Annual Health Care Complaint Data Report

Report to the Legislature

Measurement Year 2017

STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Michael Wilkening, 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
www.opa.ca.gov/ComplaintsReports/Documents/ComplaintDataReport-2017.pdf
Report data tables are available at
www.opa.ca.gov/ComplaintsReports/Documents/ComplaintDataTables-2017.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/ComplaintReports/Pages/default.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).

- DMHC and CDI 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 fourth annual Complaint Data Report catalogs 49,024 consumer health care complaints closed in 2017. 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 26,073,409 enrollees submitted 19,200 complaints, reflecting a decrease of 26 percent from the number of 2016 complaints.
    - The enrollment reflects full-service health plans only, excluding specialty plans reported in prior years.
- DHCS program enrollment of 13,491,018 enrollees submitted 6,603 complaints, reflecting a decrease of three percent from the number of 2016 complaints.
- CDI plan enrollment of 1,927,977 enrollees submitted 3,885 complaints, reflecting an increase of 35 percent from the number of 2016 complaints.
    - CDI reported non-jurisdictional complaint records for the first time. Of the 7,534 total complaints reported for 2017, there were 3,649 non-jurisdictional cases that resulted in a referral to an outside agency or department.
- Covered California plan enrollment of 1,391,392 enrollees submitted 15,687 complaints, reflecting a decrease of 23 percent from the number of 2016 complaints.

Top five statewide complaint reasons:

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

Top five statewide complaint results:

1. Upheld/Health Plan Position Substantiated
2. Withdrawn/Complaint Withdrawn
3. Overturned/Health Plan Position Overturned
4. Compromise Settlement/Resolution
5. Insufficient Information

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 231 days (22 days on average)
- DHCS – 0 to 698 days (79 days on average)
- CDI – 0 to 668 days (80 days on average)
- Covered California – 0 to 339 days (66 days on average)

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

Enhancements to the 2017 report include new:

- Charts showing the months that consumers filed complaints with the state service centers.
- Medi-Cal Managed Care plan analysis based on DMHC data.
- Reason-to-results analysis of DHCS data.
- Data on CDI non-jurisdictional complaints referred to other agencies or departments.

Methodology and Data Elements

This fourth year Complaint Data Report evaluates health care complaints closed January through December 2017 and other information collected from four state reporting entities about their service centers' 2017 consumer assistance activities. For some categories, OPA also displays data from the 2015 and 2016 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 an annual 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 2017 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 plan's 2017 enrollment. A higher complaint ratio indicates more complaints per member.

OPA obtained enrollment figures from the reporting entities for the health plans licensed or overseen by each entity. DMHC and CDI provided December 2017 enrollment data and DHCS and Covered California provided March 2017 enrollment data, same as in 2015 and 2016. DMHC's enrollment total excludes specialty health plans that were included in prior year totals. Due to reporting methodology differences, enrollment figures may not be comparable from year to year.

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 Complaint Page at www.opa.ca.gov/ComplaintReports/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 2017. 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.

- DMHC reported jurisdictional complaints regarding health plan issues for care delivery and enrollment, as well as some non-jurisdictional complaints it resolved.
- DHCS reported formal State Fair Hearings data that included health care delivery complaints about Medi-Cal. Some complaints regarding Medi-Cal health plans also were reported by DMHC. Most problems regarding Medi-Cal eligibility issues are addressed at the county level rather than through a State Fair Hearing.
- CDI reported jurisdictional health care complaints about the insurance companies and producers it regulates, as well as reported for the first time non-jurisdictional complaints the department referred to other entities.
- Covered California reported formal and informal State Fair Hearings about its eligibility determinations and enrollment activities. The reported complaints included dual agency appeals involving Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal. Health care delivery and enrollment complaints about Covered California health plans were reported by DMHC.

Figure 3.1

2017 Reporting Entity Complaints, Plans, and Enrollment

Reporting Entity	Number of Complaints	Number of Plans with at Least One Complaint	Total Number of Enrollees
DMHC	19,200	70	26,073,409
DHCS	6,603	85	13,491,018
CDI	7,534	89	1,927,977
Covered CA	15,687	Not Applicable	1,391,392

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. DMHC's enrollment is for full-service plans only, a methodology change from prior reports. CDI's 2017 complaint total includes non-jurisdictional case data not reported in prior years.

Enrollment volumes noted in Figure 3.1 likely include individuals who are counted more than once because they are enrolled in multiple plan types, such as dental and vision, or otherwise have coverage with oversight by more than one reporting entity. Due to timing and other methodology differences, some of the figures reported above are not comparable between entities or with prior measurement years.

- DMHC enrollment for December 2017 is for full-service health plans. In prior years, the DMHC enrollment figure included specialty plans, such as dental and vision.
- The DHCS enrollment figure is for March 2017 Medi-Cal enrollment, which includes 10,868,375 beneficiaries in Managed Care and 2,622,643 in Fee-for-Service. The DHCS number of plans represents units of plans contracted per county. A health plan that has a Medi-Cal contract for multiple counties may be counted more than once.
- The CDI complaint total includes non-jurisdictional complaints. Its enrollment figure for December 2017 includes covered lives for major medical plans, limited benefit (mini-med only) plans, and student health plans. CDI did not report plan names within the complaint data and instead submitted complaint totals for nine plans with more than 25 cases closed in 2017.
- Covered California's reported complaints do not pertain to health plans. Its enrollment from March 2017 excludes individuals who had not paid for coverage as well as individuals only enrolled in a dental plan.

B. Statewide Consumer Assistance Centers

The following table provides information about the DMHC, DHCS, CDI, and Covered California service centers that reported 2017 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. (except state holidays) Service for urgent issues available after hours and on state holidays
DMHC Website (www.hmohelp.ca.gov)	

DHCS Medi-Cal 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)
Ombudsman Webpage (www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx)	

DHCS Medi-Cal Telephone Service Center (Contractor: Conduent State Healthcare 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. (except some holidays) Extended hours for provider technical assistance

Medi-Cal TSC Webpage (www.dhcs.ca.gov/individuals/Pages/Medi-CalMemberHelpline.aspx)

DHCS Medi-Cal Dental Program Beneficiary Customer Service Center (Previously listed as the Denti-Cal Telephone Service Center. Contractor: Delta Dental)

Main Phone Number	1-800-322-6384
TTY / TDD Line	1-800-735-2922
Other Phone Lines	1-866-290-6310 (New line as of Sept. 2017 for patients new to the Medi-Cal Dental Program)
Days/Hours Open	Monday - Friday, 8:00 a.m. - 5:00 p.m. (except state holidays) Some automated services available through the Interactive Voice Response system 7 days a week, 24 hours a day; Voicemail checked daily

DHCS Medi-Cal Dental Program Website (www.denti-cal.ca.gov)

CDI Consumer Services Division

Main Phone Number	1-800-927-4357 or 213-897-8921 (Consumer Hotline)
TTY / TDD Line	1-800-482-4833
Other Phone Lines	1-800-967-9331 (Producer 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) Extended hours during peak season around open enrollment: Monday-Friday, 8:00 a.m. to 8:00 p.m., Saturday, 8:00 a.m. to 6:00 p.m.

Covered California Website (www.coveredca.com)

2017 Consumer Assistance Volumes

The reporting entity service centers that provided data to OPA received 7,423,511 requests for assistance from consumers in 2017, a nearly three percent decrease over the prior year (7,644,780 requests in 2016). 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

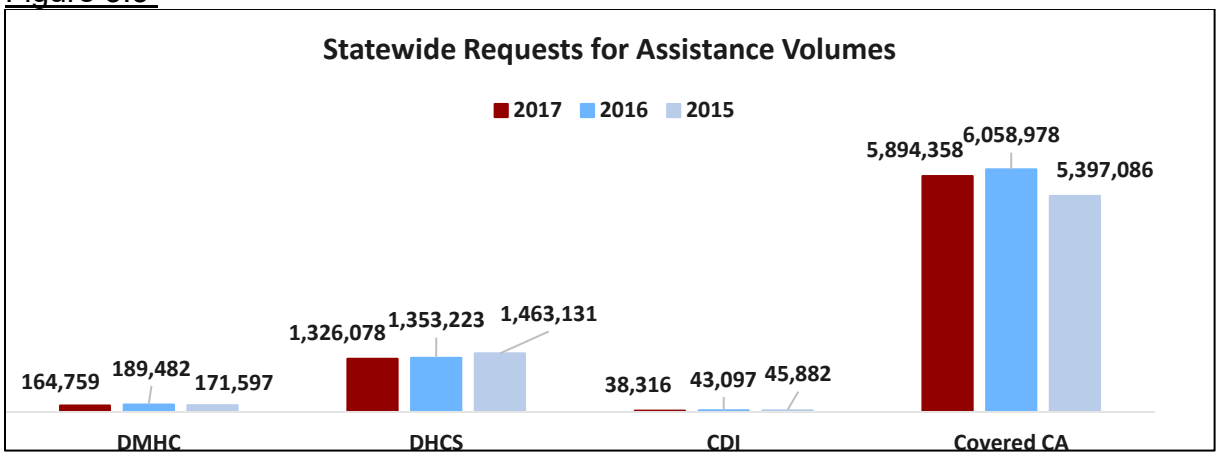
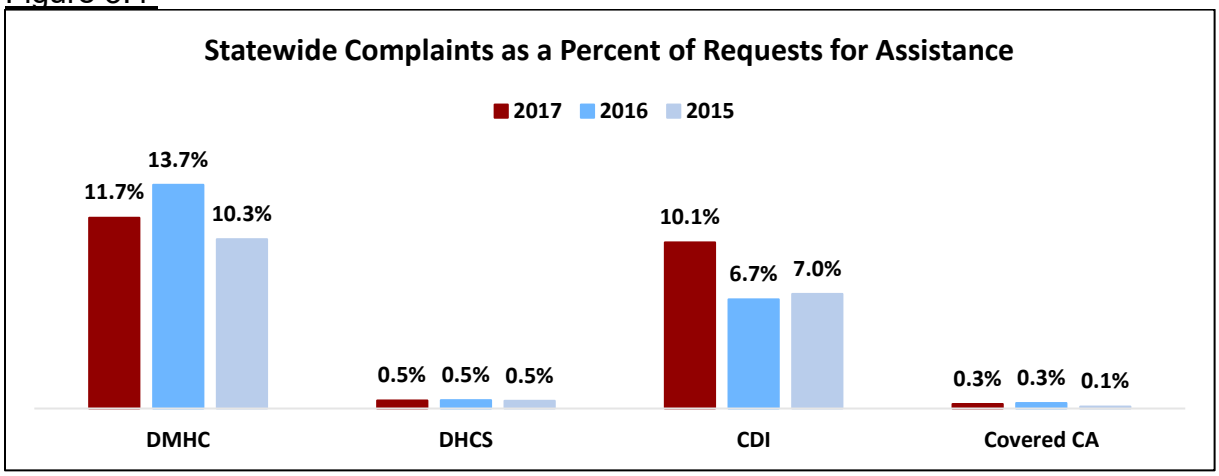


Figure 3.4



Note: For trend analysis, the chart excludes CDI's newly reported non-jurisdictional complaints from CDI's 2017 calculation. Non-jurisdictional cases are those the department referred to other entities. CDI's 2017 figure is 19.7 percent if non-jurisdictional complaints are counted.

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 the years that followed.

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/ComplaintsReports/Pages/AnnualComplaintReports.aspx.

C. Statewide Health Care Complaint Data

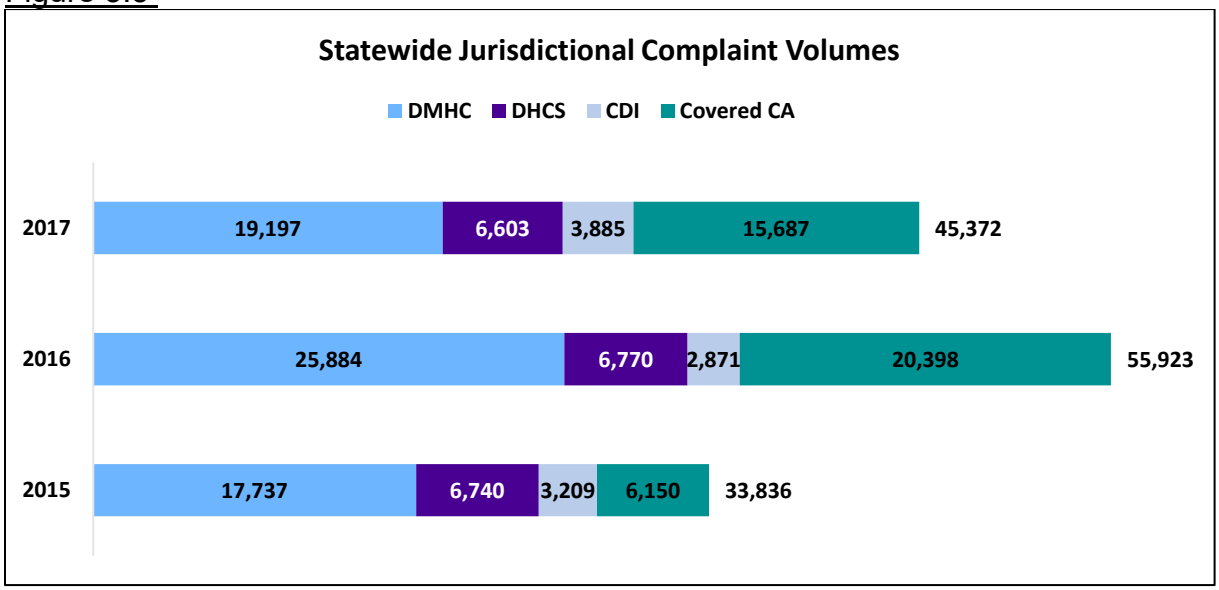
The four reporting entities submitted 49,024 consumer complaints to OPA for Measurement Year 2017, including non-jurisdictional complaints reported for the first time by CDI.

The statewide jurisdictional complaint volume of 45,372 was a 19 percent decrease in volume over the prior year (55,923 complaints in 2016).

Volume of Closed Complaints

The chart below displays the statewide complaint volume for the 45,372 jurisdictional complaints in 2017, along with the comparable statewide volumes from 2015 and 2016.

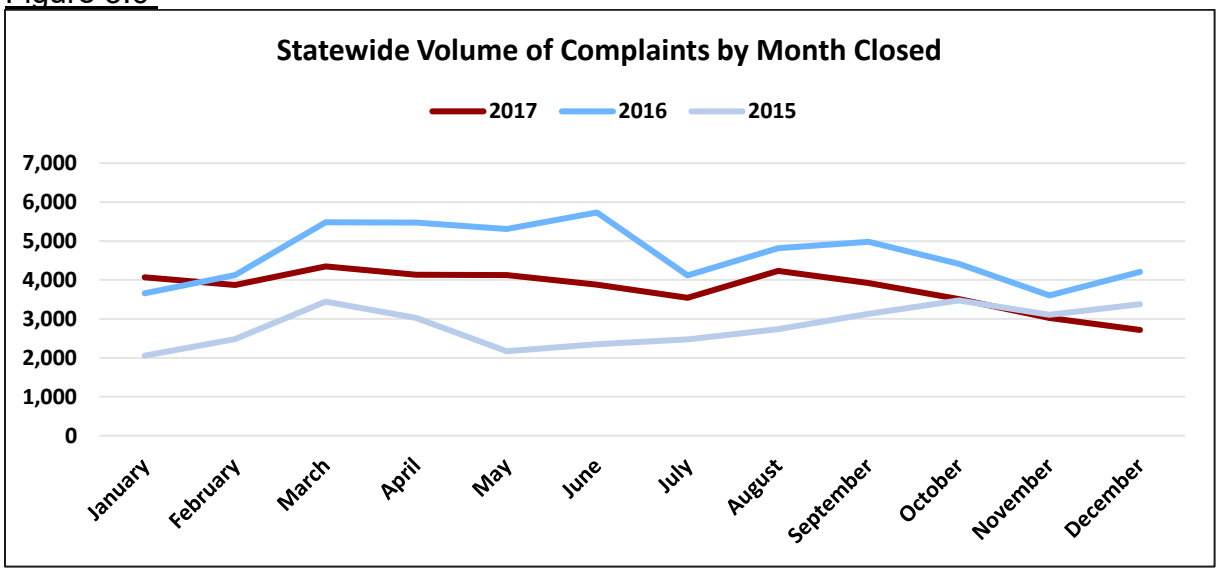
Figure 3.5



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. CDI's newly reported non-jurisdictional complaint dataset was excluded from the statewide three-year trend analysis, along with three cases referred by DMHC to outside agencies or departments in 2017.

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

Figure 3.6

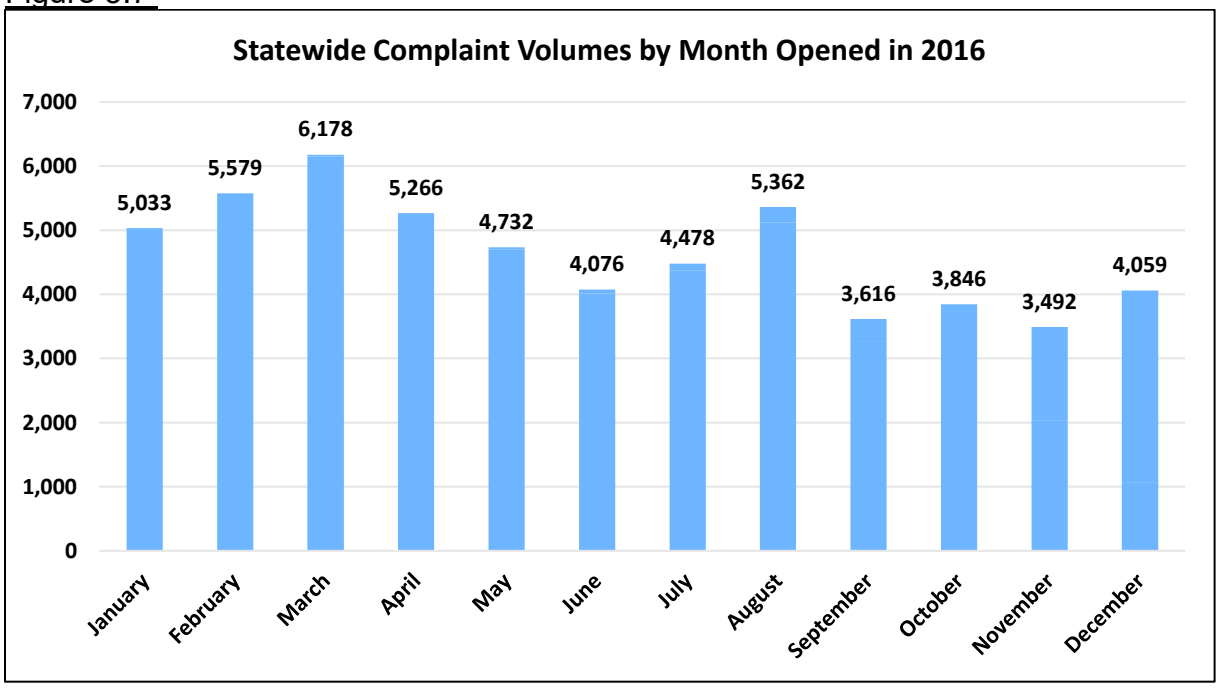


Volume of Opened Complaints

The following chart displays jurisdictional complaint monthly volumes determined by the date the complaint case was initiated by the consumer. A two-year analysis was necessary to capture volumes of complaints opened in late 2016 but closed in 2017. The chart accounts for 55,717 jurisdictional complaints opened in 2016, including:

- 49,707 cases closed in 2016 (Measurement Year 2016 data)
- 6,010 cases closed in 2017 (Measurement Year 2017 data)

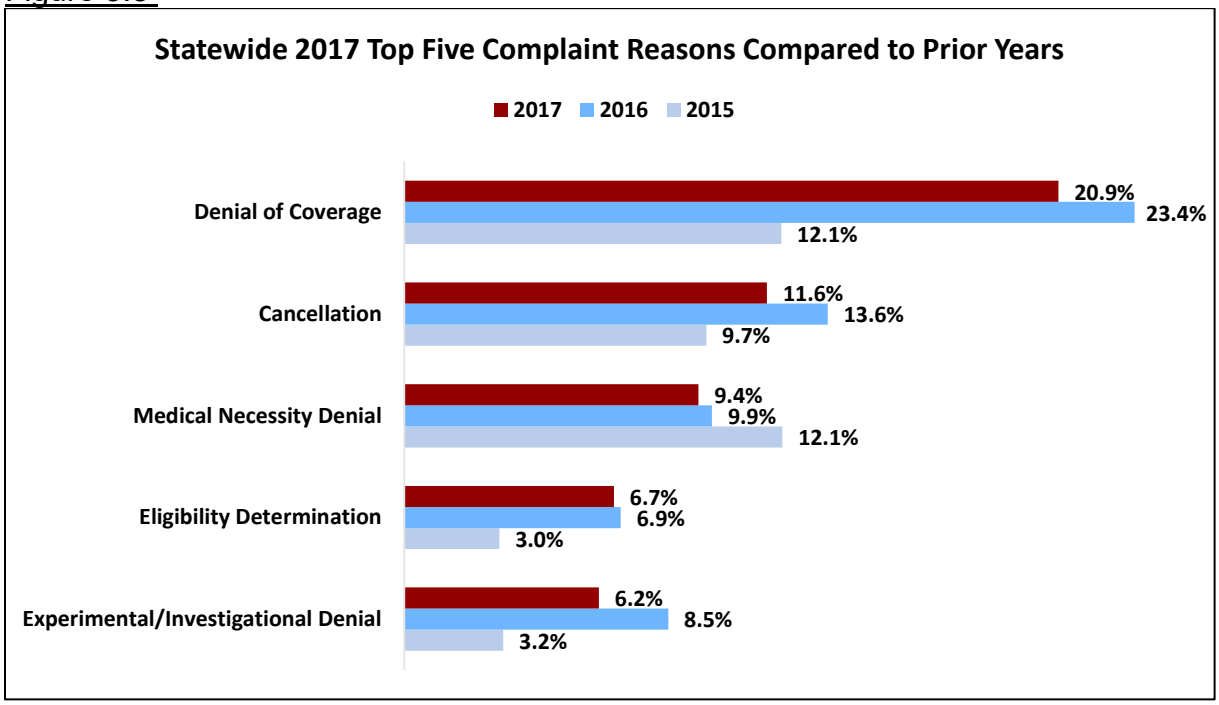
Figure 3.7



Complaint Reasons

The following chart displays the most common jurisdictional complaint reasons reported statewide for 2017, along with the 2015 and 2016 data for those same categories. Some of the differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Figure 3.8



Note: Experimental/Investigational Denial includes complaints that CDI reported under the reason category Experimental. The chart analysis excludes 4,539 reasons submitted by DMHC and CDI in 2017 for non-jurisdictional cases referred to other entities.

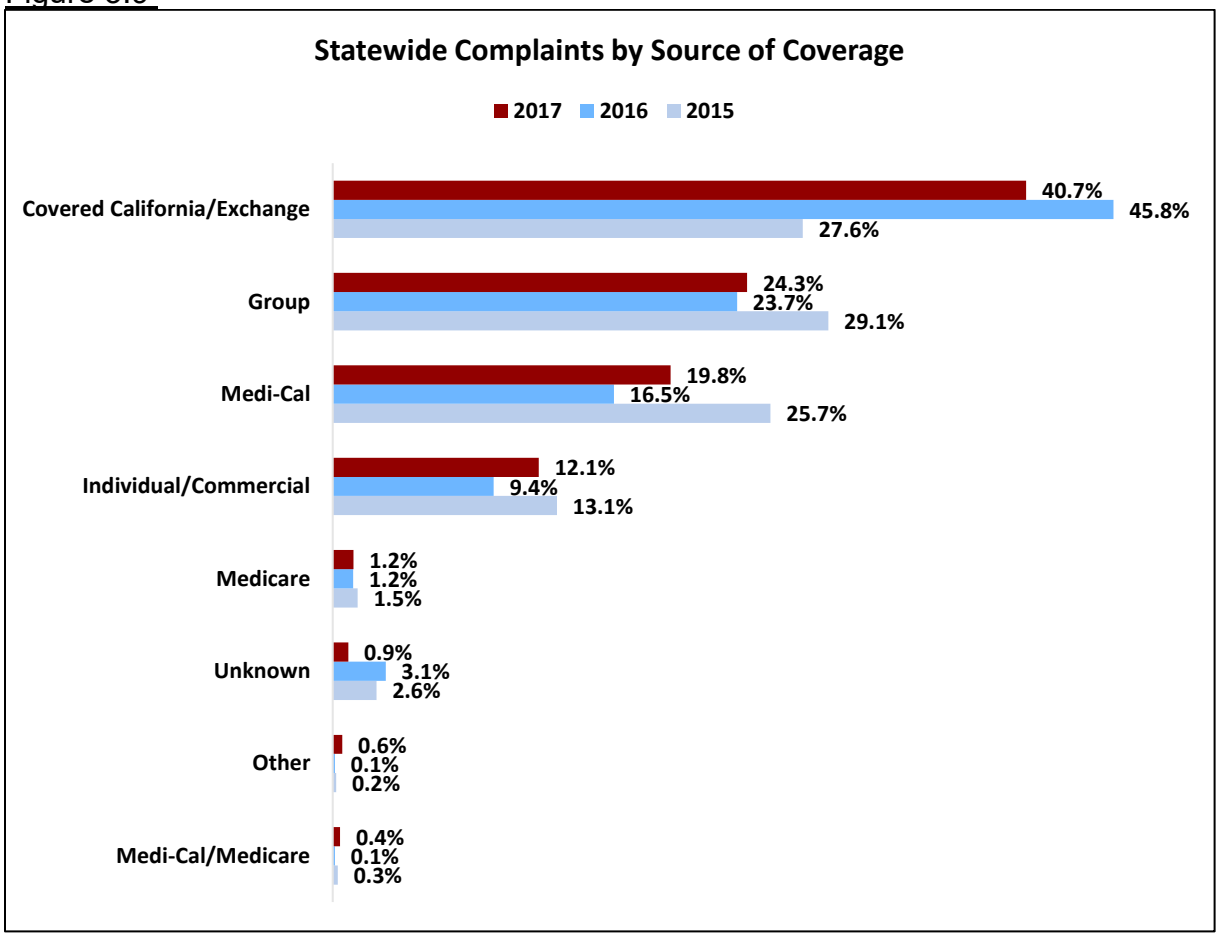
The top five reasons accounted for 55 percent (25,829) of the jurisdictional complaint reasons in 2017. The other 45 percent not displayed were reported among 76 different reason categories. The total number of reasons (47,030) exceeded the number of complaints (45,372) because some complaints had multiple reasons reported.

Source of Coverage

The following chart displays the 2017 distribution of the 45,372 jurisdictional complaints submitted by the four reporting entities compared to prior year distributions in the 2015 and 2016 data.

Due to differences in complaint reporting methodologies used by the reporting entities, complaint comparisons across sources of coverage should be interpreted with caution. For example, the Covered California/Exchange category includes complaint volumes for an informal complaint type not reported for other sources of coverage.

Figure 3.9



Note: Due to differences in complaint systems and reporting methodologies, comparisons of sources of coverage should be interpreted with caution. Low-volume categories were combined under Other for display purposes, including complaints with sources of coverage reported in 2017 as COBRA, CalPERS, Uninsured, and State Specific (Other). Other for 2015 and 2016 includes only COBRA.

- Covered California/Exchange complaints decreased in volume by 28 percent from the prior year (25,604 in 2016 to 18,542 in 2017). The decrease was largely associated with a drop in its informal resolution State Fair Hearing complaints.
    - Most of the statewide complaints for this source were submitted by Covered California, including formal State Fair Hearings (47% of the 18,542 complaints) and Informal Resolution types (38%).
    - Approximately 15 percent were DMHC-reviewed complaints.
- The commercial source of coverage categories had a combined volume of 16,515 complaints submitted by DMHC and CDI.
    - Complaints about Group coverage decreased in volume by nearly 17 percent from the prior year (from 13,260 complaints in 2016 to 11,029 in 2017). The associated percentage distribution in Figure 3.8 increased slightly only due to larger volume decreases in other sources of coverage.
    - Individual/Commercial complaints increased in both percentage distribution and volume compared to the prior year (4% volume increase from 5,282 in 2016 to 5,486 in 2017).

    - DMHC continued to account for most of the statewide commercial complaints (79% of Group and 72% of Individual/Commercial in 2017).
    - CDI reviewed a higher percentage of the statewide commercial complaints compared to the prior year (reviewed 15% in 2016 and 24% in 2017).
- Most of the 8,987 statewide Medi-Cal complaints were State Fair Hearings submitted by DHCS. Approximately 27 percent were resolved by DMHC.
    - Complaints about Medi-Cal coverage decreased in volume by nearly three percent from the prior year (9,223 in 2016). The associated percentage distribution in Figure 3.8 increased slightly only due to larger volume decreases in other sources of coverage.
- DMHC submitted all of the Unknown, Other, and Medicare complaints and most (70%) of the Medi-Cal/Medicare complaints.

Language

Figure 3.10 compares the top complaint reasons by the primary language identified for the complainant. The percentage shown is the distribution among the specified language category. The number of complaint reasons exceeds the number of complaints because some complaints had more than one reason.

The percentage distribution of statewide jurisdictional complaints by primary language was similar to prior years, with an uptick in Refused/Unknown (13% in 2016 compared to 17% in 2017). English accounted for most (76%) of the complaints, followed by Spanish (4%) and Other languages (3%). The statewide volumes by language category:

- English – 34,478 complaints (76%) with 35,365 reasons
- Spanish – 2,004 complaints (4%) with 2,010 reasons
- Other languages – 1,188 complaints (3%) with 1,213 reasons
- Refused/Unknown – 7,702 complaints (17%) with 8,442 reasons

Figure 3.10

Statewide 2017 Top Five Complaint Reasons by Primary Language

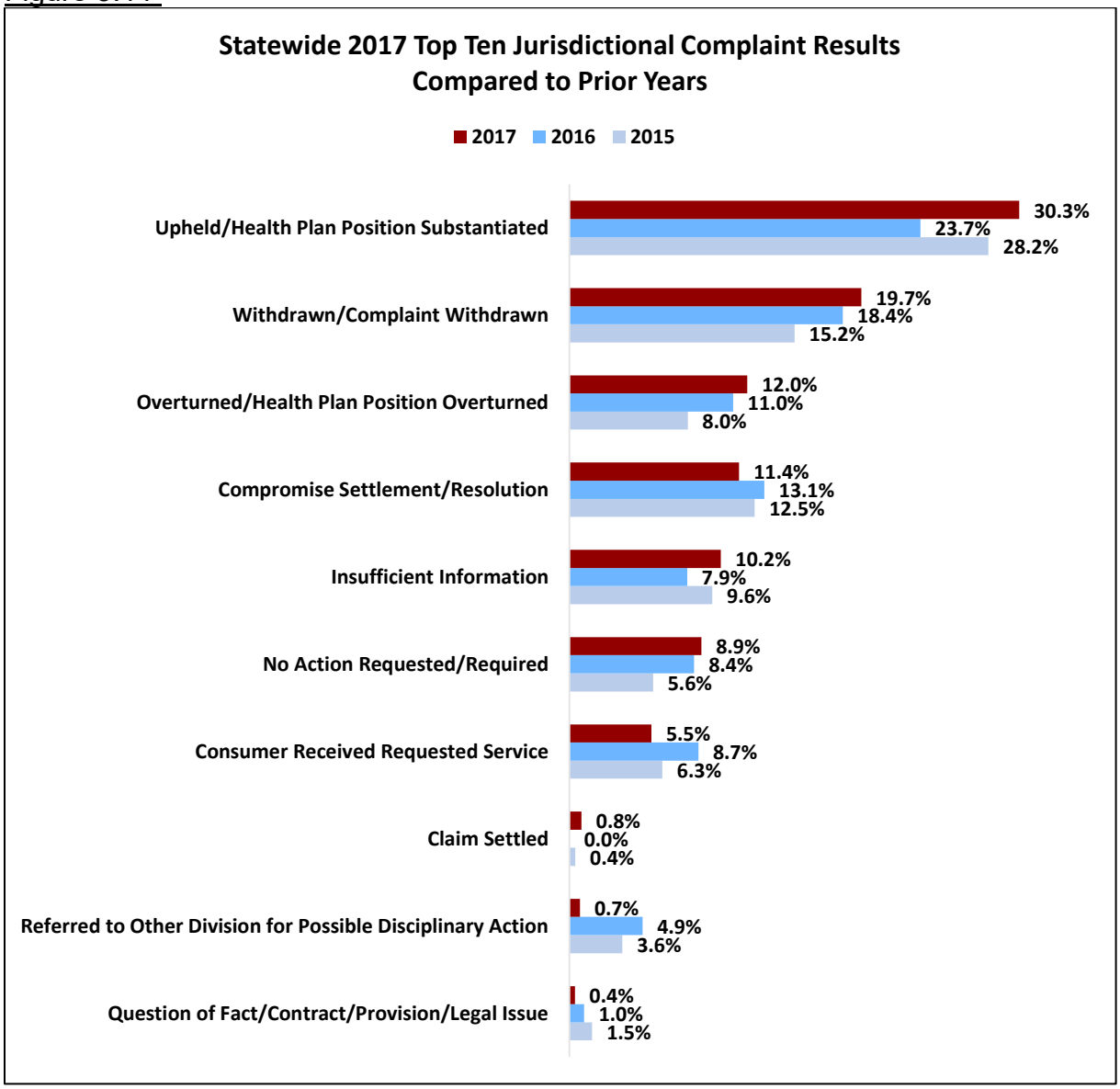
	English (% of English)	**Spanish** (% of Spanish)	**Other Languages** (% of Other Languages)	**Refused/Unknown** (% of Refused/Unknown)
1	Denial of Coverage (24%)	Denial of Coverage (45%)	Denial of Coverage (33%)	Quality of Care (19%)
2	Cancellation (14%)	Cancellation (14%)	Cancellation (14%)	Pharmacy Benefits (18%)
3	Medical Necessity Denial (10%)	Eligibility Determination (13%)	Eligibility Determination (13%)	Claim Denial (14%)
4	Eligibility Determination (8%)	Medical Necessity Denial (9%)	Medical Necessity Denial (7%)	Dis/Enrollment (11%)
5	Experimental/Investigational Denial (7%)	Provider Attitude and Service (3%)	Co-Pay, Deductible, and Co-Insurance Issues (6%)	Medical Necessity Denial (8%)

Results

The following chart shows the most common results of 2017 jurisdictional complaint reviews, as well as the 2015 and 2016 data for the same results categories. The top ten categories accounted for nearly all (99.9%) of the 49,088 jurisdictional results in 2017. The number of results exceeded the number of complaints because some complaints

had more than one result reported. Some differences between measurement years may be due in part to changes in data collection and reporting rather than incidence.

Figure 3.11



Resolution Time

The statewide average time to resolve a consumer health care complaint was 50 days, one day fewer than the 2016 average. 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. For example, a longer duration may be due to:

- A tracking system that counts the open date of re-opened complaints at the point when the complaint was first initiated rather than the time of re-opening.
- A close date determined at a later point after additional oversight activities are completed rather than when the consumer is notified about the decision.
- 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.

