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Manage to Care:

How California Can Better Inform Consumers About Managed Care

A report prepared by Consumers Union and the Center for Health Care Rights

June 1999

ACKNOWLEDGEMENTS

Several staff of the Center for Health Care Rights helped make this report possible. Bridget Sheehan-Watanabe provided insightful comments, Heather Burns provided data analysis, and Demetria Boykins-Chestnutt lent critical administrative support. The Lewin Group, in particular David Stapleton, Gina Livermore, and Scott Scrivner, provided guidance into the development of a sound methodology for assessing the statistical significance of complaint rates. In addition, we appreciate the work of the staff of the Health Rights Hotline, who model how a program can collect, analyze, and report information on consumers' problems in ways that can help improve the health care system.

Consumers Union's staff contributions are also gratefully acknowledged. We thank Elisa Odabashian for her painstaking editing of this report. Diana Bianco, Robin Kane, and Harry Snyder also shared helpful insights. We also recognize those whose grace, humor, and hard work contributed to the production of this report: Minerva Novoa was responsible for design and layout, Ven Barrameda and Annamarie Simmons produced the charts and tables, and Carol Rivas Pollard provided her usual sterling administrative support.

The Center for Health Care Rights (the "Center") is a California-based nonprofit organization dedicated to assuring consumer access to quality health care through information, education counseling, advocacy, and research programs. The Center was founded in 1984 as the Medicare Advocacy Project and currently provides individual and systemic advocacy for elderly and disabled Medicare beneficiaries as Los Angeles County's Health Insurance Counseling and Advocacy Program. The Center also has a long history of promoting protections for all consumers enrolled in health maintenance organizations and other managed care plans. The Center conducts research and policy advocacy on the oversight and monitoring of managed care and is currently the sponsor of the Health Rights Hotline, a pilot program providing individual assistance to all health care consumers in the Sacramento-area.

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Manage to Care:

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June 1999

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EXECUTIVE SUMMARY

In a time of increasing distrust in and confusion about the health care system, Californians need better information about managed care. They need information about the differences between health maintenance organizations ("HMOs") and medical groups, information on their rights, information on how to navigate an increasingly complex health care system, and information about how the State is ensuring that all HMOs provide a basic level of quality health care. One source of this information should be the California Department of Corporations (the "Department"), which oversees HMOs. This report documents the very limited and flawed efforts that the Department has undertaken in these areas under past administrations. More importantly, the report makes recommendations that can serve as part of a new day for the Department and the State of California – a day in which consumers can look to a state agency for unbiased information and assurance of protection.

In "Manage to Care: How California Can Better Inform Consumers About Managed Care," Consumers Union and the Center for Health Care Rights examine how the Department has presented itself to the public and made its products and services accessible to consumers. Specifically, the study makes findings and recommendations about annual reports on complaints to the Department's toll-free complaint line ("Annual Hotline Reports"); reports on the timeliness of HMOs' internal grievance procedures ("Late Grievance Reports"); and reports on periodic reviews of HMOs' compliance with medical and organizational requirements ("Medical Survey Reports"). Some of the key findings and recommendations are:

The Department has been an invisible regulator.

Few people know that the Department is the state agency that regulates HMOs, so it is hardly surprising that consumers generally are unaware that they can turn to the Department for help with HMO problems. The Department has made ineffective use of the media to publicize its role as regulator, the toll-free hotline for HMO complaints, and the reports on HMO performance that the Department is required by law to provide consumers. The Department has not effectively promoted itself or its complaint hotline through telephone books. It has not published consumer education materials to help consumers make informed HMO choices, nor provided analysis to consumers of the data it compiles.

Recommendations

- ☑ The Department should dramatically increase its visibility by launching an ongoing media campaign, increasing telephone book listings, developing educational materials, and promoting its products (*e.g.*, Annual Hotline Reports, Late Grievance Reports, and Medical Survey Reports).
- ☑ The Department should develop its materials with a focus on effective communication with consumers. To help consumers make informed choices in the health care

marketplace, the Department should coordinate, and to the extent possible, consolidate managed care information from all state sources.

- ☑ The Department should also develop a plan to provide all Californians with comparative information ("report cards") on HMOs and medical groups in their area.

Due to inadequate promotion and weak data collection, analysis, and reporting, the complaint hotline is not as useful to consumers as it was intended to be.

Since 1995, the State has operated a toll-free hotline that consumers with complaints about their HMOs can call for assistance. Despite the hotline's potential for both resolving complaints and providing comparative information on HMOs, the Department has not adequately informed consumers about the hotline. Insufficient promotion of the hotline in telephone books and through the media, as well as inconsistent notice of the hotline in correspondence from HMOs and medical groups to consumers, hinders awareness, and ultimately, use of the hotline. In addition, the Annual Hotline Reports do not show whether individual complaints are upheld or denied, nor does it state how long the Department takes to resolve complaints.

Recommendations

- ☑ The Department should ensure vigorous promotion of the hotline telephone number, including prominent inclusion of the hotline information in HMOs' Evidences of Coverage (the formal description of an enrollee's rights and responsibilities with respect to an HMO) and in letters from HMOs and medical groups.
- ☑ The Annual Hotline Report should include information on all calls received, on the disposition of complaints, and on how long the Department takes to resolve complaints.
- ☑ The Annual Hotline Report should analyze and present information in a more consumer-friendly manner, including complaints about medical groups as well as HMOs.

Variations in reporting standards for Late Grievance Reports and the lack of comparative measures make information on HMO complaint handling nearly meaningless to consumers.

Since 1997, HMOs have been required to file Late Grievance Reports with the Department on a quarterly basis. These reports give information about grievances filed by consumers that have been pending with an HMO for 30 or more days. This information is an important indicator of how quickly an HMO resolves grievances.

Although individual HMOs file Late Grievance Reports, the Department does not summarize these reports in a way that would facilitate comparisons among HMOs. In addition, inconsistent definitions and reporting standards, including possible differences in how HMOs define "grievance," make valid comparisons about grievance handling impossible. Clear

guidelines are needed in a number of key areas, including the timing of which grievances to report and the closing date of grievances for reporting purposes.

Recommendations

- ☑ The Department should standardize for HMOs which grievances to include in the Late Grievance Report, clarifying whether pending or only closed grievances should be reported and defining when a grievance is closed for reporting purposes.
- ☑ The Department should prepare and publicize a consumer-friendly annual summary report with useful comparative measures, such as rates of late grievances per 10,000 enrollees, late grievances as a percentage of all grievances filed, time taken to resolve grievances, and percentage of grievances upheld or overturned.

The effectiveness of medical surveys is severely undercut by the Department's failure to conduct surveys and publish Medical Survey Reports in a timely manner and to provide consumer-friendly summaries to the public.

