Annual Health Care Complaint Data Report

Report to the Legislature

Measurement Year 2016

STATE OF CALIFORNIA
Edmund G. Brown Jr., Governor

HEALTH AND HUMAN SERVICES AGENCY
Diana S. Dooley, Secretary

OFFICE OF THE PATIENT ADVOCATE
Monisha Avery, Acting 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.

This report is available online at http://www.opa.ca.gov/Documents/ComplaintDataReport-2016Data.pdf
Data tables from this report are available online at http://www.opa.ca.gov/Documents/ComplaintDataTables-2016.pdf

Contents

Section 1 – Executive Summary

The Office of the Patient Advocate (OPA) is required to develop and implement an annual multi-departmental Complaint Data 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).

Both current and prior year reports are available through the OPA website: www.opa.ca.gov/Pages/ComplaintDataReports.aspx.

OPA is statutorily required to collect, analyze, and publicly report health care complaint data through an annual Complaint Data Report. Statute specifies four state reporting entities that are required to provide data: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and California's state-based Health Benefit Exchange (Covered California).

- CDI and DMHC reported complaint data from their respective consumer service center divisions.
- Covered California and DHCS reported complaint data from the California Department of Social Services (CDSS) State Fair Hearings Division.

This third annual Complaint Data Report catalogs 55,923 consumer health care complaints closed in 2016. 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. Enrollment volumes noted below likely include individuals who are counted more than once because they are enrolled in multiple plan types, such as dental, mental health, vision, and other plan types.

- DMHC plan enrollment of 56,062,035 enrollees submitted 25,884 complaints, reflecting an increase of 46 percent from the number of 2015 complaints.
- DHCS program enrollment of 13,656,586 enrollees submitted 6,770 complaints, reflecting an increase of less than one percent (0.4%) from the number of 2015 complaints.
- CDI plan enrollment of 2,041,819 enrollees submitted 2,871 complaints, reflecting a decrease of 11 percent from the number of 2015 complaints.
- Covered California plan enrollment of 1,384,640 enrollees submitted 20,398 complaints, reflecting an increase of 232 percent from the number of 2015 complaints.
    - Most of this growth was due to an increase in informal resolutions, a process through which the consumer’s complaint is resolved by Covered California without a State Fair Hearing taking place.

Top five statewide complaint reasons:

1. Denial of Coverage
2. Cancellation
3. Medical Necessity Denial
4. Experimental/Investigational Denial
5. Eligibility Determination

Top five statewide complaint results:

1. Upheld/Health Plan Position Substantiated
2. Withdrawn/Complaint Withdrawn
3. Compromise Settlement/Resolution
4. Overturned/Health Plan Position Overturned
5. Consumer Received Requested Service

The order of the top results is not directly associated with order of the top reasons. A statewide reason-to-result analysis is not available because many complaint records had multiple reasons and results.

The range of time to resolve a complaint varied between reporting entities.

- DMHC – 0 to 1,298 days (28 days on average)
- DHCS – 0 to 411 days (80 days on average)
- CDI – 0 to 669 days (90 days on average)
- Covered California – 0 to 262 days (66 days on average)

This year's report includes new displays, including complaint reason-to-results analysis when feasible as well as new Covered California health plan complaint ratios.

OPA and the reporting entities continue to work to make improvements to standardize the data with fewer unknown data elements. Some of the differences between measurement years may be due to changes in data collection and reporting rather than actual differences in incidence or performance. In addition, differences in complaint systems make direct comparison between the reporting entities inexact for many complaint categories. Because of variances in data collection, analyses about many of the data elements are reported in the respective sections about each reporting entity, rather than aggregated statewide.

Section 2 – Background and Methodology

OPA is statutorily charged under the California Health and Safety Code §136000 with implementation of a multi-departmental complaint data reporting initiative. OPA is required to annually report health care complaint data and related consumer assistance information from four state entities – 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 made enhancements to report displays and features, including:

- Improvements to current and prior report publications' accessibility features for people using screen readers and other assistive technology. OPA consulted with Department of Rehabilitation staff on best practices for improving accessibility.
- Reorganized report subsections to group similar data categories.
- New reason-to-results analysis of DMHC and Covered California data.
- New Covered California health plan complaint ratios based on DMHC data.
- Updated displays to align with data re-categorizations requested by DHCS for 2015 to designate Managed Care and Fee-for-Service under the "product type" category rather than "source of coverage."
- Additional documents available on the OPA website to provide the report data tables and expanded information on methodology.

Reporting entities continue to show improvement in data collection and reporting.

- Three reporting entities continued to improve reporting for demographic categories. Both DHCS and CDI had higher percentages of complaints with race, ethnicity, and primary language identified. DMHC reported data on race for the first time in 2016 and improved categorizations of its ethnicity data.
- DHCS reported a small number of complaints from new internal sources of State Fair Hearings data.

Methodology and Data Elements

This third year Complaint Data Report evaluates health care complaints closed January through December 2016 and other information collected from four state reporting entities about their service centers' 2016 consumer assistance activities. For some categories, OPA also displays data from the 2014 and 2015 measurement years. The four reporting entities (DMHC, DHCS, CDI, and Covered California) provided OPA with non-aggregated complaint data for the three measurement years included in this report. These entities provided their complaint records through a biannual data submission process using standard data categories and elements. Overall consumer assistance volumes, protocols details, and other service center information were reported by the

entities through an annual supplemental survey. The 2016 complaint types submitted were:

- **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)]
- **CDI** – Standard Complaints and Independent Medical Reviews
- **Covered California** – State Fair Hearings (conducted by CDSS) and State Fair Hearings: Informal Resolution (referred by CDSS for resolution by Covered California without a hearing)

In order to provide a more equitable comparison of health plans of various sizes, OPA calculated health plan complaint ratios by taking the number of closed complaints associated with a health plan and dividing it by the number of covered lives the plan had in 2016. A higher complaint ratio indicates more complaints per member.

OPA obtained enrollment from the reporting entities for the health plans licensed or overseen by each entity. Changes to methodologies continue to be made to better align with reporting entities' usual collection and reporting processes. Due to timing and other reporting methodology differences, enrollment figures may not be comparable from year to year.

- For 2016, same as the prior year, DMHC and CDI provided December enrollment data and DHCS and Covered California provided March enrollment data.
- The DMHC 2016 methodology changed to only include County Organized Health System (COHS) Medi-Cal lives licensed with the department, which is through one COHS plan. All plans' COHS enrollments were included in prior year reports.

Data elements that appear in this report are defined in the Glossary in Appendix A. The elements were largely based on the National Association of Insurance Commissioners' complaint coding, with adjustments and additions to better align with state reporting entity programs. Additional information about the report methodology is available on the OPA website's Complaint Page at www.opa.ca.gov/Pages/AbouttheComplaintDataReports.aspx.

Additional Guidance about the Complaint Data Analysis

The differences in complaint systems remain an ongoing challenge for meaningful analysis of health care complaint data across reporting entities. OPA and the reporting entities continue to collaborate to standardize and enhance reporting. Although potentially indicative of systemic and emerging issues, the data presented in this report may provide an imperfect comparison between measurement years, reporting entities, coverage types, and similar categories. OPA's analysis of many data categories remain in separate reporting entity sections rather than aggregated statewide due to complaint system differences. These differences also are important to keep in mind when considering information shown in some statewide section displays.

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 serve millions of Californians each year through health care coverage and regulatory oversight programs. These entities provided to OPA data about health care complaints and other information about their consumer assistance service centers, which are the help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by the entity.

This Statewide Complaint Data section provides an overview of the complaints reported to OPA for measurement year 2016. Sections 4-7 have additional information on the individual reporting entities.

It is important to note that the complaints reported by each entity differ significantly due to variances in entity functions, complaint systems, and data availability. OPA urges caution about drawing conclusions when comparing complaint numbers across entities and coverage sources.

- Covered California reported formal and informal State Fair Hearings data that included all aspects of its eligibility determinations and enrollment activities. Health care delivery complaints about Covered California health plans were reported by DMHC.
- DHCS reported formal State Fair Hearings data that included health care delivery complaints about Medi-Cal, such as claim denials. DMHC also reported health care delivery complaints regarding Medi-Cal Managed Care plans. Most Medi-Cal complaints about eligibility determinations and enrollment issues are addressed at the county level rather than through a State Fair Hearing.
- DMHC included non-jurisdictional complaints it addressed within its reported complaint dataset, while CDI reported all non-jurisdictional complaints it addressed within the inquiry data category.

The following table displays data for each reporting entity for the:

- Volume of consumer complaints closed in 2016 (complaint reviews completed by the entity or its associated complaint review program),
- Number of health plans with at least one complaint closed in 2016 among the entity data reported, and
- Total enrollment in health coverage overseen by the entity.

Figure 3.1

2016 Reporting Entity Complaints, Plans, and Enrollment

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

Note: Due to differences in timing and reporting methodologies, the data in this table may not correspond to data published by the departments in other reports. In addition, direct comparisons across reporting entities are imprecise due to variances in department functions, complaint systems, and data availability.

Enrollment volumes noted above likely include individuals who are counted more than once because they are enrolled in multiple plan types, such as dental, vision, and other plan types. Due to timing and other methodology differences, some of the figures reported above are not comparable between entities or with prior measurement years.

- The DMHC enrollment figure for December 2016 consists of enrollment in full-service and specialty health plans regulated by the department. This figure includes Medi-Cal enrollment for managed care plans that license their Medi-Cal lives with the department, including the Medi-Cal lives for one County Organized Health System (COHS) plan. Prior reports counted all COHS plans' Medi-Cal enrollment.
- Among the DHCS contracted managed care plans, there were 87 health plan service areas out of 103 with at least one complaint in 2016. The DHCS enrollment figure is for March 2016 Medi-Cal enrollment, which includes 10,558,269 beneficiaries in managed care and 3,098,317 in fee-for-service.
- The CDI enrollment figure for December 2016 includes covered lives for major medical plans, limited benefit (mini-med only) plans, and student health plans.
- Covered California's complaints do not have associated health plans reported. Its enrollment from March 2016 excludes individuals who had not paid for coverage.

B. Statewide Consumer Assistance Centers

The following table provides information about the DMHC, DHCS, CDI, and Covered California service centers that reported 2016 consumer assistance data.

Figure 3.2

Consumer Assistance Service Centers by Reporting Entity

DMHC 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

DMHC Website (www.healthhelp.ca.gov)

DHCS Medi-Cal Managed Care Office of the Ombudsman

Main Phone Number	1-888-452-8609
TTY / TDD Line	California Relay Service (711)
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. (except state holidays)

Managed Care Ombudsman Webpage (www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx)
Mental Health Ombudsman Webpage (www.dhcs.ca.gov/services/MH/Pages/MH-Ombudsman.aspx)

DHCS Mental Health Ombudsman

The Mental Health Ombudsman merged with the Medi-Cal Managed Care Office of the Ombudsman in February 2017. See the listing above.

DHCS Medi-Cal Telephone Service Center (Contractor: Conduent as of 2017)

Main Phone Number	1-800-541-5555 (fee-for-service beneficiary and provider assistance)
TTY / TDD Line	916-635-6491
Days/Hours Open	Monday - Friday, 8:00 a.m. to 5:00 p.m. Extended hours for provider technical assistance

DHCS Medi-Cal Website (www.medi-cal.ca.gov)

DHCS 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

DHCS Denti-Cal Website (www.denti-cal.ca.gov)

CDI 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 (calls returned by noon the next business day)

CDI Website (www.insurance.ca.gov)

Covered California Service Center (Rancho Cordova, Fresno, and Faneuil Service Centers)

Main Phone Number	1-800-300-1506
TTY / TDD Line	1-888-889-4500
Other Phone Lines	العربية (Arabic): (800) 826-6317 中文 (Chinese): (800) 300-1533 Hmoob (Hmong): (800) 771-2156 한국어 (Korean): (800) 738-9116 ру́сский (Russian): (800) 778-7695 Tagalog (Filipino): (800) 983-8816 Հայերեն (Armenian): (800) 996-1009 فارسی (Farsi): (800) 921-8879 Khmer: (800) 906-8528 Lao: (800) 357-7976 Español (Spanish): (800) 300-0213

Tiếng Việt (Vietnamese): (800) 652-9528

Days/Hours Open Monday - Friday, 8:00 a.m. to 6:00 p.m. (except state holidays)

Covered California Website (www.coveredca.com)

2016 Consumer Assistance Volumes

The reporting entity service centers that provided data to OPA received 7.64 million requests for assistance from consumers in 2016, an eight percent increase over the prior year. Requests for assistance encompass the total volume of consumer contacts. The vast majority of the requests for assistance were not to initiate a formal complaint, but were inquiries from consumers who required education, referrals, or other assistance.

Figure 3.3

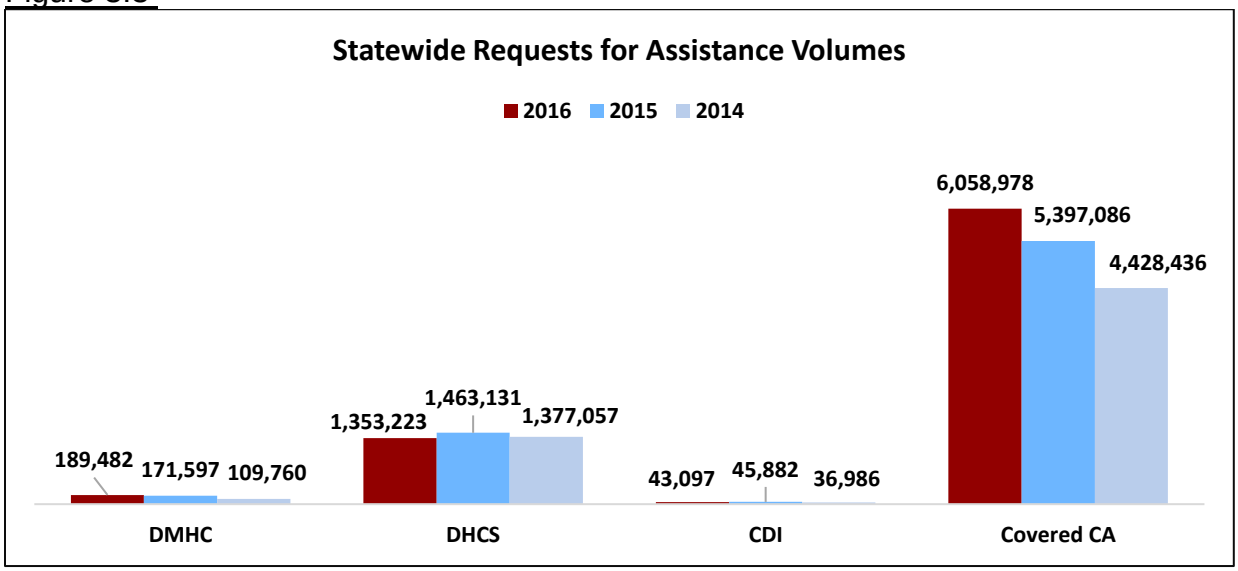
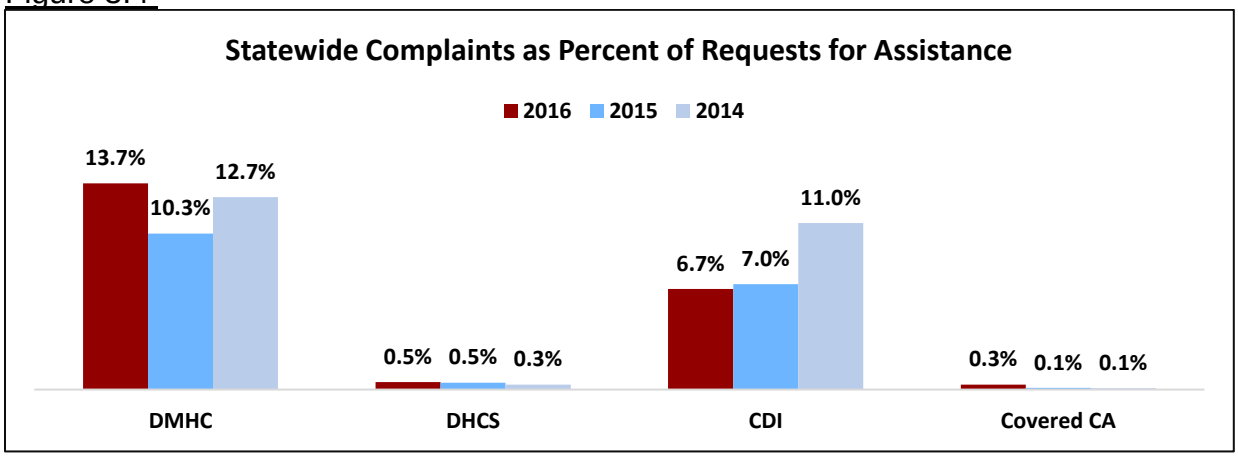


Figure 3.4



Service Center Protocols

The reporting entities' service centers provided information about their protocols for handling consumer requests for assistance for the 2014 Baseline Report and submitted updates for 2015 and 2016. Updates to service center systems are highlighted in Sections 4 – 7. Unless otherwise noted, service center descriptions outlined in prior reports are still applicable. Protocols information from prior reports are available online at www.opa.ca.gov/Pages/ComplaintDataReports.aspx.

- Most service centers did not report significant changes in protocols or service center systems for 2016.
- DHCS reported that the Mental Health Ombudsman unit merged with the Medi-Cal Managed Care Office of the Ombudsman in early 2017.

C. Statewide Health Care Complaint Data

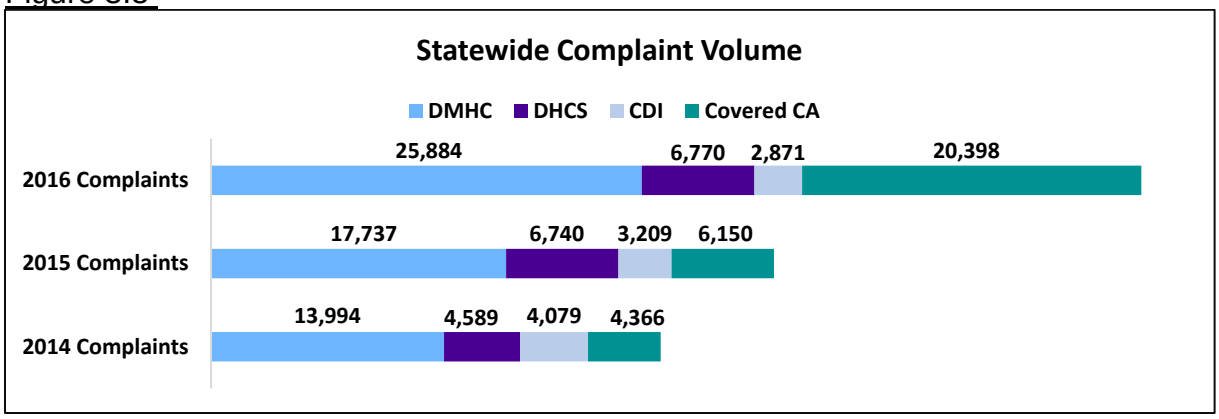
The four reporting entities submitted 55,923 consumer complaints to OPA for Measurement Year 2016, a 65 percent increase in statewide complaint volume over the previous year (33,836 complaints in 2015).

- DMHC reported 46 percent of the 2016 complaints. Covered California and DHCS accounted for 37 percent and 12 percent of the statewide complaint total, respectively. CDI reported five percent of the 2016 complaints.
- The complaint data was reported on 36 different product types, reflecting the different commercial and public health care coverage products overseen by the reporting entities.
- The complaint type of Standard Complaint accounted for the most complaints (33%), followed by State Fair Hearing: Informal Resolution (26%), State Fair Hearing (22%), Independent Medical Review (17%), Quick Resolution (1%), and Urgent Nurse Case (0.2%).

Volume of Closed Complaints

The chart below displays the breakdown of the annual statewide complaint volume for three measurement years. In addition to the 55,923 complaints reported for 2016, the chart shows the 2015 statewide volume of 33,836 and the 2014 statewide volume of 27,028.

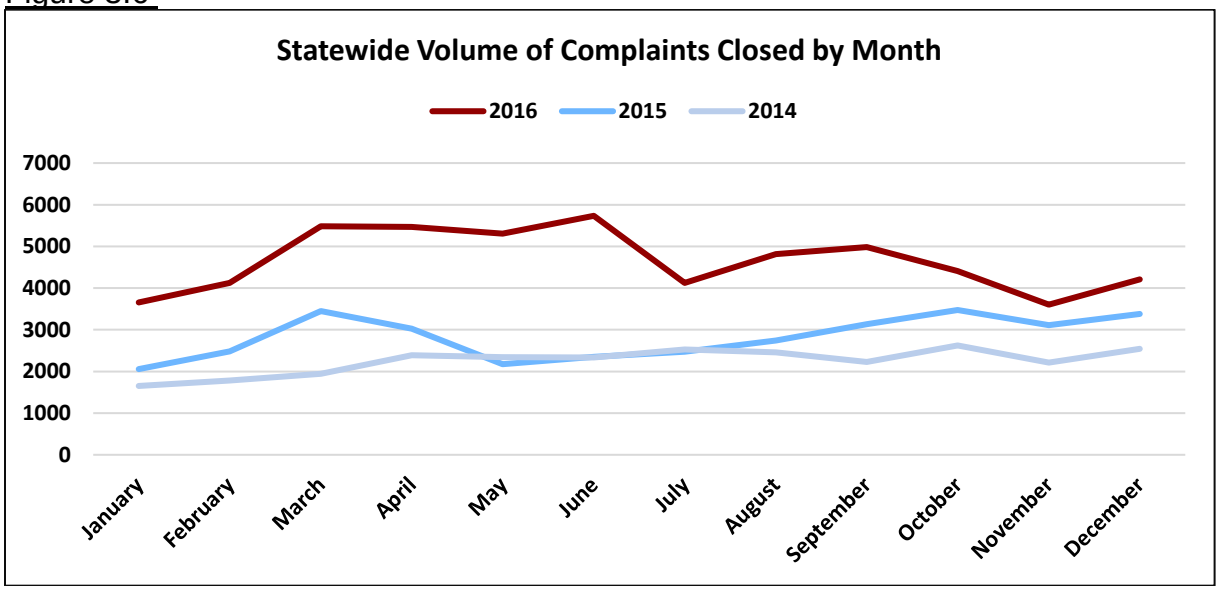
Figure 3.5



Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution.

The following chart compares monthly statewide complaint volumes over three years. The monthly volume was determined by the date the complaints closed.

Figure 3.6

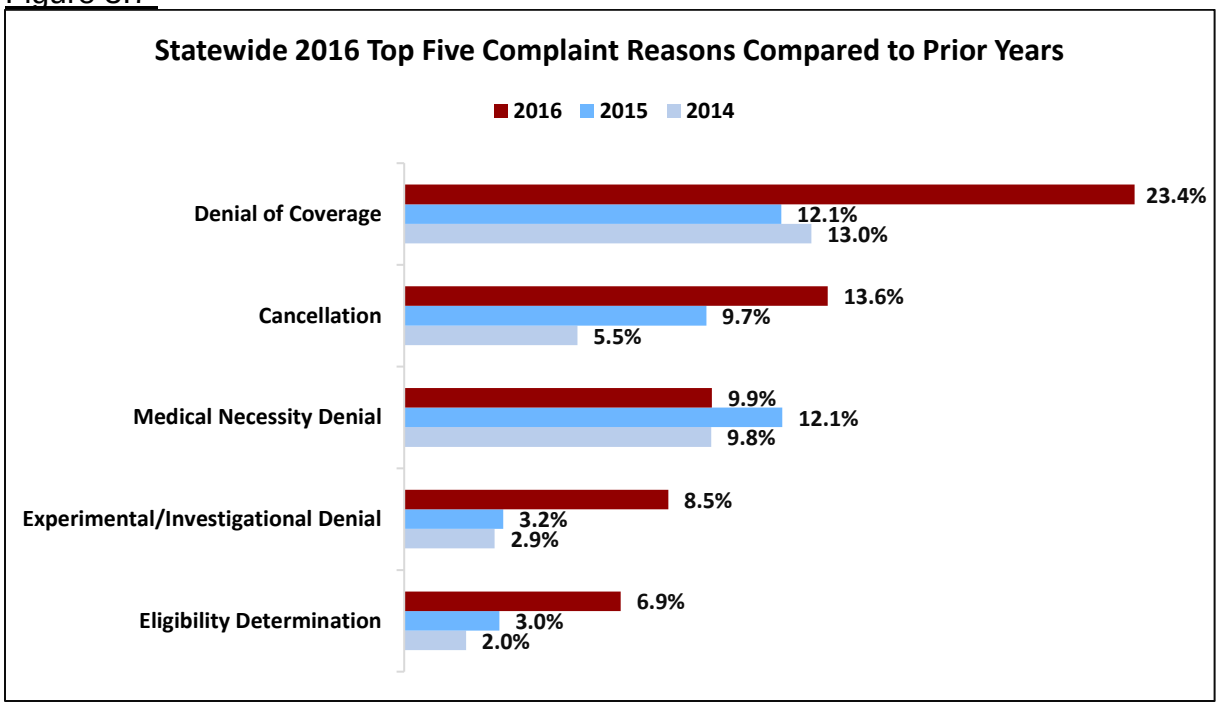


Complaint Reasons

The following chart displays the most common complaint reasons reported statewide for 2016, along with the 2014 and 2015 data for those same complaint reason categories.

The top five complaint reasons shown in the chart account for 62 percent (35,715) of all complaint reasons submitted in 2016. The other 38 percent not displayed were reported among 86 different complaint reason categories. The total number of complaint reasons (57,446) exceeded the number of complaints (55,923) in 2016 because some complaints had multiple reasons reported.

Figure 3.7



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

Some of the differences between measurement years may be due to changes in data collection and reporting, rather than changes in incidence. For example, Covered California began reporting data regarding the complaint type State Fair Hearing: Informal Resolution in 2015. This complaint type accounted for a larger portion of the overall statewide complaint volume in 2016 (26%) than in 2015 (13%), which contributed to increased rankings for three associated complaint reasons (Denial of Coverage, Cancellation, and Eligibility Determination).

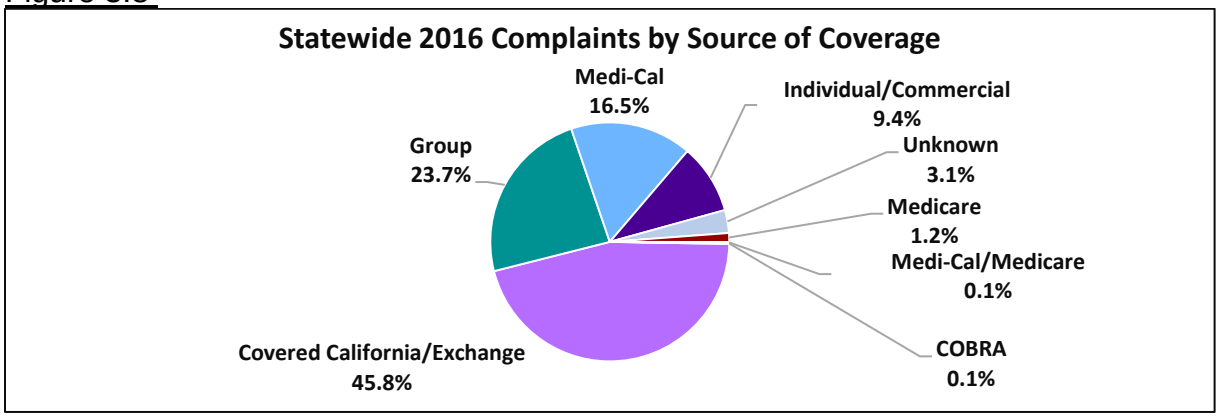
- Covered California's State Fair Hearing: Informal Resolutions accounted for nearly three-fourths of the statewide complaints regarding Denial of Coverage and Eligibility Determination.
    - Denial of Coverage became the top statewide complaint reason in 2016 (second most common in 2015).
    - Eligibility Determination experienced a 267 percent increase in statewide volume from the prior year to become the fifth most common reason in 2016 (ranked 13th in 2015).
- Cancellation increased in ranking from third to second most common reason in 2016, with a 126 percent increase in statewide volume over the prior year.
    - DMHC reviewed most of the Cancellation complaints (60% of the statewide volume).
    - Over one-fourth (26%) of the Cancellation complaints were Covered California's State Fair Hearing: Informal Resolutions.

- Medical Necessity Denial dropped from the top complaint ranking to the third most common reason in 2016, despite a 32 percent increase in volume from the prior year.
- Experimental/Investigational Denial increased in ranking to become the fourth most common reason reported in 2016, with a 330 percent increase in volume over the prior year (ranked 12th in 2015).
    - DMHC noted that its increase in Experimental/Investigational Denial complaints largely involved health plan denials of Digital Breast Tomosynthesis (a three-dimensional mammogram).
- Pharmacy Benefits dropped from fourth in 2015 to become the tenth most common reason in 2016.
    - A reporting change contributed to the increase between 2014 and 2015 for this complaint reason. DHCS re-categorized some complaints previously reported under Quality of Care into Pharmacy Benefits and other more distinct categories.
- Co-Pay, Deductible, and Co-Insurance Issues dropped from fifth in 2015 to the sixth most common reason in 2016.

Source of Coverage

The following chart displays the distribution of source of coverage of the 55,923 complaints submitted by the four reporting entities for 2016.

Figure 3.8



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

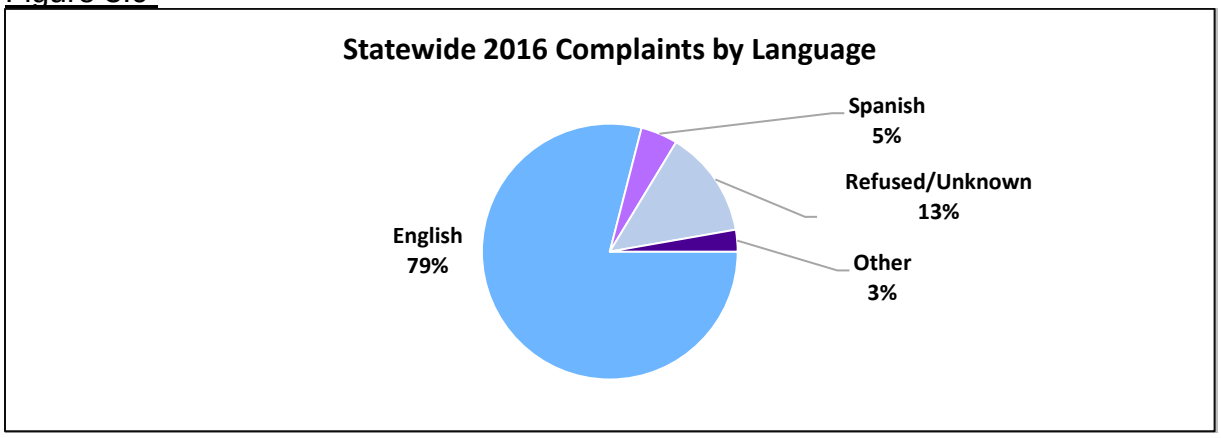
- The commercial source of coverage categories had a combined volume of 18,542 complaints submitted by the DMHC and CDI.
    - DMHC reviewed most (86%) of the 13,260 Group complaints.
    - Nearly one-fifth of the 5,282 Individual/Commercial complaints were reviewed by CDI.
- Over half (57%) of the 25,604 statewide Covered California/Exchange complaints were informal resolutions of State Fair Hearings. Approximately one-fifth were DMHC-reviewed complaints. The rest (22%) were resolved through the full State Fair Hearing process.

- Most of the 9,223 statewide Medi-Cal complaints were State Fair Hearings submitted by DHCS. Over one-fourth (27%) were resolved by DMHC.
- DMHC submitted all of the Unknown, COBRA, and Medicare complaints and most (85%) of the Medi-Cal/Medicare complaints.

Language

The following chart displays the percentage of statewide complaints by the primary language of the complainant. A greater percentage of complaints had a primary language identified in 2016 than the prior year (18% Refused/Unknown in 2015).

Figure 3.9



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

Figure 3.10 compares the top complaint reasons by the primary language identified for the complainant. The percentage shown is the distribution among the complaint reason total for the specified language category.

The number of complaint reasons exceeds the number of complaints because some complaints had more than one reason.

The statewide complaint volumes by language category:

- English - 44,400 complaints (79%) with 45,387 reasons
- Spanish - 2,665 complaints (5%) with 2,681 reasons
- Other languages - 1,543 complaints (3%) with 1,579 reasons
- Refused/Unknown - 7,315 complaints (13%) with 7,799 reasons

Figure 3.10

Statewide 2016 Top Five Complaint Reasons by Primary Language

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

Product Type

The four reporting entities submitted complaints involving 36 product type categories, which span the different health plan models, delivery systems, and other characteristics of the coverage overseen by each entity. Additional information about product types can be found in individual reporting entity Sections 4 – 7.

- Most of DMHC's complaint reviews continue to involve the HMO product type (60% of DMHC complaints). DMHC reported complaints for five product type categories.
- Medi-Cal Managed Care continued to be DHCS's most commonly identified product type (42% of DHCS complaints). DHCS reported complaints for seven product type categories, including the new category of Long Term Care. DHCS requested the new Long Term Care category and was the only entity to report this product type.
- CDI's most commonly reported product type was Large Group (29%). CDI submitted complaints for 24 product type categories.
- Covered California's top known product type continued to be Silver (38% of its complaints, behind Unknown with 42%). Covered California reported complaints for six product type categories.

The range of product types identified for the 2016 complaints was similar to prior years.

