# Annual Health Care Complaint Data Report

## Report to the Legislature for Measurement Year 2020


STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Mark Ghaly, Secretary

CENTER FOR DATA INSIGHTS AND INNOVATION
John Ohanian, Director and Agency Chief Data Officer

## Statutory Requirement

Assembly Bill 172 (Chapter 696, Statutes of 2021) added the following provision in law: Health and Safety Code §130204 (requirements previously under §136000).

> (b) The center shall produce an annual report to be made publicly available on the center's internet website by December 31, 2022, 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 State Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:
>
> (1) The types of calls received and the number of calls.
>
> (2) The call center's role with regard to each type of call, question, complaint, or grievance.
>
> (3) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.
>
> (4) The protocol for referring or transferring calls outside the jurisdiction of the call center.
>
> (5) The call center's methodology of tracking calls, complaints, grievances, or inquiries.
>
> (c) (1) The center may collect 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, insurer or plan data, appeals, 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 center shall submit a report by December 31, 2022, 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.
>
> (2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the center data concerning call centers to meet the reporting requirements in this section in the time, data elements, manner, and format requested by the center.
>
> (3) For the purpose of publicly reporting information as required in paragraph (1) and this paragraph about the problems faced by consumers in obtaining care and coverage, the center shall analyze data on consumer complaints, appeals, and grievances resolved by the agencies listed in subdivision (b), 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 through the CDII webpage: www.chhs.ca.gov/home/data/

Additional report documents can be found via the OPA webpage: www.opa.ca.gov/ComplaintsReports/

# Contents

# Section 1 – Executive Summary

The Center for Data Insights and Innovation (CDII) is statutorily required to produce an annual multi-departmental Complaint Data Report under the authority and specifications established by AB 172 (Chapter 696, Statutes of 2021). The reporting requirements transitioned to CDII from the Office of the Patient Advocate (OPA), which had originally been mandated to develop a baseline Complaint Data Report and annual reports thereafter by AB 922 (Chapter 552, Statutes of 2011).

Statute specifies four state reporting entities that are required to provide data to CDII (and previously to OPA): the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California).

Complaints addressed through this report include written or oral complaints, grievances, appeals, independent medical reviews, hearings, and similar processes to resolve a consumer's problem or dispute. DMHC and CDI reported complaint data from their respective consumer assistance service center divisions. DHCS and Covered California reported complaint data from the California Department of Social Services (CDSS) State Fair Hearings Division.

This seventh annual Complaint Data Report catalogs 35,139 jurisdictional complaints for Measurement Year 2020 (complaints closed January 1 – December 31, 2020).

- DMHC submitted 15,884 complaints from its 27,681,442 plan enrollees.
    - The DMHC 2020 complaint volume was only slightly lower (0.2%) than the prior year, but represented the fourth straight year of a decrease.
- DHCS submitted 4,959 complaints from its 12,516,576 beneficiaries.
    - The DHCS 2020 complaint volume was only slightly lower (0.3%) than the prior year, but also represented the fourth straight year of a decrease.
- CDI submitted 3,217 complaints from its 2,399,058 plan enrollees.
    - The CDI 2020 complaint volume was 30 percent (30.5%) lower than the prior year.
    - CDI reported 7,020 total complaints, including non-jurisdictional complaints that closed with a referral to an outside agency or department or similar result.
- Covered California submitted 11,079 complaints from its 1,527,722 plan enrollees and other applicants.
    - The Covered California 2020 complaint volume was 11 percent (11.3%) higher than the prior year.
    - Covered California noted that the increase in complaints is associated with an increase in applications in 2020 and related appeals about the eligibility determinations and enrollment.

The 2020 top five statewide complaint reasons (with percentage distribution):

1. Denial of Coverage (17.3%)
2. Medical Necessity Denial (11.1%)
3. Eligibility Determination (9.9%)
4. Co-Pay, Deductible, and Co-Insurance Issues (6.9%)
5. Pharmacy Benefits (5.1%)

The 2020 top five statewide complaint results (with percentage distribution):

1. Upheld/Health Plan Position Upheld (35.0%)
2. Withdrawn/Complaint Withdrawn (27.8%)
3. Compromise Settlement/Resolution (9.8%)
4. Advised Complainant (7.2%)
5. Overturned/Health Plan Position Overturned (6.6%)

The order of the top results is not directly associated with the order of the top reasons.

The 2020 complaint resolution times:

- Statewide - 34 days on average (ranging from 0 to 570 days)
- DMHC - 24 days on average (ranging from 0 to 183 days)
- DHCS - 47 days on average (ranging from 0 to 528 days)
- CDI - 64 days on average (ranging from 0 to 570 days)
- Covered California - 36 days on average (ranging from 0 to 333 days)

Differences in complaint systems make direct comparisons between the reporting entities inexact for many of the complaint categories. Because of this, much of the data analyses remain separated in the respective sections about each reporting entity rather than in the aggregated statewide analysis. In addition, it is important to note that some differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence or performance.

Although this report notes some standout issues in the statewide and entity-specific sections, more in-depth research would be required to understand the full impact of the COVID-19 pandemic on the complaints consumers filed with state programs about their health care coverage and services.

## Section 2 – Background and Methodology

The Center for Data Insights and Innovation (CDII) is statutorily charged under the California Health and Safety Code §130204 with implementation of a multi-departmental complaint data reporting initiative. CDII took over this requirement from the Office of the Patient Advocate (OPA) in October 2021 after the enactment of AB 172 (Chapter 696, Statutes of 2021). CDII is now 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").

This seventh year Complaint Data Report evaluates health care complaints closed January 1 through December 31, 2020, and other information collected by OPA (now CDII) from the four state reporting entities about their service centers' 2020 consumer assistance activities. For some categories, CDII also displays data from the 2018 and 2019 measurement years.

DMHC, DHCS, CDI, and Covered California submitted to OPA (now CDII) non-aggregated complaint data 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 2020 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)

Although OPA (now CDII) and the reporting entities continued to collaborate to standardize and enhance reporting, it is important to keep in mind that the data presented in this report may provide an imperfect comparison between measurement years, reporting entities, coverage types, and similar categories. Because of the differences in complaint systems, many data categories are displayed in separate reporting entity sections rather than aggregated statewide.

More information about the report methodology and the glossary of terms are available online through the CDII / OPA webpage: [www.opa.ca.gov/ComplaintsReports/](www.opa.ca.gov/ComplaintsReports/)

# 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 the Office of the Patient Advocate, which has since transitioned to the new Center for Data Insights and Innovation (CDII), data about health care complaints and other information about their consumer assistance service centers. The service centers are the help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by the entity.

Sections 4-7 have additional data and information on the individual reporting entities. The complaints reported by each entity differ significantly due to variances in functions, complaint systems, and data availability. CDII urges caution about drawing conclusions when comparing information across entities and coverage sources.

- DMHC reported complaints regarding health plan issues for both health care delivery and enrollment, including those about commercial plans, most Covered California plans, and certain Medi-Cal plans.
- DHCS reported formal State Fair Hearings about Medi-Cal eligibility and enrollment and about some health care delivery issues, including Medi-Cal managed care plan benefits.
- CDI reported complaints about the health insurance companies and producers it regulates and non-jurisdictional complaints referred to other entities.
- Covered California reported State Fair Hearings requested about eligibility determinations and enrollment, including dual agency appeals involving Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal.

**Figure 3.1 Reporting Entity 2020 Complaints and Enrollment**

| Reporting Entity | Complaint Volume | Total Number of Enrollees |
|---|---|---|
| DMHC | 15,884 | 27,681,442 |
| DHCS | 4,959 | 12,516,576 |
| CDI | 7,020 | 2,399,058 |
| Covered California | 11,079 | 1,527,722 |

*Note: Due to differences in timing and reporting methodologies, the data in this table may not match data published by the departments in other reports. Direct comparisons across entities are imprecise due to variances in entity complaint and reporting systems. Enrollment volumes likely include individuals who are counted more than once from enrollment in multiple plans and across entities. CDI's complaint total includes non-jurisdictional complaints not reported for years prior to 2017.*

The reporting entities noted that the COVID-19 pandemic had the following impact on complaints in 2020:

- DMHC reported that there were observable shifts in some of its complaint treatment categories, which may be due in part to the COVID-19 pandemic but are difficult to attribute to any particular factor at this time.
- DHCS indicated that the department did not see a significant impact on complaints and inquiries received from Medi-Cal beneficiaries due to COVID-19.
- CDI noted that the department detected shifts in volumes for some complaint reasons due to the pandemic. For example, there was an increase in complaints from consumers seeking premium refunds due to physician office closures and a decrease in complaints involving claims for selective medical procedures.
- Covered California indicated that its volumes of complaints and inquiries increased as it handled a surge in applications from consumers seeking health coverage during the 2020 COVID-19 special enrollment period. Nearly 200,000 more Californians gained coverage with Covered California in 2020 compared to the prior year (an increase of 13%).

## B. Statewide Consumer Assistance Centers

The following state service centers reported 2020 consumer assistance data to CDII:

- DMHC Help Center
- DHCS Medi-Cal Office of the Ombudsman
- DHCS Medi-Cal Telephone Service Center
- DHCS Medi-Cal Dental Telephone Service Center
- CDI Consumer Services Division
- Covered California Service Center

These service centers collectively received 7,830,377 requests for assistance from consumers in 2020, the highest volume ever submitted for this report. Rather than complaint initiations, nearly all of the statewide requests for assistance (99.6%) were inquiries from consumers who required information, referrals, or other assistance.

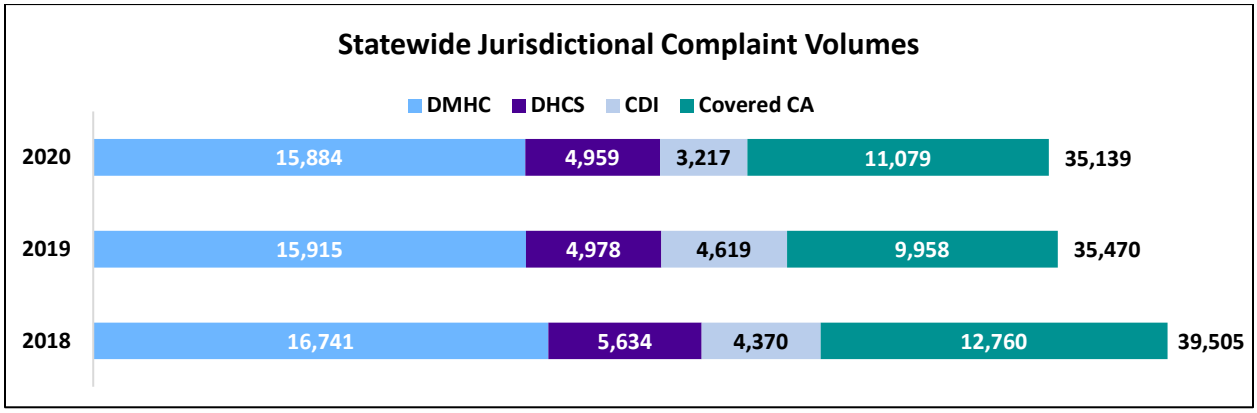
- The 21 percent increase in statewide requests for assistance from the prior year (6,458,041 requests in 2019) is primarily attributable to a 28 percent increase in inquiries to Covered California from consumers seeking health coverage.
- The Medi-Cal Telephone Service Center was the only DHCS service center to experience an increase in inquiries from 2019 to 2020, with six percent more inquiries received.
- Requests for assistance fell for both regulators, DMHC and CDI.

## C. Statewide Health Care Complaint Data

DMHC, DHCS, CDI, and Covered California reported a combined volume of 35,139 jurisdictional complaints closed in 2020, a slight decrease from the previous year (35,470 in 2019).

- Covered California was the only entity with an increased complaint volume in 2020 compared to the prior year, driven by a spike in applications for coverage during the 2020 COVID-19 special enrollment period.
    - With a surge in applications, there was a significant increase in complaints resolved by Covered California to address eligibility and enrollment issues.
    - Covered California noted that internal improvements and staff training allowed for more complaints to be addressed informally without requiring a formal State Fair Hearing.

**Figure 3.2**

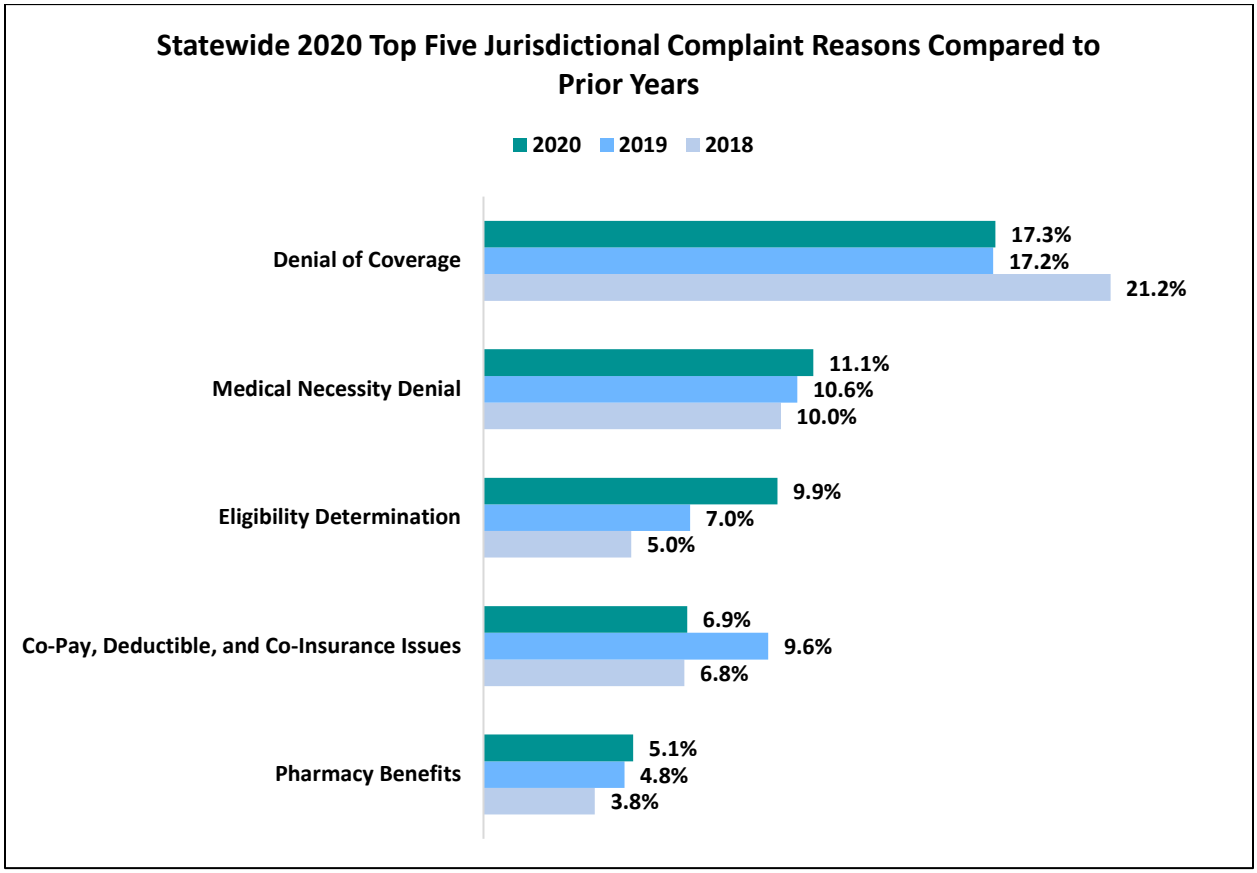



*Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution. The DMHC totals include non-jurisdictional complaints, including 1,567 non-jurisdictional complaints reported for 2020.*

### Complaint Reasons

The following chart displays the most common reasons for the 35,139 jurisdictional complaints closed in 2020, along with the 2018 and 2019 data for the same categories.

**Figure 3.3**



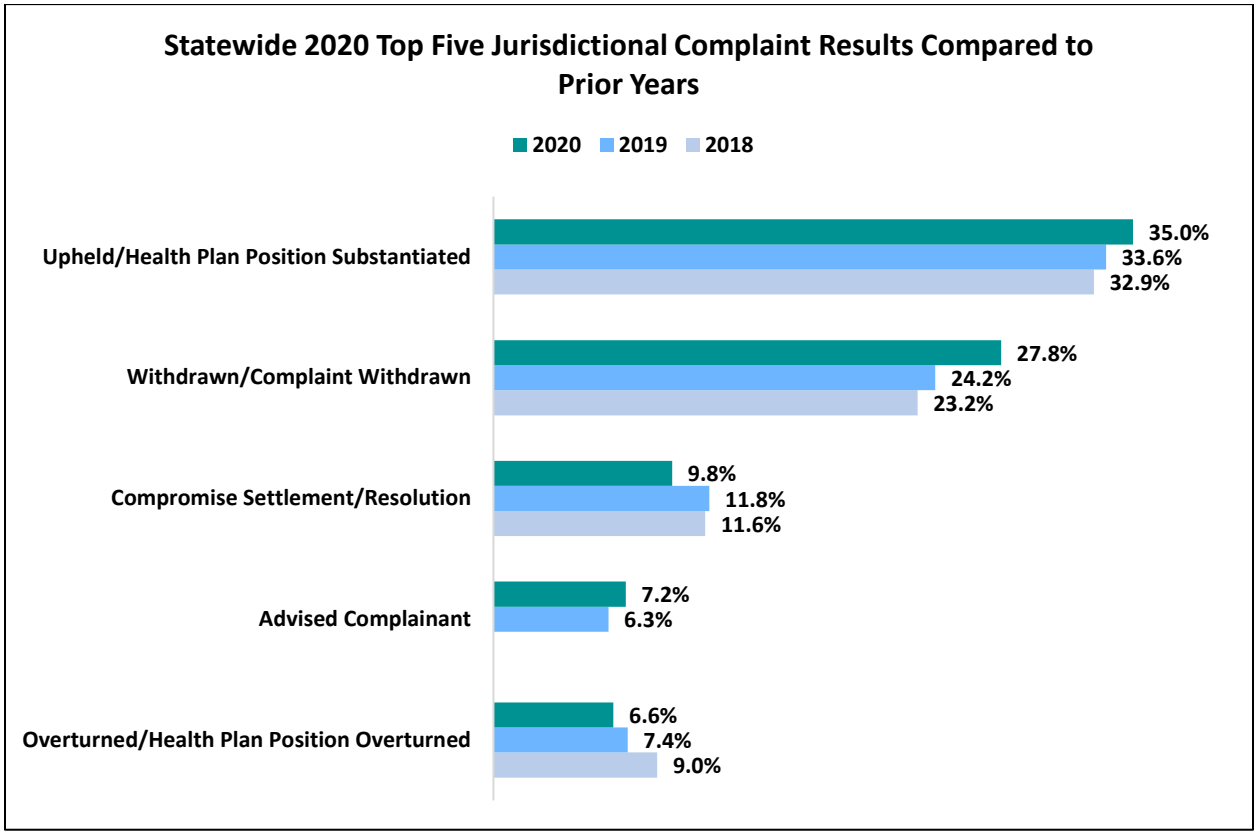

*Note: The number of reasons exceeded the number of complaints because some cases had more than one reason submitted (43,185 reason entries from the 35,139 complaints in 2020). Some differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.*

## Complaint Results

The following chart displays the most common results for the 35,139 jurisdictional complaints closed in 2020, along with the 2018 and 2019 data for the same categories.

- Results categories considered as favorable to the complainant include: Overturned/Health Plan Position Overturned and Compromise Settlement/Resolution.
- Categories considered as 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.

**Figure 3.4**




*Note: The number of results exceeded the number of complaints because some cases had more than one result reported (45,444 results entries from the 35,139 complaints in 2020). Differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.*

## Resolution Time

The 2020 statewide average complaint resolution time was 34 days, a seven-day decrease from the 2019 average. The complaint resolution time is counted from the day a reporting entity opened the consumer complaint until the day the reporting entity closed the case.

- The 17 percent decrease in the statewide average is likely due to a combination of factors, including the decreased number of complaints with outlier durations due to regulatory activities and increased proportions of complaint types that typically have shorter review periods.

**Figure 3.5 2020 Complaint Resolution Times (in Days) by Reporting Entity**

| Reporting Entity | Minimum Duration | Maximum Duration | Average Resolution Time |
|---|---|---|---|
| DMHC | 0 | 183 | 24 |
| DHCS | 0 | 528 | 47 |
| CDI | 0 | 570 | 64 |
| Covered California | 0 | 333 | 36 |

*Note: The analysis excludes CDI's submitted non-jurisdictional complaints, which took four days on average to resolve in 2020.*

It is important to note that meaningful conclusions about performance cannot be drawn when comparing entity resolution times due to differences in complaint review protocols and tracking systems. For example, a longer duration may be due to:

- A close date representing the date additional oversight or enforcement activities were completed rather than when the case was closed to the consumer.
- A tracking system that counts the open date of re-opened complaints as the initial filing date instead of the date the case was re-opened.
- A case opened at the initial stage of an overall complaint process, which typically requires more time for gathering information pertinent to the complaint review from the involved parties.

**Demographic and Other Complaint Categories**

Sections 4-7 outline additional details about demographic and other complaint elements submitted by each reporting entity. The 2020 statewide complaint distributions were similar to prior years' distributions for most categories.

For the primary language of the complainant, English continued to account for most of the statewide complaints (83.4% of the 35,139 complaints in 2020), Refused/Unknown for around eight percent (8.0%), Spanish for approximately five percent (5.2%), and Other Languages combined for around three percent (3.4%).

The following table displays the top complaint reasons reported by primary language, along with each reason's percentage distribution for the specified language.

**Figure 3.6 Statewide 2020 Top Five Complaint Reasons by Primary Language**

| Rank | English (% of English) | Spanish (% of Spanish) | Other Languages (% of Other) | Refused/Unknown (% of Refused/Unknown) |
|---|---|---|---|---|
| 1 | Denial of Coverage (18.1%) | Denial of Coverage (22.5%) | Denial of Coverage (18.4%) | Pharmacy Benefits (32.9%) |
| 2 | Medical Necessity Denial (10.9%) | Eligibility Determination (18.5%) | Eligibility Determination (14.6%) | Claim Denial (18.9%) |
| 3 | Eligibility Determination (9.7%) | Medical Necessity Denial (9.6%) | Medical Necessity Denial (8.1%) | Medical Necessity Denial (16.0%) |
| 4 | Co-Pay, Deductible, and Co-Insurance Issues (7.5%) | Quality of Care (5.8%) | Co-Pay, Deductible, and Co-Insurance Issues (6.6%) | Eligibility Determination (4.5%) |
| 5 | Delays/No Response (5.0%) | Scope of Benefits (5.3%) | Scope of Benefits (5.4%) | Denial of Coverage (4.0%) |

# Section 4 – Department of Managed Health Care

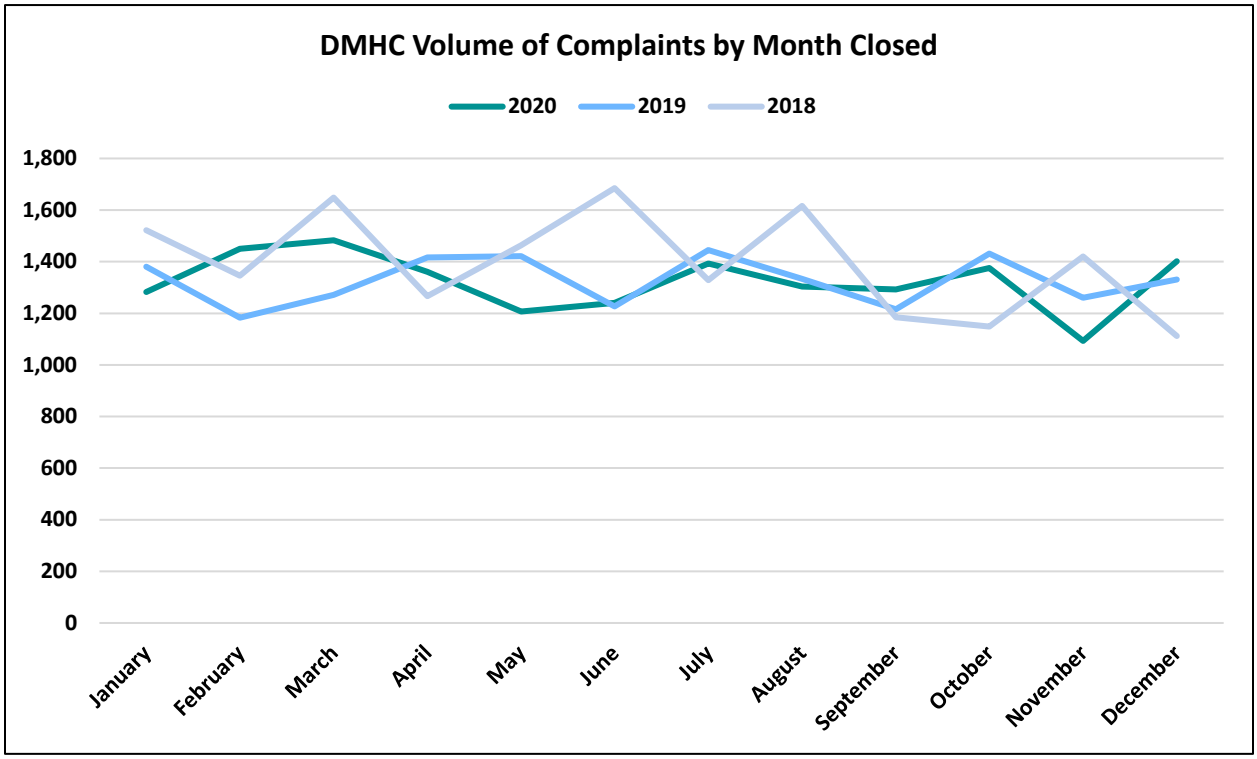
## A. Overview

The Department of Managed Health Care (DMHC) regulates 95 percent of enrollment in state-regulated health plans. The DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services.