The following table displays the minimum, maximum, and average number of days each reporting entity took to resolve jurisdictional complaints in 2017. The DMHC, DHCS, and CDI average resolution times decreased from the prior year, while Covered California's average duration was unchanged.

Figure 3.12
2017 Complaint 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	231	22
DHCS	0	698	79
CDI	0	668	80
Covered California	0	339	66

Note: The table excludes non-jurisdictional complaints reported for the first time by CDI in 2017. CDI's average duration was four days for non-jurisdictional complaints referred to outside entities. DHCS and CDI indicated that their complaint data submissions included re-opened cases tracked by the original filing date rather than the re-open date.

The following table shows statewide average resolution times for each complaint type for jurisdictional complaints in 2017.

Figure 3.13
Statewide 2017 Average Resolution Times by Complaint Type

Complaint Type	Average Resolution Time (in days)	Reported By
CDSS State Fair Hearing	78	DHCS and Covered CA
CDSS State Fair Hearing: Informal Resolution	52	Covered CA
Independent Medical Review	36	DMHC and CDI
Complaint/Standard Complaint	32	DMHC and CDI
Urgent Nurse Case	6	DMHC
Quick Resolution	5	DMHC

All complaint types except for Independent Medical Review (IMR) decreased in average duration from the prior year.

Section 4 – Department of Managed Health Care

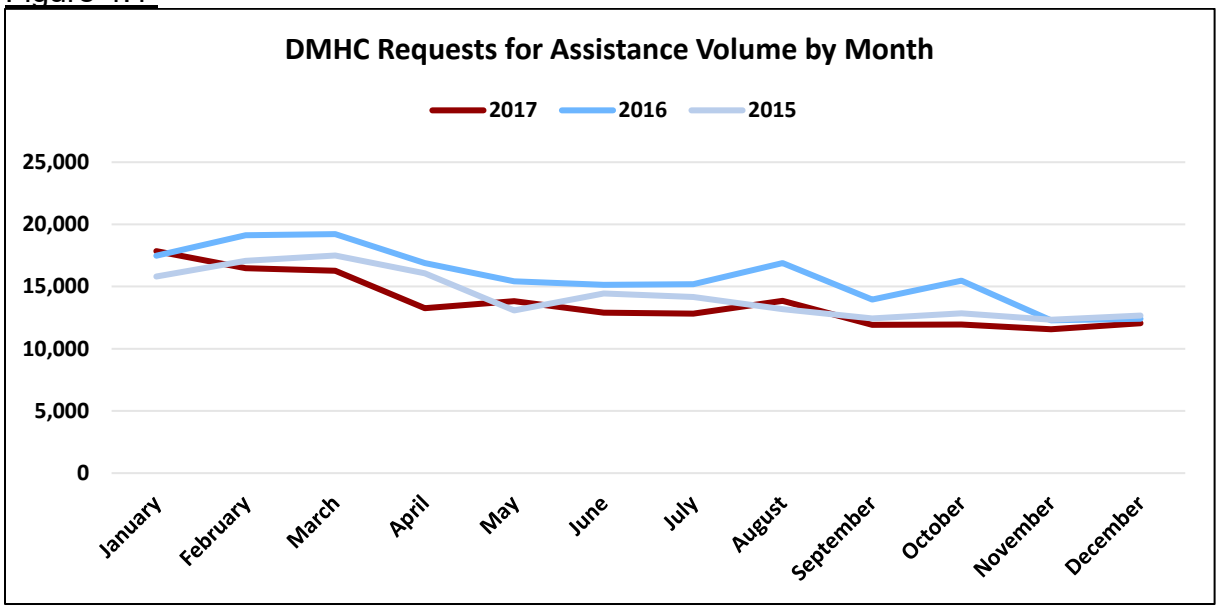
A. Overview

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 164,759 requests for assistance from consumers in 2017, a 13 percent decrease in volume from the prior year. Requests for assistance include jurisdictional and non-jurisdictional complaints and inquiries. In addition to reduced incidence of a variety of health care issues, DMHC noted that the department's new self-serve telephone options starting in November 2017 contributed to a decrease in the number of calls answered by Help Center agents.

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 consumer assistance volumes by month for three reporting years. The Help Center received 164,759 requests for assistance in 2017, 189,482 in 2016, and 171,597 in 2015.

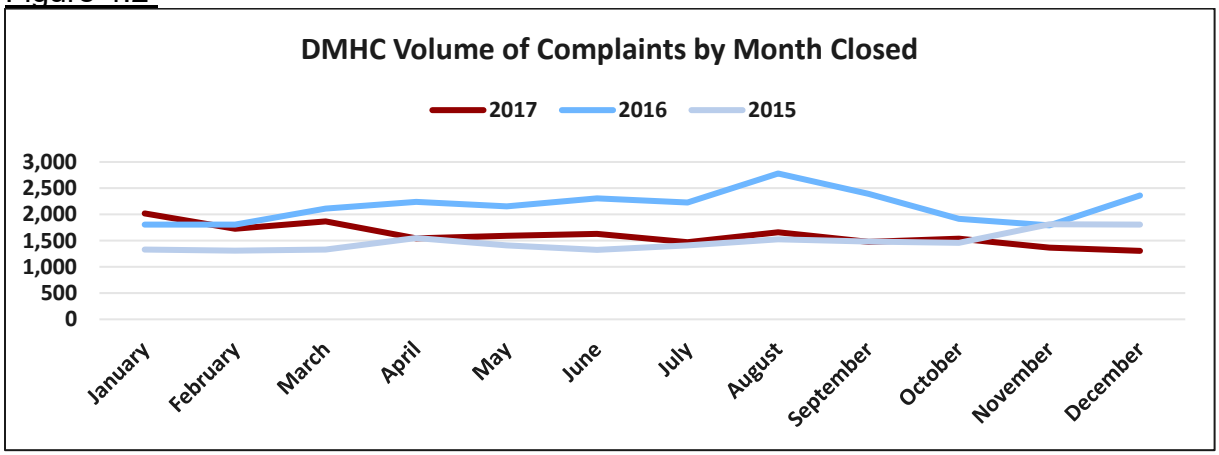
DMHC reported 19,200 complaints in 2017, a 26 percent decrease in volume over the prior year (25,886 complaints).

DMHC indicated that this decrease is due in part to its decision not to report health plan grievance process violations in the 2017 submission (these violations accounted for approximately four percent of the 2016 complaints). DMHC noted that there also was a downward trend in complaint filings, including fewer complaints regarding denials for

three-dimensional mammography (which spiked in 2016) and regarding Covered California plan cancellations.

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

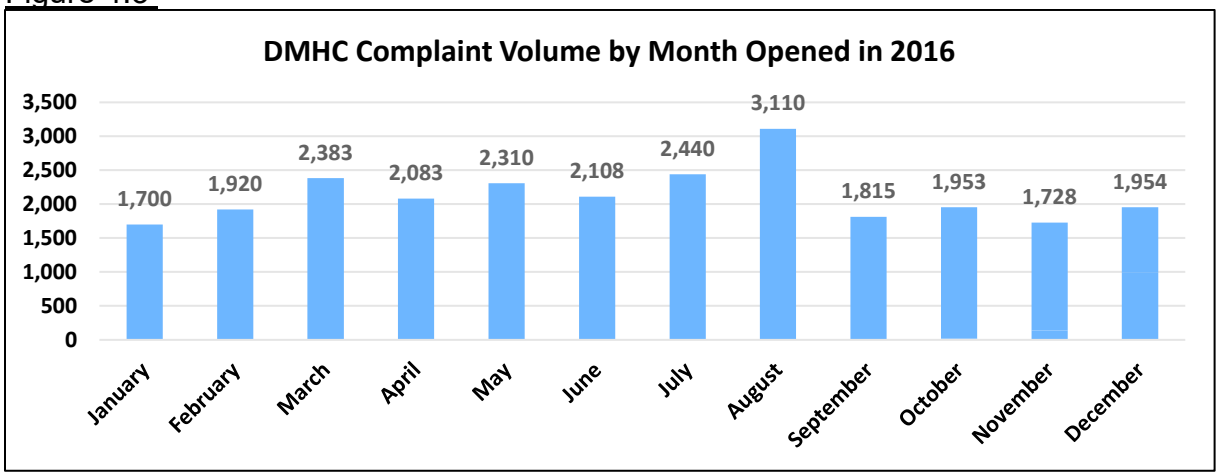
Figure 4.2



Note: This chart displays annual complaint volumes distributed by the month the complaint reviews ended. There were 19,200 complaints closed in 2017, 25,884 complaints closed in 2016, and 17,737 complaints closed in 2015.

The following chart shows the months that consumers initiated complaints with DMHC in 2016. A two-year analysis was necessary to include complaint volumes for those opened in the winter months of 2016 but closed in 2017 (MY 2017 data).

Figure 4.3



Complaint Type Overview

Most of DMHC's 19,200 complaints reviewed in 2017 were the complaint type Standard Complaint (66%), followed by Independent Medical Review (29%), Quick Resolution (4%), and Urgent Nurse Case (1%)

- 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 procedures.
- The Quick Resolution process is used by the DMHC service center to open communication lines 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.

Figure 4.4

DMHC Help Center Complaint Standards

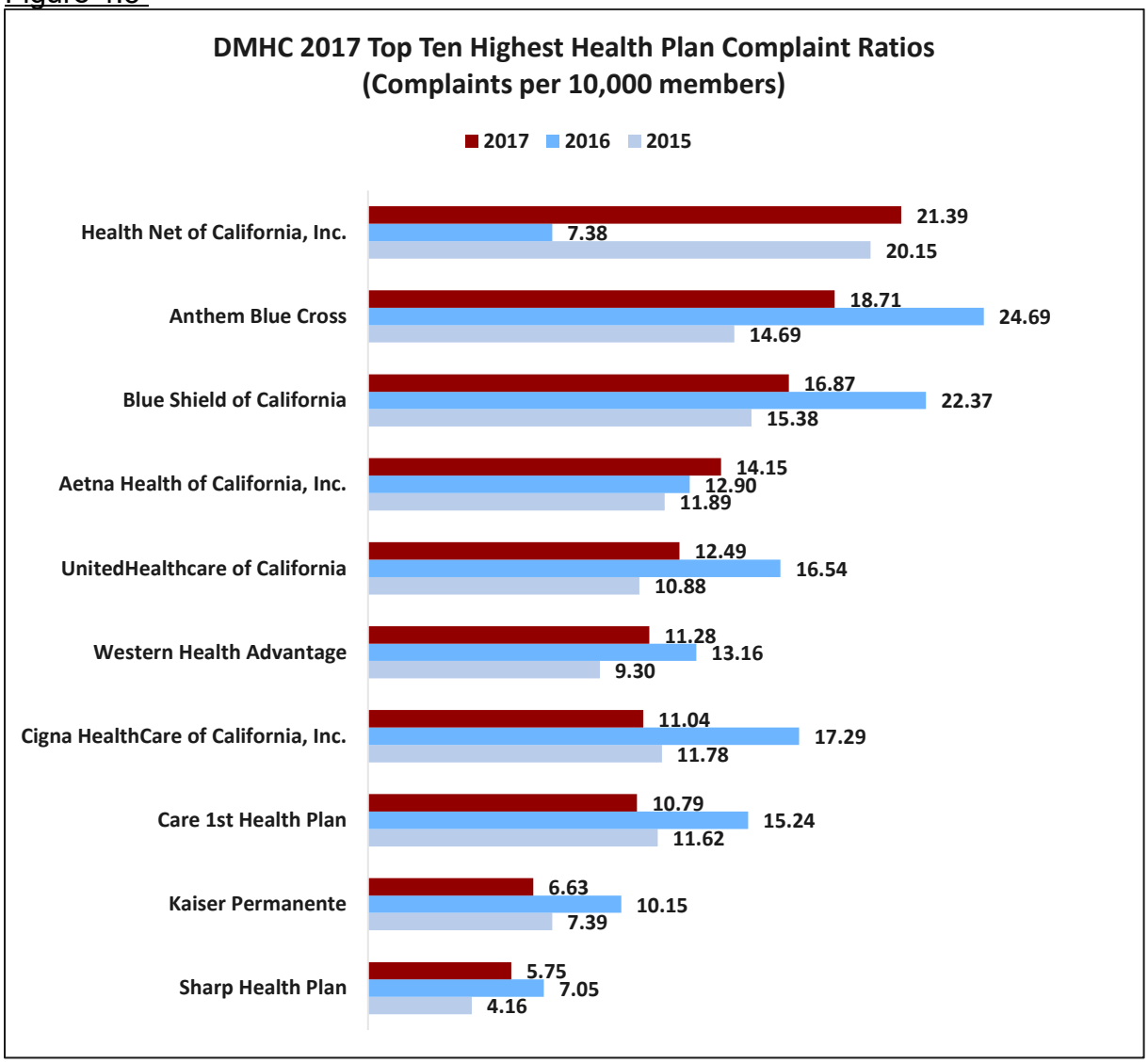
Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
Standard Complaint	*Contact Center:* Intake and routing *Independent Medical Review/Complaint Branch:* Casework *Legal Branch:* Casework for more complex legal cases	30 days from receipt of a completed complaint application	21 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	27 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	6 days
Quick Resolution	*Contact Center:* Intake and casework resolution	10 days	5 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.

B. Complaint Ratios, Reasons, and Results

The following chart shows the health plans regulated by DMHC with the highest complaint ratios in 2017, 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 4.5



Note: The chart above displays the full-service health plans with the highest complaint ratios for 2017 among plans with at least 70,000 members. The display also shows the 2015 and 2016 complaint ratios for the health plans represented. Health Net of California, Inc.'s complaint ratios include complaints regarding Health Net Community Solutions.

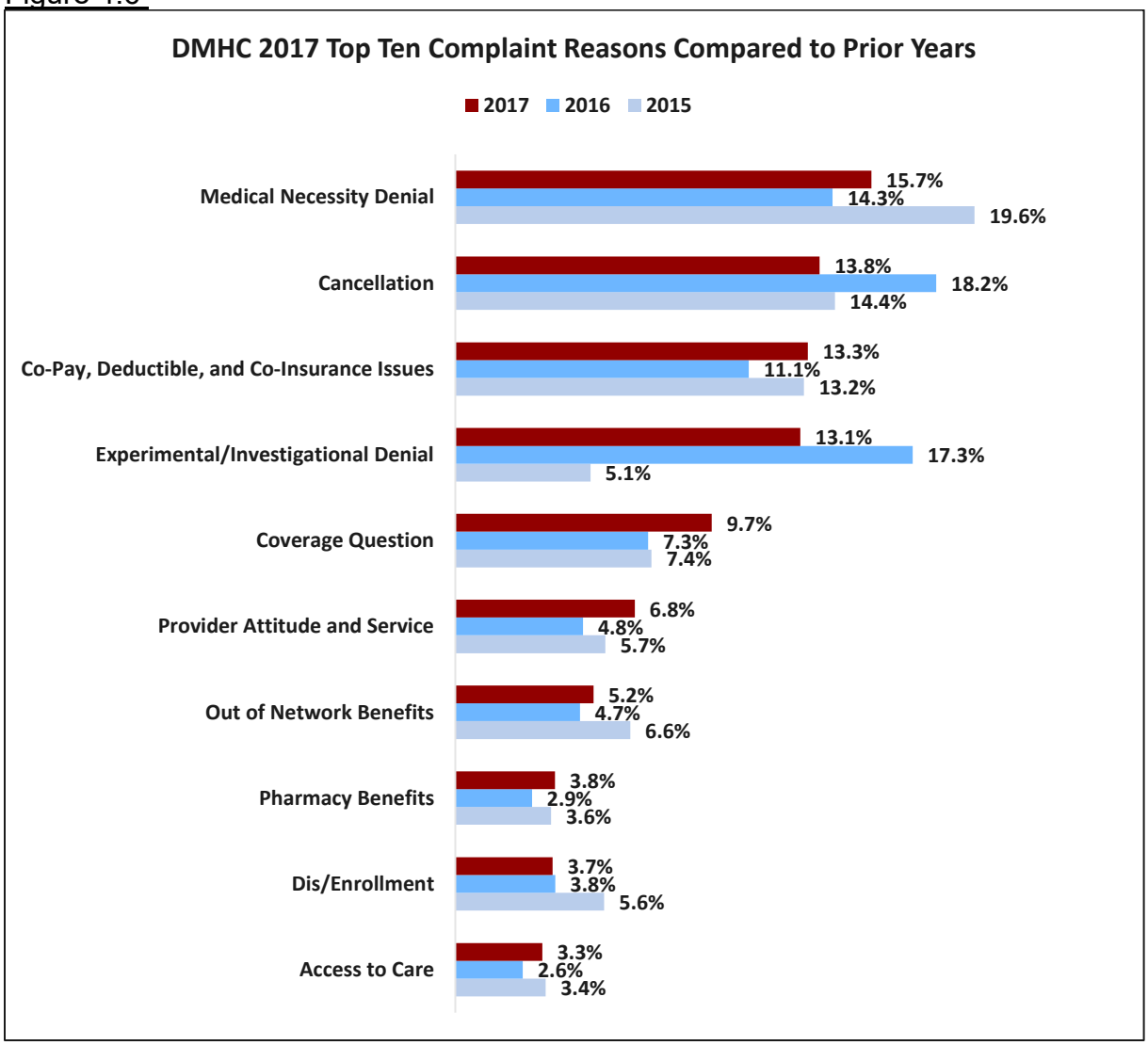
Plans with a specialty license through DMHC (such as vision or dental) typically have a lower complaint ratio than full-service plans. The specialty plans with enrollment reported over 70,000 members had an average complaint ratio of 0.14 complaints per 10,000 members in 2017. The following specialty health plans had the highest complaint ratios (complaints per 10,000 members) per license type among plans with over 70,000 members:

- Dental: Personal Dental Services (1.26)
- Behavioral: Cigna Behavioral Health of California, Inc. (0.41)
- Dental/Vision: MetLife (0.83)
- Chiropractic: OptumHealth Physical Health of California (0.09)
- Vision: EYEEXAM of California, Inc. (0.02)

Top Ten Reasons for Complaints

The following chart displays the top ten most common reasons for complaints reviewed by DMHC in 2017. The top ten complaint reason categories account for 88 percent of the 19,200 complaints. DMHC reported 32 different reason categories.

Figure 4.6



Note: The complaint reason categories represented in this chart are the top reasons for 2017 and the distribution of those same reason categories in the 2015 and 2016 data. The reasons displayed may not have been the same top reasons in 2015 and 2016.

- Of the 2017 top ten reasons, only Provider Attitude and Service experienced a raw volume increase from the prior year. Several reasons increased in percentage distribution ranking despite a raw volume decrease.
- Medical Necessity Denial was the top complaint reason with 3,022 complaints in 2017, increasing in ranking from third most common in 2016.
- Cancellation complaints decreased in ranking (1st to 2nd) with a 44 percent decrease in volume from the prior year.
- Experimental/Investigational Denial dropped in ranking from second in 2016 to the fourth most common reason for complaints in 2017.
    - DMHC noted that the decrease in volume and ranking was likely due in part to health plans' adjustment of mammography policies, which lead to fewer disputed denials of Digital Breast Tomosynthesis filed with DMHC.
- The Other Violation of Insurance Law/Regulation reason category (ranked eighth in 2016) was not reported in 2017.
    - In prior years, DMHC reported violations by health plans of Knox-Keene Act grievance system requirements under this category.
    - DMHC indicated that these violations were excluded from the 2017 submission because the department determined that the violations were not consumers' primary reason for initiating a complaint and were instead problems identified after the complaint was reviewed and closed with the consumer.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table shows the most common topics of inquiries and complaints in 2017 that were outside of DMHC's jurisdiction to address, volume of requests for assistance for the topic, 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.

The volumes shown are only inquiries addressed by DMHC staff and do not include certain common calls addressed within the service center's Interactive Voice Response system, such as automated referrals to particular health plans, Health Care Options, and Covered California based on a caller's inputted telephone selections.

Figure 4.7

DMHC Help Center 2017 Top Ten Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Volume	Referred to
1 (most common)	General Inquiry/Info	8,203	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)
2	Enrollment Disputes	1,237	Covered California DHCS Health Consumer Alliance (HCA) Partner

Ranking	Inquiry Topic	Volume	Referred to
			California Department of Social Services (DSS) HICAP
3	Claims/Financial	994	CDI Covered California CMS DHCS Out-of-State Department of Insurance (DOI)
4	Coverage/Benefits Disputes	936	DHCS CMS CDI HICAP HCA Partner
5	Provider Customer Service	309	California Department of Consumer Affairs (DCA) CMS DHCS HICAP California Department of Public Health (CDPH)
6	Wrong Number	270	Covered California DHCS CDI CMS U.S. Department of Labor (DOL)
7	Access to Care	230	DHCS CMS CDI HCA Partner HICAP
8	Coordination of Care	150	CMS HICAP DHCS HCA Partner CDI
9	Plan Customer Service	93	CMS HICAP CDI DHS Covered California
10	Appeal of Denial/IMR	30	CDI CMS Out-of-State DOI DOL CalPERS

Note: DMHC ranking of topics and referrals were based on data.

DMHC noted that Covered California is no longer a top non-jurisdictional inquiry topic in part due to new IVR phone system self-serve options, which helped steer callers to the

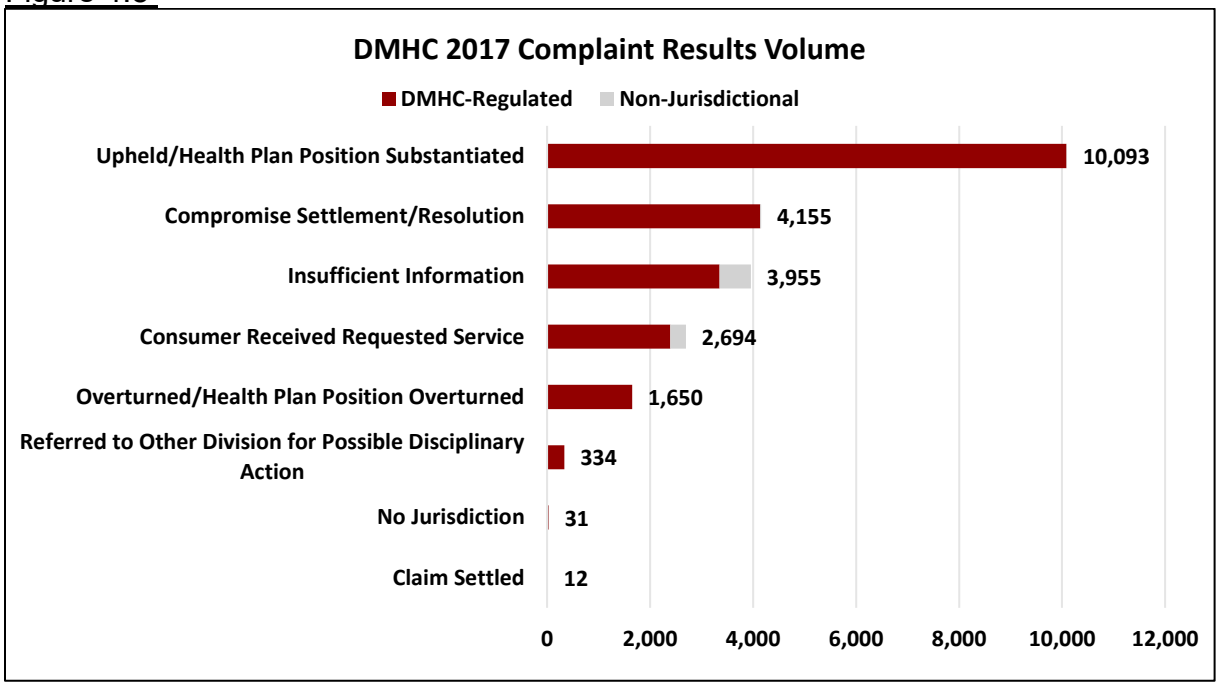
Covered California service center rather than to a DMHC agent. Implemented in November 2017, this system update was in place in time for most of Covered California's open enrollment period. DMHC also indicated that Covered California's enrollees are likely experiencing fewer issues with Covered California coverage processes.

Complaint Results

DMHC reported 22,928 complaint results from the 19,200 complaints closed in 2017. The number of complaint results exceeds the number of complaints because some complaints had more than one result. Approximately 19 percent of the DMHC complaints had two results reported.

The following chart displays 22,924 of the 22,928 complaint results submitted by DMHC, omitting two results categories with low volumes. The display also shows volumes of non-jurisdictional complaints (a regulator other than DMHC identified) and those within DMHC's jurisdiction (DMHC identified as the regulator). Approximately 15 percent of the Insufficient Information complaints and 11 percent of the Consumer Received Requested Service complaints identified a regulator other than DMHC.

Figure 4.8

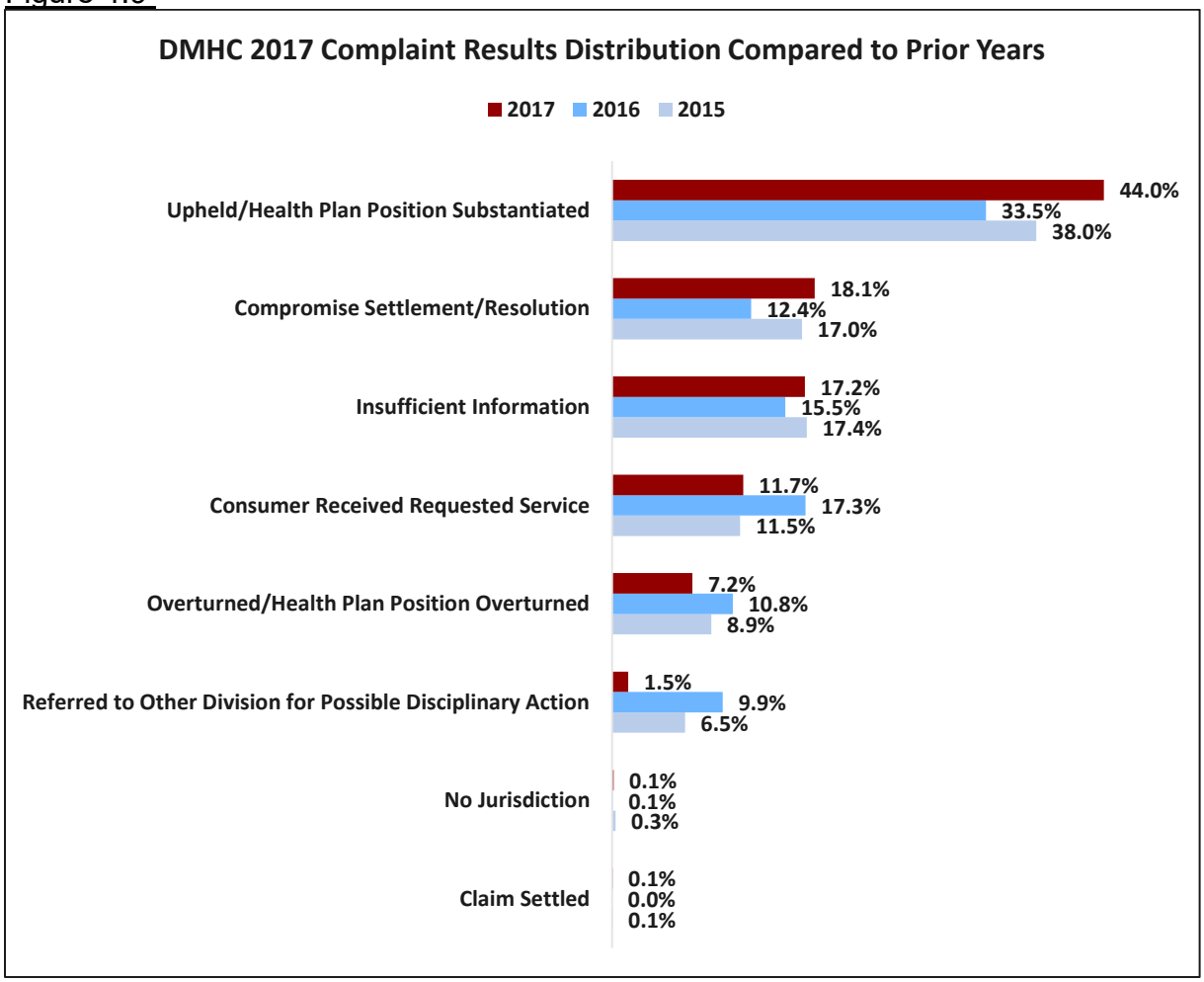


Note: The chart excludes two results categories with volumes ten and under. DMHC uses criteria to determine complaint outcomes that does not closely match the standardized, NAIC-based results categories. Therefore, the data in this table may not directly correspond to complaint outcomes published by 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 2017, along with the distribution of the same results categories in 2015 and 2016 data. The chart represents nearly all (99.98%) of the 22,928 complaint results for 2017, 30,555 of the 30,706 results for 2016, and 21,502 of the 21,583 results for 2015. In all three years shown, 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.

Figure 4.9



Note: The chart displays the top 2017 complaint results and the percentage distributions for the same eight complaint results categories in 2015 and 2016 data. Two results categories reported for 2017 were excluded from display due to low volumes.

The following tables show the complaint results for the three most common complaint reasons reported by DMHC for 2017: Medical Necessity Denial (3,022), Cancellation (2,646), and Co-Pay, Deductible, and Co-Insurance Issues (2,560).

This reason-to-result analysis treats dual results reported for a complaint reason as a single, combined result. Approximately 19 percent of the 19,200 DMHC complaints in

2017 had two results reported. Among the complaints with dual results, there were only two different combinations of results entries reported.

Figure 4.10

DMHC 2017 Results for Medical Necessity Denial Complaints

Complaint Result	Percentage of Medical Necessity Denial Complaints
Consumer Received Requested Service	34.8%
Upheld/Health Plan Position Substantiated	33.6%
Overturned/Health Plan Position Overturned	31.2%
Insufficient Information	0.2%
No Jurisdiction	0.1%
Referred to Outside Agency/Dept.	0.1%

Figure 4.11

DMHC 2017 Results for Cancellation Complaints

Complaint Result	Percentage of Cancellation Complaints
Two Results: Upheld/Health Plan Position Substantiated **and** Compromise Settlement/Resolution	44.2%
Upheld/Health Plan Position Substantiated	32.7%
Insufficient Information	16.7%
Two Results: Referred to Other Division for Possible Disciplinary Action **and** Overturned/Health Plan Position Overturned	5.3%
Referred to Other Division for Possible Disciplinary Action	1.1%

Figure 4.12

DMHC 2017 Results for Co-Pay, Deductible, and Co-Insurance Issues Complaints

Complaint Result	Percentage of Co-Pay, Deductible, and Co-Insurance Issues Complaints
Upheld/Health Plan Position Substantiated	39.4%
Insufficient Information	34.1%
Two Results: Upheld/Health Plan Position Substantiated **and** Compromise Settlement/Resolution	25.5%
Two Results: Referred to Other Division for Possible Disciplinary Action **and** Overturned/Health Plan Position Overturned	0.8%
Referred to Other Division for Possible Disciplinary Action	0.3%

Resolution Time

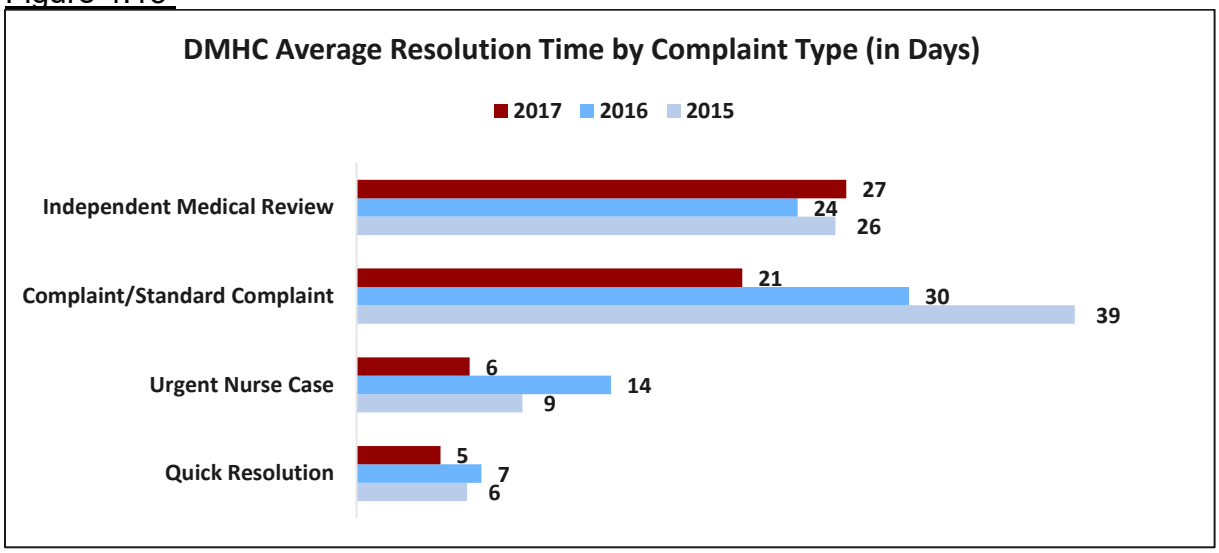
DMHC's average resolution time for all complaints closed in 2017 was 22 days, a six-day decrease from the prior year (28-day average in 2016).

- Jurisdictional complaints closed by DMHC also averaged 22 days.

- The reported non-jurisdictional complaints (where a regulator other than DMHC was identified) took the department 16 days on average to close.
- All complaint types but Independent Medical Review significantly decreased in average resolution time from the prior year.

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

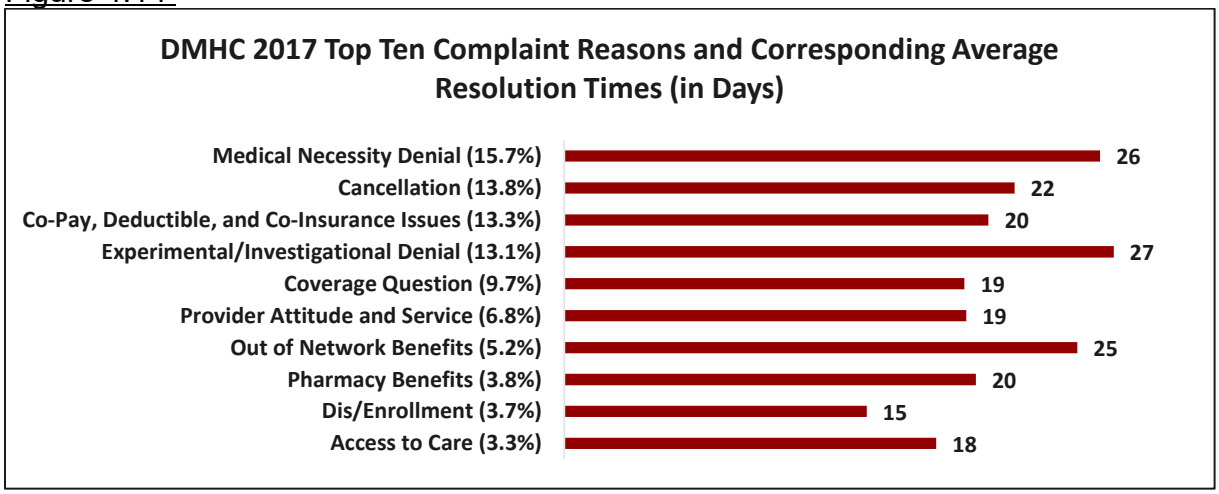
Figure 4.13



Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint. 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 2017 and the average number of days for DMHC to complete its complaint review for those reasons.