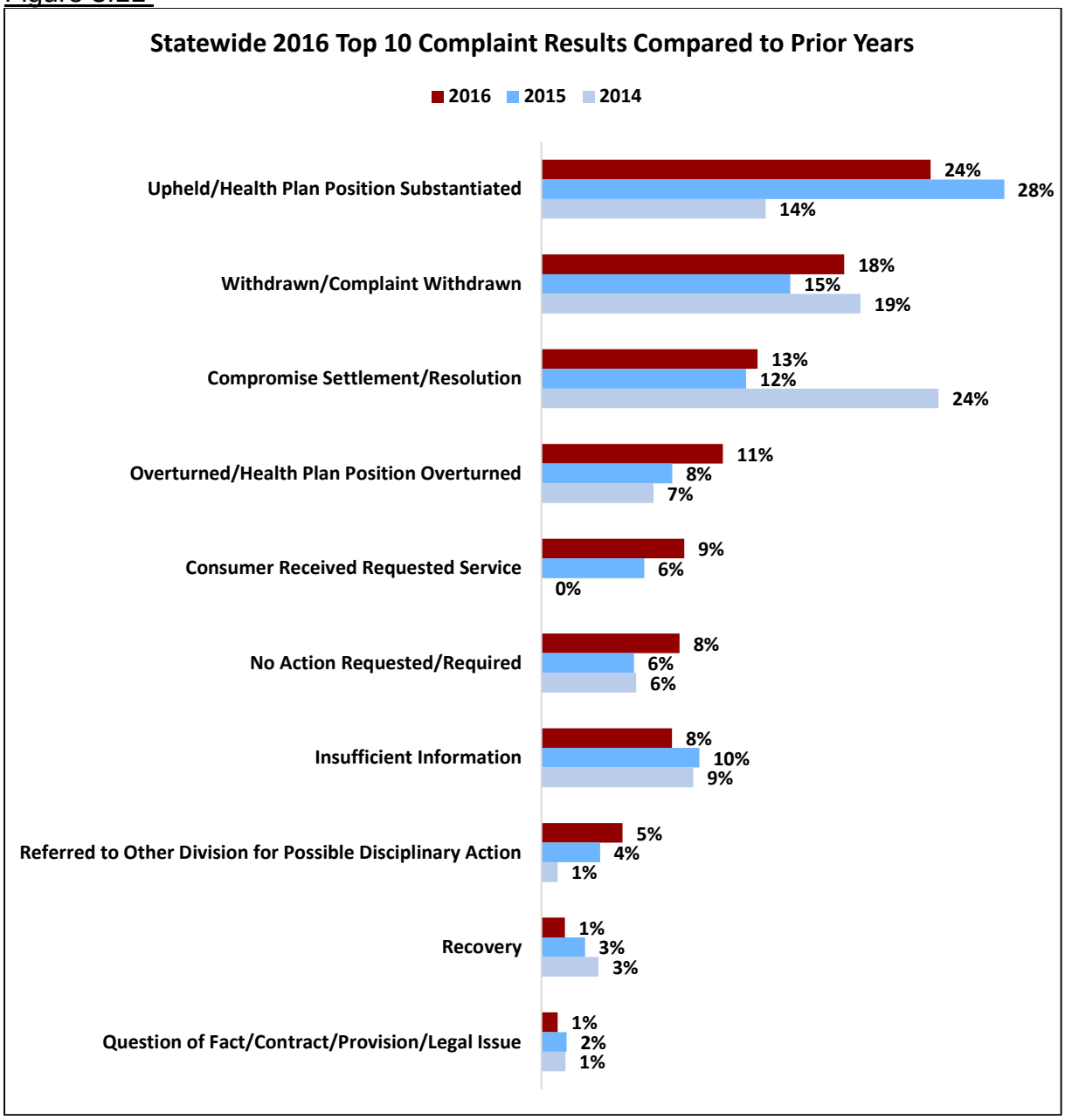
Results

The following chart displays the most common results of complaint reviews closed in 2016, as well as the 2014 and 2015 data for the same complaint results categories. The top ten results categories account for 98 percent of the 2016 statewide results.

For 2016, the reporting entities submitted 55,923 complaints with 61,766 results among 27 different complaint results categories. The number of results exceeds the number of complaints because some complaints had multiple results reported.

Some of the differences between measurement years may be due to changes in data collection and reporting. For example, the complaint reason category Consumer Received Requested Service was first reported in 2015.

Figure 3.11



Resolution Time

The statewide average time to resolve a consumer health care complaint was 51 days. Resolution times are counted from the day a reporting entity opened a complaint from a consumer until the day the reporting entity closed the case.

It is important to note that meaningful conclusions about performance cannot be drawn when comparing entity resolution times due to the array of differences in complaint review requirements and protocols, time standards, and complaint tracking procedures. These differences may affect the timing of open or close dates and overall complaint duration. A longer duration may be due to:

- More complex complaint review requirements to fulfill prior to issuing a decision and closing the complaint.
- A close date determined at a later point after additional oversight activities are completed rather than when the consumer is notified about the decision. For example, CDI closes complaints at the end of its final regulatory investigation period.
- The acceptance of complaints from consumers at an earlier stage in an overall health plan complaint process, which may require more time for gathering initial information pertinent to a complaint review. For example, consumers are able to submit a complaint to CDI concurrent with their insurer's internal review period. DHCS beneficiaries have been able to request a State Fair Hearing at any time, including before their health plan has reviewed the complaint.

The following table displays the minimum, maximum, and average number of days each reporting entity took to resolve complaints in 2016. All entities reported at least one complaint that was resolved on the same day the consumer initiated the complaint (displayed in the table as zero days).

Figure 3.12
Resolution Times by Reporting Entity

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

Figure 3.13 shows the statewide average resolution time for each complaint type.

- The CDSS State Fair Hearing calculation includes complaints submitted by DHCS and Covered California.
- The Complaint/Standard Complaint and Independent Medical Review categories include data from the two regulators, DMHC and CDI.
- The CDSS State Fair Hearing: Informal Resolution category reflects only Covered California's complaints.
- The Urgent Nurse Case and Quick Resolution categories reflect only DMHC's complaints.

Figure 3.13

Statewide 2016 Average Resolution Time by Complaint Type

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

Section 4 – Department of Managed Health Care

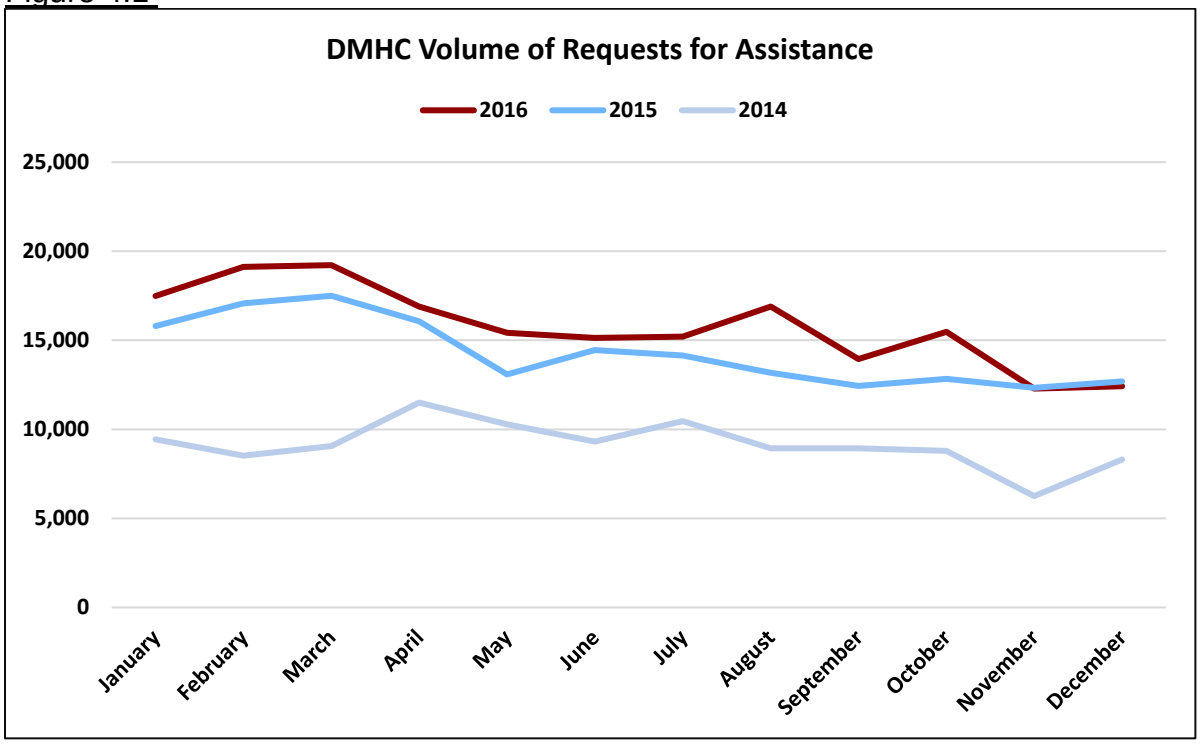
A. Overview

The Department of Managed Health Care (DMHC) regulates 96 percent of enrollment in 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 care enrollees receive the medical care and services to which they are entitled.

The DMHC Help Center received 189,482 requests for assistance from consumers in 2016, a ten percent increase in volume from the prior year. Requests for assistance include jurisdictional and non-jurisdictional complaints and inquiries.

The following chart compares DMHC's consumer assistance volumes by month for three reporting years.

Figure 4.1

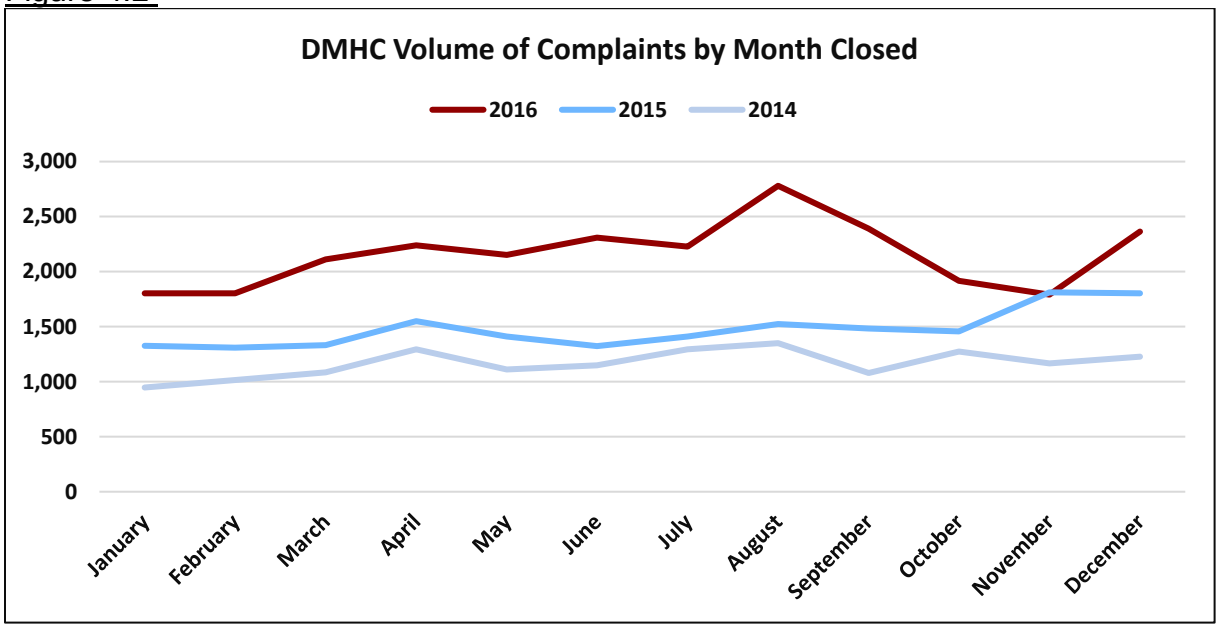


Note: This chart displays the DMHC Help Center's 2014, 2015, and 2016 consumer assistance volumes by month. The Help Center received 189,482 requests for assistance in 2016, 171,597 in 2015, and 109,760 in 2014.

DMHC reported 25,884 complaints in 2016, a 46 percent increase in volume over the prior year (17,737 complaints). DMHC indicated that this volume increase is a continuation of a multi-year trend, but can be attributed in part to increased stakeholder engagement.

The following chart compares the complaint volumes across a three-year period distributed by the month the complaint closed.

Figure 4.2



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

Complaint Type Overview

Most of DMHC's 25,884 complaints reviewed in 2016 were the complaint type of Standard Complaint (64.4%), followed by Independent Medical Review (32.3%), Quick Resolution (2.9%), and Urgent Nurse Case (0.4%)

- Complaints that qualify for an Independent Medical Review (IMR) involve disputes about the medical necessity of a treatment, an experimental or investigational therapy for a medical condition, or a denial related to emergency or urgent medical services.
- All other issues are typically reviewed by DMHC as a Standard Complaint.
- DMHC reviews urgent clinical issues through expedited complaint review procedures.
- The Quick Resolution process is used by the DMHC service center to open the lines of communication between the health plan and consumer to resolve issues without the consumer having to go through the full grievance process. The consumer's issue is typically addressed through a three-way call between the consumer, health plan, and the department. Issues that DMHC may address include selecting a Primary Care Physician or getting a timely appointment.

The following table outlines the complaint types reported by DMHC. The table lists updated information about the standards according to changes DMHC made in mid-2016 to its Help Center's complaint review procedures.

Figure 4.3

DMHC Help Center Complaint Standards

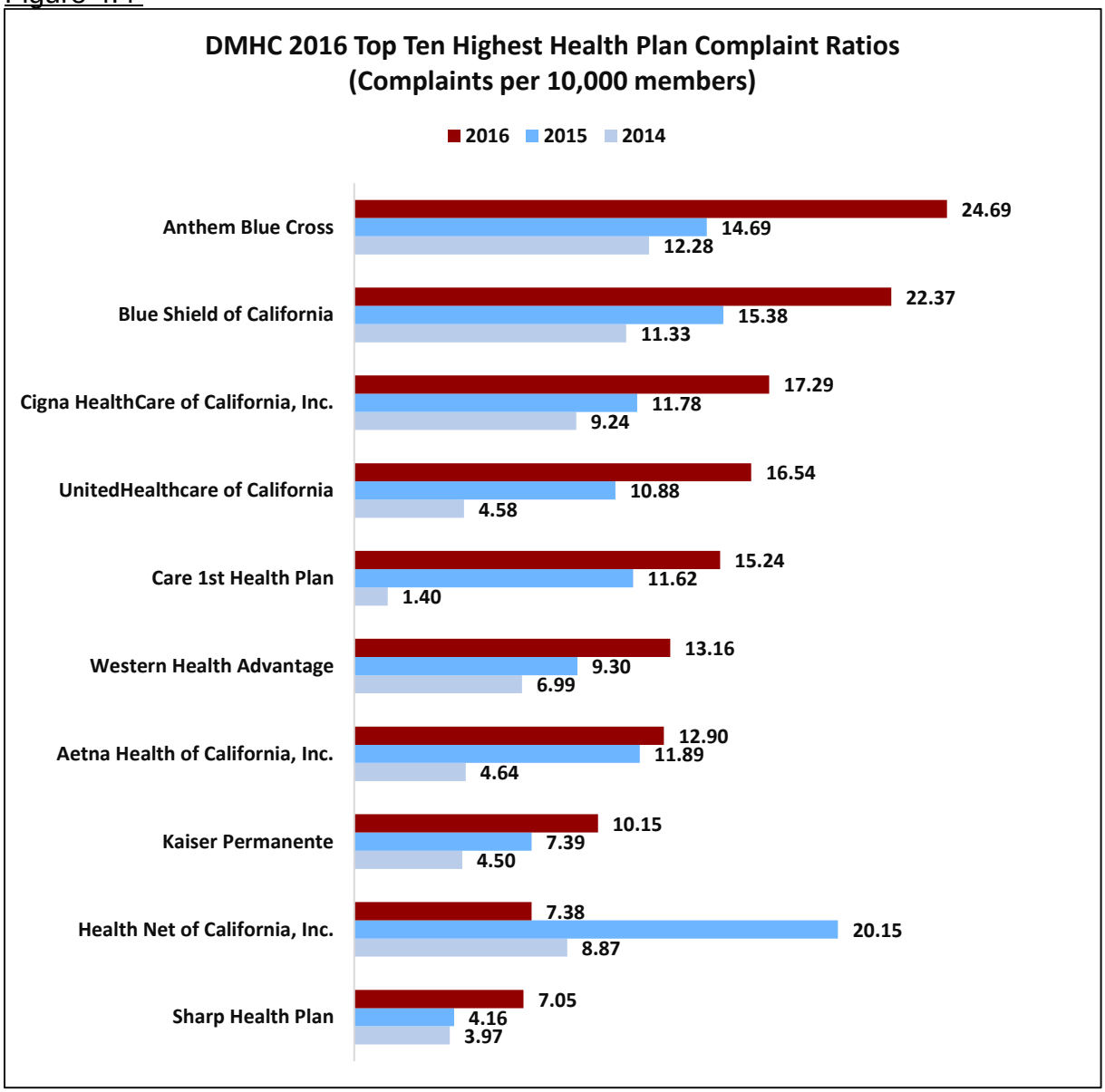
Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
Standard Complaint	*Contact Center:* Intake and routing *Independent Medical Review/Complaint Branch:* Casework *Legal Branch:* Casework for more complex legal cases	30 days from receipt of a completed complaint application	30 days
Independent Medical Review (IMR)	*Contact Center:* Intake and routing *Independent Medical Review/Complaint Branch:* Casework *IMR contractor (MAXIMUS):* External Review decision *Legal Branch:* Legal review if needed	30 days from receipt of a completed IMR application 7 days for Expedited IMR cases	24 days Calculation includes time prior to the completion of the IMR application
Urgent Nurse	*Contact Center:* Intake, initial casework, and routing *Independent Medical Review/Complaint Branch:* Casework, open an IMR if needed	10 calendar days from receipt of a request for assistance	14 days
Quick Resolution	*Contact Center:* Intake and casework resolution	10 days	7 days

Note: The timeframes for DMHC's time standards are based on the date that DMHC receives a completed complaint/IMR application. Resolution times were counted from the date that any initial information was received from a consumer. DMHC may review complaints involving consumers with urgent clinical issues as Urgent Nurse Case complaints, or through expedited IMR and Standard Complaint processes. DMHC clarified its Urgent Nurse time standard as 10 calendar days, rather than 7 business days as reported for measurement year 2015.

B. Complaint Ratios, Reasons, and Results

The following chart shows the health plans regulated by DMHC with the highest complaint ratios in 2016, among plans with enrollment over 70,000. All of the health plans displayed have a full-service license with DMHC. A higher complaint ratio means more complaints were closed per member.

Figure 4.4



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

Plans with a specialty license through DMHC, such as vision or dental, and with enrollment reported over 70,000 members had an average complaint ratio of 0.13 complaints per 10,000 members.

The following specialty health plans have the highest complaint ratios (complaints per 10,000 members) per license type among plans with over 70,000 members:

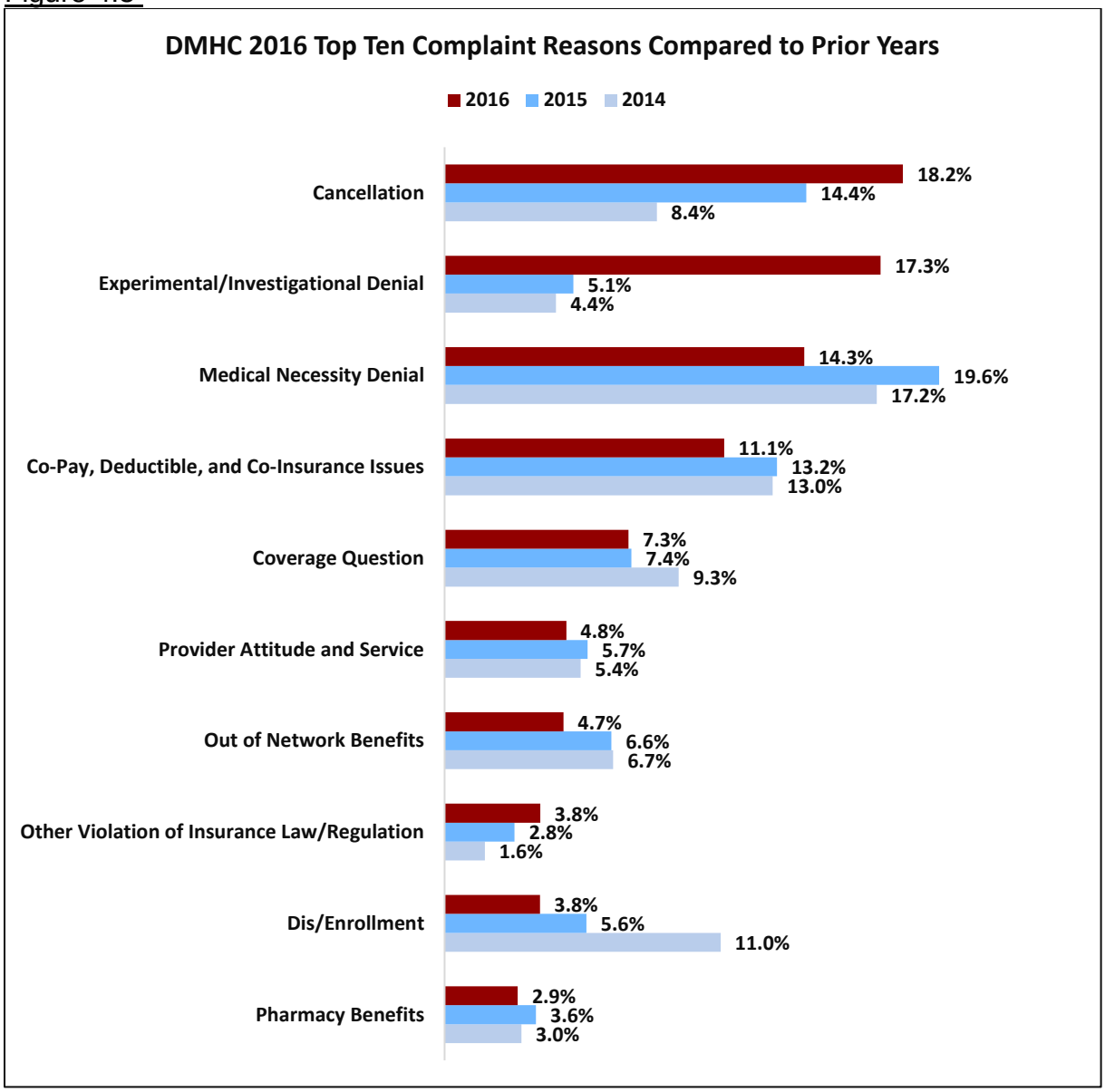
- Dental: Western Dental Plan (0.9)
- Behavioral: OptumHealth Behavioral Solutions of California (0.69)

- Dental/Vision: MetLife (0.43)
- Chiropractic: Landmark Healthplan of California (0.14)
- Vision: FirstSight Vision Services (0.05)

Top Ten Reasons for Complaints

The following chart displays the top ten most common reasons for complaints reviewed by DMHC in 2016. The top ten complaint reason categories account for 88 percent of the 25,884 complaints. DMHC reported 41 different reason categories.

Figure 4.5



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

- Cancellation was the top complaint reason with 4,709 complaints, increasing in volume (85% increase) and ranking (second most common reason in 2015) from the prior year.
- Experimental/Investigational Denial (4,478 complaints) increased in volume by 394 percent from the prior year to become the second most common reason for complaints in 2016 (eighth most common reason in both 2014 and 2015).
    - DMHC noted that the increase was due in part to the department's targeted outreach to health care stakeholders. DMHC also indicated that much of the increase involved denials of Digital Breast Tomosynthesis (a three-dimensional mammogram of the breast) by health plans.
- Medical Necessity Denial, which was the top reason in both 2014 and 2015, dropped to the third most common reason in 2016 even with an increase in overall volume from the prior year (from 3,483 complaints in 2015 to 3,694 in 2016).
- Other Violation of Insurance Law/Regulation appeared for the first time among the top ten reasons (11th in 2015 and 15th in 2014).
- Among the top ten reasons, Dis/Enrollment was the only reason that decreased in volume from the prior year (from 999 complaints in 2015 to 979 in 2016).

Top Ten Topics for Non-Jurisdictional Inquiries

The following table shows the most common topics of inquiries and complaints in 2016 that were outside of DMHC's jurisdiction to address, as well as the organizations to which the consumers were referred. For each inquiry topic, referral organizations are listed in order of most common referral to least common referral.

Figure 4.6

DMHC Help Center 2016 Top Ten Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Referred to
1 (most common)	General Inquiry/Info	Department of Health Care Services (DHCS) Covered California Centers for Medicare and Medicaid Services (CMS) California Department of Insurance (CDI) Health Insurance Counseling & Advocacy Program (HICAP) Health Consumer Alliance (HCA) Partners Department of Labor (DOL)
2	Covered California	Covered California DHCS HCA Partners
3	Enrollment Disputes	DHCS Covered California HCA Partners
4	Claims/Financial	CDI Covered California

Ranking	Inquiry Topic	Referred to
		CMS DHCS
5	Coverage/Benefits Disputes	DHCS CMS HICAP CDI
6	Access to Care	DHCS CMS HICAP
7	Quality of Care	CMS HICAP DHCS
8	Provider Customer Service	California Department of Consumer Affairs CMS DHCS
9	Wrong Number	DHCS Covered California
10	Appeal of Denial / Independent Medical Review	CMS DHCS CDI DOL

Note: DMHC ranking was based on data.

Complaint Results

DMHC reported 30,706 complaint results from the 25,864 complaints closed in 2016. The number of complaint results exceeds the number of complaints because some complaints had more than one result. Approximately 19 percent of the 25,864 DMHC complaints in 2016 had two results reported.

The following table displays all of the 30,706 complaint results submitted by DMHC within ten complaint results categories. DMHC noted that many of the complaints reported with the result of Insufficient Information were outside of the department's jurisdiction.

Figure 4.7

DMHC 2016 Complaint Results

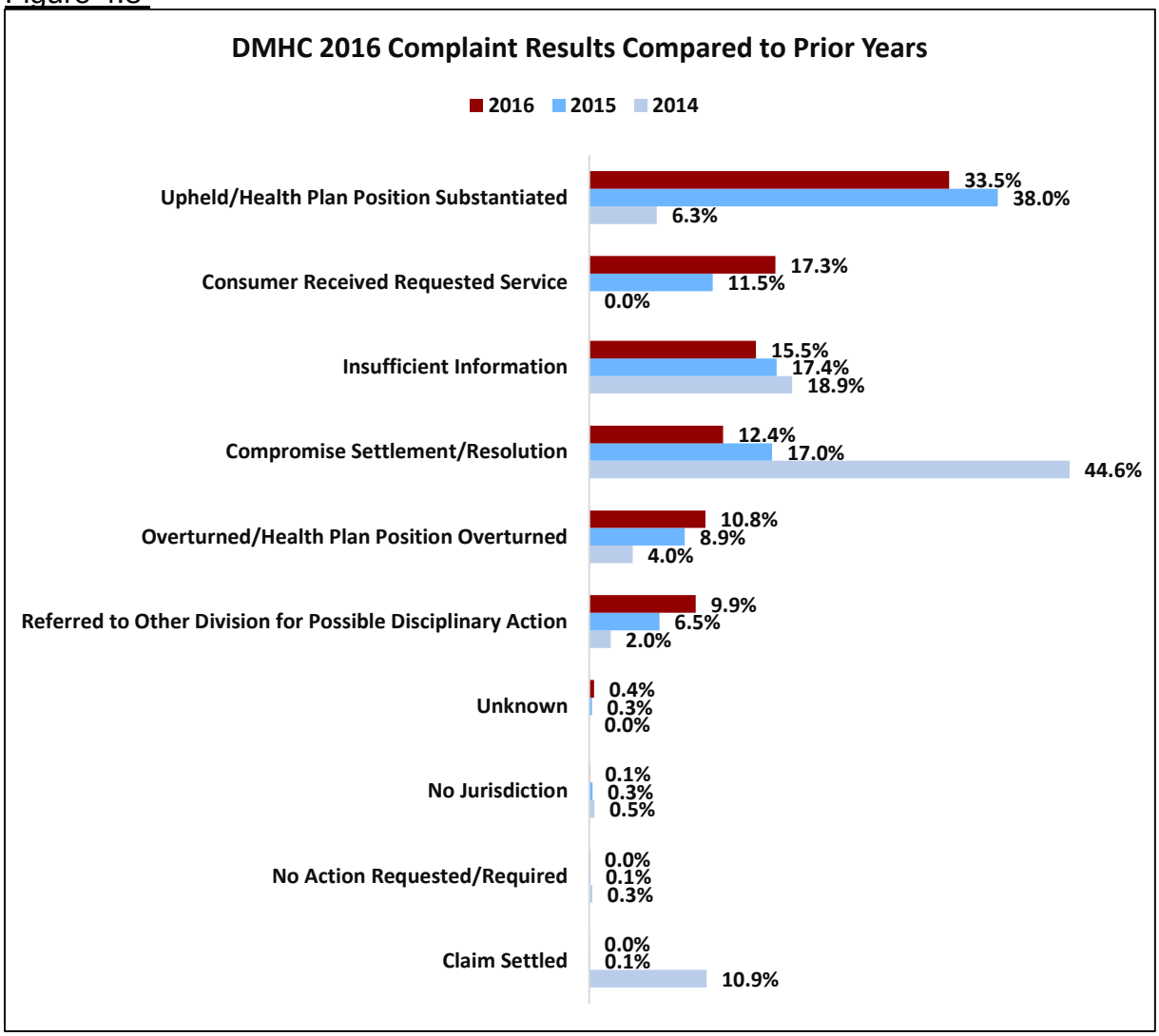
Complaint Result	2016 Volume
Upheld/Health Plan Position Substantiated	10,275
Consumer Received Requested Service	5,315
Insufficient Information	4,762
Compromise Settlement/Resolution	3,819
Overturned/Health Plan Position Overturned	3,316
Referred to Other Division for Possible Disciplinary Action	3,042
Unknown	137
No Jurisdiction	19
No Action Requested/Required	14
Claim Settled	7

Note: DMHC uses criteria to determine complaint outcomes that does not closely match the standardized, NAIC-based results categories. Therefore, the data in this table may not directly correspond to complaint outcomes published by DMHC in other reports. Results categories considered favorable to the complainant include: Consumer Received Requested Service, Compromise Settlement/Resolution, Overturned/Health Plan Position Overturned, and Referred to Other Division for Possible Disciplinary Action. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan, but indicates that the consumer received services or a similar positive outcome.

The following chart shows the percentage distribution of the top complaint results in 2016, along with the distribution of the same results categories in 2014 and 2015 data. The chart represents all of the 30,706 complaint results for 2016 and all of the 21,583 results for 2015. Approximately 12 percent of the 13,994 results in 2014 are not shown because they were within categories not reported in 2016. In 2015 and 2016, the complaint results exceeded the number of complaints because some complaints had more than one result reported.

Some differences between reporting years may be due to changes in data collection and reporting, rather than incidence. For example, the results categories Consumer Received Requested Service and Unknown were first reported by DMHC in 2015. DMHC did not report the Withdrawn/Complaint Withdrawn category in the years after 2014.

Figure 4.8



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

The following tables show the complaint results for the three most common complaint reasons reported by DMHC for 2016: Cancellation (4,709 complaints), Experimental/Investigational Denial (4,478), and Medical Necessity Denial (3,694).

This reason-to-result analysis treats dual results reported for a complaint reason as a single, combined result. None of DMHC's complaints had multiple reasons. Approximately 19 percent of the 25,864 DMHC complaints in 2016 had two results reported. Among the complaints with dual results, there were only two different combinations of results reported.

Figure 4.9

DMHC 2016 Results for Cancellation Complaints

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

Figure 4.10

DMHC 2016 Results for Experimental/Investigational Denial Complaints

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

Figure 4.11

DMHC 2016 Results for Medical Necessity Denial Complaints

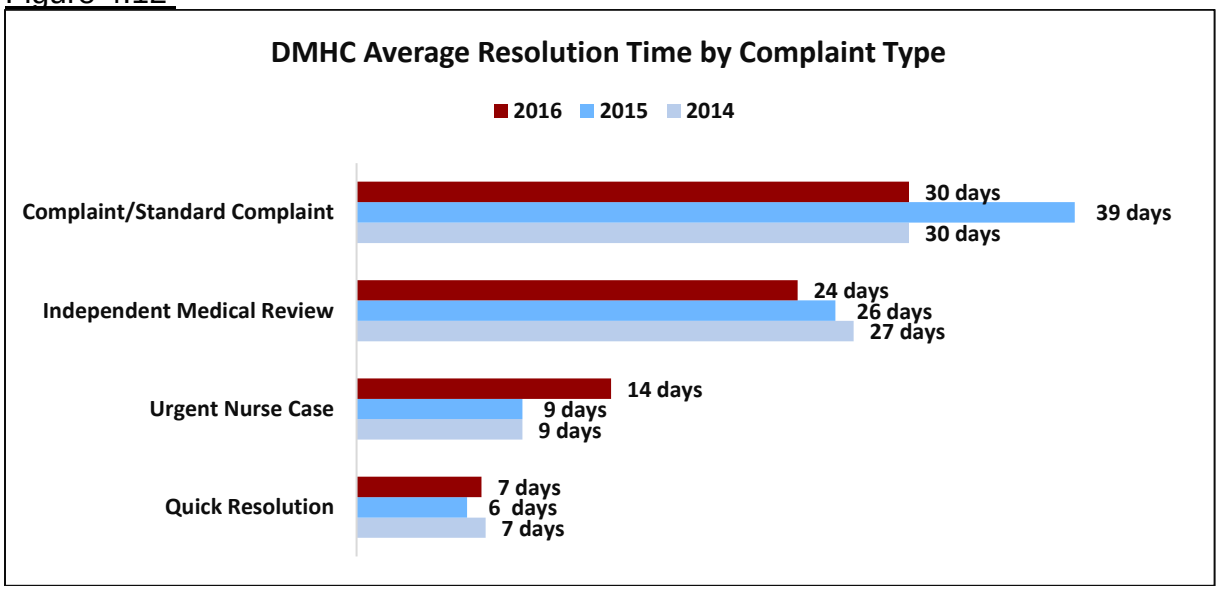
Complaint Result	Percentage of Medical Necessity Denial Complaints
Consumer Received Requested Service	52.08%
Overturned/Health Plan Position Overturned	23.98%
Upheld/Health Plan Position Substantiated	23.93%

Resolution Time

DMHC's average resolution time for complaints closed in 2016 was 28 days, a five-day decrease from the prior year (33 days on average in 2015). The average resolution time decreased for Standard Complaints and Independent Medical Reviews, despite a significant increase in volume for both complaint types compared to the prior year (37 percent volume increase in Standard Complaints and 84 percent increase in IMRs).

The following chart displays the average resolution time by complaint type.

