Measurement Year 2017 Data Tables

For the Office of the Patient Advocate's Annual Health Care Complaint Data Report

Section 3 – Statewide Data Tables

A. Overview

Figure 3.1 2017 Reporting Entity Complaints, Plans, and Enrollment

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

Note: Due to differences in timing and reporting methodologies, the data in this table may not correspond to data published by the departments in other reports. In addition, direct comparisons across reporting entities are imprecise due to variances in department functions, complaint systems, and data availability. DMHC's enrollment is for full-service plans only, a methodology change from prior reports. CDI's 2017 complaint total includes non-jurisdictional case data not reported in prior years.

B. Statewide Consumer Assistance Centers

Figure 3.2 Consumer Assistance Service Centers by Reporting Entity
See complete report for service center hours and contact information.

Figure 3.3 Statewide Requests for Assistance Volumes

Reporting Entity	2015 Volume	2016 Volume	2017 Volume
DMHC	171,597	189,482	164,759
DHCS	1,463,131	1,353,223	1,326,078
CDI	45,882	43,097	38,316
Covered California	5,397,086	6,058,978	5,894,358

Figure 3.4 Statewide Complaints as Percent of Requests for Assistance

Reporting Entity	2015 Percentage	2016 Percentage	2017 Percentage
DMHC	10.3%	13.7%	11.7%
DHCS	0.5%	0.5%	0.5%
CDI	7.0%	6.7%	10.1%
Covered California	0.1%	0.3%	0.3%

C. Statewide Health Care Complaint Data

Figure 3.5 Statewide Jurisdictional Complaint Volumes

Measurement Year	Statewide Total	DMHC Volume	DHCS Volume	CDI Volume	Covered CA Volume
2015	33,863	17,737	6,740	3,209	6,150
2016	55,923	25,884	6,770	2,871	20,398
2017	45,372	19,197	6,603	3,885	15,687

Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution. CDI's newly reported non-jurisdictional complaint dataset was excluded from the statewide three-year trend analysis, along with three cases referred by DMHC to outside agencies or departments in 2017.

Figure 3.6 Statewide Volume of Complaints by Month Closed

Month	2015 Volume	2016 Volume	2017 Volume
January	2,056	3,658	4,067
February	2,480	4,128	3,871
March	3,446	5,486	4,349
April	3,026	5,471	4,131
May	2,173	5,307	4,123
June	2,347	5,734	3,883
July	2,474	4,121	3,539
August	2,740	4,813	4,237
September	3,134	4,981	3,917
October	3,474	4,411	3,513
November	3,109	3,603	3,025
December	3,377	4,210	2,717

Figure 3.7 Statewide Complaint Volumes by Month Opened in 2016

Month in 2016	Volume of Complaints Opened
January	5,033
February	5,579
March	6,178
April	5,266
May	4,732
June	4,076
July	4,478
August	5,362
September	3,616
October	3,846
November	3,492
December	4,059

Figure 3.8 Statewide 2017 Top Five Complaint Reasons Compared to Prior Years

Complaint Reason	2015 Percentage	2016 Percentage	2017 Percentage
Denial of Coverage	12.1%	23.4%	20.9%
Cancellation	9.7%	13.6%	11.6%
Medical Necessity Denial	12.1%	9.9%	9.4%
Eligibility Determination	3.0%	6.9%	6.7%
Experimental/Investigational Denial	3.2%	8.5%	6.2%

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

Figure 3.9 Statewide Complaints by Source of Coverage

Source of Coverage	2015 Percentage	2016 Percentage	2017 Percentage
Covered California/Exchange	27.6%	45.8%	40.7%
Group	29.1%	23.7%	24.3%
Medi-Cal	25.7%	16.5%	19.8%
Individual/Commercial	13.1%	9.4%	12.1%
Medicare	1.5%	1.2%	1.2%
Unknown	2.6%	3.1%	0.9%
Other	0.2%	0.1%	0.6%
Medi-Cal/Medicare	0.3%	0.1%	0.4%

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

Figure 3.10 Statewide 2017 Top Five Complaint Reasons by Primary Language

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

Figure 3.11 Statewide 2017 Top Ten Jurisdictional Complaint Results Compared to Prior Years

Complaint Result	2015 Percentage	2016 Percentage	2017 Percentage
Upheld/Health Plan Position Substantiated	28.2%	23.7%	30.3%
Withdrawn/Complaint Withdrawn	15.2%	18.4%	19.7%
Overturned/Health Plan Position Overturned	8.0%	11.0%	12.0%
Compromise Settlement/Resolution	12.5%	13.1%	11.4%
Insufficient Information	9.6%	7.9%	10.2%
No Action Requested/Required	5.6%	8.4%	8.9%
Consumer Received Requested Service	6.3%	8.7%	5.5%
Claim Settled	0.4%	0.0%	0.8%
Referred to Other Division for Possible Disciplinary Action	3.6%	4.9%	0.7%
Question of Fact/Contract/Provision/Legal Issue	1.5%	1.0%	0.4%

Figure 3.12 2017 Complaint Resolution Times by Reporting Entity

Reporting Entity	Minimum Number of Days to Resolve a Complaint	Maximum Number of Days to Resolve a Complaint	Average Resolution Time (in days)
DMHC	0	231	22
DHCS	0	698	79
CDI	0	668	80
Covered California	0	339	66

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

Figure 3.13 Statewide 2017 Average Resolution Times by Complaint Type

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

Section 4 – Department of Managed Health Care Data Tables

A. Overview

Figure 4.1 DMHC Requests for Assistance Volume by Month

Month	2015 Volume	2016 Volume	2017 Volume
January	15,805	17,483	17,850
February	17,068	19,123	16,472
March	17,497	19,217	16,281
April	16,065	16,890	13,252
May	13,087	15,414	13,840
June	14,457	15,140	12,907
July	14,149	15,199	12,817
August	13,181	16,900	13,842
September	12,433	13,949	11,923
October	12,841	15,469	11,959
November	12,333	12,286	11,567
December	12,681	12,412	12,049

Note: This chart displays the DMHC Help Center's consumer assistance volumes by month for three reporting years. The Help Center received 164,759 requests for assistance in 2017, 189,482 in 2016, and 171,597 in 2015.