At least once every three years, the Department is required to conduct a review of each HMO's compliance with medical and organizational requirements ("medical survey"), followed by a publicly available report within 180 days of the survey's completion. Consumers Union's 1996 report examining medical surveys, "A Shot in the Dark," found that the Department was not conducting medical surveys or publishing Medical Survey Reports in a timely fashion. Furthermore, the Medical Survey Reports and their summaries were difficult for consumers to get, and those that were obtained were difficult to understand.

Regrettably, the Department's performance regarding medical surveys is largely unchanged since our 1996 report. Consumers are placed at risk because the Department continues not to meet statutory requirements for completing medical surveys. In fact, the Department met the 3-year timeframe for completing surveys in only 1 of the 12 medical surveys we reviewed. Furthermore, for each Medical Survey Report we reviewed, the Department failed to comply with the requirement of publishing the report within 180 days of completing the corresponding medical survey. On average, the Department took more than a year to release Medical Survey Reports. In addition to being dilatory, the Department has made the Medical Survey Reports difficult to understand. The summaries of Medical Survey Reports, meant particularly for the public, have similar weaknesses. They are too long and are almost incomprehensible due to their reliance on medical and legal jargon.

Recommendations

- ☑ The Department should perform the surveys and release the Medical Survey Reports in a timely fashion. The statutory mandate of three years between surveys and six months for Medical Survey Report release are reasonable minimums that can and should be met.

- ☑ The Department should standardize the report format and prepare consumer-friendly, jargon-free summaries that are readily accessible to consumers.

While this report focuses on the Department's public face, equally important are the Department's regulatory efforts that underpin the reports discussed here. Because we did not audit the Department's actual handling of hotline complaints, how medical surveys were conducted, or how HMOs handled grievances, these elements are outside the scope of this report. Furthermore, this report does not consider two other vital Department functions: enforcement actions and financial audits of HMOs. Each of these tasks is critical to ensuring the medical and fiscal soundness of HMOs and are areas in which the Department must make public the scope and nature of its activities.

Governor Davis and his Administration must face a number of critical issues before oversight by the State can catch up to the reality of the health care system in California. The Davis Administration must make the State's regulatory oversight of HMOs credible. To that end, communicating with the consumers of California is key. That is the subject of this report. With the new Administration, the time has come to change course, shift the focus toward educating consumers, and move California into the vanguard of managed care consumer protection and information. Regardless of which state agency is responsible for oversight of HMOs, this report provides guidance to improve its service to California's health care consumers.

INTRODUCTION

California has experienced an explosion in the growth of managed care, the system whereby health care plans control costs by monitoring services offered, providers used, and fees charged. Yet, the state agency charged with regulating the largest segment of the managed care industry and protecting consumers, the Department of Corporations (the "Department"),[1] has not kept pace with the rapid changes. The Knox-Keene Act,[2] California's statute regulating health care service plans or health maintenance organizations ("HMOs"),[3] was groundbreaking in scope when it was enacted in 1975. Since then, numerous amendments have strengthened one of the law's key purposes of "[a]ssuring that subscribers and enrollees are educated and informed of the benefits and services available in order to make a rational choice in the [managed care] marketplace."[4] Under past administrations, the Department's fulfillment of the purpose and legal obligation to inform Californians has been woefully inadequate.

Consumers need reliable, objective information about the quality of care delivered by HMOs. In choosing an HMO, consumers have questions specific to their families' health care needs, in addition to more general questions about HMO policies. Much of the information currently available to consumers is produced by HMOs and tends to be laden with advertising aimed at selling rather than educating. Truly unbiased information could be provided by the Department, and the quality of that information is a measure of how effectively the Department performs its regulatory role. With some 25 million Californians in HMOs, educating and informing consumers about HMO quality and customer service is a serious undertaking.

In "Manage to Care: How California Can Better Inform Consumers About Managed Care," Consumers Union's West Coast Regional Office and the Center for Health Care Rights jointly examine the public face of the Department's work – how it has promoted itself and informed consumers, purchasers, and the general public about managed care in California. This report looks at how the Department promotes awareness of its activities, as well as how it presents to the public three sets of information mandated by statute:

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[1] We use the term "Department" throughout this report, although our recommendations may be relevant to the Department – or any successor regulatory body – as well as to other parts of the state government.

[2] CAL. HEALTH & SAFETY CODE § 1340 *et seq.* (West 1990 & Supp. 1998).

[3] A health care service plan, commonly referred to as a health maintenance organization or "HMO," provides health care services to subscribers or enrollees, or pays for, or reimburses any part of the cost for those services, in return for a prepaid or periodic charge (premium). CAL. HEALTH & SAFETY CODE § 1345 (f) (West Supp. 1998). Depending on its license, an HMO may provide a full-scope of services, or it may provide specialized services (*e.g.*, dental, vision, psychological, or chiropractic). Unless otherwise noted, throughout this report we use "HMO" to describe those entities regulated by the Department that provide a full range of health care services.

[4] CAL. HEALTH & SAFETY CODE § 1342 (b) (West 1990).

- "**Annual Hotline Reports**" – annual reports on complaints to the Department's toll-free hotline.
- "**Late Grievance Reports**" – reports on the timeliness of HMOs' internal grievance procedures.
- "**Medical Survey Reports**" – reports on periodic reviews of HMOs' compliance with medical and organizational requirements.

The recommendations embodied in this report address changes that should be implemented by the Department or any successor regulatory body. We believe that the Department has broad statutory authority to implement these recommendations. To the extent that the Department does not have the power to implement our recommendations, legislative changes should be considered to effect them.

States with far less managed care penetration than California have embarked on campaigns to educate consumers about managed care, with some producing "report cards" on HMOs (*e.g.*, Maryland, Massachusetts, Minnesota, New Jersey, Oklahoma, Oregon, and Texas), and others developing consumer educational and resource material. By contrast, the Department offers sparse consumer education materials, no telephone book listing for its toll-free complaint line outside of the Sacramento area code, and a website that barely reveals its regulatory role over HMOs. During past administrations, the Department has done far too little to communicate its mission to consumers, assuming a passive posture and reacting (if at all) only to extraordinary pressure.

While this report focuses on the Department's public face, equally important are the Department's regulatory efforts that underpin the reports discussed here. Because we did not audit the Department's actual handling of hotline complaints, how medical surveys were conducted, or how HMOs handled grievances, these elements are outside the scope of this report. Furthermore, this report does not consider two other vital Department functions: enforcement actions and financial audits of HMOs. Each of these tasks is critical to ensuring the medical and fiscal soundness of HMOs and are areas in which the Department must make public the scope and nature of its activities.

There are a range of critical issues that Governor Davis and his Administration must face for oversight by the State to catch up to the reality of the health care system in California. The Davis Administration must make the State's regulatory oversight of HMOs credible. To that end, communicating with the consumers of California is key. With the new Administration, the time has come to change course, to ensure high quality care, to educate consumers, and to move California into the vanguard of managed care consumer protection and information.