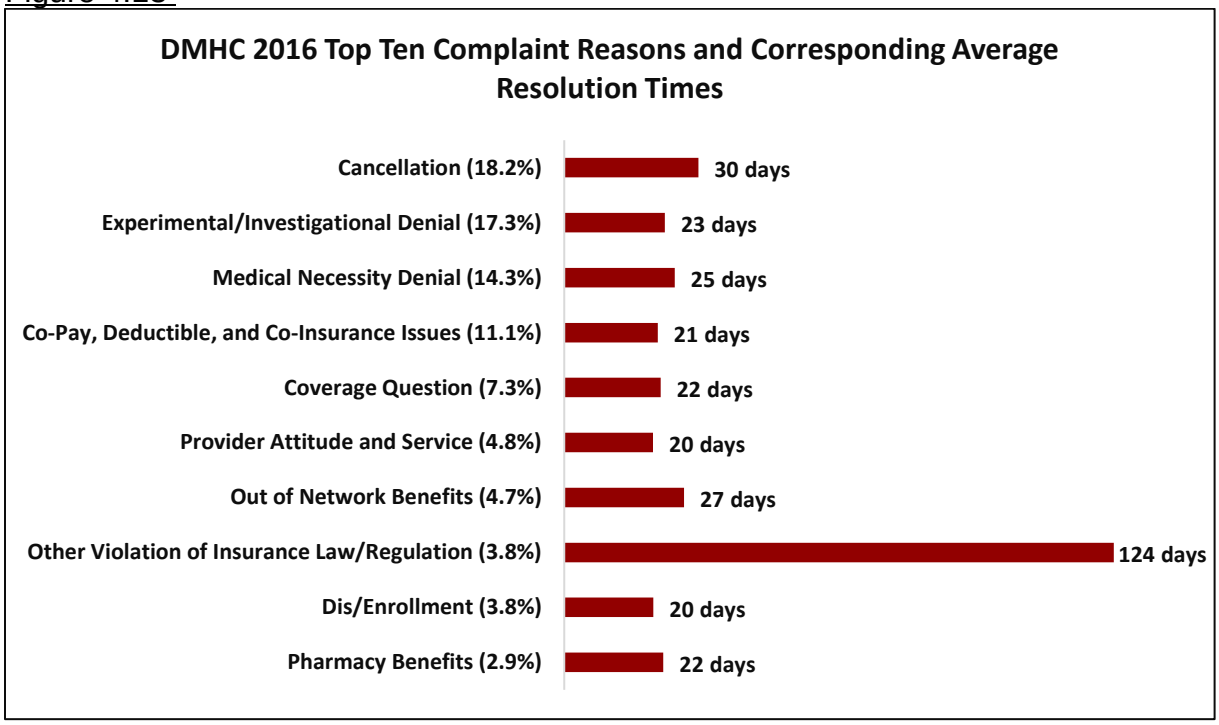
Figure 4.12



Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint. The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Figures detailing average resolution times include case durations with time prior to the completion of the complaint/IMR application.

The following chart displays the percentages for the ten most frequent complaint reasons in 2016 and the average number of days for DMHC to complete its complaint review for those reasons.

Figure 4.13



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

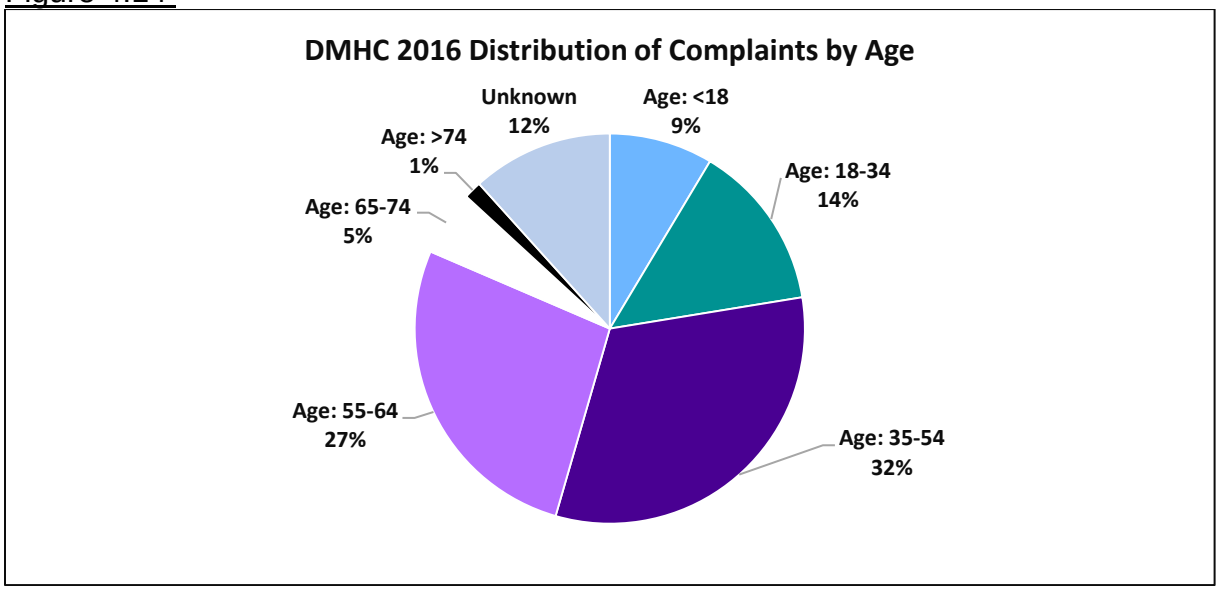
DMHC noted that Other Violation of Insurance Law/Regulation complaints mostly involved health plan grievance process issues, some of which were not identified by the department until after the complaint was closed to the consumer. DMHC often closed the case with the consumer and then processed any violations by the health plan of grievance system requirements in the Knox-Keene Act.

C. Demographics and Other Complaint Elements

Age

The following chart shows the distribution of the 25,864 complaints reported for 2016 by age. The average age of the complainants was 45 years old, same as in 2015.

Figure 4.14



- Experimental/Investigational Denial became the top complaint reason for age groups between ages 35-74, with an increase in volume and ranking from the prior year.
- Medical Necessity Denial was the top reason for age groups under age 35.
- Coverage Question was the top reason for consumers age 75 and older.
- Cancellation was the top reason for those whose age was unknown.

Gender

Of the 25,864 complaints, 62.8 percent identified a female complainant and 36.8 percent a male complainant. Gender was also reported as unknown (0.4%).

Complaint volumes increased from the prior year for both reported genders, but at a higher rate for complainants identified as female (64% increase, compared to 23% for male).

- With a 538 percent increase in volume over 2015, Experimental/Investigational Denial complaints with a female complainant accounted for nearly 16 percent of all complaints closed by DMHC in 2016. DMHC indicated that the increase in Experimental/Investigational Denial complaints primarily among female complainants is associated with the increase in Independent Medical Review cases for health plan denials of Digital Breast Tomosynthesis (a 3D mammogram of the breast).
- Experimental/Investigational Denial was the top complaint reason for female complainants in 2016 (ranked sixth in 2015), but ninth most common for male complainants (same ranking as 2015).
- Cancellation was the top complaint reason for both male complainants and unknown gender in 2016 and the second most common reason for female complainants.

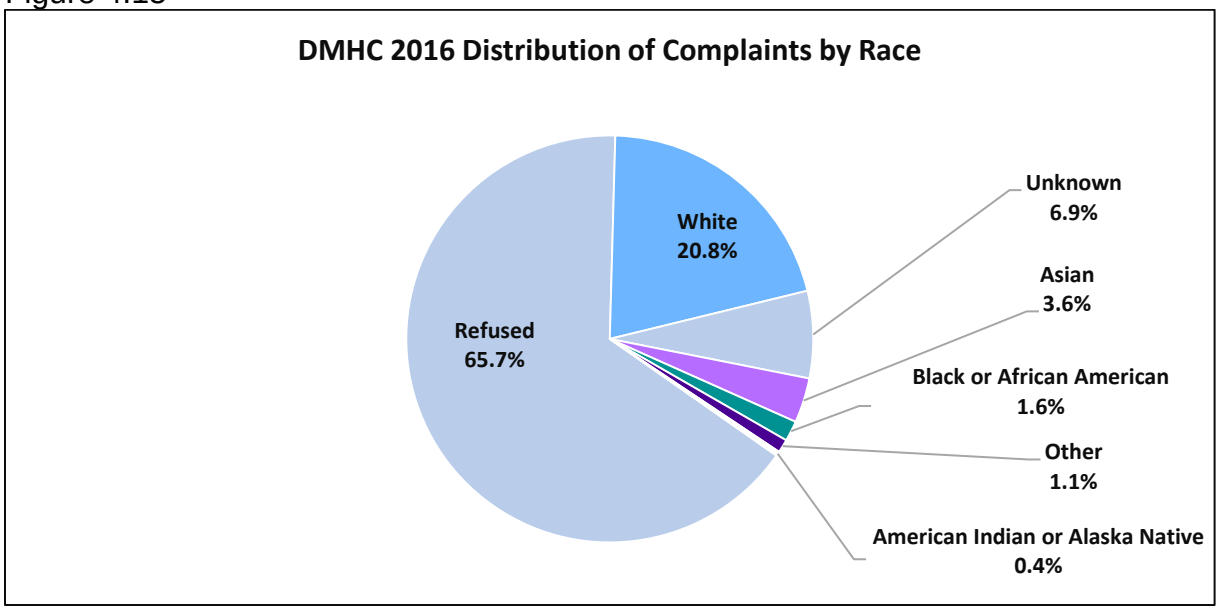
Race and Ethnicity

DMHC has made improvements to data collection and reporting for race and ethnicity categories. In January 2016, DMHC implemented changes to its consumer complaint form and department database to better capture race and ethnicity data.

- DMHC reported data on race for the first time for 2016, after making significant changes to its data collection to add race categories.
- DMHC improved its ethnicity categorizations and was able to differentiate complaints where the consumer declined to provide their ethnicity. In prior years, the department's data collection was limited to two categories: Hispanic or Latino and Not Hispanic or Latino.
- Most of the 2016 complaints did not have race or ethnicity identified because the complainant declined to provide the information (Refused).

The following chart shows the distribution of the 25,864 complaints reported for 2016 by the identified race of the complainant.

Figure 4.15



Medical Necessity Denial and Co-Pay, Deductible and Co-Insurance Issues were among the top three complaint reasons across all known race categories, with variations in ranking. Dis/enrollment was the most common reason for Unknown and Experimental/Investigational Denial was the top reason for Refused.

Most complainants declined to identify their ethnicity (64.9% Refused). One-third of the complainants identified their ethnicity as Not Hispanic or Latino. Nearly two percent (1.8%) of the complainants identified as Hispanic or Latino.

- Cancellation was the most common complaint reason for complainants identified as Hispanic or Latino and as Not Hispanic or Latino.
- Experimental/Investigational Denial was the most common complaint reason for Refused (ranked 11th for Hispanic or Latino and 7th for Not Hispanic or Latino).

Language

Most complainants (97%) identified their primary language as English. Nearly two percent of complaints reported primary language as Spanish and under one percent as Other languages (including Arabic, Armenian, Cambodian, Cantonese, Farsi, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese).

- Cancellation was the top complaint reason for English, Spanish, and Other.
- Co-Pay, Deductible, and Co-Insurance Issues was the second most common complaint reason for Spanish and Other (ranked fourth for English).
- Experimental/Investigational Denial was the second most common complaint reason for English-speakers, with an increase in volume by 400% over the prior year (ranked 11th for Spanish and Other).

Mode of Contact

The initial modes of contact for DMHC's complaints have been consistent throughout the past three reporting years, with mail as the most common mode consumers use to initiate a complaint review (40.4% of complaints in 2016), followed by online (34.8%), fax (20.4%), and telephone (3.9%). DMHC also reported a small number of complaints (less than half a percent) that were initiated by email and in-person.

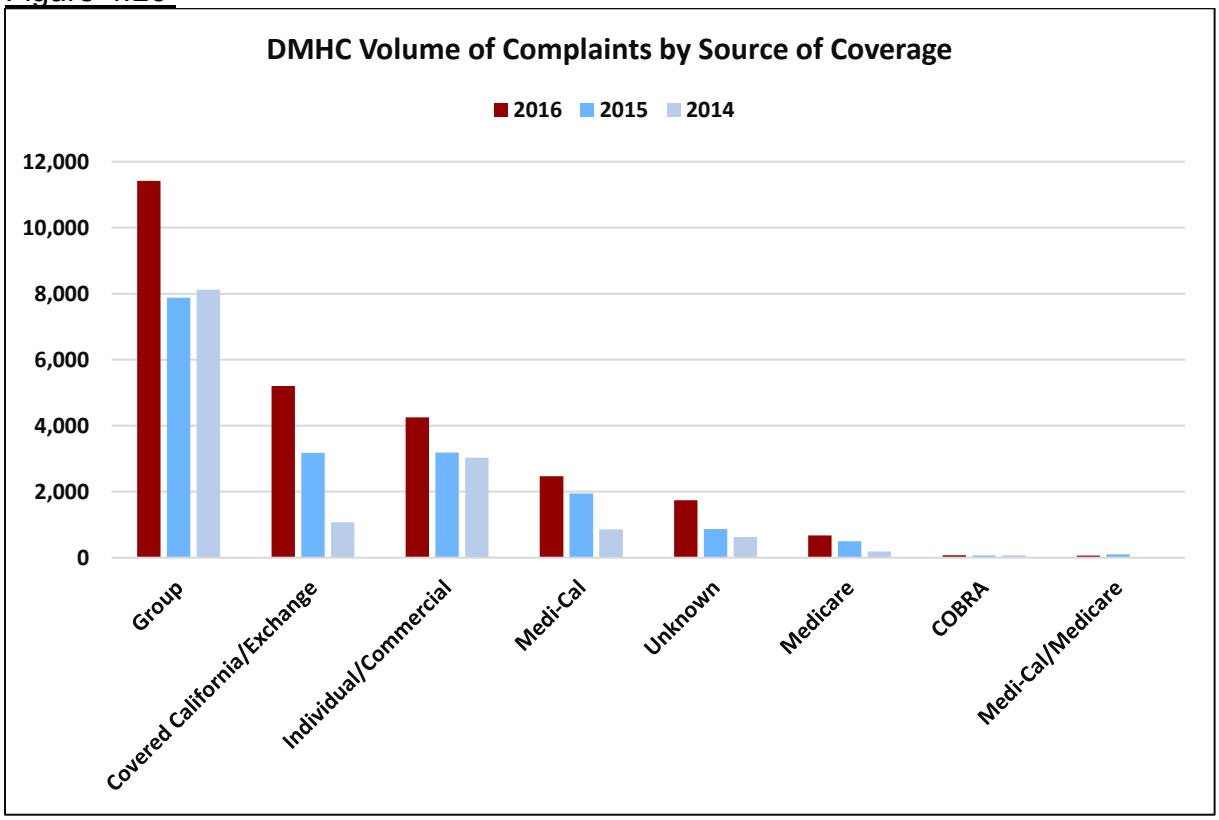
Regulator

DMHC continues to be the identified regulator of most of the complaints the department reviews (94% in 2016). The percentage of complaints reviewed by DMHC that pertain to coverage regulated by other entities has not fluctuated much over the past three reporting years (6% in 2016, 7% in 2015, and 5% in 2014). For 2016, DMHC reported complaints with the regulator identified as the U.S. Department of Labor (3%), California Department of Insurance (2%), and Other (1%).

Source of Coverage

The following chart displays the complaint volume by source of coverage over three reporting years. The percentage distribution for 2016 was similar to the prior year.

Figure 4.16

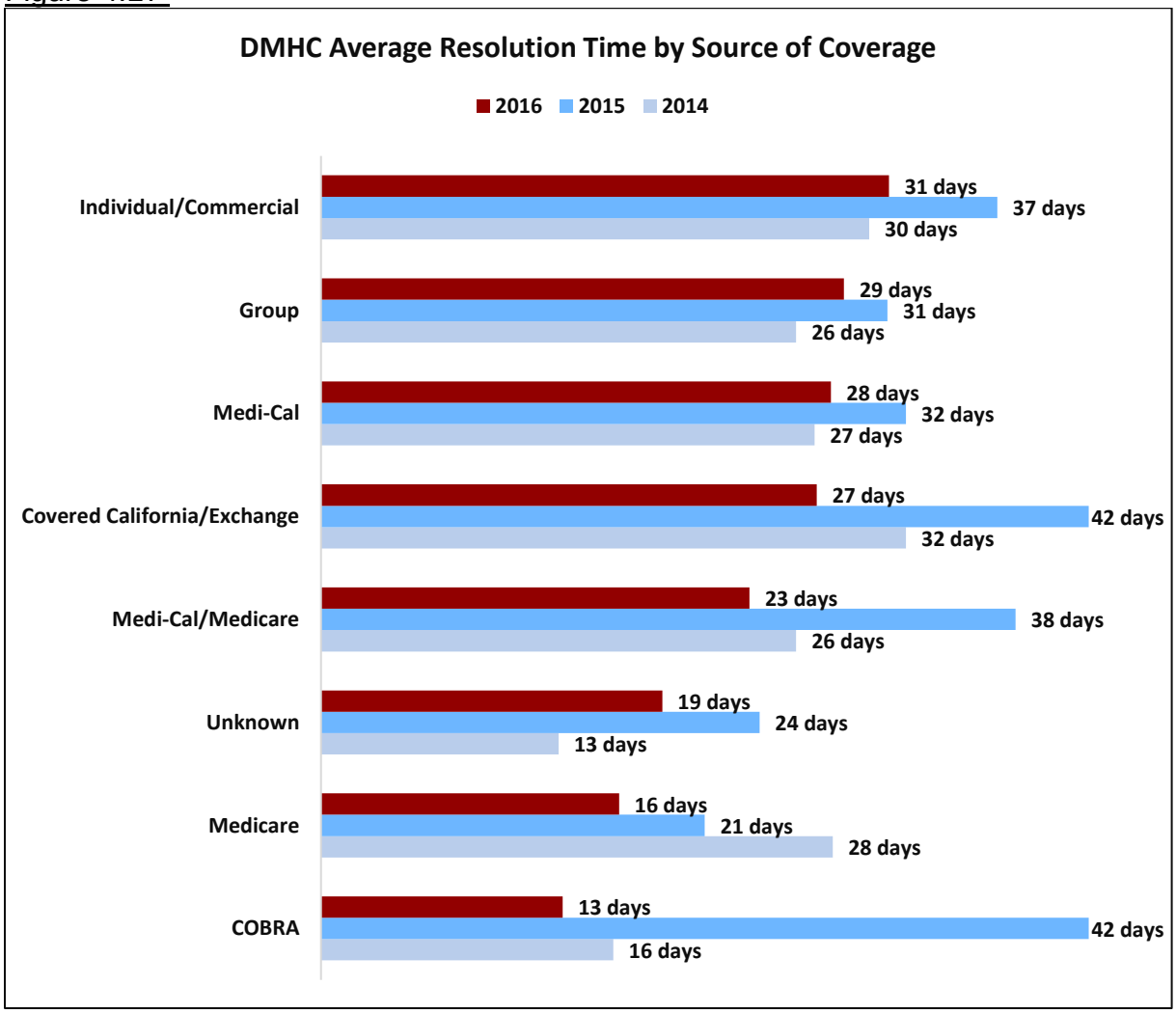


Note: Prior year reports displayed source of coverage categories for Medi-Cal Fee-for-Service and Medi-Cal Managed Care. This differentiation is now by product types rather than source of coverage.

- A majority (60.5%) of the complaints reviewed continue to be regarding commercial sources of coverage in 2016 (44.1% Group and 16.4% Individual).
- Covered California/Exchange accounted for one-fifth (20.1%) of the complaints.
- The other reported sources of coverage included Medi-Cal (9.5%), Unknown (6.7%), Medicare (2.6%), COBRA (0.3%), and Medi-Cal/Medicare (0.2%).

The following chart compares annual averages for the number of days it took for DMHC to review complaints associated with each reported source of coverage.

Figure 4.17



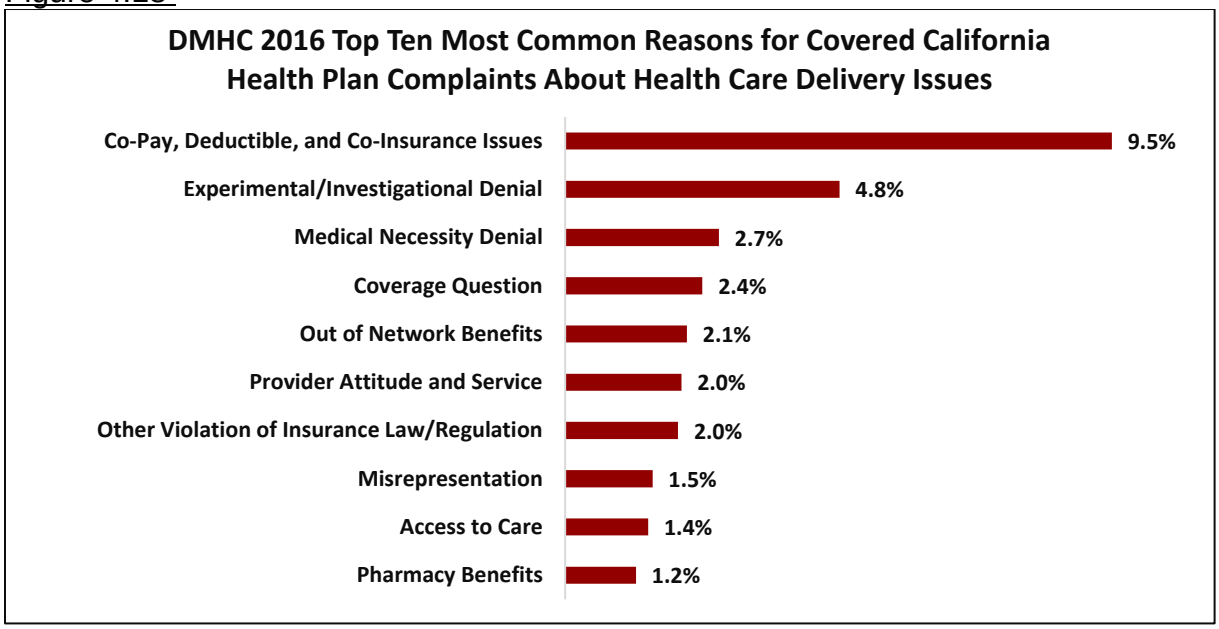
Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

DMHC regulates most of the health plans offered through the Covered California marketplace. Figures 4.18 – 4.20 address complaints about these marketplace health plans that DMHC reviewed in 2016. Section 7 of this report addresses State Fair Hearings about Covered California program decisions on eligibility and enrollment.

- DMHC reported 5,206 complaints in 2016 with Covered California/Exchange identified as the source of coverage.
- There were 31 different complaint reason categories reported for this source of coverage.
- Cancellation was the complaint reason for the majority (57%) of the Covered California health plan complaints.

The following chart displays the most common Covered California health plan complaints that DMHC reviewed in 2016 regarding health care delivery issues.

Figure 4.18



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

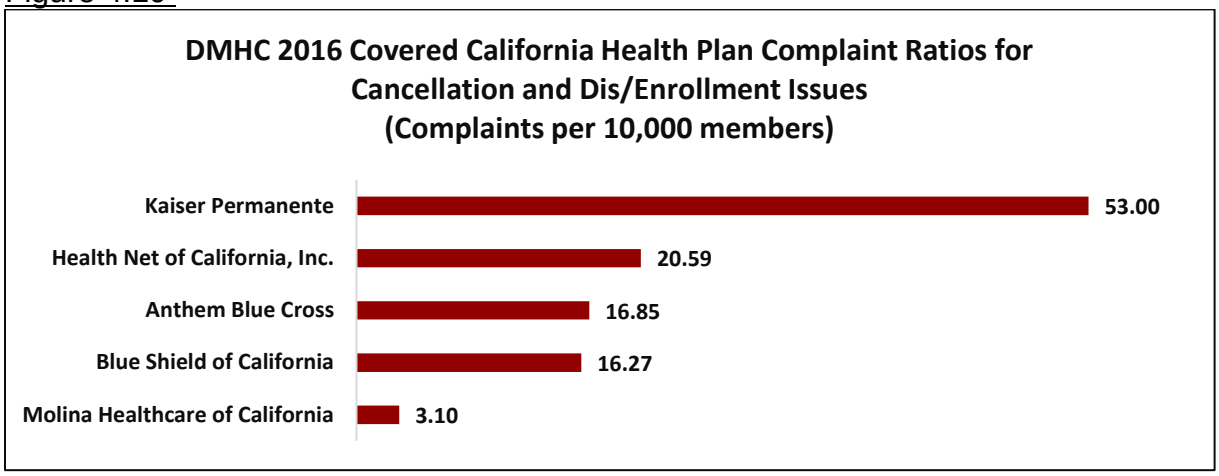
The following charts display Covered California health plan complaint ratios of complaints per 10,000 Covered California members.

- The average complaint ratio for Covered California health plans was 37.2 complaints per 10,000 members.
- Most Covered California health plan complaints (57%) reviewed by DMHC were for the Cancellation complaint reason. The average Covered California plan complaint ratio drops to 13 complaints per 10,000 members when Cancellation and Dis/enrollment complaints are excluded.

The ratios were calculated using the total number of health plan complaints reviewed by DMHC in 2016 where Covered California/Exchange was identified as the source of coverage. This health plan complaint total was divided by 1/10,000 of the health plan's Covered California enrollment, using enrollment figures reported by Covered California for health plan effectuated coverage in March 2016.

The following chart shows Covered California health plan complaint ratios of Cancellation and Dis/Enrollment complaints per 10,000 members, among plans with over 70,000 Covered California enrollees. Due to the analysis focus on enrollment-related issues, the ratio calculations only include Covered California plan complaints for Cancellation and Dis/Enrollment complaint reasons. All other complaint reasons were excluded from the ratio calculations.

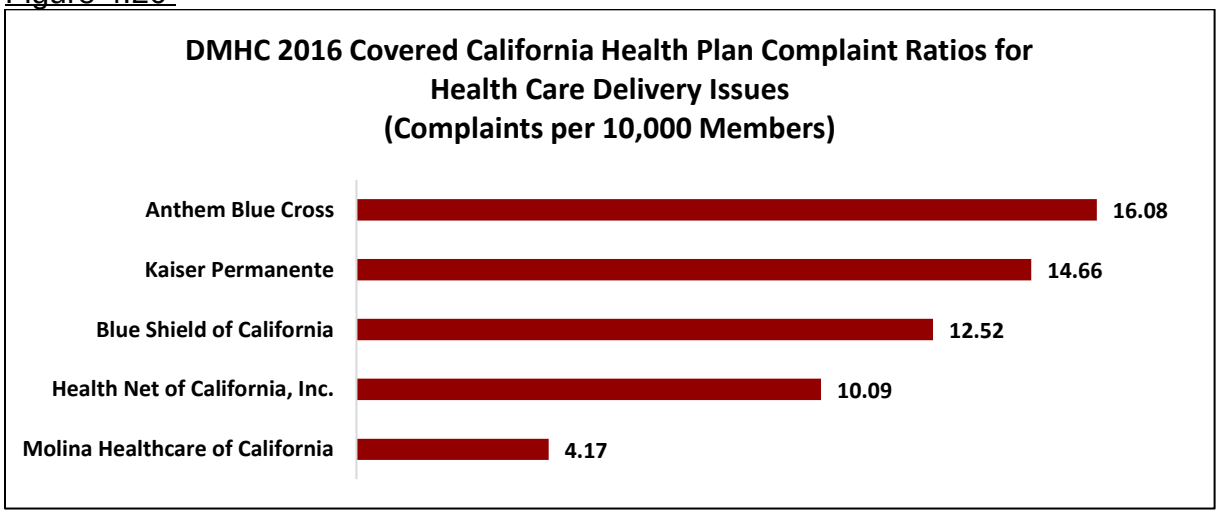
Figure 4.19



Note: The display shows health plans with Covered California enrollment over 70,000 members. The ratio was calculated based on the volume of Cancellation and Dis/Enrollment complaints, and excludes complaints for other reported reasons.

The following chart displays Covered California plan complaint ratios of health care delivery complaints per 10,000 members, among plans with Covered California enrollment over 70,000. Due to the analysis focus on health care delivery, the complaint volumes for Cancellation and Dis/Enrollment complaint reasons were excluded from the ratio calculations.

Figure 4.20



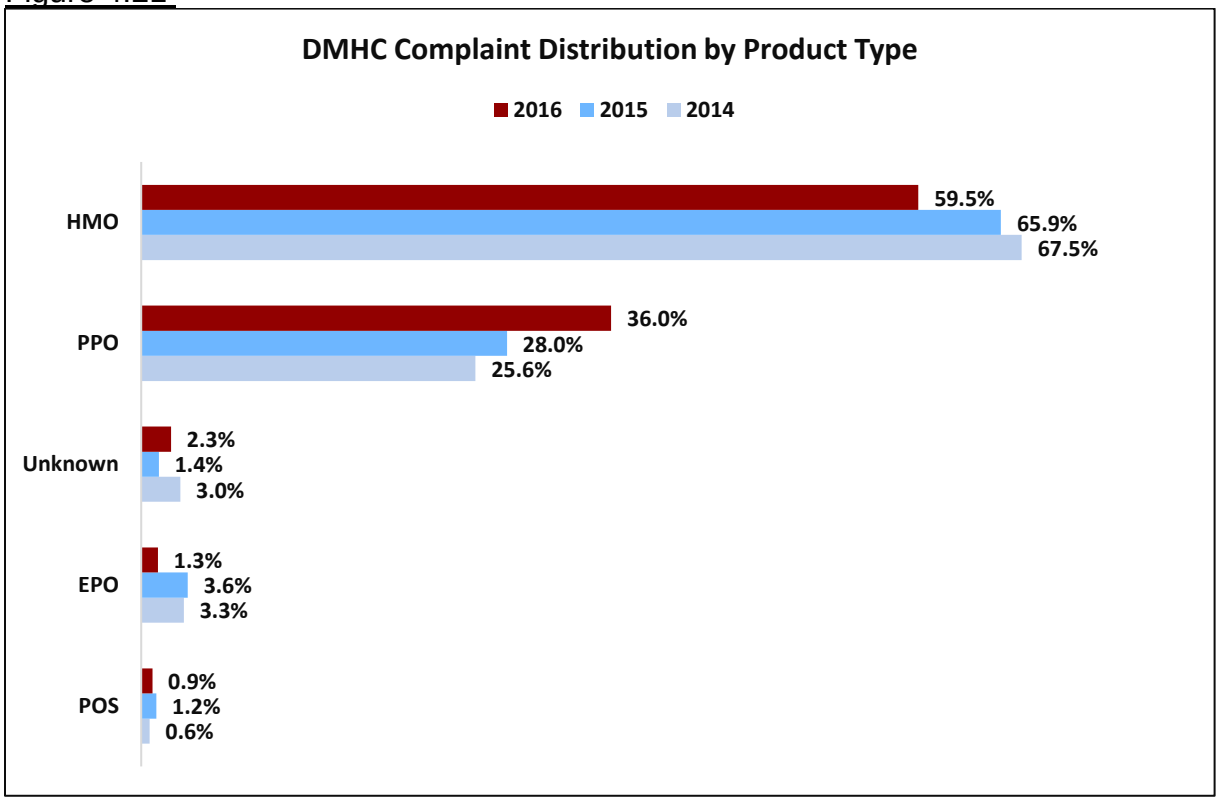
Note: The display shows health plans with Covered California enrollment over 70,000 members. Cancellation and Dis/Enrollment complaint reason volumes were excluded from the complaint ratio calculations.

Product Type

DMHC reported seven primary product type categories for 2016, indicating the health plan model. Most complaints had a single product type identified. DMHC reported a second product type for complaints with Medi-Cal source of coverage, indicating Fee-for-Service or Managed Care. Most Medi-Cal complaints had HMO identified as the primary product type.

The following chart displays the DMHC complaint distribution by the primary product type for three reporting years.

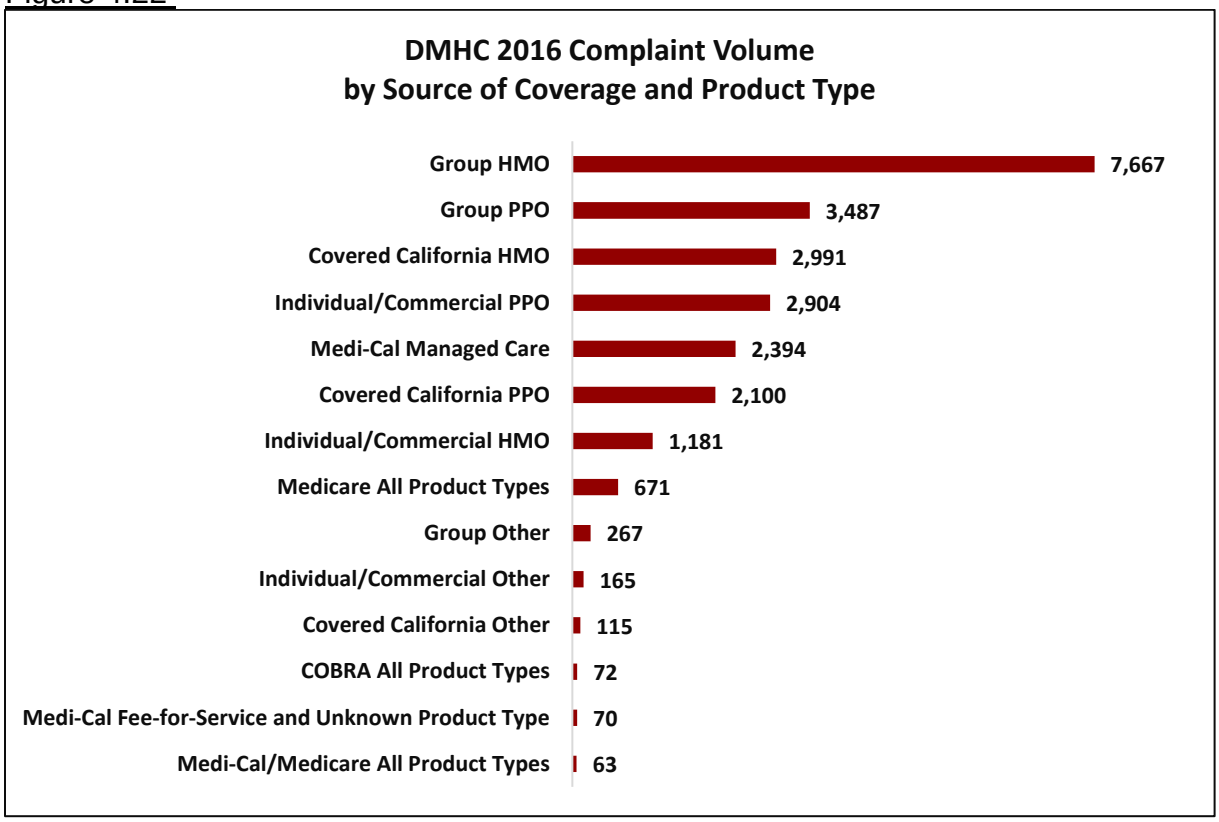
Figure 4.21



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

The following chart displays 2016 complaint volumes grouped by source of coverage and product type categories. The chart accounts for 93 percent (24,147 complaints) of the DMHC-reported complaints, omitting those where the source of coverage was unknown.