In 2020, DMHC's Help Center received 130,233 requests for assistance from consumers. The annual volume of complaints closed decreased slightly from 15,915 in 2019 to 15,884 complaints in 2020.

While the DMHC did not experience a rise in the overall volume of complaints in 2020, the department noted that there were observable shifts among consumer complaints by the disputed treatment category, including an increase in complaints concerning mental health, diagnostic image and screening, diagnostic/MD evaluation, and pharmacy. Although it's difficult to pinpoint the exact reason for these shifts during 2020, the department continues to analyze the complaint data to identify trends that may be attributable to COVID-19.

**Figure 4.1**




The following table outlines DMHC's complaint standards for its four reported complaint types. Most of DMHC's 2020 complaints were the Standard Complaint type (70.8% of

the 15,884 complaints), followed by Independent Medical Review (25.9%), Quick Resolution (2.8%), and Urgent Nurse Case (0.4%).

**Figure 4.2 DMHC Help Center Complaint Standards**

| Complaint Type | Primary Unit(s) Responsible and Roles | Time Standard | Average Resolution Time in 2020 |
|---|---|---|---|
| Standard Complaint | Contact Center: Intake and routing<br>Independent Medical Review/Complaint Branch: Casework<br>Legal Affairs Branch: Casework for more complex legal cases | 30 days, from receipt of a completed complaint application | 24 days |
| Independent Medical Review (IMR) | Contact Center: Intake and routing<br>Independent Medical Review/Complaint Branch: Casework<br>IMR Contractor (MAXIMUS or IPRO): External Review decision<br>Legal Affairs Branch: Legal review if needed | 45 days, from receipt of a completed IMR application<br>7 days for cases that qualify for an expedited IMR | 23 days<br>Calculation includes time prior to the completion of the IMR application and time for the adoption of the determination |
| Urgent Nurse | Contact Center: Intake, initial casework, and routing<br>Independent Medical Review/Complaint Branch: Casework, opens an IMR if an external review is needed | N/A | 14 days<br>Calculation includes time after the case is closed to the consumer while services received are confirmed |
| Quick Resolution | Contact Center: Intake and casework resolution | N/A | 4 days |

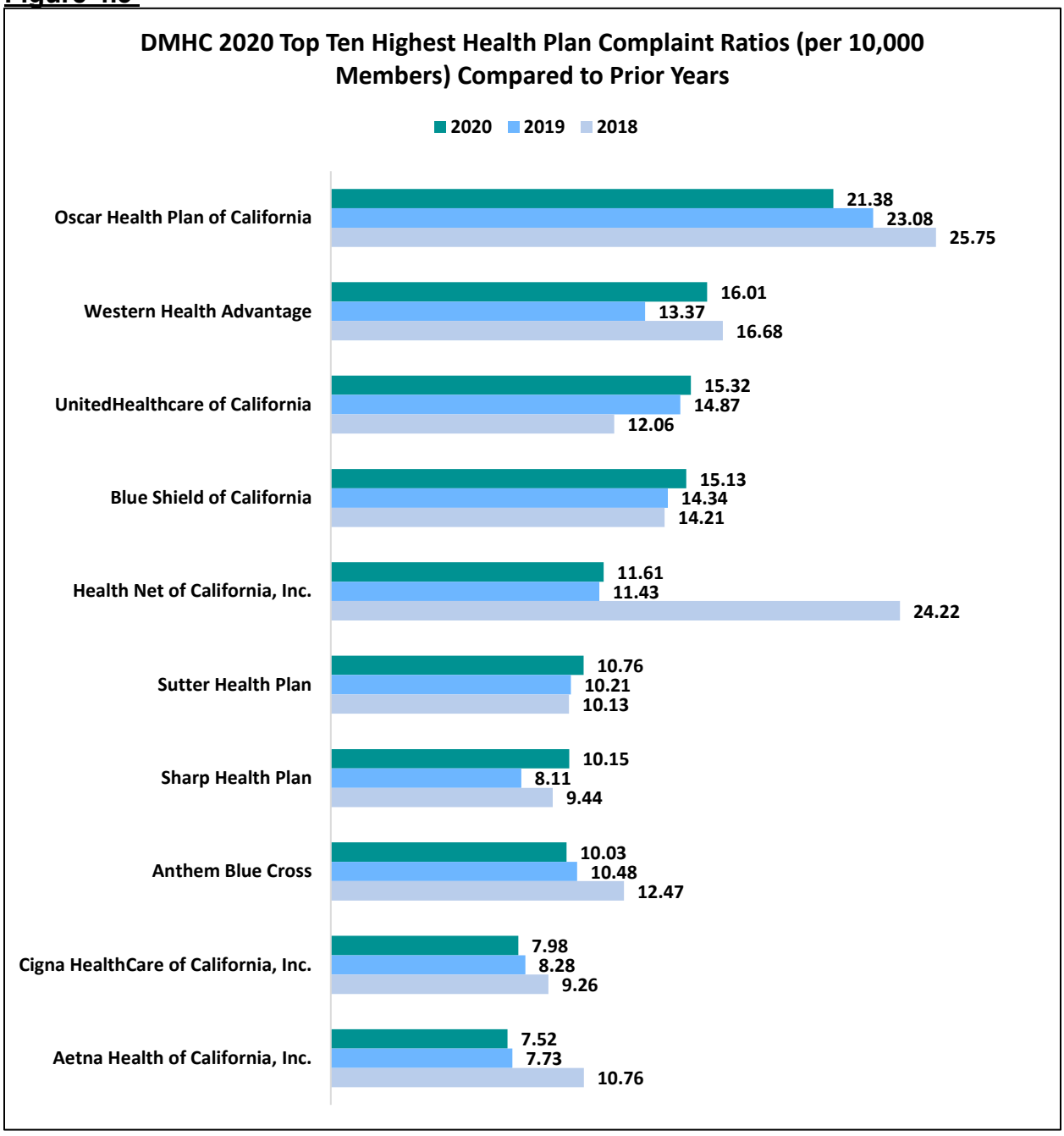
*Note: The timeframes for DMHC's time standards are based on the date the DMHC receives a completed complaint/IMR application. DMHC may review complaints involving consumers with urgent clinical issues as Urgent Nurse Case complaints, or through expedited IMR and Standard Complaint processes.*

## B. Complaint Ratios, Reasons, and Results

### Health Plan Complaint Ratios

The following chart displays the DMHC-regulated full-service health plans with the highest complaint ratios in 2020 among plans with enrollment over 70,000 members.

**Figure 4.3**




*Note: The display excludes health plans with enrollment under 70,000 members in 2020. The 2020 ratio for Anthem Blue Cross consists of data reported for Blue Cross of California and Blue Cross of California Partnership Plan. The 2019 and 2020 ratios for Aetna Health of California, Inc. also include data reported for Aetna Better Health of California Inc. For the trend comparisons, the data was not separated.*

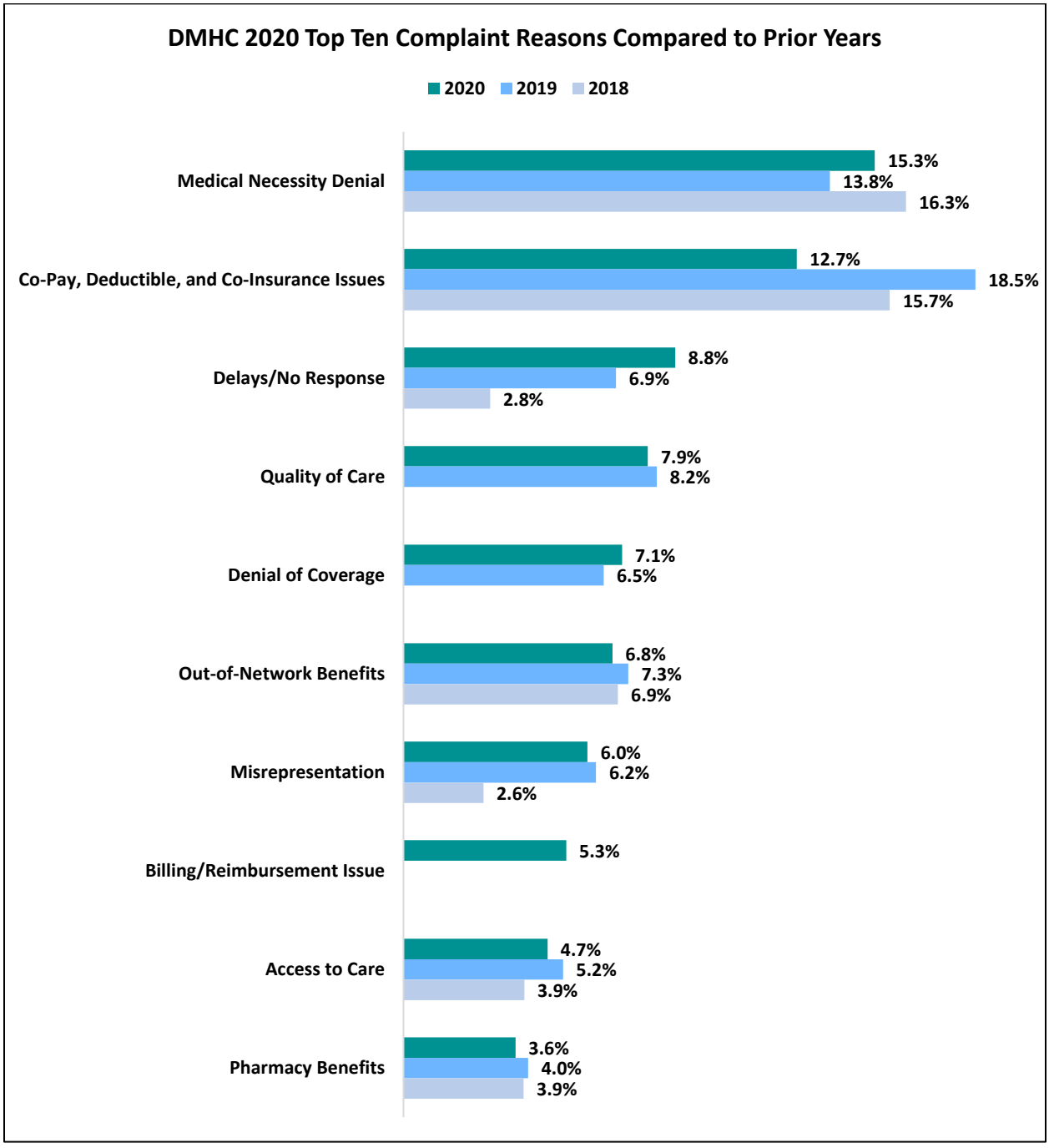
## Complaint Reasons

The following chart displays the most common complaint reasons reported by DMHC in 2020, as well as the 2018 and 2019 data for those same reason categories. The volume of reasons reported exceeded the number of complaints because many complaint cases had more than one reason reported.

Some differences between measurement years may be due in part to reporting changes rather than changes in incidence. For example:

- For MY 2020, some complaints previously submitted as Co-Pay, Deductible, and Co-Insurance were reported for the first time as Billing/Reimbursement Issue.
- Starting MY 2019, some complaints previously submitted under other categories were reported for the first time as Quality of Care or as Denial of Coverage.

**Figure 4.4**



### Inquiry Topics and Referrals

The following table displays the most common topics of inquiries and complaints in 2020 that were outside of DMHC's jurisdiction to address. For each inquiry topic, referral organizations are listed in order of most common referral to least common referral.

The volumes shown are only those addressed by the DMHC Help Center staff and do not include certain common calls addressed within DMHC's Interactive Voice Response system, such as for automated referrals to Covered California, Health Care Options, and particular health plans.

**Figure 4.5 DMHC Help Center 2020 Top Non-Jurisdictional Inquiries**

| Ranking | Inquiry Topic | Volume | Organization(s) Referred To |
|---|---|---|---|
| 1 (most common) | General Inquiry/Information | 4,556 | Department of Health Care Services (DHCS), Covered California, Other, Health Insurance Counseling and Advocacy Program (HICAP), California Department of Insurance (CDI), Centers for Medicare and Medicaid Services (CMS), U.S. Department of Labor (DOL) – South, DOL-USA |
| 2 | Provider Service/Attitude | 842 | Department of Consumer Affairs (DCA), California Department of Public Health (CDPH), HICAP, Other, DHCS, Federal Health and Human Services (HHS) |
| 3 | Claims/Financial | 734 | CDI, HICAP, DCA, Out-of-State Department of Insurance (DOI), Covered California, Other, DHCS, DOL-USA, CMS, DOL-South, CDPH |
| 4 | Enrollment Disputes | 506 | Covered California, DHCS, HICAP, Other, CDI, DOL-South, California Department of Social Services (CDSS) |
| 5 | Coverage/Benefits Dispute | 412 | HICAP, DHCS, DCA, CDI, CMS, CDSS, Out-of-State DOI, Covered California |
| 6 | Access Complaints | 325 | DHCS, DCA, HICAP, CMS, CDSS, Other, Federal HHS, Covered California |
| 7 | Plan Service/Attitude | 136 | HICAP, Federal HHS, DHCS, DCA, CMS, Other, CDI, Covered California |
| 8 | Coordination of Care | 120 | HICAP, DHCS, DCA, CMS, Other, CDPH, CDSS, Out-of-State DOI |
| 9 | Appeal of Denial – Independent Medical Review | 42 | CDI, DCA, DHCS, CDSS, HICAP, Other, Out-of-State DOI, CALPERS, CMS |

*Note: The volume is a count of issues within a call case. In the Help Center's Customer Relationship Management system, a case can record up to three issues. As a result, the total number of issues (7,673) is greater than the total number of non-jurisdictional call cases (7,267) reported in Figure 4.15.*

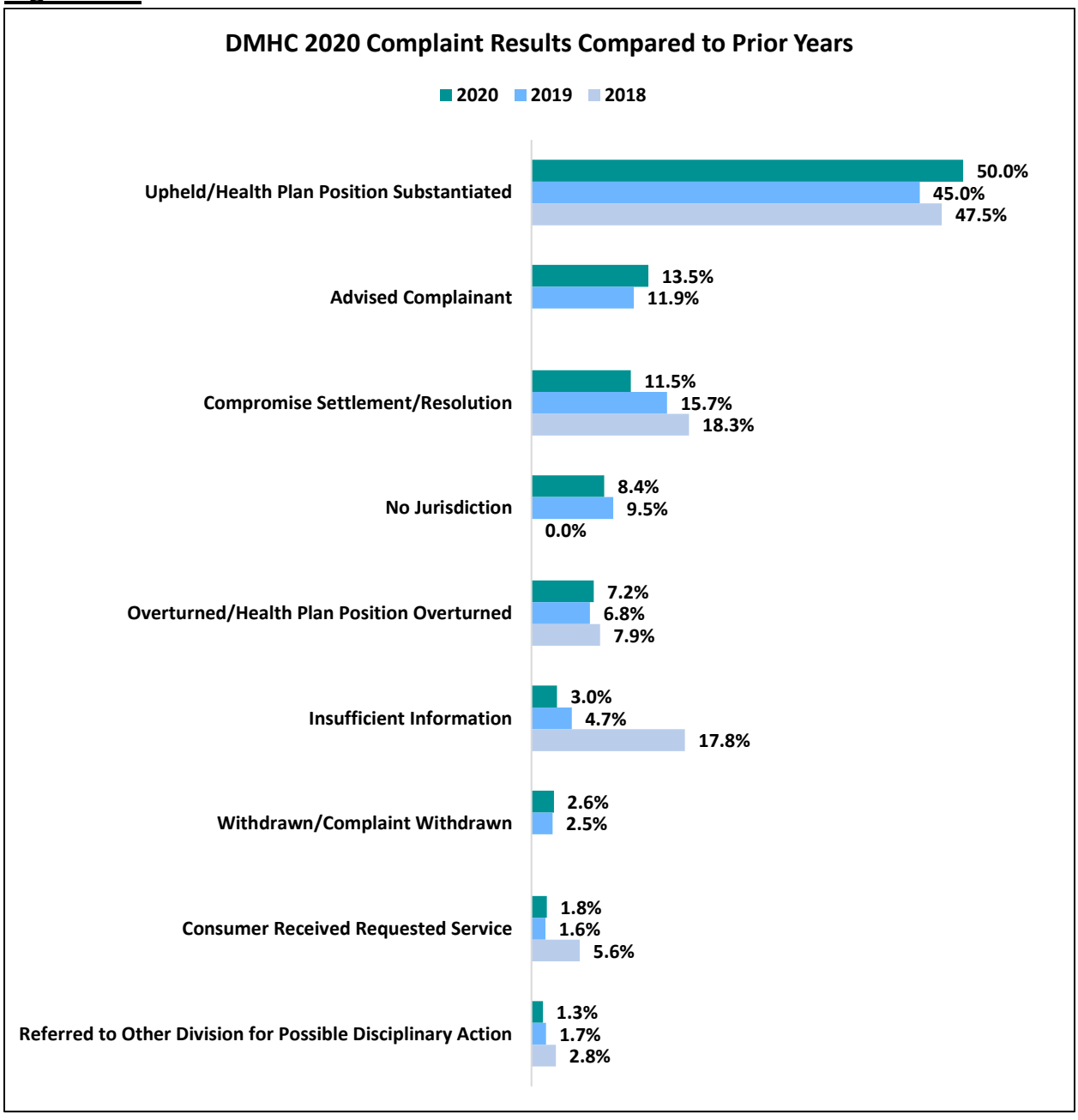
### Complaint Results

The following chart displays DMHC's 2020 complaint results, along with the 2018 and 2019 data for those same results categories.

Some differences may be due in part to changes in data collection and reporting rather than changes in incidence. For example:

- For MY 2019, some complaints previously submitted under other categories were reported as Advised Complainant, Withdrawn/Complaint Withdrawn, or as No Jurisdiction.

**Figure 4.6**




*Note: Two results categories with low volumes were excluded from the display: Claim Settled and Policy Not in Force. Results categories considered to be favorable to the consumer complainant include: Overturned/Health Plan Position Overturned; Consumer Received Requested Service; Compromise Settlement/Resolution; and Referred to Other Division for Possible Disciplinary Action. Results considered to be favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories shown 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 three figures display the 2020 results for DMHC's most commonly reported complaint reasons.

**Figure 4.7**

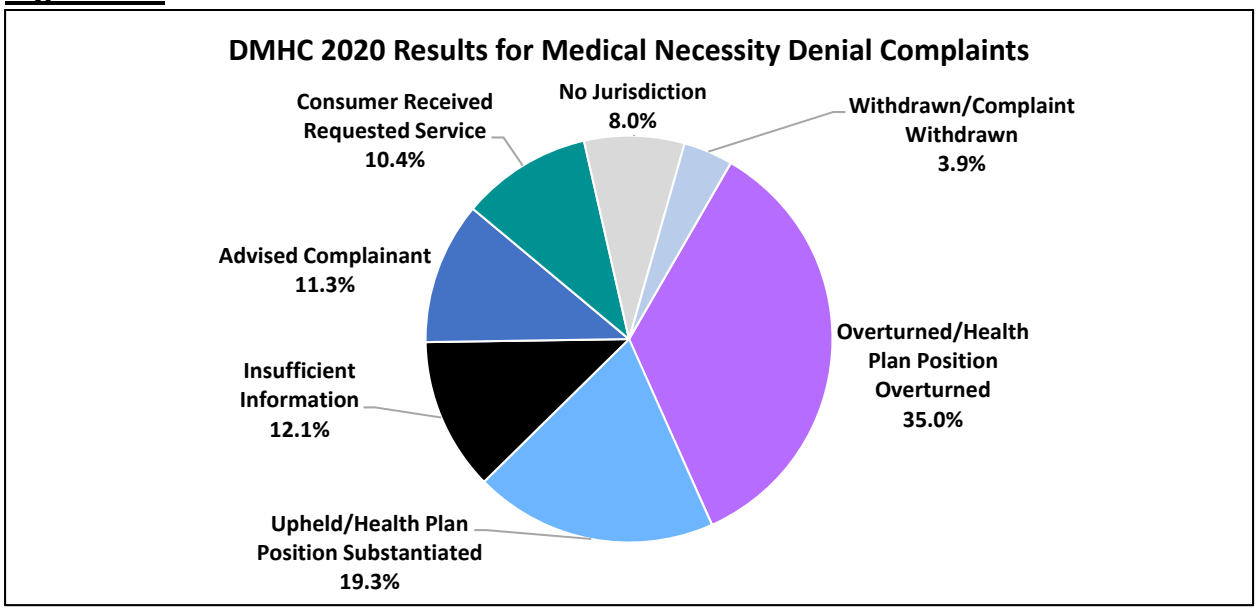



**Figure 4.8**

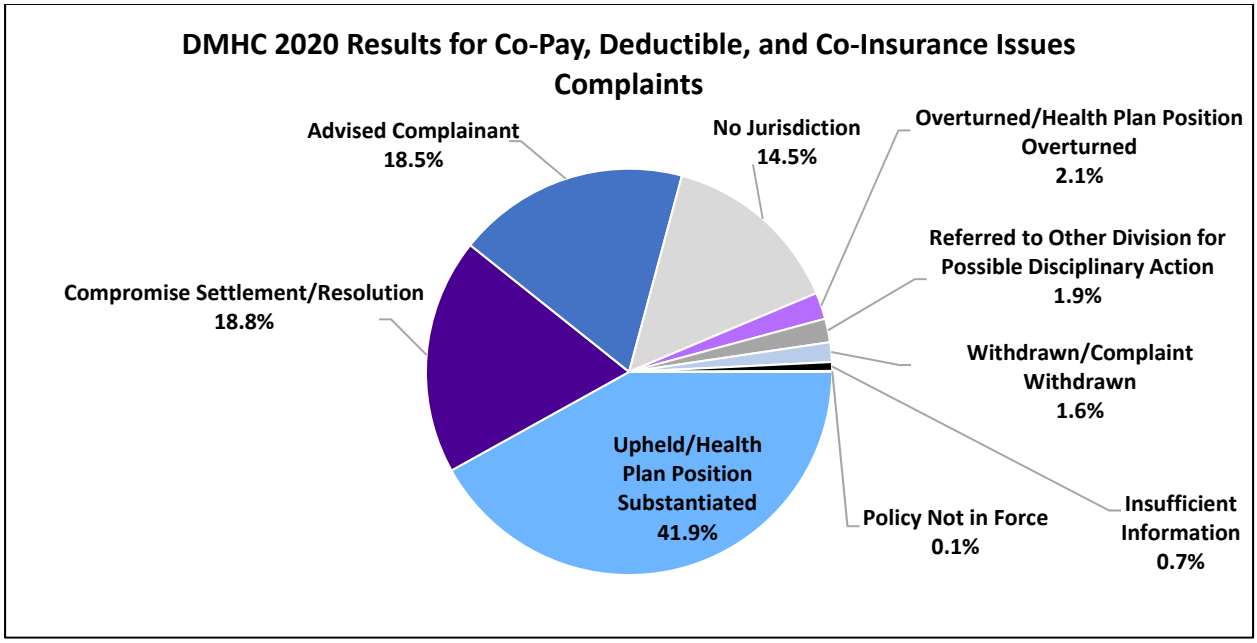
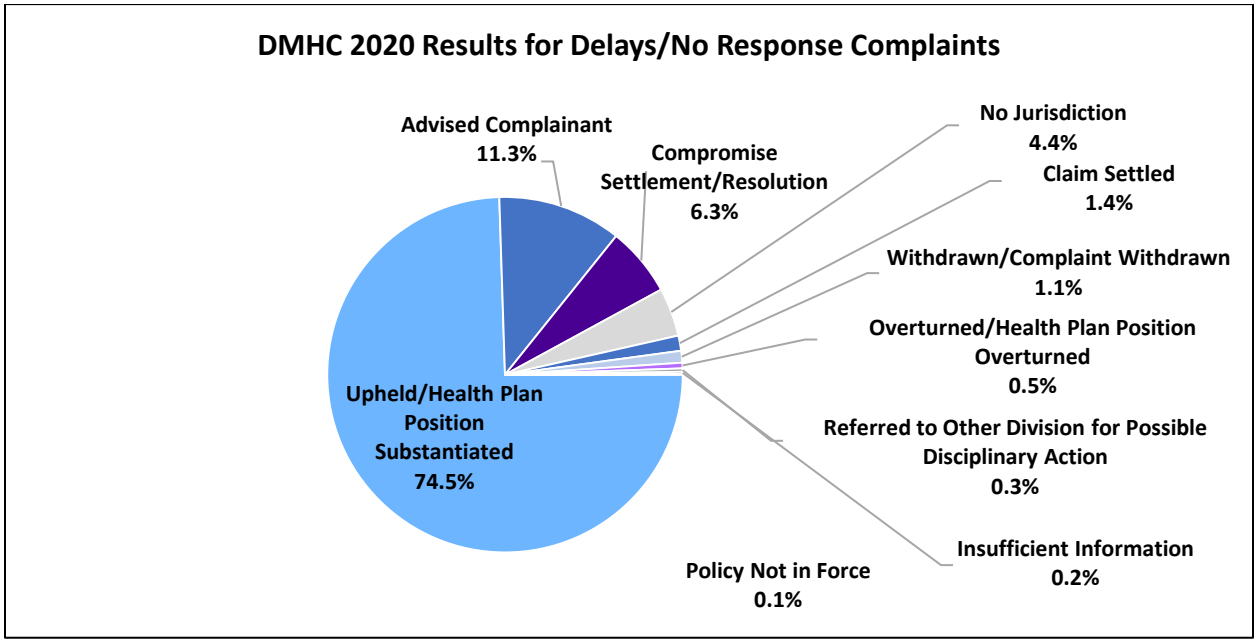