I. PROMOTION OF THE DEPARTMENT AND ITS SERVICES TO CONSUMERS

Under prior administrations, the Department was an invisible regulator. Few consumers knew that the Department regulated HMOs, and the Department took few proactive steps to increase its visibility.[5] As a result, consumers who had problems with their HMOs were likely not to know they could seek help from the Department. Furthermore, few consumers were aware that the Department is charged with providing information on HMOs.

It stands to reason that the Department must be visible if it is going to help consumers get quality health care and accurate information in order to make informed choices. This section of the report looks, in general terms, at the Department's performance in making itself and its resources known to Californians. The Department's toll-free hotline is particularly important to consumers who either have problems or want information, and it should be the centerpiece of the Department's promotional efforts.

The Department's toll-free hotline should be the centerpiece of the Department's promotional efforts.

Findings

1. The Department has made insufficient use of the media to promote itself, its hotline, or the information it is required to provide consumers. One way to generate awareness of the Department's enforcement role, the toll-free hotline, and other consumer information is to engage in a concerted effort to garner media coverage. The annual release of hotline complaint data ("Annual Hotline Report") and other reports generated by the Department provide "hooks" for media coverage on activities related to the Department's health care oversight functions.

Since 1995, the Department has issued only four news releases regarding the hotline. The first release, in October 1995, announced the establishment of the hotline. Later, in August 1996, June 1997, and June 1998, the Department publicized the release of the Annual Hotline Report for the previous calendar years. A computer search of media coverage of the Department's hotline in newspapers and newswires[6] found only:

- Two articles in 1995 announcing the opening of the hotline.
- Four articles covering the release of the 1995 Annual Hotline Report.
- Eight articles covering the 1996 Annual Hotline Report.

[5] According to one recent poll, less than one in four Californians (23%) with a problem with their HMO were aware of the Department's toll-free hotline. Helen H. Schauffler & Lee D. Kemper, "Task Force Survey Finds 76% of Insured Californians Satisfied, 42% Report Problems," Survey Brief to the Managed Health Care Improvement Task Force, p. 7 (January 1998). Of those who reported having a problem with their HMO in the past year, only 4% contacted a state or local agency for assistance. "Improving Managed Health Care in California," Managed Health Care Improvement Task Force, Vol. 2, p. 31 (January 1998) ["Task Force Report"]. This figure reflects assistance sought from both the Department and local agencies.

[6] Media coverage of the hotline was analyzed based on searches of the Lexis-Nexis database.

Our search found no print media coverage of the 1997 Annual Hotline Report.

In 1998, the Department put out nine press releases regarding oversight of HMOs, as compared to 16 press releases on the Department's oversight of securities regulation. Of those nine HMO-related releases, not one referred to the Department's Medical Survey Reports released during the year or to Late Grievance Reports, and only two mentioned the hotline as a resource available to consumers.

2. The Department does not promote itself or its consumer information services through government and community service listings in telephone books or through directory assistance. Consumers who want assistance are likely to turn to their local telephone book or call directory assistance.[7] Generally, the White Pages of local telephone books include a special "Government" section (blue pages) and local Yellow Pages include a free "Community Services" section at the front of the directory, both of which are logical places to find information about the Department.

Based on a review of the current telephone books for California's major metropolitan areas, the Department's telephone book listings are minimal, and the hotline was listed in only one.

Based on a review of the current telephone books (both Yellow and White pages) for California's major metropolitan areas,[8] the Department's telephone book listings are minimal, and the hotline was listed in only one. Among the findings from that review of telephone books and from calls made to directory assistance:

- Some telephone books do not list the Department at all. Other telephone books list "Corporations, Department of" in the State Government section, but contain no reference to the hotline or the Department's function as a resource for consumers in HMOs. Those that contain a listing for the Department generally only include the address and telephone number of the local Department office. Of the seven telephone books reviewed, only Sacramento's included any specific listing of the Department's hotline. It listed "HMO Consumer Services Unit (800) 400-0815," as a subset under "Corporations, Department of."[9]

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[7] An example of the difference that telephone book listings and directory assistance can make in reaching consumers is illustrated by the experience of the Health Rights Hotline, a project of the Center for Health Care Rights, which offers information and counseling services to health care consumers in the Sacramento area. From July to December 1997, before the Health Rights Hotline was listed in area telephone books, directory assistance was the source of less than 1% of its calls. One year later, after the Health Rights Hotline became listed in telephone books, overall call volume doubled, and telephone books and directory assistance were the source of almost 10% of the calls.

[8] Telephone books of Fresno, Los Angeles, Oakland, Sacramento, San Diego, San Francisco, and San Jose were reviewed. The telephone books are current through 1999 or beyond.

[9] By contrast, the "Consumer Information and Assistance" number for the Department of Insurance was listed in the Government Section of each telephone book reviewed.

- The Department hotline is not listed in any of the free Community Services sections in the telephone books reviewed. Examples of other state agency listings in Community Service sections include the Medical Board of California, and the Healthy Families and Medi-Cal Programs (under the "Health Care" section).[10]
- The Department's consumer hotline is not listed in the Yellow Pages under any listing (*e.g.*, "Consumer Protection," "HMOs," or "Health Plans").
- Calls to directory assistance asking for the state agency that regulates HMOs were similarly unhelpful. Directory assistance in six of the seven major metropolitan areas called did not give information about the Department or its toll-free hotline number.[11] The operator for Sacramento's directory assistance was the only one able to inform us that the Department was responsible for HMO oversight and that the Department has a "Consumer Services Unit" with a toll-free telephone number.

3. HMOs do not effectively promote the Department's hotline. The Knox-Keene Act requires HMOs to notify enrollees about the hotline in two places: correspondence to consumers as part of the grievance process, such as in denial letters, and the HMOs' Evidence of Coverage (the formal description of an enrollee's rights and responsibilities with respect to an HMO).[12] In 1997, the Department assessed $897,500 in fines to 80 HMOs for failure to provide notice to enrollees of their right to submit unresolved grievances to the Department and for failure to publish the toll-free number in the specified format.[13]

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[10] The Department of Insurance was not listed in the Community Service sections of the Yellow Pages reviewed.

[11] We made directory assistance calls to the same cities whose telephone books we reviewed. See note 8, *supra*. In each call, we posed the inquiry in three ways, asking for: the number for the state agency that regulates HMOs, the number for the state agency that regulates health plans, and the number for the state agency responsible for health insurance. Only for Sacramento did the operators give us the Department's telephone number in response to any of the three questions. In two cities, directory assistance referred us to the directory assistance number for Sacramento because we were looking for a state agency.