Figure 4.2 DMHC Volume of Complaints by Month Closed

Month	2015 Volume	2016 Volume	2017 Volume
January	1,327	1,804	2,019
February	1,309	1,803	1,729
March	1,331	2,112	1,867
April	1,549	2,239	1,545
May	1,410	2,151	1,593
June	1,323	2,309	1,629
July	1,409	2,228	1,471
August	1,523	2,780	1,659
September	1,483	2,389	1,476
October	1,457	1,915	1,538
November	1,812	1,791	1,369
December	1,804	2,363	1,305

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

Figure 4.3 DMHC Complaint Volume by Month Opened in 2016

Month in 2016	Volume of Complaints Opened
January	1,700
February	1,920
March	2,383
April	2,083
May	2,310
June	2,108
July	2,440
August	3,110
September	1,815
October	1,953
November	1,728
December	1,954

Figure 4.4 DMHC Help Center Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
Standard Complaint	*Contact Center:* Intake and routing *Independent Medical Review/ Complaint Branch:* Casework *Legal Branch:* Casework for more complex legal cases	30 days from receipt of a completed complaint application	21 days
Independent Medical Review (IMR)	*Contact Center:* Intake and routing *Independent Medical Review/Complaint Branch:* Casework *IMR contractor (MAXIMUS):* External Review decision *Legal Branch:* Legal review if needed	30 days from receipt of a completed IMR application 7 days for Expedited IMR cases	27 days Calculation includes time prior to the completion of the IMR application
Urgent Nurse	*Contact Center:* Intake, initial casework, and routing *Independent Medical Review/Complaint Branch:* Casework, open an IMR if needed	10 calendar days from receipt of a request for assistance	6 days
Quick Resolution	*Contact Center:* Intake and casework resolution	10 days	5 days

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

B. Complaint Ratios, Reasons, and Results

Figure 4.5 DMHC 2017 Top Ten Highest Health Plan Complaint Ratios (Complaints per 10,000 Members)

Health Plan	2015 Ratio	2016 Ratio	2017 Ratio
Health Net of California, Inc.	20.15	7.38	21.39
Anthem Blue Cross	14.69	24.69	18.71
Blue Shield of California	15.38	22.37	16.87
Aetna Health of California, Inc.	11.89	12.90	14.15
UnitedHealthcare of California	10.88	16.54	12.49
Western Health Advantage	9.30	13.16	11.28
Cigna HealthCare of California, Inc.	11.78	17.29	11.04
Care 1st Health Plan	11.62	15.24	10.79
Kaiser Permanente	7.39	10.15	6.63
Sharp Health Plan	4.16	7.05	5.75

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

Figure 4.6 DMHC 2017 Top Ten Complaint Reasons Compared to Prior Years

Complaint Reason	2015 Percentage	2016 Percentage	2017 Percentage
Medical Necessity Denial	19.6%	14.3%	15.7%
Cancellation	14.4%	18.2%	13.8%
Co-Pay, Deductible, and Co-Insurance Issues	13.2%	11.1%	13.3%
Experimental/Investigational Denial	5.1%	17.3%	13.1%
Coverage Question	7.4%	7.3%	9.7%
Provider Attitude and Service	5.7%	4.8%	6.8%
Out of Network Benefits	6.6%	4.7%	5.2%
Pharmacy Benefits	3.6%	2.9%	3.8%
Dis/Enrollment	5.6%	3.8%	3.7%
Access to Care	3.4%	2.6%	3.3%

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

Figure 4.7 DMHC Help Center 2017 Top Ten Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Volume	Referred to
1 (most common)	General Inquiry/Info	8,203	Department of Health Care Services (DHCS) Covered California Centers for Medicare and Medicaid Services (CMS) California Department of Insurance (CDI) Health Insurance Counseling & Advocacy Program (HICAP)
2	Enrollment Disputes	1,237	Covered California DHCS Health Consumer Alliance (HCA) Partner

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

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

Figure 4.8 DMHC 2017 Complaint Results Volume

Complaint Result	Total Volume	DMHC-Regulated Volume	Non-Jurisdictional Volume
Upheld/Health Plan Position Substantiated	10,093	10,084	9
Compromise Settlement/Resolution	4,155	4,141	14
Insufficient Information	3,955	3,346	609
Consumer Received Requested Service	2,694	2,392	302
Overturned/Health Plan Position Overturned	1,650	1,650	0
Referred to Other Division for Possible Disciplinary Action	334	334	0
No Jurisdiction	31	29	2
Claim Settled	12	12	0
Referred to Outside Agency/Dept.	3	3	0
Withdrawn/Complaint Withdrawn	1	1	0

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

Figure 4.9 DMHC 2017 Complaint Results Distribution Compared to Prior Years

Complaint Result	2015 Percentage	2016 Percentage	2017 Percentage
Upheld/Health Plan Position Substantiated	38.0%	33.5%	44.0%
Compromise Settlement/Resolution	17.0%	12.4%	18.1%
Insufficient Information	17.4%	15.5%	17.2%
Consumer Received Requested Service	11.5%	17.3%	11.7%
Overturned/Health Plan Position Overturned	8.9%	10.8%	7.2%
Referred to Other Division for Possible Disciplinary Action	6.5%	9.9%	1.5%
No Jurisdiction	0.3%	0.1%	0.1%
Claim Settled	0.1%	0.0%	0.1%

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

Figure 4.10 DMHC 2017 Results for Medical Necessity Denial Complaints

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

Figure 4.11 DMHC 2017 Results for Cancellation Complaints

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

Figure 4.12 DMHC 2017 Results for Co-Pay, Deductible, and Co-Insurance Issues Complaints

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

Figure 4.13 DMHC Average Resolution Time by Complaint Type (in Days)

Complaint Type	2015 Average Resolution Time	2016 Average Resolution Time	2017 Average Resolution Time
Independent Medical Review	26	24	27
Complaint/Standard Complaint	39	30	21
Urgent Nurse Case	9	14	6
Quick Resolution	6	7	5

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

Figure 4.14 DMHC 2017 Top Ten Complaint Reasons and Corresponding Average Resolution Times (in Days)