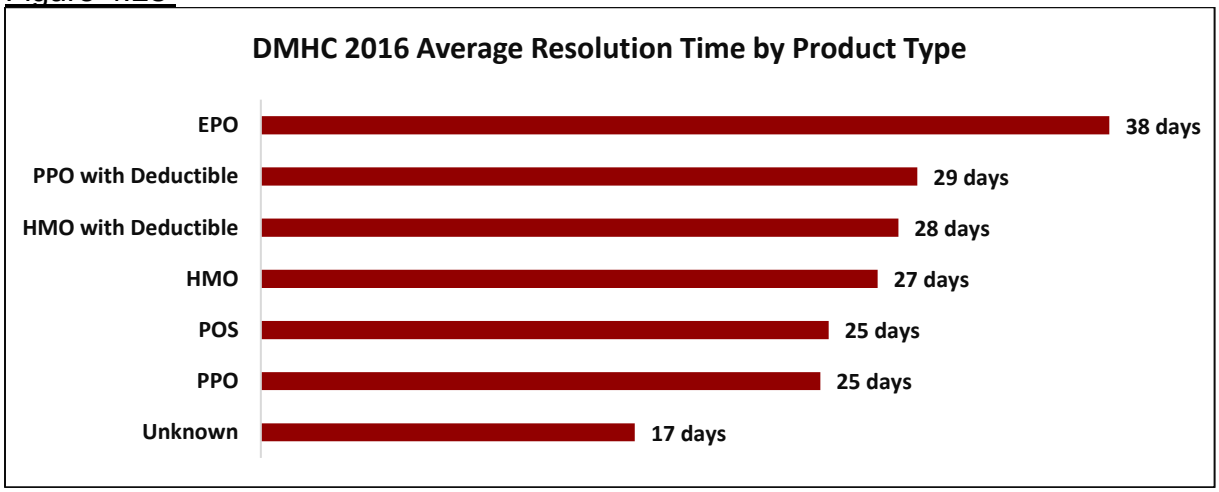
Figure 4.22



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

The following chart shows the average number of days it took in 2016 for DMHC to resolve complaints associated with each reported product type.

Figure 4.23



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

D. Consumer Assistance Center Details

The DMHC Help Center reports receiving 189,482 requests for assistance from consumers in 2016. This volume was a 10 percent increase from 2015 (171,597). Of the requests received, 164,573 (86.9%) were by telephone, 10,471 (5.5%) were by mail, 1,125 (0.6%) were by email, 8,266 (4.4%) were through the online contact form, and 5,046 (2.7%) were via fax.

Service Center Telephone Call Metrics

The DMHC Help Center reports receiving 164,573 total telephone calls from consumers in 2016. The following table shows the response from DMHC regarding some of its telephone call metrics.

Figure 4.24

DMHC Help Center – 2016 Telephone Metrics

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

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

Consumer Assistance Protocols

DMHC reported several changes to their Help Center protocols and standards since 2015.

- The functions of the Help Center's Call Center and the Initial Review Branches have been combined into the Contact Center Branch. Under updated procedures, the Contact Center staff have an increased role in initial casework on certain urgent complaints.
- The Independent Medical Review and Clinical Review Branches have been combined into the Independent Medical Review/Complaint Branch.

- With the recent addition of bilingual staff who speak Cantonese, Hmong, Mandarin, and Tagalog, the Help Center now has capacity to provide direct consumer assistance in six languages (including English and Spanish). DMHC uses a contracted language line to assist consumers who speak other languages.

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, substance use treatment, and long term care services. Approximately one-third of Californians receive health care services financed or organized by DHCS. In 2016, more than 13 million Californians received health care through Medi-Cal. For this report, DHCS provided complaint data regarding State Fair Hearings, a dispute resolution process conducted by the California Department of Social Services (CDSS) State Hearings Division.

- DHCS has provided State Fair Hearings data related to its Medi-Cal Managed Care, Medi-Cal Fee-for-Service, Mental Health Services, and Denti-Cal programs since 2014.
- For 2016, DHCS reported a small volume (less than 1% of the 6,770 complaints) of State Fair Hearings data from the following new sources:
    - **Breast Cancer and Cervical Cancer Treatment Program** – Hearings involving a special program that provides treatment coverage for individuals diagnosed with breast or cervical cancer.
    - **Benefits Division** - Hearings involving Fee-for-Service members with certain benefits-related issues, mostly pertaining to durable medical equipment such as wheelchairs.
    - **Long Term Care Division In-Home Operations Branch** – Hearings involving two Home and Community-Based Services (HCBS) waiver services – the Medi-Cal Nursing Facility/Acute Hospital Waiver and the In-Home Operations Waiver. These special programs allow certain Medi-Cal beneficiaries to avoid hospitalization or nursing facility placement. HCBS waivers are not part of the Medi-Cal State Plan benefit.
    - **California Medicaid Management Information Systems (CA-MMIS) Division Conlan and Provider Assistance Unit** – Hearings involving Fee-for-Service members related to certain claims reimbursement issues.
- Because hearings sometimes involve multiple DHCS units, some of the types of hearings issues from the new data sources overlap with and were reported in prior years by the original DHCS sources.

DHCS also reported information about the consumer assistance services provided in 2016 through the following service centers:

- **Medi-Cal Managed Care Office of the Ombudsman** – The Managed Care Ombudsman provides guidance and referrals to help Medi-Cal managed care plan members receive all medically necessary covered services for which plans are contractually responsible.
- **Mental Health Ombudsman** – The Mental Health Ombudsman helped Medi-Cal members navigate the mental health plan system. The Mental Health Ombudsman unit merged with the Managed Care Office of the Ombudsman in

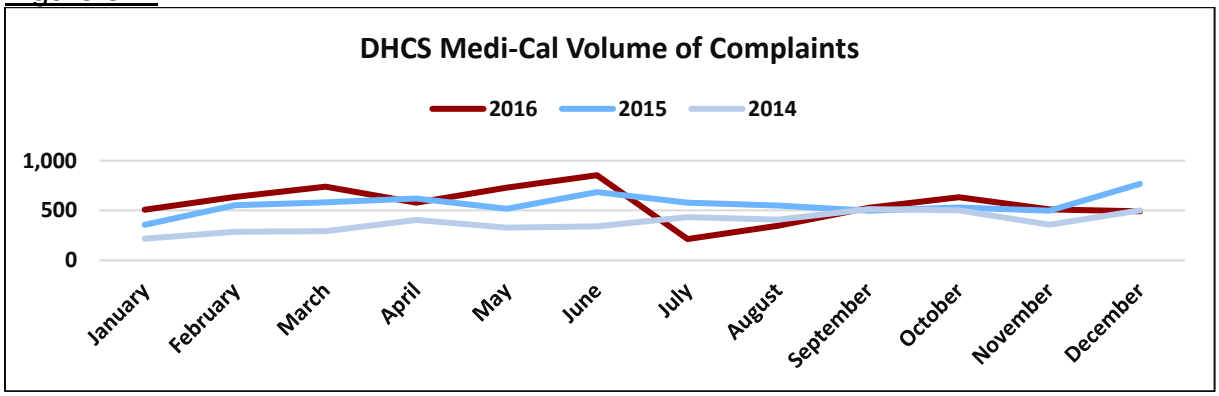
February 2017. This report includes 2016 data regarding the former Mental Health Ombudsman unit's consumer assistance activities.

- **Medi-Cal Telephone Service Center** – Operated by the Fiscal Intermediary (FI) contractor, the Medi-Cal Telephone Service Center assists beneficiaries and medical providers regarding Medi-Cal fee-for-service billing and related issues.
- **Denti-Cal Beneficiary Telephone Service Center** – Operated by the dental FI contractor, 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.

DHCS reported 1,346,453 requests for assistance from consumers in 2016, including 6,770 State Fair Hearings closed in 2016. Medi-Cal enrollment reported to OPA increased by 1.6 percent from the prior year (March 2015 to March 2016 enrollment).

The following chart shows the DHCS complaint volumes reported for 2014, 2015, and 2016 distributed by the month each complaint closed. The 2016 complaint volume slightly increased (0.4%) over the 2015 volume (6,740).

Figure 5.1



The following table displays information about the State Fair Hearing process, which was the complaint type reported by DHCS for 2016. 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 complaint initiation and closing.

Figure 5.2

Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions. Urgent clinical issues may qualify for an expedited hearing process.	90 days from the hearing request date	80 days

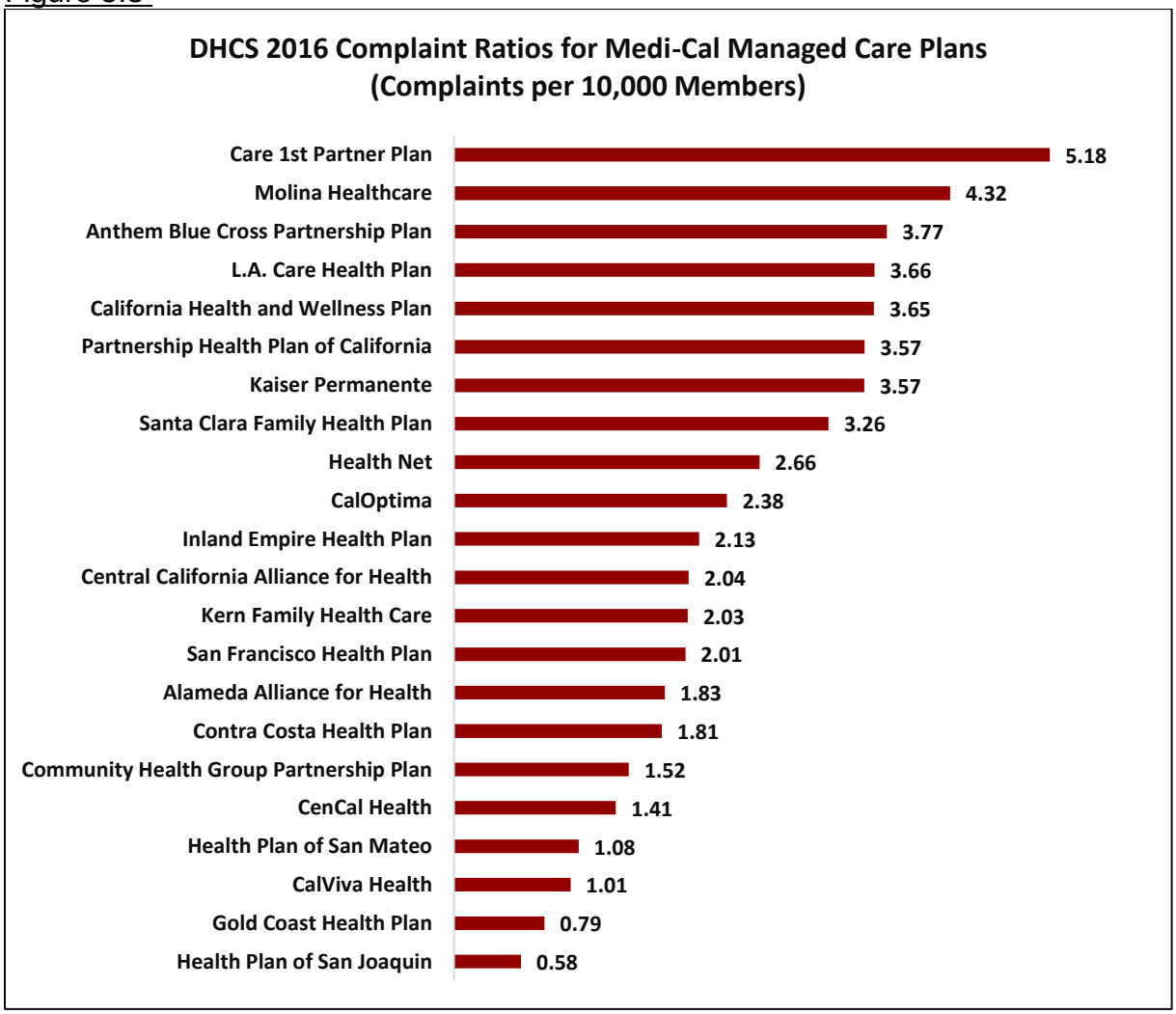
Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14.

B. Complaint Ratios, Reasons, and Results

The following chart shows statewide complaint ratios for Medi-Cal managed care plans. A higher complaint ratio means more complaints were closed per member. The Medi-Cal managed care product type accounted for the largest percentage (41%) of the 6,770 DHCS complaints. Some of the health plans displayed serve multiple counties, including under different Medi-Cal contracting models.

The complaint ratio was calculated using the number of complaints reported statewide for 2016 associated with each health plan. The health plan's statewide complaint total was divided by 1/10,000 of the plan's statewide Medi-Cal enrollment, so that the ratio represents the plan's complaints per 10,000 Medi-Cal members. Only health plans with statewide Medi-Cal enrollment over 70,000 are displayed.

Figure 5.3

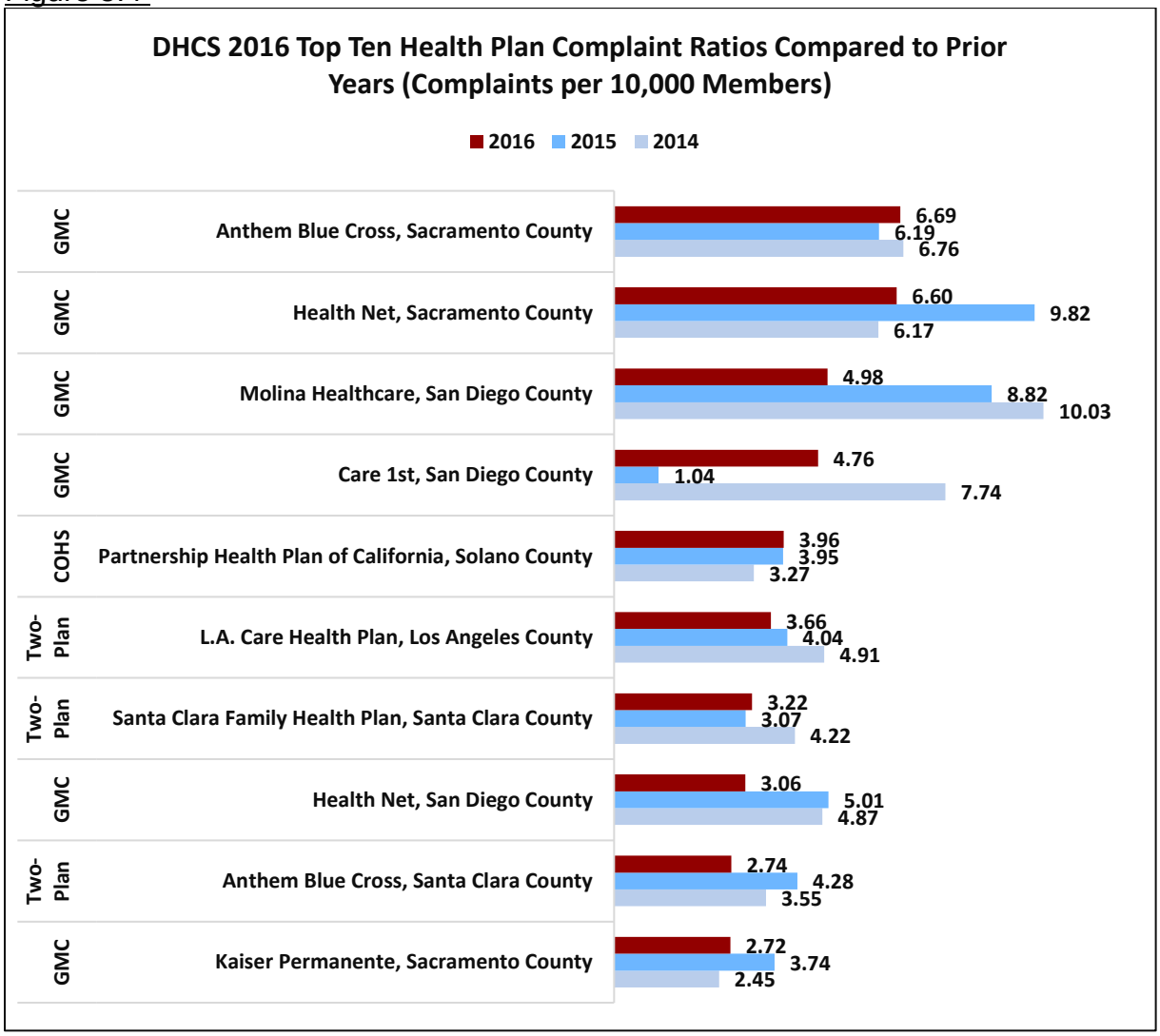


Note: Many of the health plans shown on the chart serve multiple counties, including under different Medi-Cal contracting models. DHCS typically monitors quality issues by county contract. Because OPA has used different methodologies and combined data for analysis, the figures in this chart will not directly correlate with reports produced by DHCS.

The following chart displays the Medi-Cal plans with the highest complaint ratios per county among those with over 70,000 enrollment, as well as the ratios for those same plans in 2014 and 2015 and the associated Medi-Cal contracting model. A higher complaint ratio indicates that more complaints were closed per member.

The complaint ratio was calculated using the total number of complaints by county residents against a health plan. This complaint total was divided by 1/10,000 of the health plan's county enrollment for 2016. Complaint ratios could not be calculated for around one percent of the Medi-Cal managed care complaints because either the plan name or associated county enrollment was unknown. DHCS reported enrollment for 103 health plan/county units, 15 of which had zero complaints and 53 of which had at least one complaint but did not meet the enrollment threshold for display.

Figure 5.4



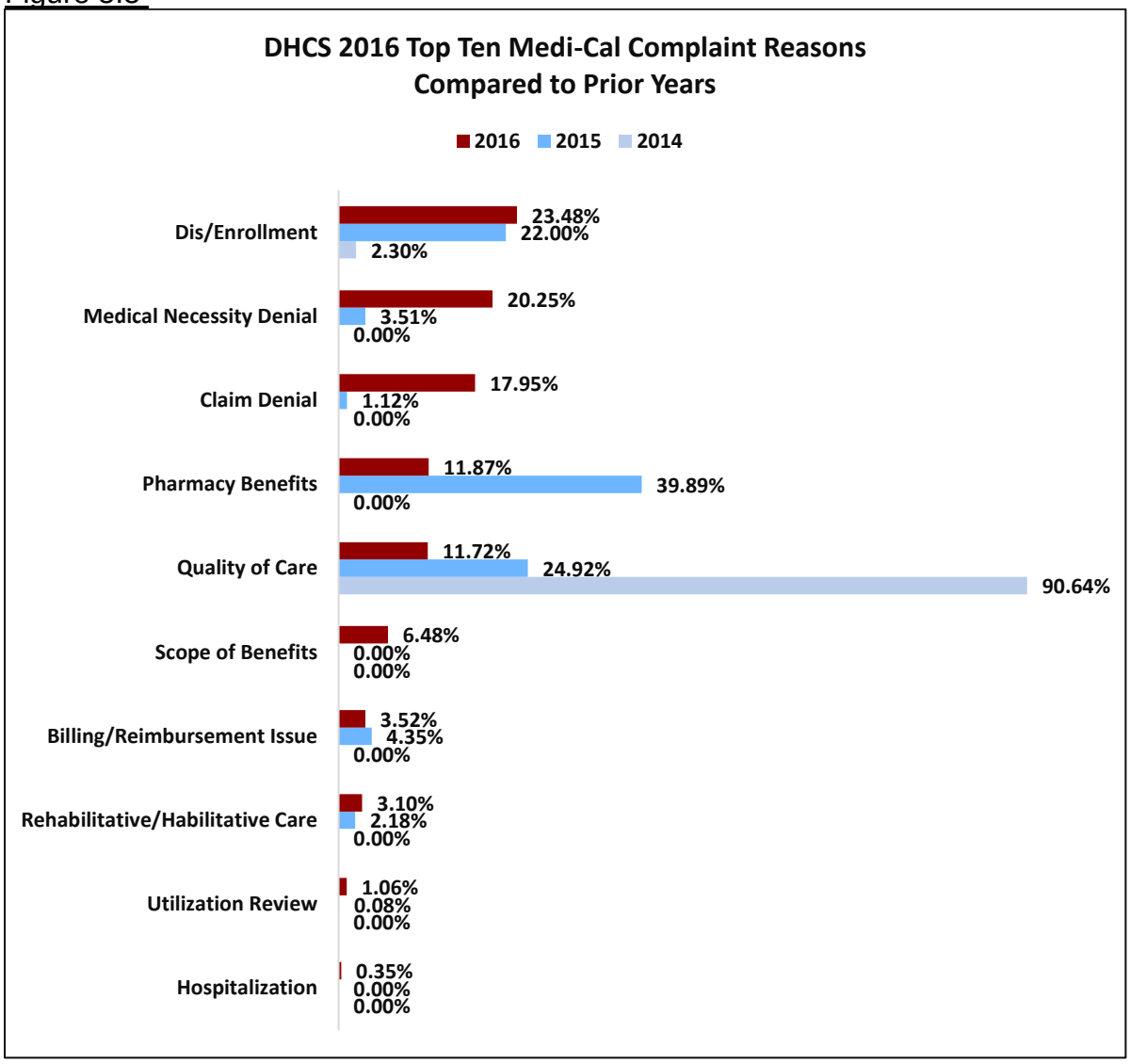
Note: This chart shows the health plans with the highest complaint ratios among plans with county enrollment over 70,000 members in 2016, as well as the ratios for the same plans in 2014 and 2015. The health plans displayed were not necessarily the plans with the highest complaint ratios in 2014 and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

Top Ten Reasons for Jurisdictional Complaints

The total number of Medi-Cal Managed Care and Fee-for-Service complaint reasons in 2016 (5,476) exceeds the total number of related complaint cases (5,461) because some cases had more than one reason. The top ten reasons represent nearly all of Medi-Cal Managed Care and Fee-for-Service complaint reasons in 2016 (99.8%).

Although OPA has displayed multiple years of data reported by DHCS, please note that changes to data categorizations between measurement years may affect trending for some complaint reasons. Significant differences may actually reflect a change in data collection and reporting rather than a change in incidence. For example, DHCS reported most complaints under a broad Quality of Care category in 2014. Some of these Quality of Care complaints were reported under Pharmacy Benefits and other more distinct standardized categories for 2015 and later.

Figure 5.5



Top Ten Topics for Non-Jurisdictional Inquiries

The following table displays the most common inquiry topics consumers contacted DHCS's service centers about in 2016, as well as the department or other service center the consumers were referred to about each inquiry topic. Each service center provided a separate ranking of its most common inquiry topics.

Figure 5.6

DHCS 2016 Service Centers' Top Topics for Non-Jurisdictional Inquiries

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

Note: Managed Care Ombudsman ranking was based on data.

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

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

Medi-Cal Telephone Service Center Ranking	Inquiry Topic	Referred to
1	Beneficiary Inquiry/Eligibility	County Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Denti-Cal
4	Beneficiary Inquiry/Eligibility	Medicare
5	Beneficiary Inquiry/Coverage	Pharmacy
6	Beneficiary Inquiry/Coverage	Medicare Part D
7	Beneficiary Inquiry/Coverage	Other Coverage
8	Provider Application Status	Provider Enrollment
9	Beneficiary Inquiry/Coverage	Low Income Subsidy
10	Technical	Vendor

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

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

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

Complaint Results

The number of complaint results (6,901) reported by DHCS for 2016 exceeded the number of complaints (6,770) because some complaint cases had more than one result.

The following table displays the top ten most common results for DHCS complaints closed in 2016. The top ten categories accounted for 99.8 percent (6,889 results) of the total complaint results for 2016.

Figure 5.7

DHCS 2016 Top Ten Complaint Results

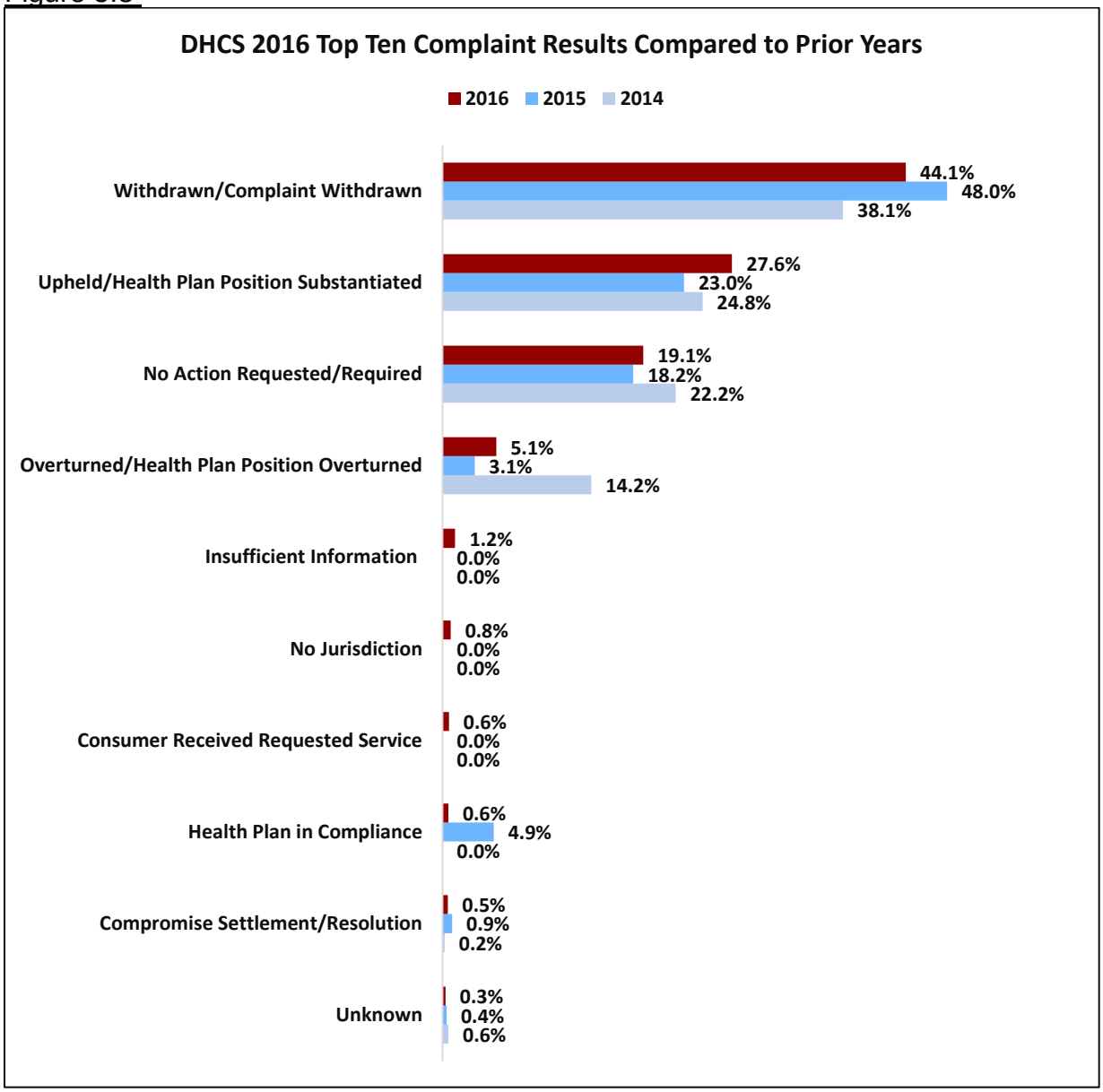
Complaint Result	Volume
Withdrawn/Complaint Withdrawn	3,043
Upheld/Health Plan Position Substantiated	1,902
No Action Requested/Required	1,318
Overturned/Health Plan Position Overturned	353
Insufficient Information	83
No Jurisdiction	54
Consumer Received Requested Service	43
Health Plan in Compliance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

Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Consumer Received Requested Service, and Compromise Settlement/Resolution. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated and Health Plan in Compliance. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan, but indicates that the consumer received services or a similar positive outcome.

The following chart shows the 2016 top ten complaint results compared to prior years. Withdrawn/Complaint Withdrawn continues to be the most common result of the DHCS complaints.

Some differences between measurement years may be due to changes in DHCS data collection and reporting rather than changes in incidence. DHCS reported a wider variety of results categories, with seven categories reported in 2016 that had zero results reported in prior years. Referred to Outside Agency/Department was not reported for 2016, but was the sixth most common result in 2015.

Figure 5.8



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

DHCS indicated that a large volume of the Withdrawn/Complaint Withdrawn results is due to a deferred services issue usually resolved with a favorable outcome for Medi-Cal

beneficiaries prior to a State Fair Hearing. DHCS noted that a Notice of Action letter may prompt beneficiaries to file for a hearing, even though it may not be necessary.

- A Notice of Action letter for deferred services is sent to a beneficiary whenever a request for payment of proposed services is returned to his or her doctor or other medical provider for additional information or correction, in order for DHCS to process the request.
- Most requests for payment for proposed services are approved once the provider submits the correct information.
- Beneficiaries may choose to file for a State Fair Hearing based on information provided in the Notice of Action letter that outlines their right to request a hearing if they are dissatisfied or concerned with the action indicated in the notice.
- Once a request for payment for proposed services is approved, the associated hearing request is withdrawn.

Resolution Time

For DHCS complaints closed in 2016, the cases took 80 days on average to resolve. The average resolution time decreased by 22 days from the prior reporting year. The following charts (Figures 5.9 – 5.11) display the average resolution times for the top complaint reasons for the product type specified.

Figure 5.9

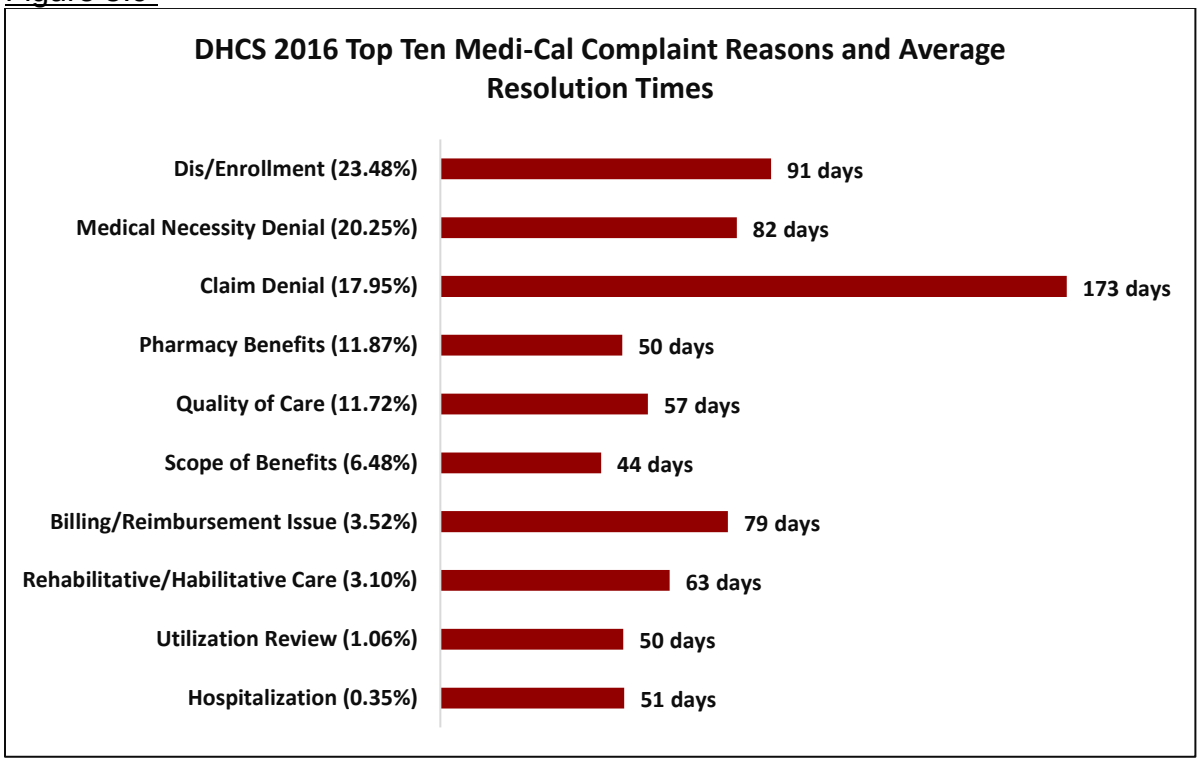


Figure 5.10

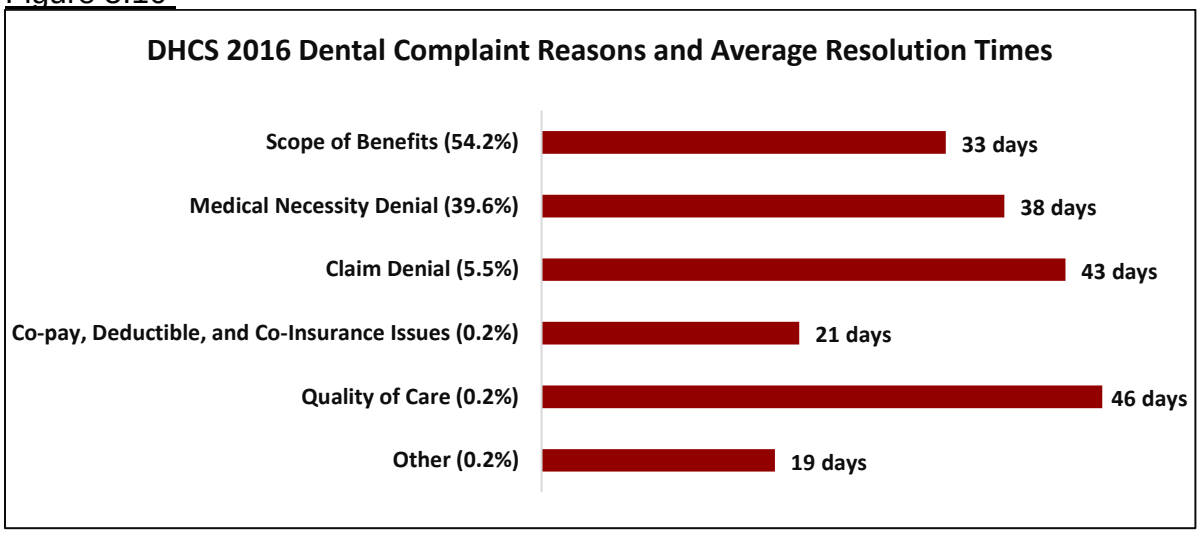
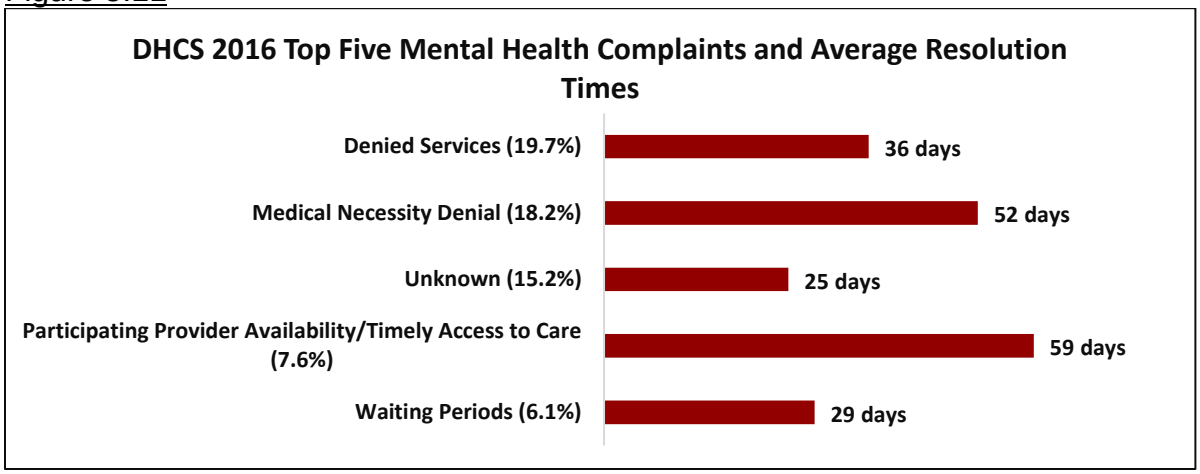


Figure 5.11

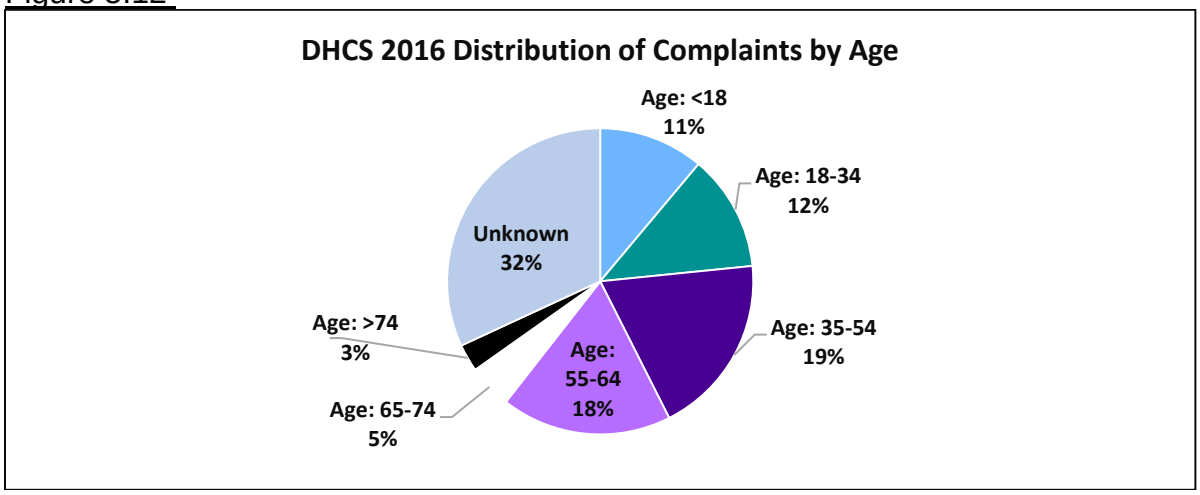


C. Demographics and Other Complaint Elements

Age

The average age of complainants (44 years old) was unchanged and distribution among known age groups varied slightly (within 2%) from the prior year. The percentage of complaints increased for Unknown age, nearly all of which pertained to the Fee-for-Service product type.