[12] The following statement is required on copies of HMO grievance procedures, on HMO complaint forms, on all written notices to enrollees required under the grievance process of the HMO, and on every Evidence of Coverage:

> The California Department of Corporations is responsible for regulating health care service plans. The department has a toll-free telephone number [1-800-telephone number] to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the plan and use the plan's grievance process. If you need the department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the department's toll-free number. CAL. HEALTH & SAFETY CODE § 1368.02 (b) (West Supp. 1998).

When an HMO contracts with a medical group – as they frequently do in California – these notice requirements apply to the medical group as well. CAL. HEALTH & SAFETY CODE § 1367 (h) (West Supp. 1998).

[13] "25 More HMOs Fined for Failure to Inform Enrollees of 800#," Department of Corporations Press Release No. 97-17 (May 1, 1997).

We reviewed an informal sampling of correspondence to consumers related to the grievance process, as well as Evidences of Coverage from HMOs and medical groups in the Sacramento area. Our goal for this review was to assess the extent to which consumers get easy access to information about the hotline from their HMOs and medical groups.

Correspondence to consumers from HMOs and medical groups in the Sacramento area shows that HMOs and medical groups generally inform consumers of their right to call the Department hotline for assistance. However, a significant percentage of letters we reviewed from both HMOs and medical groups that should contain such a notice did not. Specifically, some HMOs appear to omit the hotline notice in letters denying underwriting to individuals due to pre-existing conditions or in initial letters denying payment or coverage.[14]

The Department must approve all Evidences of Coverage. While the requisite hotline notice is included in some form in all Evidences of Coverage that we reviewed, great variation exists as to where consumers will find this information.[15] Some of the variations that may affect consumers' ability to find the information about the hotline include:

- Evidences of Coverage can range from 15 to over 80 pages in length. Ease of finding the reference to the hotline will vary depending on the length and format of the Evidence of Coverage.
- The form of HMOs' disclosures varies greatly, with some HMOs providing separate Evidences of Coverage, Summaries of Benefits, Member Handbooks, Disclosure Forms and Question & Answer booklets (with reference to the hotline in some, but not each of these documents), while other HMOs provide combined documents.
- The location of the hotline information varies greatly. In many cases, the hotline number is found in sections that a consumer could easily identify when looking at a table of contents. But in some cases the hotline information is buried in sections of the Evidence of Coverage where a consumer would not intuitively look, such as under the

[14] It is possible that other correspondence containing the hotline notice may have been sent along with the letters we reviewed, but we did not see any. In any event, it appears that relevant correspondence does not always include the hotline notice.

[15] The observations about HMOs' notice in their Evidences of Coverage is based upon a review of twenty 1997 and 1998 Evidences of Coverage or other plan disclosure documents from eight HMOs (Aetna, Blue Cross, Blue Shield, Health Net, Health Plan of the Redwoods, Kaiser Foundation Health Plan, Omni, and PacifiCare). In most cases the hotline notice is taken verbatim from the statute, while others add helpful parentheticals or substitute the HMO name for the generic text. Examples of clarifying edits inserted in text (**bold text** for additions made by some HMOs) include:

- "The California Department of Corporations is responsible for regulating health care service plans **(xxx health plan is a health care service plan)**."
- "If you have a grievance against **[name of HMO]**, you should contact the plan and use the plan's grievance process" (instead of "the health plan").

following headings: "Binding Arbitration," "Important Things to Know," and "Other Provisions" (or "General Provisions").

4. The Department does not publish educational material for consumers about its regulatory role or about managed care. Under prior administrations, the Department did not disseminate educational materials for consumers of which we are aware beyond very limited communications to some hotline callers. The Department could educate consumers about its role as the HMO regulator by producing brochures or posters for providers' offices. Moreover, the Department does not provide information to consumers on the managed care system (*e.g.*, differences between HMOs and PPOs), as well as information comparing HMOs and on navigating the health care system.

The Department's reports generally include only raw data on HMOs, with little or no analysis, discussion, or graphical presentation.

5. The Department provides virtually no analysis of the data it is mandated to make public. The Department's reports generally include only raw data on HMOs, with little or no analysis, discussion, or graphical presentation. For example, the Department's Annual Hotline Reports and Late Grievance Reports do not provide trends over time, easy comparisons among HMOs, or graphical displays of problem types or grievance rates. Similarly, the Department's Medical Survey Reports lack any evaluation of the surveyed HMO in light of its past surveys, or comparison to other HMOs.

Recommendations

1. Expand the Department's outreach and promotion efforts through a wide array of venues. Consumers generally are not aware of which state agency regulates HMOs or the services the Department can provide. Some specific recommendations to improve the Department's efforts are:

- Develop a name, image, and promotional plan for itself and its services.
- Adopt an Internet promotion plan. The Department should develop a plan for better use of the Internet as a resource for consumers. This should include not only a review of its website,[16] but also an assessment of what links and tools the Department should provide to better inform consumers.
- Pursue media coverage of the availability and appropriate use of the hotline and the information developed by the Department for consumers (*e.g.*, Annual Hotline Reports, Late Grievance Reports, and Medical Survey Reports). To promote media coverage, the Department should:

[16] The Department's website (http://www.corp.ca.gov) does not make the Department's HMO regulatory role readily apparent to its visitors.

a. Release its reports with analyses that "tell a story" in ways that are accessible to the public and the press (*e.g.*, using graphics, making comparisons among HMOs, and highlighting how consumers can resolve problems with their HMOs).[17]

b. Place public service announcements on radio and television that educate consumers about their rights and responsibilities as health care consumers.

c. Seek opportunities for Department staff to appear on radio and television to highlight the Department's role as regulator, and to publicize the hotline and managed care information available to consumers.

d. Include information about the hotline with all health-related press material released by the Department.

e. Investigate ways to partner with providers, community organizations, purchasers, and HMOs to promote the Department's services and educate the public.

- Make the Department and its hotline number accessible in all local telephone books and directory assistance listings. Recognizing that consumers who have a problem with their HMO are unlikely to look under "Corporations" for assistance, the Department should be listed under a heading which consumers are likely to find (*e.g.*, "HMOs," "Health Plans," "Health Maintenance Organizations," or "Managed Care"). The Department should ensure that the hotline is listed in the free Community Service section of all Yellow Pages and should assess the cost-effectiveness of purchasing additional listings in the Yellow Pages, versus other forms of outreach (*e.g.*, posters and educational materials).

2. Educate consumers about how to select and use managed care health delivery systems. The Department should develop and widely distribute health care educational materials for consumers and enhance its website to promote its educational functions more prominently. These educational efforts should be sensitive to the need to reach lower literacy levels and be culturally and linguistically appropriate. Because of California's diverse population, what is considered culturally and linguistically appropriate will vary by community, and consumer education materials should reflect this diversity. These materials should be distributed to consumers in providers' offices, hospitals, clinics, and other places where consumers receive health services. Since focusing solely on HMOs does not fully reflect the marketplace reality, consumer education materials should cover all types of health plans (*e.g.*, HMOs and PPOs) and all levels of care (*e.g.*, individual providers, medical groups and hospitals).