Complaint Reason	Percentage of Complaints	Average Resolution Time (in Days)
Medical Necessity Denial	15.7%	26
Cancellation	13.8%	22
Co-Pay, Deductible, and Co-Insurance Issues	13.3%	20
Experimental/Investigational Denial	13.1%	27
Coverage Question	9.7%	19
Provider Attitude and Service	6.8%	19
Out of Network Benefits	5.2%	25
Pharmacy Benefits	3.8%	20
Dis/Enrollment	3.7%	15
Access to Care	3.3%	18

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

C. Demographic and Other Complaint Elements

Figure 4.15 DMHC 2017 Distribution of Complaints by Age

Age	Percentage of Complaints
Under 18 Years Old	8%
18-34 Years Old	16%
35-54 Years Old	32%
55-64 Years Old	27%
65-74 Years Old	7%
Over 74 Years Old	2%
Unknown Age	8%

Figure 4.16 DMHC 2017 Distribution of Complaints by Race

Race	Percentage of Complaints
American Indian or Alaska Native	0.4%
Asian	5.1%
Black or African American	2.8%
Native Hawaiian	0.01%
Other	3.1%
Other Pacific Islander	0.01%
Refused	49.4%
Unknown	8.0%
White	31.1%

Figure 4.17 DMHC 2017 Distribution of Complaints by Ethnicity

Ethnicity	Percentage of Complaints
Hispanic or Latino	4.8%
Not Hispanic or Latino	46.5%
Refused	48.8%

Figure 4.18 DMHC Volume of Complaints by Source of Coverage

Source of Coverage	2015 Volume	2016 Volume	2017 Volume
Group	7,883	11,421	8,706
Individual/Commercial	3,191	4,250	3,924
Covered California/Exchange	3,179	5,206	2,765
Medi-Cal	1,949	2,464	2,446
Medicare	497	671	552
Unknown	868	1,737	412
Medi-Cal/Medicare	103	63	139

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

Figure 4.19 DMHC Average Resolution Time by Source of Coverage (in Days)

Source of Coverage	2015 Average Resolution Time	2016 Average Resolution Time	2017 Average Resolution Time
Group	31	29	23
Individual/Commercial	37	31	23
Covered California/Exchange	42	27	22
Medi-Cal	32	28	21
Unknown	24	19	20
Medi-Cal/Medicare	38	23	18
Medicare	21	16	21

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

Figure 4.20 DMHC 2017 Top Ten Reasons for Covered California Health Plan Complaints Compared to Prior Year Distribution

Complaint Reason	2016 Percentage	2017 Percentage
Cancellation	57.0%	44.4%
Co-Pay, Deductible, and Co-Insurance Issues	9.5%	11.3%
Dis/Enrollment	7.9%	7.2%
Medical Necessity Denial	2.7%	7.2%
Experimental/Investigational Denial	4.8%	5.1%
Provider Attitude and Service	2.0%	3.4%
Coverage Question	2.4%	3.4%
Out of Network Benefits	2.1%	3.3%
Pharmacy Benefits	1.2%	2.7%
Plan/Staff Attitude and Service	0.4%	2.3%

Figure 4.21 DMHC Covered California Plan Complaint Ratios for Cancellation and Dis/Enrollment Issues (Complaints per 10,000 Members)

Health Plan	2016 Complaint Ratio	2017 Complaint Ratio
Kaiser Permanente	53.00	13.17
Anthem Blue Cross	16.85	11.47
Health Net of California, Inc.	20.59	10.90
Blue Shield of California	16.27	10.87
Molina Healthcare of California	3.10	2.91

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

Figure 4.22 DMHC Covered California Plan Complaint Ratios for Health Care Delivery Complaints (Complaints per 10,000 Members)

Health Plan	2016 Complaint Ratio	2017 Complaint Ratio
Anthem Blue Cross	16.08	13.11
Blue Shield of California	12.52	12.83
Health Net of California, Inc.	10.09	8.04
Kaiser Permanente	14.66	7.08
Molina Healthcare of California	4.17	4.40

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

Figure 4.23 DMHC 2017 Top Ten Reasons for Medi-Cal Plan Complaints

Complaint Reason	Percentage of Medi-Cal Plan Complaints
Medical Necessity Denial	30.5%
Coverage Question	13.4%
Provider Attitude and Service	11.6%
Access to Care	9.2%
Pharmacy Benefits	5.8%
Out of Network Benefits	5.3%
Co-Pay, Deductible, and Co-Insurance Issues	5.0%
Coordination of Benefits	3.8%
Denied Services	2.7%
Delays/No Response	2.5%

Figure 4.24 DMHC Complaint Distribution by Product Type

Product Type	2015 Percentage	2016 Percentage	2017 Percentage
HMO	65.9%	59.5%	56.0%
PPO	28.0%	36.0%	36.3%
EPO	3.6%	1.3%	4.0%
Unknown	1.4%	2.3%	2.1%
POS	1.2%	0.9%	1.0%
Other	-	-	0.6%

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

Figure 4.25 DMHC Complaint Volume by Source of Coverage and Product Type

Source of Coverage and Product Type	2016 Volume	2017 Volume
Group HMO	7,667	5,215
Group PPO	3,487	3,201
Medi-Cal Managed Care	2,394	2,427
Individual/Commercial PPO	2,904	2,348
Covered California HMO	2,991	1,352
Covered California PPO	2,100	1,179
Individual/Commercial HMO	1,181	1,102
Medicare All Product Types	671	552
Individual/Commercial Other	165	474
Group Other	267	290
Covered California Other	115	234
Medi-Cal/Medicare All Product Types	63	139
COBRA All Product Types	72	84
Medi-Cal Other	70	19

Note: Some product type categories with low complaint volumes were combined for analysis. Other includes Exclusive Provider Organization, Point-of-Sale (POS), and Unknown product type categories. HMO and PPO include complaints reported as HMO with Deductible and PPO with Deductible, respectively. Medi-Cal Managed Care cases were all reported with HMO as the primary product type. Medi-Cal Other combines all other reported product types, including Fee-for-Service and Unknown.