Figure 4.14



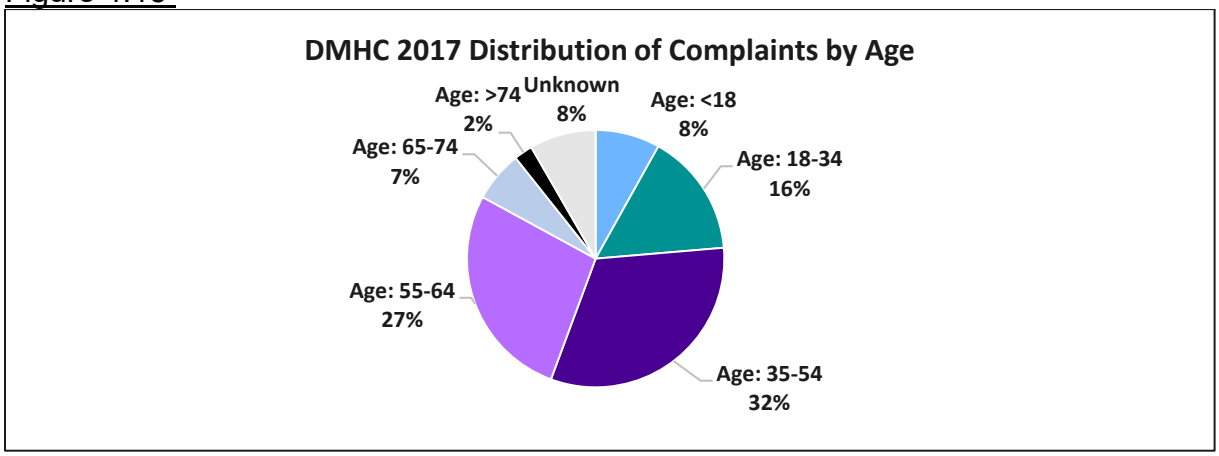
Note: Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

C. Demographics and Other Complaint Elements

Age

The following chart shows the distribution of the 19,200 complaints reported for 2017 by age. A higher percentage of the 2017 complaints had age identified (92%) than the prior year (88% in 2016). The average age of the complainants was 46 in 2017, a slight increase over the average of 45 years old in 2016 and 2015.

Figure 4.15



The top reasons reported for 2017 were similar to 2016, with shifts in rankings for most age groups due to a significant decrease in Cancellation complaints.

- Medical Necessity Denial remained the top reason for under age 35.
- Experimental/Investigational Denial remained the top reason for ages 35-74.
- Co-Pay, Deductible, and Co-Insurance Issues was the top reason for ages 75 and older.
- Despite dropping in ranking for most known age groups, Cancellation remained the top reason for complainants whose age was Unknown.

Gender

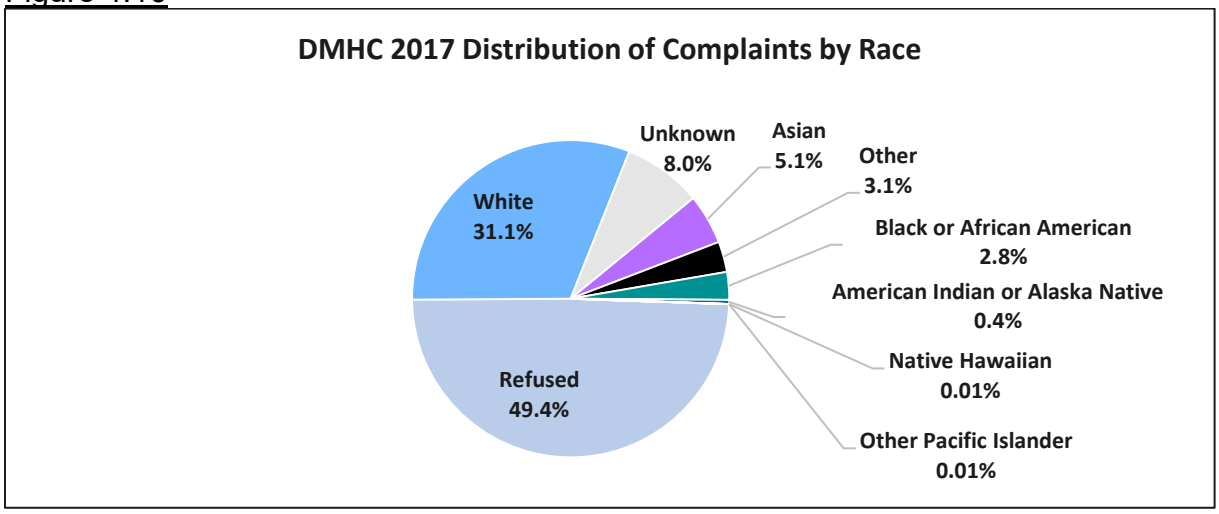
Of DMHC's 19,200 complaints, gender was identified as Female for most cases (59%), followed by Male at 39 percent, and Other at less than one percent. Approximately two percent of the complaints did not identify gender (1.7% Unknown). DMHC reported complaints with gender identified as Other for the first time in 2017. Complaint volumes decreased from the prior year at a higher rate for Female than Male.

- Cancellation remained the top complaint reason for both Male and Unknown gender complainants, but dropped in ranking for Female (second in 2016 to fourth in 2017).
- Experimental/Investigational Denial remained the top complaint reason for Female complainants.

Race and Ethnicity

The following chart shows the distribution of the 19,200 complaints reported for 2017 by the identified race of the complainant. A higher percentage of complaints had race identified (47% in 2017) than the prior year (27% in 2016).

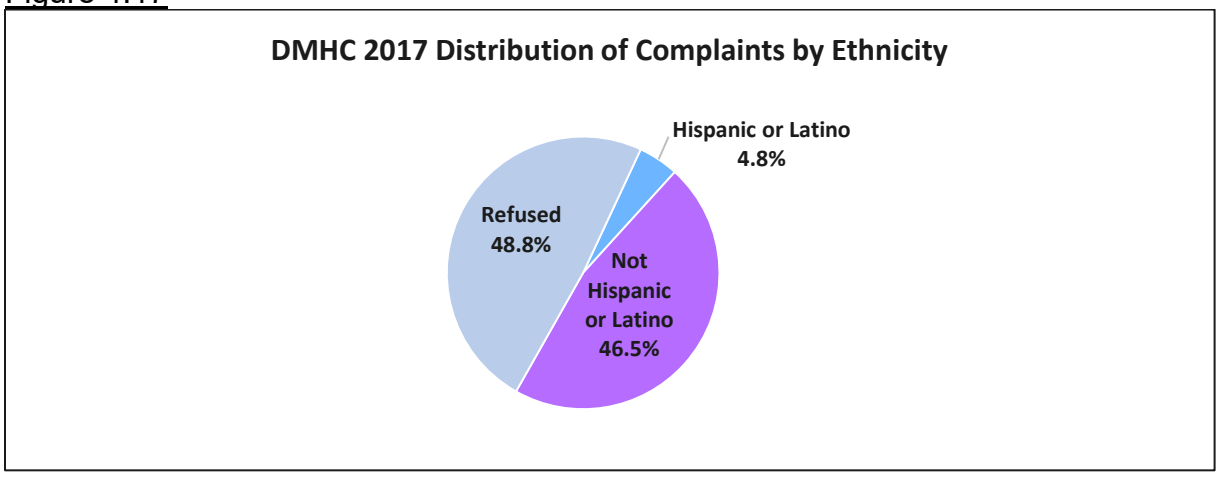
Figure 4.16



- Medical Necessity Denial ranked among the top three complaint reasons across all known race categories, and was the top reason for White, Black or African American, and Other combined (race categories with low complaint volumes).
- Co-Pay, Deductible, and Co-Insurance Issues was the top reason for Asian.
- Experimental/Investigational Denial was the top reason for complaints without race identified (Refused/Unknown).

The following chart shows the distribution of the 19,200 complaints reported for 2017 by the identified ethnicity of the complainant. A higher percentage of complaints had ethnicity identified (51% in 2017) than the prior year (35% in 2016).

Figure 4.17



- For complainants with ethnicity identified, Medical Necessity Denial replaced Cancellation as the top complaint reason. In 2017, Cancellation was the second most common reason for Hispanic or Latino and third for Not Hispanic or Latino.
- Experimental/Investigational Denial remained the most common complaint reason for Refused (ranked ninth for Hispanic or Latino and seventh for Not Hispanic or Latino).

Language

Most complainants (95.7%) identified their primary language as English, followed by Spanish (2.3%) and other languages (2.1% combined language categories). At least one complaint was reported in 2017 for each of the following languages: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Russian, Tagalog, and Vietnamese.

- Medical Necessity Denial was the top complaint reason for English, replacing Cancellation (dropped to second in 2017).
- For Spanish, Cancellation remained the most common reason just barely ahead of Provider Attitude and Service (which increased from fourth in 2016 to second in 2017).
- For Other languages, Co-Pay, Deductible, and Co-Insurance Issues replaced Cancellation (dropped to third in 2017) as the top complaint reason.

Mode of Contact

In 2017, the online mode of contact (45%) surpassed mail (34%) for the first time as the most common mode consumers used to initiate a complaint review with DMHC. DMHC also reported complaints initiated by fax (15%), telephone (5%), and email (1%).

Regulator

DMHC continued to be the identified regulator of most of the complaints the department reviews (95% in 2017).

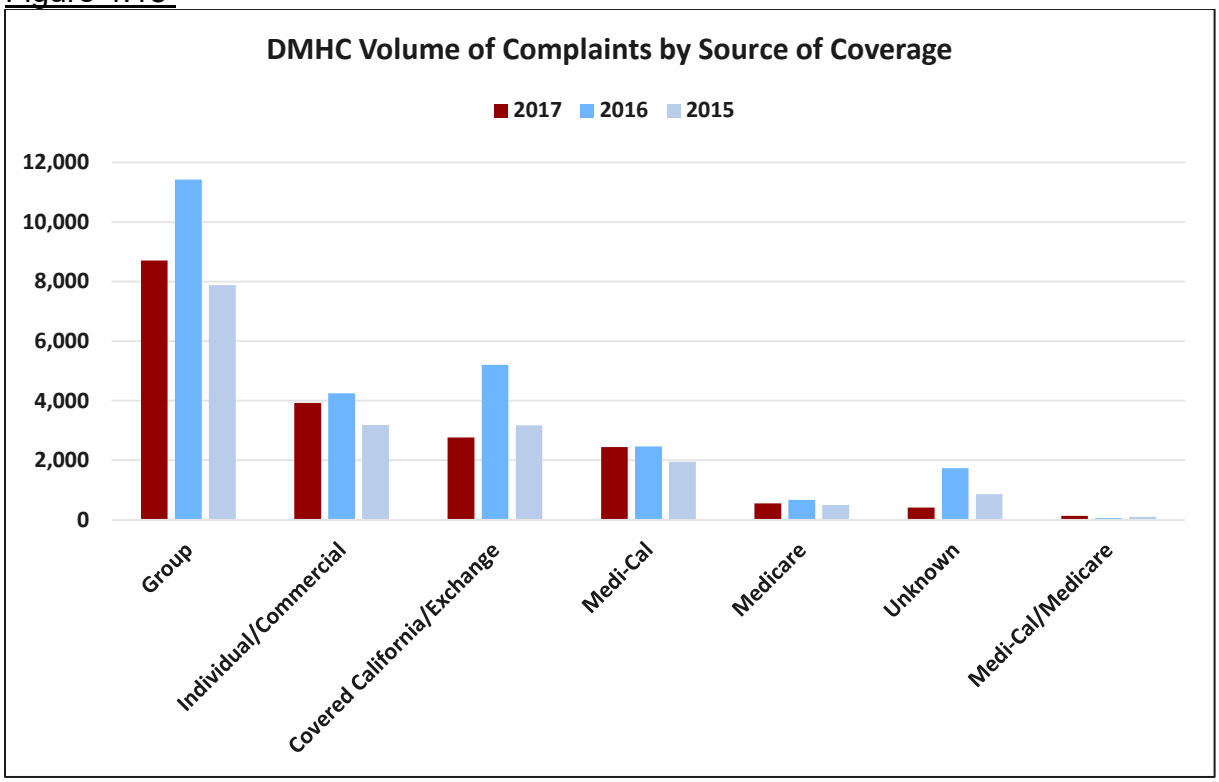
- The percentage of complaints reviewed by DMHC that pertain to coverage regulated by other entities has not fluctuated much over the past four reporting years (5% in 2017, 6% in 2016, 7% in 2015, and 5% in 2014).
- For 2017, DMHC reported non-jurisdictional complaints with the regulator identified as the U.S. Department of Labor (2%), California Department of Insurance (2%), and Other (1%).

Source of Coverage

DMHC reported Uninsured as a new source of coverage category in 2017, a change to align with the department's data collection. This new category accounted for less than one percent of DMHC's 2017 complaints.

The following chart displays complaint volumes by source of coverage over three reporting years.

Figure 4.18

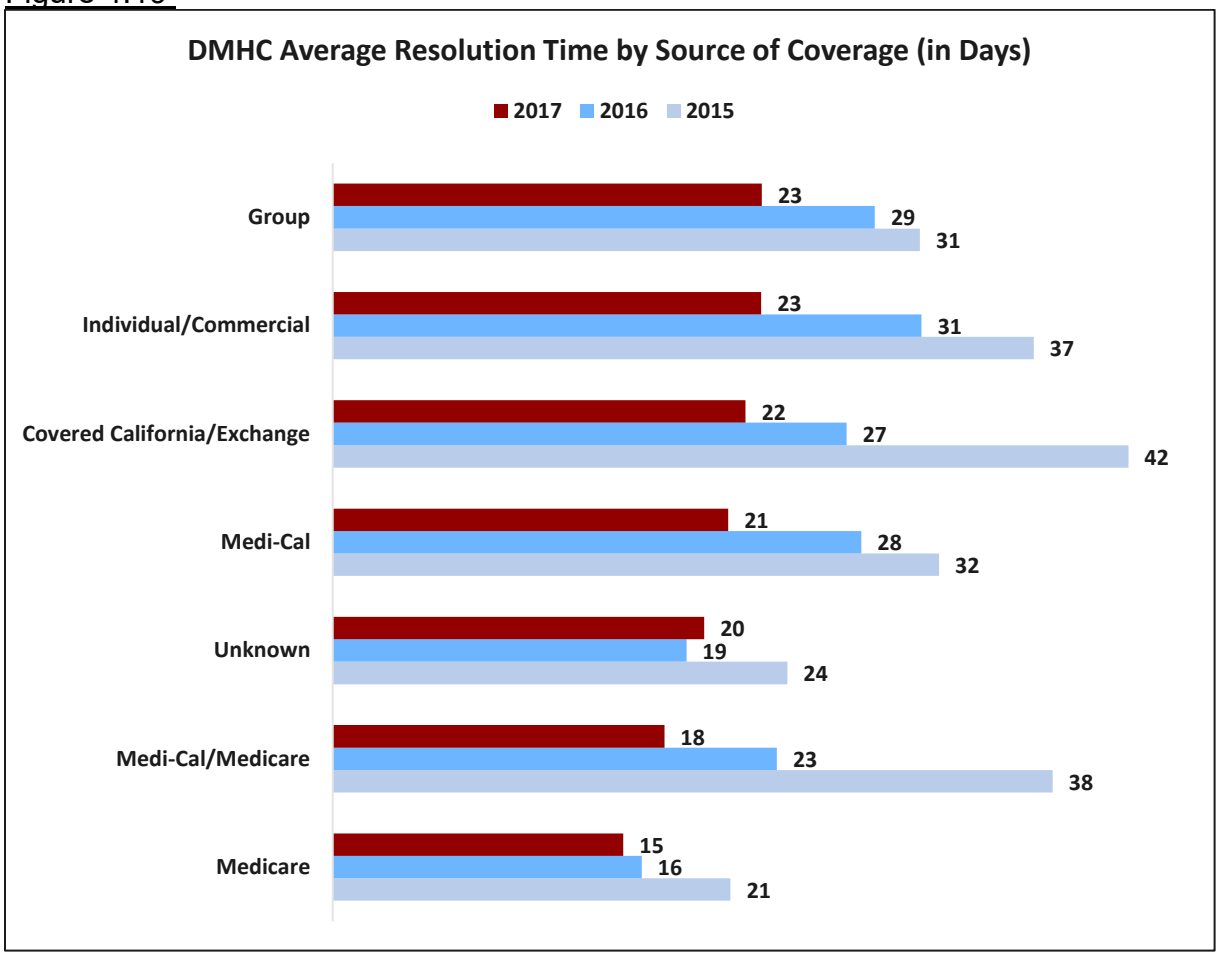


Note: Source of Coverage categories with under 100 complaints in 2017 were excluded from the display. The categories with the volume under 100 in 2017 were CalPERS, COBRA, Uninsured, and State Specific (Other).

- A majority of the complaints reviewed continued to be regarding commercial sources of coverage (45% Group and 20% Individual).
- Covered California/Exchange accounted for 14 percent of the complaints.
- The other reported sources of coverage included Medi-Cal (13%), Medicare (3%), and Unknown (2%).
- Four categories had distributions under one percent: Medi-Cal/Medicare, CalPERS, COBRA, Uninsured, and State Specific (Other).

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 4.19



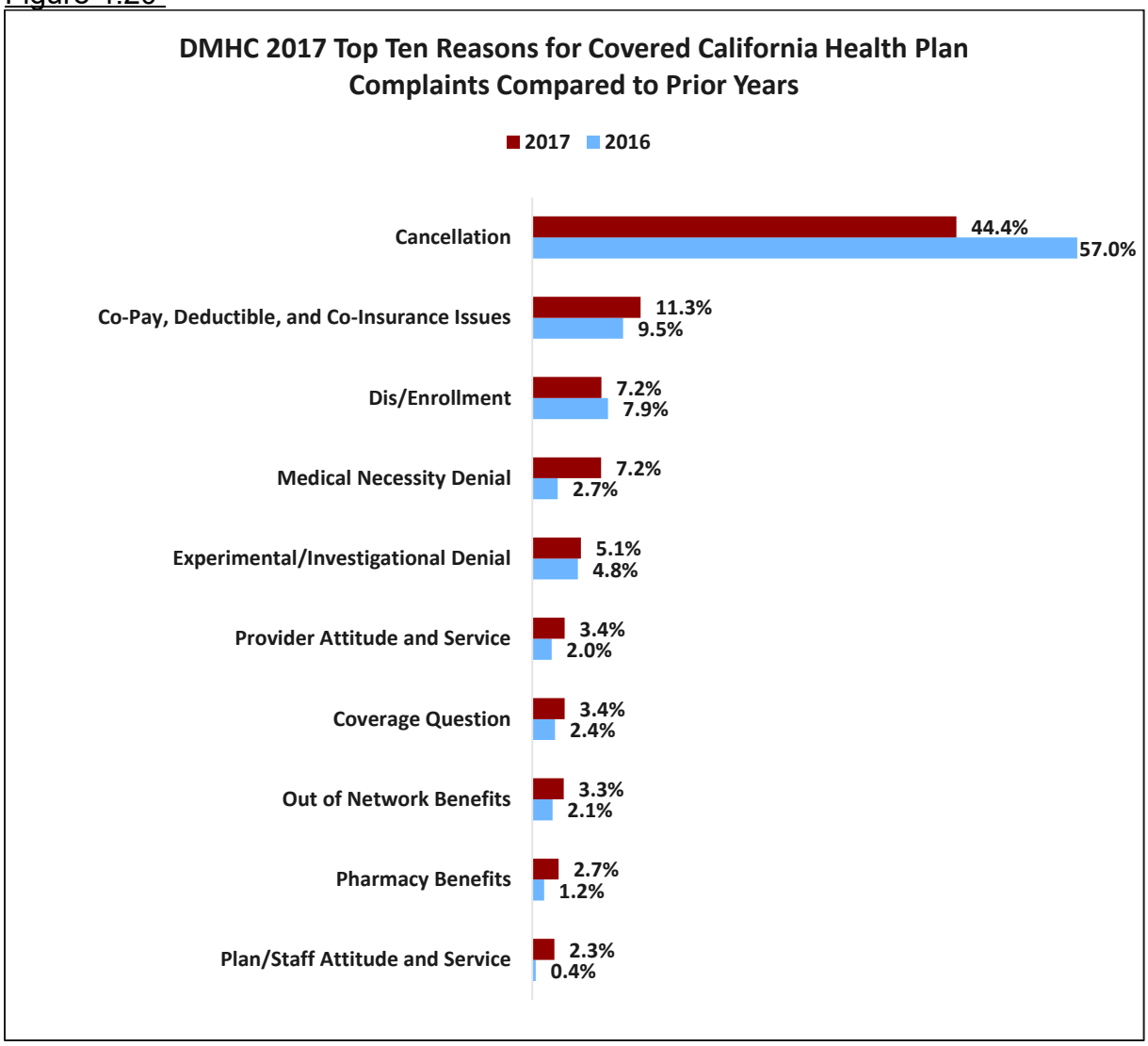
Note: Sources of coverage categories with low complaint volumes were excluded from the display, including CalPERS, COBRA, State Specific (Other), and Uninsured. Resolution times were counted from the date DMHC received any initial information from a consumer to the date that DMHC closed the complaint.

DMHC regulates most of the health plans offered through the Covered California marketplace. Figures 4.20 – 4.22 address complaints about these marketplace health plans that DMHC closed in 2017. Section 7 of this report addresses State Fair Hearings about Covered California program decisions on eligibility and enrollment.

- DMHC reported 2,765 complaints in 2017 with Covered California/Exchange identified as the source of coverage, a 47 percent decrease in volume over the prior year (5,206 in 2016).
- Cancellation continued to be the top reason for Covered California health plan complaints despite a 59 percent decrease in volume over the prior year.

The following chart displays the top ten most common Covered California health plan complaints that DMHC reviewed in 2017. The chart also shows the percentage distribution for those same reason categories in 2016. The top ten reason categories account for 90 percent of the Covered California plan complaints in 2017.

Figure 4.20



- Medical Necessity Denial and Plan/Staff Attitude and Service were the only top ten categories that increased in raw volume from 2016 to 2017.
- Other categories increased in percentage distribution due to the significant decrease in Cancellation complaints that outpaced the other categories' volume decreases.

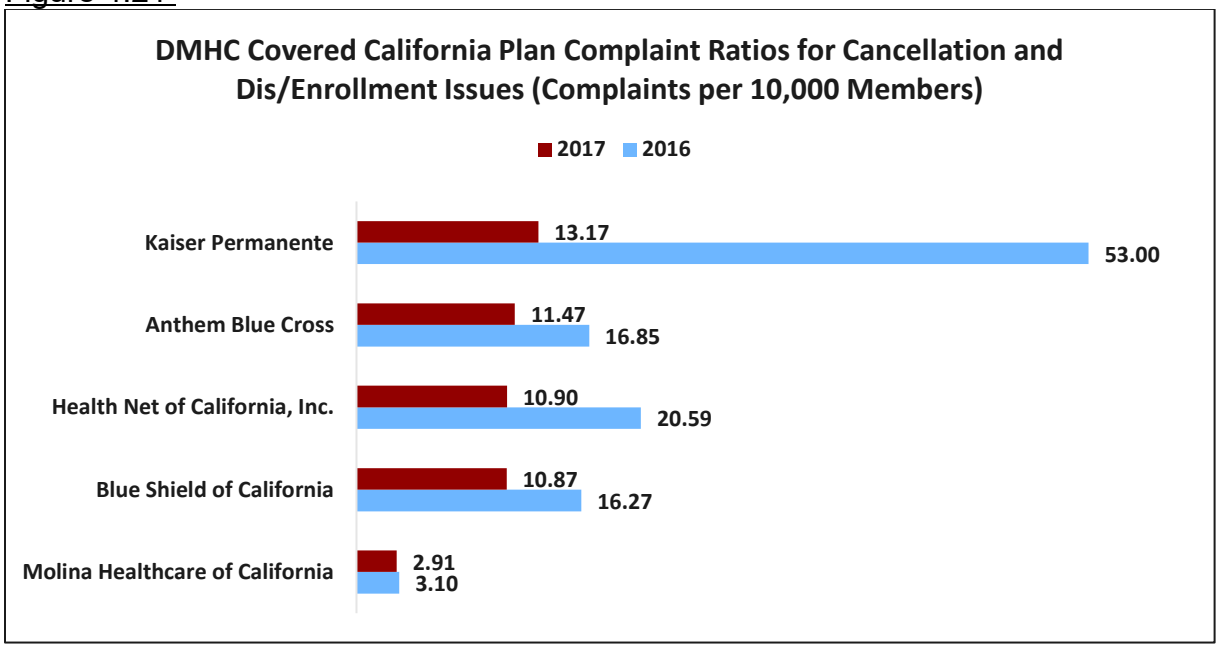
Figures 4.21 and 4.22 display Covered California health plan complaint ratios of complaints per 10,000 Covered California members.

- The 2017 average complaint ratio for Covered California health plans was 19.6 complaints per 10,000 members, a decrease from the 2016 ratio of 37.2.
- The average Covered California plan complaint ratio drops to 9 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 closed by DMHC during the measurement year 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 plans' effectuated coverage in March of the measurement year.

The following chart shows the 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 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.

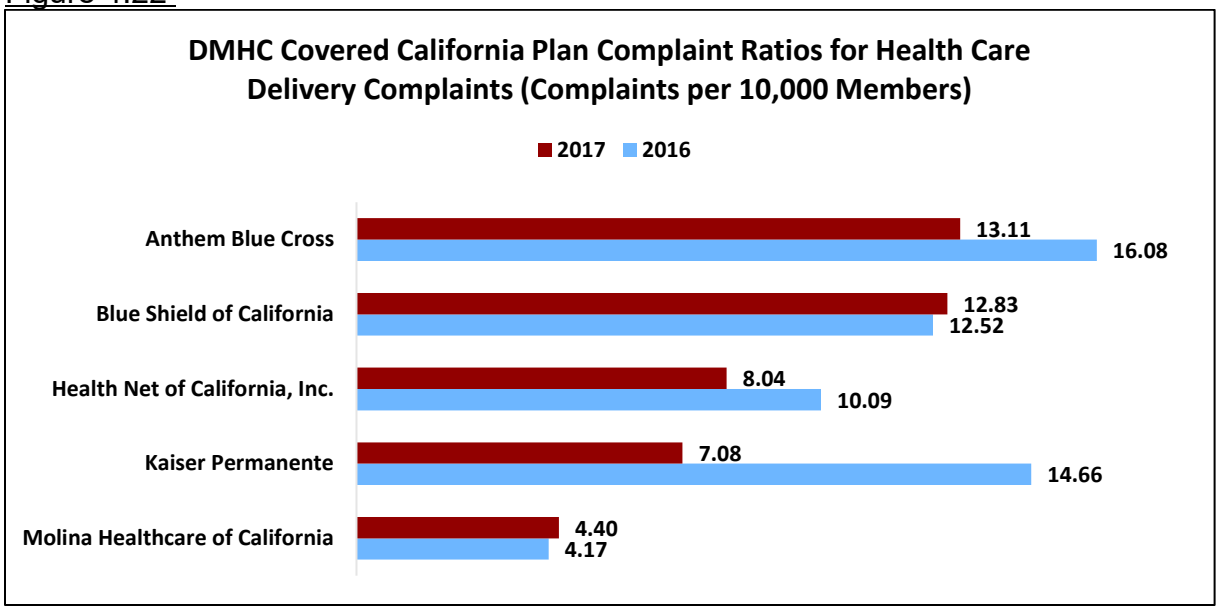
Figure 4.21



Note: The display excludes health plans with Covered California enrollment under 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 focus on health care delivery, the complaint volumes for Cancellation and Dis/Enrollment complaint reasons were excluded from the ratio calculations.

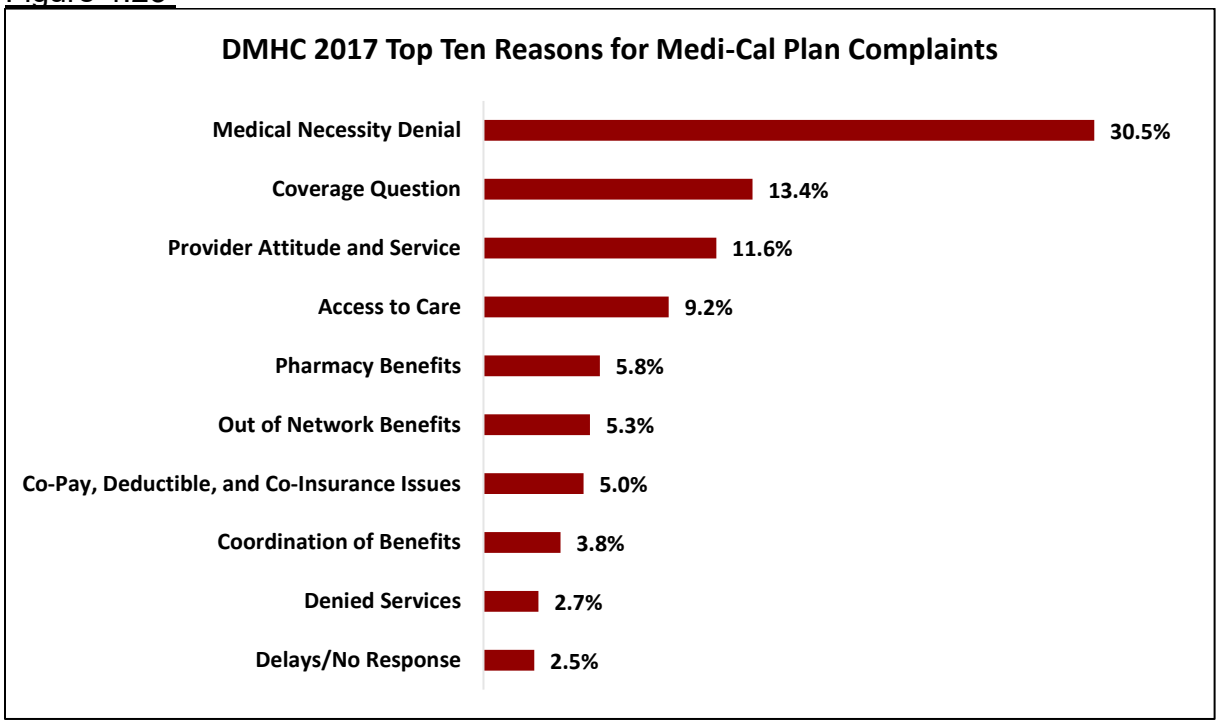
Figure 4.22



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

The following chart displays the top ten most common reasons for Medi-Cal health plan complaints that DMHC closed in 2017. DMHC reported 2,446 complaints in 2017 with Medi-Cal identified as the source of coverage, a less than one percent decrease in volume over the prior year. The top ten reason categories account for 90 percent of DMHC's reported Medi-Cal plan complaints.

Figure 4.23

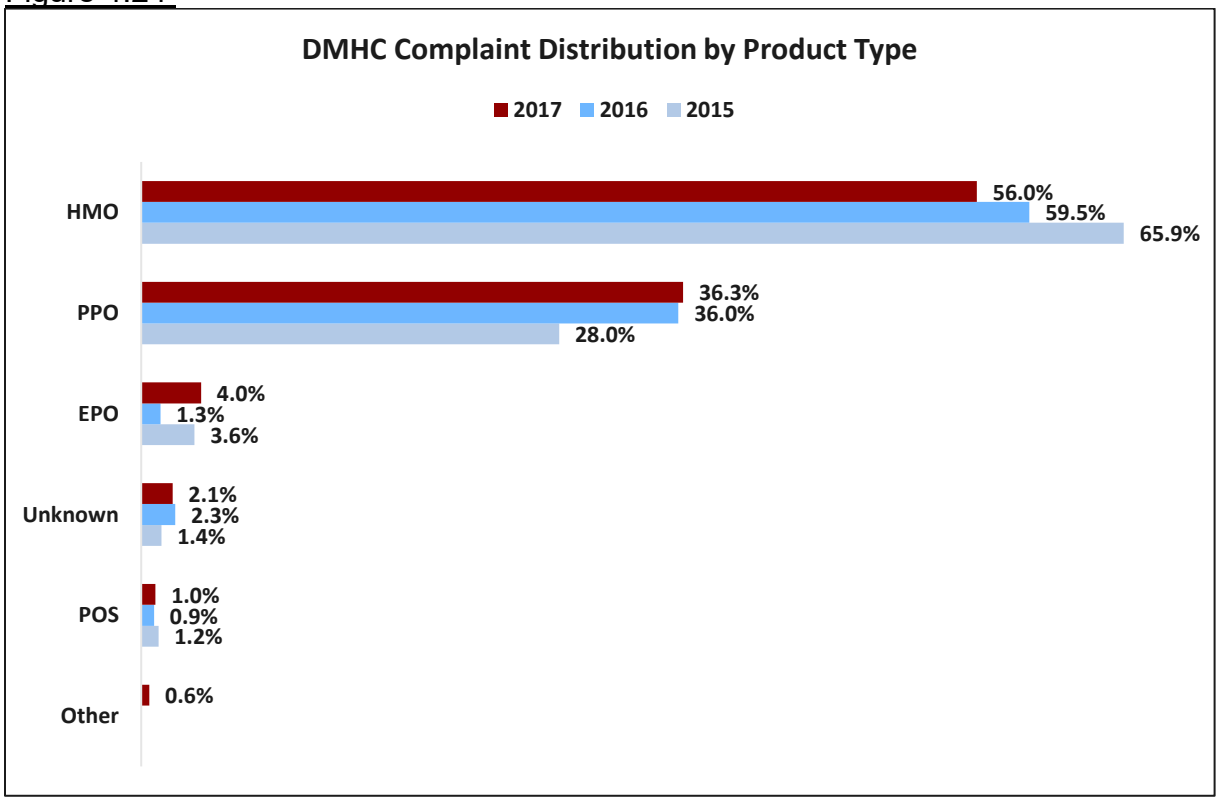


Product Type

DMHC reported nine primary product type categories for 2017, including categories to identify the health plan model. Discount plans, a product type unique to DMHC oversight, were reported for the first time in 2017. Uninsured also was a new category reported by DMHC in 2017. Nearly all DMHC complaints had a single product type identified.