The Department should develop and widely distribute health care educational materials for consumers and enhance its website to promote its educational functions more prominently.

[17] See Section II of this report for a discussion of ways the Department could analyze the complaint data collected.

3. Report on the feasibility of preparing comparative "report cards" that reflect consumer satisfaction and experience by HMOs and by medical groups. While some states have developed report cards on HMOs, California lags far behind. The Department should develop a plan to provide all Californians with comparative information on the HMOs and medical groups in their area. The Department can help to ensure that all HMOs and all medical groups are included in a statewide report card and that the information is collected efficiently. The Department should coordinate and, to the extent possible, consolidate its HMO and medical group information with that collected by other state agencies, including the Department of Health Services (in its data collection on facilities) and the Department of Insurance.

4. Explore the possibility of consolidating the Department's complaint hotline with the State's other health-related consumer complaint services. Many consumers in managed care plans do not know whether they are enrolled in a HMO or a PPO. The State should consider providing consumers with one telephone number that could be called regarding any managed care-related problems, with provisions to transfer the caller to the appropriate oversight body, *e.g.*, the Department of Corporations or Department of Insurance (which regulates PPOs and traditional indemnity plans), or other appropriate entities, such as the Medical Board (which regulates physicians).

***5. Strive for effective communication*.** The information on HMO performance that the Department has gathered is of little value to consumers if it is difficult to interpret or obtain. The Department should seek expert consultation on the most effective ways to communicate and package for consumers the complex and rich information from the Annual Hotline Reports, Late Grievance Reports, and Medical Survey Reports and summaries. For example, the Department should:

- Present all materials in plain language, eliminating jargon and acronyms.
- Consider presenting data visually. Data can often be more easily understood if it is presented in graphs or charts, rather than page after page of numbers. The Department should consider presenting its data in pie charts, bar graphs, or other formats that allow for comparisons among HMOs and quick identification of major issues.
- Provide meaningful analysis of the data, including comparative information, rather than just raw numbers.
- Make materials easily obtainable and inexpensive. A consumer-friendly website, for example, with downloadable versions of all available reports would enable consumers to gain access to the Department's materials easily and quickly. The Department should, however, be mindful that many consumers do not have access to computer technology, so there must be a concerted effort to reach these consumers through well-disseminated print materials.

6. Ensure prominent inclusion of the hotline information in HMOs' Evidences of Coverage and in letters from HMOs and medical groups. The Department should ensure that all HMOs and contracted medical groups effectively promote the availability of the hotline in their materials to consumers. Some specific recommendations are:

- Assess the current level of consumer awareness of the hotline based on the location of the required notice in HMOs' Evidences of Coverage.
- Review HMO communications of various types – initial denial notices, responses to grievances, notifications of non-billing – and clarify to HMOs which of their correspondence must include notice of the Department hotline.
- Consider establishing standards for the promotion of the Department's hotline in HMO or medical group newsletters and in providers' offices.

II. DEPARTMENT COMPLAINT HOTLINE

Beginning in 1995, the Department was required to issue an annual aggregate summary of complaints against HMOs filed with the Department by enrollees.[18] This summary must include the total number of complaints filed and the types of complaints.[19] In late 1995, the Department established a toll-free hotline for receiving complaints from consumers regarding HMOs.[20] The hotline represents a rare proactive effort by the Department to help consumers. The hotline has multiple functions. First, it is the initial point of access to the Department for individuals who have complaints about their HMO. The hotline can be a vital means of educating the Department regarding HMO audits, investigations, and enforcement actions that may need to be undertaken. In addition, the information from the hotline can empower consumers by giving them additional comparative information on California HMOs.

Since the creation of the hotline, the Department has issued three Annual Hotline Reports on complaints made by consumers (for the years 1995, 1996 and 1997). While the Department is required to make these reports a matter of "public record," the law provides little guidance as to their form and content.[21] The Department's Annual Hotline Report includes a summary chart that details, by HMO, the number of complaints received,[22] each HMO's enrollment, and the number and rate of issues per 10,000 enrollees of each HMO in four broad categories.[23] In addition to the complaint information, the summary includes the number of

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[18] CAL. HEALTH & SAFETY CODE § 1397.5 (West Supp. 1998).

[19] *Id.*

[20] Before 1995, the Department received complaints by mail and through the Department's general telephone line. The toll-free hotline was mandated by law effective 1996, which provided for special appropriations. CAL. HEALTH & SAFETY CODE § 1356 (b) (West Supp. 1998).

[21] *See* CAL. HEALTH & SAFETY CODE § 1397.5 (West Supp. 1998).

[22] While no legal distinction may exist under California law between a "complaint" and a "grievance," in order to distinguish problems brought to the Department from those filed with HMOs, this report uses the term "complaint" solely to describe a problem filed with the Department. *See* CAL. HEALTH & SAFETY CODE § 1368.02 (a) (West Supp. 1998) (requiring the Department to "establish and maintain a toll-free telephone number for the purpose of receiving complaints"). In Section III of this report, the term "grievance" is used to describe a problem filed with HMOs by consumers. *See* CAL. HEALTH & SAFETY CODE § 1368 (a)(1) (West Supp. 1998) (mandating HMOs to "establish and maintain a grievance system approved by the [D]epartment under which enrollees may submit their grievances to the plan").

[23] See Appendix 1 (1997 Annual Hotline Report, pp. 1 – 2) for an example of the summary chart. The Department's four categories on the Annual Hotline Report are: (1) Accessibility (four specific issues), (2) Benefits/Coverage (eight specific issues), (3) Claims (six specific issues), and (4) Quality of Care (14 specific issues).

The summary also includes separate subtotals and averages for each type of HMO regulated by the Department (full service HMOs, as well as specialty HMOs providing vision, dental, psychological, and chiropractic care). Beyond the summary report, which provides some basis on which to compare regulated HMOs, the report also includes a separate page for each HMO for which the Department received a complaint. These individual HMO listings detail the number of issues and the rate per 10,000 enrollees in each of the 32 issue categories. See example at Appendix 2, containing the listing for Aetna Health Plans from the 1997 Annual Hotline Report. Aetna was chosen because it is first alphabetically among full-service HMOs.

"Referrals to Plan" for each HMO. This figure represents the number of enrollees who contacted the Department but were referred back to their HMO because the Department deemed their complaints to be "not urgent" and their complaints had not been filed with their HMO for the shorter of the following: completion the HMO's grievance process or 60 days.