Figure 5.12



The top complaint reasons were similar across known age groups and between measurement years, but with differences in ranking. In 2016:

- Medical Necessity Denial was the top reason for Under Age 18 and Ages 35-54.
- Dis/Enrollment was the top reason for Ages 18-34 and Ages 55-64.
- Scope of Benefits was the top reason for complainants Age 65 and older.
- Claim Denial was the top reason for Age Unknown.

Gender

DHCS reported the complainant's gender as Female for 41 percent, Male for 28 percent, and Unknown for 31 percent of the 6,770 complaints closed in 2016. OPA combined complaints with gender identified as Refused with the Unknown category for analysis due to the low volume (two complaints). Nearly all of the complaints with gender Unknown were regarding the product type Fee-for-Service. The 2016 distribution of complaints by gender is similar to the 2015 distribution (within 2%).

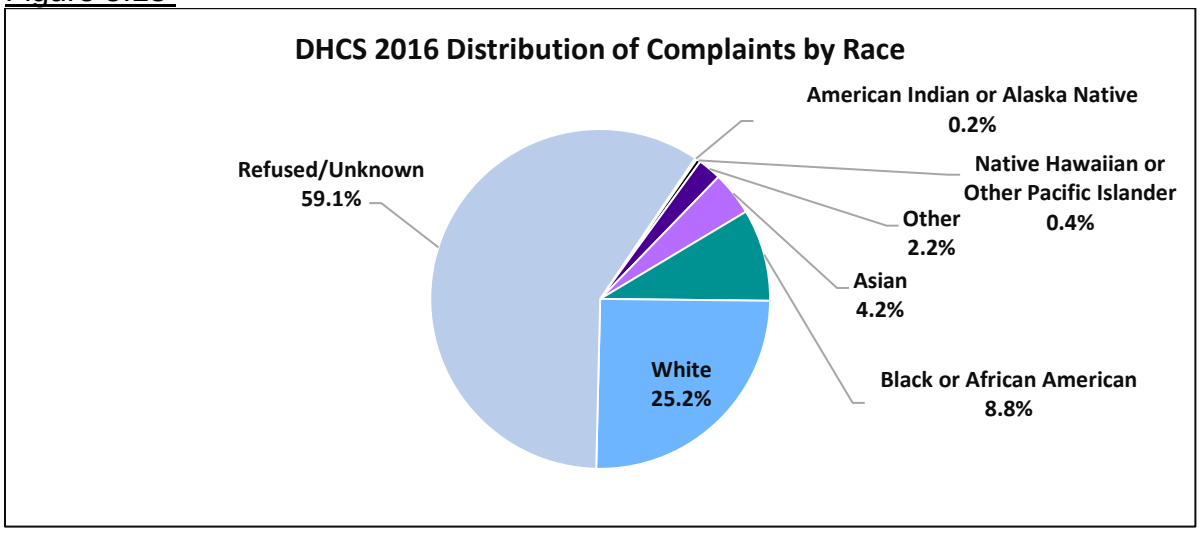
There were similar complaint reasons reported for Male and Female in 2016, with Medical Necessity Denial and Dis/enrollment as the top two reasons and slight differences in the rankings that followed. For Refused/Unknown, Claim Denial and Pharmacy Benefits were the top two complaint reasons. Pharmacy Benefits was no longer among the top complaint reasons reported for complainants with gender identified as Male and Female. Differences in rankings between measurement years may be due to changes in data collection and reporting rather than incidence changes.

Race and Ethnicity

DHCS identified race and ethnicity for more complaints in 2016 (41% of the 6,770 complaints for both race and ethnicity) than in the previous years. Of the 2015 complaints reported, 32 percent had race identified and 10 percent had ethnicity

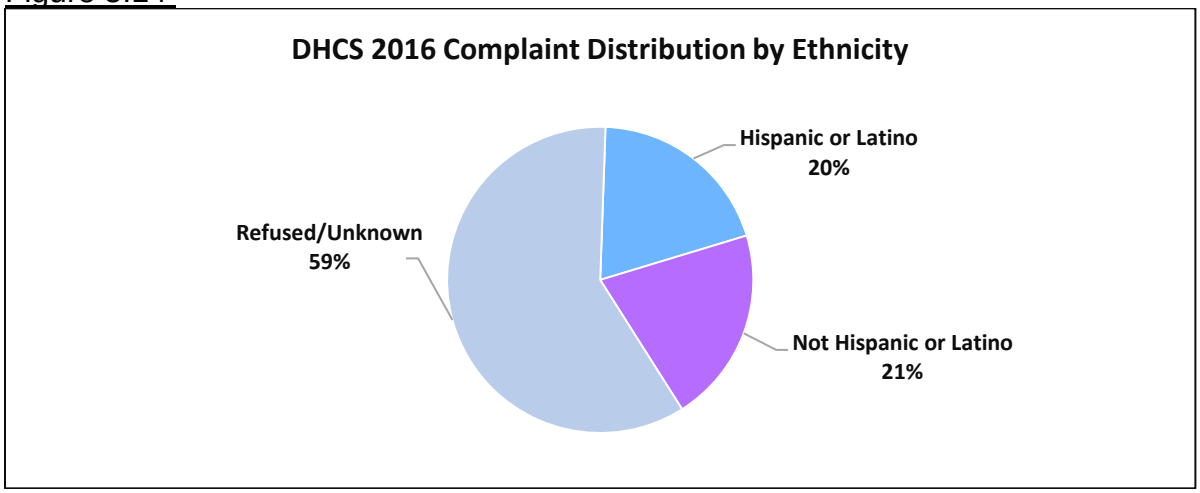
identified. None of the 2014 complaints had race or ethnicity identified. Most of the 2016 complaints with Unknown race or ethnicity were for the product type of Fee-for-Service.

Figure 5.13



OPA combined race categories with low volumes reported (under 5%) to analyze complaint reasons. The top complaint reasons appear similar across known race categories analyzed, with some differences in ranking order. Medical Necessity Denial increased in ranking across all categories, and was either the top complaint reason or second most common reason. Dis/enrollment was either ranked first or second among known race categories. Claim Denial was the top reason for Refused/Unknown.

Figure 5.14



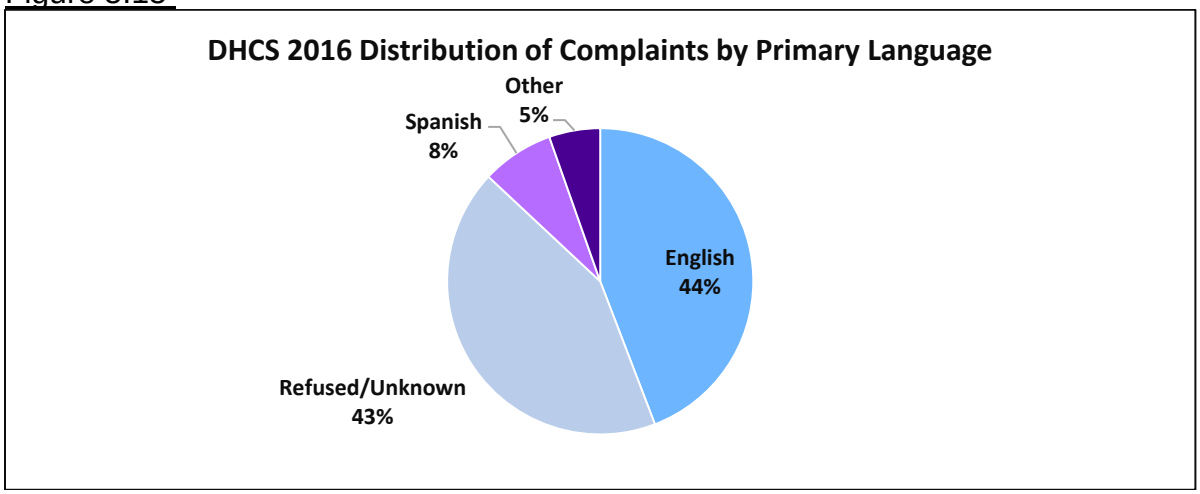
Medical Necessity Denial increased in rankings across all ethnicity categories and was the top reason for complainants identified as Hispanic or Latino and who refused to identify their ethnicity. Quality of Care was the top reason for Not Hispanic or Latino. Claim Denial was the most common reason for complaints with Unknown ethnicity.

Language

More complaints had primary language identified than in previous years (57% identified in 2016, 55% in 2015, and none in 2014).

The volume of complaints with Spanish identified as the primary language increased by 91 percent over the prior year. The volumes associated with Other languages increased by 39 percent and English increased by 20 percent. Overall complaint volume increased by 4 percent over the prior year.

Figure 5.15



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

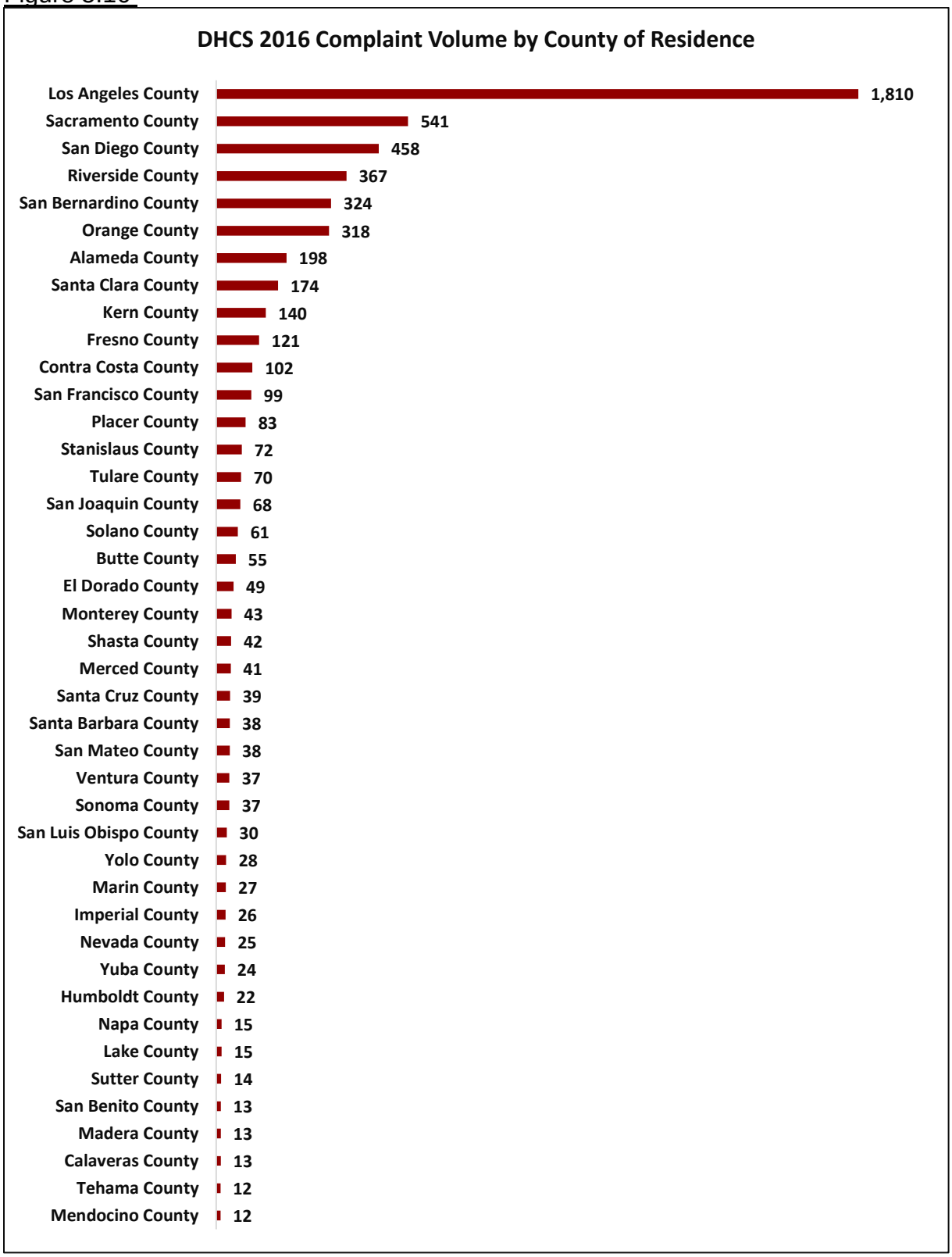
- Complainants whose primary language was Spanish or English had the same top two complaint reasons: Medical Necessity Denial and Dis/enrollment.
- For Other reported languages, the ranking was reversed with Dis/enrollment first and Medical Necessity Denial second.
- Claim Denial and Pharmacy Benefits were the top two complaint reasons for Refused/Unknown.
- Medical Necessity Denial increased in ranking across reported language categories from the prior year. It is unknown how much of this increase is due to differences in data collection and reporting.

County of Residence

The following chart displays the volume of complaints by the complainant's county of residence.

Approximately 15 percent of the 6,770 complaints were Unknown. Three California counties did not have any complaints in 2016.

Figure 5.16



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

Mode of Contact

Most (65%) of the complaint cases reported by DHCS for 2016 had an unknown initial mode of contact. Mail was the most common known mode of contact, identified for nearly 22 percent of all complaint cases. Almost 13 percent of the DHCS complaints were initiated by phone and less than one percent were initiated by email.

Regulator

Most (64%) of the 2016 complaint cases reported by DHCS identified Other as the regulator, indicative of combined state and federal Medi-Cal program oversight. DMHC was the regulatory authority for 2,399 (35%) of the complaints. There were 29 complaints where the regulator was Unknown.

Source of Coverage

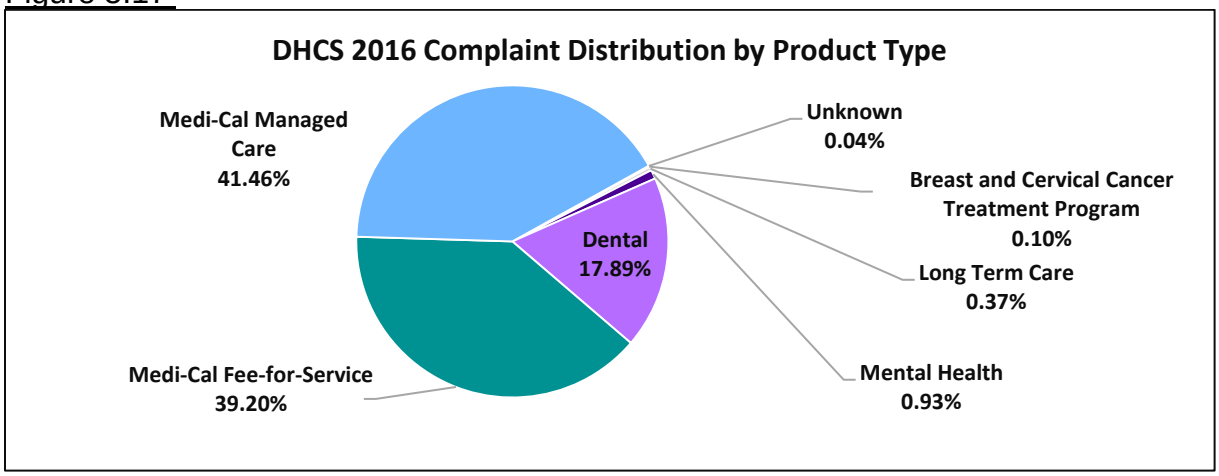
Medi-Cal was the source of coverage for nearly all of the complaints reported by DHCS (6,759 out of 6,770). Less than one percent of the complaints identified Medi-Cal/Medicare as the source of coverage.

Product Type

The following chart displays the product type distribution of DHCS's 6,770 complaints, representing the Medi-Cal program's different delivery systems. For better alignment with DHCS data classifications, OPA updated the 2016 product type categories to include Medi-Cal Managed Care, Medi-Cal Fee-for-Service, and Long Term Care.

- Fee-for-Service and Managed Care designations previously were displayed under source of coverage. DHCS started submitting its data with these designations under product type in 2015.
- Long Term Care is a new product type category. Previous product types for long term care indicated either SCAN or PACE (managed care plans for the Senior Care Action Network and Program of All-Inclusive Care for the Elderly), which did not match new DHCS data.

Figure 5.17

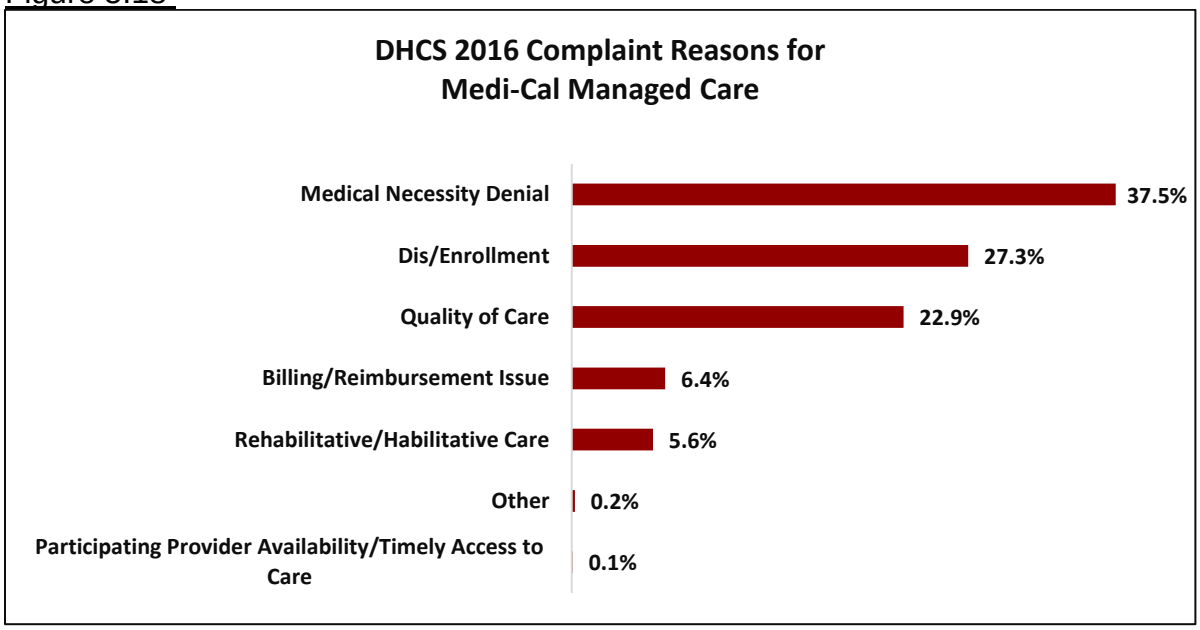


- Of the 1,211 Dental complaints, over half (53%) were regarding Fee-for-Service, nearly five percent were regarding Managed Care, and 42 percent did not identify a secondary dental product type. Los Angeles and Sacramento are the only counties with Medi-Cal Dental Managed Care.
- Approximately one-fourth of the 2,654 Medi-Cal Fee-for-Service complaints indicated a secondary product type of Pharmacy Benefits.
- Approximately one-fourth of the Long Term Care complaints indicated a secondary product type of Home Health Care. Long Term Care was a new product type category reported by DHCS. In prior years, DHCS reported data from its Managed Care Division regarding SCAN, PACE, and other long term care issues. This year, DHCS also reported data from its Long Term Care Division's In-Home Operations Branch regarding two Medicaid Waivers programs – the Nursing Facility/Acute Hospital Waiver and the In-Home Operation Waiver.
- DHCS reported new hearings data from the Breast Cancer and Cervical Cancer Treatment Program, which had not previously contributed data for this report.
- The Fee-for-Service complaints include hearings associated with the DHCS Benefits Division and the CA-MMIS Division's Conlan and Provider Assistance Unit, which had not previously contributed data for this report. DHCS indicated that the majority of the Benefits Division's complaints were regarding durable medical equipment, such as wheelchairs. All of the complaints from the Conlan and Provider Assistance Unit were regarding claim denials.

Complaint Reasons by Product Type

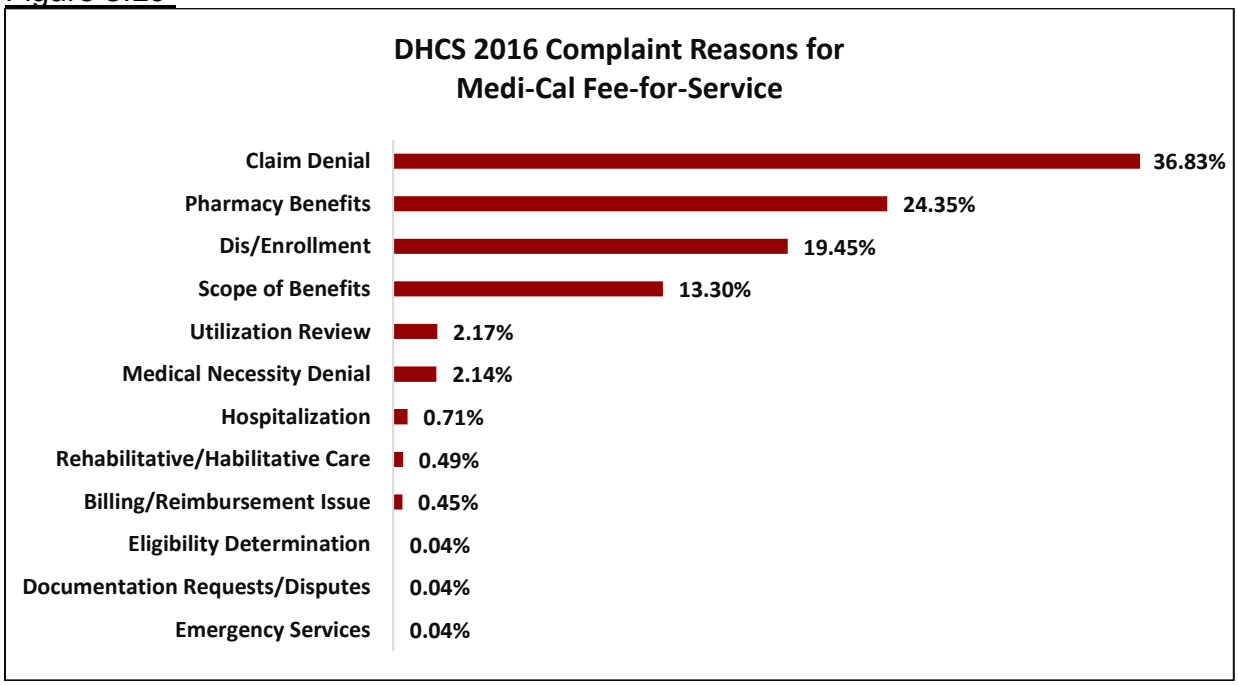
The following chart displays the complaint reasons for the product type of Medi-Cal Managed Care, which was associated with 2,807 complaints. None of the Managed Care complaints had a second complaint reason.

Figure 5.18



The following chart displays the complaint reasons DHCS reported for the 2,654 complaints with Medi-Cal Fee-for-Service identified as the product type. There were 15 Fee-for-Service complaints with a second complaint reason (2,669 reasons total).

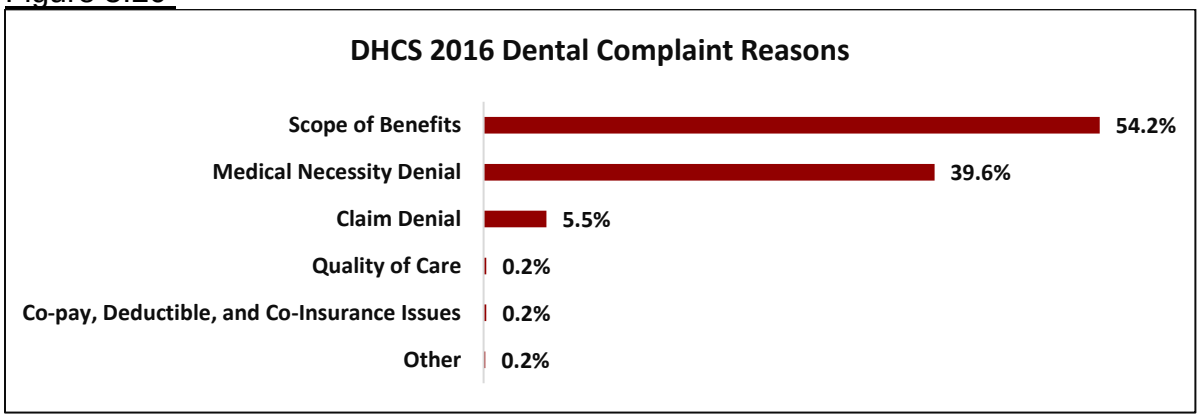
Figure 5.19



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

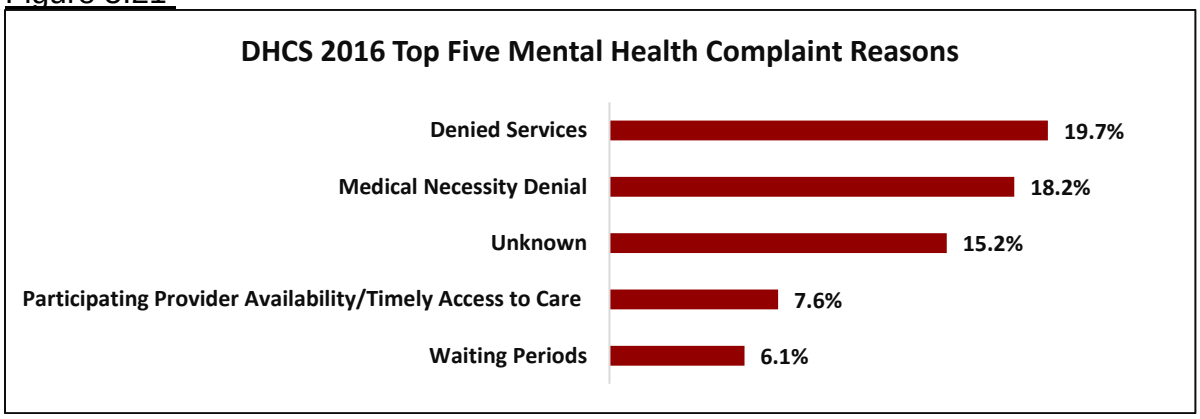
The following chart shows the complaint reasons for the 1,211 complaint cases with Dental identified as the product type. None of the Dental complaints had a second complaint reason reported. Sixty-eight percent of the Dental complaints had a second product type reported. The top three most common complaint reasons were the same regardless of whether the secondary product type indicated Dental Fee-for-Service or Dental Managed Care, or was unknown.

Figure 5.20



The following chart displays the top complaint reasons for the 63 complaints with Mental Health identified as the Product Type. The Top Five Complaint Reasons represent two-thirds of all reported Mental Health complaint reasons (66 reasons). The other 33 percent not shown were reported among 17 different categories of complaint reasons.

Figure 5.21



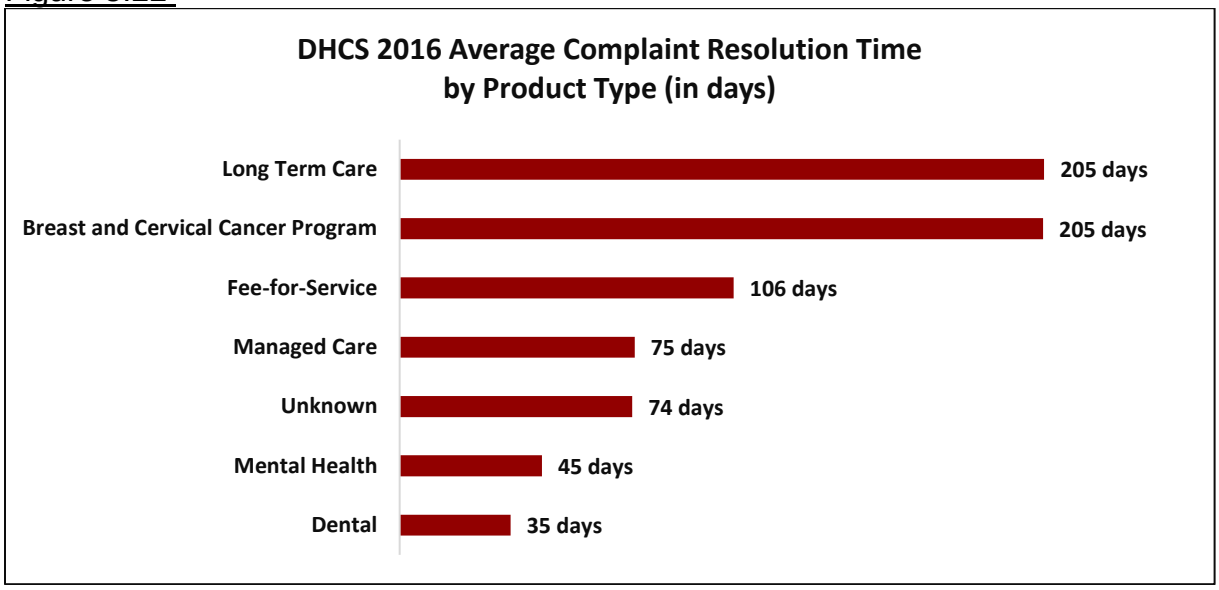
Note: The number of Mental Health complaint reasons (66) exceeded the number of Mental Health complaints (63) reported by DHCS because some complaints had more than one reason.

Because of the low volume of complaints, OPA did not create additional charts for Breast and Cervical Cancer Treatment Program, Long Term Care, or Unknown.

- All complaint reasons reported for the Breast and Cervical Cancer Treatment Program were Claim Denial.
- Claim Denial also was the most common reason for Long Term Care complaints (88% of 26 complaint reasons).

The following chart shows the 2016 average resolution times for the product types reported by DHCS.

Figure 5.22



D. Consumer Assistance Center Details

Consumer Assistance Protocols

DHCS reported that there were not any significant changes to any of their service centers' consumer assistance protocols or systems in 2016. Although the Mental Health Ombudsman is currently a part of the Medi-Cal Managed Care Office of the Ombudsman (as of February 2017), the 2016 Mental Health Ombudsman statistics are listed separately within this report.

Consumer Assistance Volumes by Service Center

DHCS reported 1,346,453 requests for assistance from consumers to its service centers. Of the requests received, the majority (95.7%) were by telephone (1,288,769), followed by email (4%) and mail (0.3%). Just 15 requests were made by other means.