Figure 4.26 DMHC 2017 Average Resolution Time by Product Type (in Days)

Product Type	Average Resolution Time (in Days)
PPO with Deductible	24
HMO with Deductible	21
EPO	21
HMO	21
PPO	21
Unknown	18
POS	18
Uninsured	15
Discount	14
Fee for Service	13

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

D. Consumer Assistance Center Details

Figure 4.27 DMHC Help Center – 2017 Telephone Metrics

Metric	Measurement	Estimated or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	6,223*	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	82,465	Data
Number of jurisdictional inquiry calls	44,978**	Data
Number of non-jurisdictional calls	10,808**	Data
Average number of calls received per jurisdictional complaint case	0.37 status check calls per complaint case	Data
Average wait time to reach a CSR	0:02:18	Data
Average length of talk time (time between a CSR answering and completing a call)	0:07:35	Data
Average number of CSRs available to answer calls (during Service Center hours)	On average 15 agents (full-time equivalent)	Data

*Note: * DMHC's abandoned calls are those that abandon after being queued for a Contact Center agent and not calls contained in the IVR.*

*** DMHC reported inquiry metrics from its case management database showing a combined volume which is more than its phone system records of calls handled by its Contact Center agents. DMHC indicated that this difference may be due to inquiry calls by providers calling to check on the status of multiple cases at one time.*

Section 5 – California Department of Health Care Services Data Tables

A. Overview

Figure 5.1 DHCS Medi-Cal Complaint Volume by Month Closed

Month	2015 Volume	2016 Volume	2017 Volume
January	357	509	444
February	553	635	604
March	583	740	662
April	620	580	622
May	519	729	665
June	686	854	482
July	579	214	474
August	549	346	802
September	497	528	716
October	531	634	446
November	499	510	381
December	767	491	305

Figure 5.2 DHCS Complaint Volume by Month Opened in 2016

Month in 2016	Volume of Complaints Opened
January	41
February	270
March	533
April	505
May	635
June	852
July	276
August	483
September	737
October	873
November	826
December	919

Figure 5.3 Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions. Urgent clinical issues may qualify for an expedited hearing process.	90 days from the hearing request date	79 days

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

B. Complaint Ratios, Reasons, and Results

Figure 5.4 DHCS 2017 Medi-Cal Managed Care Plan Complaint Ratios (Complaints per 10,000 Members)

Health Plan	Complaint Ratio
Anthem Blue Cross Partnership Plan	4.76
Care 1st Partner Plan	4.67
L.A. Care Health Plan	4.17
Molina Health Care	3.96
Santa Clara Family Health Plan	3.59
Health Net	3.44
California Health and Wellness Plan	2.99
Partnership Health Plan of California	2.90
CalOptima	2.57
Kaiser Permanente	2.41
Alameda Alliance for Health	2.13
San Francisco Health Plan	2.05
Contra Costa Health Plan	2.02
Community Health Group Partnership Plan	2.01
Inland Empire Health Plan	1.83
Kern Family Health Care	1.46
CenCal Health	1.40
Health Plan of San Joaquin	1.18
Health Plan of San Mateo	1.16
Central California Alliance for Health	1.13
CalViva Health	1.05
Gold Coast Health Plan	0.92

Note: Plans with Medi-Cal enrollment under 70,000 members statewide were excluded from the display. Many of the health plans shown on the chart serve multiple counties, including under different Medi-Cal contracting models. DHCS typically monitors quality issues by county contract. Because OPA has used different methodologies and combined data for analysis, the figures in this chart will not directly correlate with reports produced by DHCS.

Figure 5.5 DHCS 2017 Top Ten Health Plan Complaint Ratios Compared to Prior Years (Complaints per 10,000 Members)

Health Plan and County	DHCS Contract Model	2015 Ratio	2016 Ratio	2017 Ratio
Anthem Blue Cross, Sacramento County	GMC	6.19	6.69	7.24
Health Net, Sacramento County	GMC	9.82	6.60	5.98
Care 1st, San Diego County	GMC	1.04	4.76	4.67
Molina Healthcare, San Diego County	GMC	8.82	4.98	4.27
L.A. Care Health Plan, Los Angeles County	Two-Plan	4.04	3.66	4.11
Health Net, Los Angeles County	Two-Plan	3.69	2.33	3.73
Santa Clara Family Health Plan, Santa Clara County	Two-Plan	3.07	3.22	3.41
Molina Healthcare, San Bernardino County	Two-Plan	4.30	2.16	2.94
Anthem Blue Cross, Santa Clara County	Two-Plan	4.28	2.74	2.75
Partnership Health Plan of California, Sonoma County	COHS	2.81	1.63	2.57

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

Figure 5.6 DHCS 2017 Top Ten Medi-Cal Complaint Reasons Compared to Prior Years

Complaint Reason	2015 Percentage	2016 Percentage	2017 Percentage
Quality of Care	24.9%	11.7%	29.2%
Pharmacy Benefits	39.9%	11.9%	27.8%
Dis/Enrollment	22.0%	23.5%	16.8%
Medical Necessity Denial	3.5%	20.3%	8.4%
Denied Services	0.0%	0.0%	7.0%
Billing/Reimbursement Issue	4.4%	3.5%	4.4%
Scope of Benefits	0.0%	6.5%	2.6%
Claim Denial	1.1%	18.0%	1.2%
Rehabilitative/Habilitative Care	2.2%	3.1%	0.9%
State Specific (Other)	0.3%	0.1%	0.6%

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

Figure 5.7 DHCS 2017 Service Centers' Top Topics for Non-Jurisdictional Inquiries

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

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

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

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

Medi-Cal Dental Program Service Center Ranking	Inquiry Topic	Referred to
1 (most common)	Referrals	Managed Care Plan Health Care Options
2	Benefits Identification Card	County Social Services Office
3	Eligibility	County Social Services Office
4	Other Health Coverage addition or removal	County Social Services Office Medi-Cal Telephone Service Center Dhcs.ca.gov website
5	Share of Cost	County Social Services Office
6	Complaint against Office (non-treatment)	Dental Board
7	Non-Covered Services	State Legislator

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

Figure 5.8 DHCS 2017 Top Ten Complaint Results

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

Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Consumer Received Requested Service, and Compromise Settlement/Resolution. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan, but indicates that the consumer received services or a similar positive outcome. For DHCS, the category No Action Requested/Required indicates that the case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.