Over 75% of the calls to the hotline in 1997 and 1998 were "inappropriate" for the Department.

In this section, we assess how effectively the Department has collected complaint data and conveyed it to the public.[24] The potential of the hotline can only be realized if it supplies information to consumers and the Department in a manner that facilitates HMO comparison and identification of areas for investigation.

Findings

1. A high rate of "inappropriate" calls to the hotline indicates that many callers may not understand the function or requirements of the hotline. The hotline is designed to serve as a resource for enrollees who are having problems with their HMOs. If these callers have not yet contacted their HMO, they are referred back to their HMO. Those callers who have already been to their HMO and meet the Department's screening are sent a compliant form that consumers must return for a complaint to be opened. If the Department is doing its job properly, callers who are neither referred back to their HMO nor sent a complaint form presumably are inappropriate for the hotline (*e.g.*, their problem may fall under the province of another state agency). Based on a review of the Department's call volume reporting, over 75% of the calls to the hotline in 1997 and 1998 were "inappropriate" for the Department (see Table 1).

[24] This report does not include an assessment of the Department's actual handling of consumer complaints. Over the past three years, consumer groups have raised concerns about a number of aspects of how the Department processes complaints, including the following: the Department is not effectively serving Medicare or Medi-Cal HMO enrollees; consumers who contacted the hotline were not told the results of the Department's investigation of their complaints; and the Department's findings are often inconclusive, stating that the Department did not have sufficient information to determine whether a Knox-Keene violation occurred. While these issues are beyond the scope of this report, a recent audit by the California State Auditor found that in roughly one-quarter of all complaint "resolutions," the Department determined that it did not have sufficient information or clear statutory support to decide whether a complaint involved a Knox-Keene violation. "Department of Corporations' Regulation of Health Care Plans: Despite Recent Budget Increases, Improvements in Consumer Protection Are Limited," California State Auditor, Report No. 97118.2, Table 5 at p. 22 (April 1999) ["Auditor's Report"]. The same audit also found that the Department fails to notify consumers when their complaints take longer to resolve than the 60 days permitted under the Knox-Keene Act. *Id.* at p. 23. There are, however, indications that the Department under the Davis Administration has begun to address some of the shortcomings identified.

Table 1. Calls to the Department's Hotline, 1997-1998*

	1997		1998	
	Number	**Percent**	**Number**	**Percent**
Total Calls Answered	69,784	100%	70,276	100%
Callers Sent Complaint Form or Referred to HMO	17,055	24%	15,833	23%
"Inappropriate" Calls to Hotline	52,729	76%	54,443	77%

* Source: The data on call volume are derived from internal Department reports "Consumer Services Unit Call/RFA Volume" ("CSU Report") for 1997 and for 1998. These internal reports provide aggregate call information, including a monthly accounting of: the total number of calls to the hotline, the number of calls answered (unanswered calls reflect callers who do not wait to speak to a Department staff person), the number of calls referred to HMOs, the number of complaint forms sent, and the number of complaints "opened." The Annual Hotline Report reflects only completed complaint forms that lead to the opening of a complaint, other written correspondence with information that meets the criteria of a completed complaint form, and complaints that involve an emergency.

2. The Department's failure to track the source of complaints limits its ability to evaluate its promotion efforts and to increase use of the hotline. The Department does not collect information on how the caller found out about the hotline. This information could help determine the source of inappropriate calls. It could also be a tool to identify HMOs that appear to be doing a particularly good (or bad) job of informing consumers of the existence of the hotline and their right to use it in Evidences of Coverage or correspondence.

3. Growing numbers of callers are being referred back to their HMOs. In 1998, over twice as many callers to the hotline were referred back to their HMO than in 1997 (see Table 2). The Department's practice of referring consumers to their HMO may be correct, given the goal of encouraging prompt resolution of problems as close to their source as possible. However, the significant increase in the proportion of callers referred back to their HMOs suggests either that an increasing proportion of consumers are calling the Department without seeking to resolve the problem with their HMOs first, or that the Department has changed its practices. Either way, the change means that a far smaller proportion of callers to the hotline in 1998 will actually have a formal complaint opened by the Department and that the Annual Hotline Report will reflect far fewer problems.

In 1998, over twice as many callers to the hotline were referred back to their HMO than in 1997.

Table 2. Distribution of Hotline Calls Between Those Referred to HMO and Sent Complaint Forms*

	1997		1998	
	Number	**Percent**	**Number**	**Percent**
Total Number of Calls Either Referred to HMO or Sent Complaint Forms	17,055	100%	15,833	100%
Callers Sent Complaint Forms	13,371	78%	8,363	53%
Callers Referred to HMO	3,684	22%	7,470	47%

* Source: CSU Reports for 1997 and 1998.

4. Information from the vast majority of consumers who contacted the Department about problems with their HMOs is not reflected in the Annual Hotline Reports. The Department's practice of including in its Annual Hotline Report only data from complaints that are formally opened (usually based upon a returned complaint form) means that the Department's report does not reflect the vast majority of consumers who contact the hotline with problems. While many callers to the hotline appear to be "inappropriate" and other callers may be rightly sent back to their HMO, a huge disparity still exists between the number of consumers who contact the hotline with a problem and the number of calls reflected in the Annual Hotline Report. In 1997, for example, because Annual Hotline Reports only reflect complaints opened (and reference the number of consumers "referred to plan"), information was not collected on the nature of problems from the 83% of the consumers who requested and were sent complaint forms, but who did not return them. This represents a wealth of potential data that is lost, both for the Department and the public (see Table 3).

Table 3. Number of Complaint Forms Sent & Complaints Opened, 1997*

	Number	**Percent**
Complaint Forms Sent by the Department	13,371	100%
Complaint Forms Sent Resulting in Complaints Opened	2,323	17%
Complaint Forms Sent That Do Not Result in Open Complaints	11,048	83%

* Source: The number of complaint forms sent is from the CSU Report for 1997, and the number of complaints opened is from the 1997 Annual Hotline Report. Because a complaint may be opened based on written correspondence from a consumer who has not called the hotline for a complaint form and in urgent circumstances without receipt of a written form, the actual percentage of complaint forms sent that result in complaints being opened by the Department in 1997 is certainly lower than 17%.