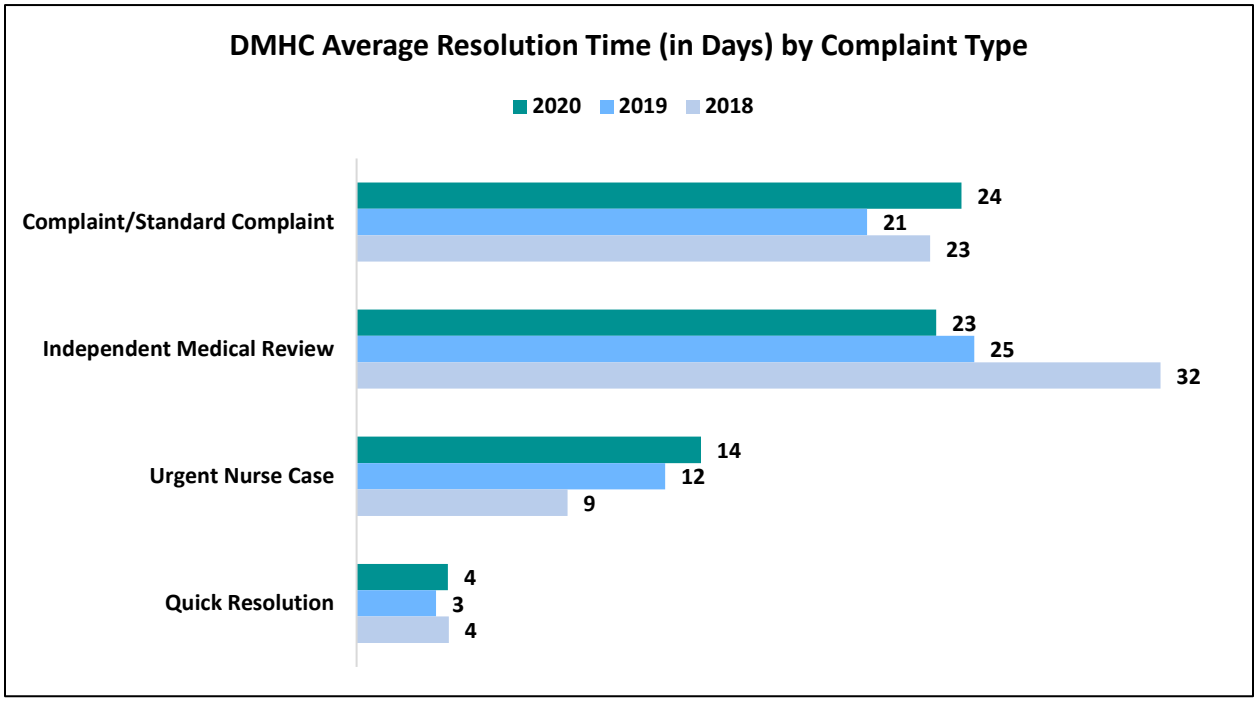
**Figure 4.9**




## Resolution Time

DMHC's average complaint resolution time in 2020 was 24 days, a three-day increase from the prior year but remaining below the 2018 average (25 days).

**Figure 4.10**



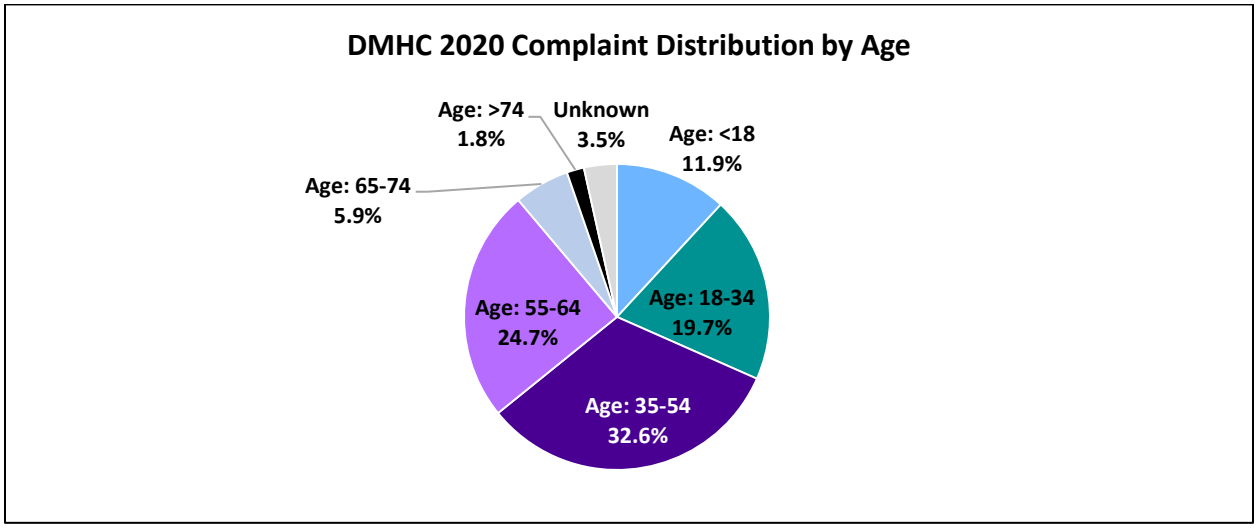

*Note: The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Figures detailing average resolution times include case durations with time prior to the completion of the complaint/IMR application.*

## C. Demographics and Other Complaint Elements

### Age

The average age of DMHC complainants in 2020 was 43 years old. The volume of complaints reported with Age Unknown fell for the fourth year. Complaint volumes slightly increased compared to the prior year for all known age group categories except for Age 55-64 and Age 75 and older.

**Figure 4.11**




### Gender

Female continued to be the most commonly reported gender of DMHC's complainants (57.0% of the 15,884 complaints in 2020). DMHC also submitted complaints with Male (41.6%) or Other (0.9%) identified. A half percent of the complaints were Unknown.

### Race

Nearly half of the DMHC 2020 complaints did not have race identified (36.3% Refused and 11.1% Unknown). White was the most commonly known category (36.5%), followed by Asian (6.3%), Black or African American (4.3%), Other (4.3%), Other Pacific Islander (0.7%), American Indian or Alaska Native (0.4%), and Native Hawaiian (0.1%).

### Ethnicity

The 2020 distribution of complaints by ethnicity was similar to the previous year. Not Hispanic or Latino accounted for over half of the DMHC complaints (52.5% of the 15,884 complaints in 2020) and Refused for over a third (36.3%). Hispanic or Latino accounted for eleven percent (11.1%).

### Language

English continued to be identified for the majority of the DMHC complaints (93.5% of the 15,884 complaints in 2020). DMHC complaint volumes and distributions increased

slightly in 2020 for complainants whose primary language was identified as Spanish (3.8%) and for Other languages combined (2.8%).

### Mode of Contact

Higher volumes of DMHC's complaints were initiated by the Online, Email, and Telephone modes of contacts in 2020 compared to the prior year, while volumes dropped for Mail and Fax. Online continued to be the most common mode of contact (53.6% of the 15,884 complaints in 2020), followed by Mail (25.4%), Fax (13.3%), Email (4.4%), and Telephone (3.3%).

### Regulator

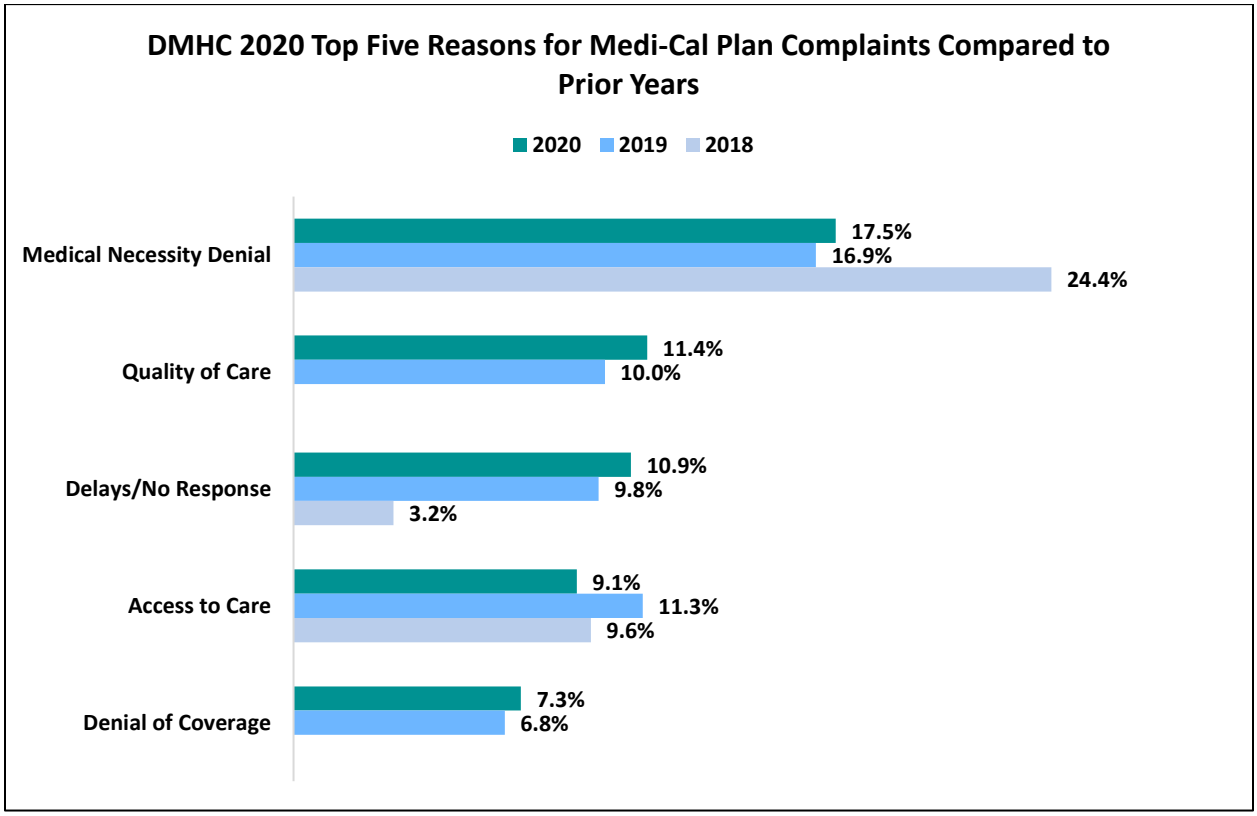
DMHC continued to be the regulator identified for most of its complaints (90.1% of the 15,884 complaints in 2020). Other reported regulators were the federal Department of Labor (3.2%), Centers for Medicare and Medicaid Services (1.8%), Other (1.3%), California Department of Insurance (1.2%), Out-of-State Department of Insurance (1.0%), and the U.S. Office of Personnel Management (0.4%). Nearly one percent involved a health care complaint without a regulator (0.9% No Regulator).

### Source of Coverage

DMHC's 2020 complaint distribution by Source of Coverage was similar to the prior year. Group coverage accounted for nearly half of the 2020 complaints (49.1% of the 15,884 complaints). The next most common coverage sources were Medi-Cal (17.0%), Covered California/Exchange (12.9%), Individual/Commercial (12.8%), CalPERS (3.6%), Medicare (2.4%), and Medi-Cal/Medicare (1.1%). Other identified coverage sources with low volumes (each under one percent) were COBRA, Uninsured, and State Specific (Other).

DMHC reported 2,699 complaints in 2020 with Medi-Cal as the coverage source. The following chart displays the top reasons for these Medi-Cal plan complaints, along with the 2018 and 2019 data for the reason categories.

**Figure 4.12**

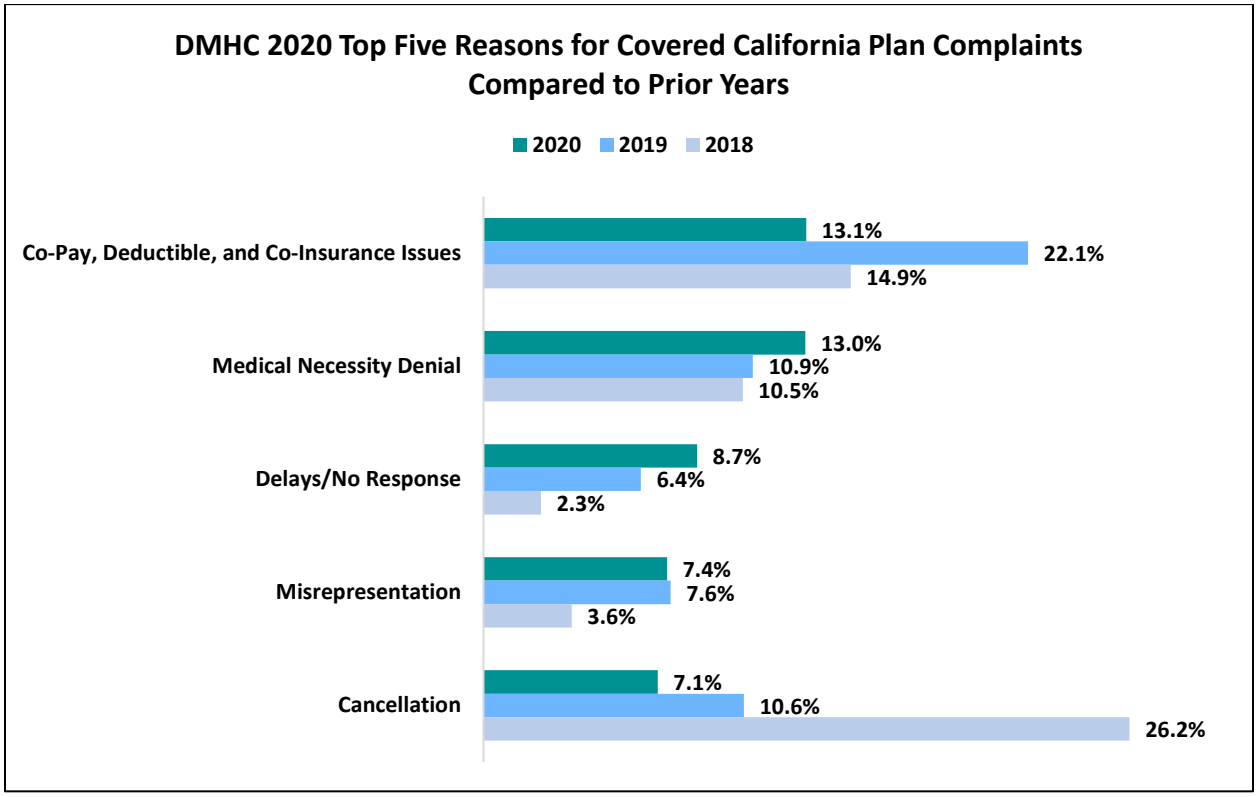



*Note: The number of Medi-Cal plan reasons exceeded the number of complaints because some complaints had more than one reason reported (3,832 reasons from 2,699 complaints in 2020). Differences between measurement years may be due in part to changes in data reporting rather than changes in incidence. Measurement Year 2019 was the first time DMHC reported complaints under the categories of Denial of Coverage and Quality of Care.*

DMHC reported 2,052 complaints in 2020 with Covered California/Exchange as the coverage source. DMHC regulates most of the health plans offered through the Covered California marketplace.

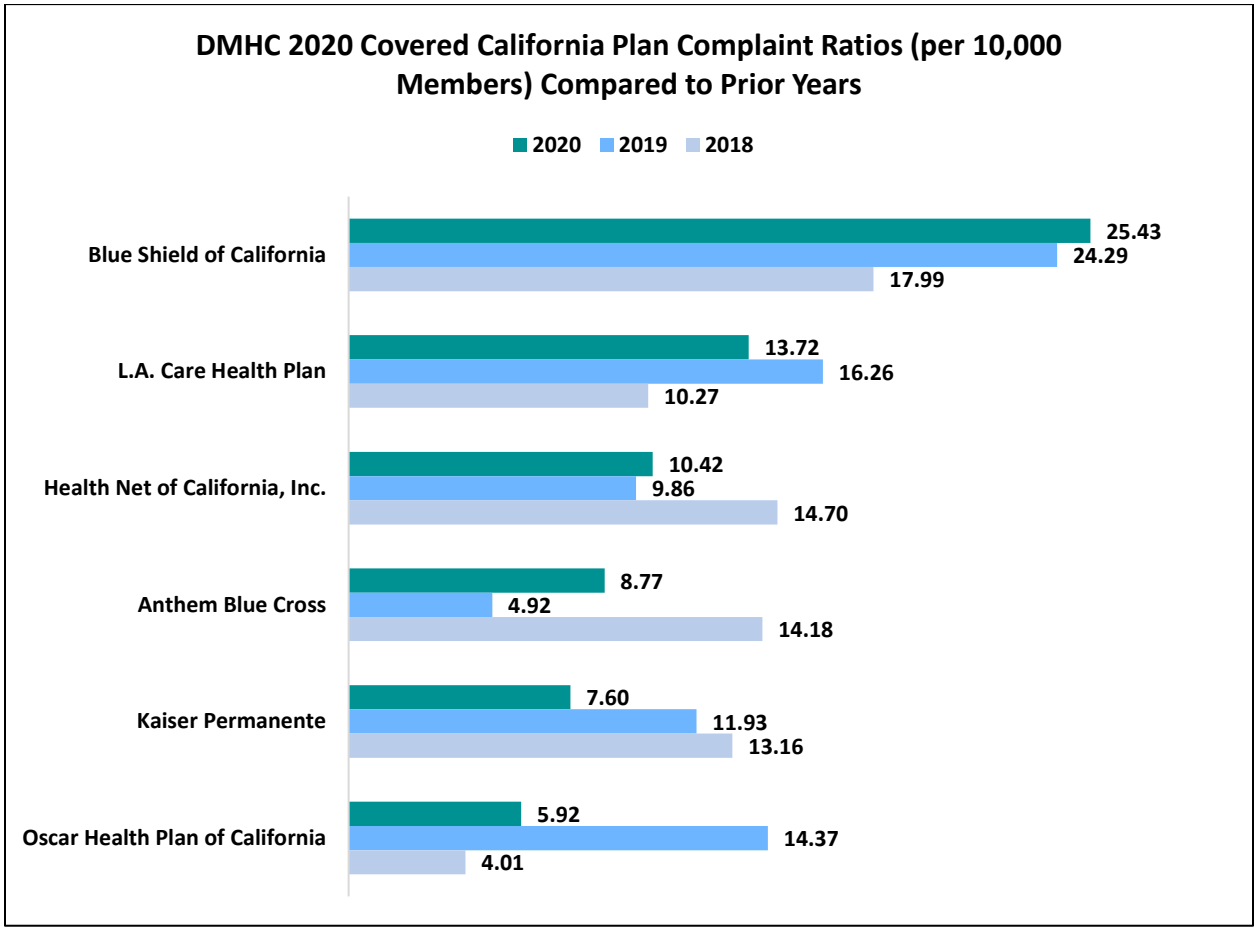
Figures 4.13-4.14 address these Covered California plan complaints.

**Figure 4.13**




*Note: The number of reasons exceeded the number of complaints because some complaints had more than one reason reported (2,944 reasons from 2,052 complaints in 2020). Differences between measurement years may be due in part to changes in reporting rather than changes in incidence.*

**Figure 4.14**




*Note: The display excludes plans with Covered California enrollment under 70,000 members in 2020.*

### Product Type

DMHC reported health plan models under product type. DMHC's 2020 complaint distribution was similar to the prior year, with HMO accounting for most of the complaints (61.8% of the 15,884 complaints) and PPO for nearly a third (32.5%). DMHC also reported product types of EPO (3.1%), POS (1.7%), and Unknown (0.7%). Other submitted product types accounted for less than one percent combined (Uninsured, Discount, and Fee-for-Service).

## D. Consumer Assistance Center Details

The DMHC Help Center received 130,233 requests for assistance from consumers in 2020, including 103,830 requests by telephone.

**Figure 4.15 DMHC Help Center – 2020 Telephone Metrics**

| Yearly Metrics | Measurement |
|---|---|
| Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR) | 1,219 |
| Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR) | 69,370 |
| Number of Jurisdictional Inquiry Calls* | 15,604 |
| Number of Non-Jurisdictional Calls* | 7,262 |
| Average Wait Time to Reach a CSR | 0:01:17 |
| Average Length of Talk Time (time between a CSR answering and completing a call) | 0:09:42 |
| Average Number of CSRs Available to Answer Calls (during Service Center hours) | 10 full-time equivalent staff on average |

**The Help Center agents handled 33,241 calls in 2020, of which 22,866 were inquiries recorded as jurisdictional (15,604) and non-jurisdictional (7,262).*

### Consumer Assistance Protocols

DMHC reported the following updates to its consumer assistance protocols or systems in 2020 to improve complaint tracking and standardization.

- Revised its policy and procedure for compliance determinations on standard complaints.
- Updated its complaint system categorizations and definitions for:
    - Coverage/Benefits Disputes related to coverage denials for services provided outside of the plan's service area.
    - Provider Service/Attitude complaints related to excessive in-office waiting times.

# Section 5 – Department of Health Care Services

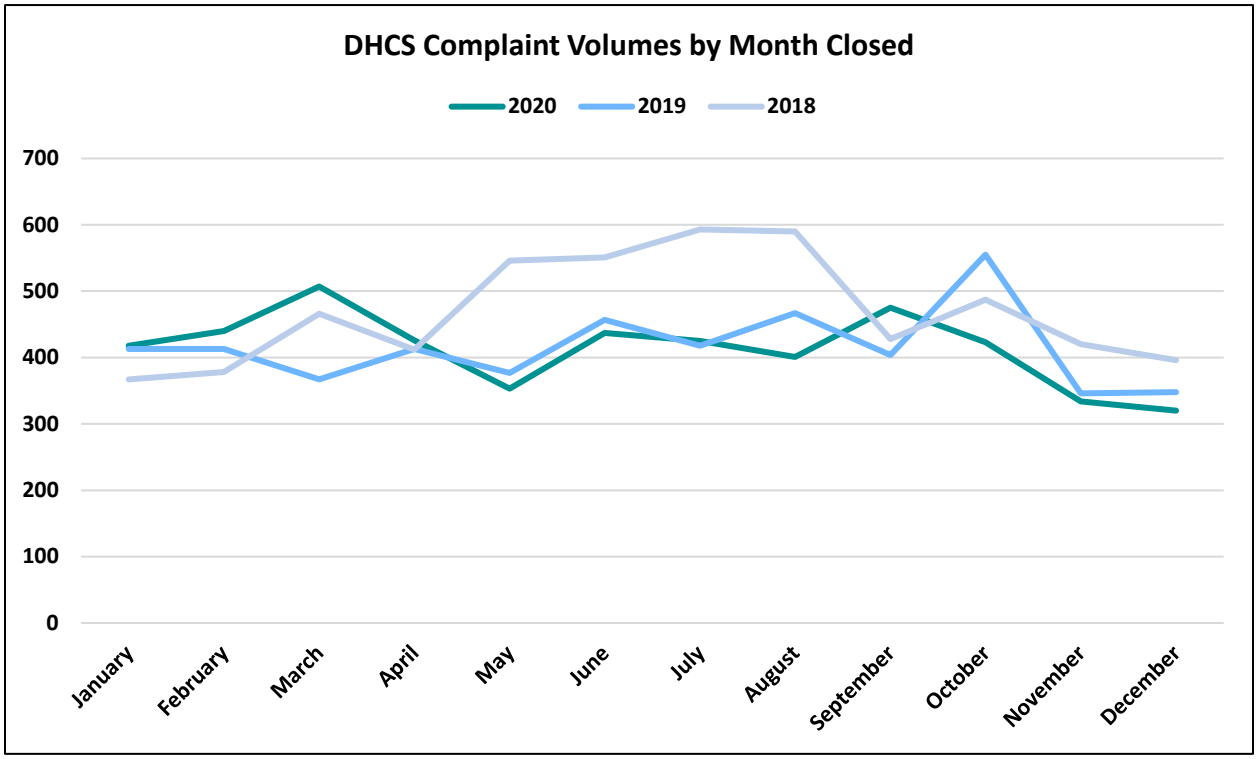
## A. Overview

The Department of Health Care Services (DHCS) operates the Medi-Cal program, which is a public health care program that provides comprehensive health care services at no or low-cost for low-income Californians. In 2020, around 13 million people received services from the Medi-Cal program. At the time of this report publication, this number is around 14 million.