The following charts show the DHCS consumer assistance volumes by month for each of its four service centers. The DHCS service centers' consumer requests for assistance are categorized as inquiries, as these service centers offer information and referrals rather than complaint resolution determinations. In 2016 the:

- ***Managed Care Ombudsman*** received 290,289 inquiries, a 15 percent decrease from 2015 (340,434). Of the inquiries, 236,768 (81.6%) were by telephone and 53,521 (18.4%) were by email.

- ***Mental Health Ombudsman*** received 7,737 inquiries, a three percent increase from 2015 (7,509). Of the inquiries, 7,473 (96.6%) were by telephone, three (0%) were by mail, 246 (3.2%) were by email, and 15 (0.2%) were by other means.
- ***Medi-Cal Telephone Service Center*** received 586,935 inquiries from beneficiaries, all by telephone, an eight percent increase from 2015 (541,982).
- ***Denti-Cal Telephone Service Center*** received 461,492 inquiries, a 19 percent decrease from 2015 (566,364). Of the inquiries, 457,593 (99.2%) were by telephone and 3,899 (0.8%) were by mail.

Figure 5.23

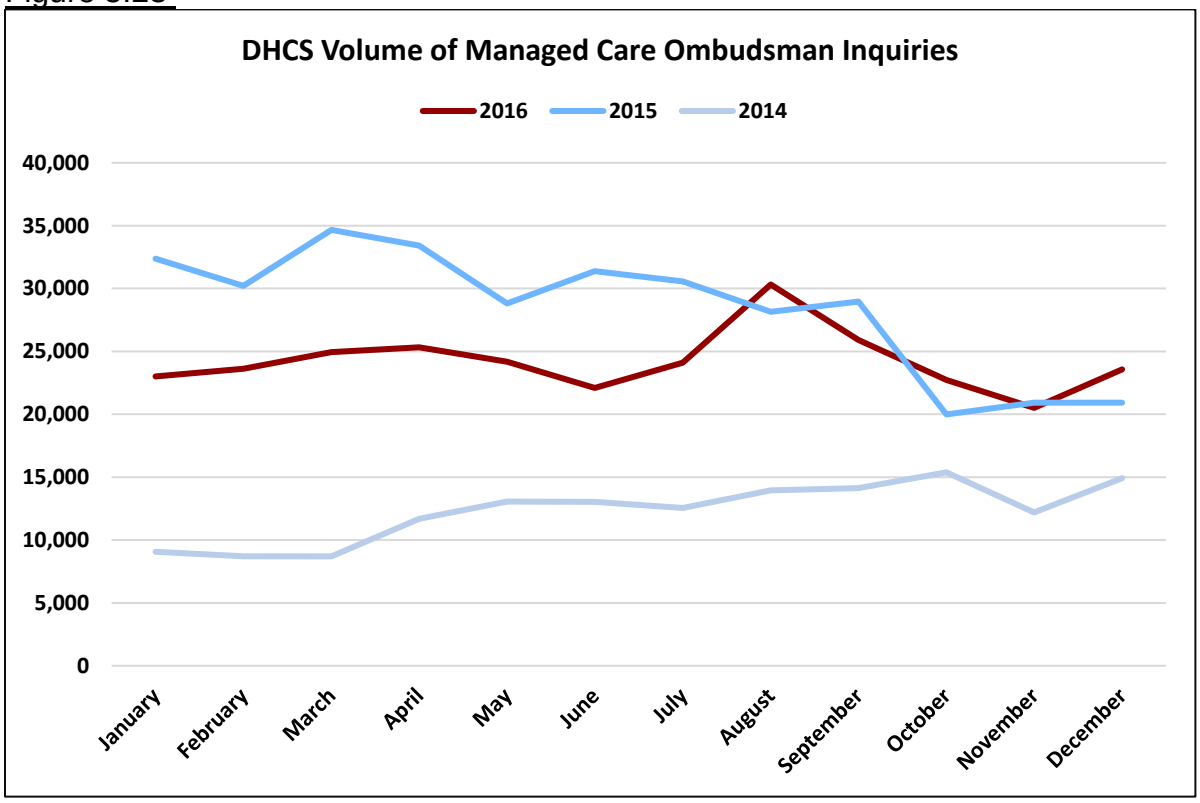


Figure 5.24

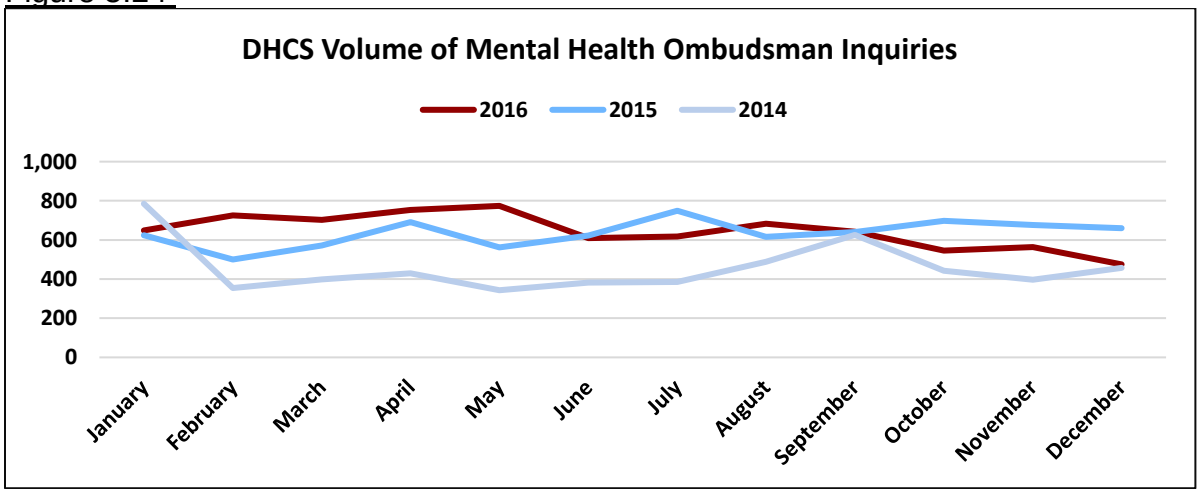


Figure 5.25

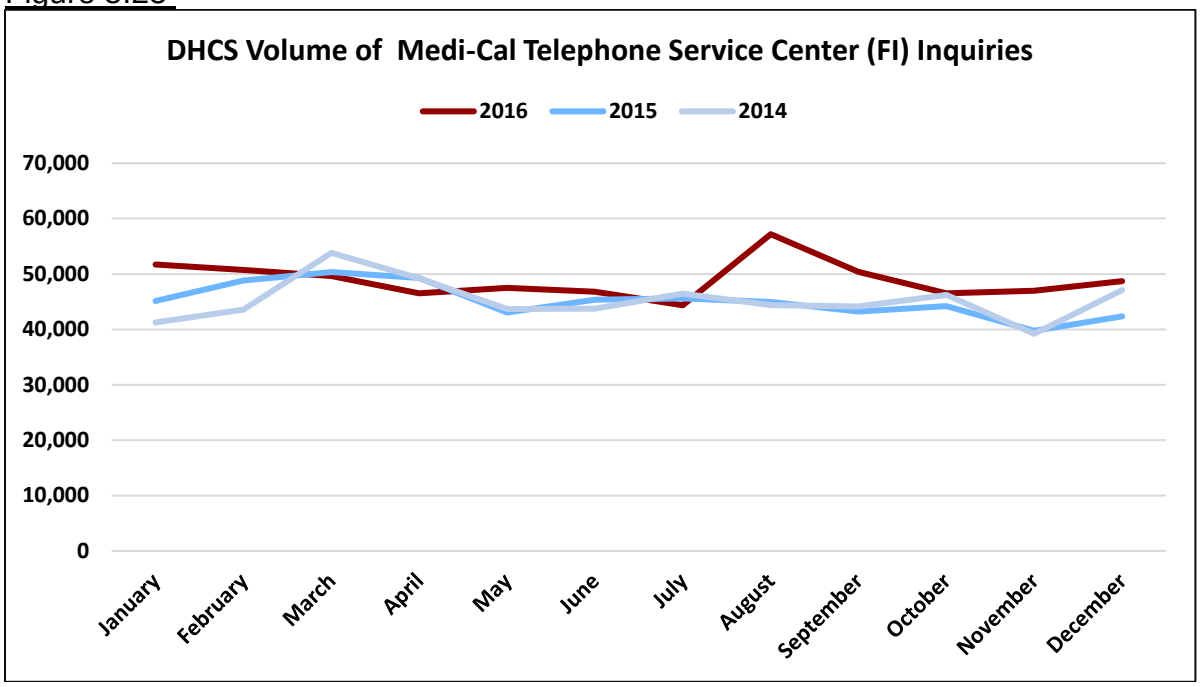
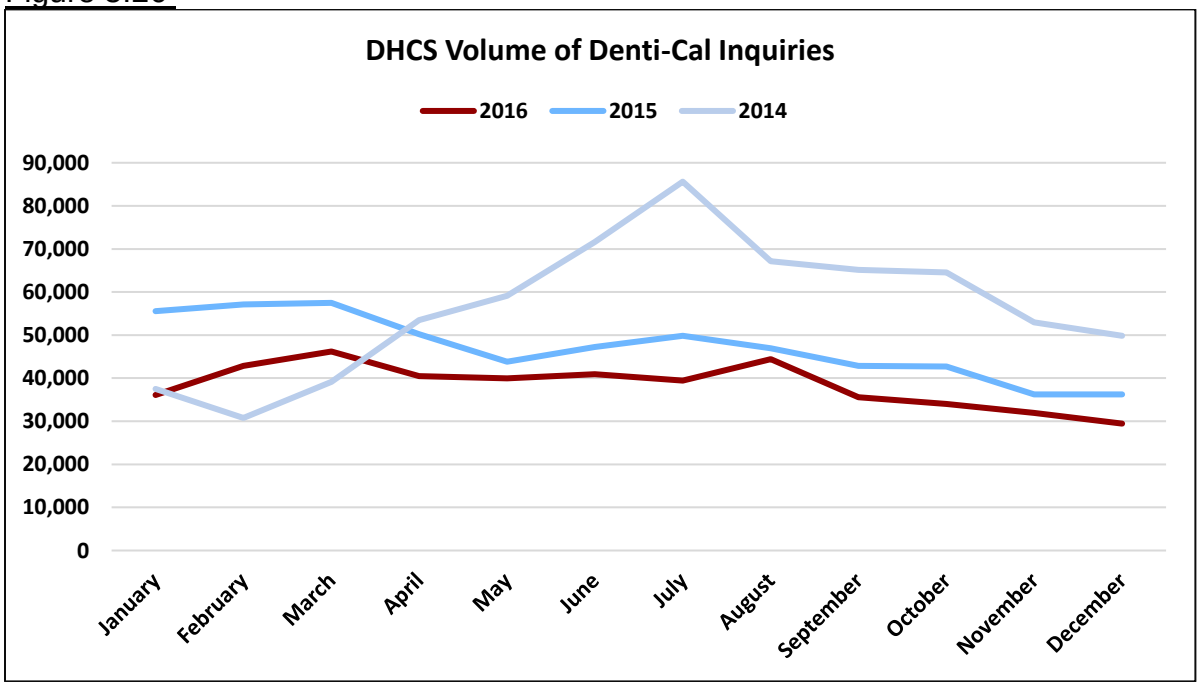


Figure 5.26



DHCS Service Centers' Telephone Call Metrics

The following table shows the response from DHCS regarding its service centers' telephone call metrics.

Figure 5.27

DHCS Service Centers' 2016 Telephone Metrics

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

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

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

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

**** Estimated by DHCS.*

Section 6 – California Department of Insurance

A. Overview

The California Department of Insurance (CDI) oversees more than 1,300 insurance companies and licenses more than 400,000 agents, brokers, adjusters, and business entities. 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.

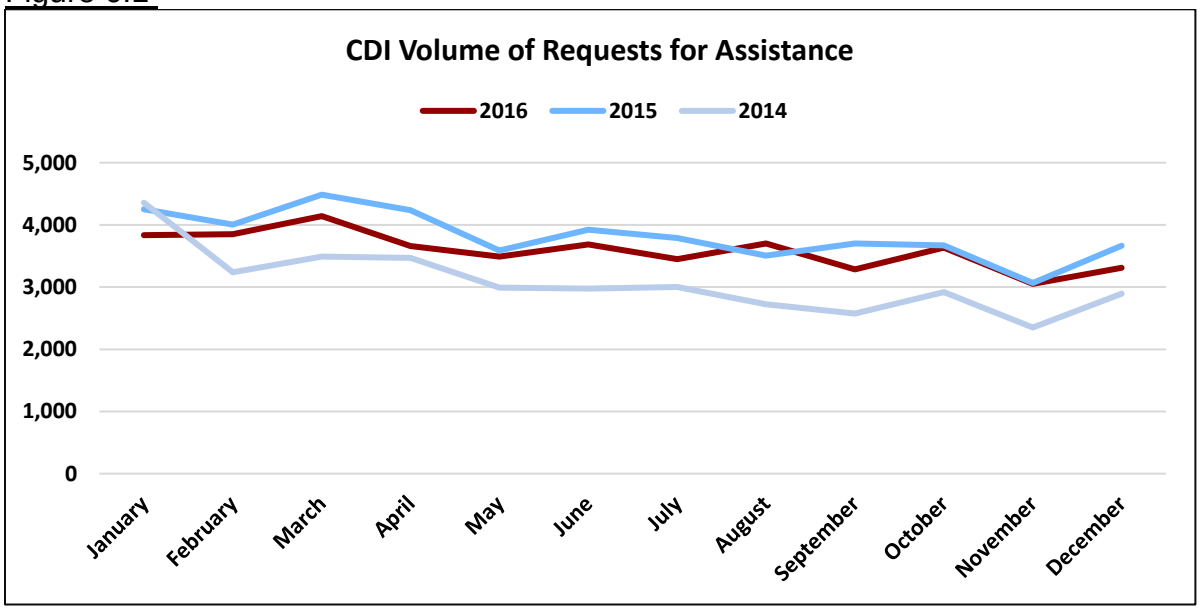
This report only includes CDI's health care coverage complaints, and not those related to life insurance, long term care, or other lines of business. For reporting standardization purposes, OPA refers to the health insurance companies associated with CDI-reported complaints as health plans.

CDI closed 2,871 jurisdictional complaints in 2016, an 11 percent decrease over the previous year (3,209 complaints in 2015), and a nearly 30 percent decrease compared to the baseline report year (4,079 complaints in 2014).

CDI received 43,097 requests for assistance from health care consumers in 2016, a six percent decrease in overall volume from the prior year (45,882 in 2015). The 2016 requests for assistance volume is nearly 17 percent higher than the baseline report year (36,986 in 2014). The requests for assistance volumes include both inquiries and complaints outside of CDI's jurisdiction to resolve. CDI reported that the department provided assistance to consumers for 6,796 non-jurisdictional complaints in 2016.

The following chart compares CDI's consumer assistance volumes by month for a three-year-period.

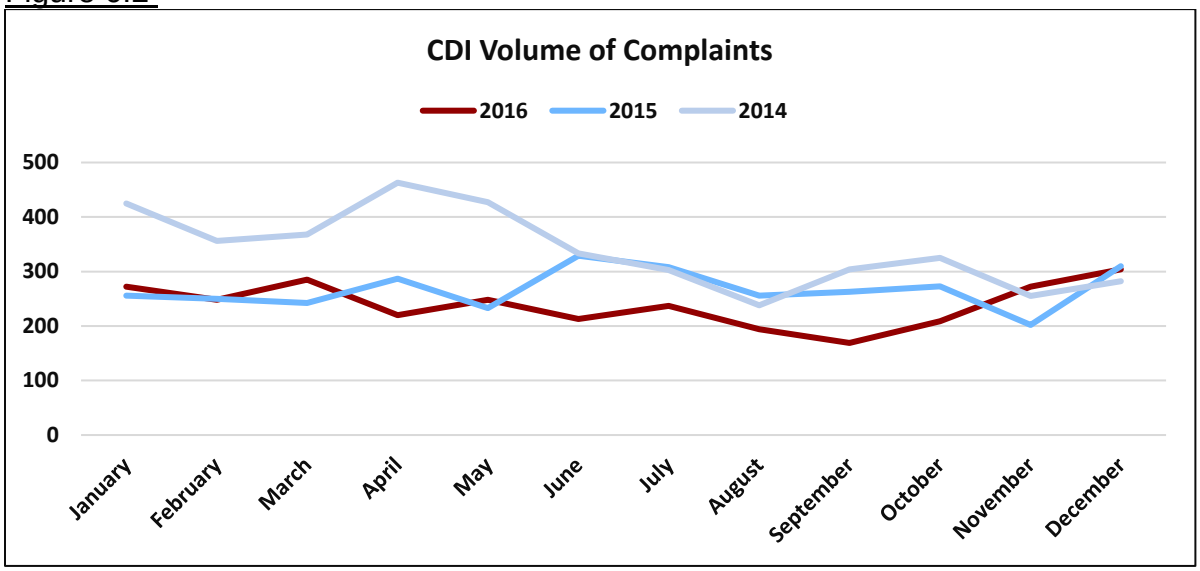
Figure 6.1



The following chart displays volumes distributed by the month the complaint closed for the 2016 total of 2,871 complaints; 2015 total of 3,209 complaints; and 2014 total of 4,079 complaints.

- The volumes shown are for complaints regarding CDI-regulated products and exclude non-jurisdictional complaints that may have been addressed by the department during the measurement year.

Figure 6.2



Complaint Type Overview

CDI reported two different types of health care complaint processes: Standard Complaint and Independent Medical Review (IMR).

- Complaints that qualify for IMR involve disputes about the medical necessity of a treatment, an experimental or investigational therapy for certain medical conditions, or a claim denial for emergency or urgent medical services.
- CDI's compliance officers review all other issues through a Standard Complaint process.

The average resolution times noted in Figure 6.3 were calculated based on the durations of all 2016 complaints reported for the complaint type specified. CDI's complaint duration reflects the date from initial receipt of the complaint to the date the complaint was closed after completion of the final regulatory review.

- Consumers can submit a complaint to CDI concurrent with the health plan's internal complaint review period.

- The close date does not reflect the date when the case was closed to the consumer complainant.
- CDI indicated in prior reporting years that its regulatory review period is 30 days on average.

Figure 6.3

CDI Complaint Standards

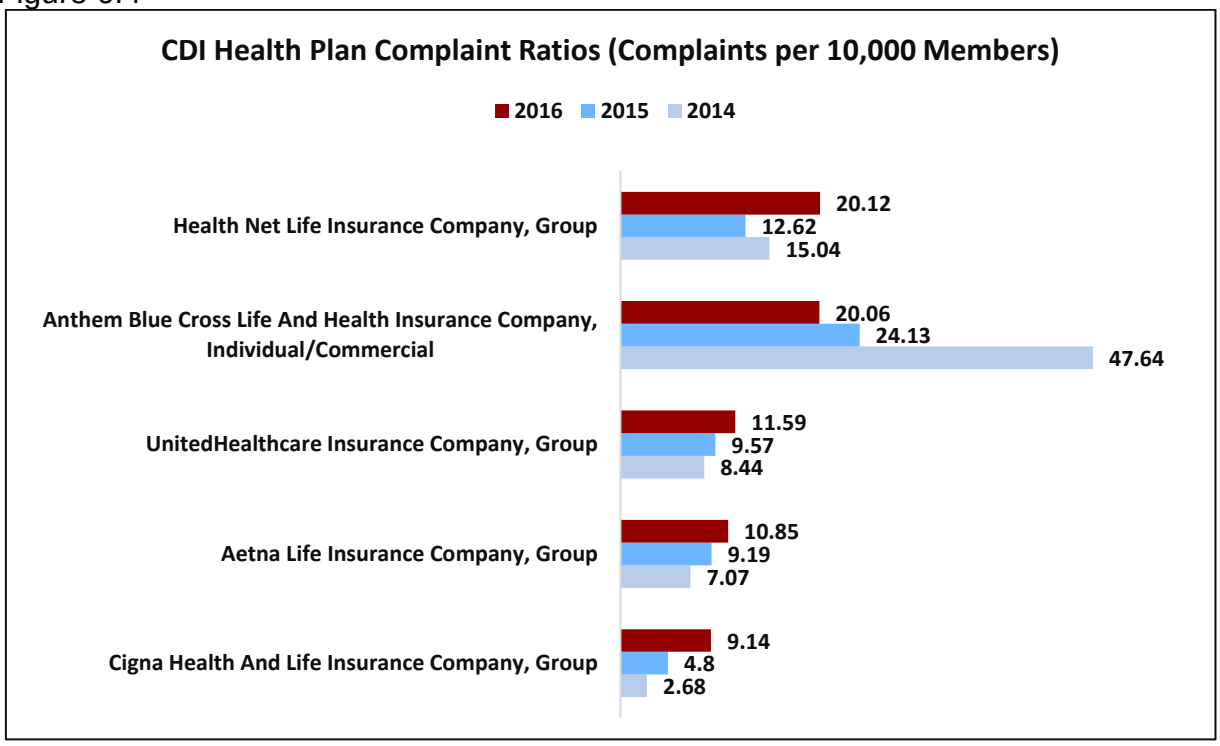
Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2016
Standard Complaint	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau and Rating and Underwriting Services Bureau:* Compliance officers respond to written complaints *Consumer Law Unit:* Legal review (if needed)	30 working days, or 60 days (if reviewed concurrently with health plan level review)	88 days Calculation includes time for regulatory review after the case is closed to the consumer complainant
Independent Medical Review (IMR)	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau*: Intake and casework *IMR Organization (contractor-MAXIMUS):* Case review and decision *Consumer Law Unit:* Legal review (if needed) Urgent clinical issues that qualify are addressed through an expedited IMR process	30 working days, or 60 days (if reviewed concurrently with health plan level review)	94 days Calculation includes time for regulatory review after the case is closed to the consumer complainant. Calculation also includes cases that met urgent clinical criteria.

B. Complaint Ratios, Reasons, and Results

CDI closed 2,871 complaints in 2016 regarding 113 commercial group or individual health plan products.

The following chart shows the complaint ratios for the health plans regulated by CDI with at least one complaint closed in 2016 and with either group or individual enrollment exceeding 70,000 covered lives. A higher complaint ratio means that more complaints were closed per member.

Figure 6.4



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

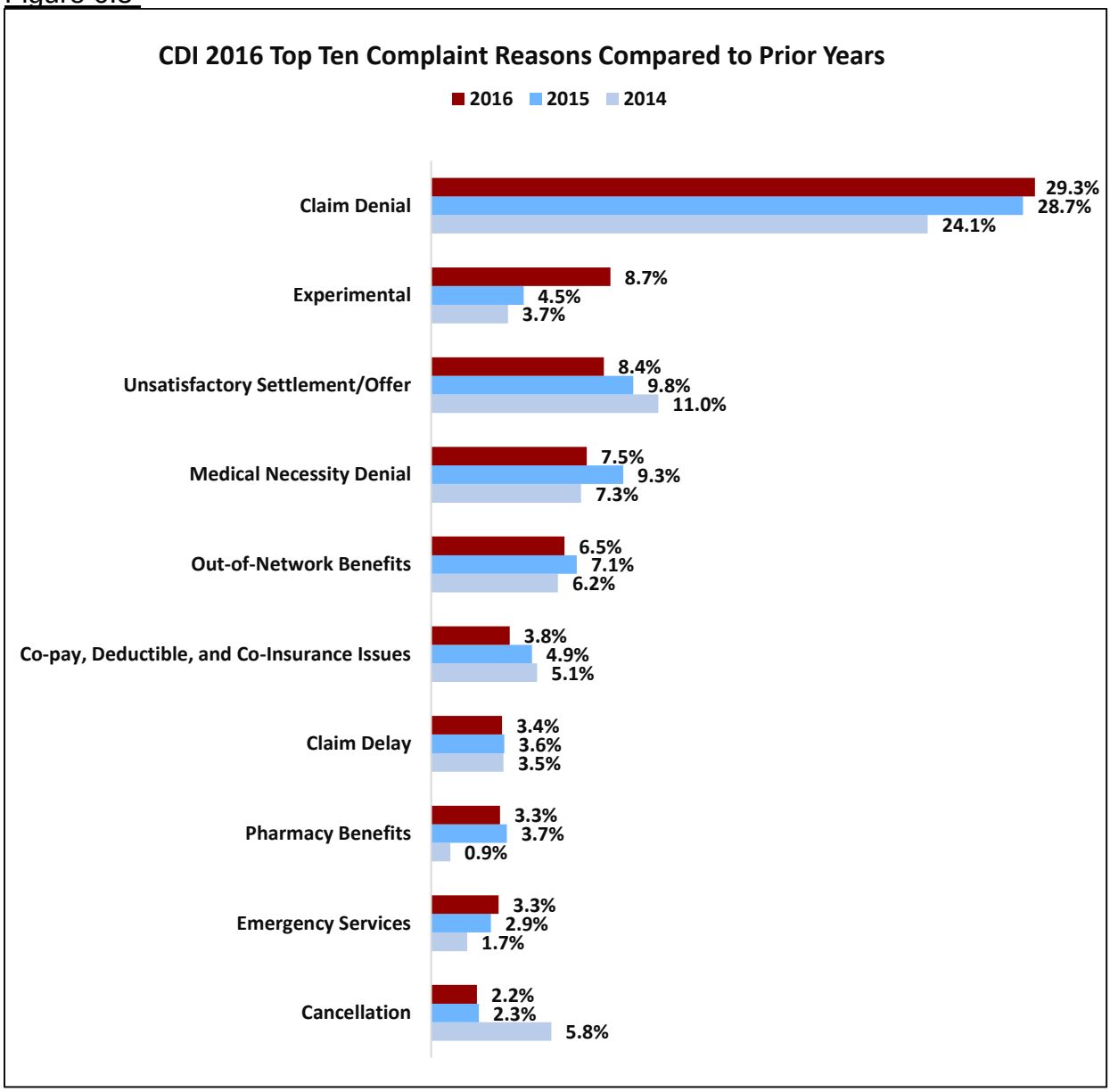
Top Ten Reasons for Jurisdictional Complaints

Many consumer complaints reported by CDI involved more than one issue. CDI reported multiple reasons for 43 percent (1,222) of its complaints for 2016, which is why the total number of complaint reasons (4,093) exceeds the total number of complaints (2,871).

The following chart displays the top ten most common reasons for complaints in 2016, as well as the percentage reported for those same categories in 2014 and 2015. The top ten complaint reason categories account for 76 percent of the 4,093 complaint reasons reported for 2016. There were 67 reason categories with at least one complaint in 2016.

Claim Denial remained the top complaint reason in 2016, accounting for 29.3 percent (1,199) of the complaint reasons reported. Experimental was the second most common reason with just under nine percent in 2016, increasing in volume by nearly 40 percent and ranking over the prior year (sixth most common reason in 2015).

Figure 6.5



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

Top Ten Topics for Non-Jurisdictional Inquiries

Approximately one-fifth of the telephone calls that CDI's consumer assistance service center received in 2016 were for inquiries or complaints outside of CDI's jurisdiction to address or resolve.

The following table displays the CDI's most common consumer referral topics in 2016, as well as the departments to which those inquiries were referred.

Figure 6.6

CDI 2016 Top Ten Topics for Non-Jurisdictional Inquiries

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

Note: Ranking estimated by CDI.

- Claim Denial continued to be the top inquiry topic.
- Subsidy/Enrollment increased from fourth to second most common inquiry topic from 2015 to 2016.
- The third ranked topic of Claim Handling Delay was ranked seventh in 2015.
- Cancellation and Policyholder Service were not among the top ten in 2015.
- Pharmacy Benefits was also ranked ninth in the prior year.
- The following topics decreased in ranking from the prior year: Co-pay/Out-of-Pocket Charges, Out-of-Network Benefits, Medical Necessity, and Premium/Billing.

Complaint Results

CDI reported multiple results for approximately one-fourth (24.6%) of the complaints closed in 2016, which is why the total number of results (3,761) exceeds the total number of complaints (2,871).

The following table and chart display the ten most common complaint results in 2016. The top ten results categories account for 96 percent of all results reported for 2016. The other four percent not shown were associated with 11 different result categories.

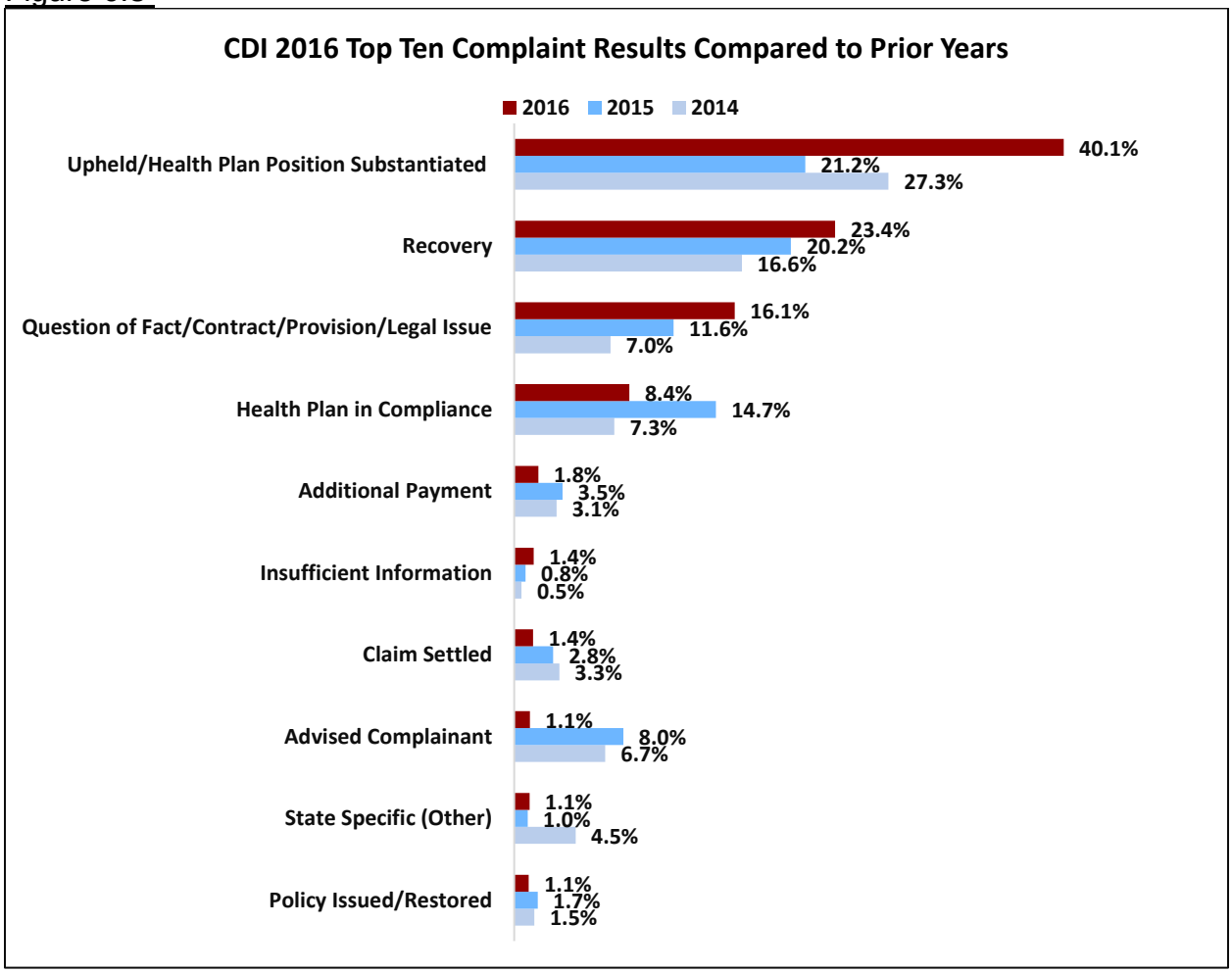
Figure 6.7

CDI 2016 Top Ten Complaint Results

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

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

Figure 6.8



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

Resolution Time

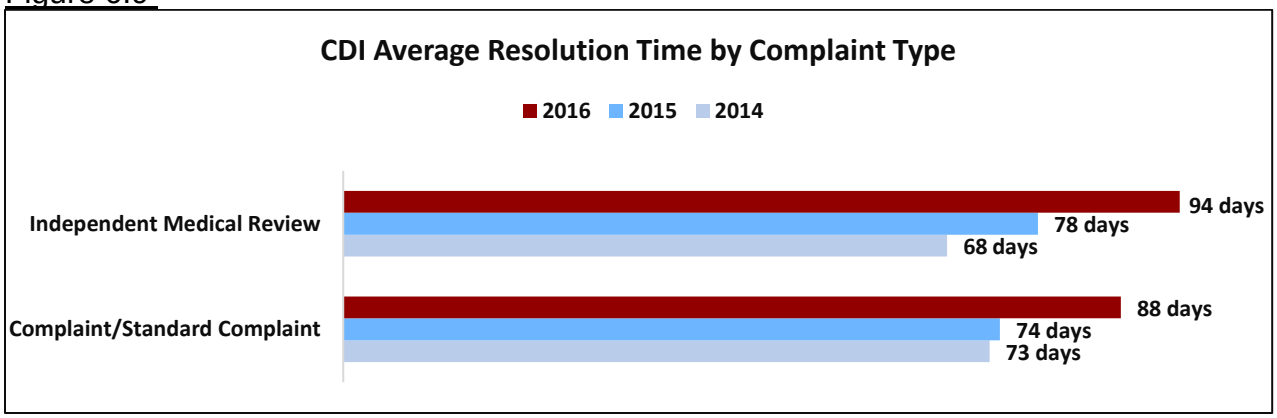
CDI took 90 days on average to resolve complaints in 2016.

The CDI complaint duration period reflects the open date when the department received the initial complaint through the close date when the department completed its final regulatory review.

- Since CDI allows for concurrent review, average resolution time calculations include complaints opened prior to the completion of the health plan internal complaint review period.
- The close date reported by CDI does not reflect the date the complaint was closed to the complainant, but rather the conclusion of the department's regulatory investigation period.
- CDI indicated for prior year reports that its final regulatory review period is 30 days on average.

The following chart shows a three-year-comparison of average resolution times for CDI's two reported complaint type processes. Average resolution times have increased each measurement year for both complaint types.