Figure 5.9 DHCS 2017 Top Ten Complaint Results Compared to Prior Years

Complaint Result	2015 Percentage	2016 Percentage	2017 Percentage
Withdrawn/Complaint Withdrawn	48.0%	44.1%	38.5%
Upheld/Health Plan Position Substantiated	23.0%	27.6%	36.1%
No Action Requested/Required	18.2%	19.1%	16.8%
Overturned/Health Plan Position Overturned	3.1%	5.1%	5.5%
Compromise Settlement/Resolution	0.9%	0.5%	1.7%
Claim Reopened	0.0%	0.1%	0.4%
Consumer Received Requested Service	0.0%	0.6%	0.3%
Unknown	0.4%	0.3%	0.3%
No Jurisdiction	0.0%	0.8%	0.1%
Insufficient Information	0.0%	1.2%	0.1%

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

Figure 5.10 DHCS 2017 Results for Quality of Care Complaints

Complaint Result	Percentage of Quality of Care Complaints
Upheld/Health Plan Position Substantiated	47.1%
Withdrawn/Complaint Withdrawn	28.2%
No Action Requests/Required	12.2%
Overturned/Health Plan Position Overturned	9.3%
Compromise Settlement/Resolution	3.0%
Dual Result: Consumer Received Requested Service and Overturned/Health Plan Position Overturned	0.1%
Unknown	0.1%

Figure 5.11 DHCS 2017 Results for Pharmacy Benefits Complaints

Complaint Result	Percentage of Pharmacy Benefits Complaints
Withdrawn/Complaint Withdrawn	58.3%
No Action Requests/Required	21.6%
Upheld/Health Plan Position Substantiated	16.9%
Overturned/Health Plan Position Overturned	1.9%
Compromise Settlement/Resolution	0.7%
Dual Result: Insufficient Information and No Action Requested/Required	0.3%
Dual Result: Consumer Received Requested Service and Overturned/Health Plan Position Overturned	0.2%
Unknown	0.2%

Figure 5.12 DHCS 2017 Results for Medical Necessity Denial Complaints

Complaint Result	Percentage of Medical Necessity Denial Complaints
Withdrawn/Complaint Withdrawn	41.3%
Upheld/Health Plan Position Substantiated	32.0%
No Action Requests/Required	20.8%
Overturned/Health Plan Position Overturned	1.9%
Dual Result: Consumer Received Requested Service and Overturned/Health Plan Position Overturned	1.3%
Unknown	1.3%
No Jurisdiction	0.5%
State Specific (Other)	0.3%
Dual Result: Insufficient Information and No Action Requested/Required	0.2%
Dual Result: Advised Complainant and Overturned/Health Plan Position Overturned	0.1%
Compromise Settlement/Resolution	0.1%
Consumer Received Requested Service	0.1%

Figure 5.13 DHCS 2017 Top Ten Medi-Cal Complaint Reasons and Average Resolution Times (in Days)

Complaint Reason	Percentage of Medi-Cal Complaints	Average Resolution Time (in Days)
Quality of Care	29.2%	118
Pharmacy Benefits	27.8%	52
Dis/Enrollment	16.8%	108
Medical Necessity Denial	8.4%	39
Denied Services	7.0%	84
Billing/Reimbursement Issue	4.4%	101
Scope of Benefits	2.6%	111
Claim Denial	1.2%	298
Rehabilitative/Habilitative Care	0.9%	102
State Specific (Other)	0.6%	78

Figure 5.14 DHCS 2017 Dental Complaint Reasons and Average Resolution Times (in Days)

Complaint Reason	Percentage of Dental Complaints	Average Resolution Time (in Days)
Scope of Benefits	46.7%	25
Medical Necessity Denial	45.3%	28
Claim Denial	7.3%	33
State Specific (Other)	0.6%	26
Quality of Care	0.1%	35
Co-Pay, Deductible, and Co-Insurance Issues	0.1%	7

Figure 5.15 DHCS 2017 Top Five Mental Health Complaints and Average Resolution Times (in Days)

Complaint Reason	Percentage of Mental Health Complaints	Average Resolution Time (in Days)
Medical Necessity Denial	70.9%	62
Continuation of Benefits	14.5%	89
Plan/Staff Attitude and Service	3.6%	53
Coverage Question	3.6%	32
Delays/No Response	3.6%	46

C. Demographics and Other Complaint Elements

Figure 5.16 DHCS 2017 Distribution of Complaints by Age

Age	Percentage of Complaints
Age: <18	11%
Age: 18-34	15%
Age: 35-54	22%
Age: 55-64	20%
Age: 65-74	6%
Age: >74	3%
Unknown	23%

Figure 5.17 DHCS 2017 Complaints by County of Residence per 10,000 Medi-Cal Beneficiaries

County	Ratio of Complaints per 10,000 Members
Placer County	16.36
El Dorado County	9.71
Calaveras County	9.71
Sacramento County	8.86
Nevada County	8.00
San Benito County	7.84

County	Ratio of Complaints per 10,000 Members
Butte County	7.57
Marin County	6.94
Shasta County	6.37
Tehama County	6.21
Yuba County	6.07
San Diego County	5.82
Sutter County	5.82
Los Angeles County	5.72
Medi-Cal Average	4.89
Mendocino County	4.79
Santa Clara County	4.65
Lake County	4.59
Contra Costa County	4.57
San Bernardino County	4.56
Alameda County	4.34
San Francisco County	4.29
Riverside County	4.02
Yolo County	4.00
Kern County	3.94
Orange County	3.90
Santa Cruz County	3.89
Imperial County	3.68
Sonoma County	3.31
San Joaquin County	3.30
Stanislaus County	3.24
Solano County	3.06
Humboldt County	3.02
Santa Barbara County	2.83
San Luis Obispo County	2.76
Tulare County	2.71
Fresno County	2.66
Madera County	2.54
San Mateo County	2.47
Ventura County	2.34
Kings County	2.06
Merced County	1.64
Monterey County	1.44

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

Figure 5.18 DHCS 2017 Complaint Distribution by Delivery System

Product Type	Percentage of Complaints
Medi-Cal Managed Care	47.05%
Medi-Cal Fee-for-Service	34.65%
Dental	16.27%
Mental Health	0.83%
Long Term Care	0.51%
Medi-Cal Coordinated Care	0.51%
Unknown	0.14%
Breast and Cervical Cancer Program	0.03%

