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](image)

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

<table>
<thead>
<tr>
<th>DMHC Help Center - 2015 Telephone Metrics</th>
<th>Reporting Entity Estimated Metric or Based on Data</th>
</tr>
</thead>
</table>
| **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

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Inquiry Topic</th>
<th>Referred to</th>
</tr>
</thead>
</table>
| 1       | 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

<table>
<thead>
<tr>
<th>DMHC Help Center Complaint Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint Process</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Standard Complaint</strong></td>
</tr>
<tr>
<td><strong>Independent Medical Review (IMR)</strong></td>
</tr>
<tr>
<td><strong>Urgent Clinical</strong></td>
</tr>
<tr>
<td><strong>Quick Resolution</strong></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Complaints per 10,000 Enrollment</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net of California Inc.</td>
<td></td>
<td>8.87</td>
<td>20.15</td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td></td>
<td>11.33</td>
<td>15.38</td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td></td>
<td>12.28</td>
<td>14.69</td>
</tr>
<tr>
<td>AETNA Health of California Inc.</td>
<td></td>
<td>11.89</td>
<td>11.89</td>
</tr>
<tr>
<td>Cigna HealthCare of California Inc.</td>
<td></td>
<td>9.24</td>
<td>11.78</td>
</tr>
<tr>
<td>Care 1st Health Plan</td>
<td></td>
<td>11.62</td>
<td>11.62</td>
</tr>
<tr>
<td>UnitedHealthcare of California</td>
<td></td>
<td>10.88</td>
<td>10.88</td>
</tr>
<tr>
<td>Western Health Advantage</td>
<td></td>
<td>6.99</td>
<td>9.3</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan, Inc.</td>
<td></td>
<td>7.39</td>
<td>4.16</td>
</tr>
<tr>
<td>Sharp Health Plan</td>
<td></td>
<td>3.97</td>
<td>3.97</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Complaint/Standard Complaint</th>
<th>39 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Medical Review</td>
<td>26 days</td>
</tr>
<tr>
<td>Urgent Nurse Case</td>
<td>9 days</td>
</tr>
<tr>
<td>Quick Resolution</td>
<td>6 days</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Average Resolution Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPO</td>
<td>41 days</td>
</tr>
<tr>
<td>PPO</td>
<td>37 days</td>
</tr>
<tr>
<td>Medi-Cal Managed Care</td>
<td>33 days</td>
</tr>
<tr>
<td>HMO</td>
<td>32 days</td>
</tr>
<tr>
<td>POS</td>
<td>28 days</td>
</tr>
<tr>
<td>Medi-Cal Fee for Service</td>
<td>24 days</td>
</tr>
<tr>
<td>Unknown</td>
<td>7 days</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>DMHC Average Resolution Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered California/Exchange</td>
<td>42</td>
</tr>
<tr>
<td>COBRA</td>
<td>42</td>
</tr>
<tr>
<td>Medi-Cal/Medicare</td>
<td>38</td>
</tr>
<tr>
<td>Individual/Commercial</td>
<td>37</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>32</td>
</tr>
<tr>
<td>Group</td>
<td>31</td>
</tr>
<tr>
<td>Unknown</td>
<td>24</td>
</tr>
<tr>
<td>Medicare</td>
<td>21</td>
</tr>
</tbody>
</table>

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 17,737 complaints 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.

![DMHC Mode Of Contact By Volume](Image)

**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.
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.
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).

![DMHC Top 10 Complaint Results](image)

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).
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.