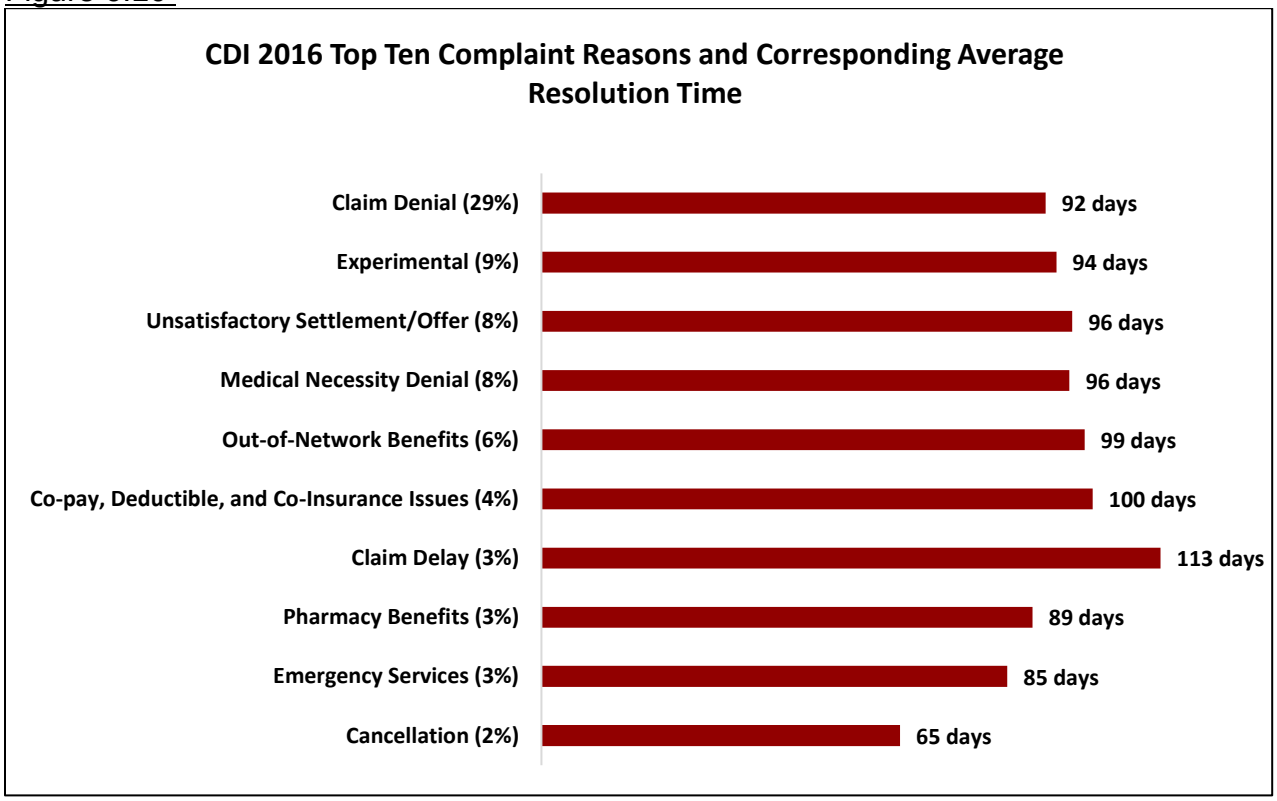
Figure 6.9



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

The following chart shows the average number of days it took for CDI to resolve the most common complaint reasons reported for 2016.

Figure 6.10



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

C. Demographics and Other Complaint Elements

Age

The average age of consumers who had complaints reviewed in 2016 by CDI was 46. Over a third (35%) of complaints came from consumers in the 35-54 age category and one third (33%) came from those in the 55-74 age range. Complaints from consumers aged 18-34 made up 17 percent of complaints. Those who were younger than 18 or older than 74 years of age accounted for 12 percent of total complaints (9% and 3%, respectively). Three percent of consumers refused to disclose or did not identify their age.

- Claim Denial continued to rank as the top complaint reason across all age groups and among consumers for which age data was unknown.

- Unsatisfactory Settlement/Offer also was among the top three complaint reasons across all age groups.
- Medical Necessity Denial rounded out the top three reasons for complainants under age 35.
- Experimental was among the top three complaint reasons for those between 35 and 74 years old.
- Unsatisfactory Refund of Premium was the third most common reason for complainants 75 and older.

Gender

Most of the consumers who had complaints reviewed by CDI in 2016 were identified as female (58% female, 42% male).

- Claim Denial was the top complaint reason for both female and male complainants.
- Among female complainants, Experimental was the second most common reason in 2016, with an increase in volume of 93 percent and ranking from the previous year (ranked 5th in 2015).
- Among male complainants, Experimental replaced Co-pay, Deductible, and Co-Insurance Issues as the fifth most common reason, with an increase in volume of 10 percent from the previous year.
- The volume of the other four most common complaint reasons for both genders decreased from the previous year.

Race

CDI reported a higher percentage of complaints with race identified (55%) than the previous year (42%). Fewer complainants refused to identify their race (29.7% Refused) and a lower percentage of complaints were submitted with race Unknown (15.6%).

Of the consumers whose complaints were reviewed by CDI, 45 percent identified as White. Complainants also indicated race categories of: American Indian or Alaska Native (0.3%), Asian (4.9%), Black or African American (1.7%), Native Hawaiian or Other Pacific Islander (0.4%), or Other (2.3%).

- Claim Denial continues to rank as the top complaint reason across all race categories.
- Experimental was the fourth most common reason for White and second most common reason for Refused/Unknown.
- Co-Pay, Deductible, and Co-Insurance Issues was the fifth most common reason for Other race categories combined.
- Unsatisfactory Settlement/Offer, Out-of-Network Benefits, and Medical Necessity Denial rounded out the top five reasons for all categories analyzed.

Ethnicity

Forty-six percent of CDI's complaint records did not include data for ethnicity. Four percent of the consumers who submitted complaints to CDI identified their ethnicity as Hispanic or Latino. Half of the complainants were identified as Non-Hispanic or Latino.

- Claim Denial continued to rank as the top complaint reason across all reported categories of ethnicity.
- Unsatisfactory Settlement/Offer was the second most frequently cited complaint reason among consumers who identified their ethnicity.
- Co-Pay, Deductible, and Co-Insurance Issues was the third most common reason for consumers who identified as Hispanic or Latino.
- Experimental entered the top five in 2016 for Non-Hispanic or Latino and Refused/Unknown (ranked fourth and second, respectively), increasing in volume and ranking from the prior year.

Language

Of the 2,871 consumers who submitted complaints to CDI, most (61%) identified English as their primary language, while 3 percent identified a language other than English (including 1% Spanish and 2% distributed across 11 other languages). The remaining 36 percent of complainants refused to disclose or did not identify a primary language.

- Claim Denial continued to rank as the top complaint reason across all language categories.
- Unsatisfactory Settlement/Offer and Out-of-Network Benefits were the second and third most frequently cited complaint reasons for English and Refused/Unknown.
- For consumers who identified a language other than English as their primary language, Co-pay, Deductible, and Co-Insurance Issues and Experimental ranked as the second and third most frequently cited complaint reasons, respectively.

Mode of Contact

All of CDI's 2,871 complaints were initiated using one of four modes of contact: Counter/In-Person, Mail, Telephone, or Online. Mail submissions continued to account for the majority of complaint initiations (60%). More consumers submitted complaints online for 2016 (33%) than in the prior year, with an increase in both overall volume and percentage of the total submissions. Telephone submissions accounted for seven percent and Counter/In-Person for less than one percent of the complaint initiations.

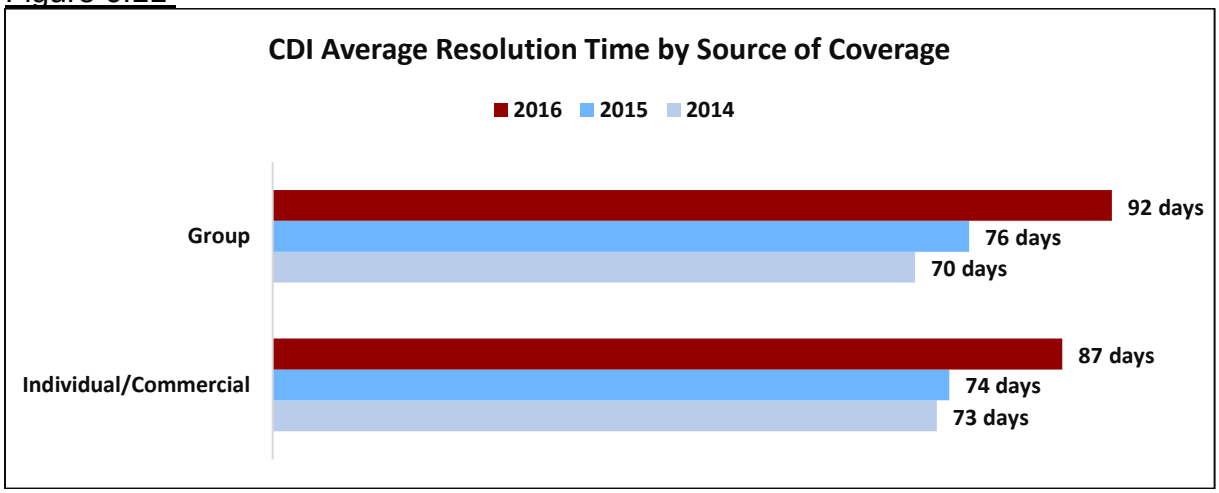
Regulator

CDI was the regulatory authority identified for all 2,871 complaints reported for 2016.

Source of Coverage

CDI's 2,871 consumer complaints had one of two coverage sources identified: Group or Individual/Commercial. The Group coverage source accounted for 64 percent of complaints and Individual/Commercial accounted for 36 percent.

Figure 6.11



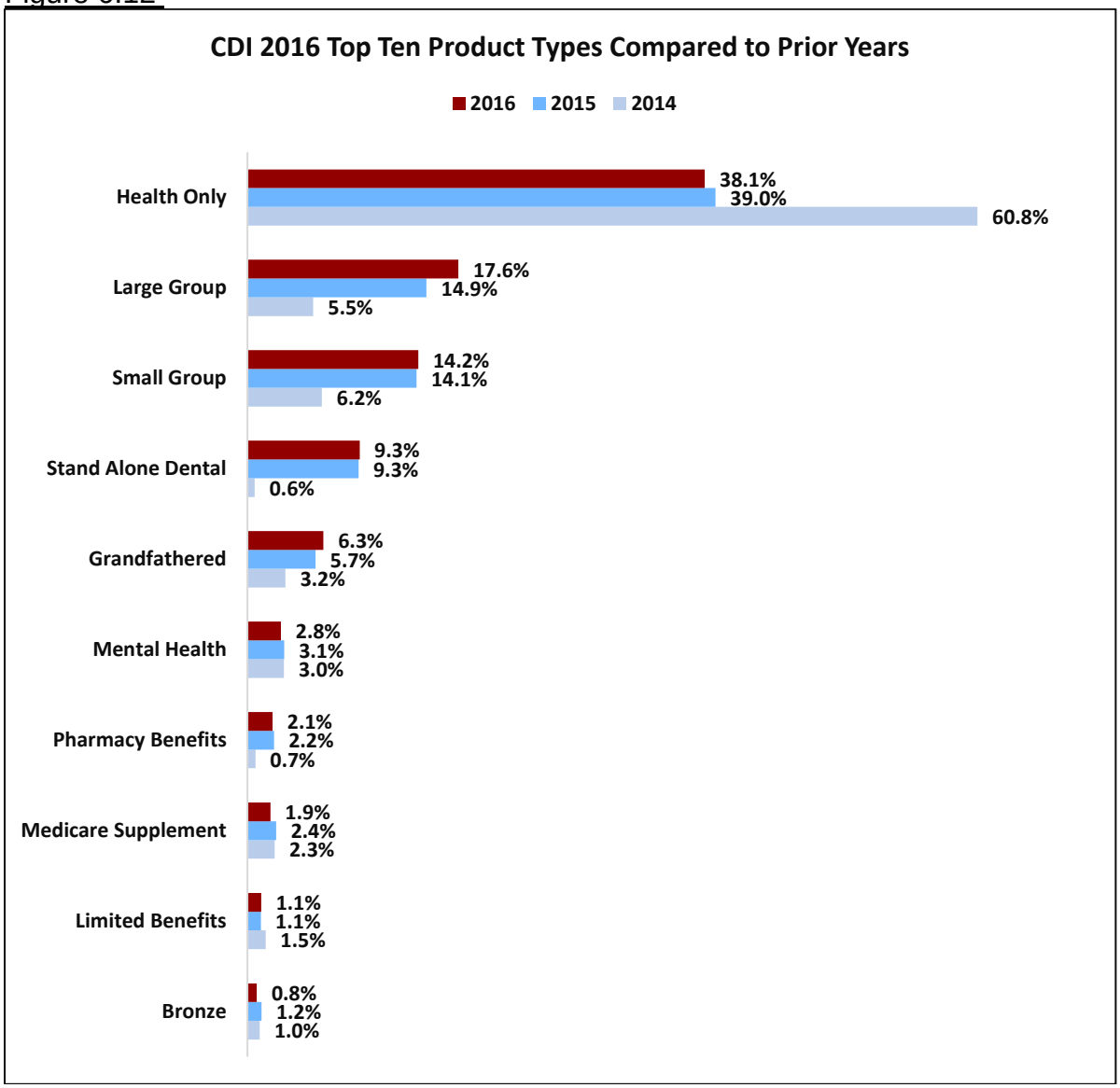
Note: The CDI complaint duration reflects the date from initial receipt of the complaint to the end of the final regulatory review. The close date does not reflect the date when the complaint was closed to the complainant. Consumers can submit a complaint to CDI concurrent with the health plan's internal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

Product Type

Consumer complaints reviewed by CDI in 2016 included 26 product type categories. The total number of product type entries reported (5,234) exceeded the number of complaint cases (2,871) because some complaints had more than one product type identified. Most CDI complaint cases (60%) had two product types identified. Health Only continued to be the most common product type identified, accounting for 38 percent (1,993) of the entries in 2016.

The following chart shows the most common product type categories reported by CDI for 2016 and the distribution of complaints within those same categories in 2014 and 2015.

Figure 6.12



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

D. Consumer Assistance Center Details

CDI's service center reported receiving 43,097 requests for assistance from consumers in 2016. Although there was a 6 percent decrease from 2015 (45,882), the requests for assistance volume remains higher than the 2014 baseline report year.

Of the requests for assistance received in 2016, 33,434 (77.6%) were made by telephone, 1,737 (4%) were mailed, 945 (2.2%) were submitted online, and 185 (0.4%) were made in person. CDI also identified 6,796 non-jurisdictional complaints (15.8%) where the mode of contact was unspecified.

Service Center Telephone Call Metrics

The CDI Consumer Services Division reports receiving 33,244 total telephone calls from consumers in 2016. The following table shows the survey response from CDI regarding some of its service center telephone call metrics.

Figure 6.13

CDI Consumer Services Division – 2016 Telephone Metrics

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

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

Consumer Assistance Protocols

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

Section 7 – Covered California

A. Overview

Covered California, the state's health benefit exchange, provides a state-based health insurance marketplace for consumers to buy health insurance and qualify for financial assistance to help pay their insurance costs. Covered California serves as an active purchaser, selecting and establishing criteria for the health plans that can sell products on the Covered California marketplace.

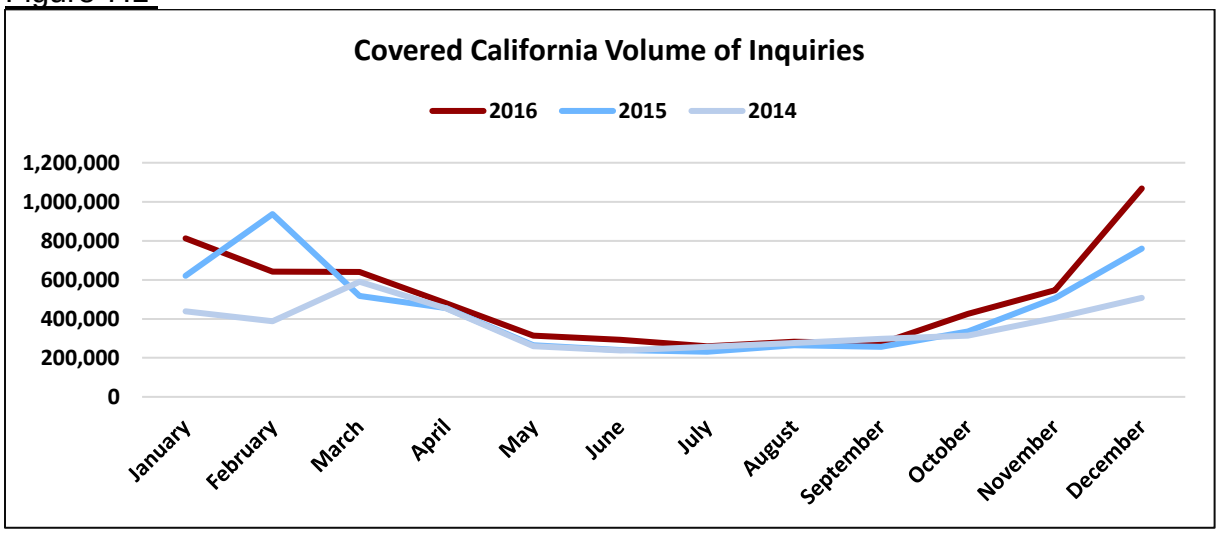
This report includes information reported by Covered California regarding:

- Covered California complaints that were adjudicated by the California Department of Social Services (CDSS) through the State Fair Hearing process with a decision from an Administrative Law Judge.
- State Fair Hearing requests that were resolved informally by Covered California without completing the hearing process.
- Consumer assistance provided by the Covered California Service Center to help Californians understand their health care coverage options and apply for coverage and associated financial assistance.

Covered California received 6,058,978 requests for assistance from consumers in 2016, a 12 percent increase in volume from 2015 (5,397,086). The requests for assistance volume includes inquiries to the Covered California Service Center and complaints resolved formally and informally through a State Fair Hearing.

The following chart compares the monthly volume of consumer inquiries to the Covered California Service Center for a three-year-period. The annual volumes were 6,038,580 inquiries in 2016; 5,390,936 in 2015; and 4,424,070 in 2014. The 2014 volume includes 250,697 Small Business Health Options Program (SHOP) contacts. SHOP contacts were not reported for 2015 or 2016.

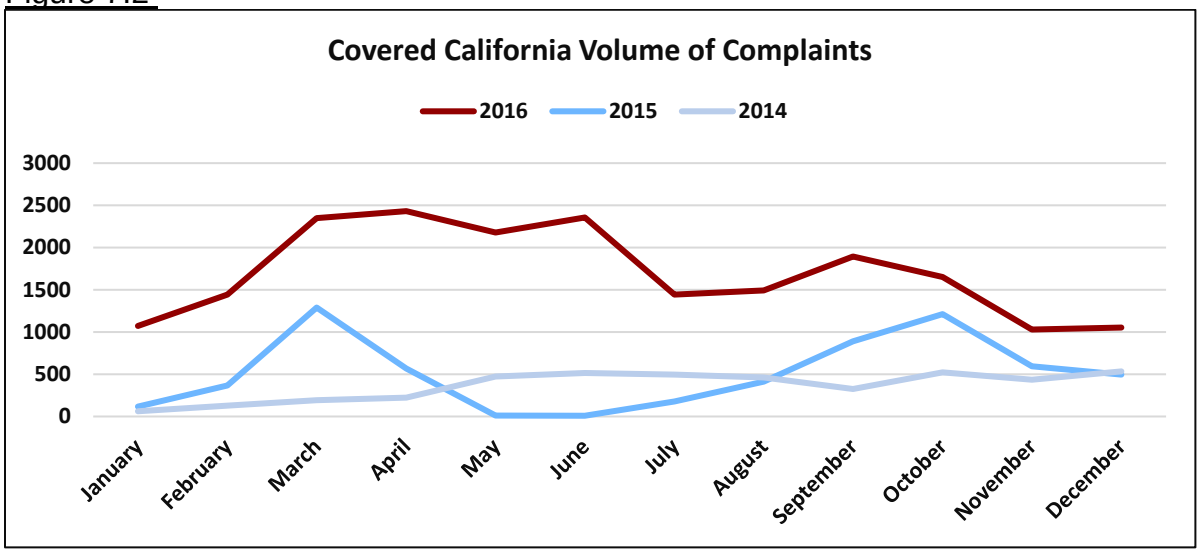
Figure 7.1



The following chart compares Covered California's complaint volumes by month closed over a three-year period. There were 20,398 complaints reported in 2016, a 232 percent increase in complaint volume from the prior year (6,150 complaints in 2015).

Most of this growth was due to an increase in the State Fair Hearing: Informal Resolution complaint type, a process through which the consumer's complaint is resolved by Covered California without a hearing taking place. Covered California is actively exploring other potential reasons for the increase seen between 2015 and 2016, and will provide any relevant information in future reports.

Figure 7.2

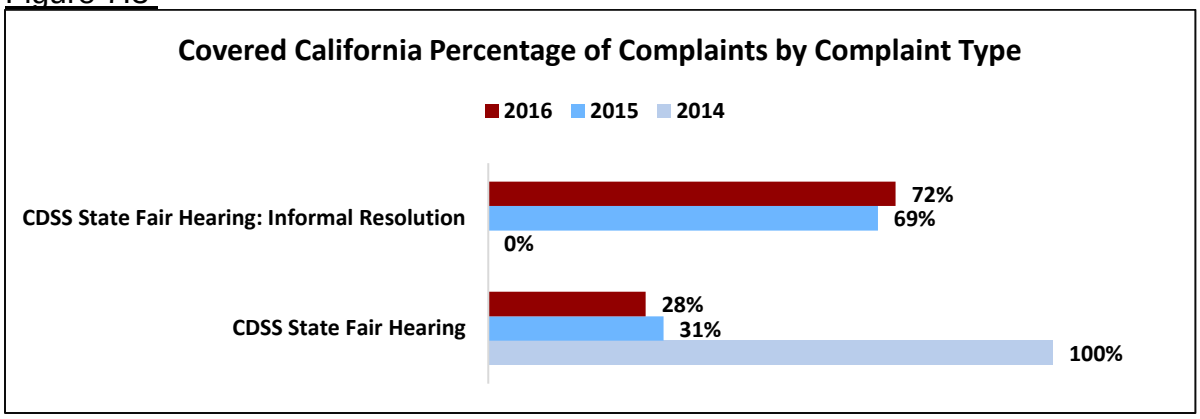


Complaint Type Overview

The following chart compares the distribution of Covered California complaints by complaint type over a three-year period. Since 2015, Covered California has reported two complaint types associated with the State Fair Hearings process:

- **State Fair Hearing** indicates that a consumer's complaint was resolved by CDSS through a hearing and decision by an Administrative Law Judge.
- **State Fair Hearing: Informal Resolution** indicates that a hearing was requested, but the consumer's complaint was resolved by Covered California without a hearing taking place.

Figure 7.3



The following table outlines the processes for Covered California complaints.

Figure 7.4

Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2016
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Covered California eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving consumers with urgent clinical issues.	No later than 90 days from the date the hearing request was filed	86 days
State Fair Hearing: Informal Resolution	*CDSS State Hearings Division:* Reviews requests for State Fair Hearings and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge. *Covered California staff*: Reviews complaint outlined in the State Fair Hearing request and conducts casework to resolve the complaint.	Up to 45 days from the date the appeal was filed	59 days

Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14. The Covered California Service Center staff address Service Center complaints that are not State Fair Hearing appeals, and escalate issues to internal supervisors, subject matter experts, and customer resolution teams as needed. Covered California's External Coordination Unit addresses certain non-appeal issues escalated by the Service Center that involve consumers with urgent access to care issues.

B. Complaint Ratios, Reasons, and Results

Covered California reported its 20,398 complaints within three complaint reason categories involving program eligibility issues.

No complaint ratios were calculated based on the complaint data submitted by Covered California because its complaint records did not include information on health plan complaints. Covered California health plan complaints are addressed through the health plan grievance and regulator complaint review processes rather than through a State Fair Hearing.

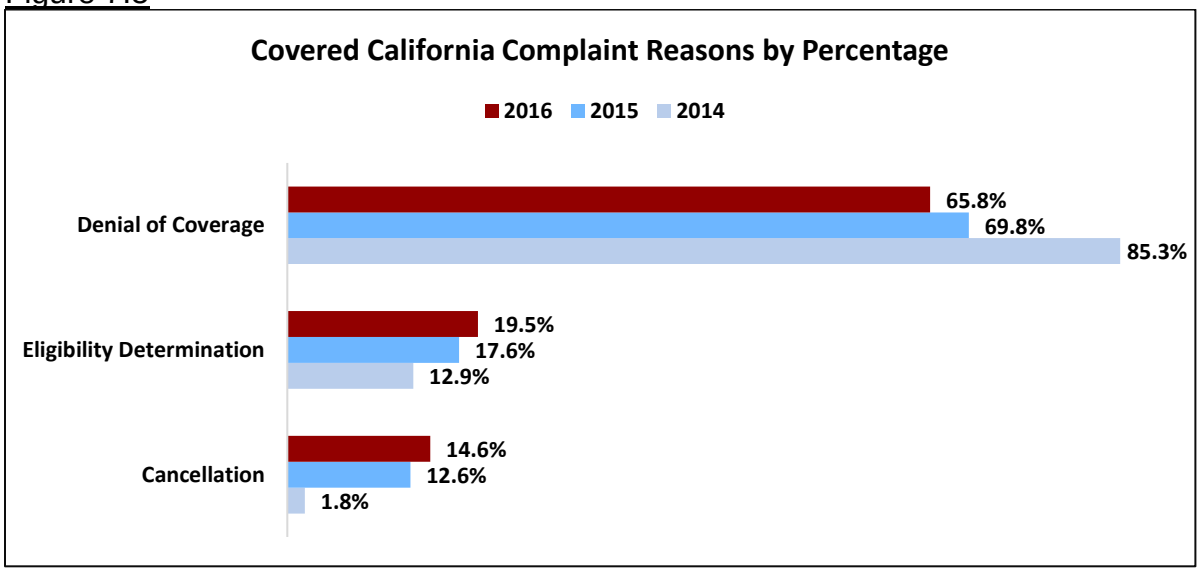
See Section 4.C. for information about Covered California health plan complaints resolved by the Department of Managed Health Care in 2016.

Reasons for Jurisdictional Complaints

The following chart compares the annual distribution of complaints among the three complaint reason categories reported by Covered California. The chart accounts for all 4,366 complaints in 2014, all 6,150 complaints in 2015, and all 20,398 complaints in 2016. No Covered California complaint had a second complaint reason reported.

Denial of Coverage (13,430 complaints) continued to be the top complaint reason, with a 212 percent increase in volume from the prior year. However, complaints for the other two reason categories increased in volume at a higher rate (Eligibility Determination increased by 268% and Cancellation by 285%).

Figure 7.5



Top Ten Reasons for Inquiries

The following table displays the top ten inquiries made by consumers to the Covered California Service Center in 2016, including for both jurisdictional and non-jurisdictional topics. The most common non-jurisdictional consumer referrals continue to be regarding Medi-Cal topics.

- The top inquiry topic, for the jurisdictional issue of application/case status, was unchanged from the prior year.
- The second most common inquiry topic, 1095-A Inquiry/Assistance, was reported for the first time. The Form 1095-A provided information that Covered California enrollees needed to prepare their federal taxes.

Figure 7.6

Covered California 2016 Top Ten Jurisdictional and Non-Jurisdictional Inquires

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

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

Complaint Results

The following table displays all of the 20,398 complaint results reported by Covered California for 2016. All of the complaints submitted by Covered California had a known complaint result reported. No complaint had more than one result reported.

Figure 7.7

Covered California 2016 Complaint Results

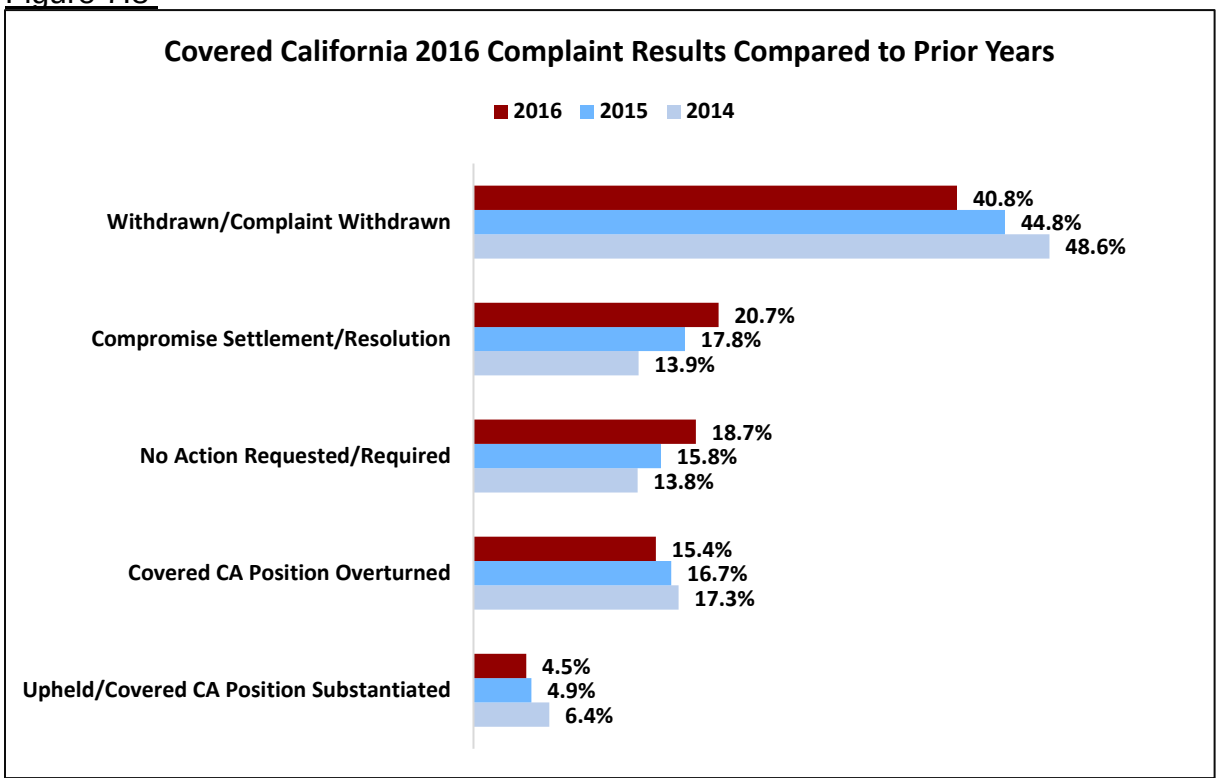
Complaint Result	2016 Volume
Withdrawn/Complaint Withdrawn	8,315
Compromise Settlement/Resolution	4,213
No Action Requested/Required	3,824
Covered CA Position Overturned	3,138
Upheld/Covered CA Position Substantiated	908

Note: Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Covered CA Position Overturned. Results categories considered favorable to Covered CA include: Upheld/Covered CA Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against Covered California, but indicates that the consumer received services or a similar positive outcome.

The following chart compares the annual percentages of the complaint results reported by Covered California over a three-year period.

- Withdrawn/Complaint Withdrawn continues to be the top complaint result, but has dropped in percentage distribution each year.
- Covered CA Position Overturned decreased in ranking from the third most common result in 2015 to the fourth most common result in 2016.

Figure 7.8



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

Figures 7.9 – 7.11 provide a reason-to-result analysis for each of the three complaint reasons reported by Covered California in 2016. All three complaint reasons had similar results distributions.

The following table shows complaint results for all 13,430 complaints reported with the Denial of Coverage complaint reason.

Figure 7.9

Covered California 2016 Results for Denial of Coverage Complaints

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

The following table shows the complaint results for all 2,986 complaints reported with the Cancellation complaint reason.

Figure 7.10
Covered California 2016 Results for Cancellation Complaints

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

The following table shows the complaint results for all 3,982 complaints reported with the Eligibility Determination complaint reason.

Figure 7.11
Covered California 2016 Results for Eligibility Determination Complaints

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

Resolution Time

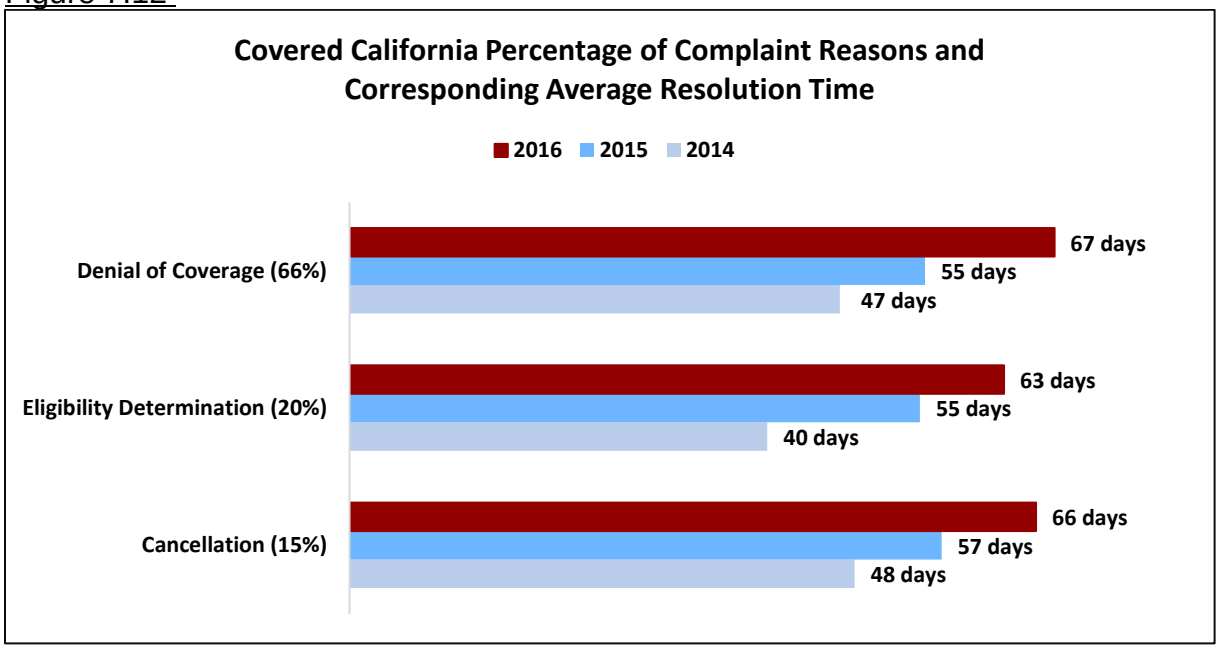
Covered California complaints took on average 66 days to resolve in 2016.