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

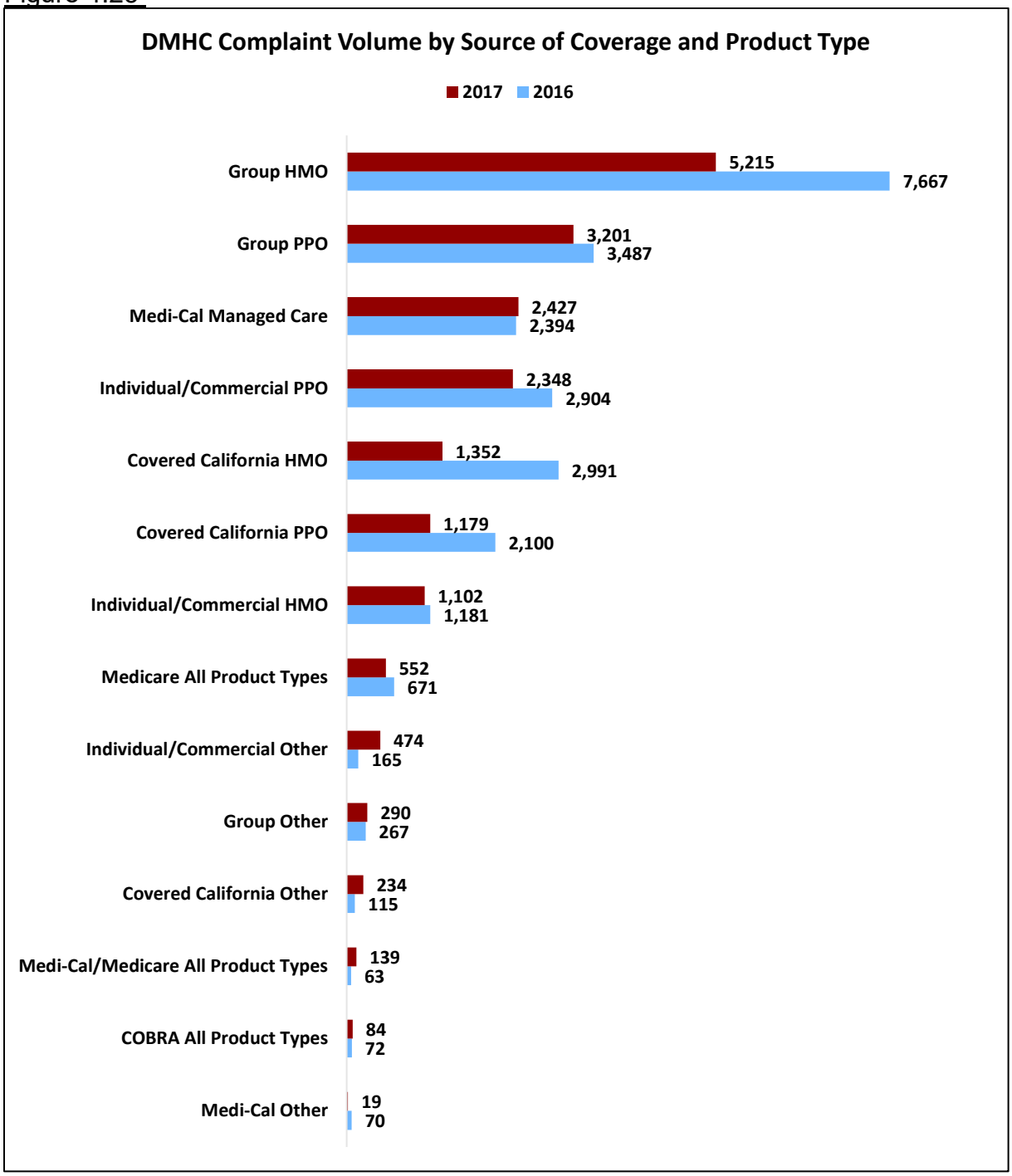
Figure 4.24



Note: HMO includes complaints reported under the HMO with Deductible product type category. PPO includes complaints reported under the PPO with Deductible product type category. Other combines categories with low complaint volumes, including Discount, Fee-for-Service, and Uninsured.

The following chart displays 2016 and 2017 complaint volumes grouped by source of coverage and product type categories. The chart accounts for 97 percent of the 2017 complaints and 93 percent of the 2016 complaints, omitting low-volume categories and those where the source of coverage was unknown.

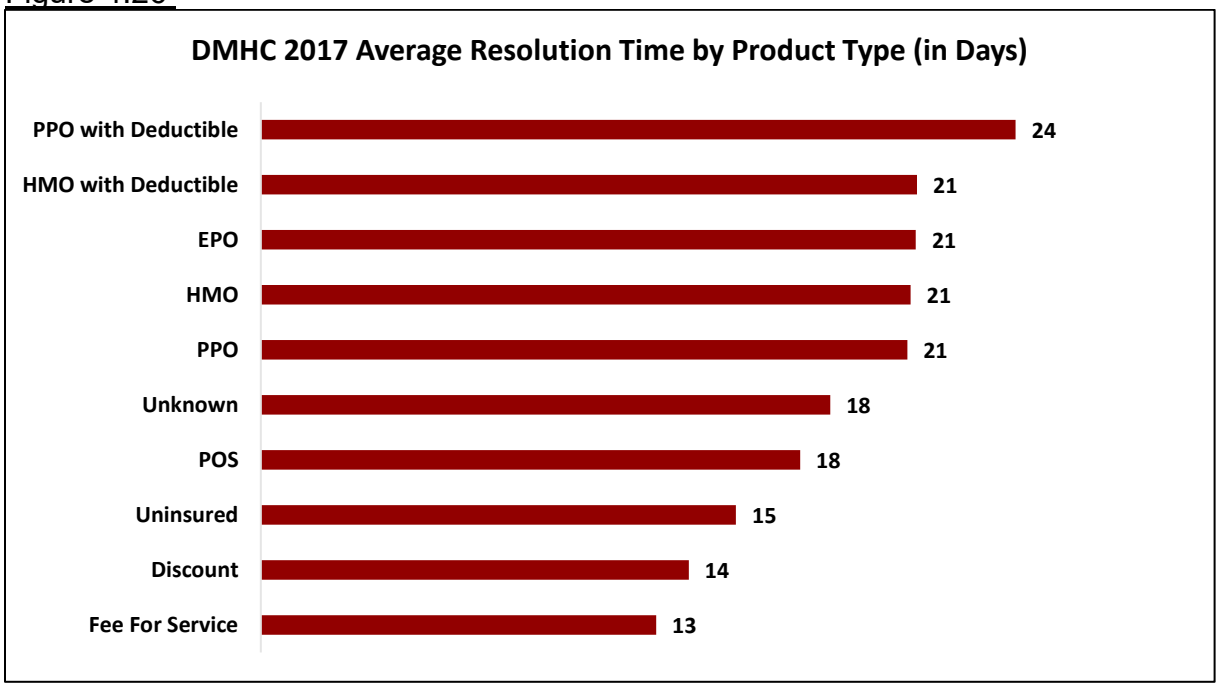
Figure 4.25



Note: Some product type 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. Medi-Cal Managed Care cases were all reported with HMO as the primary product type. Medi-Cal Other combines all other reported product types, including Fee-for-Service and Unknown.

The following chart shows the average number of days it took in 2017 for DMHC to resolve complaints associated with each reported product type.

Figure 4.26



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 164,759 requests for assistance from consumers in 2017. This 15 percent decrease in volume from the prior year was the first decrease over four measurement years (increases from 109,760 in 2014 to 171,597 in 2015, and to 189,482 in 2016).

The online contact form increased in use from the prior year, although the volumes decreased across all other modes. Of the requests for assistance, 144,964 (88%) were made by telephone, 8,562 (5%) through the online contact form, 7,117 (4%) by mail, 2,943 (2%) via fax, and less than one percent by email and counter/in-person.

Service Center Telephone Call Metrics

The DMHC Help Center reports receiving 144,964 telephone calls from consumers in 2017, a 12 percent volume decrease from the 164,573 calls in 2016. The following table shows the response from DMHC regarding some of its telephone call metrics.

Figure 4.27

DMHC Help Center – 2017 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)	6,223*	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	82,465	Data
Number of jurisdictional inquiry calls	44,978**	Data
Number of non-jurisdictional calls	10,808**	Data
Average number of calls received per jurisdictional complaint case	0.37 status check calls per complaint case	Data
Average wait time to reach a CSR	0:02:18	Data
Average length of talk time (time between a CSR answering and completing a call)	0:07:35	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 for a Contact Center agent and not calls contained in the IVR.*

*** DMHC reported inquiry metrics from its case management database showing a combined volume which is more than its phone system records of calls handled by its Contact Center agents. 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 the following updates to Help Center systems, protocols and standards since 2016.

- The Help Center updated its IVR phone system in November 2017 to improve callers' self-service options to receive information or a referral without speaking to a DMHC agent. Callers can now be directly transferred to one of nine health plans, Covered California, or to Medi-Cal's Health Care Options.
- DMHC implemented an updated policy for Urgent Nurse complaints in 2017. Although complaint review procedures did not change, the policy was updated to clarify definitions and procedures to improve internal processing of complaints.
- DMHC's Help Center added an Audit Process of Closing Letters to its quality assurance processes. This quality review by Help Center supervisors is to ensure appropriate actions were taken and communicated to consumers about their filed complaint.

Section 5 – California Department of Health Care Services

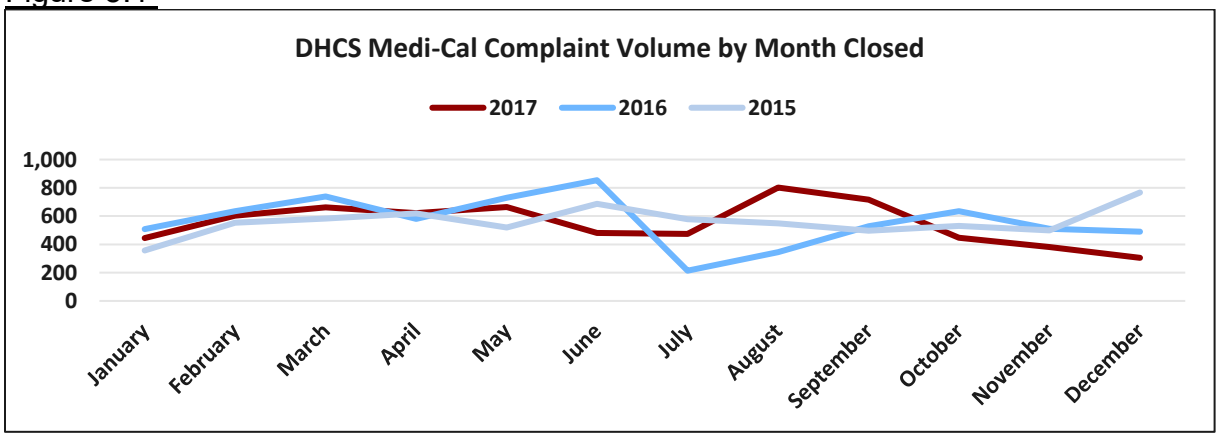
A. Overview

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. In 2017, more than 13 million Californians received health care financed or organized by DHCS through the Medi-Cal program. 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 reported 1,326,078 requests for assistance from consumers in 2017, including 6,603 State Fair Hearings and inquiries to the following three consumer assistance service centers:

- **Office of the Ombudsman** – The Office of the Ombudsman provides guidance and referrals to help Medi-Cal managed care members receive all medically necessary covered services for which plans are contractually responsible. The Office of the Ombudsman also creates a bridge between the county mental health plan system and those in need of services. The Mental Health Ombudsman merged with the Managed Care Ombudsman in February 2017.
- **Medi-Cal Telephone Service Center** – Operated by a Fiscal Intermediary (FI) contractor, this service center assists beneficiaries and medical providers regarding Medi-Cal fee-for-service billing and related issues.
- **Medi-Cal Dental Program Beneficiary Customer Service Center** – Operated by a dental FI contractor, this service center provides guidance to beneficiaries regarding dental providers who accept Medi-Cal, screenings, share-of-cost and co-payments, Treatment Authorization Requests, covered services, and filing complaints. This service center was previously reported as the Denti-Cal Beneficiary Telephone Service Center.

The following chart shows the DHCS complaint volumes reported for 2015, 2016, and 2017 distributed by the month each complaint closed. The complaint volume decreased by 2.5 percent over 2016 (6,770 hearings in 2016 to 6,603 hearings in 2017).

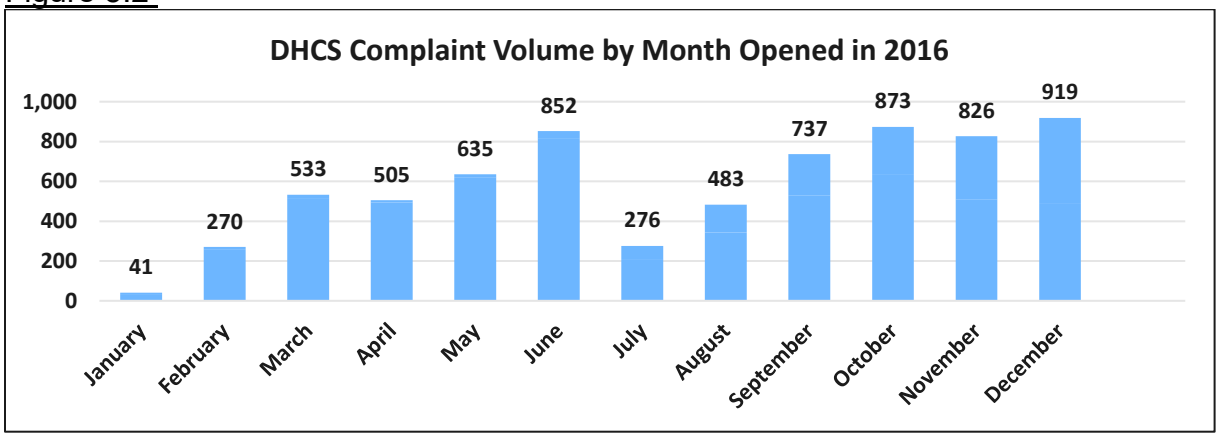
Figure 5.1



The following chart displays DHCS complaint volumes by the month that consumers initiated State Fair Hearings in 2016. A two-year analysis was necessary to better capture the volumes of complaints opened in the autumn and winter months and closed in the next calendar year. The chart accounts for 6,950 cases that were initiated in 2016, including:

- 5,444 cases that closed in 2016 (Measurement Year 2016 data)
- 1,506 cases that closed in 2017 (Measurement Year 2017 data)

Figure 5.2



Complaint Type Overview

The following table displays information about the State Fair Hearing process, which was the complaint type reported by DHCS for 2017. 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 5.3

Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
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	79 days

Note: State Fair Hearing time standard from All County Letter 14-14 issued by CDSS on 2/7/14. All Plan Letter 17-006 issued by DHCS on 5/9/17 updated Medi-Cal managed care plan grievance and appeal requirements, including changes to when beneficiaries can request a State Fair Hearing.

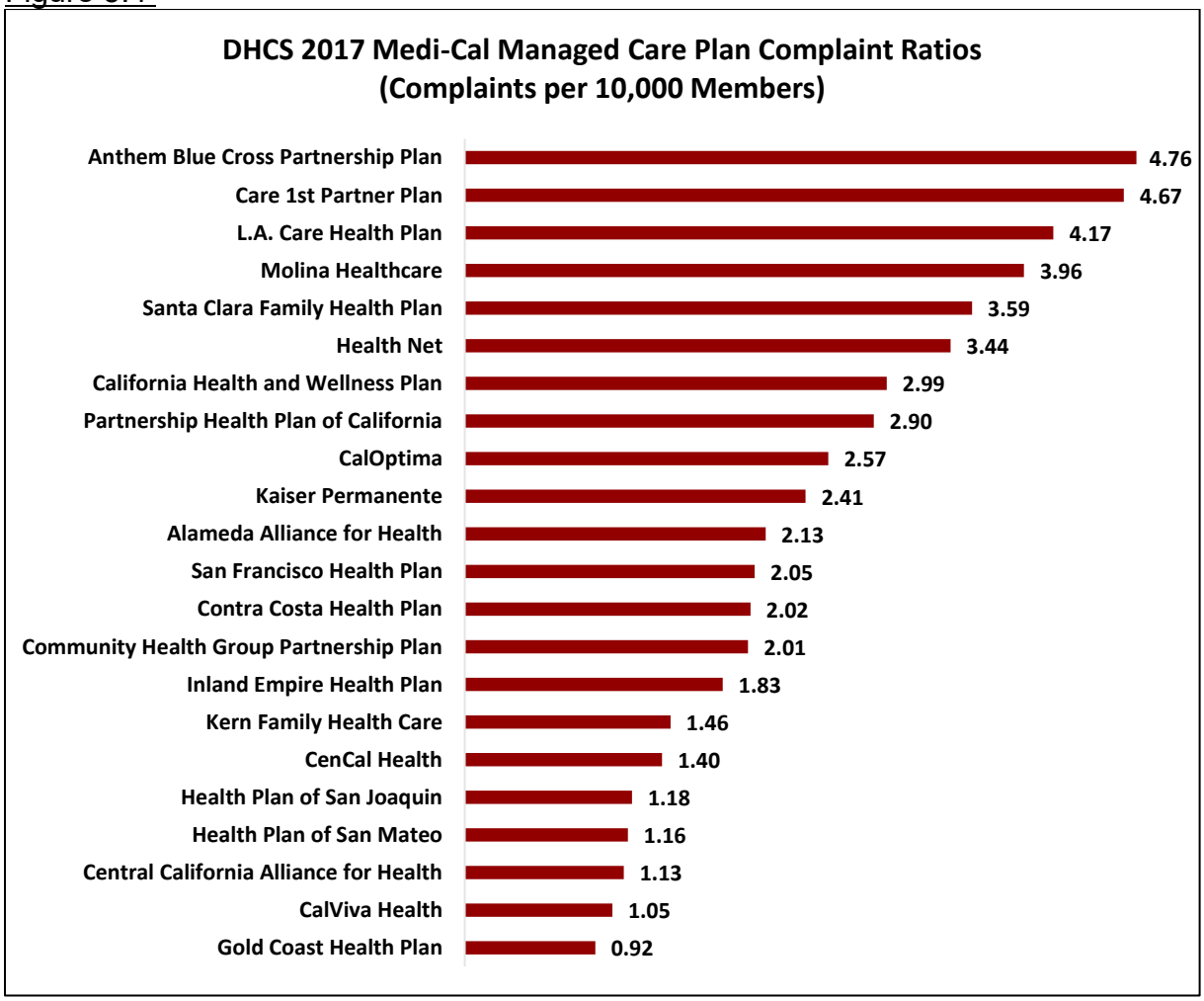
DHCS issued new guidelines that were implemented in July 2017 for grievances and appeals involving Medi-Cal Managed Care and Dental Managed Care plans. For complaints about their plan, Managed Care plan members are now required to file a grievance or appeal with their plan before requesting a State Fair Hearing with CDSS.

B. Complaint Ratios, Reasons, and Results

Medi-Cal Managed Care health plans accounted for the largest percentage (47%) of the 6,603 complaints compared to other delivery systems reported by DHCS for 2017. Most Medi-Cal beneficiaries are enrolled in Managed Care plans.

The following chart shows statewide complaint ratios for Medi-Cal Managed Care plans of plan complaints per 10,000 Medi-Cal members. A higher complaint ratio means more complaints were closed per member. Each ratio was calculated using the number of plan complaints reported statewide for 2017 and the plan's statewide Medi-Cal enrollment. Only plans with statewide Medi-Cal enrollment over 70,000 are displayed. Some of the plans displayed serve multiple counties, including under different Medi-Cal contracting models.

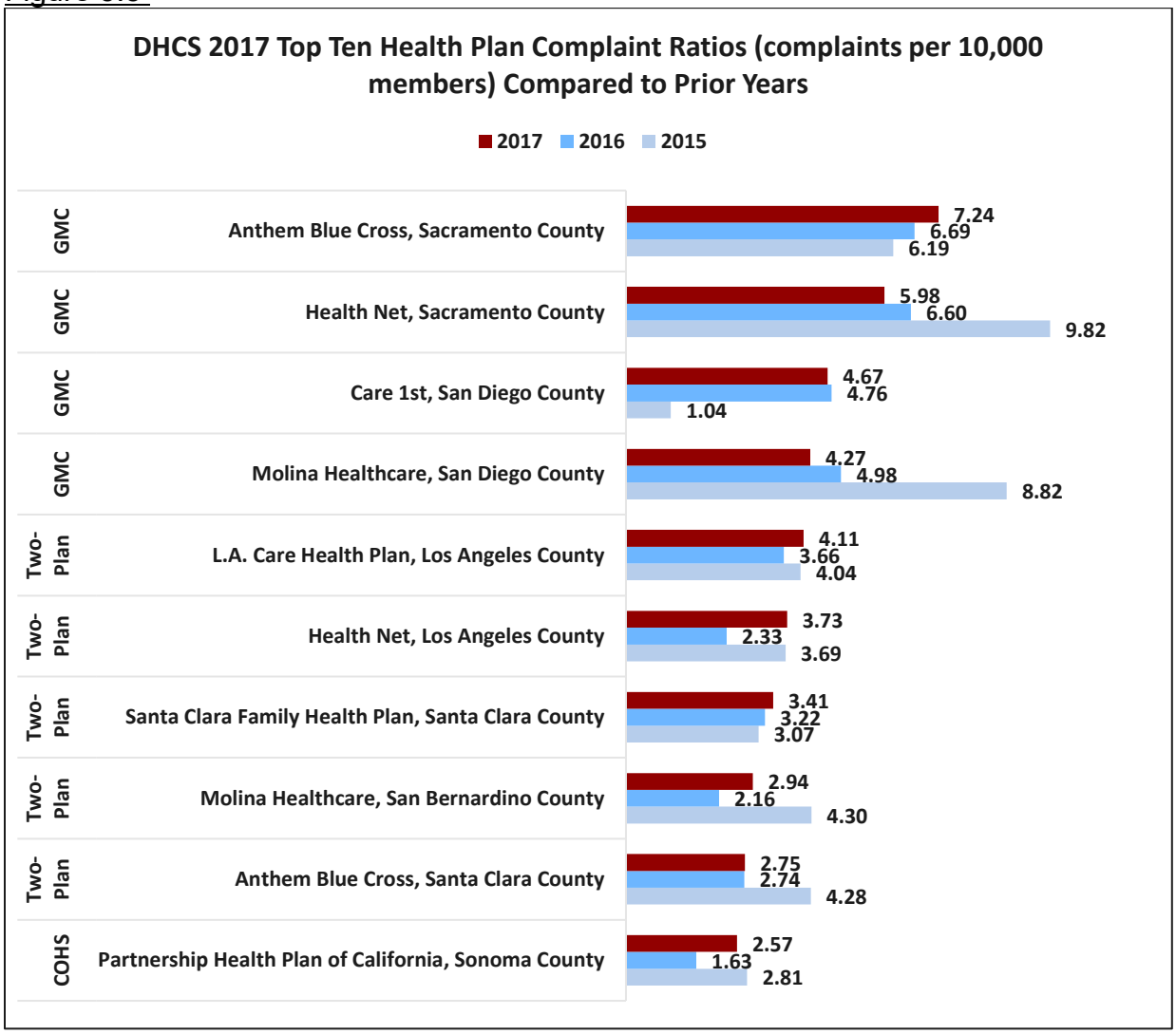
Figure 5.4



Note: Plans with Medi-Cal enrollment under 70,000 members statewide were excluded from the display. 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 2015 and 2016 ratios for those same plans. The chart also shows the associated Medi-Cal contracting model, including County Organized Health System (COHS), Geographic Managed Care (GMC), and Two-Plan models. 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 2017.

Figure 5.5



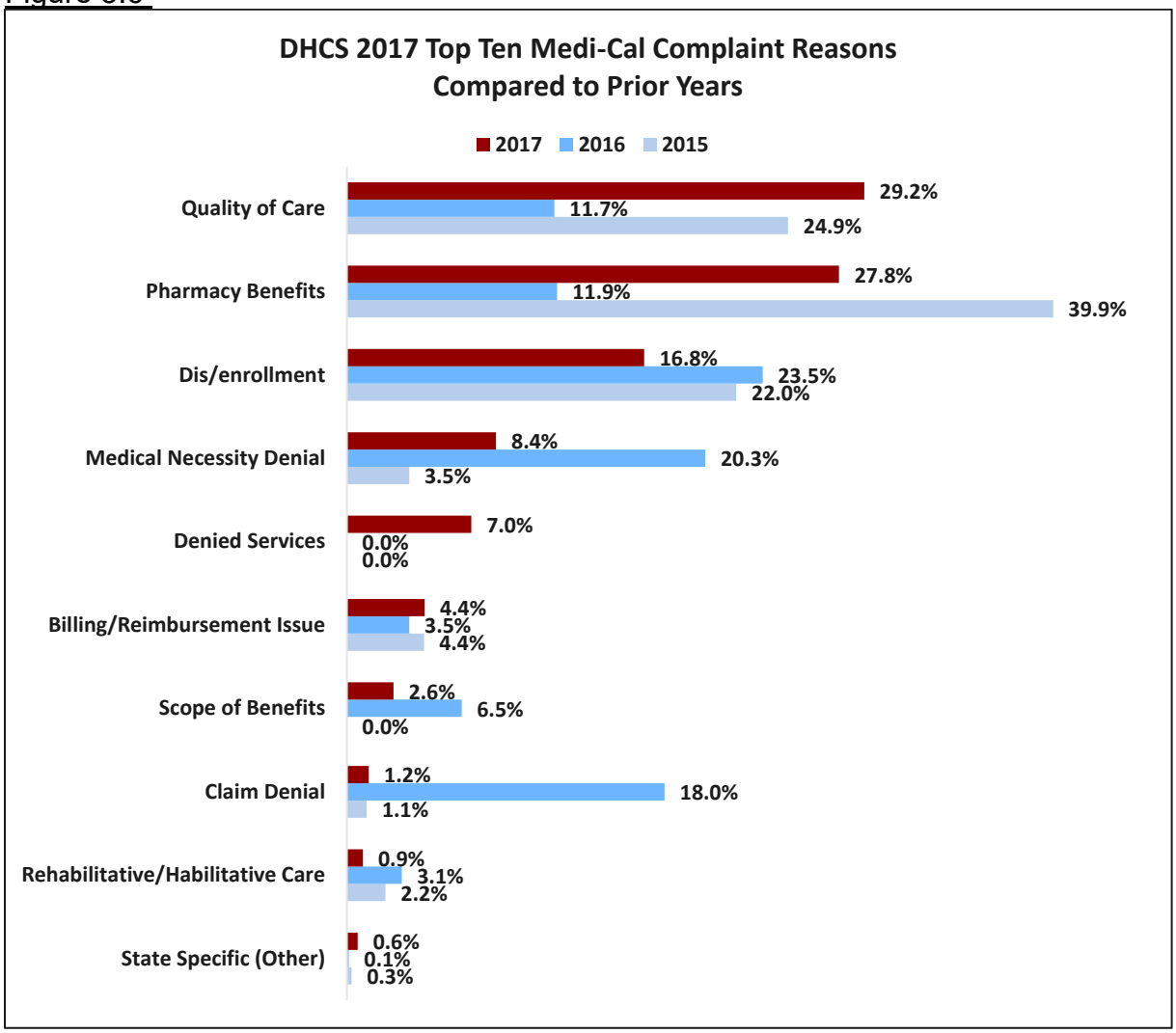
Note: This chart shows the health plans with the highest complaint ratios among plans with county enrollment over 70,000 members in 2017, as well as the ratios for the same plans in 2015 and 2016. The health plans displayed were not necessarily the plans with the highest complaint ratios in 2015 and 2016.

Top Ten Reasons for Jurisdictional Complaints

The total number of Medi-Cal Managed Care and Fee-for-Service complaint reasons reported by DHCS in 2017 (5,399) exceeded the total number of related complaint cases (5,395) because some cases had more than one reason.

The top ten reasons in the following chart represent nearly all of Medi-Cal Managed Care and Fee-for-Service complaint reasons in 2017 (99%). Although multiple years of data are shown, please note that data categorization changes between measurement years have affected trending for the complaint reasons. Significant differences may actually reflect a change in data collection and reporting rather than a change in incidence. For example, some issues reported under Quality of Care and Pharmacy Benefits in 2015 and 2017 were categorized under other complaint reasons in 2016. DHCS also reported the reason category Denied Services for the first time in 2017.

Figure 5.6



Note: The complaint reasons displayed are the top ten complaint reasons for 2017 and the distribution of those same complaint reasons in the 2015 and 2016 data. Significant year-to-year changes may be due to changes in data collection and reporting rather than a change in incidence.

Top Ten Topics for Non-Jurisdictional Inquiries

The following table displays the most common inquiry topics consumers contacted DHCS's service centers about in 2017, as well as the department or other service

center the consumers were referred to about each inquiry topic. The consumer assistance volume for each inquiry topic is displayed for the Office of the Ombudsman, which was able to provide non-jurisdictional inquiry rankings based on tracked data.

Figure 5.7

DHCS 2017 Service Centers' Top Topics for Non-Jurisdictional Inquiries

Office of the Ombudsman Ranking	Inquiry Topic	Referred to	Volume
1 (most common)	Medi-Cal Eligibility	County Social Services Office	58,272
2	Fee-For-Service	DHCS Fee-For-Service Help Line (Medi-Cal Telephone Service Center)	10,371
3	Health Care Options	Health Care Options	7,606
4	Medicare	1-800 Medicare	5,240
5	Covered California	Covered California	4,584
6	Dental Services	Medi-Cal Dental Program	2,182
7	State Fair Hearings	California Department of Social Services	1,863
8	Mental Health	County Mental Health	1,655

Note: Office of the Ombudsman ranking was based on data.

Medi-Cal Telephone Service Center Ranking	Inquiry Topic	Referred to
1 (most common)	Beneficiary Inquiry/Eligibility	County Social Services Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Medi-Cal Dental Program
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 estimated by DHCS.

Medi-Cal Dental Program Service Center Ranking	Inquiry Topic	Referred to
1 (most common)	Referrals	Managed Care Plan 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 Medi-Cal Telephone Service Center Dhcs.ca.gov website
5	Share of Cost	County Social Services Office
6	Complaint against Office (non-treatment)	Dental Board
7	Non-Covered Services	State Legislator

Note: Medi-Cal Dental Program Beneficiary Customer Service Center ranking was estimated by DHCS.

Complaint Results

The number of complaint results (6,631) reported by DHCS for 2017 exceeded the number of complaints (6,603) because some complaint cases had more than one result. The following table displays the top ten most common results for DHCS complaints closed in 2017. The top ten categories accounted for nearly all (99.9%) of the total complaint results for 2017.

Figure 5.8

DHCS 2017 Top Ten Complaint Results

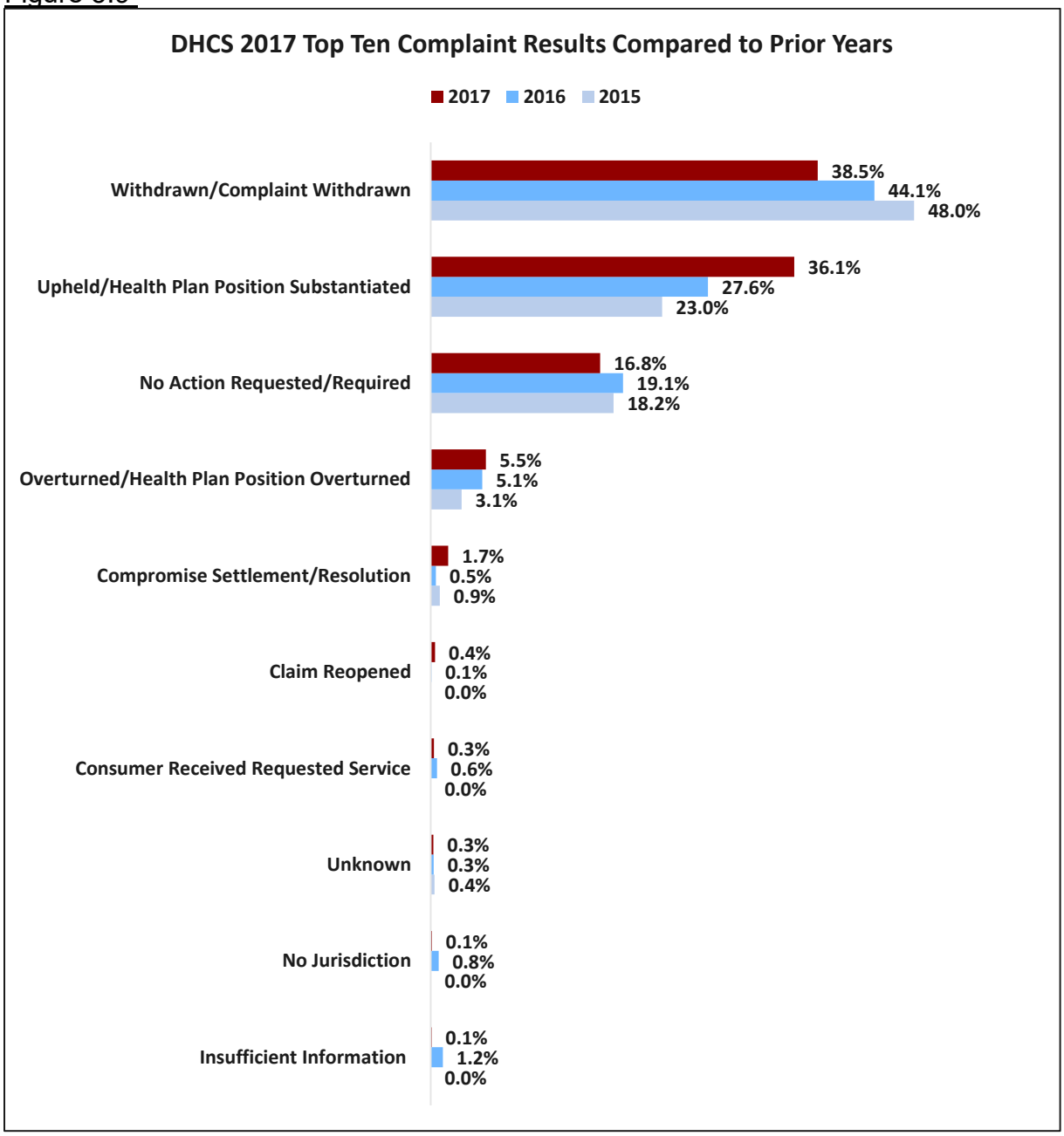
Complaint Result	Volume
Withdrawn/Complaint Withdrawn	2,550
Upheld/Health Plan Position Substantiated	2,395
No Action Requested/Required	1,117
Overturned/Health Plan Position Overturned	363
Compromise Settlement/Resolution	116
Claim Reopened	28
Consumer Received Requested Service	21
Unknown	18
No Jurisdiction	9
Insufficient Information	7

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. 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. For DHCS, the category No Action Requested/Required indicates that the case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.

Withdrawn/Complaint Withdrawn continues to be the most common result of the DHCS complaints, despite a decrease in volume and percentage distribution from 2016. DHCS indicated that many of the Withdrawn/Complaint Withdrawn cases involve a deferred services issue usually resolved by medical providers with a favorable outcome for Medi-Cal beneficiaries prior to a State Fair Hearing.

The following chart shows the percentage distributions of the 2017 top ten complaint results compared to prior years. Some differences between measurement years may be due to changes in DHCS data collection and reporting rather than changes in incidence.

Figure 5.9



Note: The complaint results represented are the top complaint results for 2017 and the distribution of the same complaint results in the 2015 and 2016 data.