Figure 5.19 DHCS 2017 Top Five Complaint Reasons for Medi-Cal Managed Care

Complaint Reason	Percentage of Managed Care Complaints
Quality of Care	37.8%
Dis/Enrollment	18.3%
Pharmacy Benefits	16.8%
Denied Services	12.1%
Billing/Reimbursement Issue	7.3%

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

Figure 5.20 DHCS 2017 Top Five Complaint Reasons for Medi-Cal Fee-for-Service

Complaint Reason	Percentage of Fee-for-Service Complaints
Pharmacy Benefits	42.7%
Medical Necessity Denial	19.9%
Quality of Care	17.5%
Dis/Enrollment	14.8%
Claim Denial	2.9%

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

Figure 5.21 DHCS 2017 Dental Complaint Reasons

Complaint Reason	Percentage of Dental Complaints
Scope of Benefits	46.7%
Medical Necessity Denial	45.3%
Claim Denial	7.3%
State Specific (Other)	0.6%
Quality of Care	0.1%
Co-Pay, Deductible, and Co-Insurance Issues	0.1%

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

Figure 5.22 DHCS Average Complaint Resolution Time by Product Type

Product Type	2016 Average Resolution Time (in Days)	2017 Average Resolution Time (in Days)
Long Term Care	205	101
Managed Care	75	99
Fee-for-Service	106	76
Medi-Cal Coordinated Care	Not Reported	68
Mental Health	45	65
Dental	35	27

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

D. Consumer Assistance Center Details

Figure 5.23 DHCS Office of the Ombudsman Inquiries

Month	2015 Volume	2016 Volume	2017 Volume
January	32,389	23,001	24,301
February	30,210	23,611	21,918
March	34,664	24,945	21,401
April	33,423	25,321	18,835
May	28,817	24,180	19,699
June	31,382	22,089	18,111
July	30,577	24,101	18,332
August	28,162	30,323	19,402
September	28,955	25,906	17,605
October	19,991	22,726	17,770
November	20,934	20,510	16,066
December	20,930	23,576	15,506

Figure 5.24 DHCS Medi-Cal Telephone Service Center Inquiries

Month	2015 Volume	2016 Volume	2017 Volume
January	45,099	51,689	54,651
February	48,836	50,744	46,076
March	50,342	49,636	56,092
April	49,264	46,536	47,802
May	43,027	47,485	47,442
June	45,345	46,806	46,809
July	45,589	44,353	44,015
August	44,948	57,182	51,154
September	43,226	50,351	45,153
October	44,205	46,490	48,063
November	39,746	46,956	43,853
December	42,355	48,707	44,709

Figure 5.25 DHCS Medi-Cal Dental Program Inquiries

Month	2015 Volume	2016 Volume	2017 Volume
January	55,543	36,089	39,633
February	57,136	42,865	36,398
March	57,484	46,198	41,045
April	50,224	40,498	34,819
May	43,859	39,997	35,932
June	47,275	40,955	36,140
July	49,866	39,451	65,053
August	46,964	44,422	59,894
September	42,844	35,607	43,123
October	42,695	34,016	41,642
November	36,237	31,934	41,766
December	36,237	29,460	39,265

Figure 5.26 DHCS Service Centers' 2017 Telephone Metrics

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

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

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

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

**** Estimated by DHCS.*

Section 6 – California Department of Insurance Data Tables

A. Overview

Figure 6.1 CDI Requests for Assistance Volume by Month

Month	2015 Volume	2016 Volume	2017 Volume
January	4,252	3,833	3,390
February	4,004	3,850	3,207
March	4,486	4,141	3,630
April	4,237	3,662	3,145
May	3,587	3,491	3,207
June	3,922	3,687	3,033
July	3,790	3,448	2,797
August	3,504	3,702	3,475
September	3,699	3,286	3,002
October	3,669	3,635	3,359
November	3,066	3,052	3,141
December	3,666	3,310	2,930

Figure 6.2 CDI Volume of Jurisdictional Complaints by Month Closed

Month	2015 Volume	2016 Volume	2017 Volume
January	256	272	419
February	250	248	345
March	242	285	345
April	287	220	421
May	233	248	302
June	329	213	259
July	308	237	250
August	256	194	345
September	263	169	375
October	273	209	237
November	202	272	268
December	310	304	319

Figure 6.3 CDI Volume of Jurisdictional Complaints by Month Opened in 2016

Month in 2016	Volume of Complaints Opened
January	230
February	276
March	289
April	258
May	270
June	265
July	238
August	288
September	227
October	255
November	270
December	284

Figure 6.4 CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard (if applicable)	Average Resolution Time in 2017
Standard Complaint	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau and Rating and Underwriting Services Bureau:* Compliance officers respond to written complaints *Consumer Law Unit:* Legal review (if needed)	30 working days, or 60 days (if reviewed concurrently with health plan level review)	78 days Calculation includes time for regulatory review after the case is closed to the consumer complainant
Independent Medical Review (IMR)	*Consumer Communications Bureau:* Assistance to callers *Health Claims Bureau*: Intake and casework *IMR Organization (contractor-MAXIMUS):* Case review and decision *Consumer Law Unit:* Legal review (if needed) Urgent clinical issues that qualify are addressed through an expedited IMR process.	30 working days, or 60 days (if reviewed concurrently with health plan level review)	88 days Calculation includes time for regulatory review after the case is closed to the consumer complainant. Calculation also includes cases that met urgent clinical criteria.