5. The content and format of current public reporting of complaints filed with the Department greatly limits the usefulness of the data. For complaint information to be a useful tool for either consumers or the Department, it must be well analyzed and clearly presented. The content and format of the Department's annual complaint reports, however, have a number of flaws that seriously undercut the usefulness of the data for consumers and call into question the Department's ability to use the data to ensure that consumers are receiving quality health care. Some of the shortcomings of the Annual Hotline Reports include:

- **The Department compares complaints across HMOs in only four broad areas.** The Annual Hotline Report compares HMOs by four broad categories: accessibility, benefits and coverage, claims, and quality of care. It is not possible for a consumer – or the Department, based on the analysis made public – to compare one HMO's rate of complaints for a particular type of complaint to the average of all HMOs. For instance, if a consumer is interested in complaints about "Denials of Care," while HMO-specific pages detail the number and rate of complaints per 10,000 enrollees for each HMO, nowhere does the report show the overall number of complaints of this type or the overall rate per 10,000 enrollees. Instead, the Department's report collapses these complaints with other categories as part of the "claims" group.
- **No data appears on complaint disposition.** The Department has an obligation to investigate complaints and make findings of whether an HMO's conduct is in or out of compliance with its obligations under its contract or the Knox-Keene Act.[25] While HMOs have expressed concern that consumers would misinterpret the Department's inclusion of findings about complaint disposition,[26] without such findings it is difficult for a consumer to compare HMOs' performance. The State Auditor's April 1999 report found that the proportion of complaints in which the Department upheld the HMO was noticeably higher for the second half of 1998 than for fiscal year 1996-1997 (47% versus 40%). In finding HMOs in compliance 47% of the time, the State Auditor also found that the Department held HMOs out of compliance in only 28% of complaints received and made no finding in 25% of complaints.[27] This information is not part of any of the Department's public reports.
- **The Annual Hotline Report does not reflect how long the Department takes to resolve complaints.** The Annual Hotline Report is a means by which consumers can compare HMOs, but it should also serve as a tool to hold the

The Annual Hotline Report should serve as a tool to hold the Department accountable.

[25] CAL. HEALTH & SAFETY CODE § 1368.04 (a) (West Supp. 1998).

[26] The Knox-Keene Act currently requires the Department to include a disclaimer in the Annual Hotline Report that it has "neither investigated nor determined whether the complaints compiled … are reasonable or valid." CAL. HEALTH & SAFETY CODE § 1397.5 (b) (West Supp. 1998). This requirement may limit the Department's ability to include dispositions without a change in the Knox-Keene Act and may need to be amended so that this critical information can be made available to the public.

[27] Auditor's Report, *supra* note 24, at pp. 21 – 22.

Department accountable. The Department is required to establish and maintain a system of tracking complaints that are pending and unresolved with the Department for 60 days or more.[28] The State Auditor's recent report found that more than half of the complaints filed with the Department and open at the end of 1998 had not been resolved within 60 days.[29]

- **Full-service HMOs and those entities granted limited Knox-Keene licenses are not differentiated from one another in the data.** The Department grants limited Knox-Keene licenses to entities that undertake full-risk from existing HMOs.[30] Enrollees in these limited licensees (*e.g.*, FPA Medical Management, MedPartners, and Brown & Toland) are reflected as enrollees in both the HMO and the limited licensee. Because complaints are counted only once, while some enrollees are counted twice, the overall figure of complaints per 10,000 enrollees is diluted.
- **The complaint data only includes information on HMOs, not on medical groups.** Increasingly, medical care is being coordinated and delivered by medical groups under contract to HMOs. With the exception of the inclusion of limited licensees that are medical groups, the Annual Hotline Reports do not reflect the reality of the health care marketplace since they only include information on HMOs.

Recommendations

1. Collect and report information on all hotline calls received, not just on opened complaints. The Department reports data on only two categories of complaints: complaints opened and calls "referred to plan." Because of this, an enormous amount of important information is lost. The Department should expand its data collection to include information on matters for which consumers are sent complaint forms or referred back to HMOs. This data should be included in the Department's annual report. Some of the reasons to report on all complaints include:

- Patterns of complaints by enrollees coming to the Department may indicate that a particular HMO is not adequately informing enrollees of internal grievance processes.
- The fact that an enrollee has not yet availed him or herself of an HMO's grievance procedure does not make the complaint any less valid. While this information can, and should be, reported with appropriate descriptions so consumers do not confuse the data on pre- and post-grievance complaints, it is still an indicator of consumers' problems.

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[28] CAL. HEALTH & SAFETY CODE § 1368 (b)(4) (West Supp. 1998).

[29] Auditor's Report, *supra* note 24, at p. 21. Of the 565 complaints open with the Department on December 31, 1998, 305 (54%) had been open with the Department for 60 or more days. *Id.* at p. 19.

[30] Limited licensees may undertake total responsibility for an enrollee's health care (accepting full capitation as payment from fully licensed HMOs) and are subject to all Knox-Keene Act requirements except those relating to marketing.

- Publication of all complaint data provides an incentive for HMOs to take steps to minimize the number of enrollee complaints.
- HMOs will have incentives both to promote their own grievance procedures and to resolve complaints effectively and expeditiously.
- By publicly reporting only those complaints where a consumer has received a formal decision or participated in an HMO's grievance process for at least 60 days, the Department renders meaningless the statutory guideline that HMOs resolve grievances in 30 days, whenever possible.

2. Track how consumers find the hotline. The Department should ask callers how they learned about the toll-free hotline. The volume of complaints about an HMO is partly a function of how well that HMO discloses to its enrollees the right to file a grievance with the HMO or request assistance from the Department. Tracking how the caller got to the hotline is critical to assessing an HMO's compliance with its obligation to publicize the toll-free number and to enabling the Department to understand how better to promote the hotline.

3. Make the Annual Hotline Report more useful. The Department must go beyond presenting raw data. It must analyze the information in order to make it more useful to consumers and to its own regulatory staff. Below are some examples of how the complaint data can be better presented and analyzed:

- **Group complaints to facilitate ready comparison of major areas of concern and provide comparative information on each specific type of complaint**. The Department's Annual Hotline Report allows for the comparison of HMOs only by its four major groupings. With this system, it is often difficult to tell under which heading certain types of key consumer complaints are found.[31] While the most helpful grouping of types of complaints will always be subject to debate, to illustrate a more informative categorization of the Department's specific complaint categories, we have grouped problems into six major areas of concern as follows (see Table 4):
    a. **Denial/Coverage Disputes**: combining "Dispute Over Covered Service," "Plan Denial of Treatment," and "Provider Entity Denial of Treatment."
    b. **Liability for Payment**: combining "Insufficient Payment," "Refusal to Pay Equipment," and "Refusal to Pay Treatment."
    c. **Inappropriate Care**: combining "Inappropriate Ancillary Care," "Inappropriate Physician Care," "Plan Inappropriate Care," and "Provider Entity Inappropriate Care."
    d. **Specialty Care Access**: combining "Lack of Specialist Availability," "Plan Refusal to Refer," and "Provider Entity Refusal to Refer."

[31] For example, a consumer having a problem getting referred to a specialist might be coded under the current system as an "Accessibility Problem" (Lack of Specialist Availability), or a "Quality of Care Problem" (Plan Denial of Treatment, Plan Refusal to Refer, or Provider Entity Refusal to Refer).

e. **Customer Service**: combining "Lack of Telephone Accessibility," "Slow Payment," "Poor Physician/Staff Attitude, and "Slow Reply."

f. **Other**: the remaining 15 issues.