The following charts show the results for the three most common complaint reasons reported for 2017: Quality of Care, Pharmacy Benefits, and Medical Necessity Denial.

Of the 6,603 DHCS complaint cases in 2017, approximately 0.2 percent of the cases had two reasons reported and approximately 0.4 percent had two results reported. Among the cases with dual results, there were only three different combinations of results entries reported. The reason-to-result analysis below counted dual results as a

single, combined result. For the complaint cases with two reasons, the analysis applied the reported result or result combination to both reasons.

Figure 5.10

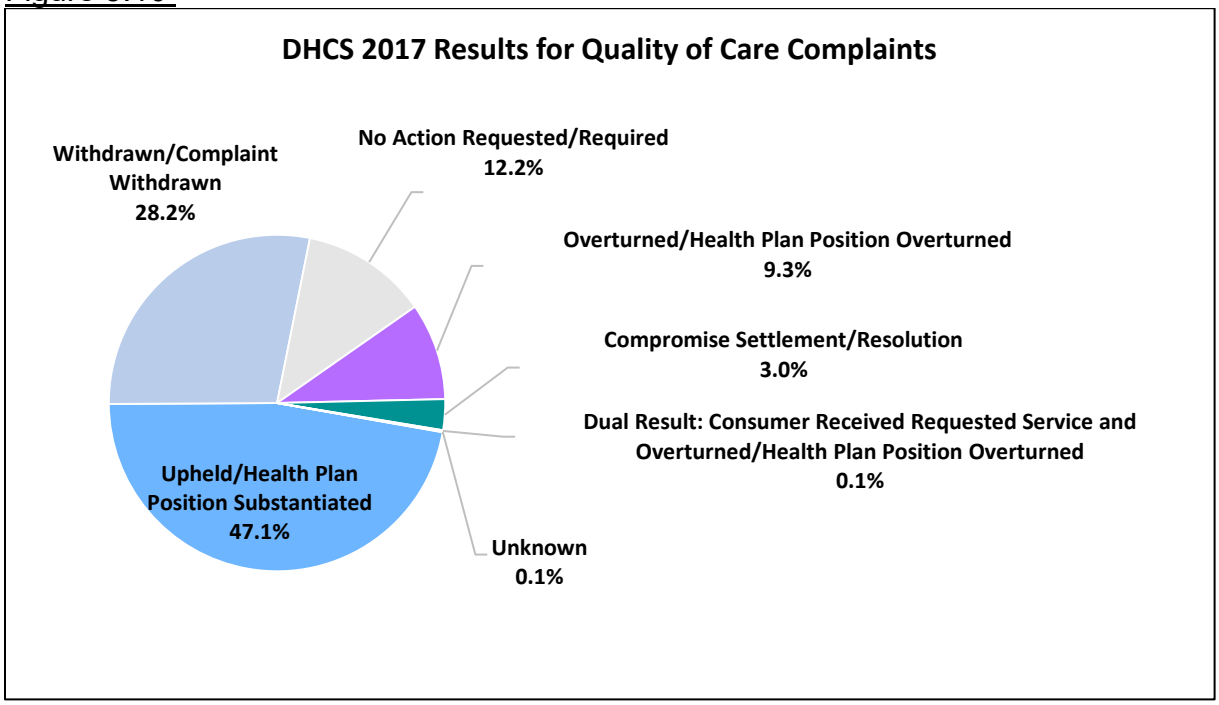


Figure 5.11

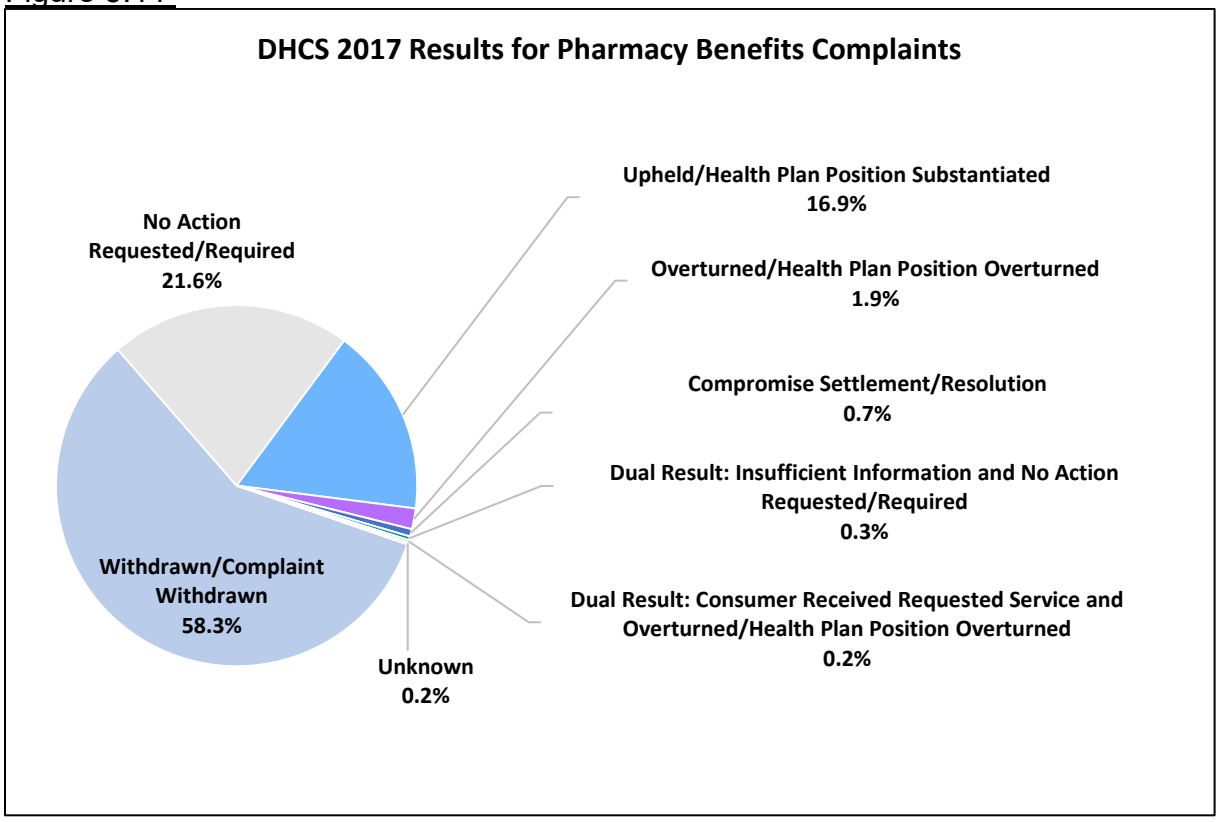
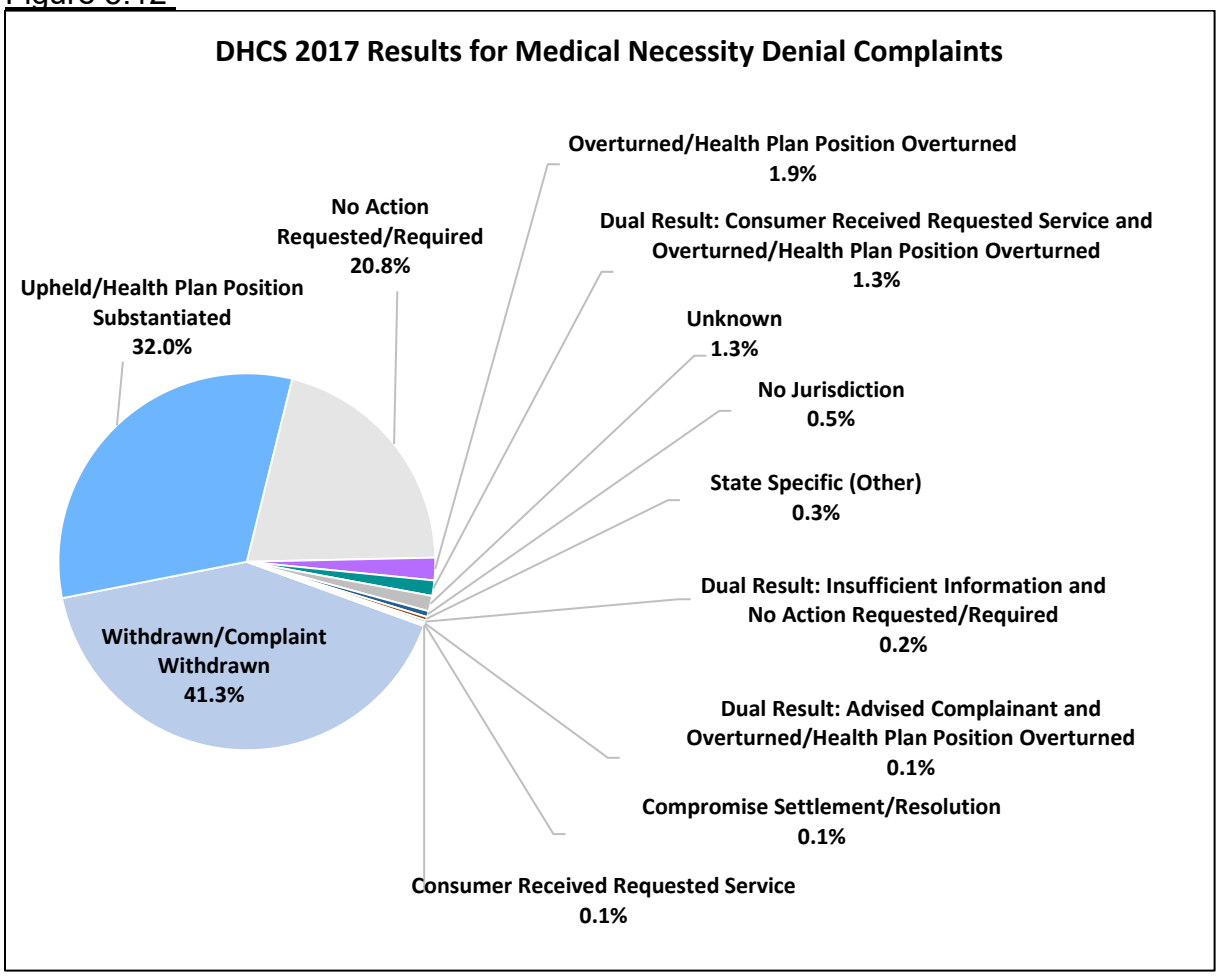


Figure 5.12



Resolution Time

DHCS complaints closed in 2017 took 79 days on average to resolve, a decrease of one day from the prior year.

The following charts (Figures 5.10 – 5.12) display the average resolution times for the top complaint reasons for the Medi-Cal health care, dental, and mental health systems.

Figure 5.13

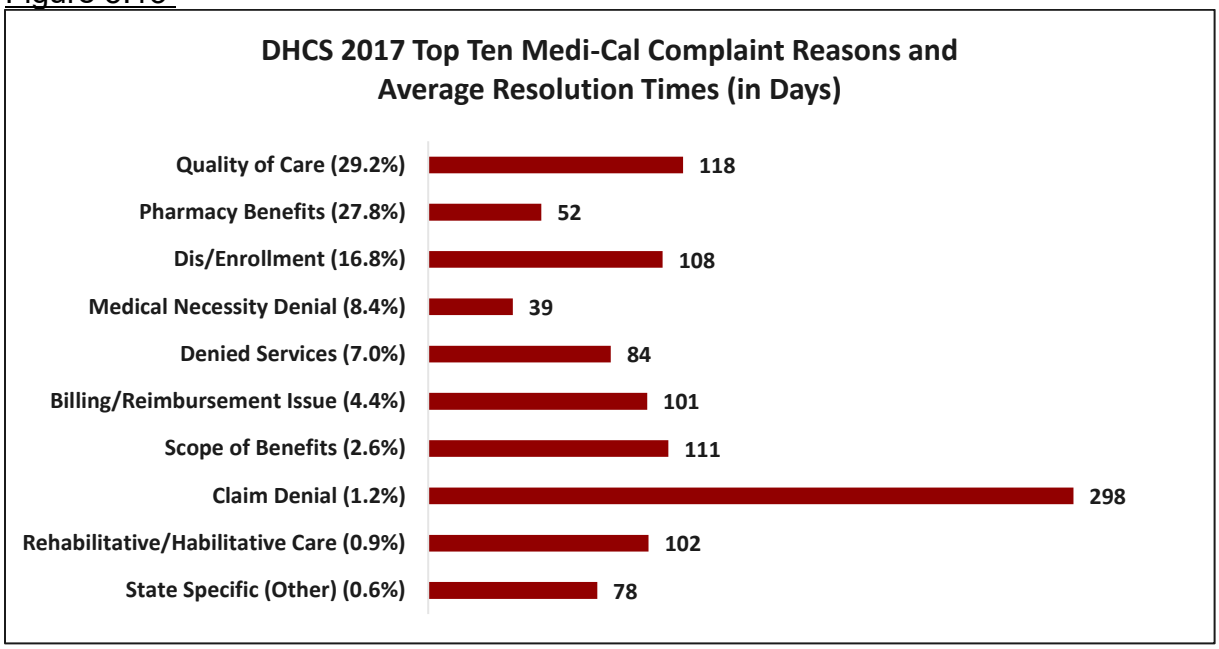


Figure 5.14

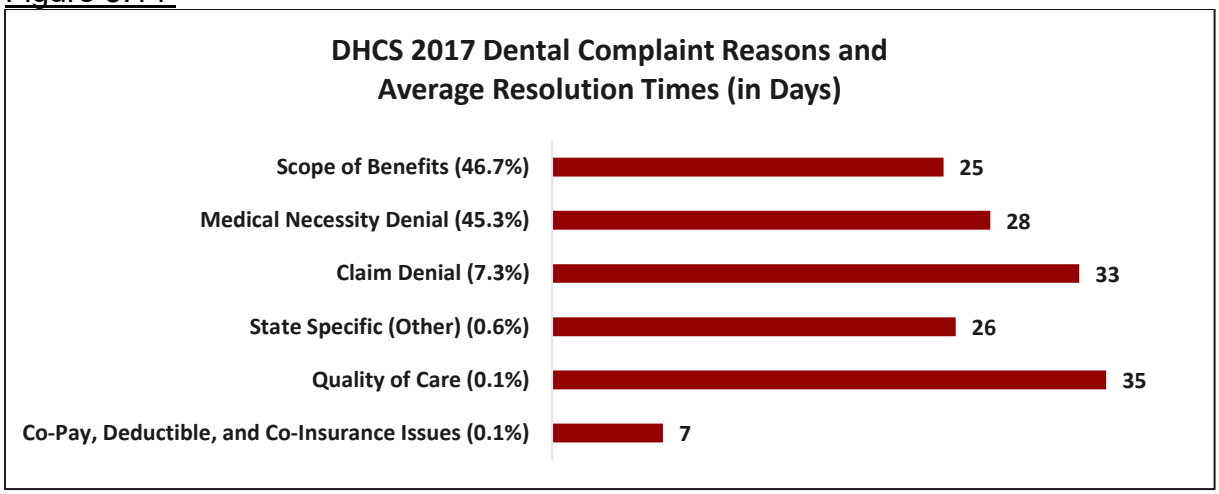
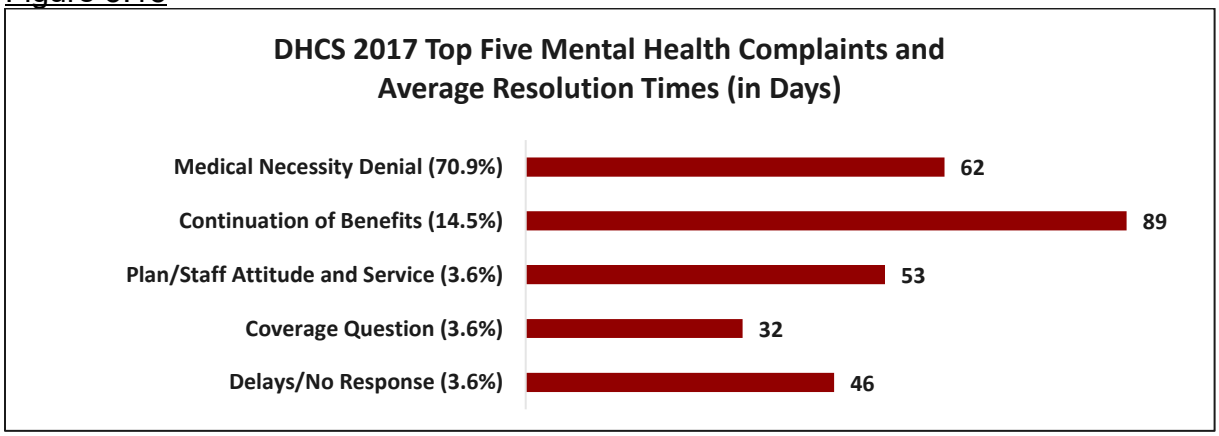


Figure 5.15



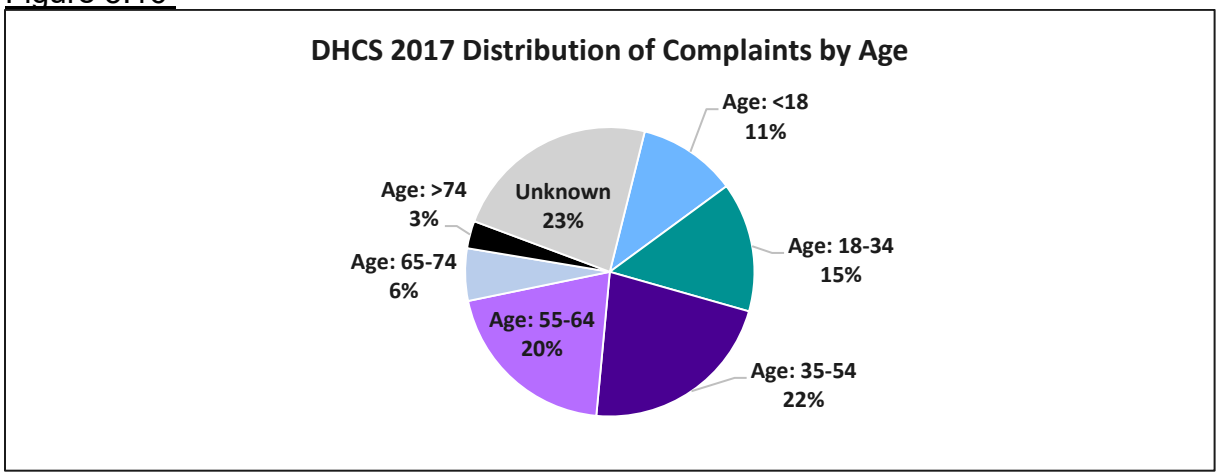
C. Demographics and Other Complaint Elements

Differences in findings between measurement years are likely due in part to changes in data collection and reporting rather than incidence. Some categories of demographic data for complainants enrolled in Medi-Cal Managed Care are not available for the 2017 report. DHCS will resume reporting the demographic data categories for Medi-Cal Managed Care complaints in 2018.

Age

The complainants' average age was 44 years old, unchanged from 2015 and 2016 averages. More complaints had age identified than the prior year, with a 29 percent decrease in the volume of Unknown and increases in the volumes of all known age groups except for Under Age 18.

Figure 5.16



- Medical Necessity Denial was the top complaint reason for Under Age 18.
- Quality of Care was the top complaint reason for all other known age groups.
- Pharmacy Benefits was the top complaint reason for age Unknown.

Gender

DHCS reported more complaints with gender identified compared to 2016, with a 28 percent reduction in the volume of Unknown. Of the 6,603 complaints in 2017, the complainant's gender was identified as Female for 47 percent, Male for 30 percent, and Unknown for 23 percent. Nearly all complaints with gender Unknown (97%) were regarding Medi-Cal Fee-for-Service. Quality of Care was the top complaint reason for both Female and Male complainants in 2017.

Race and Ethnicity

Fewer 2017 complaints regarding Medi-Cal Managed Care identified race and ethnicity than the prior year, contributing to an increase in the combined Refused/Unknown

category and drop in the percentage distributions of known race and ethnicity categories.

- Eighty-five percent of the 6,603 complaints in 2017 were reported as Refused or Unknown in the race category, followed by White (11%), Black or African American (2%), Asian (1%), Other (1%), Native Hawaiian or Other Pacific Islander (under 1%), and American Indian or Alaska Native (under 1%).
- Eighty-six percent of the 6,603 complaints in 2017 were reported as Refused or Unknown in the ethnicity category, followed by Not Hispanic or Latino (9%), and Hispanic or Latino (5%).

Language

Fewer complaints had primary language identified than in the prior two years (16% identified in 2017, 57% in 2016, and 55% in 2015).

- Thirteen percent of the 6,603 complaints in 2017 reported English in the Primary Language category.
- Spanish accounted for two percent of the complaints.
- Other languages accounted for one percent of the complaints, including complaints with Primary Language identified as Arabic, Armenian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other, Russian, Tagalog, and Vietnamese.

Medical Necessity Denial remained the top reason for complainants whose primary language was Spanish. Scope of Benefits was the top reason for English and Other languages. For Refused/Unknown, Quality of Care was the top reason.

County of Residence

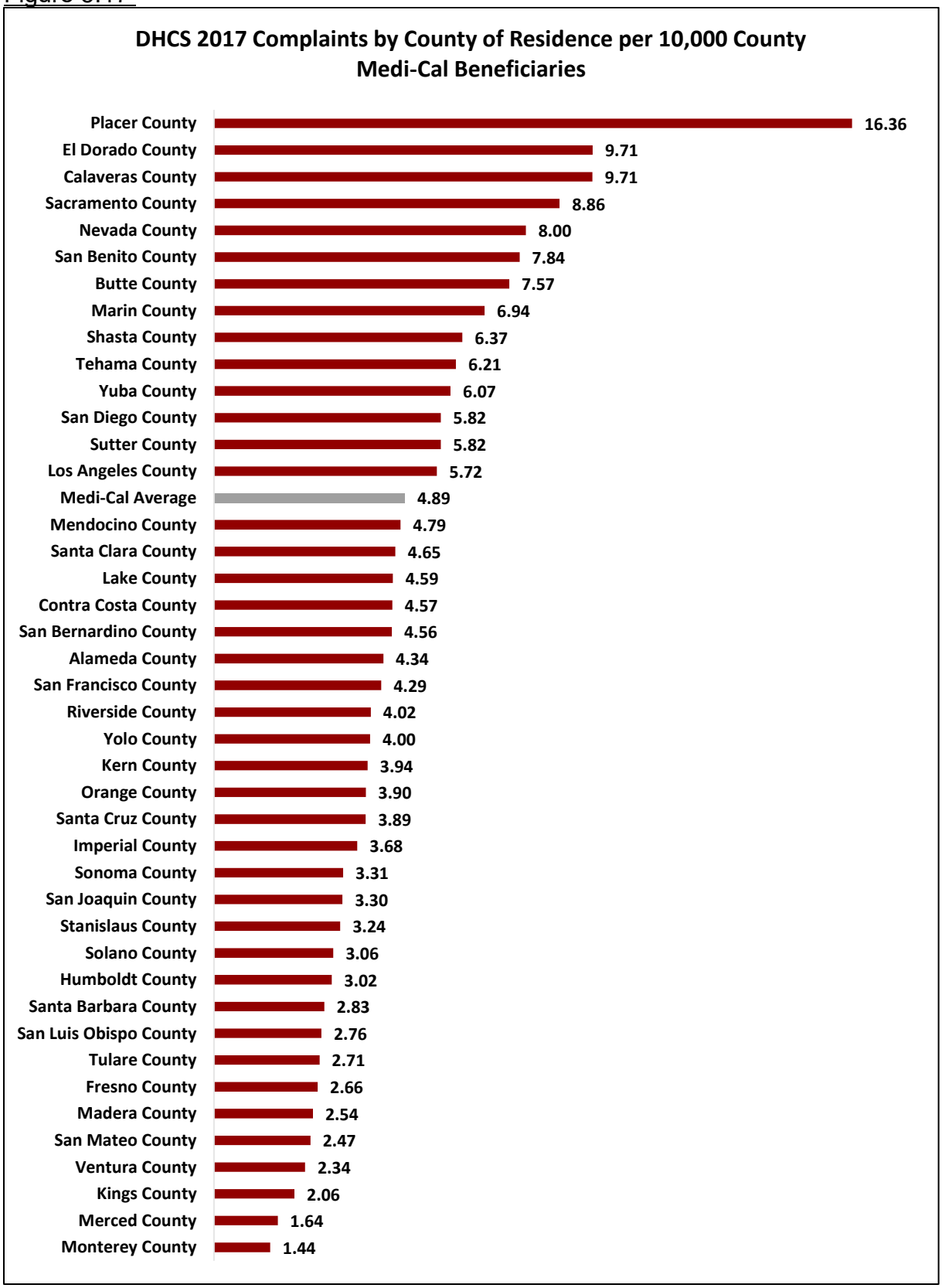
Approximately 98 percent of the 6,603 DHCS complaints had the complainant's county of residence identified.

The following chart displays county Medi-Cal complaint ratios based on the county's 2017 complaint volume total divided by the number of Medi-Cal beneficiaries who reside in the county. The ratios were then calculated per 10,000 Medi-Cal beneficiaries.

Counties with fewer than 11 complaints or fewer than 10,000 Medi-Cal beneficiaries were excluded from the chart. However, the Medi-Cal average ratio shown on the chart does take those excluded counties into account.

- Three California counties did not have any complaints reported in 2017 (Alpine, Modoc, and Sierra).
- Counties with at least one complaint but excluded from display for low complaint or enrollment volumes included: Amador, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Napa, Plumas, Sierra, Siskiyou, Tuolumne, and Trinity.

Figure 5.17



Note: Eighteen counties with complaint volumes under 11 or Medi-Cal enrollment under 10,000 were excluded from display.

Mode of Contact

Most (60%) of the DHCS 2017 complaints had an unknown initial mode of contact. Mail was the most common known mode of contact (nearly 28% of all complaints). About 12 percent of complaints were initiated by phone. Less than one percent were initiated by email, fax, or counter/in-person.

Regulator

Most (59%) of the DHCS 2017 complaints identified Other as the regulator, indicative of combined state and federal Medi-Cal program oversight. DMHC was the regulator identified for 2,729 complaints (41%), with an increase in volume and percentage distribution from 2016. There were four complaints where the regulator was Unknown.

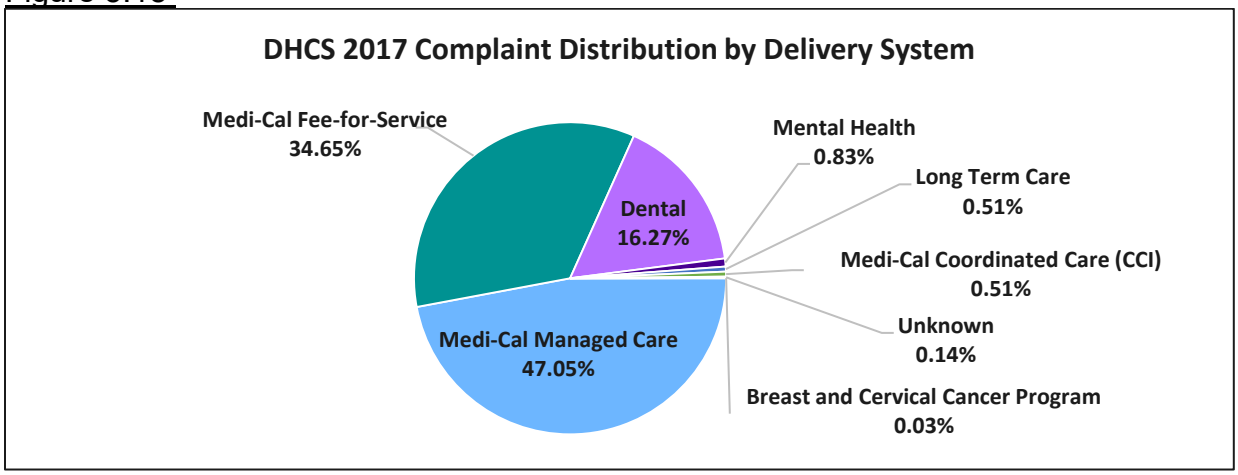
Source of Coverage

Medi-Cal continued to be the source of coverage identified for nearly all of the DHCS complaints (99.1% of the 6,603 complaints in 2017). Less than one percent identified Medi-Cal/Medicare as the source of coverage.

Product Type

The following chart displays the distribution of DHCS's 6,603 complaints by product type, representing the Medi-Cal program's different health care delivery systems.

Figure 5.18

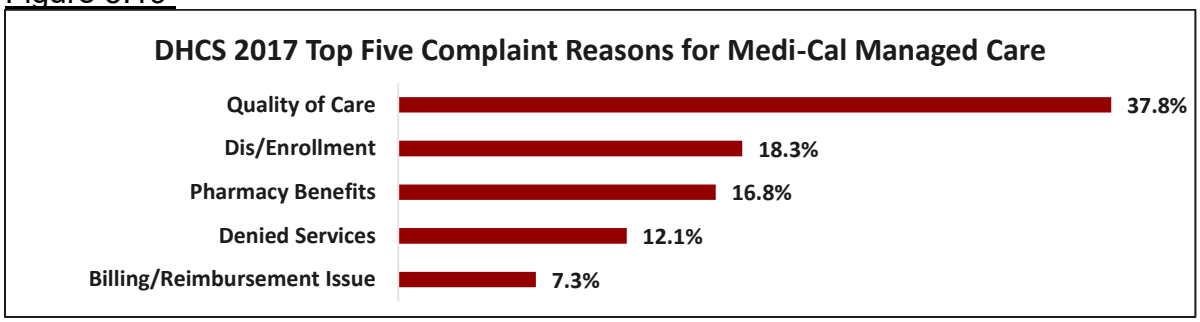


- Most of the 1,074 Dental complaints (94%) were regarding Fee-for-Service and nearly six percent were regarding Managed Care. Los Angeles and Sacramento are the only counties with Medi-Cal Dental Managed Care.
- No other delivery system had a second product type identified in 2017, a change from the prior year where second types were identified for approximately one-fourth of Long Term Care and Medi-Cal Fee-for-Service cases.

Complaint Reasons by Product Type

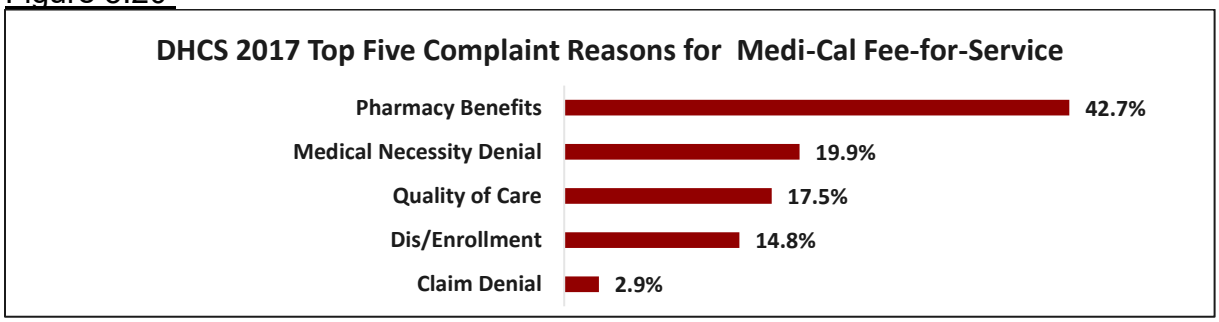
Figures 5.19-5.21 display the top complaint reasons for the various Medi-Cal delivery systems reported to OPA under product type.

Figure 5.19



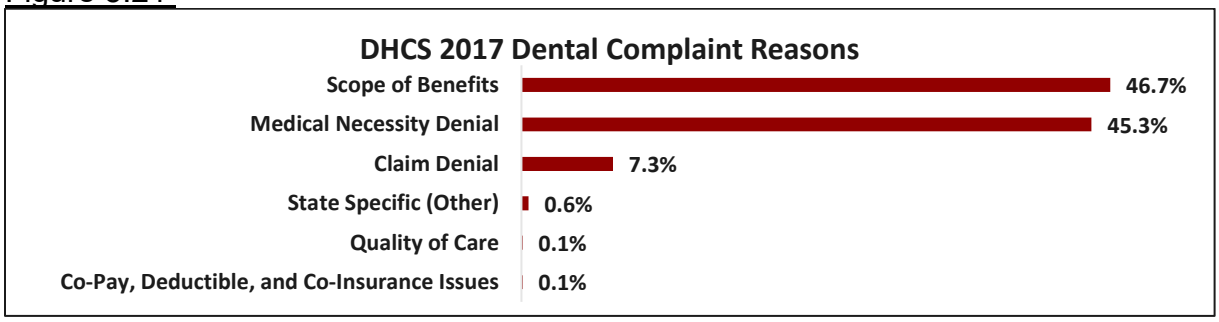
Note: The number of Managed Care complaint reasons exceeded the number of Managed Care complaints reported by DHCS because some complaint cases had more than one reason. The top five represent 92 percent of the reported 3,111 Managed Care complaint reasons.

Figure 5.20



Note: The top five represent 98 percent of the reported 2,288 Fee-for-Service complaint reasons.

Figure 5.21



Note: The chart accounts for all of the reported 1,074 Dental complaints.

All of the Dental complaints had a second product type reported, with 94 percent Fee-for-Service and six percent Managed Care.

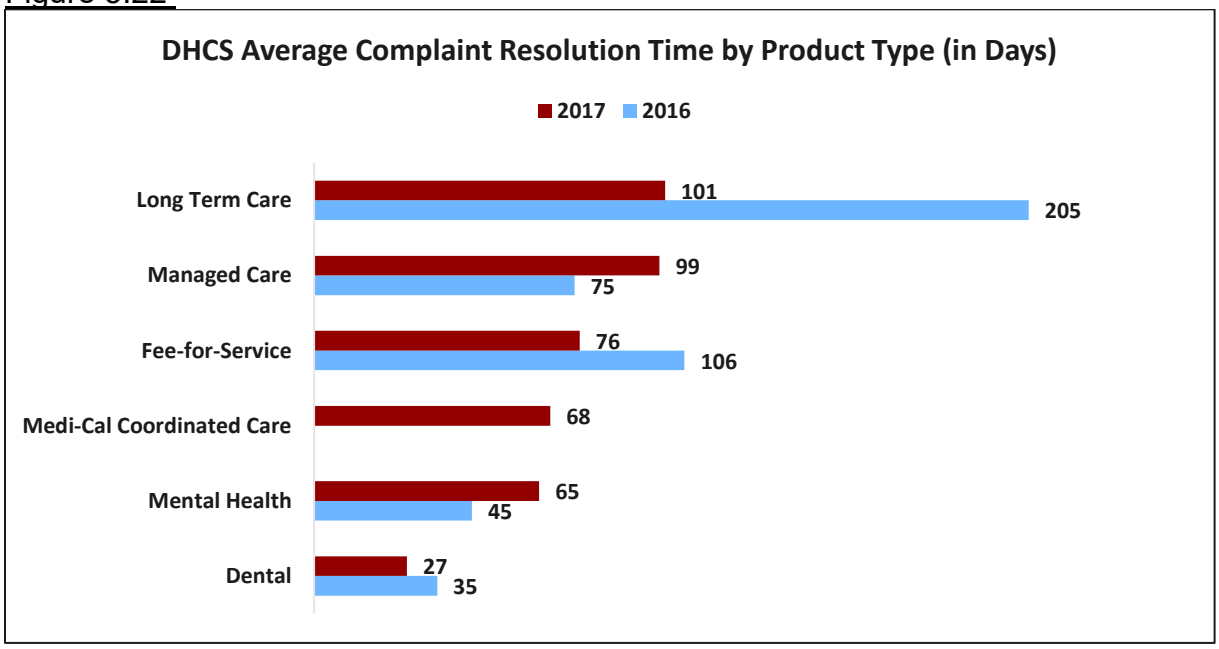
- For Dental Fee-for-Service, Medical Necessity Denial was the top reason and Scope of Benefits was second most common.
- For Dental Managed Care, Scope of Benefits was the top reason and Medical Necessity Denial was second most common.