B. Complaint Ratios, Reasons, and Results

Figure 6.5 CDI Health Plan Complaint Ratios (per 10,000 Members)

Health Plan	2016 Ratio	2017 Ratio
Health Net Life Insurance Company	55.79	28.86
Anthem Blue Cross Life And Health Insurance Company	34.43	26.13
Cigna Health And Life Insurance Company	13.65	14.87
Aetna Life Insurance Company	8.83	7.74
UnitedHealthcare Insurance Company	12.11	7.70

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

Figure 6.6 CDI 2017 Top Ten Jurisdictional Complaint Reasons Compared to Prior Years

Complaint Reason	2015 Percentage	2016 Percentage	2017 Percentage
Claim Denial	28.7%	29.3%	34.1%
Medical Necessity Denial	9.3%	7.5%	7.8%
Experimental	4.5%	8.7%	7.7%
Unsatisfactory Settlement/Offer	9.8%	8.4%	6.7%
Out-of-Network Benefits	7.1%	6.5%	5.6%
Claim Delay	3.6%	3.4%	4.3%
Emergency Services	2.9%	3.3%	2.8%
Preventive Care	2.4%	2.2%	2.7%
Rehabilitative/Habilitative Care	0.8%	1.2%	2.7%
Authorization Dispute	1.6%	1.7%	2.1%

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

Figure 6.7 CDI 2017 Top Ten Reasons for Non-Jurisdictional Complaints

Complaint Reason	Percentage of Non-Jurisdictional Complaints
Claim Denial	32.6%
Claim Delay	10.8%
Unsatisfactory Settlement/Offer	7.7%
Out-of-Network Benefits	4.8%
Pharmacy Benefits	3.9%
Medical Necessity Denial	3.8%
Authorization Dispute	3.1%
Emergency Services	3.1%
Co-Pay, Deductible, and Co-Insurance Issues	2.8%
State Specific (Other)	2.4%

Figure 6.8 CDI 2017 Top Ten Topics for Non-Jurisdictional Inquiries

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

Note: Ranking estimated by CDI.

Figure 6.9 CDI 2017 Top Ten Complaint Results

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

Note: Results categories considered favorable to the complainant include: Overturned/Health Plan Position Overturned, Claim Settled, Compromise Settlement/Resolution, and Referred to Other Division for Possible Disciplinary Action. Results categories considered favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of other categories shown is neutral or cannot be determined.

Figure 6.10 CDI 2017 Jurisdictional Complaint Results Compared to Prior Years

Complaint Result	2015 Percentage	2016 Percentage	2017 Percentage
Upheld/Health Plan Position Substantiated	21.2%	40.1%	36.5%
Insufficient Information	0.8%	1.4%	26.9%
Overturned/Health Plan Position Overturned	0.0%	0.0%	10.5%
Claim Settled	2.8%	1.4%	10.0%
Compromise Settlement/Resolution	2.0%	1.0%	6.2%
Question of Fact/Contract/Provision/Legal Issue	11.6%	16.1%	4.7%
No Action Requested/Required	0.1%	0.6%	4.5%
Withdrawn/Complaint Withdrawn	0.0%	0.0%	0.5%
Referred to Other Division for Possible Disciplinary Action	0.0%	0.1%	0.3%

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

Figure 6.11 CDI Average Resolution Time for Jurisdictional Complaints by Complaint Type

Complaint Type	2015 Average Resolution Time (in Days)	2016 Average Resolution Time (in Days)	2017 Average Resolution Time (in Days)
Independent Medical Review	78	94	88
Complaint/Standard Complaint	74	88	78

Note: For better comparison with 2015 and 2016 jurisdictional complaint data, the chart excludes non-jurisdictional complaints reported in 2017. The CDI complaint duration reflects the date from initial receipt of the complaint to the end of the final regulatory review. The close date does not reflect the date when the complaint was closed to the complainant. Consumers can submit a complaint to CDI concurrent with the health plan's internal review period. For applicable complaints, the duration period may include the health plan's internal review period, the Independent Medical Review Organization's review time, as well as CDI's regulatory investigation period.

Figure 6.12 CDI 2017 Average Resolution Times (in Days) for the Top Ten Jurisdictional Complaint Reasons

Complaint Reason	Percentage of Complaint Reasons	Average Resolution Time (in Days)
Claim Denial	34%	80
Medical Necessity Denial	8%	116
Experimental	8%	84
Unsatisfactory Settlement/Offer	7%	107
Out-of-Network Benefits	6%	108
Claim Delay	4%	98
Emergency Services	3%	91
Preventive Care	3%	81
Rehabilitative/Habilitative Care	3%	143
Authorization Dispute	2%	81

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

C. Demographics and Other Complaint Elements

Figure 6.13 CDI 2017 Top Ten Product Types for Jurisdictional Complaints Compared to Prior Years

Product Type	2015 Percentage	2016 Percentage	2017 Percentage
Health Only	39.0%	38.1%	37.8%
Large Group	14.9%	17.6%	18.1%
Stand Alone Dental	9.3%	9.3%	13.4%
Small Group	14.1%	14.2%	11.0%
Grandfathered	5.7%	6.3%	6.6%
Mental Health	3.1%	2.8%	3.5%
Medicare Supplement	2.4%	1.9%	2.3%
Limited Benefits	1.1%	1.1%	1.2%
Pharmacy Benefits	2.2%	2.1%	0.9%
Platinum	0.6%	0.4%	0.7%

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

D. Consumer Assistance Center Details

Figure 6.14 CDI Consumers Services Division – 2017 Telephone Metrics

Metric	Measurement	Estimated or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	814	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	1,152	Data
Number of jurisdictional inquiry calls	23,772	Data
Number of non-jurisdictional calls	4,840	Data
Average number of calls received per jurisdictional complaint case	Not measured	
Average wait time to reach a CSR	0:00:44	Data
Average length of talk time (time between a CSR answering and completing a call)	0:05:59*	Data
Average number of CSRs available to answer calls (during Service Center hours)	Varies based on need	

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

Section 7 – Covered California Data Tables

A. Overview

Figure 7.1 Covered California Volume of Inquiries

Month	2015 Volume	2016 Volume	2017 Volume
January	620,060	812,430	874,080
February	936,924	642,637	568,550
March	517,711	639,586	548,321
April	455,796	479,181	442,564
May	265,224	314,083	350,429
June	239,435	292,400	281,249
July	231,415	259,484	250,893
August	264,498	283,615	255,505
September	257,341	275,268	268,129
October	335,727	425,371	379,041
November	506,039	546,304	651,630
December	760,766	1,068,221	1,008,280

Figure 7.2 Covered California Volume of Complaints by Month Closed

Month	2015 Volume	2016 Volume	2017 Volume
January	116	1,073	1,185
February	368	1,442	1,193
March	1,290	2,349	1,476
April	570	2,432	1,543
May	11	2,179	1,563
June	9	2,358	1,513
July	178	1,442	1,344
August	412	1,493	1,431
September	891	1,895	1,350
October	1,213	1,653	1,294
November	596	1,030	1,007
December	496	1,052	788