For this report, DHCS provided complaint data for Medi-Cal issues addressed through State Fair Hearings, a dispute resolution process conducted by the California Department of Social Services (CDSS) State Hearings Division. DHCS also reported data on consumer inquiries made to three consumer assistance service centers: Office of the Ombudsman, Medi-Cal Telephone Service Center, and Medi-Cal Dental Telephone Service Center.

DHCS reported 1,247,642 requests for assistance from consumers in 2020, including 4,959 State Fair Hearings and 1,242,683 inquiries to the three DHCS service centers. The following chart displays the monthly volumes for the 4,959 complaints in 2020, the 4,978 complaints in 2019, and the 5,634 complaints in 2018.

**Figure 5.1**




The following figure displays information about the State Fair Hearing process, the complaint type reported by DHCS.

**Figure 5.2 Medi-Cal State Fair Hearing Standards**

| Complaint Type | Primary Unit(s) Responsible and Role | Time Standard | Average Resolution Time in 2020 |
|---|---|---|---|
| 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. | 90 days from the hearing request date | 47 days |

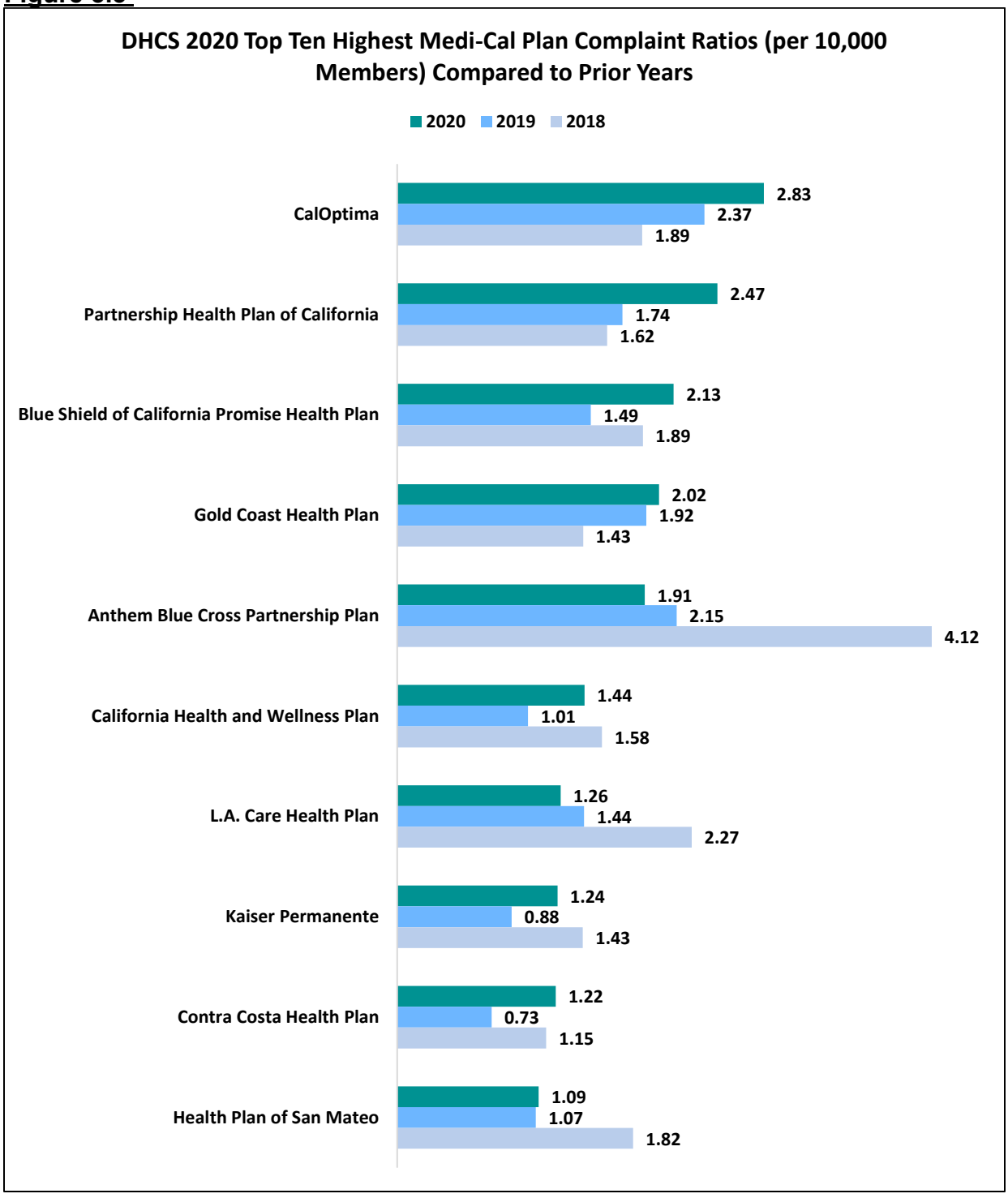
*Note: The State Fair Hearing time standard is from All County Letter 14-14 issued by CDSS on 2/17/2014.*

## B. Complaint Ratios, Reasons, and Results

### Health Plan Complaint Ratios

The following chart displays ratios of the Medi-Cal managed care plans' statewide State Fair Hearings per 10,000 plan members.

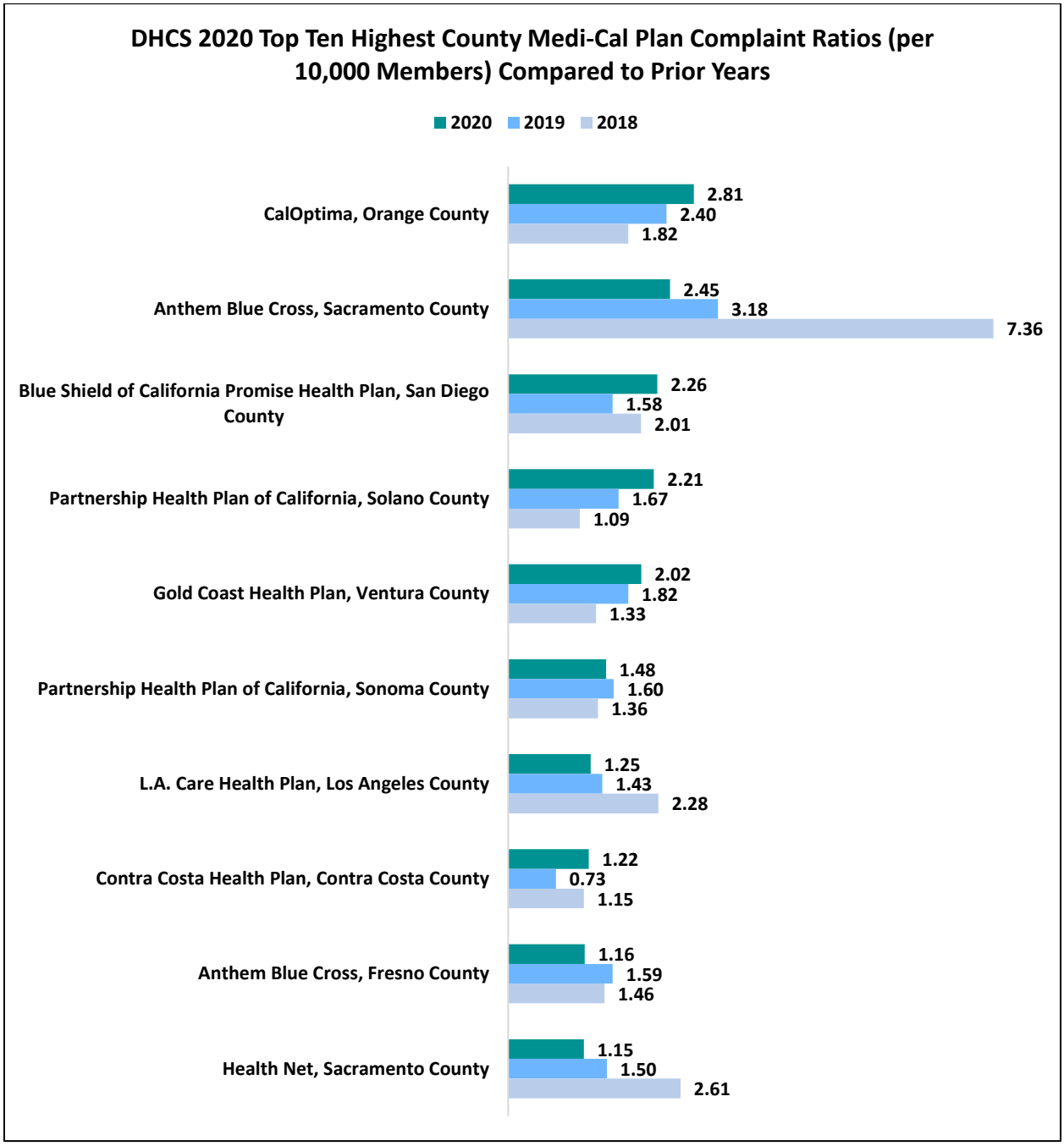
**Figure 5.3**




*Note: The above display excludes Medi-Cal plans with 2020 statewide enrollment under 70,000 members. OPA has combined data for health plans that serve multiple counties, including under different Medi-Cal contracting models. DHCS reports likely vary because the department typically monitors quality issues by county contract.*

The following chart displays ratios of the Medi-Cal manage care plans' State Fair Hearings in a county per 10,000 plan members.

**Figure 5.4**



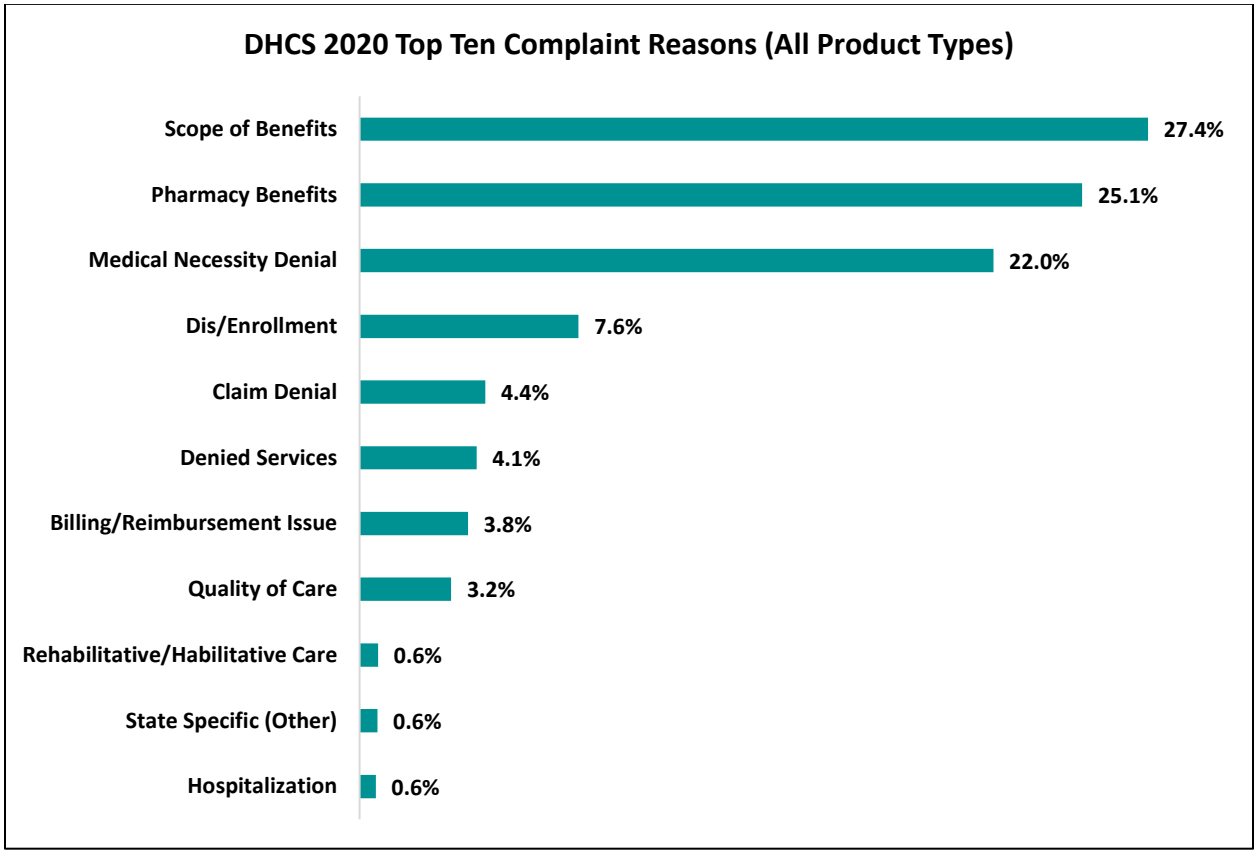

*Note: The above display excludes plans with 2020 county Medi-Cal enrollment under 70,000 members.*

## Complaint Reasons

The following chart shows the top complaint reasons in 2020 for all DHCS delivery systems, which were reported to OPA as product types. The total number of submitted complaint reasons (4,998) exceeded the number of complaints (4,959) because some cases had more than one reason reported.

Differences between measurement years may be due in part to changes in reporting rather than changes in incidence.

**Figure 5.5**

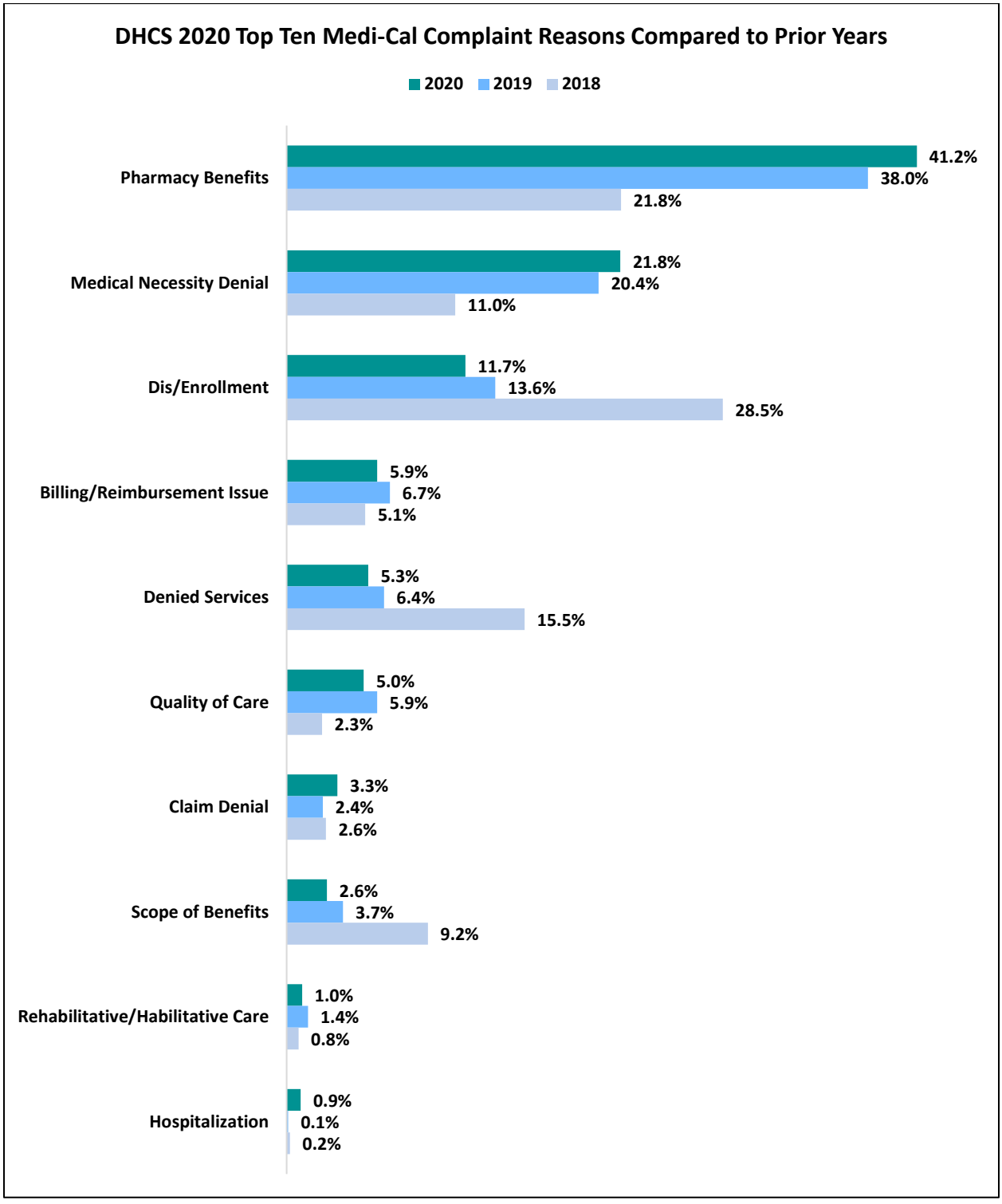



The top complaint reasons by DHCS delivery system (with each reason's distribution among the specified delivery system):

- Dental – Scope of Benefits (70.7%)
- Fee-for Service – Pharmacy Benefits (59.4%)
- Managed Care – Pharmacy Benefits (18.2%)
- Mental Health – Denied Services (33.9%)
- Long Term Care – Dis/Enrollment (50.0%)
- Medi-Cal Coordinated Care – Denied Services (18.5%)

The following chart displays the top complaint reasons in 2020 for Medi-Cal Managed Care and Fee-for-Service, as well as the 2018 and 2019 data for those same reasons.

**Figure 5.6**




*Note: This display excludes complaints for Medi-Cal Dental, Medi-Cal Behavioral Health, Medi-Cal Coordinated Care, and Long Term Care. Differences between measurement years may be due in part to reporting changes rather than changes in incidence.*

DHCS indicated that the increases in complaint volumes for Pharmacy Benefits and Medical Necessity Denial are largely due to reporting changes. Some cases reported

under those categories in 2020 were previously reported as Denied Services or Scope of Benefits.

DHCS also noted that the multi-year decreases in Dis/Enrollment volumes are largely attributable to changes in the Medical Exemption Request (MER) review process. Newly eligible beneficiaries with pre-existing, complex medical conditions may request a temporary exemption from mandatory managed care enrollment in order to continue receiving active medical treatments from a fee-for-service Medi-Cal provider. In August 2018, the department began transitioning its MER review process to an external contractor (MAXIMUS), which provides medically qualified personnel to review MERs.

### Inquiry Topics and Referrals

The following figures display the most common inquiry topics consumers contacted the DHCS service centers about in 2020, as well as the department or other service center to which the consumers were referred.

**Figure 5.7 Office of the Ombudsman 2020 Top Topics for Non-Jurisdictional Inquiries**

| Ranking | Inquiry Topic | 2020 Volume | Organization(s) Referred to |
|---|---|---|---|
| 1 (most common) | Medi-Cal Eligibility | 46,524 | County Medi-Cal Office |
| 2 | Fee-for-Service | 7,331 | DHCS Fee-for-Service Help Line (Medi-Cal Telephone Service Center) |
| 3 | Health Care Options | 4,632 | Health Care Options |
| 4 | Medicare | 4,137 | Medicare |
| 5 | Covered California | 3,075 | Covered California |
| 6 | Mental Health | 2,727 | County Mental Health Program |
| 7 | Medi-Cal Dental | 1,596 | Medi-Cal Dental Program |
| 8 | State Fair Hearings | 1,114 | California Department of Social Services |

**Figure 5.8 Medi-Cal Telephone Service Center 2020 Top Topics for Non-Jurisdictional Inquiries**

| Ranking | Inquiry Topic | Organization(s) Referred to |
|---|---|---|
| 1 (most common) | Beneficiary Inquiry/Eligibility | County Medi-Cal 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 | Beneficiary Inquiry/Coverage | Low Income Subsidy |

*Note: The Medi-Cal Telephone Service Center ranking was estimated by DHCS and so does not have reported volumes.*

**Figure 5.9 Medi-Cal Dental Telephone Service Center 2020 Top Topics for Non-Jurisdictional Inquiries**

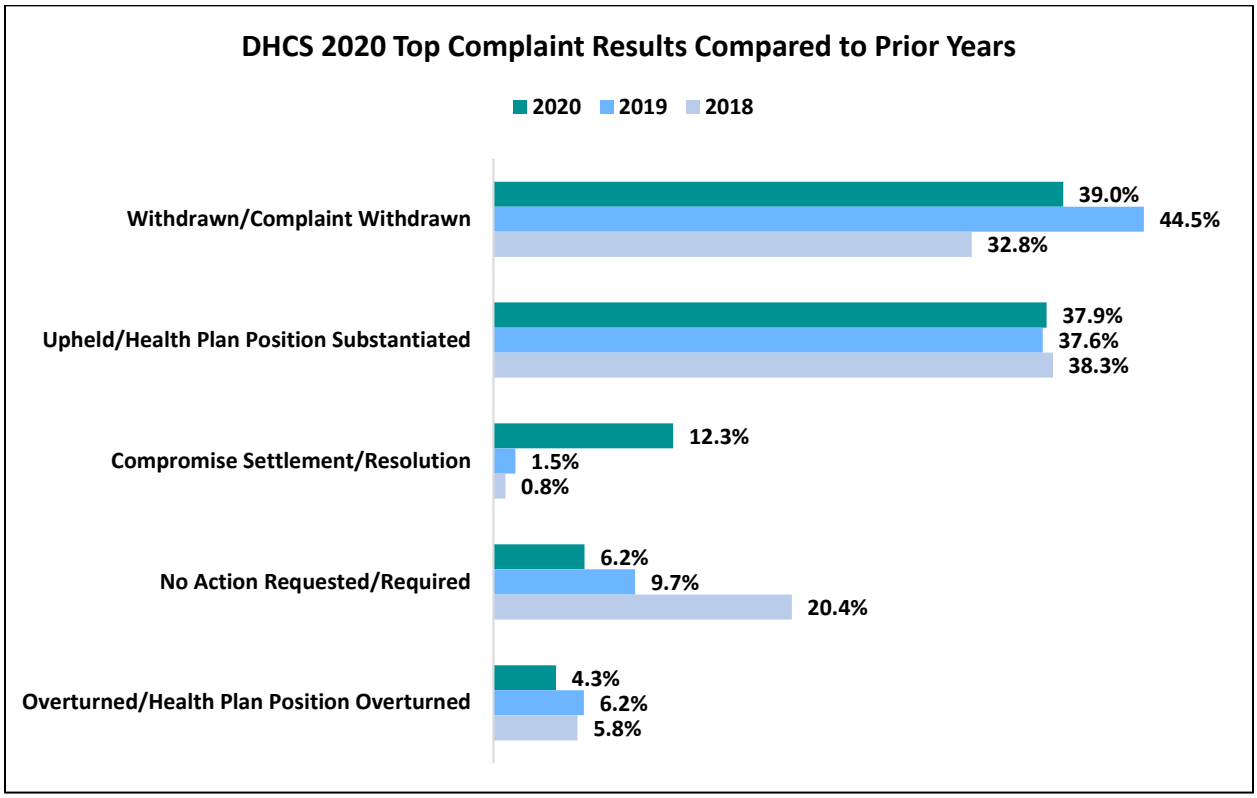
| Ranking | Inquiry Topic | 2020 Volume | Organization(s) Referred to |
|---|---|---|---|
| 1 (most common) | Miscellaneous | 16,346 | Managed Care Plan and/or California Dental Board, or County Medi-Cal Office |
| 2 | Complaint about care or treatment performed | 4,101 | California Dental Board |
| 3 | Share of Cost | 939 | California Department of Social Services |
| 4 | Complaints against office (non-treatment) | 763 | California Dental Board |

*Note: The 2020 volumes are reported through the DHCS dental contractor's Customer Relationship Management system based on system inputs. Data rankings based on the inquiry topic and referral organization is representative of actual captured informational elements.*

## Complaint Results

The following chart displays the most common complaint results submitted by DHCS for 2020, as well as the 2018 and 2019 data for those results.