Because of the low volume of complaints, OPA did not create additional charts for other delivery systems reported under product type.

- Medical Necessity Denial was the reason reported for most (70.9%) Mental Health complaints.
- All Breast and Cervical Cancer Treatment Program complaints were for an Unknown reason.
- For Long Term Care complaints, Denied Services was the top complaint reason and Eligibility Determination was second most common.
- For Medi-Cal Coordinated Care, Quality of Care and Scope of Benefits tied for the top reason.
- All Unknown product type complaints were for the reason of Claim Denial.

The following chart shows the average complaint resolution times for delivery systems reported under product type by DHCS in 2017 compared to the prior year averages.

Figure 5.22



Note: Product Types with low volumes (under 11 complaints) were excluded from the display. Medi-Cal Coordinated Care was not reported as a Product Type in 2016.

The average complaint resolution time for Fee-for-Service cases decreased while the resolution time for Managed Care cases increased. DHCS indicated that this change may be due in part to the ongoing shift of beneficiaries from Fee-for-Service into the Managed Care delivery system. A lower Fee-for-Service caseload may allow those complaints to be resolved more quickly. Conversely, a higher volume of Managed Care complaints may increase the time it takes for the complaints to process and resolve.

DHCS also noted that the decrease in the average complaint resolution time for Dental cases can be attributed to process improvements.

D. Consumer Assistance Center Details

Consumer Assistance Protocols

The following changes were made to DHCS complaint protocols and consumer assistance systems in 2017.

DHCS issued new guidelines through All Plan Letter 17-006 for complaints involving Medi-Cal Managed Care and Dental Managed Care plans. For complaints about health care delivery issues, Managed Care members must now file a grievance or appeal with their plan before requesting a State Fair Hearing with CDSS (as of July 2017). The new guidelines were issued in response to changes in federal law that were enacted to align Medicaid Managed Care regulations with the requirements of other major sources of coverage.

As of February 2017, the Mental Health Ombudsman's consumer assistance services were transitioned under the Medi-Cal Managed Care Office of the Ombudsman, which is now called the Office of the Ombudsman. The Mental Health Ombudsman consumer assistance statistics are now incorporated in the data for the Office of the Ombudsman and are no longer listed separately within this report.

The Medi-Cal Fiscal Intermediary contractor, which operates the Medi-Cal Telephone Service Center, changed its name to Conduent State Healthcare, LLC, in 2017 following a separation from its parent company Xerox State Healthcare, LLC.

Consumer Assistance Volumes by Service Center

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. DHCS reported 1,319,475 inquiries from consumers to its service centers in 2017, a two percent decrease from 2016's volume. Nearly all (99.1%) of the inquiries were made by telephone, followed by email (0.5%) and mail (0.4%).

Figures 5.23-5.25 show the DHCS consumer assistance volumes by month for each of its three service centers. In 2017, the:

- ***Office of the Ombudsman*** received 228,946 inquiries, a 21 percent decrease from 2016 (290,289) and continuing a downward trend from 2015 (340,434). Of the 2017 inquiries, 222,660 (97%) were by telephone and 6,286 (3%) were by email. The Office of the Ombudsman's 2017 data includes inquiries previously reported separately under the Mental Health Ombudsman.
- ***Medi-Cal Telephone Service Center*** received 575,819 inquiries from beneficiaries, a nearly two percent decrease from the prior year (586,935) but still above the 2015 level (541,982). All inquiries were made by telephone.
- ***Medi-Cal Dental Program Beneficiary Customer Service Center*** received 514,710 inquiries, a nearly 12 percent increase from the 2016 volume (461,492)

but still below the 2015 level (566,364). Of the 2017 inquiries, 509,148 (99%) were by telephone and 5,562 (1%) were by mail.

Figure 5.23

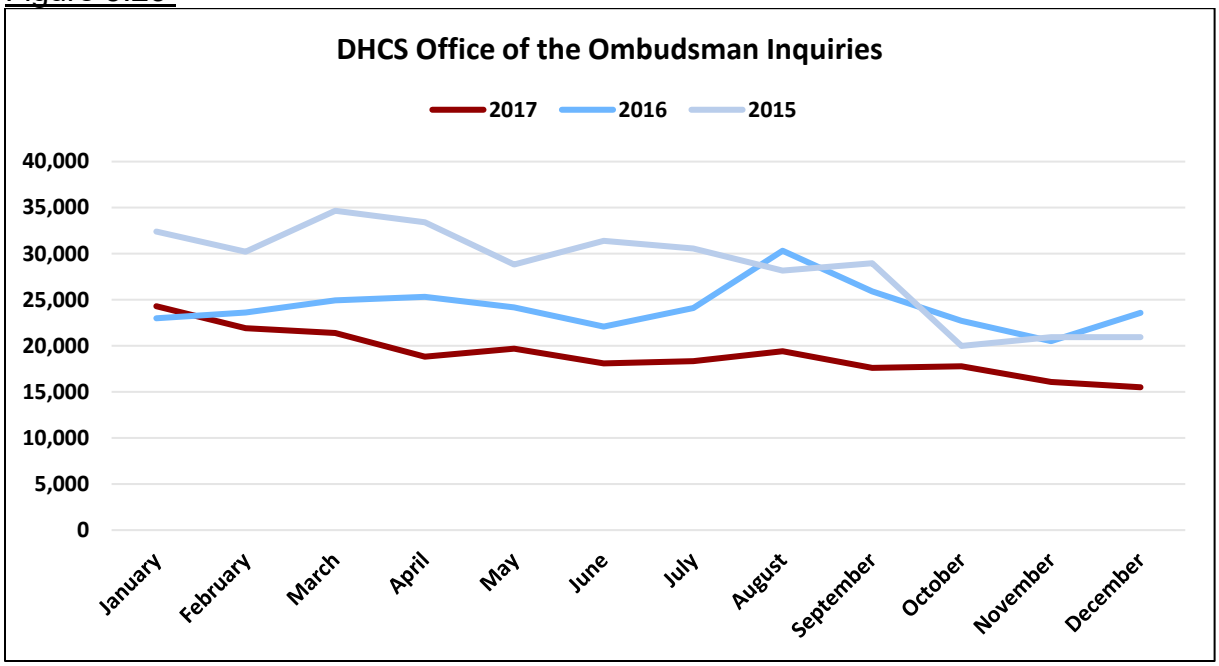


Figure 5.24

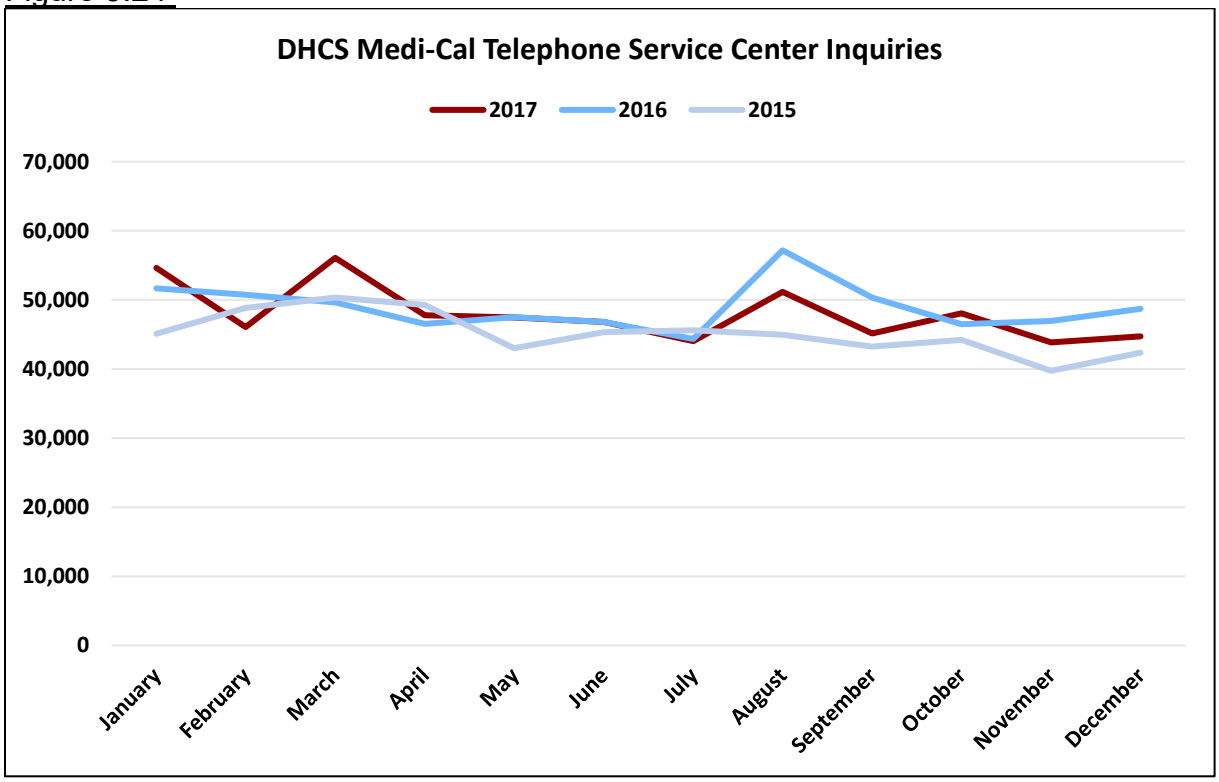
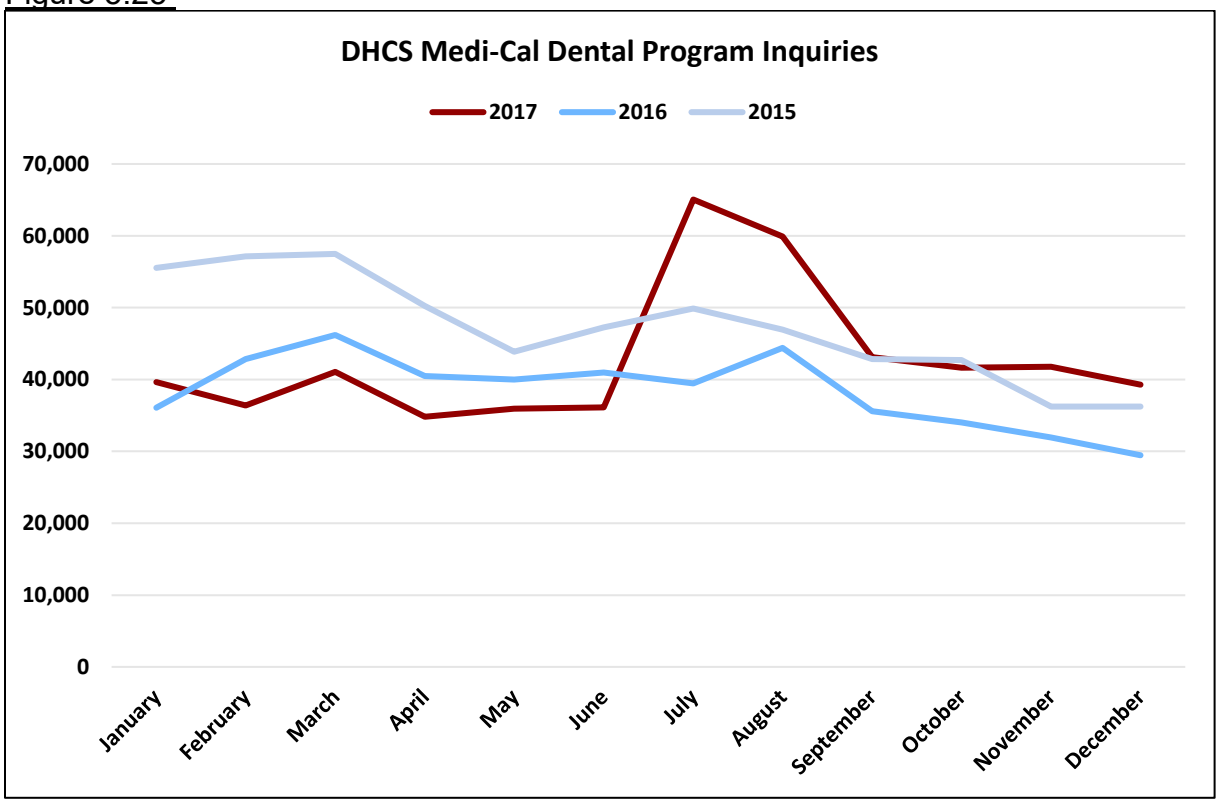


Figure 5.25



- DHCS noted that the Medi-Cal Dental Program's inquiry volume increased in July and August 2017 subsequent to mailers disseminated statewide to newly enrolled members during an outreach campaign that began in June 2017.

DHCS Service Centers' Telephone Call Metrics

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

- The Managed Care Ombudsman significantly decreased the number of abandoned calls (dropping from 53,325 in 2016 to 19,981 in 2017) and reduced average wait time to reach a DHCS customer service representative (19 minutes in 2016 to 7 minutes in 2017).

Figure 5.26

DHCS Service Centers' 2017 Telephone Metrics

Metric	Office of the Ombudsman	Medi-Cal Telephone Service Center	Medi-Cal Dental Program Service Center
Total telephone calls received	222,660	575,819*	509,148
Percent of inquiries that were phone calls	97%	100%	99%
Number of abandoned calls (Incoming calls ended by callers prior to reaching a Customer Service Representative – CSR)	19,981	50,375**	35,752
Number of calls resolved by the IVR/phone system (Caller provided and/or received information without involving a CSR)	91,773	2,634,250**	274,603
Number of jurisdictional inquiry calls	110,906	575,819	509,148
Number of non-jurisdictional calls	Indicated above in the calls resolved by the IVR, which provides contact information for non-jurisdictional issues.	Not Available	Not Available
Average number of calls received per jurisdictional complaint case	Not Available	Not Available	Not Available
Average wait time to reach a CSR	0:07:00	0:01:52	0:00:53
Average length of talk time (Time between a CSR answering and completing a call)	0:08:00	0:04:51	0:06:17
Average number of CSRs available to answer calls (Full-Time Equivalents, during Service Center hours)	21	77	86 ***

Note: Figures in this table are based on tracked data unless otherwise specified.

**This total represents only calls from Medi-Cal beneficiaries and excludes Medi-Cal provider calls. This data separation was possible for this total, but not for certain other Medi-Cal Telephone Services Center statistics in this table (see ** below).*

*** 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

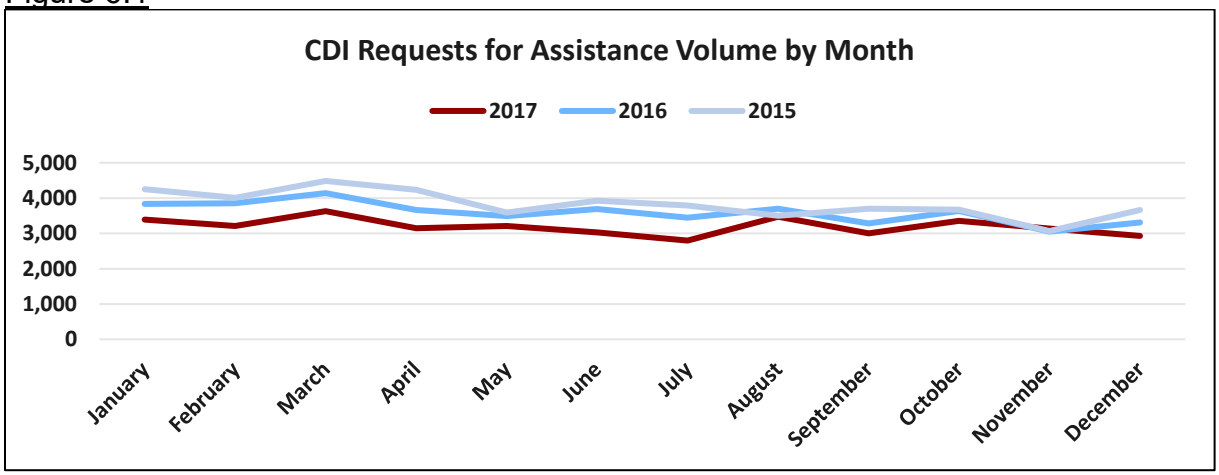
The California Department of Insurance (CDI) oversees more than 1,300 insurance companies and licenses more than 410,000 agents, brokers, adjusters, and business entities. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to 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. CDI reported non-jurisdictional complaints for the first time among its 2017 complaint data submission. For reporting standardization purposes, OPA refers to the health insurance companies associated with CDI-reported complaints as health plans. CDI submitted 7,534 complaint records for 2017, including:

- 3,649 non-jurisdictional complaints that were referred to outside agencies or departments, such as the California Department of Managed Health Care and Departments of Insurance in other states.
- 3,885 jurisdictional complaints closed by CDI, a 35 percent volume increase from the prior year (2,871 jurisdictional complaints in 2016) that also surpassed the 2015 volume of 3,209 complaints.
    - CDI indicated that the increase in complaint volume is primarily due to its improved online complaint portal, which made it easier for both consumers and health care providers to submit complaints.

The following chart compares CDI's overall consumer assistance volumes of complaints and consumer inquiries by month for a three-year-period. CDI received 38,316 requests for assistance from health care consumers in 2017, continuing a downward trend from prior years (43,097 in 2016 and 45,882 in 2015). The 2017 volume remains higher than the baseline year (36,986 in 2014).

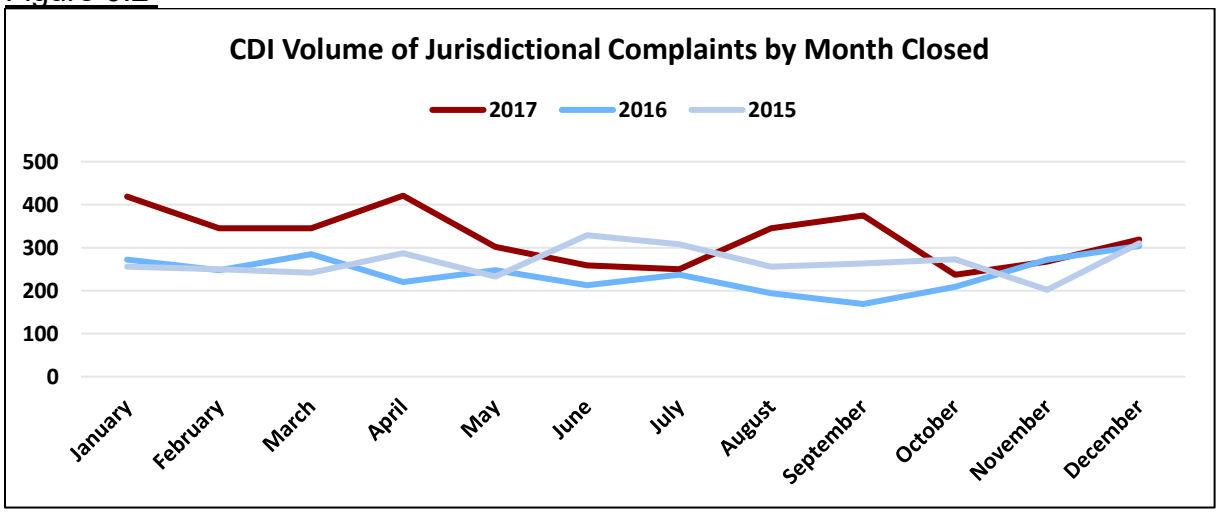
Figure 6.1



The following chart displays volumes by the month the complaint closed for the 2017 total of 3,885 complaints; the 2016 total of 2,871 complaints; and 2015 total of 3,209 complaints.

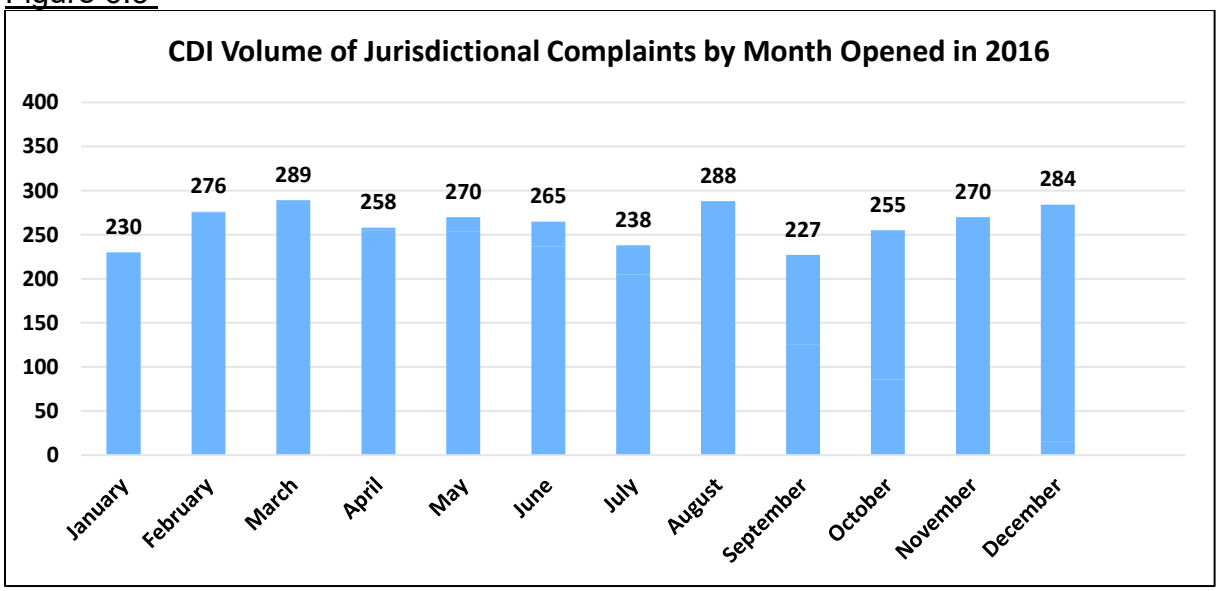
- The volumes shown are for complaints regarding CDI-regulated products and exclude non-jurisdictional complaints that were addressed by the department during the measurement year.

Figure 6.2



The following chart displays jurisdictional complaints by the month the complaint was initiated with CDI in 2016. A two-year analysis was necessary to capture volumes of complaints opened in fall and winter months, but closed during the following year. The volumes account for complaints opened in 2016 that were closed in 2016 and 2017.

Figure 6.3



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 6.4 were based on the durations of jurisdictional complaints closed in 2017 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.
- Complaints are closed to the complainant prior to CDI's regulatory review period.
- CDI indicated that its regulatory review period is 30 days on average.

Figure 6.4

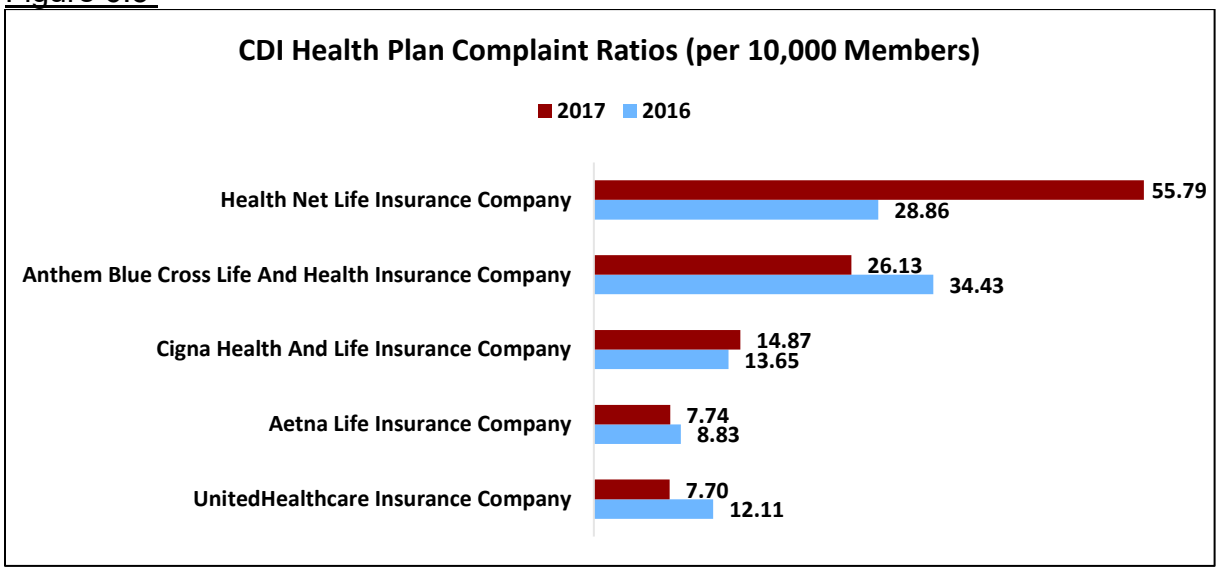
CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2017
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)	78 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)	88 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

The following chart shows the complaint ratios for the health plans regulated by CDI with at least 25 complaints closed in 2017 and with enrollment exceeding 70,000 members, as well as the 2016 ratios for those same plans. A higher complaint ratio means that more complaints were closed per member. The ratio was calculated by dividing the plan's total number of jurisdictional complaints by the plan's enrollment. Ratios are shown as complaints per 10,000 members.

Figure 6.5



Note: The 2015 ratio information is not available due to differences in prior years' complaint ratio analysis, which was based on breakdowns of plan group and individual/commercial products. CDI did not submit health plan names within the 2017 complaint data submission, but instead reported complaint totals for nine health plans that had more than 25 complaints closed by the department in 2017.

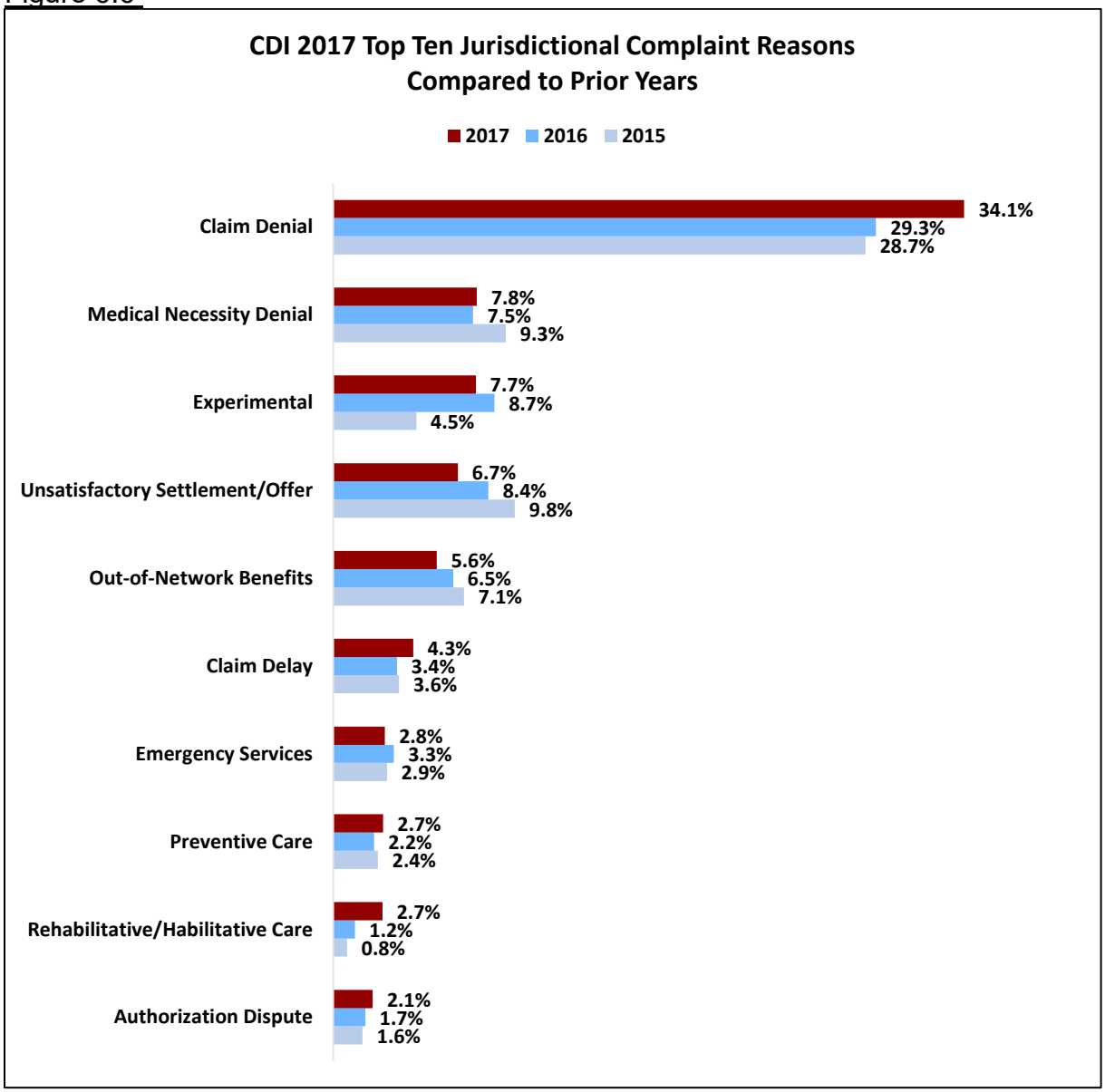
Top Ten Reasons for Jurisdictional Complaints

Many consumer complaints reported by CDI involved more than one issue. The total number of complaint reasons (5,533) reported by CDI for its jurisdictional complaints exceeded the total number of jurisdictional complaint cases (3,885) in 2017.

The following chart displays the top ten most common reasons for jurisdictional complaints in 2017, as well as the percentage distributions for those same categories in 2015 and 2016. The top ten complaint reason categories account for 76 percent of the complaint reasons reported for 2017.

Some differences between measurement years may be due in part to reporting changes, such as category consolidation, rather than changes in incidence.

Figure 6.6



Note: The complaint reasons represented in this chart are the top ten complaint reasons for 2017 and the distribution of those same complaint reasons in the 2015 and 2016 data. These reasons were not necessarily the top complaint reasons in prior years.

Top Ten Topics for Non-Jurisdictional Complaints and Inquiries

This was the first year CDI reported non-jurisdictional complaint records among its complaint data submission.

The following chart shows the top ten reasons for non-jurisdictional complaints that were referred to an outside agency or department in 2017. The number of non-jurisdictional reasons (4,536) exceeded the associated complaint cases (3,649) because some cases had more than one reason.

Figure 6.7

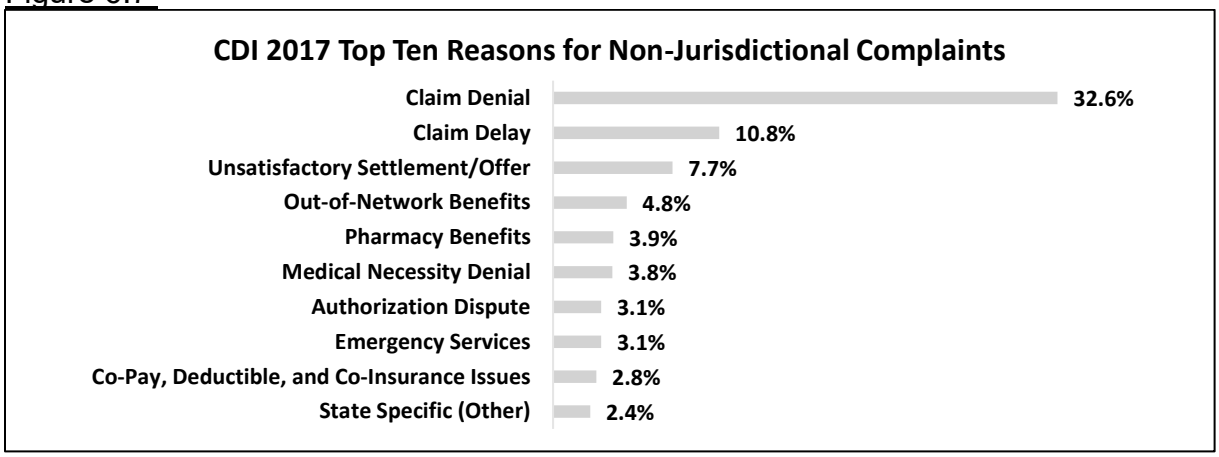


Figure 6.8 displays CDI's top referral topics for consumer inquiries, as well as the entities to which those inquiries were referred in 2017. The estimated rankings exclude non-jurisdictional complaints that are displayed in Figure 6.7. Approximately 80 percent of CDI's 38,316 requests for assistance were inquiries.

Figure 6.8

CDI 2017 Top Ten Topics for Non-Jurisdictional Inquiry and Complaint Referrals

Ranking	Non-Jurisdictional Inquiry Topic	Organization(s) Referred to
1 (most common)	Claim Denial	Department of Managed Health Care (DMHC) U.S. Department of Labor (DOL) Centers for Medicare and Medicaid Services (CMS) Various Departments of Insurance (DOIs)
2	Unsatisfactory Settlement/Offer	DMHC DOL CMS Various DOIs
3	Claim Delay	DMHC DOL CMS Various DOIs
4	Medical Necessity/Experimental	DMHC DOL
5	Out-of-Network Benefits	DMHC DOL
6	Cancellation	DMHC
7	Co-Pay/Deductible Issues	DMHC DOL
8	Authorization Disputes	DMHC
9	Premium Notice & Billing	DMHC
10	Pharmacy Benefits	DMHC CMS

Note: Ranking estimated by CDI.

Complaint Results

The following table displays the results for all 7,534 jurisdictional and non-jurisdictional complaints reported by CDI for 2017.

- Due to the inclusion of non-jurisdictional complaints for the first time in 2017, the associated result category of Referred to Outside Agency/Dept. surpassed Upheld/Health Plan Position Substantiated to become the top reported result.
- CDI reported complaints referred to other state departments of insurance under the category Referred to Outside Agency/Dept.
- None of the 2017 complaints had more than one result reported.

