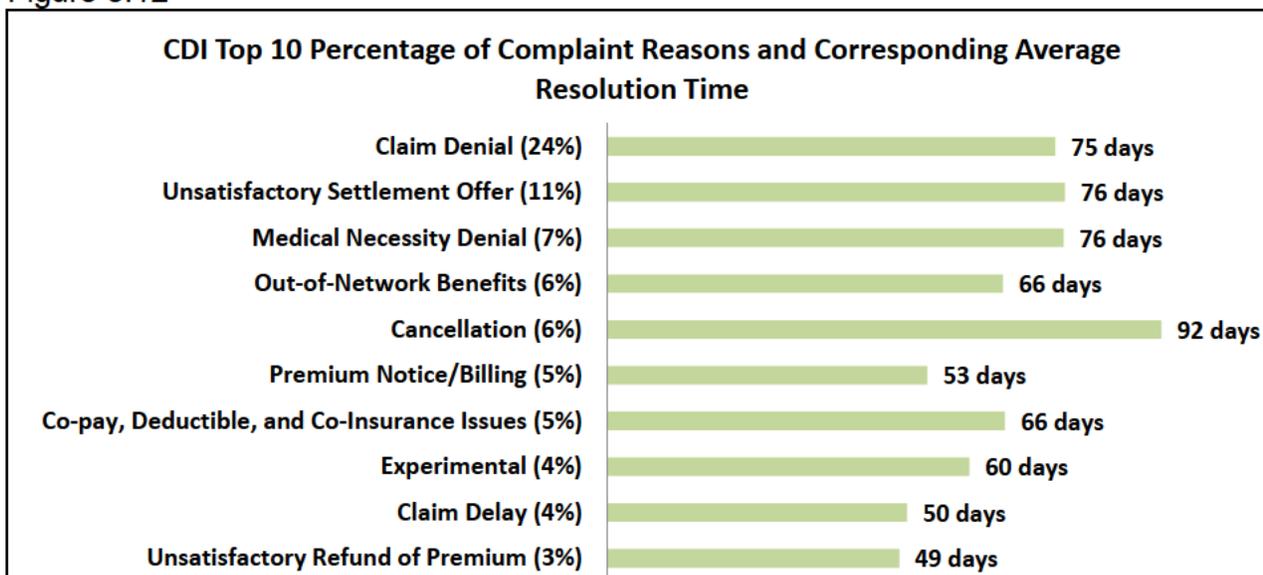
CDI identified two Sources of Coverage: Group and Individual/Commercial. Of the total 4,079 submitted complaints, Group had 2,115 (52%) complaints and Individual/Commercial had 1,964 (48%).

Complaint Reasons

The following chart displays 75 percent of Complaint Reasons submitted by CDI. The chart contains both the type and percentages of the Top 10 Complaint Reasons and the average number of days that CDI took to close those complaints. In the remaining 25 percent of complaint reasons there are 61 complaint reasons.

The 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.

Figure 8.12

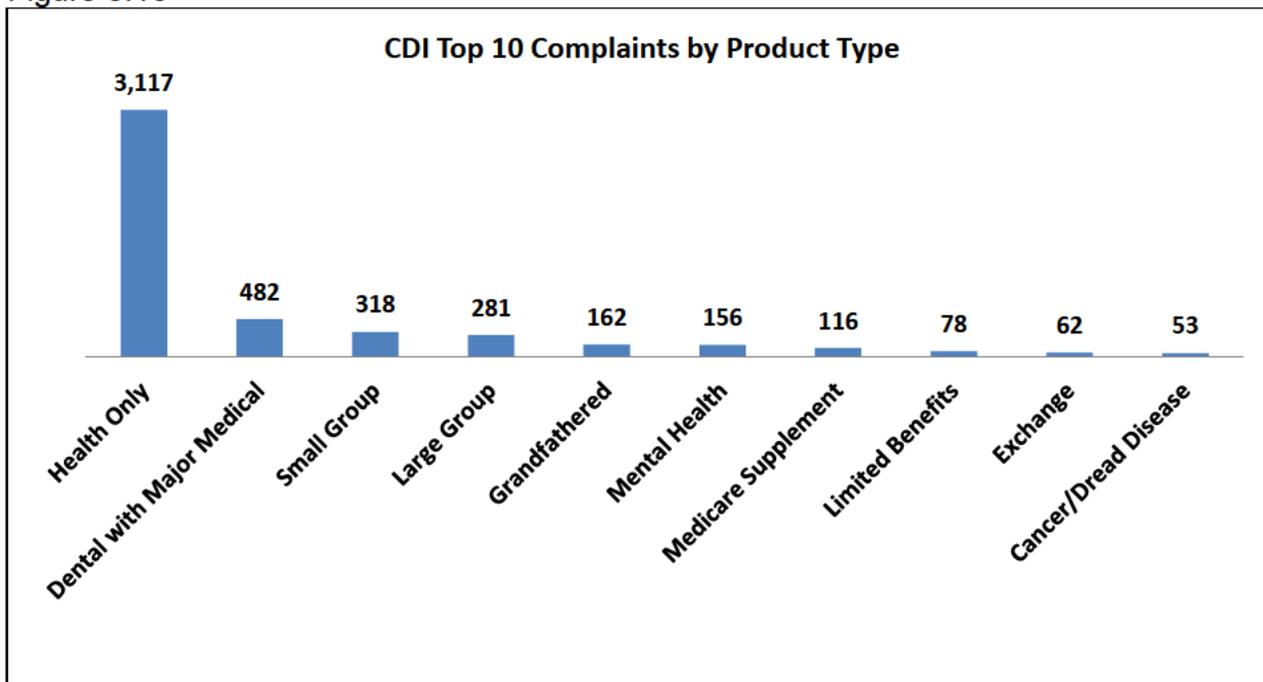


Note: Many consumer complaints involve more than one issue, possibly resulting in higher percentages. CDI complaint duration period reflects the date from initial receipt of complaint to final regulatory review period, which is 30 days on average. Generally, other reporting entities complete regulatory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

Complaint Reasons totaled 5,607 from the 4,079 complaint records submitted. Many consumer complaints involved more than one issue.

The chart below displays the Top 10 Complaints by Product Type.

Figure 8.13



D. CDI Complaint Data Results

The below table shows the 6,043 complaint results submitted by CDI for the 4,079 total complaints. Many consumer complaints include more than one complaint result. The Top 10 total Complaint Result categories constituted approximately 90.6 percent of all submitted Complaint Results. The remainder of 567 complaints, which each have under 2 percent, are not displayed.

Figure 8.14

CDI Top 10 Complaint Results	
Consumer's Money Returned	1,004 (16.61%)
Advised Complainant	402 (6.65%)
Claim Settled	199 (3.29%)
Additional Payment	187 (3.09%)
Compromise Settlement/Resolution	124 (2.05%)
Health Plan in Compliance	442 (7.31%)
Health Plan Position Substantiated	1,651 (27.32%)
Other	271 (4.48%)
Question of Fact/Contract/Law Falls Outside Regulator	1,196 (19.80%)

Note: The Top 10 Complaint Results are displayed above. The remainder of complaint results (2%) and under is not shown.