**Figure 5.10**




*Note: Five results categories with low volumes in 2020 (each accounting for less than 0.2% of the results) were excluded from the display. Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Overturned/Health Plan Position Overturned. The result category considered favorable to the health plan is 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, No Action Requested/Required indicates that the case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.*

DHCS noted that some managed care case results previously reported as Withdrawn/Complaint Withdrawn were reported as Compromise Settlement/Resolution in 2020.

DHCS and CDSS have collaborated in recent years to increase use of CDSS's formal fair hearing withdrawal process (results reported as Withdrawn/Complaint Withdrawn) and reduce non-appearance dismissals (results reported as No Action Requested/Required). Many of the Withdrawn/Complaint Withdrawn cases involve a deferred services issue resolved by the complainant's medical provider before the hearing date and with a favorable outcome for the complainant.

Figures 5.11-5.13 display the 2020 results for the top three complaint reasons reported by DHCS.

**Figure 5.11**

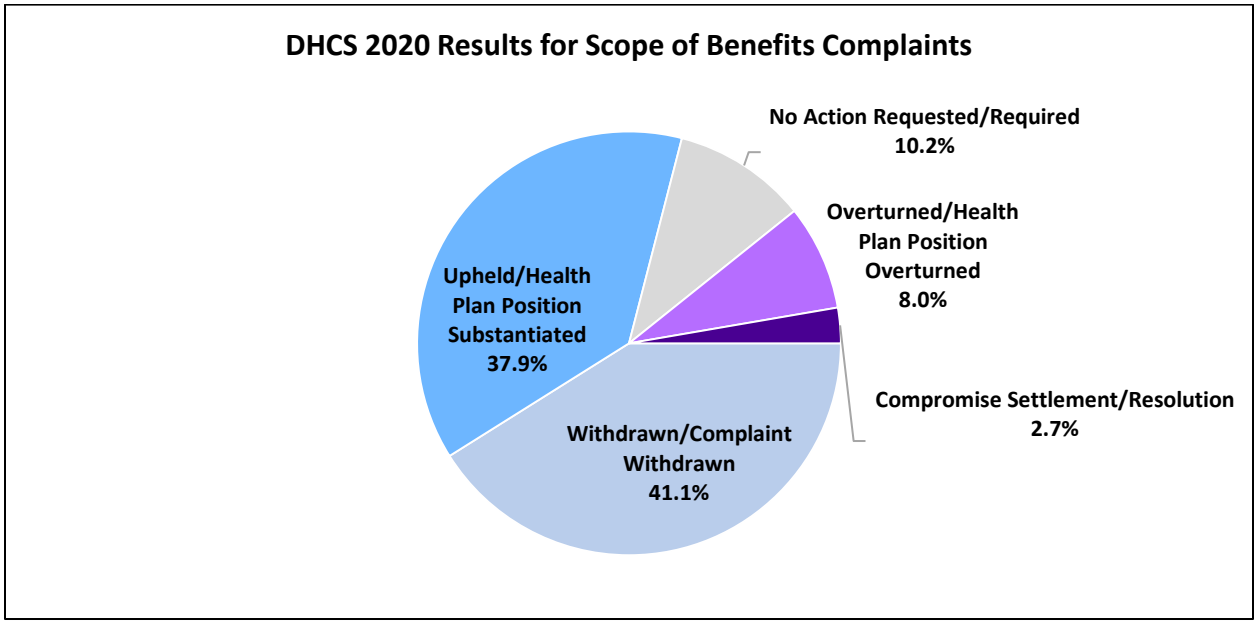


**Figure 5.12**

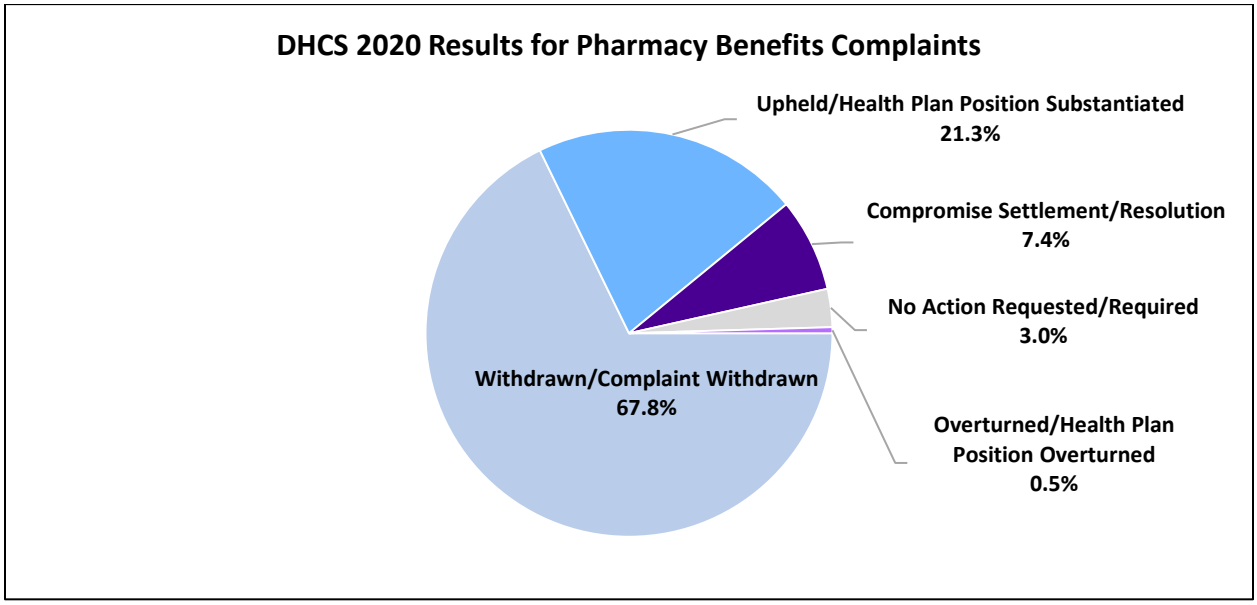
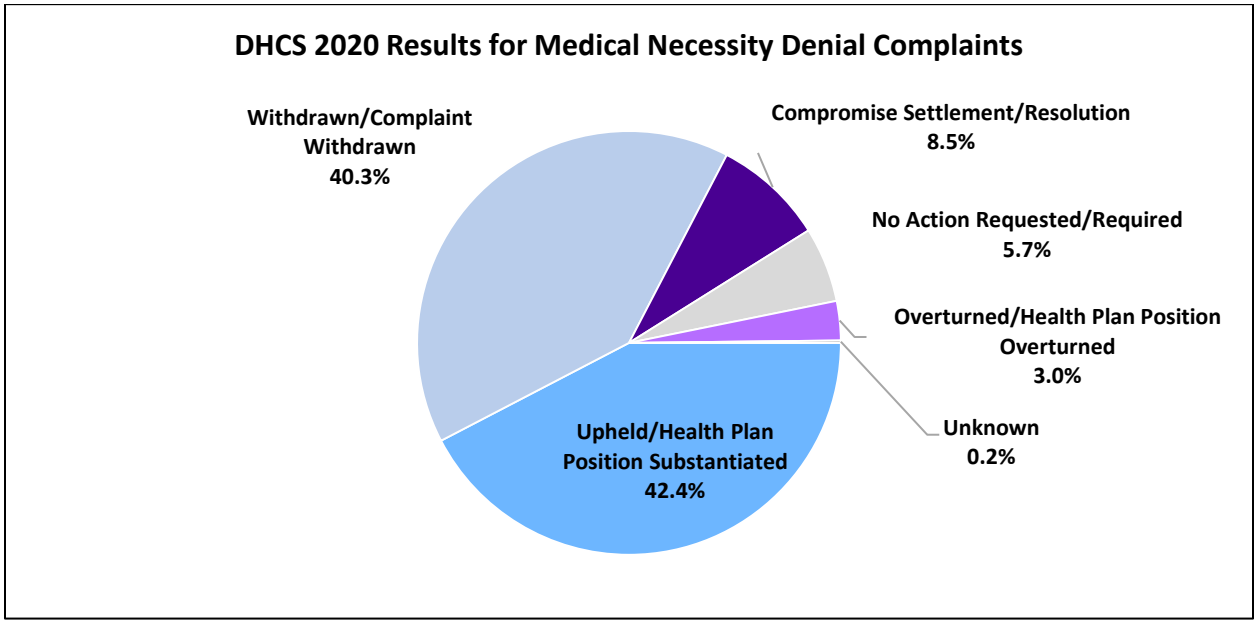



**Figure 5.13**




## Resolution Time

The 2020 State Fair Hearings submitted by DHCS took 47 days on average to resolve, four days fewer than the prior year average. Average resolution times have decreased each year since 2015.

The 2020 average resolution times by DHCS delivery system:

- Mental Health – 125 days
- Long Term Care – 112 days
- Medi-Cal Coordinated Care – 73 days

- Managed Care – 72 days
- Fee-for-Service – 44 days
- Dental – 27 days

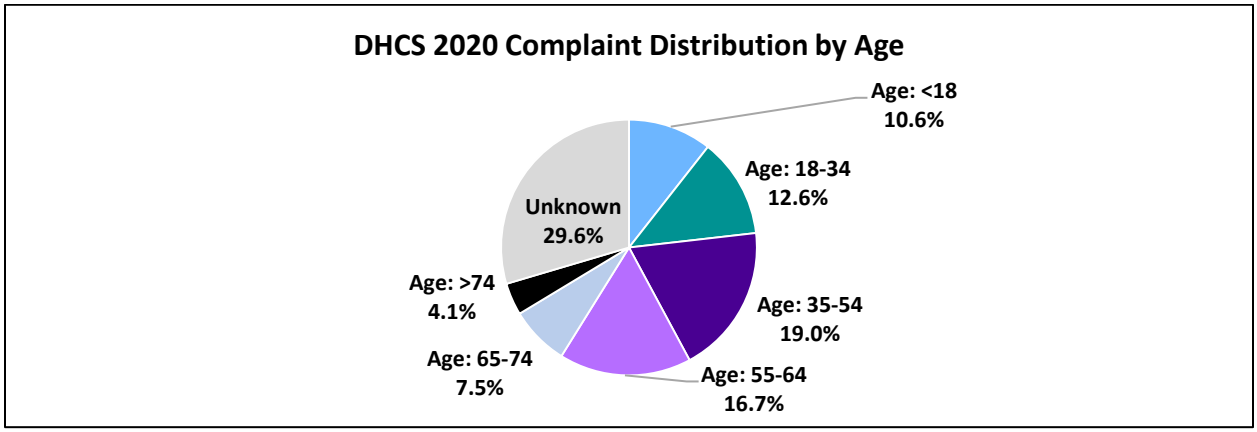
## C. Demographics and Other Complaint Elements

Differences in findings between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

### Age

The average age of the complainants in 2020 was 45 years old. Compared to the prior year, the 2020 complaint volumes decreased slightly for all known age groups while the volume submitted as Unknown increased by fifteen percent. It is unclear how much the increase in Unknown affected the decreases in the various age groups.

**Figure 5.14**




### Gender

DHCS and CDSS do not collect gender data as part of the Medi-Cal enrollment process of for State Fair Hearing filings. The data submitted to OPA under gender represents data collected about sex. For 2020, Female was identified for approximately 41 percent (40.6%) of the 4,959 complaints and Male for nearly 30 percent (29.8%). Nearly 30 percent were submitted as Unknown (29.6%).

### Race

Over 45 percent (45.1%) of the DHCS 2020 complaints did not have race identified (submitted as Refused or Unknown). White accounted for over a third of the 4,959 complaints (34.6%), followed by Black or African American (9.7%), Other (6.0%), and Asian (3.4%). Categories with low volumes (each accounting for under 1%) included Other Pacific Islander, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander.

### Ethnicity

Nearly 41 percent (40.9%) of the DHCS 2020 complaints did not have ethnicity identified (submitted as Refused or Unknown). Approximately 42 percent of the 4,959 complaints reported the complainant as being Not Hispanic or Latino (41.7%) and over 17 percent as Hispanic or Latino (17.4%).

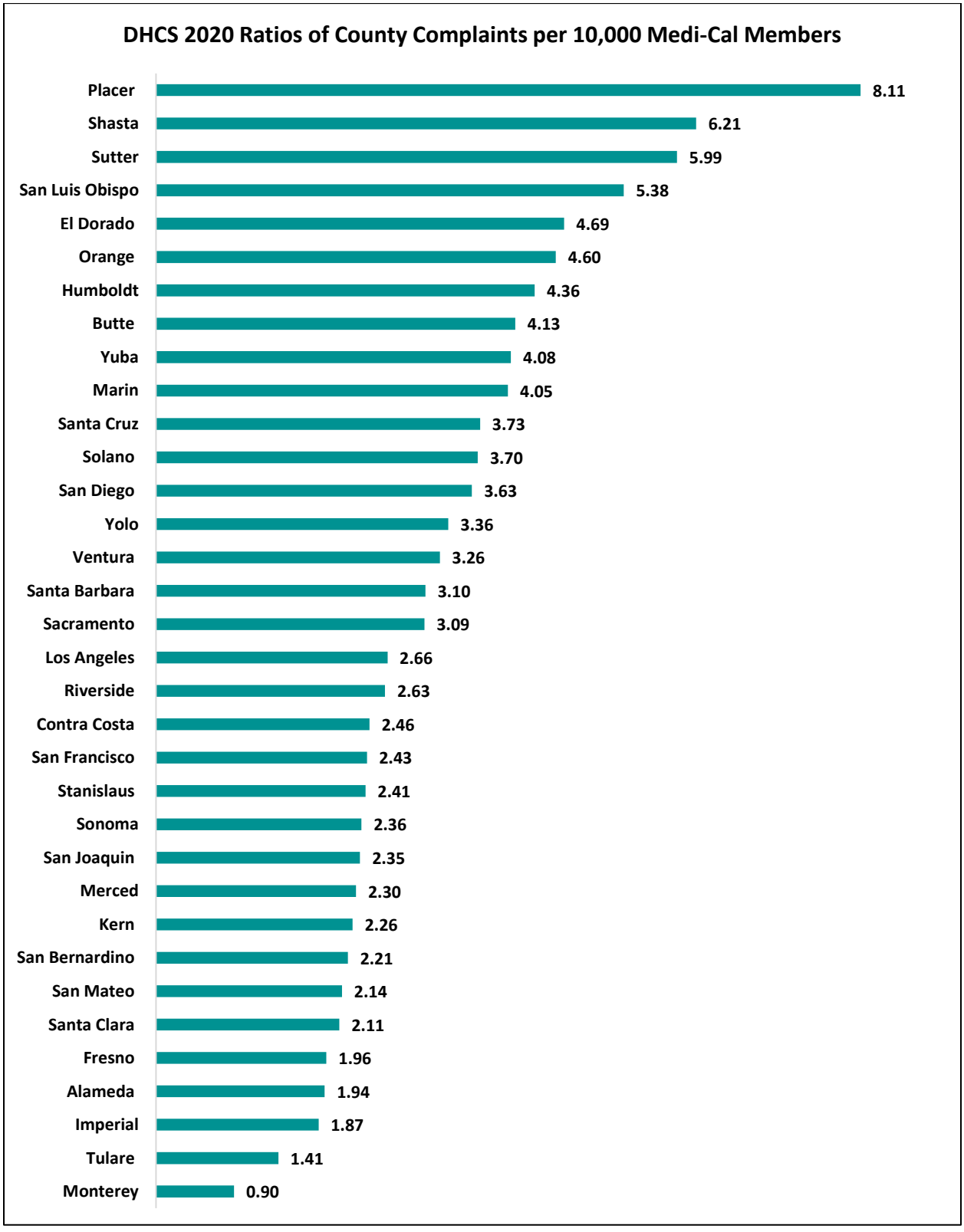
### Language

Most of the DHCS 2020 complaints indicated that the complainant's primary language was English (58.5% of the 4,959 complaints). Spanish was the next most commonly reported language (6.5%). Other languages combined accounted for four percent (4.0%), with eleven different categories reported (each under 1%). Primary language was not identified for 31 percent of the complaints (submitted as Refused or Unknown).

### County of Residence

The following chart displays county ratios based on each county's 2020 volume of complaints divided by the number of Medi-Cal beneficiaries in the county that year.

**Figure 5.15**




*Note: The above display excludes counties with fewer than 10,000 Medi-Cal beneficiaries and/or 10 or fewer complaints in 2020.*

### Mode of Contact

Mail was the most common initial mode of contact submitted in 2020 for the DHCS complaints (40.1% of the 4,959 complaints), followed by Unknown (31.5%), Telephone (28.2%), and two categories with low volumes (Online and Counter/In-Person each accounted for under 0.1%).

### Regulator

The 2020 distribution of complaints by regulator was similar to the prior year, with Other identified for most of the complaints (71.2% of the 4,959 complaints) and followed by DMHC (28.4%) and Unknown (0.3%).

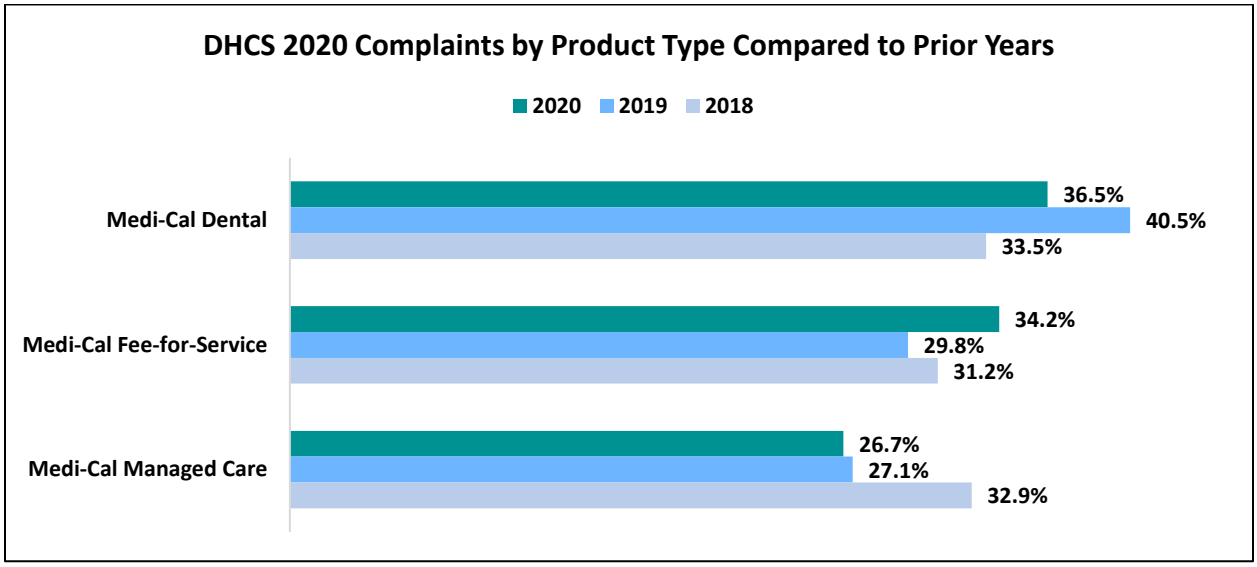
### Source of Coverage

Most of the 2020 DHCS complaints were associated with the Medi-Cal source of coverage (98.6% of the 4,959 complaints). Approximately one percent were identified as Medi-Cal/Medicare (1.3%) and just a few were Unknown (0.1%).

### Product Type

DHCS reported its health care delivery systems under product type.

**Figure 5.16**




*Note: The chart excludes product types with low reported volumes (under 1% distribution) in 2020: Long Term Care, Mental Health, Medi-Cal Coordinated Care, and Unknown.*

## D. Consumer Assistance Center Details

DHCS reported 1,242,683 consumer inquiries in 2020 for its three service centers: the Office of the Ombudsman, Medi-Cal Telephone Service Center, and Medi-Cal Dental Telephone Service Center. All of the consumer requests for assistance to these service centers are categorized as inquiries because the service centers do not make determinations for the complaints submitted by DHCS for this report.

Figures 5.17-5.19 show for each service center the monthly inquiry volumes in 2020 compared to prior years.

- The Office of the Ombudsman received 186,013 inquiries in 2020, a two percent (2.4%) decease in volume from the prior year. The Office of the Ombudsman's annual inquiry volumes have fallen each year since 2015.
- The Medi-Cal Telephone Service Center received 625,030 inquiries from beneficiaries in 2020, a six percent (6.2%) increase in volume from the prior year. The reported inquiry volumes do not include calls addressed by the Medi-Cal Telephone Service Center's Interactive Voice Response system, which also receives requests for assistance from Medi-Cal providers (volumes that could not be separated).
- The Medi-Cal Dental Telephone Service Center received 431,640 inquiries in 2020, a nearly seven percent (6.6%) decrease from the prior year volume.