Figure 7.3 Covered California Complaint Volumes by Month Opened in 2016

Month in 2016	Volume of Complaints Opened
January	2,269
February	2,578
March	2,710
April	2,252
May	1,718
June	1,442
July	1,260
August	1,298
September	962
October	1,150
November	1,097
December	1,377

Figure 7.4 Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard (if applicable)	Average Resolution Time in 2017
State Fair Hearing	*CDSS State Hearings Division:* Conducts hearings on Covered California eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving consumers with urgent clinical issues.	No later than 90 days from the date the hearing request was filed	77 days
State Fair Hearing: Informal Resolution	*CDSS State Hearings Division:* Reviews requests for State Fair Hearings and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge. *Covered California staff*: Reviews complaint outlined in the State Fair Hearing request and conducts casework to resolve the complaint.	Up to 45 days from the date the appeal was filed	5 days

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

B. Complaint Ratios, Reasons, and Results

Figure 7.5 Covered California Complaint Reasons by Percentage Distribution

Complaint Reason	2015 Percentage	2016 Percentage	2017 Percentage
Denial of Coverage	69.8%	65.8%	62.8%
Eligibility Determination	17.6%	19.5%	20.0%
Cancellation	12.6%	14.6%	17.2%

Figure 7.6 Covered California 2017 Top Ten Jurisdictional and Non-Jurisdictional Inquiries

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

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

7.7 Covered California 2017 Complaint Results

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

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

Figure 7.8 Covered California 2017 Complaint Results Compared to Prior Years

Result	2015 Percentage	2016 Percentage	2017 Percentage
Withdrawn/Complaint Withdrawn	44.8%	40.8%	45.1%
Covered California Position Overturned	16.7%	15.4%	22.1%
No Action Requested/Required	15.8%	18.7%	19.6%
Compromise Settlement/Resolution	17.8%	20.7%	7.0%
Upheld/Covered California Position Substantiated	4.9%	4.5%	6.2%

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

Figure 7.9 Covered California 2017 Results for Denial of Coverage Complaints

Complaint Result	Percentage of Denial of Coverage Complaints
Withdrawn/Complaint Withdrawn	46.09%
Covered CA Position Overturned	22.63%
No Action Requested/Required	18.42%
Compromise Settlement/Resolution	6.54%
Upheld/Covered California Position Substantiated	6.33%

Figure 7.10 Covered California 2017 Results for Eligibility Determination Complaints

Complaint Result	Percentage of Eligibility Determination Complaints
Withdrawn/Complaint Withdrawn	45.75%
No Action Requested/Required	21.20%
Covered California Position Overturned	19.29%
Compromise Settlement/Resolution	8.12%
Upheld/Covered California Position Substantiated	5.64%

Figure 7.11 Covered California 2017 Results for Cancellation Complaints

Complaint Result	Percentage of Cancellation Complaints
Withdrawn/Complaint Withdrawn	40.94%
Covered California Position Overturned	23.38%
No Action Requested/Required	22.01%
Compromise Settlement/Resolution	7.34%
Upheld/Covered California Position Substantiated	6.34%

Figure 7.12 Covered California Average Resolution Time by Complaint Reason

Complaint Reason	2015 Average Resolution Time	2016 Average Resolution Time	2017 Average Resolution Time
Denial of Coverage	55 days	67 days	65 days
Eligibility Determination	55 days	63 days	66 days
Cancellation	57 days	66 days	66 days

C. Demographics and Other Complaint Elements

Figure 7.13 Covered California 2017 County Complaint Ratios (Fair Hearings per 10,000 Members)

County of Residence	Complaint Ratio (Fair Hearings per 10,000 Members)
San Diego	78.15
San Bernardino	75.10
San Mateo	75.02
Alameda	75.00
Santa Cruz	74.18
San Francisco	70.64
Los Angeles	66.05
Riverside	66.01
Sonoma	65.64
Sacramento	62.62
County Average	61.86
San Joaquin	58.03
Solano	58.01
Orange	55.55
Ventura	54.98
San Luis Obispo	53.32
Contra Costa	51.11
Fresno	50.03
Monterey	49.51
Santa Barbara	47.22
Santa Clara	46.55
Marin	46.45
Tulare	46.25
Kern	42.81
Stanislaus	41.66
Placer	41.31
Merced	39.58
Imperial	17.44

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

Figure 7.14 Covered California Complaint Distribution by Product Type

Product Type	2015 Percentage	2016 Percentage	2017 Percentage
Silver	45.4%	38.2%	44.3%
Unknown	27.3%	42.1%	33.3%
Bronze	16.1%	13.6%	15.0%
Gold	5.4%	3.1%	4.0%
Platinum	5.0%	2.5%	2.7%
Catastrophic	0.7%	0.5%	0.7%

Figure 7.15 Covered California Average Resolution Time by Product Type

Product Type	2015 Average Resolution Time	2016 Average Resolution Time	2017 Average Resolution Time
Silver	55 days	69 days	66 days
Unknown	55 days	63 days	64 days
Bronze	56 days	71 days	69 days
Gold	59 days	68 days	63 days
Platinum	57 days	64 days	64 days
Catastrophic	60 days	76 days	69 days

D. Consumer Assistance Center Details

Figure 7.16 Covered California Service Center Metrics – 2017 Telephone Metrics

Metric	Measurement	Estimated or Based on Data
Number of abandoned calls (incoming calls terminated by callers prior to reaching a Customer Service Representative - CSR)	272,952	Data
Number of calls resolved by the IVR/phone system (caller provided and/or received information without involving a CSR)	2,486,237	Data
Number of jurisdictional inquiry calls	Not reported	
Number of non-jurisdictional calls	Not reported	
Average number of calls received per jurisdictional complaint case	Not reported	
Average wait time to reach a CSR	0:04:39	Data
Average length of talk time (time between a CSR answering and completing a call)	0:17:31	Data
Average number of CSRs available to answer calls (during Service Center hours)	865 Full-Time Equivalent	Estimated