Figure 6.9

CDI 2017 Top Ten Complaint Results

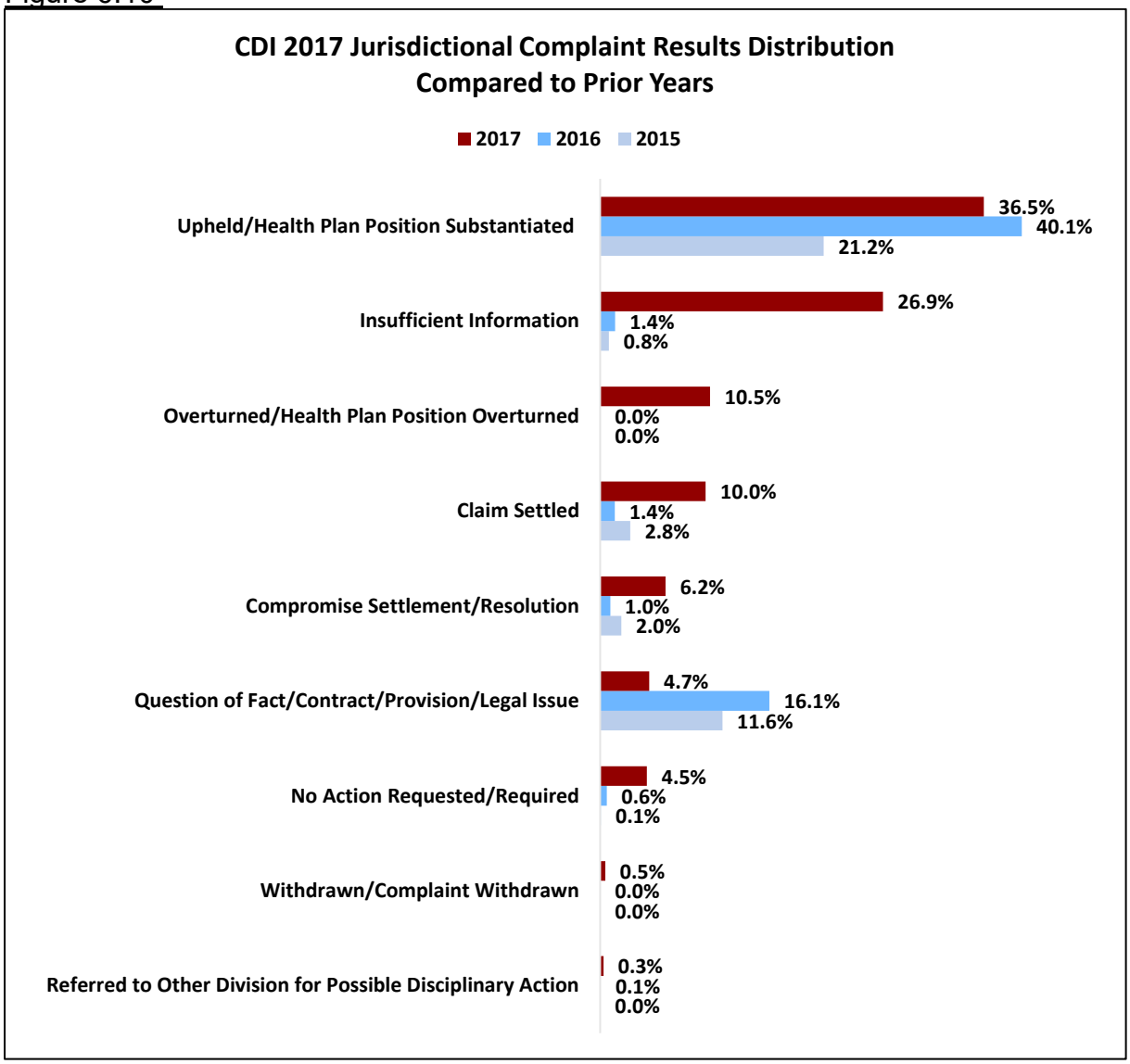
Complaint Result	2017 Volume
Referred To Outside Agency/Dept.	3,649
Upheld/Health Plan Position Substantiated	1,418
Insufficient Information	1,045
Overturned/Health Plan Position Overturned	406
Claim Settled	390
Compromise Settlement/Resolution	241
Question of Fact/Contract/Provision/Legal Issue	181
No Action Requested/Required	173
Withdrawn/Complaint Withdrawn	19
Referred to Other Division for Possible Disciplinary Action	12

Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Claim Settled, Compromise Settlement/Resolution, 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 other categories shown is neutral or cannot be determined.

The following chart shows CDI's 2017 jurisdictional complaint results distribution compared to prior years. For more equitable comparison between measurement years, newly reported 2017 non-jurisdictional complaint dataset was excluded from the analysis.

- Some remaining differences between measurement years may be due to reporting changes rather than incidence. For example, CDI reported the category Overturned/Health Plan Position Overturned for the first time in 2017.

Figure 6.10



Note: The complaint results displayed are the top jurisdictional complaint results for 2017 and the distribution of those same complaint results in the 2015 and 2016 data. The non-jurisdictional complaints in 2017 with a result of Referred to Outside Agency/Dept. were excluded from the 2017 distribution calculations. The results categories shown were not necessarily the top reasons in prior years.

Resolution Time

CDI took 80 days on average to resolve jurisdictional complaints, a ten-day decrease from the 2016 average.

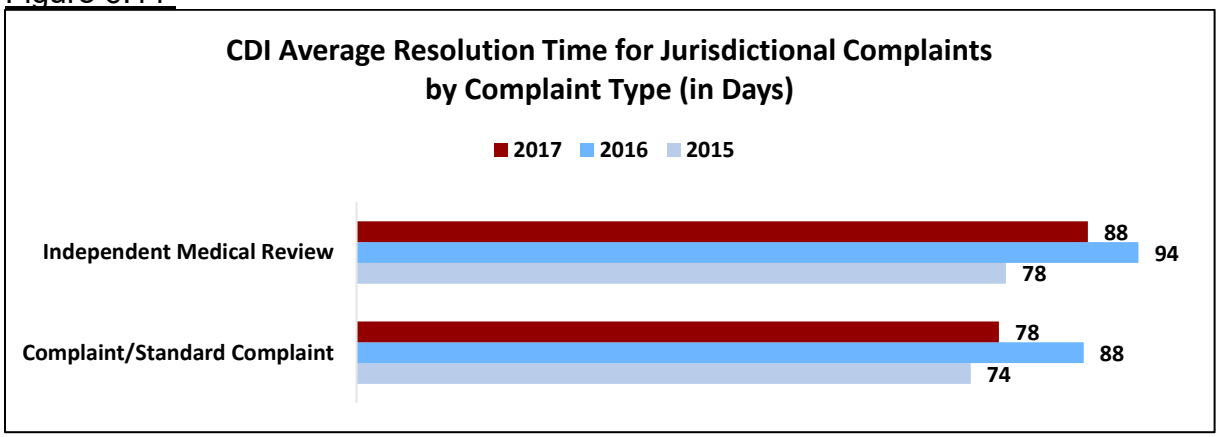
- Non-jurisdictional complaints reported for the first time by CDI in 2017 took on average four days for the department to review and refer to an outside agency or department.
- Overall, the average duration for all 7,534 jurisdictional and non-jurisdictional complaint was 43 days.

The CDI duration period for jurisdictional complaints 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 that its final regulatory review period is 30 days on average.

The following chart shows a three-year-comparison of average resolution times for jurisdictional complaints for CDI's two reported complaint type processes. Average resolution times have decreased for both complaint types compared to the prior year.

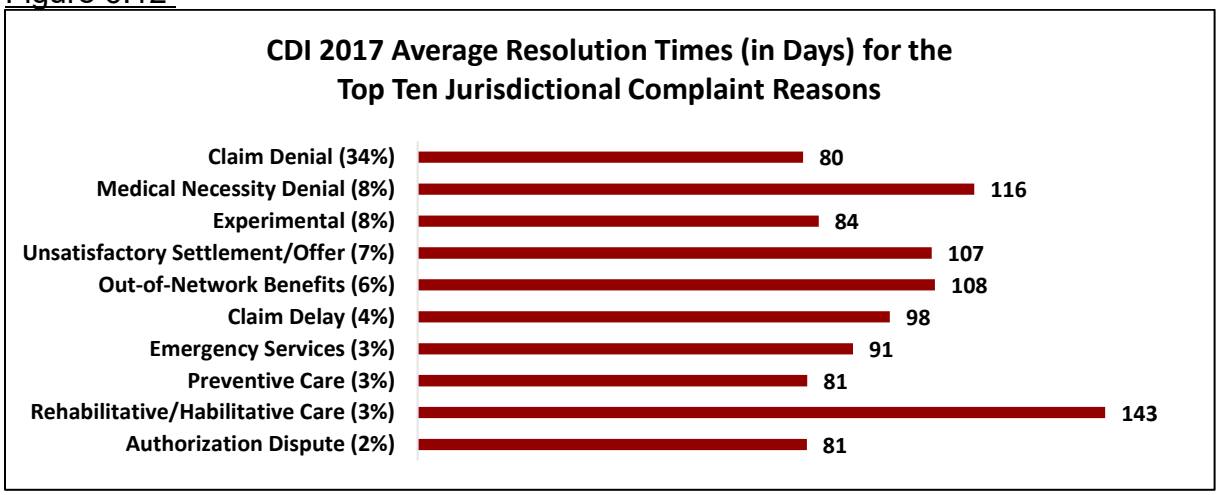
Figure 6.11



Note: For better comparison with 2015 and 2016 jurisdictional complaint data, the chart excludes non-jurisdictional complaints reported in 2017. 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 2017 jurisdictional complaints. The number of reasons exceeded the number of complaints because many of the 2017 CDI jurisdictional complaint cases had more than one reason reported per case.

Figure 6.12



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 by CDI in 2017 was 46. The jurisdictional complaint volumes of all age category groups increased from the prior year. Age distributions for CDI's newly reported non-jurisdictional complaints were similar to the jurisdictional distribution.

- Age 35-54 continued to be the age group with the most complaints, with 31 percent of the 2017 jurisdictional complaints.
- Refused/Unknown had the largest increase in percentage distribution (3% in 2016 to 11% of jurisdictional complaints in 2017).
- The distributions for the other age groups were similar to 2016.
- Claim Denial continued to be the most common complaint reason across all known age groups and among consumers whose age was not identified.

Gender

All reported CDI complaints had gender identified. Both reported genders increased in jurisdictional complaint volume from 2016. Female continued to be the gender category with the most jurisdictional complaints (55%), despite a slight drop in percentage distribution compared to 2016 (58%). Among the 2017 non-jurisdictional complaints, Female accounted for 53 percent and Male 47 percent.

- Claim Denial continued to be the top jurisdictional complaint reason for both Female and Male complainants (36% of Female and 32% of Male).

- Experimental continued to be the second most common reason among Female complainants (10% of Female) and fifth most common reason among male complainants (5% of Male).
- Medical Necessity Denial was the second most common reason among male complainants (9%) and ranked third for female (7%).

Race

A lower percentage of jurisdictional complaints had race identified than the prior year (43% identified in 2017 compared to 55% in 2016). It is unknown the extent the increase in Refused and Unknown categories affected the distribution among known categories.

- All known race categories except for White experienced an increase in jurisdictional complaint volume from the prior year.
- Refused had the most jurisdictional complaints in 2017 (43%), followed by White (33%), Unknown (14%), Asian (5%), Other (4%), Black or African American (1%), American Indian or Alaska Native (under 1%), and Native Hawaiian or Other Pacific Islander (under 1%).
- Claim Denial continued to be the top jurisdictional reason across all race categories.
- White was the most common category identified for non-jurisdictional complaints (42% of the newly reported non-jurisdictional complaints).

Ethnicity

More jurisdictional complaints had ethnicity identified than the prior year (79% identified in 2017, compared to 55% in 2016). It is unknown the extent the reduction of Refused and Unknown affected distribution among the known ethnicity categories.

- Not Hispanic or Latino (75% of 2017 jurisdictional complaints) increased in both volume and percentage distribution from the prior year.
- The percentage distribution of Hispanic or Latino remained around four percent.
- Claim Denial continued to rank as the top complaint reason across all reported categories of ethnicity.
- Among newly reported non-jurisdictional complaints, Not Hispanic or Latino was the top category (68%), followed by Refused (19%), Unknown (7%), and Hispanic or Latino (6%).

Language

A lower percentage of jurisdictional complaints had a primary language identified than the prior year (52% identified in 2017, compared to 64% in 2016).

- Jurisdictional complaint volumes increased from the prior year for all primary language categories except for Spanish.

- While English remained the top reported category (50% of 2017 jurisdictional complaints), the percentage distribution fell from the prior year (60% in 2016).
- Refused was the second most common category (34%), followed by Unknown (14%), Other Languages (2%), and Spanish (under 1%).
- Claim Denial continued to be the top jurisdictional reason across all language categories.
- Among newly reported non-jurisdictional complaints, English was the top category (63%), followed by Refused (20%), Unknown (14%), Other Languages (2%), and Spanish (1%).

Other Languages includes complaints reported with primary language identified as Korean, Mandarin, Tagalog, Vietnamese, Cantonese, Russian, Armenian, Farsi, Japanese, and Arabic.

Mode of Contact

The 2017 percentage distributions by initial mode of contact for jurisdictional complaints were similar to 2016, with a slight uptick in the online mode.

- Over half of the 3,885 jurisdictional complaints (58%) were initiated by mail, 35 percent were initiated online, and seven percent were initiated by telephone.
- Non-jurisdictional complaints reported by CDI were primarily initiated online (66% of non-jurisdictional).
- CDI noted that increased use of the online mode is likely due to a shift in consumer communication preferences as well as improvements CDI made to its online complaint portal that made it easier for consumers to file complaints and upload related documents online.

Regulator

CDI was the regulatory authority indicated for all 7,534 consumer complaints reported for 2017. Of the reported complaints, 3,885 were jurisdictional and 3,649 cases reviewed by CDI resulted in a referral to another entity to resolve.

Source of Coverage

CDI identified two sources of coverage: Group and Individual/Commercial.

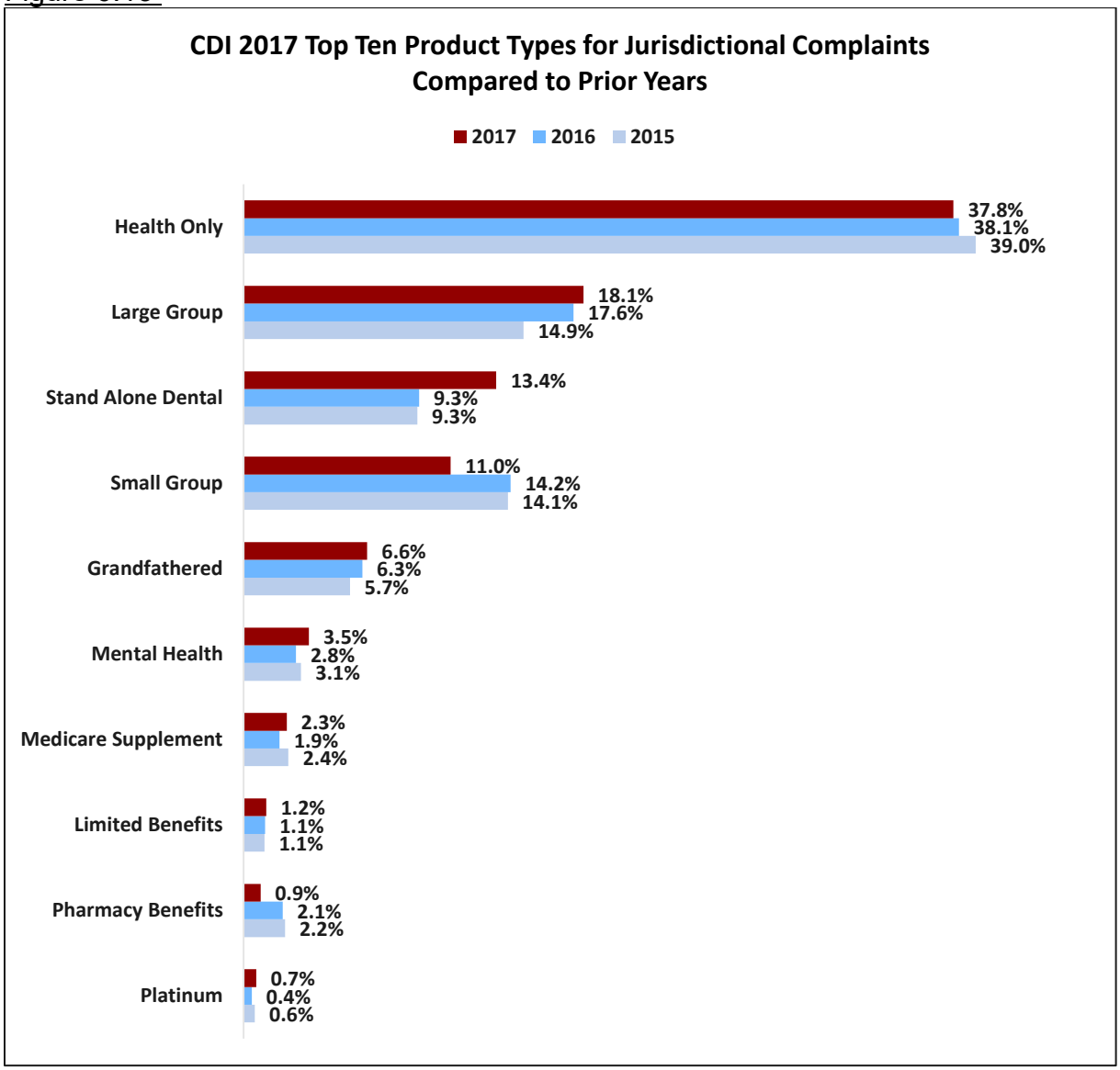
- The Group coverage source accounted for 63 percent of all 7,534 reported complaints and Individual/Commercial accounted for 37 percent.
- Of the 3,885 jurisdictional complaints, 60 percent were Group and 40 percent were Individual/Commercial.
- Jurisdictional complaints took 81 days for Group and 78 days for Individual/Commercial, 11 and 9 days fewer than the 2016 average durations respectively.

Product Type

Consumer complaints reviewed by CDI in 2017 included 23 product type categories. The total number of product type entries reported (10,160) exceeded the number of complaint cases (7,534) because many complaints had more than one product type identified.

The following chart shows the most common product type categories reported by CDI for the 2017 jurisdictional complaints and the distribution of complaints within those same categories in 2015 and 2016. Half of the 3,885 jurisdictional complaints in 2017 had a single product type identified, while 44 percent had two types and 6 percent three types.

Figure 6.13



Note: The product type categories displayed are the most common for 2017 and the distribution of those same categories in the 2015 and 2016 data. The categories shown were not necessarily among the top ten for prior years.

Among the top five product types for CDI's newly reported non-jurisdictional complaints (3,649 complaints): Health Only accounted for 51 percent, Large Group for 22 percent, Stand Alone Dental for six percent, Small Group for four percent, and Medicare Supplement for three percent.

D. Consumer Assistance Center Details

CDI's service center reported receiving 38,316 requests for assistance from consumers in 2017, a downward trend from 43,097 in 2016 and from 45,882 in 2015. Of the requests for assistance received in 2017, most continued to be made by telephone (79% - including 29,764 inquiries and 385 complaints). Online complaints were the next most common with 10 percent, followed by mailed complaints (9%), written inquiries (2%), and counter/in-person requests (under 1%).

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 6.14

CDI Consumer Services Division – 2017 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)	814	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,152	Data
Number of jurisdictional inquiry calls	23,772	Data
Number of non-jurisdictional calls	4,840	Data
Average number of calls received per jurisdictional complaint case	Not measured	
Average wait time to reach a CSR	0:00:44	Data
Average length of talk time (time between a CSR answering and completing a call)	0:05:59*	Data
Average number of CSRs available to answer calls (during Service Center hours)	Varies based on need	

** Secondary health officers may be added to the health queue depending upon volume of calls received. The data does not reflect time spent by the officer to verify jurisdiction and return a call to the consumer. Stats only reflect time of consumers' initial contact.*

Consumer Assistance Protocols

CDI implemented a new case management system for its Consumer Services Division in June 2017. Otherwise, CDI indicated there were not any other significant changes to its consumer assistance systems or protocols 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.

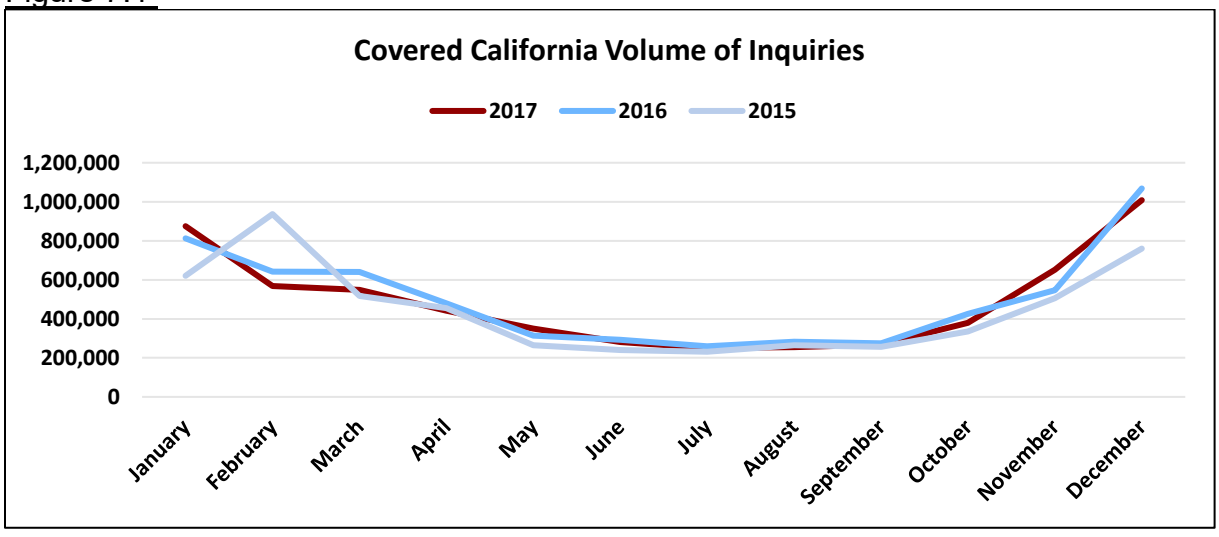
This report includes information reported by Covered California regarding:

- 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 5,894,358 requests for assistance from consumers in 2017, a three percent decrease in volume from the prior year (6,058,978 requests for assistance in 2016). The requests for assistance volume includes inquiries to the Covered California Service Center and complaints resolved formally and informally through a State Fair Hearing.

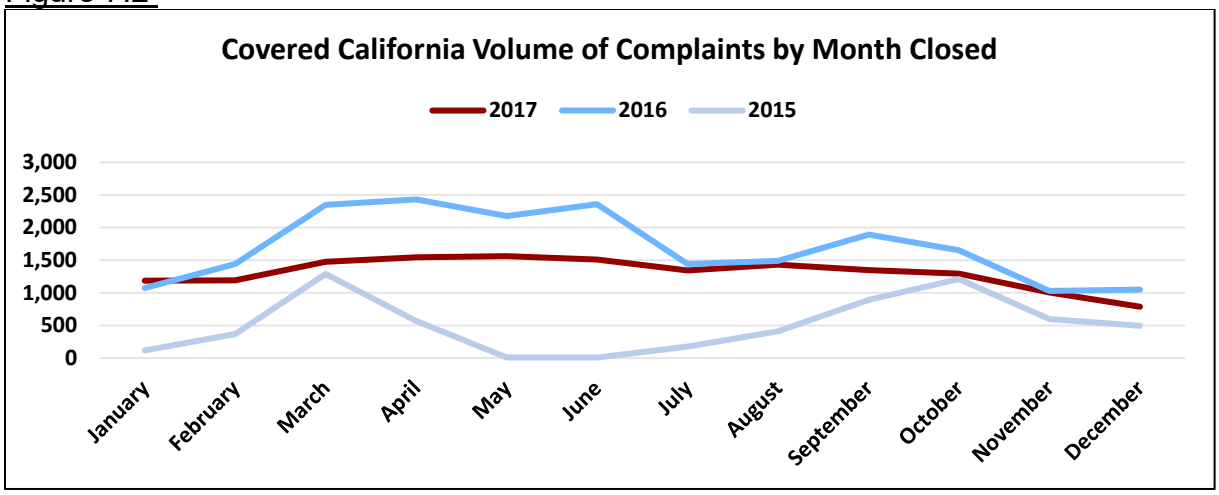
The following chart compares the monthly volumes of consumer inquiries to the Covered California Service Center for a three-year-period. The annual volumes were 5,878,671 inquiries in 2017; 6,038,580 in 2016; and 5,390,936 in 2015.

Figure 7.1



The following chart compares Covered California's complaint volumes by month closed over a three-year period.

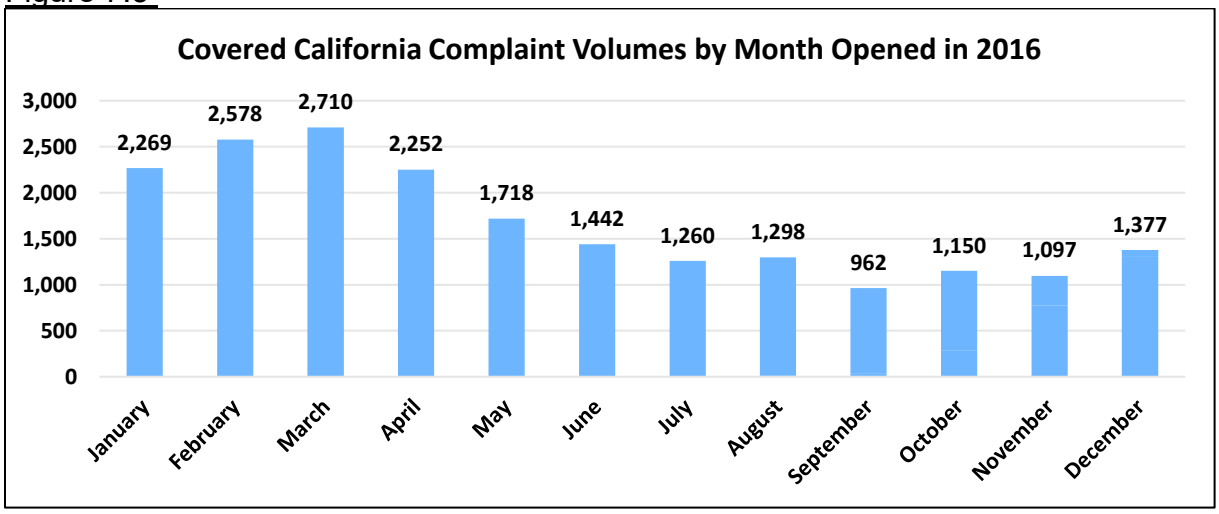
Figure 7.2



- There were 15,687 complaints closed in 2017, a 23 percent decrease in volume from 2016 (20,398) but still higher than the 2015 volume (6,150).
- This overall decrease is associated with a 52 percent drop in volume for the State Fair Hearing: Informal Resolution complaint type, which decreased in 2017 after spiking in 2016. Covered California noted that improvements made through the implementation of new programs and additional staffing resources and training contributed to the reduced number of 2017 complaints.

The following chart displays Covered California's monthly complaint volumes determined by the date the complaint case was initiated by the consumer. A two-year analysis was necessary to capture volumes of complaints opened in late 2016 but closed in 2017.

Figure 7.3



Complaint Type Overview

The following table outlines two processes for Covered California complaints.

- Most of Covered California's complaints in 2017 were formal State Fair Hearings (55%). Although there were more formal hearings closed compared to the prior year (5,686 in 2016 to 8,607 in 2017), the average duration fell by nine days.

Figure 7.4
Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
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	77 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	52 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 15,687 complaints for 2017 within three complaint reason categories involving program eligibility and enrollment issues.

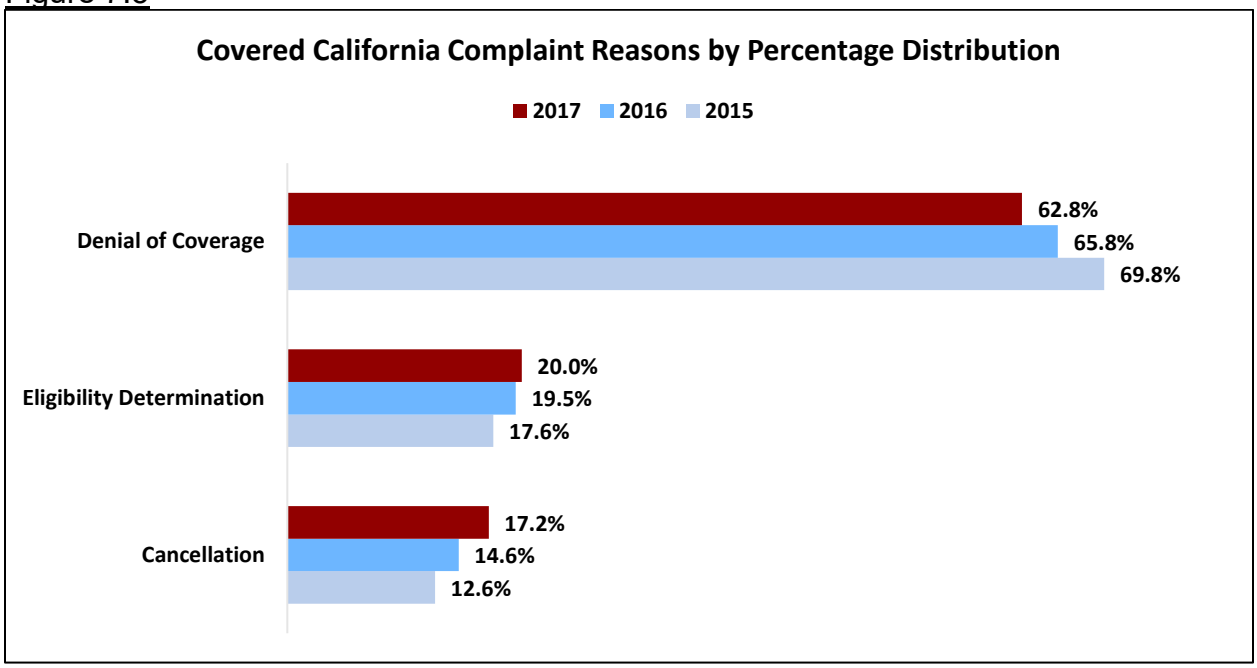
No complaint ratios were calculated based on the complaint data submitted by Covered California because its hearings are for program eligibility and enrollment reasons and not issues with health plans. Covered California health plan complaints are addressed through the health plan grievance and regulator complaint review processes rather than through a State Fair Hearing. See Section 4.C. for additional information about Covered

California health plan complaints resolved by the Department of Managed Health Care in 2017.

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 6,150 complaints in 2015, all 20,398 complaints in 2016, and all 15,687 complaints in 2017. No Covered California complaint had a second complaint reason reported.

Figure 7.5



- Complaint volumes for all three reason categories decreased in volume from 2016.
- Denial of Coverage (9,847 complaints in 2017) continued to be the top complaint reason despite a 27 percent volume decrease from the prior year.
- Percentage distributions for Eligibility Determination (3,141) and Cancellation (2,669) increased because both categories experienced smaller volume decreases than Denial of Coverage from the prior year.

Top Ten Reasons for Inquiries

The following table displays the top ten inquiries made by consumers to the Covered California Service Center in 2017 for both jurisdictional and non-jurisdictional topics.

Figure 7.6

Covered California 2017 Top Ten Jurisdictional and Non-Jurisdictional Inquires

Ranking	Inquiry Topic	Referred to
1 (most common)	Inquiry/Assistance - Application/Case Status	Not Applicable
2	Current Customer - Disenrollment / Termination	Not Applicable
3	Current Customer - Renewal	Not Applicable
4	Current Customer – Consumer's Online Account	Not Applicable
5	Inquiry/Assistance - New Enrollment	Not Applicable
6	1095-A Inquiry/Assistance	Not Applicable
7	Current Customer - Report a Change	Not Applicable
8	Provided County Contact/Number Info	Referred to Medi-Cal
9	Medi-Cal/Enrollment Inquiries	Referred to Medi-Cal
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.

- The top inquiry topic (Application/Case Status) was unchanged from 2016.
- The 1095-A inquiry topic dropped in ranking from second most common in 2016 to sixth in 2017.
- Requests from current customers for Disenrollment/Termination increased in ranking from fifth to second.
- Current Customer – Report a Change was listed in the top ten for the first time as the seventh most common topic in 2017.

Complaint Results

The following table displays all of the 15,687 complaint results reported by Covered California for 2017. 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

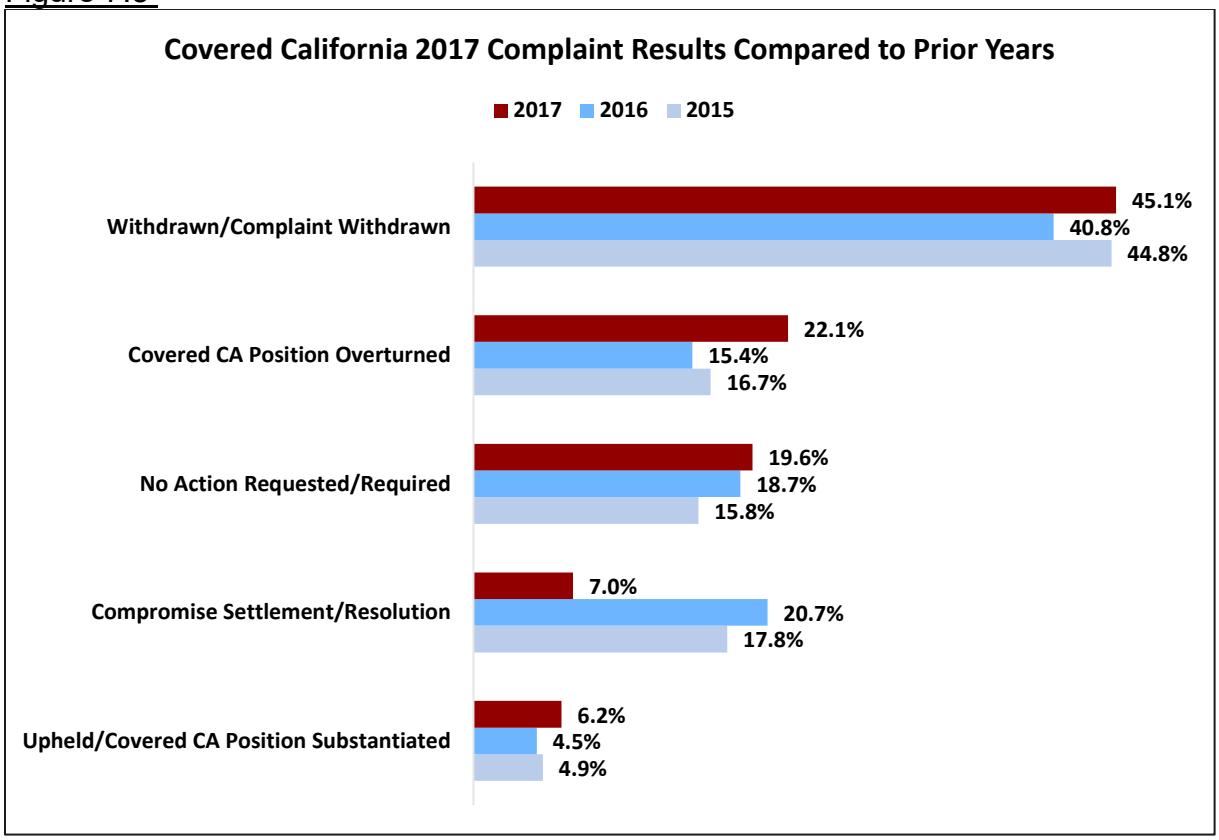
Covered California 2017 Complaint Results

Complaint Result	2017 Volume
Withdrawn/Complaint Withdrawn	7,080
Covered CA Position Overturned	3,465
No Action Requested/Required	3,074
Compromise Settlement/Resolution	1,097
Upheld/Covered CA Position Substantiated	971

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 percentage distributions of the complaint results reported by Covered California over a three-year period (6,150 complaints in 2015, 20,398 in 2016, and 15,687 in 2017).