**Figure 5.17**

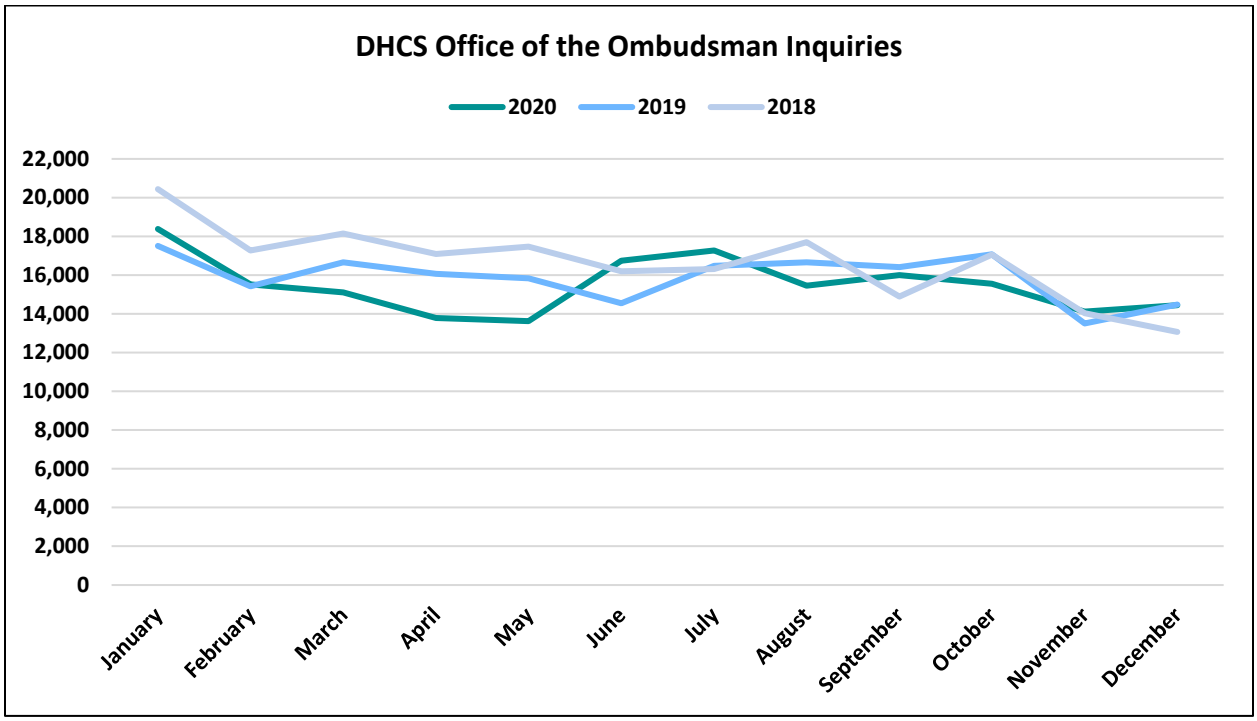


**Figure 5.18**

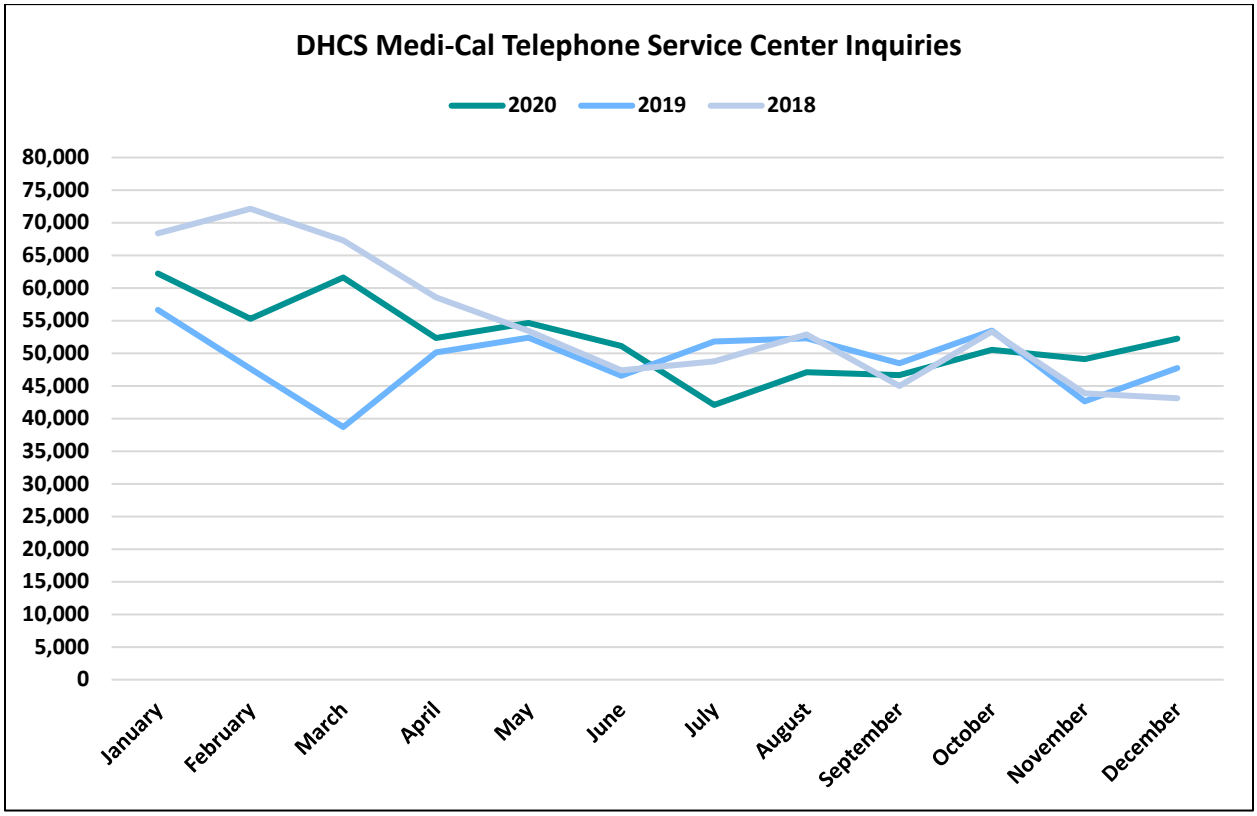
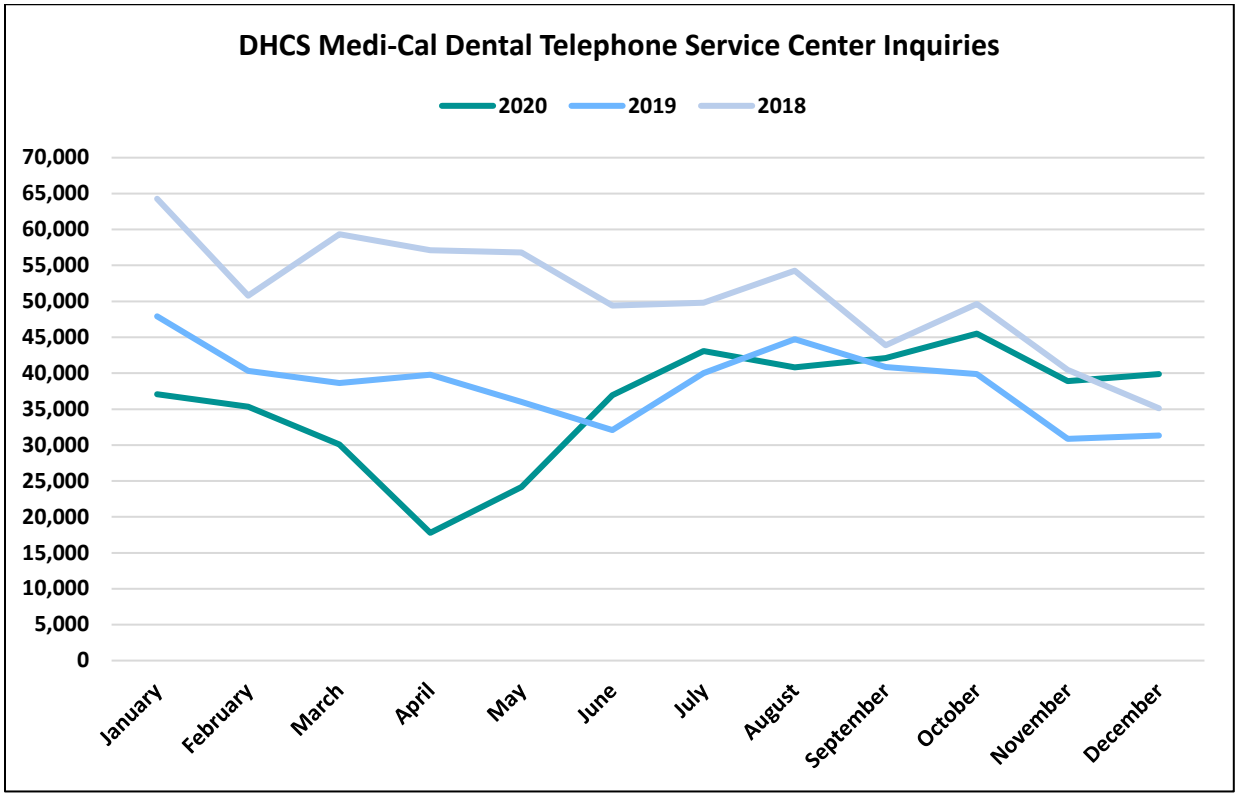



**Figure 5.19**



The following table displays the telephone metrics for the three DHCS service centers that reported data to CDII. Nearly all of the service centers' inquiries reported for 2020 were made by telephone (96.3% of the Office of the Ombudsman inquiries, 100% of the Medi-Cal Telephone Service Center inquiries, and 99.2% of the Medi-Cal Dental Telephone Service Center inquiries).

**Figure 5.20 DHCS Service Centers' 2020 Telephone Metrics**

| Metric | Office of the Ombudsman | Medi-Cal Telephone Service Center | Medi-Cal Dental Telephone Service Center |
|---|---|---|---|
| Telephone Call Volume | 179,108 | 625,030* | 428,170 |
| Number of Abandoned Calls (incoming calls ended by callers prior to reaching a Customer Service Representative-CSR) | 10,874 | 66,813 | 31,284 |
| Number of Calls Resolved by the Interactive Voice Response (IVR)/ Phone System | 64,855 | 2,851,113** | 150,410 |
| Number of Jurisdictional Inquiry Calls | 103,379 | 625,030 | 394,034 |
| Number of Non-Jurisdictional Calls | Considered the same as calls resolved by IVR | N/A | N/A |
| Average Wait Time to Reach a CSR | 3:30 | 2:46 | 1:50 |
| Average Length of Talk Time (Between a CSR answering and completing a call) | 8:00 | 3:31 | 8:45 |
| Average Number of CSRs Available to Answer Calls (during service center hours) | 18 | 90 estimated | 104 |

**The Medi-Cal Telephone Service Center telephone call volume includes only jurisdictional inquiries from beneficiaries.*

***The indicated category includes calls from both Medi-Cal beneficiaries and Medi-Cal providers. The beneficiary data could not be separated for reporting.*

### Service Center Protocols and Systems

Due to the COVID-19 pandemic, DHCS received federal Section 1135 approval to temporarily extend the deadline for a consumer to request a State Fair Hearing for a Medi-Cal program appeal. This extension went into effect March 1, 2020, and will end after the termination of the public health emergency.

- Consumers normally have up to 90 days to file a hearing request after a Medi-Cal program action by a County or DHCS (or up to 120 days after a Medi-Cal Health Plan action, allowing for the required Plan grievance review process prior to the hearing).
- With the temporary extension, consumers are allowed up to 210 days to file an appeal after a Medi-Cal program action by a County or DHCS (or up to 240 days after a Medi-Cal Health Plan action).

DHCS also reported the following updates related to its service centers:

- The Office of the Ombudsman upgraded its Customer Relationship Management system platform and changed to Salesforce as its system of record.
- The Medi-Cal Telephone Service Center's customer service representatives began working from home as of March 2020.
- The Medi-Cal Dental Telephone Service Center noted that there was a reduction in calls due to the pandemic and that additional training was provided to its staff on completing service forms within the Customer Relationship Management system.

# Section 6 – California Department of Insurance

## A. Overview

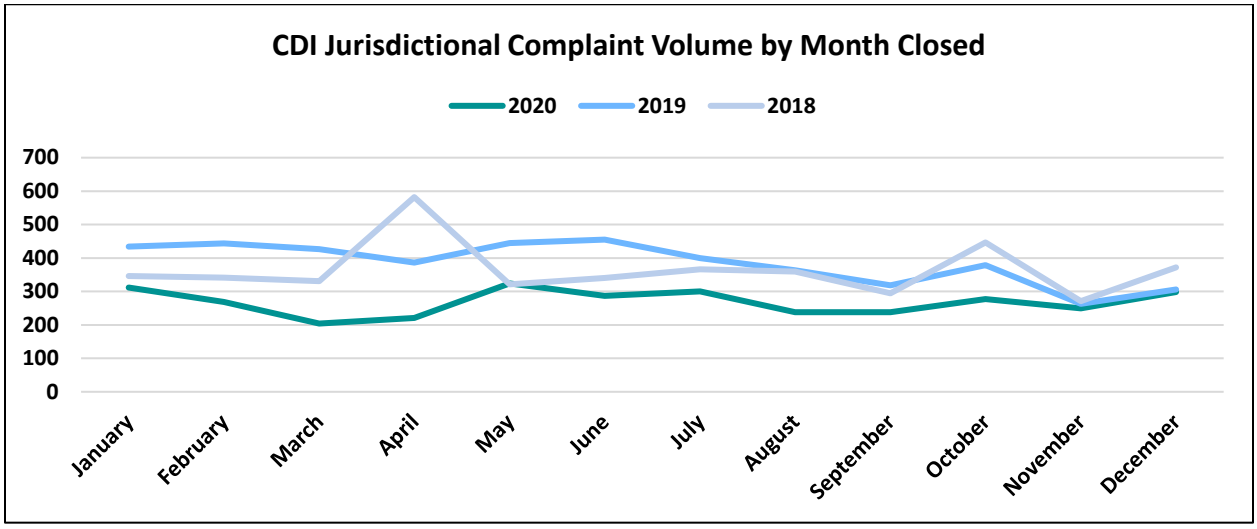
The California Department of Insurance (CDI) licenses and regulates nearly 1,400 insurance companies and more than 450,000 insurance agents, brokers, adjusters, and business entities. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance companies or producers.

This report addresses CDI's health care coverage complaints, and not those related to life insurance, long term care, or other lines of business. For standardization purposes, this report refers to the health insurance companies licensed by CDI as health plans.

CDI reported 28,070 requests for assistance from health care consumers in 2020, including 3,217 jurisdictional complaints and 3,803 non-jurisdictional complaints.

The following chart compares monthly volumes for jurisdictional complaints in 2020 to prior years (accounting for 3,217 complaints in 2020, 4,619 in 2019, and 4,370 in 2018).

**Figure 6.1**




CDI noted that its 2020 complaint volumes were affected by the COVID-19 pandemic, with fewer overall insurance claims as selective procedures and other medical services were postponed or reduced and fewer associated complaints filed.

The following figure outlines the two different complaint types reported by CDI: Standard Complaint and Independent Medical Review (IMR).

- The average resolution times noted were based on durations of jurisdictional complaints closed in 2020. 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.

**Figure 6.2 CDI Complaint Standards**

| Complaint Type | Primary Unit(s) Responsible and Roles | Time Standard | Average Resolution Time in 2020 |
|---|---|---|---|
| Standard Complaint | Consumer Communications Bureau: Assistance to callers<br>Health Claims Bureau and Underwriting Services Bureau: Compliance Officers respond to written complaints<br>Consumer Law Unit: Legal review (if needed) | 30 working days, or<br>60 days if reviewed concurrently with the health plan review | 64 days<br>Calculation includes time for regulatory review after the case is closed to the complainant |
| Independent Medical Review (IMR) | Consumer Communications Bureau: Assistance to callers<br>Health Claims Bureau: Intake and casework<br>IMR Organization (contractor – MAXIMUS): Case review and decision<br>Consumer Law Unit: Legal Review (if needed)<br>Urgent clinical issues that qualify are addressed through an expedited IMR process | 30 working days, or<br>60 days if reviewed concurrently with the health plan review | 63 days<br>Calculation includes time for regulatory review after the case is closed to the complainant |

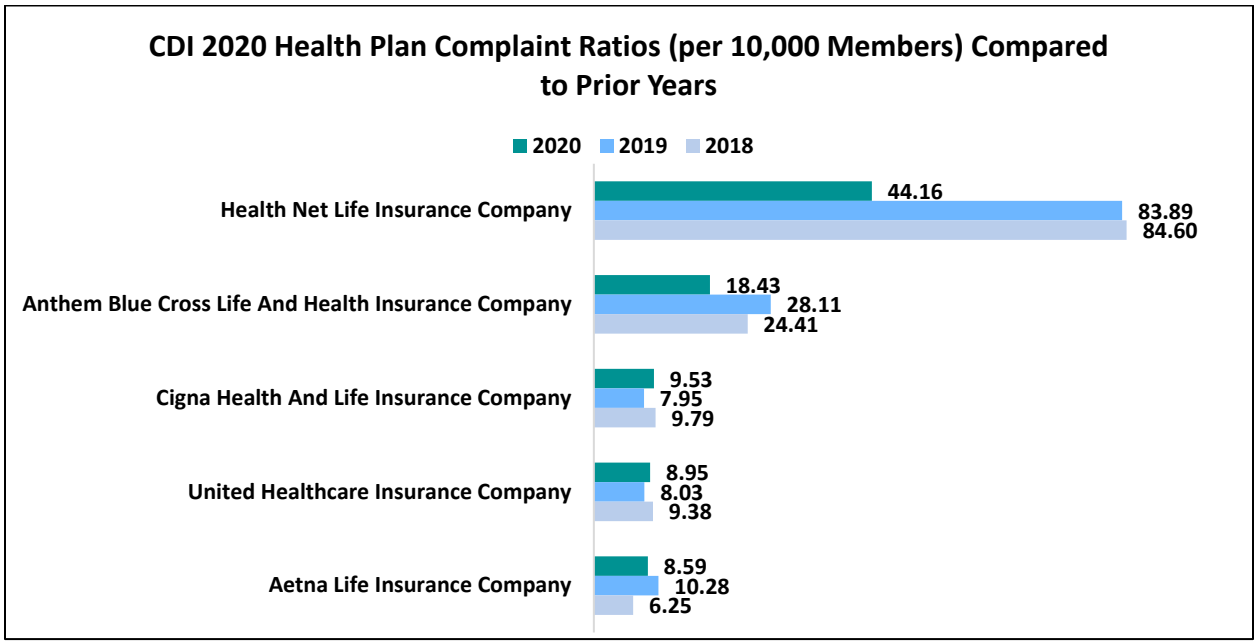
*Note: CDI leaves cases open even if the case requires more time for gathering information pertinent to the complaint review from the involved parties. This time is included in the resolution time calculation.*

## B. Complaint Ratios, Reasons, and Results

### Health Plan Complaint Ratios

The following chart displays health plan complaint ratios for the plans with at least 25 complaints closed by CDI and with enrollment exceeding 70,000 members in 2020.

**Figure 6.3**

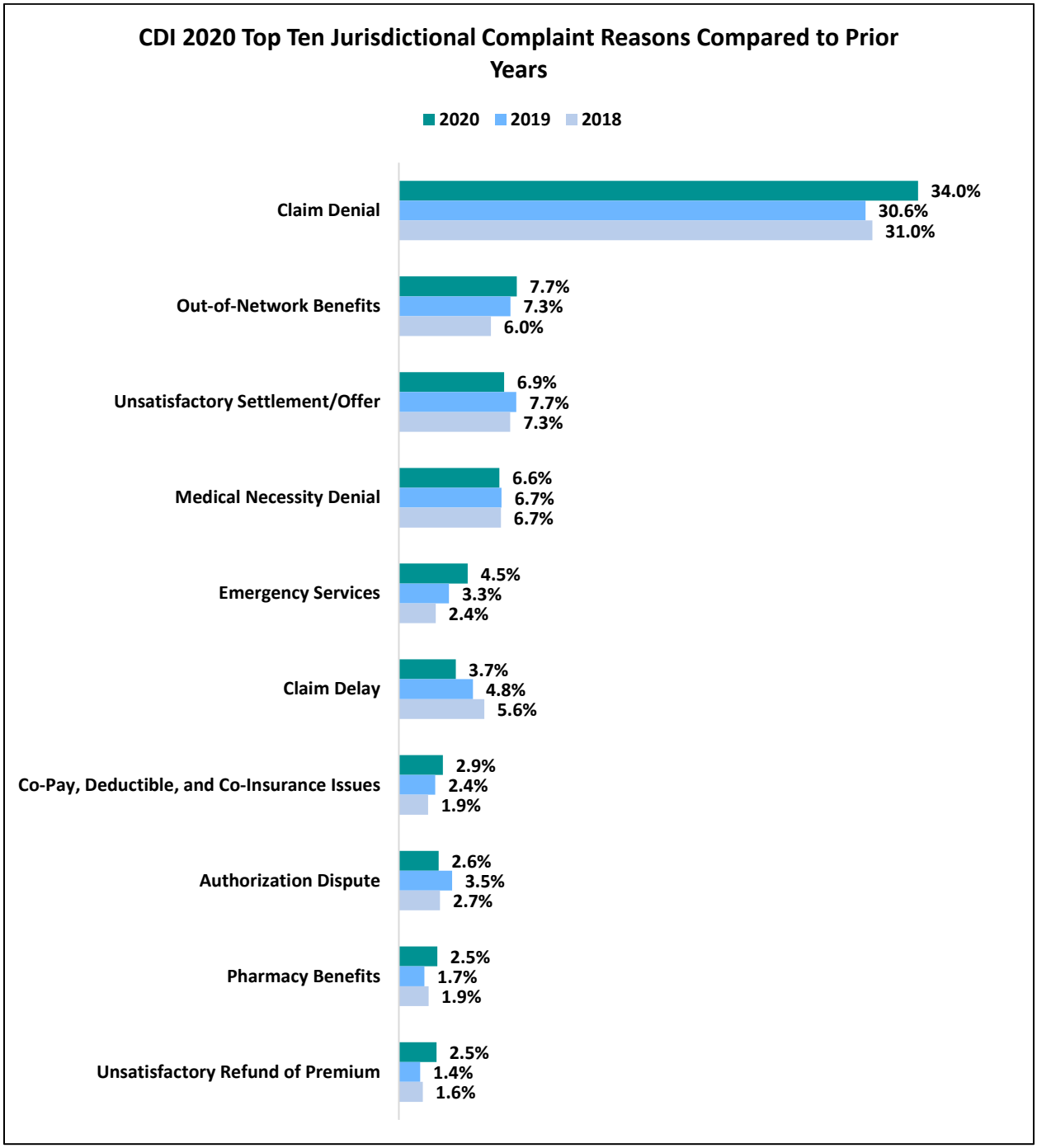



*Note: Health Net Life Insurance Company's 2018 and 2019 complaint ratio calculations included a significant number of cases initiated in 2016 and 2017 that were held open longer than usual for regulatory purposes and closed those years. This may affect comparisons with the current year.*

## Complaint Reasons

The following chart displays the 2020 top reasons for CDI's jurisdictional complaints, as well as the 2018 and 2019 data for the same categories. The number of complaint reasons exceeded the number of complaints because some complaint cases had more than one reason reported. There were 4,917 reasons submitted for the 3,217 jurisdictional complaints closed in 2020.

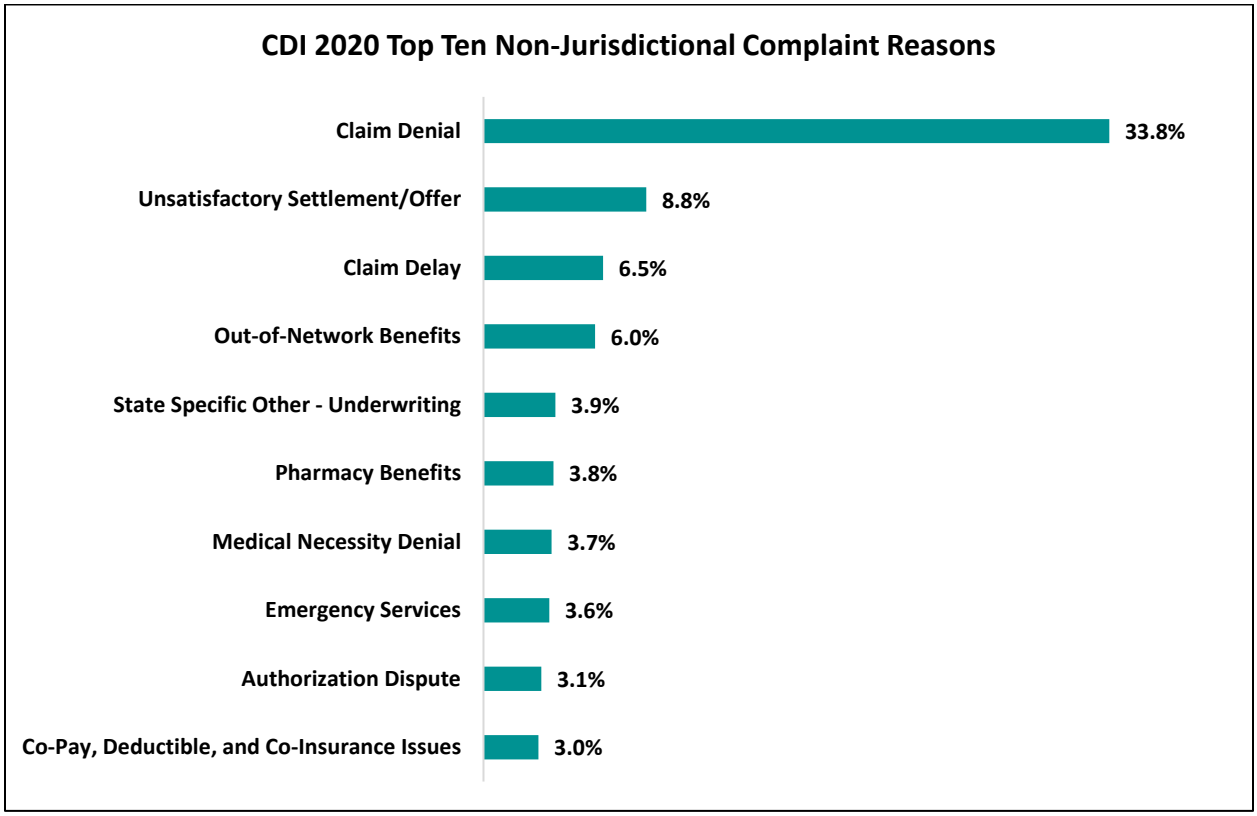
**Figure 6.4**



CDI indicated that complaint volumes for some reasons were affected by the pandemic. For example, Unsatisfactory Refund of Premium complaints increased. As consumers were receiving refunds on other lines of insurance, there also was consumer demand to obtain a refund on health policies as well while many health services were being postponed or cancelled.

The following chart displays the 2020 top reasons CDI reported for non-jurisdictional complaints. There were 5,319 reasons submitted for the 3,803 non-jurisdictional complaints in 2020.

**Figure 6.5**




The following table displays CDI's most common topics for consumer inquiry referrals, as well as the organizations to which those inquiries were referred. These estimated rankings exclude the non-jurisdictional complaints represented above in Figure 6.5.