- The average resolution time was 46 days in 2014 and 55 days in 2015.
- In 2016, the complaint type State Fair Hearing: Informal Resolution averaged 59 days and the full State Fair Hearing averaged 86 days.

The 2014 data does not differentiate the complaint type State Fair Hearing: Informal Resolution, which was first reported as a distinct category for 2015.

The following chart displays the annual average resolution times for the complaint reasons submitted by Covered California over three years. The percentage displayed in parentheses next to each complaint reason category is the 2016 percentage distribution for that complaint reason.

Figure 7.12



C. Demographics and Other Complaint Elements

Age

Covered California submitted 20,062 complaints with age identified (2% of the complaints were Unknown). The average age of the complainants was 47 years old. The age group with the most complaints continues to be ages 35-54 (42% of complaints). Less than one percent of the complainants were under age 18 or age 75 or older (0.49% combined for both age groups). Denial of Coverage remained the top complaint reason across all age groups and among age unknown.

Gender

Eighty-four percent (17,118) of the Covered California complaints had gender reported, with 46 percent of the complainants identified as female and 38 percent as male. The top complaint reasons were the same across all gender categories.

Race

Covered California submitted 12,191 complaints with race identified (40% of the complaints were unknown). Complainants were identified as White (35%), Asian (12%), Other (9%), Black or African American (3%), American Indian or Alaska Native (0.4%), and Native Hawaiian or Other Pacific Islander (0.2%). The top complaint reasons were the same across all race categories.

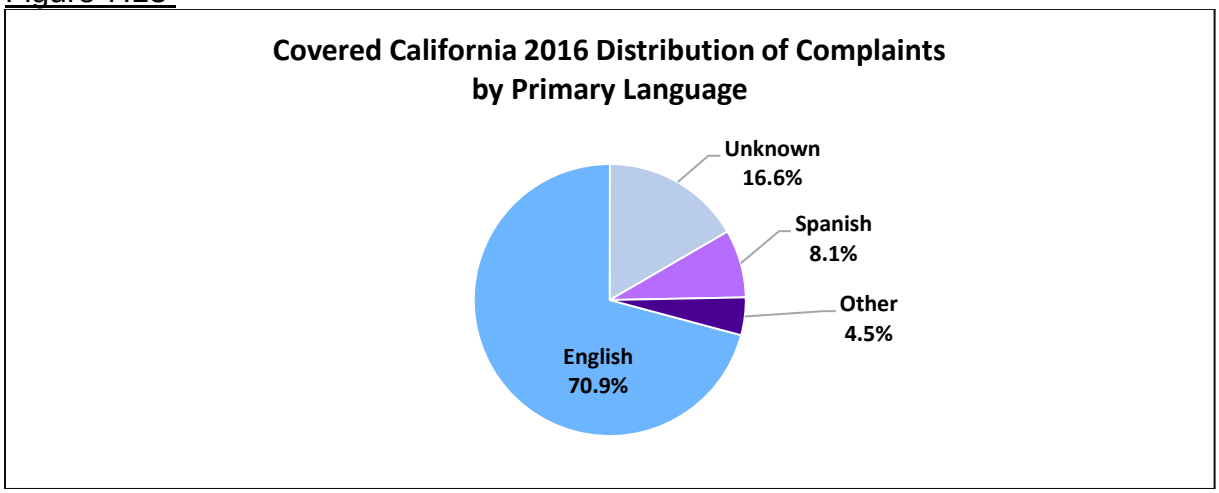
Ethnicity

Covered California reported 14,981 complaints with ethnicity identified, including 17 percent Hispanic or Latino and 57 percent Not Hispanic or Latino. Twenty-six percent of the complaints had ethnicity reported as unknown. The top complaint reasons were the same across all ethnicity categories.

Language

The following chart displays the distribution of complaints by primary language reported by Covered California in 2016. The complainant's primary language was identified for 83 percent (17,013) of the Covered California complaints. Primary language categories with low reported complaint volumes were combined for analysis under Other.

Figure 7.13



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

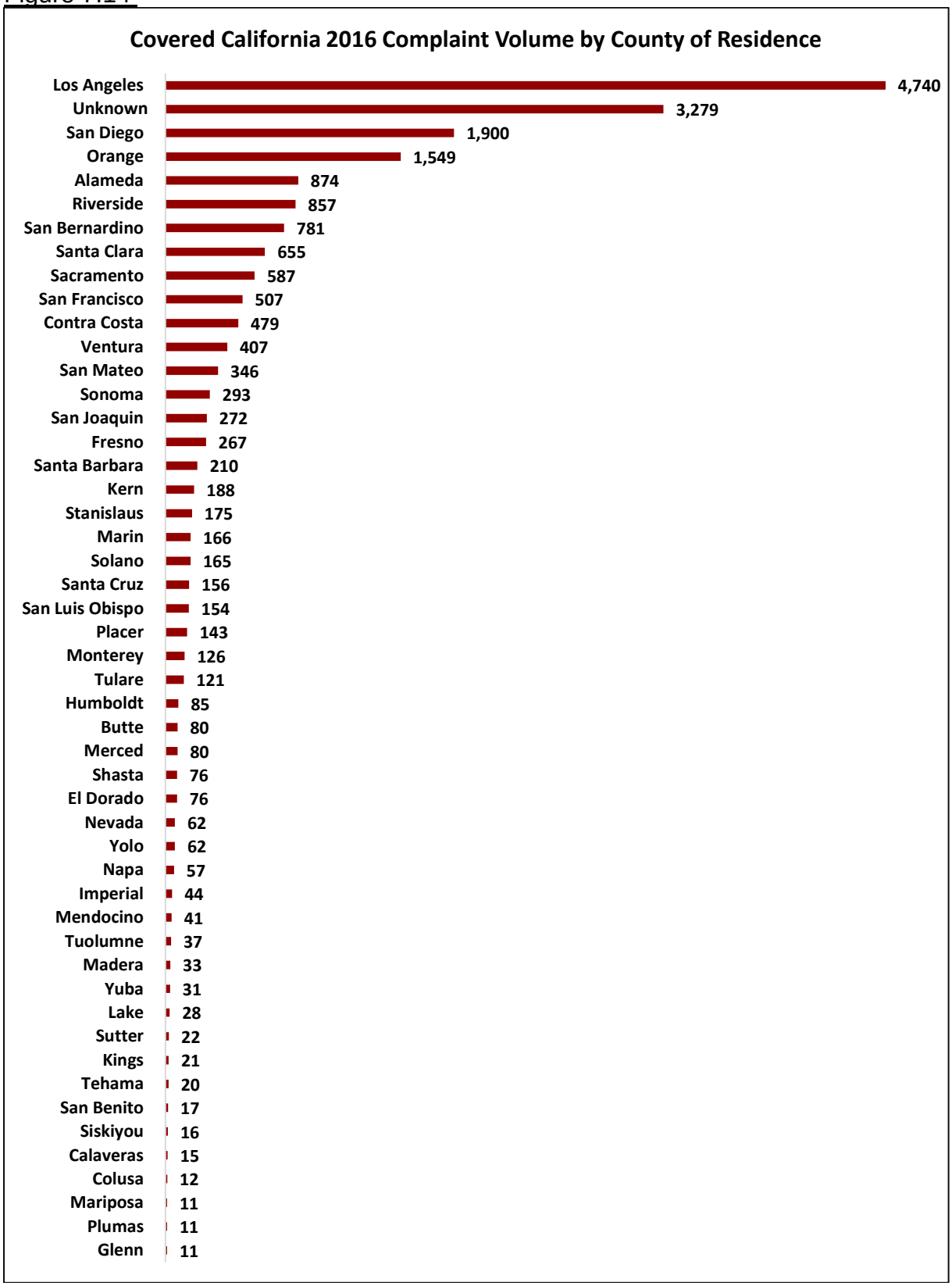
- Denial of Coverage was the top complaint reason across language categories.
- Eligibility Determination was the second most common reason for Spanish and Other languages.
- Cancellation was the second most common reason for English and Unknown.

County of Residence

The following chart shows the 2016 complaint volumes by the county of residence identified for the complainant. Counties with fewer than ten complaints are not displayed.

- Fifty-six out of 58 California counties had at least one complaint in 2016.
- Sixteen percent of the reported complaints did not have a resident county identified.

Figure 7.14



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

Mode of Contact

Telephone (57% of complaints) continued to be the most popular mode of contact used to initiate a complaint, followed by email (19%), fax (10%), mail (10%), and counter/in-person (3%). One percent of the complaints submitted by Covered California were unknown as to the mode of contact.

Regulator

Covered California did not report regulator information.

Source of Coverage

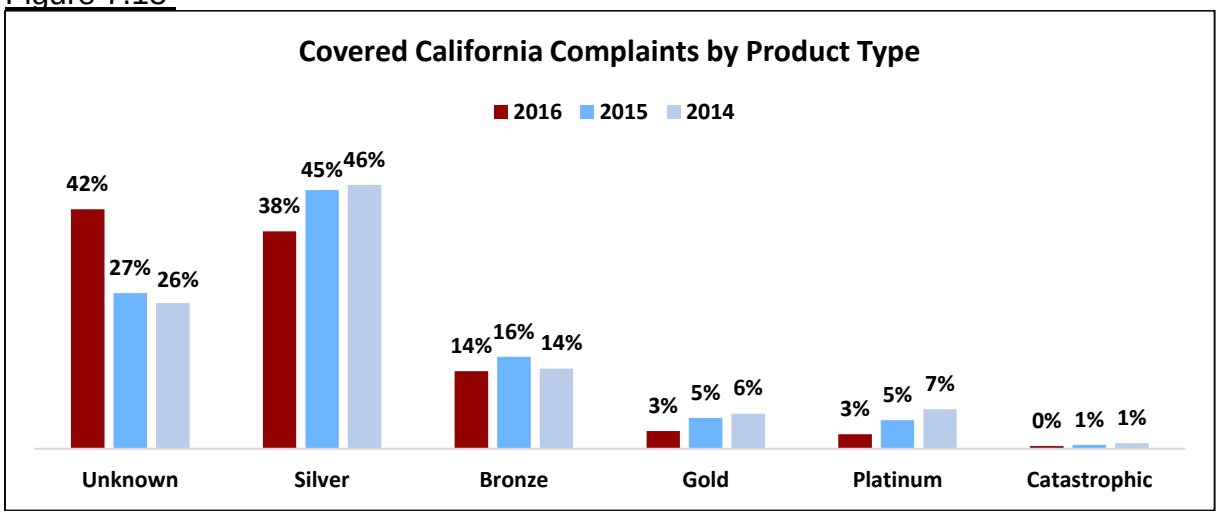
All 20,398 complaints reported for 2016 had Covered California/Exchange identified as the source of coverage.

Product Type

The following chart compares Covered California's annual complaint distribution by product type over three years. Covered California submitted product types pertaining to the metal tier associated with the complainant's level of coverage. In 2016, the product type was not identified for 42 percent (8,579 Unknown) of the reported complaints.

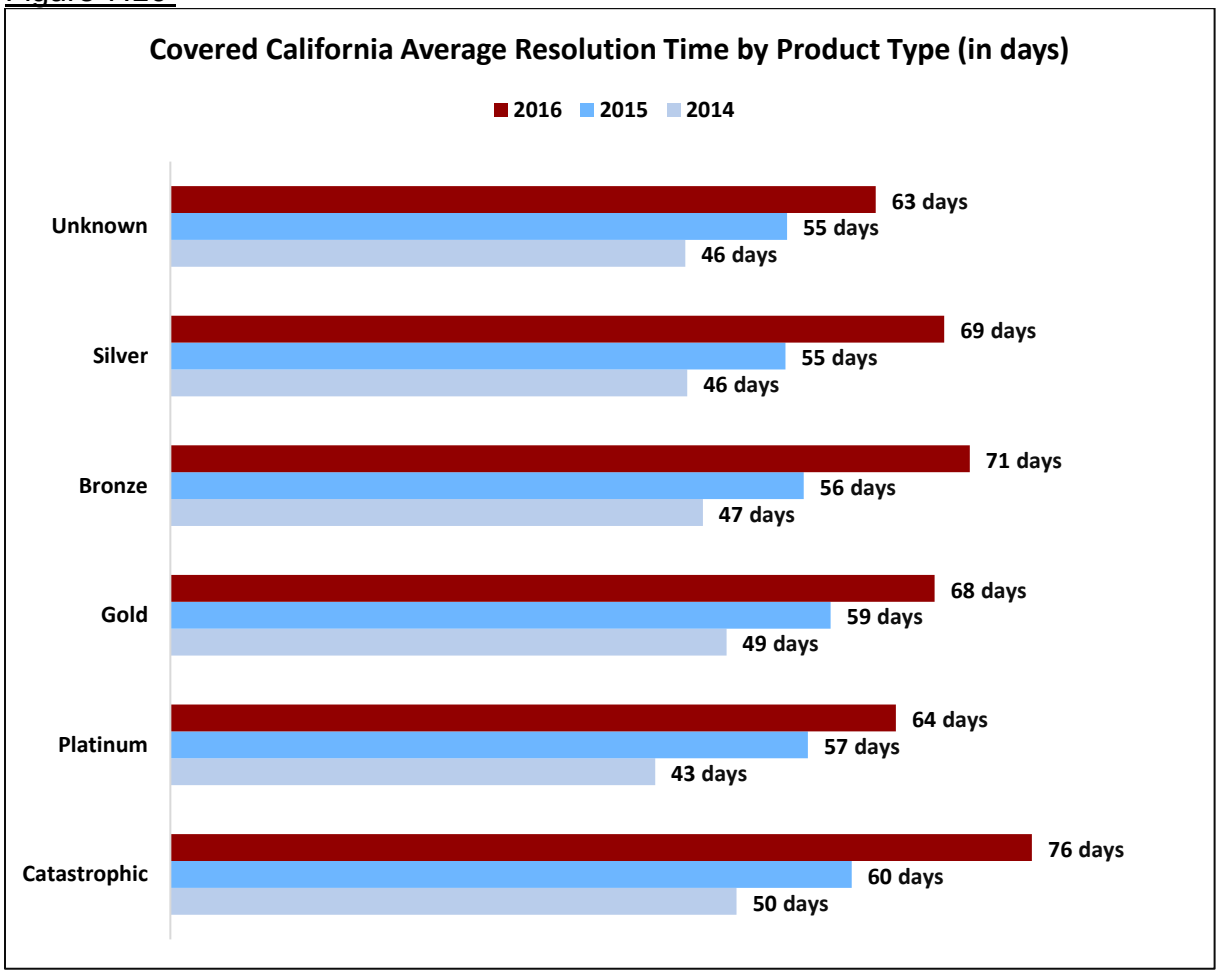
- The product type of Catastrophic indicates a minimum coverage plan only available to Covered California enrollees under age 30.
- The Silver product type indicates a metal tier that allowed some enrollees to access additional financial assistance to lower copayments, co-insurance, and deductibles. Depending on income, some individuals qualified through Covered California's eligibility determination process for both premium assistance and cost-sharing subsidies. The cost-sharing subsidies were only accessible if the enrollee that qualified selected a Silver plan.

Figure 7.15



The following chart shows the average time it took to resolve Covered California complaints by reported product type categories.

Figure 7.16



D. Consumer Assistance Center Details

Covered California's Service Center reported receiving 6,038,580 inquiries from consumers in 2016. This volume was a 12 percent increase over the comparable 2015 volume (5,390,936 contacts). Of the requests received, 5,713,848 (94.6%) were by telephone and 324,732 (5.4%) were via online chat.

Service Center Telephone Call Metrics

The Covered California Service Center received 5,713,848 telephone calls from consumers in 2016. The following table shows the response from Covered California regarding some of its service center telephone call metrics.

Figure 7.17

Covered California Service Center - 2016 Telephone Metrics

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

Consumer Assistance Protocols

Covered California reported that there were not any significant changes to its consumer assistance protocols or systems since last year's report.

Section 8 – Conclusion

OPA reviewed the third year of complaint data submitted by four reporting entities: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Department of Insurance (CDI), and Covered California. This section highlights issues that were noteworthy among the analysis of the Measurement Year 2016 data. OPA continues to urge caution in making comparisons between reporting entities and measurement years due to complaint system differences and reporting adjustments.

Volume of Complaints

Three reporting entities – DMHC, DHCS, and Covered California – continued to report an increase in the total number of complaints. DMHC's complaint volume increased by 46 percent, which may in part be associated with an increase in the number of covered lives in health plans regulated by the department as well as its targeted outreach activities. The DHCS State Fair Hearings volume saw a slight increase (0.4%) over the prior year. Covered California's increase was largely associated with the State Fair Hearing: Informal Resolution complaint type, which saw a 247 percent increase over the prior year. Its formal State Fair Hearings volume increased by 198 percent over the same period. CDI's complaint volume decreased by 11 percent over the prior year.

Complaint Reason

The 2016 data showed continued increases in the volume of the top statewide complaint reasons of Denial of Coverage and Cancellation. The State Fair Hearing: Informal Resolution complaint type reported by Covered California accounted for a larger portion of the overall statewide complaint volume in 2016 (26%) than in 2015 (13%), which contributed to increased rankings for three associated complaint reasons (Denial of Coverage, Cancellation, and Eligibility Determination).

There was a 330 percent increase in statewide complaints for the Experimental/Investigational Denial complaint reason over the prior year (907 complaints in 2015 to 4,478 in 2016), most of which were complaints reported by DMHC. DMHC indicated that the department's overall complaint volume increase was in part due to its targeted outreach to health care stakeholders. DMHC noted that the increase for the Experimental/Investigational Denial reason was largely associated with the issue of health plan denials of three-dimensional mammography of the breast, also known as digital breast tomosynthesis. A majority of the statewide Experimental/Investigational Denial complaints had a result of either Consumer Received Requested Service or Health Plan Position Overturned.

It will be important to monitor this complaint reason to determine whether the 2016 complaints may be indicative of a normal process of the health care system's adoption of new technologies as provider use expands, effectiveness is evaluated and clinical guidelines updated, and health plans and regulators adjust policies accordingly.

Complaint Results

Upheld/Health Plan Position Substantiated remained the top complaint result for DMHC and CDI. The percentage of DMHC's results for this category decreased and CDI's increased. Consumer Received Requested Service, a category first reported last year, jumped to the second most common result for DMHC. Recovery remained CDI's second most common result.

DHCS's and Covered California's top result continued to be Withdrawn/Complaint Withdrawn, although the percentage of cases reported by both entities decreased from the prior year. DHCS noted that a large volume of its Withdrawn/Complaint Withdrawn results are due to a Notice of Action letter about deferred services that may prompt beneficiaries to file for a State Fair Hearing, even though the hearing may not be necessary.

Complaint Ratios

Health plan complaint ratios were displayed for the plans with the highest ratios among plans with enrollment over 70,000 members. These ratios were based on 2016 complaint data from DMHC, DHCS, and CDI. This year, OPA developed Covered California health plan complaint ratios for the first time using data on complaints resolved by DMHC (see Figures 4.19 and 4.20).

Health plan ratios have varied, in some cases quite significantly, over the three reporting years. DMHC's health plan complaint ratios increased for most plans between 2015 and 2016. A majority of the plan ratios for CDI-regulated group and individual products over 70,000 enrollment also increased during this time period. Most DHCS health plans in each county saw a decrease from the prior year in the ratio of State Fair Hearings per 10,000 plan members in the county.

Reporting Changes

OPA will continue to work with the four reporting entities to enhance reporting and standardize data definitions and coding, where appropriate. Standardizing data allows 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 is moving to an annual data submission process for Measurement Year 2017 complaint data. In the initial reporting years, a biannual data submission process was required so that OPA could further develop and adjust data categories and elements based on the early quarters data received.

Data Limitations

Differences between coverage products and complaint systems make comparisons inexact between reporting entities. In addition, reporting adjustments to data categorizations and data sources since the baseline year make some comparisons inexact between measurement years.

Although the report provides an important snapshot of problems experienced by consumers, the data only partially represents the various and differing levels of complaint outlets available to consumers. These differences affect reported volumes and comparisons between reporting entities and across coverage types and other categories. For example, Covered California reported informal resolutions of State Fair Hearings, which addressed program eligibility issues typically resolved at the initial service center level. This type of informal complaint was only reported by Covered California.

Some levels of complaint processes are completed by organizations that do not report data to OPA. In addition, some coverage is not overseen by the state entities that provide data for this report. For example, complaints about Medicare and self-insured health plans are not fully represented.

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. Product types vary widely across reporting entities. Regulators DMHC and CDI serve consumers with different product types, primarily HMOs and PPOs respectively, which does not allow easy comparison.

The report data shown may not match precisely to similar data as published by each reporting entity in their respective departmental reports due to differences in methodology or other criteria.

Section 9 – Index of Charts and Tables

Section 3. Statewide

Section 4. Department of Managed Health Care

Section 5. California Department of Health Care Services

Section 6. California Department of Insurance

Section 7. Covered California

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. Many 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
1095-A	An IRS tax form from Covered California to the consumer to report information on enrollments in a qualified health plan in the individual market through the Marketplace, including – by month in the tax year – the premium of the qualified health plan, the premium of the second-lowest silver plan available, and the amount of advance payment of premium tax credit received by the consumer.
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.
Additional Payment	The party complained against paid more money (i.e. claims payment) than was initially paid to the policyholder or claimant.
Administrative Law Judge	A judge who resolves claims or disputes involving administrative law.
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.
Appeal	A kind of complaint in which a consumer asks for a review of a decision made by a health plan or coverage program.
Beneficiary	The person who benefits from an insurance policy or coverage program.
BIC (Benefits Identification Card)	People who are determined 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.
Billing/Reimbursement Issue	Complaint reported by DHCS regarding a problem with billing or reimbursement.
Breast Cancer and Cervical Cancer Treatment Program	A DHCS special program that provides treatment coverage for individuals diagnosed with breast or cervical cancer.
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.
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.

Term	Explanation
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	Request to a health plan or coverage program asking for payment based on the terms of the insurance policy.
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 Handling Delay	See Claim Delay
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate. CDI uses this result to indicate that the claim was settled in the consumer's favor.
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.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	A U.S. statute that requires employers sponsoring group health plans to 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. As a complaint reason, indicates a complaint regarding a health plan with COBRA as the source of coverage, or a problem obtaining continuation coverage through COBRA.
Co-Insurance	A share of the cost of a health care service. Co-insurance is a percent of the bill for a service.
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 2016 divided by the number of covered lives from a single month in 2016 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 Result	Primary outcome of the review of the consumer's complaint.
Complaint Type	A data category for complaints reported to OPA that identifies the complaint review process used by the reporting entity, such as Standard Complaint, State Fair Hearing, Independent Medical Review, Quick Resolution, and Urgent Nurse.

Term	Explanation
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 that the regulated entity or individual was in violation or otherwise at fault.
Conservatorship	A case where a judge appoints a responsible person or organization to care for an adult who cannot care for themselves or manage their own finances.
Consumer Received Requested Service	A DMHC complaint result identifying the consumer received the requested service after the complaint was filed.
Co-Pay	A fixed charge (flat fee) for a health care service. You usually pay the co-pay when you get the service. You pay the same fee each time.
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.
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.
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 Position Overturned	A Covered California complaint result identifying a complaint was resolved by Covered California to ensure compliance with applicable state law/requirement.
Covered California/ 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.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
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).
Deductible	The amount you must pay each year for health care before your health plan starts to pay.
Denial of Coverage	Complaint that coverage was improperly denied.
Denied Services	Complaint alleging that the complainant was improperly refused health-related services.
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 Federal Employees Health Benefits Program or Medicare and Medicaid programs.

Term	Explanation
Denti-Cal	DHCS program that provides dental services to Medi-Cal members.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Documentation Requests/Disputes	Complaint regarding a dispute about documentation or insufficient responses to a request for documentation.
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.
Enrollment	The process of a health plan initiating coverage for a new member or renewing a policy. Enrollment generally occurs after a coverage program or employer determines eligibility. Enrollment can also refer to the number of members who are a part of a health plan or coverage program.
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 category for the Complaint Data Report consisting of elements 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.
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.
Full-Service License	A full-service license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides a full range of basic health care services, including preventive and routine care, physician and hospital services, and emergency and urgent care.

Term	Explanation
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.
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.
Grievance	A complaint that you make to your health plan. In a grievance, you ask your health plan to solve a problem or change a decision they made about your care.
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 Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), which provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments and deductibles, and a PPO (Preferred Providers Organization).
Health Plan in Compliance	Complaint result indicating that a health plan's tendencies comply with state 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 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.
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.
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.

Term	Explanation
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	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.
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.
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 Benefit Plan	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary. These policies usually limit the services the plan will cover and have a low maximum amount the plan will pay out. Limited-benefits plans include critical illness plans, indemnity plans, and "hospital cash" policies.
Long Term Care	A product type indicating a range of services and support for personal care needs. Most long-term care isn't medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living.
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.
Managed Care Health Plan	Health plans that contract with health care providers and medical facilities to provide care for members at reduced costs. HMOs, PPOs, EPOs, and POS plans are all managed care plans.

Term	Explanation
Medicaid	Medicaid is a Federal-State jointly-funded program that provides health care coverage to eligible children and adults with low incomes, including seniors and people with disabilities. Medicaid also provides long term care and related services to beneficiaries who qualify. California's Medicaid program is called Medi-Cal and is administered by the California Department of Health Care Services.
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 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 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.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medically Necessary	Care that you need in order to prevent, find, or treat a health problem. In general, health plans only cover medically necessary care. This care must meet accepted standards of medicine. There should be evidence that you need the treatment and that it can help problems like yours.
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 their Part A and Part B benefits.
Mental Health	A product type indicating coverage for professional mental health services such as psychologist, crisis centers, and rehabilitative therapy. A mental health diagnosis involving an emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addiction); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual. (American Psychiatric Association's Diagnostic and Statistical Manual).
Mini-Med Plan	A health plan that features very limited benefits, usually limiting the services the plan will cover and with a low annual maximum amount the plan will pay out.
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.

Term	Explanation
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.
No Action Requested/Required	Complaint result indicating that the complaint review organization 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 or oversight of the reporting entity, 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.
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 filed for services that have been requested, received or determined to be, out-of-network.
Out of Pocket Charges	In addition to the monthly premium, the amount you pay for using health care services. Out of Pocket Charges include deductibles, co-pay, and co-insurance.
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. Reporting entity found the regulated entity or individual to be in violation or otherwise at fault.
PACE Long Term Care	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).
Participating Provider Availability/Timely Access to Care	Complaint alleging that no in-network provider was available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.
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.

Term	Explanation
Plan Regulator	Entity that has jurisdiction over a health plan and is responsible for enforcing relevant laws and regulations that apply to the health plan. For the Complaint Data Report, plan regulator options include California Department of Insurance (CDI), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), Department of Labor (DOL), CalPERS, Out of State Department of Insurance, Other, and Unknown.
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.
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.
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 usually see providers without prior approval from the plan.
Premium	The amount a person pays each month to keep their health plan. For many people, their employer or the government may pay all or part of the premium.
Primary Language	The language a person was exposed to from birth or a very early age, or the main language a person uses to communicate. For the Complaint Data Report, primary language data elements include Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Refused, Russian, Spanish, Tagalog, Unknown, and Vietnamese.
Product Type	A complaint data category used to identify details about specific areas of coverage, such as the health program's delivery system or 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	A health professional or heath practitioner who provides preventative, curative, promotional, or rehabilitative health care services.

Term	Explanation
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Public Guardian Office	A county office that provides conservatorship services if there is no one else who is qualified and willing to act.
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/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 or oversight of the reporting entity.
Quick Resolution (QR)	A complaint type reported by DMHC. DMHC staff use the QR process for certain issues that can be resolved without standard complaint or urgent nurse processes, 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).
Race	A demographic data category for the Complaint Data Report consisting of data elements White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Unknown, and Refused.
Recovery	A return of money or benefits to the insured/complainant.
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.
Refused/Unknown	A data element indicating that the complainant either was not asked for or refused to provide this information.
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.
Rehabilitative/Habilitative Care	Health care services that help a person keep, get back, or improve skills and functioning for daily living that did not develop at a typical age, or that have been lost or impaired because a person was sick, hurt, or disabled. As a complaint reason, a complaint regarding coverage for rehabilitative and/or habilitative services and/or devices.
Renewal	The process of continuing with a health insurance plan from one coverage year to the next.

Term	Explanation
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.
Requesting to be Terminated	An inquiry topic reported by Covered California indicating that an enrollee wants to discontinue health insurance through Covered California.
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.
SCAN Long Term Care	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.
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.
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.
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.

Term	Explanation
Specialty License	A license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides health care services in a single specialized area, such as dental, vision, or mental health.
Stand Alone Dental	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan. This type of dental plan is not a part of the medical plan.
Standard Complaint	A report data element indicating a complaint type used 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 an appeal filed with the California Department of Social Services for a State Fair Hearing that was resolved before the State Fair Hearing took place by Covered California.
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.
Subsidy	In this report, indicates a tax credit from the federal government to help eligible low-income people pay for a health plan purchased through Covered California.
Treatment Authorization Request	The form a provider uses to request authorization from Medi-Cal to provide certain health care services to a fee-for-service beneficiary prior to payment.
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.

Term	Explanation
Unknown	A complaint data element 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 (DMHC, DHCS, CDI, or Covered California) or because the complainants did not provide information to a reporting entity. As a complaint result, indicates that the outcome of the complaint was unknown.
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/Covered California Position Substantiated	A Covered California complaint result indicating that Covered California's original position appears to be in compliance with applicable statutes/regulations.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
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.
Utilization Review	Complaint regarding a technique for controlling medical expenses by reviewing utilization patterns reflected in claims information. Type, quantity, and charges related to medical services are evaluated to identify problem areas responsible for increasing cost. Specific diagnoses, procedures, service providers, and claimant group responsible for increasing cost are identified.
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.
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	Current Definition	Effect on Consumer
Additional Payment	The party complained against paid more money (i.e. claims payment) than was initially paid to the policyholder or claimant.	Neither Favorable nor Unfavorable
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.	Neither Favorable nor Unfavorable
Cancellation Notice Withdrawn	The party complained against acknowledges an error in giving notice of intent to cancel a contract of insurance. The contract will be reinstated or continued without a lapse.	Favorable to Consumer
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.	Favorable to Consumer
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate. CDI uses this result to indicate that the claim was settled in the consumer's favor.	Favorable to Consumer as used by CDI. Neither Favorable nor Unfavorable as used by DMHC, DHCS, and Covered California.
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 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
Coverage Extended	An issued policy, insurance continuation, or insurance expansion of coverage under the policy.	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
Deductible Refunded	The return of the policy owner's funds collected as a deductible.	Favorable to Consumer
Delay Resolved	A delay in provider service or information was resolved.	Neither Favorable nor Unfavorable
Fine Assessed	Reporting entity assessed monetary penalty against the regulated entity or individual.	Favorable to Consumer

Complaint Result	Current Definition	Effect on Consumer
Health Plan in Compliance	Complaint result indicating that a health plan's tendencies comply with state regulations.	Favorable to Health Plan
Information Furnished/ Expanded	Supplied requested, missing, or additional information to consumer	Neither Favorable nor Unfavorable
Insufficient Information	Complainant failed to provide sufficient information/ documentation to warrant further investigation.	Neither Favorable nor Unfavorable
No Action Requested/ Required	Complaint Result indicating that the complaint review organization 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 nor Unfavorable
No Jurisdiction	Complaint does not fall under the regulatory authority or oversight of the reporting entity, and was not referred to any outside agency, Department, or court system. Includes Action Suspended for litigation and/or formal arbitration.	Neither Favorable nor Unfavorable
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. Reporting entity 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
Policy Not in Force	Complaint result indicating that the complaint involved a policy that was not in force.	Neither Favorable nor Unfavorable
Premium Problem Resolved	The party complained against acknowledges an error in the premium and makes the appropriate adjustment in favor of the consumer.	Favorable to Consumer
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 or oversight of the reporting entity.	Neither Favorable nor Unfavorable
Rating Problem Resolved	Resolved any questions about policy rates due to underwriting criteria.	Neither Favorable nor 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 regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.	Favorable to Consumer
Referred to Outside Agency/Dept.	Complaint was referred to a different state agency/department.	Neither Favorable nor Unfavorable

Complaint Result	Current Definition	Effect on Consumer
Refund	A refund was made to the claimant.	Favorable to Consumer
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.	Neither Favorable nor Unfavorable
Unable to Assist	Lacked the necessary power, authority, or means to resolve the complaint.	Neither Favorable nor Unfavorable
Underwriting Practice Resolved	The complainant requested the discontinuation of an underwriting practice, which was the subject of the complaint or has modified its procedures to bring the underwriting practice into compliance with applicable statutes/rules.	Favorable to Consumer
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. As a complaint result, indicates that the outcome of the complaint was unknown.	Neither Favorable nor Unfavorable
Upheld/ Covered CA Position Substantiated	A Covered California complaint result indicating that Covered California's original position appears to be in compliance with applicable statutes/regulations.	Favorable to Health Plan
Upheld/Health Plan Position Substantiated	The regulated entity 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 nor Unfavorable

Appendix C. Acronyms

Acronym	Term
BIC	Benefits Identification Card
CA-MMIS	California Medicaid Managed Information Systems
CDI	California Department of Insurance
CDSS	California Department of Social Services
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COHS	County Organized Health System
CRM	Customer Relationship Management
CSD	Consumer Services Division
CSR	Customer Service Representative
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DMHC	Department of Managed Health Care
DOI	Department of Insurance
DOL	Department of Labor
EBSA	Employee Benefits Security Administration
EPO	Exclusive Provider Organization
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee-For-Service
FI	Fiscal Intermediary
GMC	Geographic Managed Care
HCA	Health Consumer Alliance
HHS	U.S. Department of Health & Human Services
HICAP	Health Insurance Counseling & Advocacy Program
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IMR	Independent Medical Review
IVR	Interactive Voice Response
NAIC	National Association of Insurance Commissioners
OHC	Other Health Coverage
OMHA	Office of Medicare Hearings and Appeals
OPA	Office of the Patient Advocate
OPM	Office of Personnel Management
PACE	Program of All-Inclusive Care for the Elderly
POS	Point of Service
PPO	Preferred Provider Organization
QR	Quick Resolution
SCAN	Senior Care Action Network
SHIP	State Health Insurance Assistance Programs
SHOP	Small Business Health Options Program
SSA	Social Security Administration

Acronym	Term
SSI	Supplemental Security Income
VA	U.S. Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration

The Office of the Patient Advocate
925 L Street, Suite 1275
Sacramento, CA 95814
(916) 324-6407

Published April 2018