Figure 7.8



Note: The chart accounts for all of the complaint results reported for 2016 and 2017. One unknown result from 2015 is not displayed.

- Although Withdrawn/Complaint Withdrawn and No Action Requested/Required increased in distribution, the raw volumes actually decreased from 2016.
- Upheld/Covered CA Position Substantiated and Covered CA Position Overturned were the only results categories that increased in volume from the prior year.
- Compromise Settlement/Resolution had the biggest decrease (74% decrease).

Figures 7.9 – 7.11 provide a reason-to-result analysis for each of the three complaint reasons reported by Covered California in 2017.

- These figures account for 9,847 complaints for the Denial of Coverage complaint reason, 3,141 complaints for Eligibility Determination, and 2,699 complaints for Cancellation.

Figure 7.9

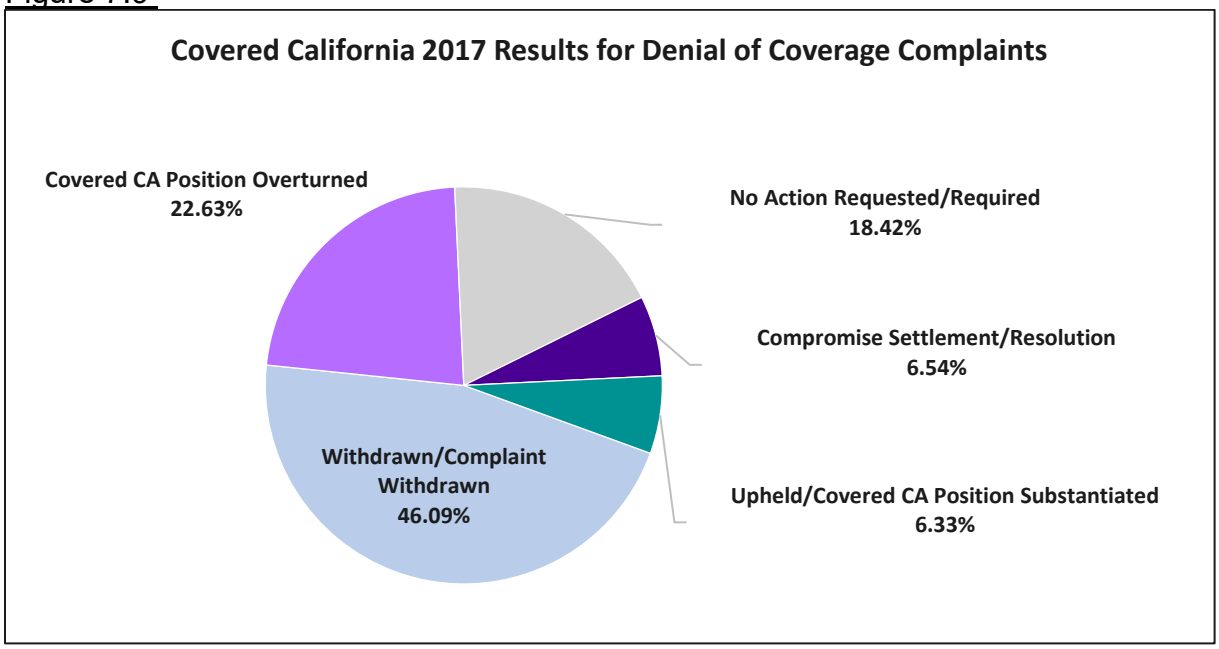


Figure 7.10

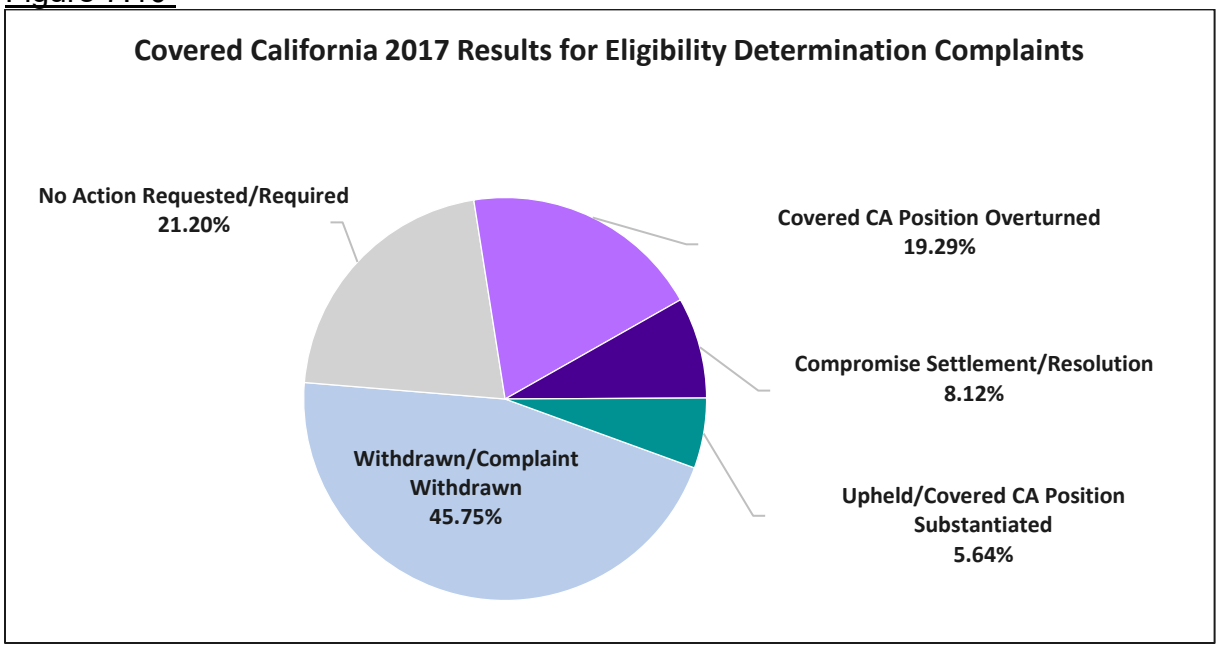
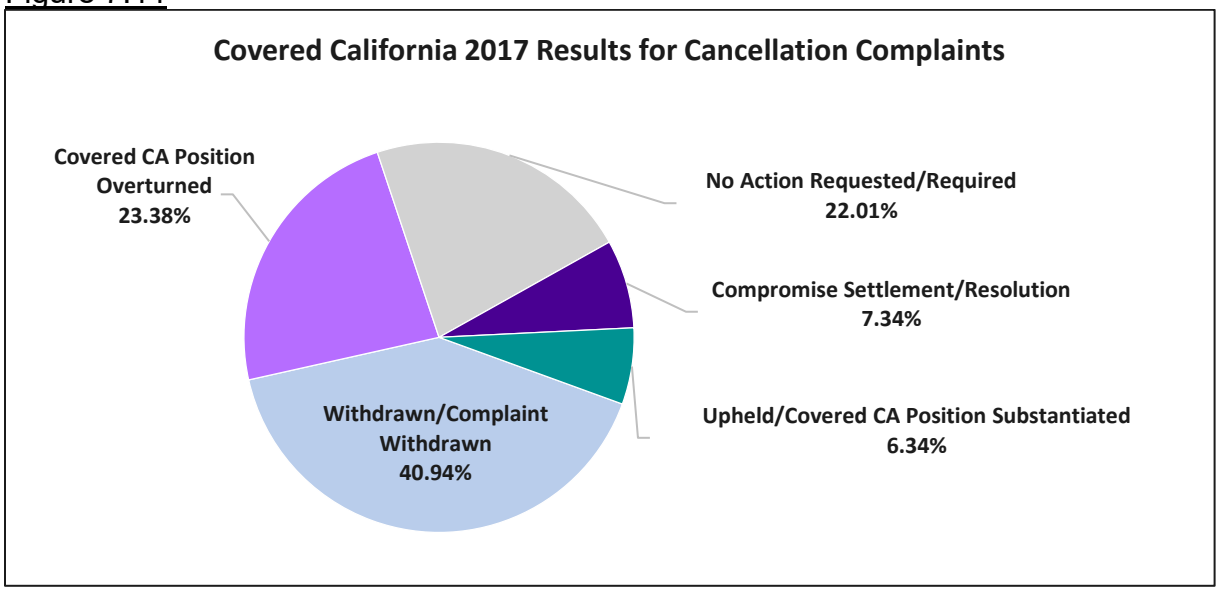


Figure 7.11



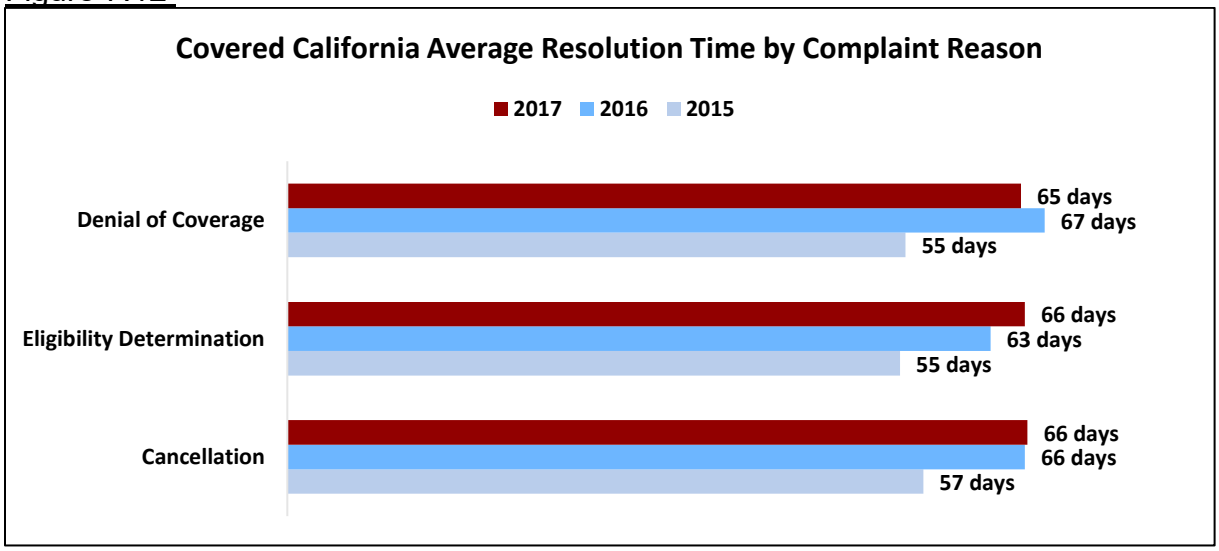
Resolution Time

Covered California complaints took on average 66 days to resolve in 2017, the same as in the prior year. Average durations decreased for both reported complaint types.

- Formal State Fair Hearings averaged 77 days (a nine-day decrease from the 86 day average in 2016), despite an increase in volume for this complaint type.
- State Fair Hearing: Informal Resolution cases averaged 52 days (a seven-day decrease from the 59 day average in 2016)

The following chart displays the annual average resolution times for the three complaint reasons submitted by Covered California over three years.

Figure 7.12



C. Demographics and Other Complaint Elements

Age

Covered California submitted 15,659 complaints with age identified for 2017 (0.2% of the complaints were Unknown). The average age of the complainants was 47 years old, same as the prior year.

- Distribution among the age groups were similar to the prior year. The most complaints continued to be for ages 35-54 (41% of complaints), followed by 55-64 (29%), 18-34 (24%), 65-74 (5.4%), 75 and older (0.3%), and under 18 (0.2%).
- Denial of Coverage remained the top complaint reason across all age groups.

Gender

A higher percentage of complaints had gender identified in 2017 than the prior year (98% identified in 2017, 84% in 2016). It is unknown the extent changes in reporting associated with the reduction in Unknown affected Male and Female categories.

- All gender categories decreased in volume from 2016.
- Fifty-three percent of complainants were Female and 45 percent Male, with both category distributions increasing from the prior year.
- The top complaint reasons were the same across all gender categories.

Race

A higher percentage of the 15,687 complaints in 2017 had race identified than the prior year (67% identified in 2017, 60% in 2016). It is unknown the extent changes in reporting associated with the reduction in Unknown affected categorization among known race categories.

- Complainants were identified as White (39%), Asian (13%), Other (10%), Black or African American (5%), American Indian or Alaska Native (0.4%), and Native Hawaiian or Other Pacific Islander (0.1%).
- Black or African American was the only race category that increased in both complaint volume (12% volume increase) and percentage distribution from 2016.
- The top complaint reasons were the same across all race categories.

Ethnicity

A higher percentage of Covered California's 15,687 complaints in 2017 had ethnicity identified than the prior year (87% identified in 2017, 73% in 2016). It is unknown the extent changes in reporting associated with the reduction in Unknown affected categorization among known ethnicity categories.

- Twenty-one percent were identified as Hispanic or Latino and 66 percent Not Hispanic or Latino.
- Denial of Coverage was the top reason for all ethnicity categories.
- Cancellation ranked second for Unknown, but was third most common for the known categories behind Eligibility Determination.

Language

A higher percentage of Covered California's 15,687 complaints in 2017 had primary language identified than the prior year (98% in 2017, 83% in 2016). It is unknown the extent changes in reporting associated with the reduction in Unknown affected categorization among known language categories.

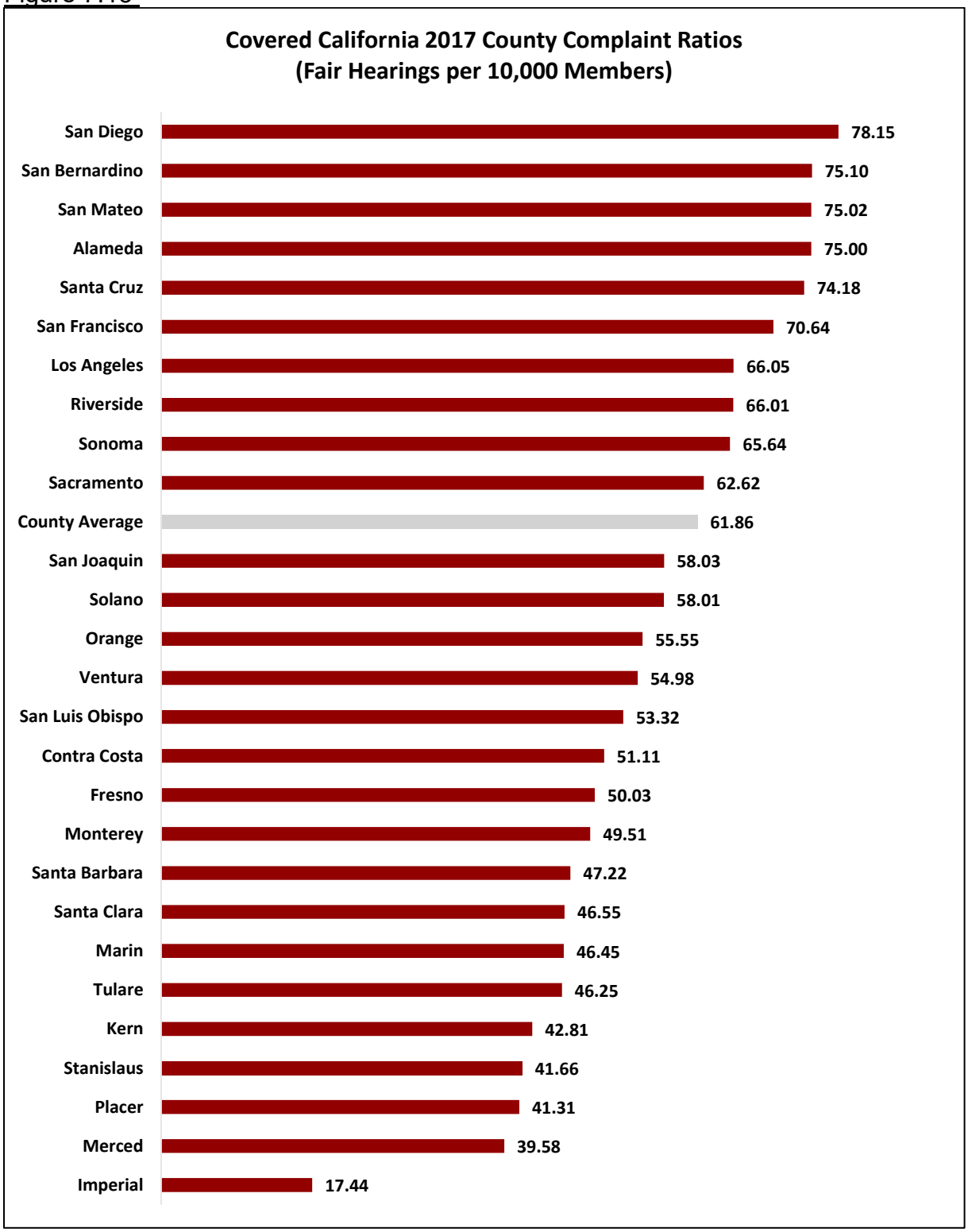
- Most complainants identified English (85%) as their primary language, followed by Spanish (9%), and Other languages (4%). The Other languages volume includes complaints reported as Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Tagalog, and Vietnamese.
- The top complaint reasons were the same for English, Spanish, Other languages, and Unknown.

County of Residence

Covered California identified County of Residence for all complaints reported for 2017, an improvement over 2016 (16% Unknown in 2016). Fifty-five of the 58 counties had at least one Covered California complaint closed in 2017.

The following chart displays complaint ratios by the county of residence identified for the complainant. The ratio is the county's volume of formal Covered California State Fair Hearings per 10,000 county residents enrolled in Covered California. The complaint volume does not include the informal resolution complaint type. Counties with ten or fewer complaints or under 10,000 Covered California enrollment are not shown.

Figure 7.13



Note: Counties not shown with ten or fewer complaints or under 10,000 Covered California enrollment: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

Mode of Contact

Telephone continued to be the most popular mode of contact used to initiate a complaint (65%), followed by email (14%), mail (9%), fax (8%), and counter/in-person (3%). Less than one percent of the complaints submitted by Covered California were unknown as to the mode of contact.

Regulator

Covered California's complaints do not address health plan issues and so do not have attributed regulator information. Covered California indicated that most (99.8%) of its members are enrolled in DMHC-regulated plans and less than one percent are enrolled in a CDI-regulated plan.

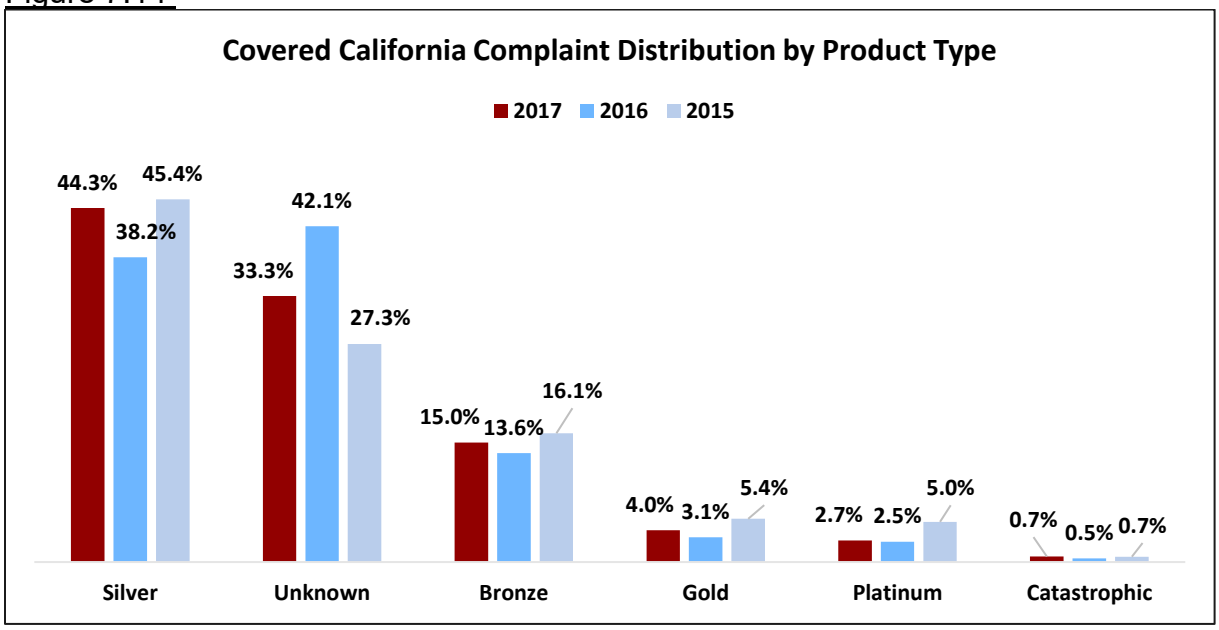
Source of Coverage

All 15,687 complaints reported for 2017 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. The product type was not identified for 33 percent of Covered California's 2017 complaints (5,226 Unknown).

Figure 7.14

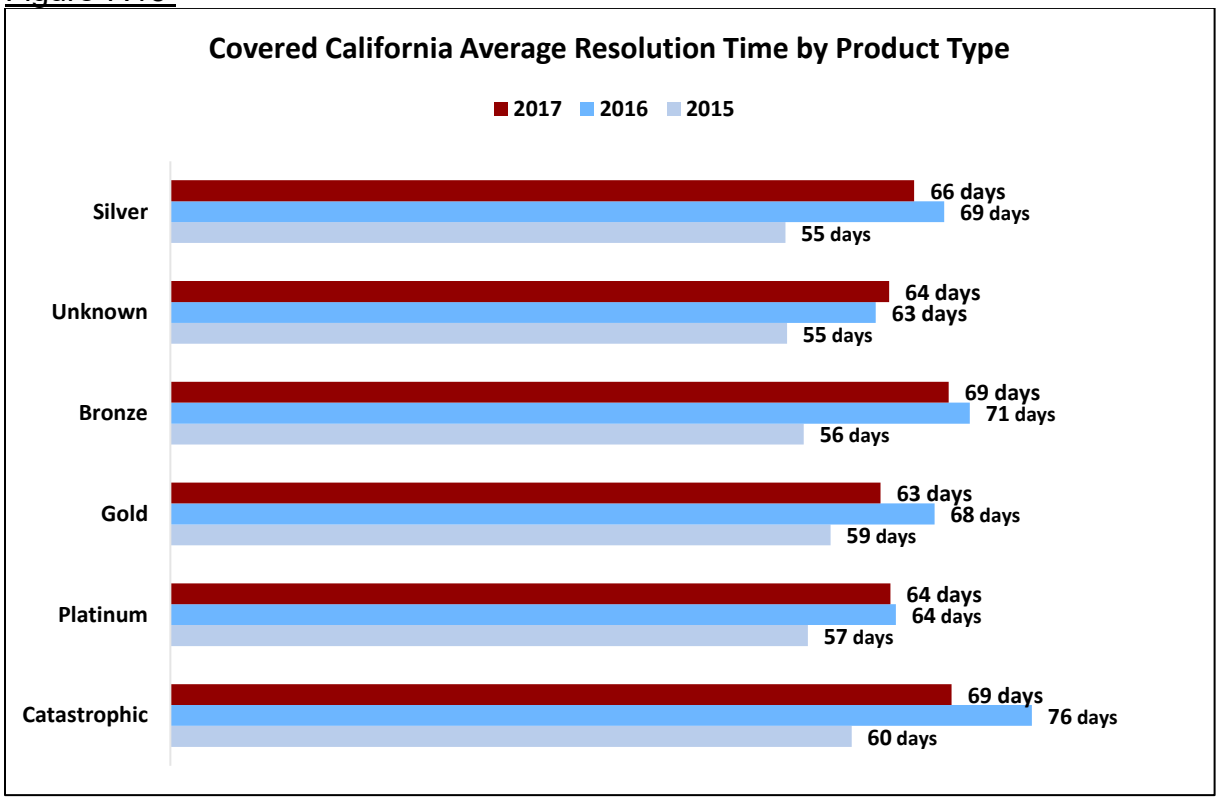


- The product type of Catastrophic indicates a minimum coverage plan only available to Covered California enrollees under age 30.

- 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.

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

Figure 7.15



D. Consumer Assistance Center Details

Covered California's Service Center reported receiving 5,878,671 inquiries from consumers in 2017, a decrease of nearly three percent over the 2016 volume (6,038,580). Most inquiries (95%) were made by telephone. Five percent were made via online chat.

Service Center Telephone Call Metrics

The Covered California Service Center received 5,557,327 telephone calls from consumers in 2017. The following table shows the survey response from Covered California regarding some of its service center telephone call metrics.

Figure 7.16

Covered California Service Center - 2017 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)	272,952	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	2,486,237	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	0:04:39	Data
Average length of talk time (time between a CSR answering and completing a call)	0:17:31	Data
Average number of CSRs available to answer calls (during Service Center hours)	865 Full-Time Equivalent	Estimated

Consumer Assistance Protocols and Systems

The Contra Costa County contract for call center services to support the Covered California Service Center ended mid-2017. Covered California continues to maintain two other call center locations in Rancho Cordova and Fresno, as well as a contract with a vendor to support call center operations during surge periods (Faneuil).

Covered California established a new Office of the Ombudsman in 2017, separating ombudsman functions from its Office of Legal Affairs. The Office of the Ombudsman is a resource for consumers who have issues they have been unable to resolve through Covered California's Service Center and established complaint and appeals processes.

Covered California also transitioned its Service Center contact center technologies to a new cloud-based system in September 2017 in order to improve functionality for its front-line customer service representatives, streamline processes, and increase capacity for the number of consumers that can be assisted by the Service Center. The new system also allows for enhanced data analytics and reporting.

Section 8 – Conclusion

OPA reviewed the fourth 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 2017 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

The four reporting entities submitted 49,024 consumer complaints to OPA for Measurement Year 2017, including non-jurisdictional complaints reported for the first time by CDI. The statewide jurisdictional complaint volume of 45,372 was a 19 percent decrease in volume over the prior year (55,923 complaints in 2016) due to decreases in complaints reported by three reporting entities – DMHC, DHCS, and Covered California. CDI was the only reporting entity that had an increased number of complaints, which the department attributed primarily due to improvements to its online complaint portal that made it easier for consumers and providers to file complaints.

Complaint Reason

Denial of Coverage remained the most common statewide complaint reason, as well as the top reason reported by Covered California.

- For DMHC, Medical Necessity Denial replaced Cancellation as the most common complaint reason. DMHC-reported complaints regarding the Covered California source of coverage for the Cancellation reason significantly decreased (44% decrease from 2016). Experimental/Investigational Denial complaints also decreased, which DMHC indicated was likely due in part to health plans adjusting policies and issuing fewer denials associated with digital breast tomosynthesis.
- Quality of Care was DHCS's most common reason in 2017. Fluctuation between measurement years among the DHCS top complaint reasons were due in part to reporting changes.
- Claim Denial remained CDI's top complaint reason.
- Complaint volumes for all three reason categories reported by Covered California (Denial of Coverage, Cancellation, and Eligibility Determination) decreased in volume from the prior year.

Complaint Results and Resolution Time

DMHC and CDI's top results remained Upheld/Health Plan Position Substantiated. DHCS's and Covered California's top result continued to be Withdrawn/Complaint Withdrawn, although the associated volume of cases reported by both entities decreased from the prior year.

The statewide average time to resolve a consumer health care complaint was 50 days, one day fewer than the 2016 average. Average resolution times decreased in 2017 for DMHC (6-day decrease), DHCS (one-day decrease), and CDI (10-day decrease). Covered California's average duration remained unchanged at 66 days.

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 2017 complaint data from DMHC, DHCS, and CDI.

- Eight of the ten DMHC-regulated health plans with the highest complaint ratios in 2017 had a lower ratio in 2017 compared to 2016 (among those over 70,000 enrollees).
- Most of the DHCS plans' statewide complaint ratios did not change much between 2016 and 2017.
- Three of the five CDI-regulated plans had a lower complaint ratio in 2017 than the prior year.
- Based on data reported by DMHC, Covered California plan complaint ratios dropped for all five displayed plans for Cancellation or Dis/Enrollment issues. All five plans' ratios for health care delivery issues either dropped or remained about the same.

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 moved to an annual data submission process for Measurement Year 2017 complaint data. This change was made based on feedback from the reporting entities to improve the efficiency of reporting processes.

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. California 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 enrollment in a qualified health plan in the individual market through the Exchange 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.
Administrative Law Judge	A judge who resolves claims or disputes involving administrative law.
Appeal	A kind of complaint in which a consumer asks for a review of a decision made by a health plan or coverage program.
Authorization Dispute	Complaint alleging that the insurer has improperly denied claim or assessed a penalty on the basis of required preauthorization not having been obtained.
Beneficiary	The person who benefits from an insurance policy or coverage program.
Benefits Identification Card (BIC)	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 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.
CalPERS (California Public Employees' Retirement System)	A source of coverage data element indicating the organization that provides health and other benefits to California public employees, retirees, and their families.
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. These plans also are called minimum coverage plans. Covered California minimum coverage plans are only available to people under age 30.
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 Reopened	Regulated entity or individual has reopened claim for further investigation or settlement negotiation. A final resolution of the claim has not been determined.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate. 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 enrollees during the same year. Some complaint ratios are based on the number of health plan complaints divided by the number of health plan enrollees. Some complaint ratios are based on the number of coverage complaints in a county divided by the number of county enrollees. The report displays complaint ratios as complaints per 10,000 members.
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.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.

Term	Explanation
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.
Consumer Received Requested Service	A complaint result indicating that the consumer received the requested service after the complaint was filed.
Continuation of Benefits	Complaint regarding COBRA (Comprehensive Omnibus Budget Reconciliation Act) enrollment and/or coverage after the insured no longer qualifies for group coverage.
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 amount 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, all Medi-Cal members are 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 Title 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.
Delays/No Response	Complaint alleging untimely response to, or failure to respond to, policyholder request for information.
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.
Denti-Cal	DHCS program that provides dental services to Medi-Cal members.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Discount Plan	A product type licensed by DMHC. Discount plan companies charge a membership fee for members to be able to access discounted prices for health care services from contracted providers. Discount plans are not insurance.

Term	Explanation
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.
Ethnicity	A demographic data category for the Complaint Data Report consisting of elements Hispanic or Latino, Not Hispanic or Latino, Unknown, and Refused.
Exchange	A product type indicating coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 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.
Fiscal Intermediary (FI)	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.
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.
Grandfathered	A product type indicating coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations). Grandfathered plans were made exempt from some provisions of the ACA.
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.

Term	Explanation
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 against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Care Delivery	The provision of health care services to members enrolled in a health plan or coverage program. Health care delivery complaints include those related to provider access, quality of care, and payment for services.
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/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.
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.

Term	Explanation
Limited Benefits 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 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.
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 Coordinated Care	A product type indicating a Medi-Cal managed care model approved by the federal government under an 1115 Waiver. The Coordinated Care Initiative’s Cal MediConnect demonstration project in certain counties provided beneficiaries with both Medicare and Medi-Cal (dual eligible) the option to receive all benefits in a single organized delivery system for medical, long-term care, and behavioral health services. The other major part of the initiative required all beneficiaries to join a Medi-Cal managed care plan to receive their Medi-Cal benefits, even if they opted out of Cal MediConnect or were not in a demonstration county.
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.

Term	Explanation
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 Supplement	A product type indicating coverage that provides for accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage. Medicare supplemental insurance is sometimes referred to as Medigap.
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.
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.
Modified Adjusted Gross Income (MAGI)	A specified methodology defining households and counting income used for determining eligibility for the most common forms of Medi-Cal and for financial assistance through Covered California.
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. For DHCS, this result indicates that the State Fair Hearing case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.
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 Health Coverage (OHC)	An inquiry topic reported by DHCS that refers to private health insurance that Medi-Cal members are required to report to ensure that Medi-Cal is the payer of last resort.
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.

Term	Explanation
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.
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. As a product type, indicates a plan that provides coverage for pharmacy benefits.
Plan/Staff Attitude and Service	A complaint reason alleging unacceptable attitude or treatment from a health plan's staff.
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.
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.
Premium Notice/Billing	A complaint reason alleging an insurer's failure to send notice regarding premium due date, premium increase/decrease, policy lapse, etc.
Preventive Care	Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, and other health problems. Most health plans must cover certain preventive services at no cost to the plan enrollee. Complaint regarding coverage for expenses arising out of preventive care/wellness services and/or chronic disease management, to include complaints about an insurer's assessment of cost-sharing (improper application of co-payments, deductibles, and co-insurance) for such services.
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.

Term	Explanation
Provider	A health professional or heath practitioner who provides preventative, curative, promotional, or rehabilitative health care services. For this report, provider may refer to an individual or a hospital, clinic, medical group, or other group of professionals that provide medical services.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
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	Government entity that has the authority to oversee and enforce relevant laws and regulations that apply to a health plan. The oversight of commercial insurance includes laws and regulations related to licensing, product regulation, financial regulation, and market conduct. 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), Out of State Department of Insurance, Other, and Unknown.
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.
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).

Term	Explanation
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report, this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
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.
Share of Cost	An inquiry type reported by DHCS indicating the amount in health care costs certain Medi-Cal beneficiaries must pay each month before Medi-Cal pays for their care. The Share of Cost is determined by a beneficiary's income.
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.
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.

Term	Explanation
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 by Covered California before the State Fair Hearing took place.
State Specific (Other)	A complaint data element indicating an element that is state-specific and cannot be conveyed with other available options. Reporting entities use further internal coding to track data as needed.
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 (TAR)	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.
Uninsured	A product type and source of coverage data element reported by DMHC indicating that the complainant was not enrolled in a health plan or public coverage program at the time of filing the complaint. Other reporting entities may categorize product type and source of coverage by the coverage the uninsured complainant lost and/or was seeking.
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.
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.

Term	Explanation
Urgent Nurse Complaint (or Urgent Nurse Case)	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.
Vision	Health insurance coverage for eye examinations and eyeglasses or contact lens prescriptions.
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 complaint result indicating that 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
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

Complaint Result	Current Definition	Effect on Consumer
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. For DHCS, this result indicates that the State Fair Hearing case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.	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
Refund	A refund was made to the claimant.	Favorable to Consumer
State Specific (Other)	A complaint data element indicating a complaint result that is state-specific and cannot be conveyed with other available options. Reporting entities use further internal coding to track data as needed.	Neither Favorable nor Unfavorable
Unable to Assist	Lacked the necessary power, authority, or means to resolve the complaint.	Neither Favorable nor Unfavorable

Complaint Result	Current Definition	Effect on Consumer
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

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Published March 2019