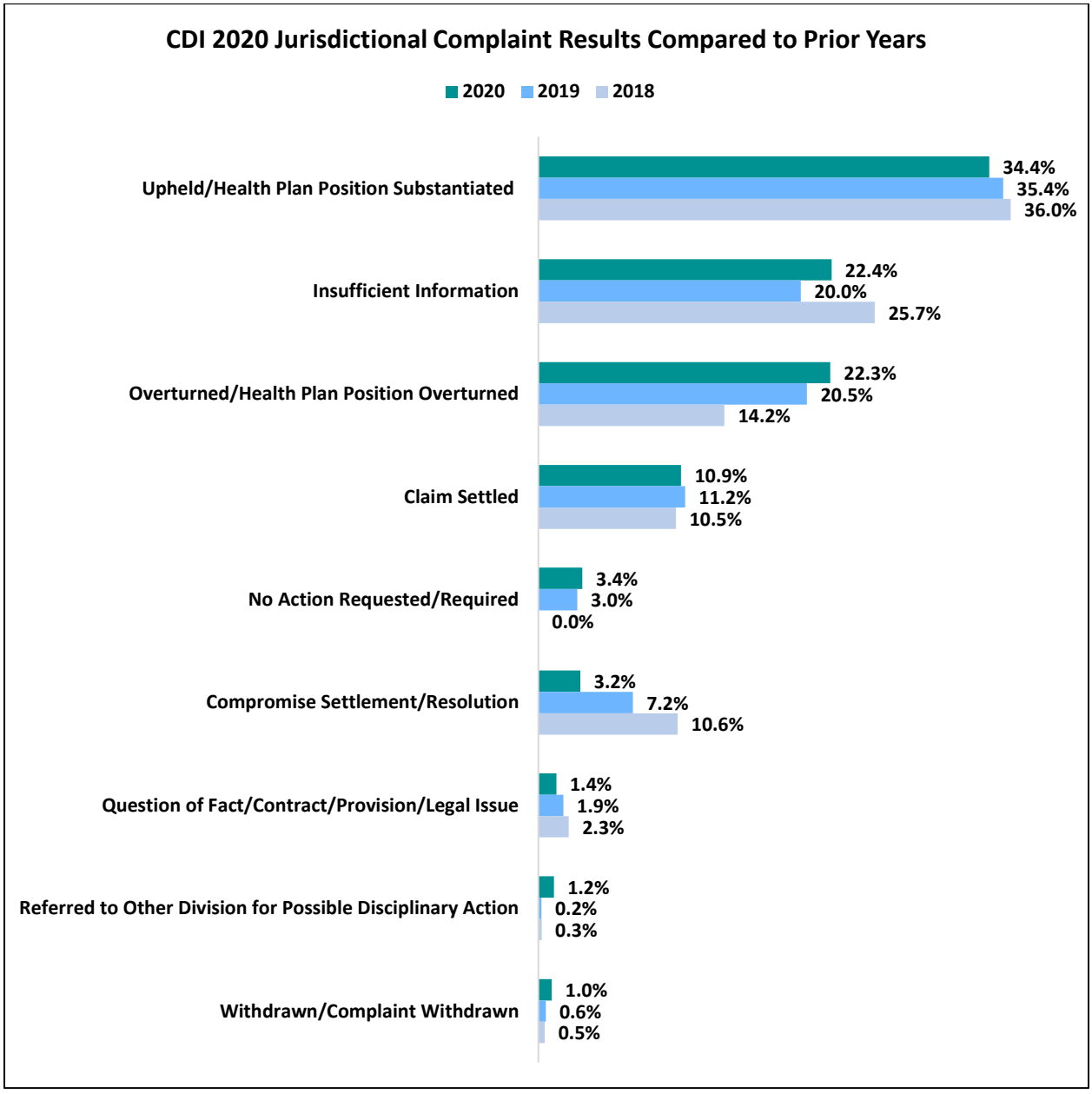
**Figure 6.6 CDI Top Ten Topics for Non-Jurisdictional Inquiries**

| Ranking | Inquiry Topic | Organization(s) Referred to |
|---|---|---|
| 1 (most common) | Claim Denial | Department of Managed Health Care (DMHC)<br>U.S. Department of Labor (DOL)<br>Centers for Medicare and Medicaid Services (CMS)<br>Various Departments of Insurance (DOIs) |
| 2 | Unsatisfactory Settlement/Offer | DMHC<br>DOL<br>CMS<br>Various DOIs |
| 3 | Claim Delay | DMHC<br>DOL<br>CMS<br>Various DOIs |
| 4 | Out of Network Benefits | DMHC<br>DOL<br>CMS<br>Various DOIs |
| 5 | Medical Necessity/Experimental | DMHC<br>Various DOIs |
| 6 | Co-Pay/Deductible Issues | DMHC<br>DOL<br>Various DOIs |
| 7 | Premium Refund | DMHC |
| 8 | Cancellation | DMHC<br>DOL<br>CMS<br>Various DOIs |
| 9 | Authorization Dispute | DMHC<br>DOL |
| 10 | Provider Availability/Timely Access to Care | DMHC<br>CMS<br>DOL |

## Complaint Results

The following chart displays CDI's 2020 results for its 3,217 jurisdictional complaints, along with the 2018 and 2019 data for the same categories.

**Figure 6.7**




*Note: Results categories considered to be 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.*

For CDI's 3,803 non-jurisdictional complaints in 2020, nearly 92 percent had the result entry of Referred to Outside Agency/Department. The other non-jurisdictional cases had a result entry of No Jurisdiction.

### Resolution Time

CDI's overall average complaint resolution time was 31 days in 2020, taking 64 days on average to close jurisdictional complaints and four days on average to close non-jurisdictional complaints.

- The 64-day average for jurisdictional complaints is shortest average duration for CDI since reporting began in 2014.
- The 38 percent decrease in average resolution time from the prior year (103 days in 2019) was due in part to fewer outlier complaints with lengthy durations due to CDI regulatory activities.
- Average resolution times for both types of jurisdictional complaint reviews reported by CDI decreased for the second straight year.
    - Standard Complaints took 64 days on average in 2020, falling from 110 days in 2019 and 125 days in 2018.
    - Independent Medical Reviews took 63 days on average in 2020, falling from 68 days in 2019 and 91 days in 2018.

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

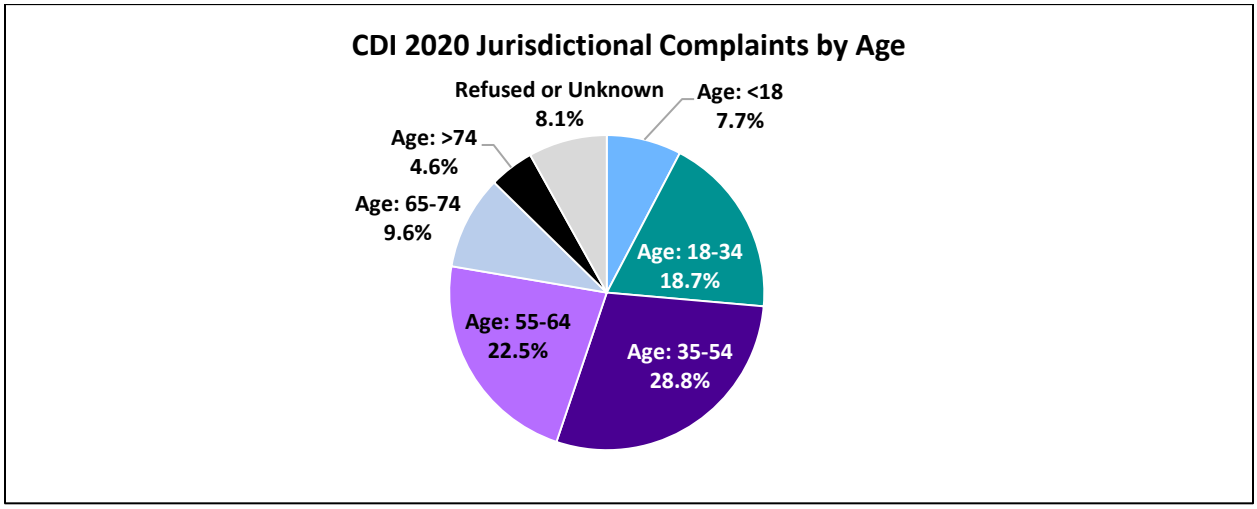
- Since CDI allows for concurrent review, average resolution time calculations include complaints opened prior to the completion of the health plan internal complaint review period.
- The close date reported by CDI does not reflect the date the complaint was closed to the complainant, but rather the conclusion of the department's regulatory investigation period.
    - CDI indicated that its final regulatory review period is 30 days on average.
    - When comparing resolution times between measurement years, it is important to note that CDI's 2018 and 2019 averages were affected by a higher than usual number of prolonged complaints (initiated in 2016 and 2017) that were held open for regulatory activities.

## C. Demographics and Other Complaint Elements

### Age

The average age of CDI's complainants in 2020 was 46 years old. Complaint volumes decreased from the prior year for all age groups.

**Figure 6.8**




### Gender

Most of CDI's 2020 complaints identified the complainant as Female (53.4% of the 3,217 jurisdictional complainants) while the rest were reported as Male (46.6%).

### Race

Forty-three percent of the CDI jurisdictional complaints in 2020 did not have race identified (41.2% Refused and 1.8% Unknown). White was the most commonly known category submitted (38.0%), followed by Asian (8.2%), Other (6.9%), Black or African American (2.6%), American Indian or Alaska Native (0.8%), and Native Hawaiian or Other Pacific Islander (0.5%).

### Ethnicity

Forty-three percent of the CDI jurisdictional complaints in 2020 did not have ethnicity identified (41.3% Refused and 1.7% Unknown). Not Hispanic or Latino accounted for half of the complaints (50.0%). Hispanic or Latino accounted for seven percent (7.1%). Complaint volumes fell compared to the prior year for both known ethnicity categories.

### Language

The distribution of complaints by the complainant's primary language was similar to the prior year. English was the most commonly reported language (66.2%) and Spanish next most common (1.2%). Twelve other languages were reported with low volumes (each accounting for under 0.5%), combining to represent approximately three percent (3.2%). Twenty-nine percent of the CDI jurisdictional complaints in 2020 did not have primary language identified (27.4% Refused and 2.0% Unknown).

### Mode of Contact

Complaint volumes for all reported initial modes of contact decreased in 2020 from the prior year. Online accounted for most of the 2020 jurisdictional complaints (51.0%),

surpassing Mail (44.7%) for the first time. Telephone accounted for approximately four percent (4.2%).

### Regulator

CDI was the reported regulator for all of its submitted complaints for 2020.

### Source of Coverage

The Group coverage source continued to account for most of CDI's complaints (60.2% of the 3,217 jurisdictional complaints in 2020). The Individual/Commercial coverage source accounted for nearly forty percent (39.8%).

### Product Type

CDI submitted 23 different product type categories in 2020. The volume of reported product types exceeded the volume of complaint cases because some CDI complaint cases were reported with more than one product type (5,656 product type entries from the 3,217 jurisdictional complaints in 2020). Health Only remained the most commonly reported product type (34.2%), followed by Large Group (22.4%), Stand Alone Dental (12.6%), Small Group (7.8%), Grandfathered (4.0%), Exchange (3.8%), Bronze (2.3%), Silver (2.3%), Medicare Supplement (2.1%), Mental Health (2.0%), Limited Benefits (1.8%), and Pharmacy Benefits (1.0%). Twelve other categories were reported with low volumes (each accounting for under 1%).

## D. Consumer Assistance Center Details

CDI's Consumer Services Division received 28,070 requests for assistance from health care consumers in 2020, including 20,117 contacts by telephone. Most requests for assistance were consumer inquiries rather than a complaint initiation.

The following table outlines the service center metrics for CDI's 2020 telephone calls.

**Figure 6.9 CDI Consumer Services Division – 2020 Telephone Metrics**

| Yearly Metrics | Measurement |
|---|---|
| Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR) | 419 |
| Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR) | 585 |
| Number of Jurisdictional Inquiry Calls | 15,868 |
| Number of Non-Jurisdictional Calls | 3,577 |
| Average Wait Time to Reach a CSR | 0:29 |
| Average Length of Talk Time (time between a CSR answering and completing a call) | 4:75* |
| Average Number of CSRs Available to Answer Calls (during Service Center hours) | Varies based on need** |

**The data does not reflect time spent by the officer to verify jurisdiction and return a call to the consumer. The metrics only reflect time of consumers' initial contacts.*

***Secondary health officers may be added to the health queue depending upon volume of calls received.*

### Consumer Assistance Protocols and Systems

CDI reported that the department implemented updates in July 2020 to its Hotline phone system and added an online chat feature.

CDI also noted that while the department did not make changes to its complaint system due to the COVID-19 pandemic, the complaint volumes and reasons may have been affected by overall health care system changes. For example, CDI noted that with the closure of physician offices and postponement of certain health services, there was an increase in consumers seeking premium refunds due to their inability to access care.

# Section 7 – Covered California

## A. Overview

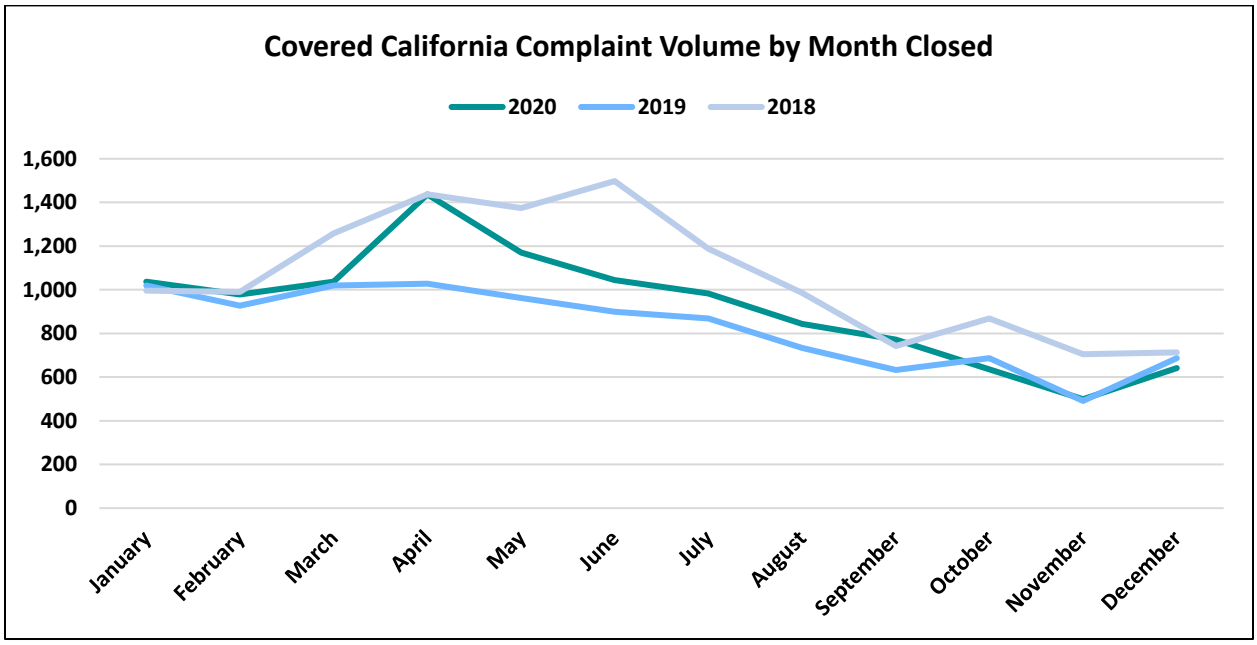
Covered California, the state's health benefit exchange, provides a state-based health insurance marketplace for consumers to buy health insurance and qualify for financial assistance to help pay their insurance costs. This report includes information reported by Covered California regarding:

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

Covered California received 6,424,432 requests for assistance from consumers in 2020, a nearly 28 percent volume increase from the prior year. Most of the requests for assistance are consumer inquiries about Covered California coverage rather than contacts to initiate a complaint. Covered California reported 2,095 State Fair Hearings, 8,984 other complaints resolved informally without a hearing, and 6,413,353 inquiries to its service center in 2020.

The following figure displays volumes by month closed for the 11,079 complaints in 2020, 9,958 complaints in 2019, and 12,760 complaints in 2018.

**Figure 7.1**



- Covered California noted that 44 percent of its complaints closed in 2020 were dual agency appeals to address eligibility determinations for Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal coverage.
- Covered California's complaint volume increased by 11 percent from 2019 to 2020.
    - The increase in complaints compared to the prior year is due to an upsurge in applicants signing up for new coverage.
    - From 2019 to 2020, the average level of enrollment in Covered California grew by over 175,000 Californians, the largest single-year increase in enrollment since 2015.
    - The overall volume of applications was higher still, as many seeking coverage applied online through CoveredCA.com and were found eligible for Medi-Cal.

The following table outlines the two complaint types reported by Covered California: State Fair Hearing and State Fair Hearing: Informal Resolution.

- Formal State Fair Hearings volumes decreased by 21 percent compared to the prior year. Volumes for this complaint type have fallen for three years straight.
- Informally-resolved State Fair Hearings volumes increased by 23 percent compared to the prior year.
- Covered California indicated that extensive business process improvements and staff training allowed for more complaints to be resolved informally in 2020 without requiring a formal State Fair Hearing.

**Figure 7.2 Covered California Complaint Standards**

| Complaint Type | Primary Unit(s) Responsible and Role | Time Standard | Average Resolution Time in 2020 |
|---|---|---|---|
| State Fair Hearing | CDSS State Hearings Division: Conducts hearings on eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving urgent health issues. | 90 days from the date the hearing request was filed | 70 days |
| State Fair Hearing: Informal Resolution | CDSS State Hearings Division: Reviews hearing request and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge | 45 days from the date the appeal was filed | 28 days |

*Note: State Fair Hearing time standard is from All County Letter 14-14 issued by CDSS on 2/7/14. The Covered California Service Center staff addresses Service Center complaints that are not State Fair Hearing appeals, and escalates 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

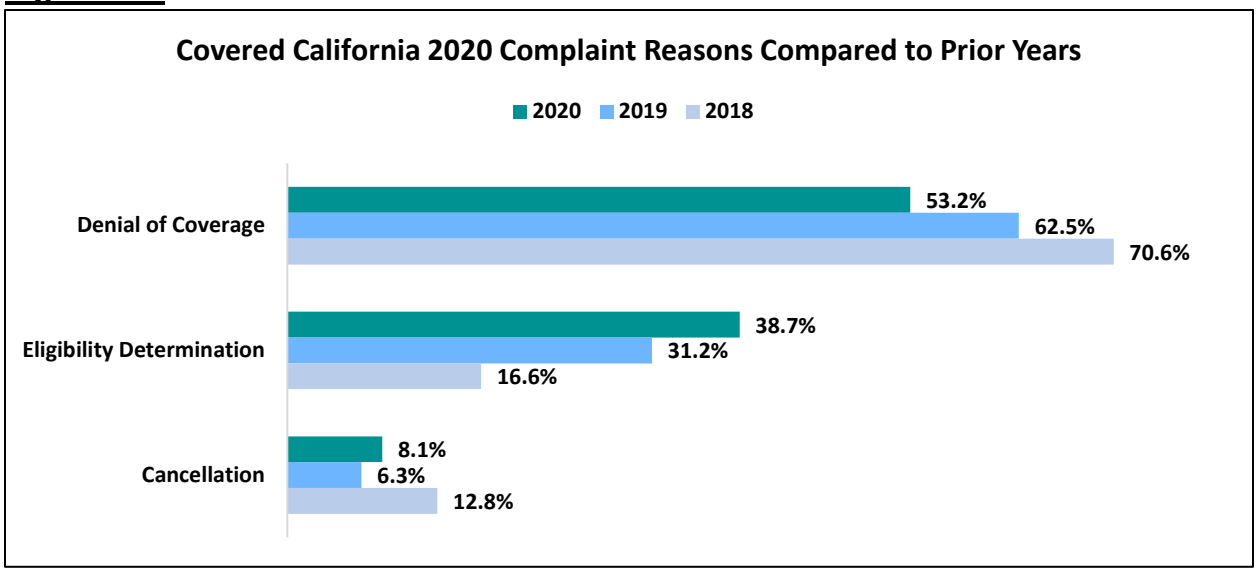
### Health Plan Complaint Ratios

Covered California health plan complaints are addressed health plan grievance and insurance regulator complaint review processes rather than through a State Fair Hearing. See Section 4.C. for information about Covered California health plan complaints resolved by the Department of Managed Health Care.

### Complaint Reasons

The following chart displays the complaint reason distribution for all 11,079 complaints in 2020, 9,958 complaints in 2019, and 12,760 complaints in 2018.

**Figure 7.3**




- Although it remained Covered California's most common complaint reason (accounting for 5,897 complaints in 2020), the volume of Denial of Coverage complaints fell for the fourth year.
- Eligibility Determination complaints increased by nearly 38 percent compared to the prior year volume (3,104 complaints in 2019 to 4,283 complaints in 2020).
- Cancellation complaints increased compared to the prior year, from 630 complaints in 2019 to 899 complaints in 2020.

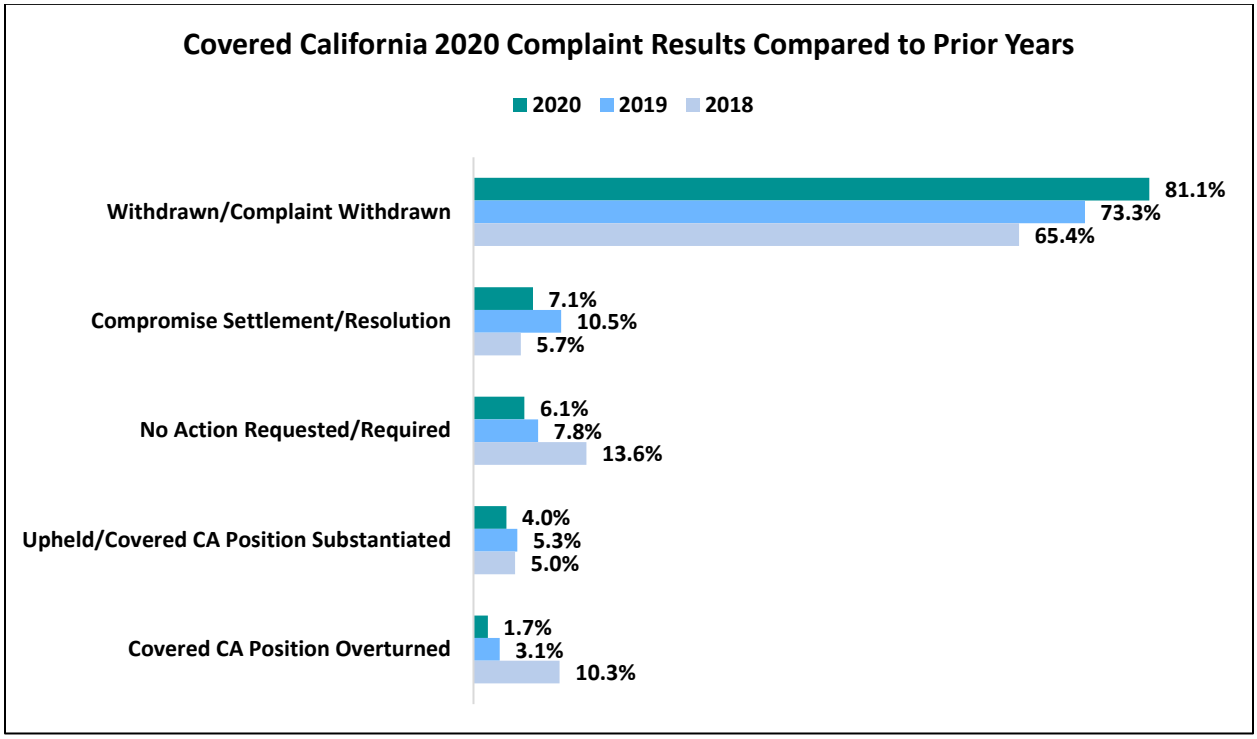
### Complaint Results

The following chart represents all complaint results reported for the 11,079 complaints in 2020, 9,958 complaints in 2019, and 12,760 complaints in 2018.

Covered California noted that the Withdrawn/Complaint Withdrawn result, its most commonly reported result, was submitted for cases where the complainant's issue was resolved informally prior to the completion of the State Fair Hearing. Covered California also noted that extensive business process improvements and staff training paved the

way for more complaints to be resolved informally, increasing the Withdrawn/Complaint Withdrawn result volume.

**Figure 7.4**




*Note: Results categories considered favorable to the complainant include: Compromise Settlement/Resolution and Covered CA Position Overturned. Results categories considered favorable to Covered California 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 the consumer received services or a similar positive outcome.*

The following figures display the 2020 results distributions for each of the three complaint reasons reported by Covered California compared to prior years' distributions.

**Figure 7.5**

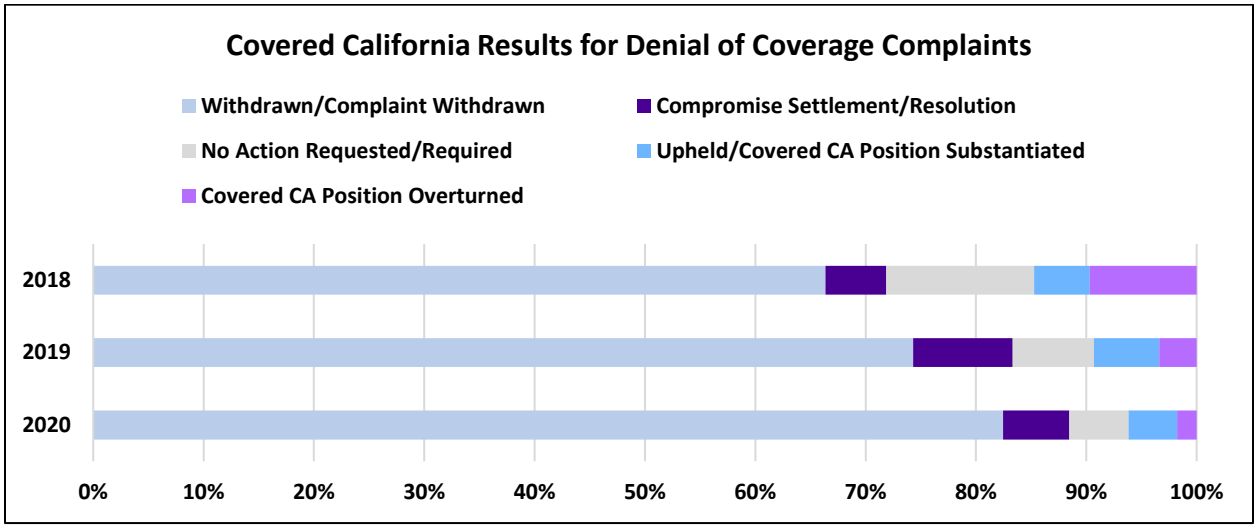


**Figure 7.6**

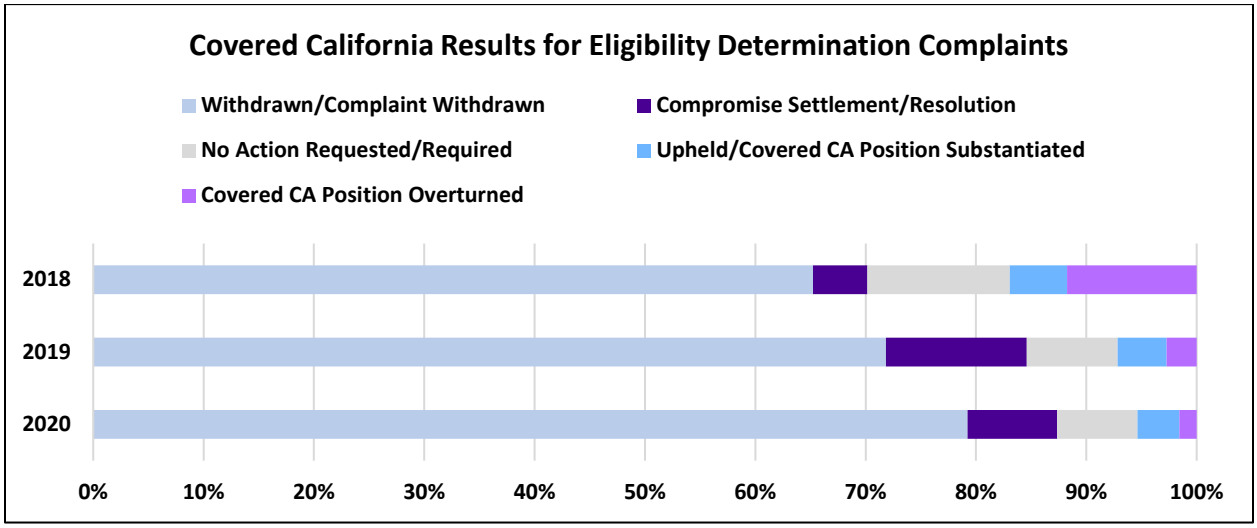
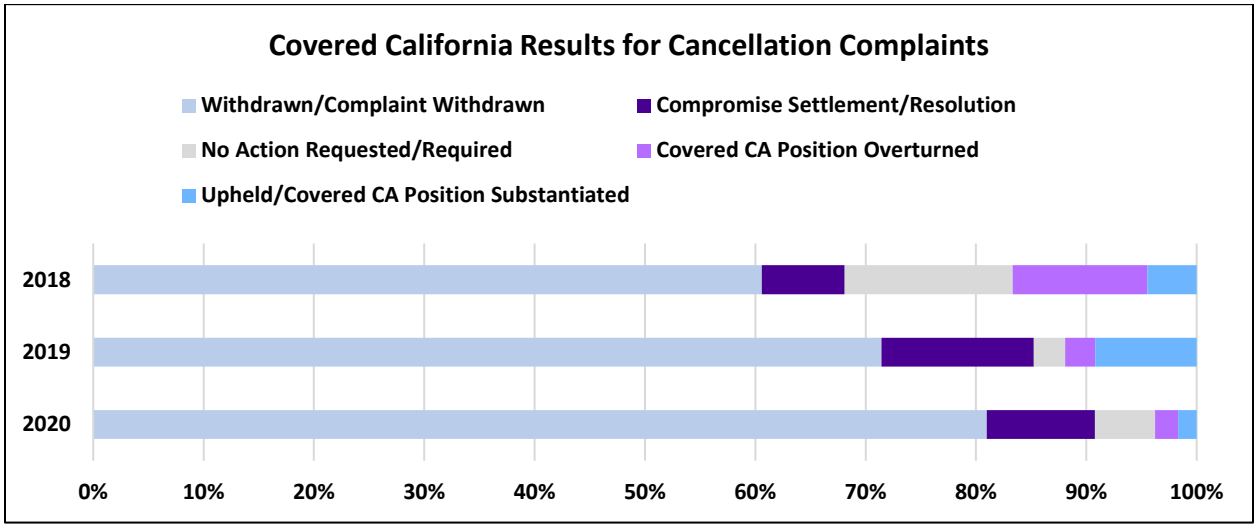



**Figure 7.7**

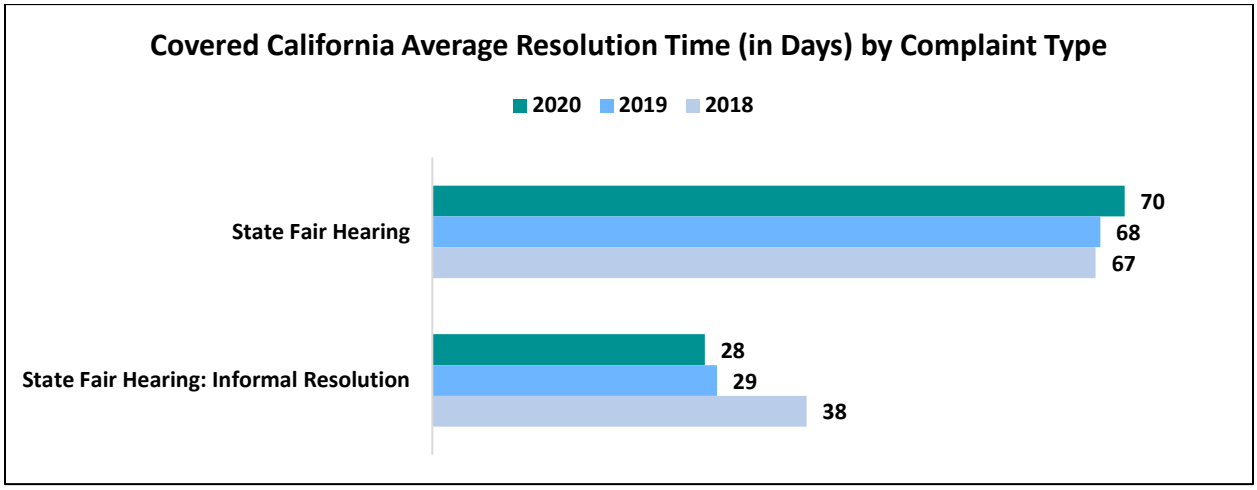



## Resolution Time

With a 36-day average in 2020, Covered California's average complaint resolution time fell for the third straight year. The overall decrease is associated with reduced durations for complaints resolved through the State Fair Hearing: Informal Resolution process.

The following figure displays the 2020 average resolution times for the two complaint types reported by Covered California, along with the 2018 and 2019 data for those types.

**Figure 7.8**




## C. Demographics and Other Complaint Elements

Covered California noted that information for some demographic categories, such as for race and ethnicity, is collected but is optional for applicants seeking coverage to provide.

### Age

The average age of Covered California's 2020 complainants was 46 years old. The 2020 complaint distribution by age group was similar to prior years. The Age 35-54 group had the most complaints (38.6% of the 11,079 complaints in 2020), followed by Age 18-34 (28.1%), Age 55-64 (26.6%), Age 65-74 (6.3%), Age 75 and older (0.3%), and Under 18 (0.2%). A small complaint volume were Age Unknown (0.1%).

### Gender

Covered California's 2020 complaint distribution by gender was similar to the prior few years. Female complainants accounted for the majority of the complaints (55.7% of the 11,079 complaints in 2020). Forty-three percent (43.5%) of the complaints were submitted with a Male complainant. Under one percent did not have the gender identified (0.8% Unknown).

### Race

White continued to be Covered California's most commonly reported race category for its complaints (36.1% of the 11,079 complaints in 2020). Nearly 35 percent of Covered California's 2020 complaints did not have race identified (34.8% Unknown). Other was the next most common known category (12.0%), followed by Asian (11.9%), Black or African American (4.5%), American Indian or Alaska Native (0.4%), and Native Hawaiian or Other Pacific Islander (0.2%).

### Ethnicity

Not Hispanic or Latino continued to be Covered California's most commonly reported ethnicity category for its complaints (67.3% of the 11,079 complaints in 2020). Hispanic or Latino accounted for over 22 percent (22.4%). Approximately 10 percent did not have the complainant's ethnicity identified (10.3% Unknown).

### Language

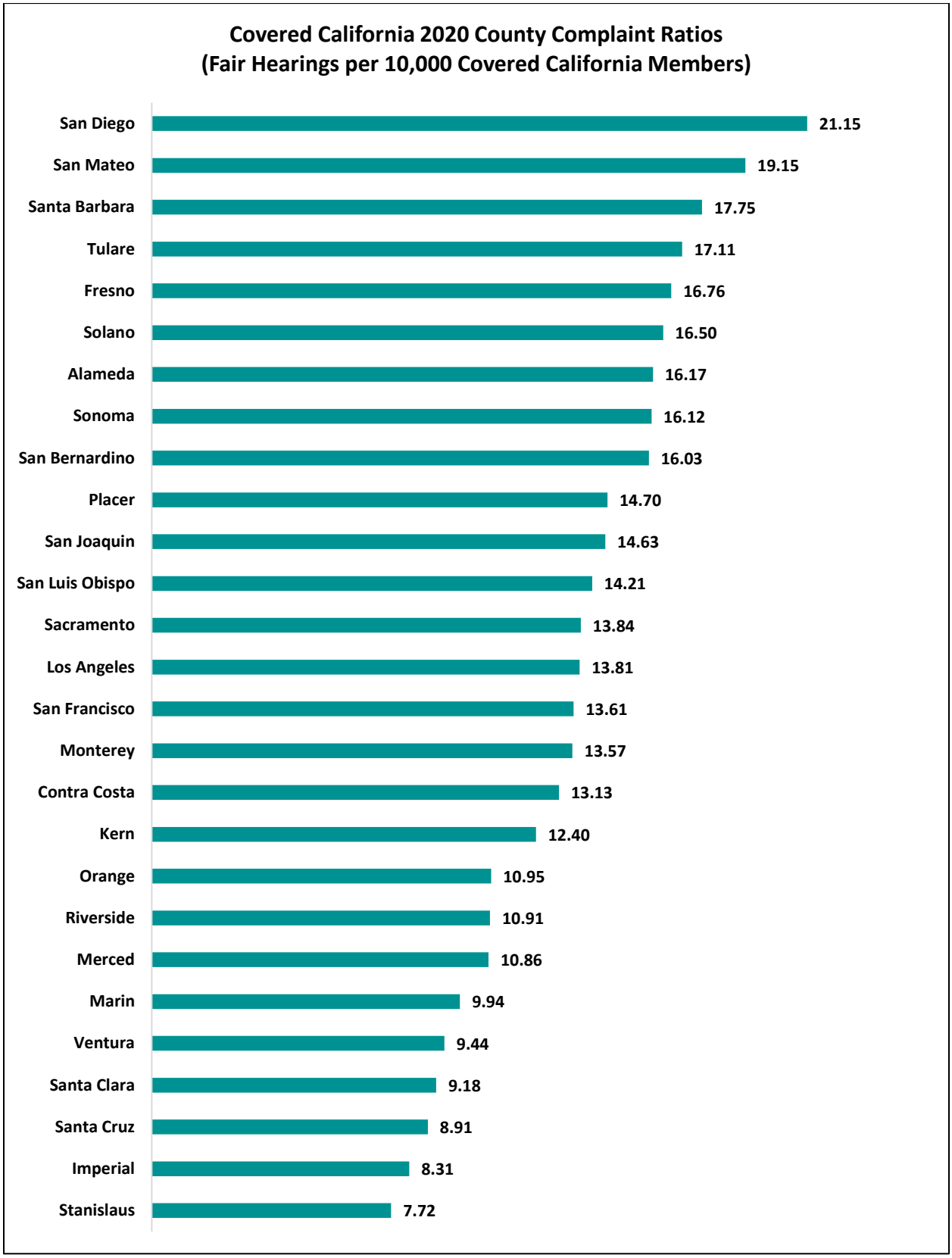
For the complainant's primary language, English continued to account for the majority of the complaints reported by Covered California (85.1% of the 11,079 complaints in 2020). Spanish was the next most common primary language with nearly eight percent (7.9%). Other languages combined accounted for four percent (11 languages reported with low complaint volumes, each accounting for 1% or less). Nearly three percent of the complaints did not have a primary language identified (2.9% Unknown).

### County of Residence

The following chart displays complaint ratios by the county of residence identified for the complainant. The ratio is the county's volume of formal State Fair Hearings per 10,000 county residents enrolled in a Covered California plan. The complaint volume used for the calculation does not include volumes for the State Fair Hearing: Informal Resolution complaint type. Counties with ten or fewer complaints or Covered California enrollment under 10,000 are excluded from the display.

- With 13.71 State Fair Hearings per 10,000 Covered California members in 2020, the average complaint ratio fell for the third straight year.
- Most of the counties represented in Figure 7.9 (23 out of 27 counties) had a complaint ratio that was lower in 2020 than the previous year.

**Figure 7.9**


Covered California 2020 County Complaint Ratios
(Fair Hearings per 10,000 Covered California Members)
San Diego 21.15
San Mateo 19.15
Santa Barbara 17.75
Tulare 17.11
Fresno 16.76
Solano 16.50
Alameda 16.17
Sonoma 16.12
San Bernardino 16.03
Placer 14.70
San Joaquin 14.63
San Luis Obispo 14.21
Sacramento 13.84
Los Angeles 13.81
San Francisco 13.61
Monterey 13.57
Contra Costa 13.13
Kern 12.40
Orange 10.95
Riverside 10.91
Merced 10.86
Marin 9.94
Ventura 9.44
Santa Clara 9.18
Santa Cruz 8.91
Imperial 8.31
Stanislaus 7.72

### Mode of Contact

Although the use of email and online modes of contact increased for the third straight year, most complaints continued to be initiated by telephone in 2020 (56.5% of the 11,079 complaints). Email was the next most common mode of contact (35.2%), followed by Online (8.3%).

### Regulator

Covered California's complaints do not address health plan issues and so do not have attributed regulator information. For 2020, Covered California reported that 96.3 percent of its members were enrolled in plans regulated by DMHC and 3.7 percent were in plans regulated by CDI.

### Source of Coverage

Most of Covered California's 2020 complaints identified Covered California as the source of coverage (71.9% of the 11,079 complaints). Unknown was reported for cases where consumers had not selected a Covered California plan when they filed an appeal (28.1% in 2020).

### Product Type

Covered California submitted complaints with product types pertaining to the metal tier associated with the complainant's level of coverage. Silver was the most commonly identified product type for the 2020 complaints (39.6% of the 11,079 complaints). Bronze accounted for 21 percent (21.0%), Gold for over seven percent (7.6%), Platinum for three percent (3.0%), and Catastrophic for under one percent (0.9%). Unknown was reported for cases where consumers had not selected a Covered California plan when they filed an appeal (28.1% in 2020).

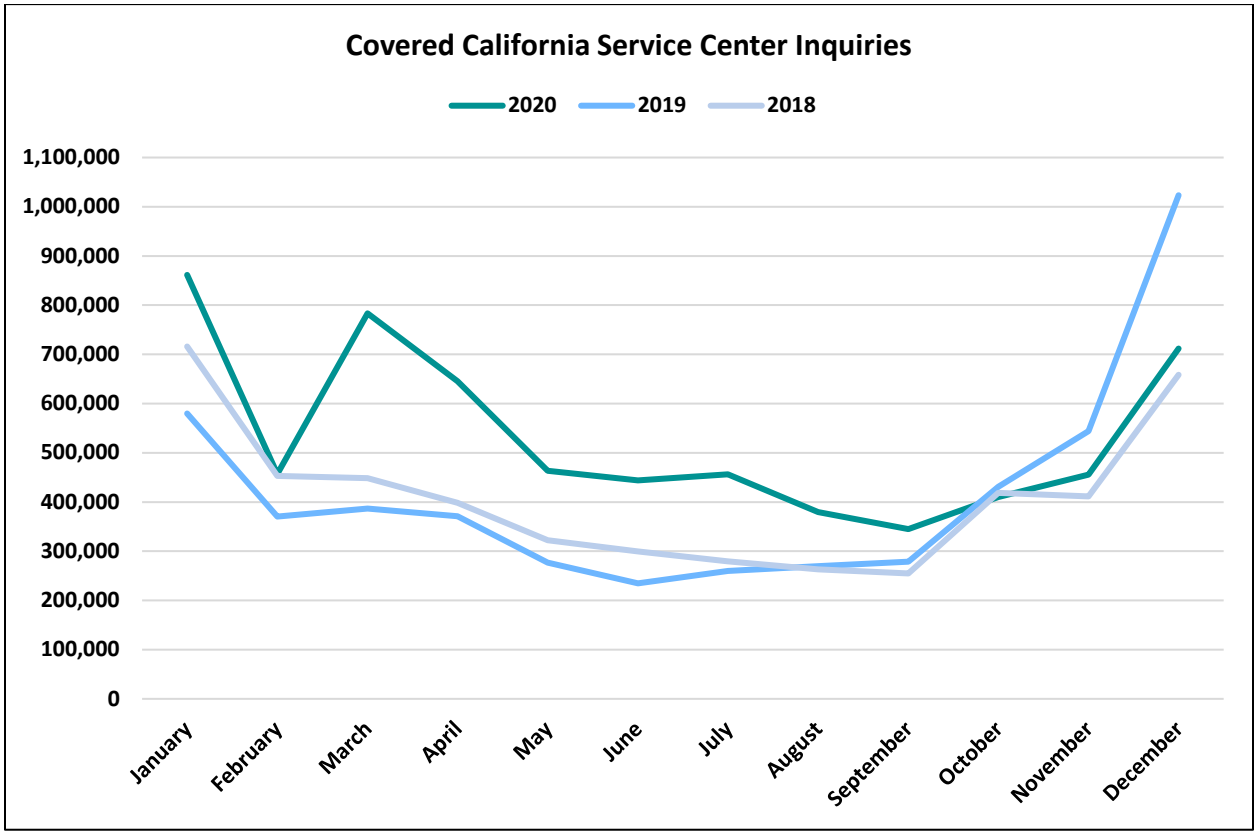
## D. Consumer Assistance Center Details

With 6,413,353 inquiries from consumers, the Covered California Service Center handled its highest-ever annual inquiry volume in 2020. The inquiry volume increased by 28 percent compared to the prior year (from 5,025,146 in 2019). Covered California attributed this spike to record enrollment in 2020, which was driven by a combination of:

- The new state subsidies providing additional help to low-income Californians and, for the first time, tax credits for middle-income consumers whose income was above 400 percent of the Federal Poverty Level (FPL);
- The new state mandate implemented which requires Californians to pay a penalty on their taxes if they remain uninsured for 4 months or longer;
- The unprecedented demand for coverage during the COVID-19 pandemic and from individuals experiencing economic hardship.

Taken together, these factors led Covered California to its highest enrollment level ever, and the most growth in a single year since 2015.

**Figure 7.10**




The following table displays the top ten inquiries made to the Covered California Service Center in 2020 for both jurisdictional and non-jurisdictional topics. Most consumer contacts with the Service Center are jurisdictional inquiries that do not have to be referred to another organization.

**Figure 7.11**

| Ranking | Inquiry Topic | Organization(s) Referred to |
|---|---|---|
| 1 (most common) | Case Status Inquiry | Not referred |
| 2 | Enrollment | Not referred |
| 3 | Provided County Contact Information | Medi-Cal Program |
| 4 | Report a Change – Income Change | Not referred |
| 5 | Inquiry about Covered California | Not referred |
| 6 | Online Account Assistance Inquiry | Not referred |
| 7 | Renewal Assistance | Not referred |
| 8 | Other | Not referred |
| 9 | Reset Password | Not referred |
| 10 | Renewal Inquiry | Not referred |

Most of the 2020 consumer inquiries to the Covered California Service Center were made by telephone (85.5% of the 6,413,353 inquiries). Nearly eight percent (7.6%) of

the inquiries were made through a chatbot session and nearly seven percent (6.9%) were made through an online chat.

The following table outlines metrics for the Covered California Service Center's telephone calls in 2020. The metrics were based on tracked data unless otherwise indicated.

**Figure 7.12 Covered California Service Center – 2020 Telephone Metrics**

| Yearly Metrics | Measurement |
|---|---|
| Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR) | 218,821 |
| Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR) | 2,488,396 |
| Average Wait Time to Reach a CSR | 0:03:49 |
| Average Length of Talk Time (time between a CSR answering and completing a call) | 0:19:35 |
| Average Number of CSRs Available to Answer Calls (during Service Center hours) | 635 Full-Time Equivalent (estimated) |

### Consumer Assistance Protocols and Systems

The Covered California Service Center was tasked with providing consumer assistance to more applicants for a longer period than usual during 2020. Normally enrollment is limited after the open enrollment period ends. Due to the pandemic, Covered California extended a special enrollment period for 2020 coverage so that anyone who was eligible could apply at any time of the year.

Covered California did not report any other changes to its consumer assistance protocols or systems in 2020.

# Section 8 – Conclusion

This Annual Health Care Complaint Data Report is the first issued by the Center for Data Insights and Innovation (CDII) since the reporting requirement transitioned from the Office of the Patient Advocate in October 2021. CDII reviewed the seventh year of complaint data submitted by four reporting entities: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and Covered California. This section highlights issues that were noteworthy for the Measurement Year 2020 analysis. CDII continues to urge caution in making comparisons between reporting entities and measurement years due to complaint system differences and reporting changes.

### Volume of Complaints

DMHC, DHCS, CDI, and Covered California reported 35,139 jurisdictional complaints closed in 2020, a slight decrease from the previous year (35,470 in 2019).

- Covered California was the only entity with an increased complaint volume in 2020 compared to the prior year (11.3% increase).
    - With a surge in applications for coverage during the pandemic, there also were more complaints to address eligibility and enrollment issues, which were State Fair Hearings resolved informally by Covered California.
- The volume of State Fair Hearings reported by DHCS decreased in 2020, mirroring a slight drop in enrollment. The DHCS 2020 complaint volume was only slightly lower (0.3%) than the prior year, but also represented the fourth straight year of a decrease.
- Complaint volumes for both regulators, DMHC and CDI, fell from the prior year despite increased numbers of people enrolled in the health coverage products that they license.
    - The DMHC 2020 complaint volume was only slightly lower (0.2%) than the prior year, but represented the fourth straight year of a decrease.
    - The CDI 2020 complaint volume was 30 percent (30.5%) lower than the prior year.

### Complaint Reasons

Denial of Coverage remained the top statewide complaint reason in 2020, for the fifth straight year, and has been Covered California's top reason since 2014.

Medical Necessity Denial replaced Co-Pay, Deductible, and Co-Insurance Issues as DMHC's top complaint reason in 2020. However, this changeover is due in part to a reporting change in 2020 that remapped some complaint volumes previously reported as Co-Pay, Deductible, and Co-Insurance Issues to Billing/Reimbursement Issue.

The most common complaint reason for DHCS complaints overall remained Scope of Benefits, largely due to its Dental-related volumes. For Medi-Cal Managed Care and Fee-for-Service, the top complaint reason was Pharmacy Benefits.

Unsatisfactory Refund of Premium complaints was in CDI's top ten for the first time since 2014. CDI noted that the increase was associated with consumers wanting their insurance premiums refunded after they were unable to access services while health care providers took measures to mitigate COVID-19 risks, including by closing physicians' offices and postponing or cancelling certain non-urgent procedures or health care services.

**Complaint Results and Resolution Time**

Upheld/Health Plan Position Upheld, the most common result for both regulators (accounting for 50% of the DMHC complaints and 34% of the CDI complaints), remained the top statewide result in 2020. Withdrawn/Complaint Withdrawn remained the top result for DHCS and Covered California. Both entities have noted that Withdrawn/Complaint Withdrawn often is reported when the consumer's complaint was resolved before the State Fair Hearing.

Complaints took on average 34 days for the entities to resolve in 2020, a shorter period compared to prior year's average. The 2020 average complaint durations per entity (with comparison to the 2019 average noted):

- DMHC - 24 days on average (an increase of 3 days)
- DHCS - 47 days on average (a decrease of 4 days)
- CDI - 64 days on average (a decrease of 37 days)
- Covered California - 36 days on average (a decrease of 3 days)

**Data Limitations**

Additional study may be required to pinpoint the impact of the COVID-19 pandemic on consumer health care complaints. Differences in coverage products, complaint systems, and reporting make comparisons inexact between reporting entities and measurement years. The data from the four state entities only partially represent the various and differing levels of complaint outlets available to consumers. For example, Covered California reported a type of informal complaint resolved at the initial service center level not represented for the other coverage sources. Medicare, self-insured plans, and certain other coverage types are not fully represented as they are not overseen by the state entities that submit data for this report. In addition, each reporting entity may use different methodologies and criteria for similar subjects addressed in their departmental reports.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