- **Compare each HMO's problem rate to the average for all HMOs.** Beyond using groupings of complaint categories, the Department should also compare the problem rate for each HMO in the 32 specific issues to the overall rate for that issue.[32]
- **Report on how complaints are resolved.** The Department's annual report should include the number and percentage of complaints in which an HMO was found in compliance with Knox-Keene, not in compliance, or in which no finding was made.
- **Perform statistical analysis of the complaint rates.** The Department should conduct and incorporate statistical analysis into the public reports to indicate whether the difference between an HMO's complaint rate and the average complaint rate is statistically significant (*i.e.*, is large enough and based on a sufficiently large sample).[33]
- **Compare the hotline complaint data to other sources.** The Department should look for trends not only within its data, but also by comparing the Department's complaint data to other complaint information. For instance, the Department should compare complaints it receives to those reported to the Center for Health Dispute Resolution (which reviews Medicare HMO denials) or independent assistance programs, such as the Health Rights Hotline.
- **Distinguish limited licensees from full-service HMOs.** A distinction should be made in the Department's report between licensees that serve only consumers who are enrolled in full-service HMOs and limited licensees who undertake full-risk from HMOs in order to present a more accurate count of complaints and prevent dilution of complaint rates.
- **Report on complaint trends.** With the data from 1998, the Department will have four years of information on consumers' problems with their HMOs. Future reports should include trend analysis to identify changes in HMOs' performance or in the nature of problems consumers are facing across all HMOs.

4. Present comparative analyses of HMOs' problem rates. Because it is difficult, if not impossible, to determine in absolute terms what is a "good" or "bad" complaint rate, consumer complaint rates need to be analyzed on a comparative basis. That is, how do the rates at which enrollees in one HMO report problems compare to other HMOs or the average rate for all enrollees? As an example of how the Department might present such data to the public, Table 4 compares how the rate at which consumers reported problems to the Department in 1997 for the ten largest HMOs compared to the average rate for all HMOs as follows:

[32] We are providing the Department sample reports that compare problem rates by HMO in each area and over the three-year period covered by the Annual Hotline Reports.

[33] *See, e.g.*, note 34.

- **Much higher than average** (the rate is more than 50% above average and the difference is statistically significant – signified on Table 4 by ↑↑).[34]
- **Higher than average** (the rate is above average, up to 50% above, and is statistically significant – signified on Table 4 by ↑).
- **Average or difference not statistically significant** (the difference from the average rate is not statistically significant – signified on Table 4 by ○).
- **Lower than average** (the rate is below average, up to 50% below, and is statistically significant – signified on Table 4 by ⇩).
- **Much lower than average** (the rate is more than 50% below average and the difference is statistically significant – signified on Table 4 by ⇩⇩).

Table 4. Sample Comparison of Reported Rates of Problems by HMO Enrollees in 1997*

HMO	All Problems Reported	Denial/ Coverage Dispute	Liability for Payment	Inappropriate Care	Specialty Care Access	Customer Service
Aetna	↑↑	↑↑	○	○	↑↑	○
Blue Cross	⇩	○	↑	⇩⇩	⇩	○
Blue Shield	⇩	○	○	⇩⇩	⇩	○
Cigna	○	○	○	○	↑↑	○
FHP	↑↑	↑↑	↑↑	↑↑	↑↑	↑↑
Foundation	↑	○	↑↑	⇩⇩	○	↑↑
Health Net	↑	↑	○	○	↑↑	↑↑
Kaiser	○	⇩	⇩	↑↑	⇩	⇩
PacifiCare	↑↑	↑↑	↑↑	↑↑	↑↑	○
Prudential	○	○	○	⇩⇩	○	○

↑↑ *Much higher than average problem rate and statistically significant*
↑ *Higher than average problem rate and statistically significant*
○ *Average problem rate or difference from average rate not statistically significant*
⇩ *Lower than average problem rate and statistically significant*
⇩⇩ *Much lower than average problem rate and statistically significant*

* Source: Derived from 1997 Annual Hotline Report. This table sets forth a comparison of problem rates for the ten largest plans in 1997, which encompassed 80% of all Californians enrolled in HMOs. These ten plans accounted for 90% of all problems reported.

[34] For this report, the test for statistical significance is at the .05 level (5%). The formula used to calculate statistical significance is available upon request from the authors of this report and has been provided directly to the Department.

In its analysis, the Department should move beyond simply presenting raw data to making observations that can help consumers, purchasers, or others interested in the data to understand the information presented. The Department could identify particularly important types of complaints (*e.g.*, denials of care) or groups of complaints (see Table 4 above) and compare the rates of complaints among HMOs. For example, with regard to the comparative problem rates presented in Table 4, the Department could make observations such as:

- Consumers in three HMOs, Aetna, FHP (subsequently acquired by PacifiCare), and PacifiCare, reported problems to the Department at a much higher rate than average.
- Consumers in two HMOs, FHP and PacifiCare, were much more likely to report problems in four out of five problem areas.
- Consumers in Kaiser Foundation Health Plan reported fewer problems in the areas of Denials of Care, Payment Disputes, Access to Specialty Care, and Customer Service, but more problems with Inappropriate Care.

5. Present the hotline data graphically. Readers of the Annual Hotline Report may find it easier to understand a table or chart that summarizes the findings visually, rather than with large amounts of raw data. One example of how the Department could present data graphically is provided in Table 4, while another example is found in the following two pie charts, comparing complaints by using the existing Department groupings of problems and the groupings suggested in this report.

Chart 1. Complaints by Type of Issue as Grouped by the Department of Corporations, 1997
(for full-service health plans)

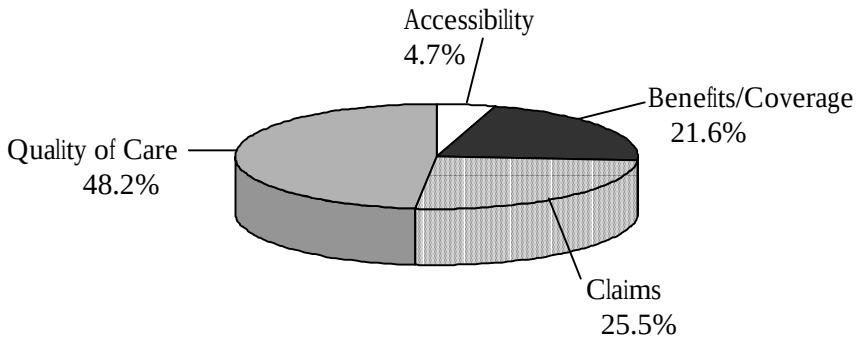
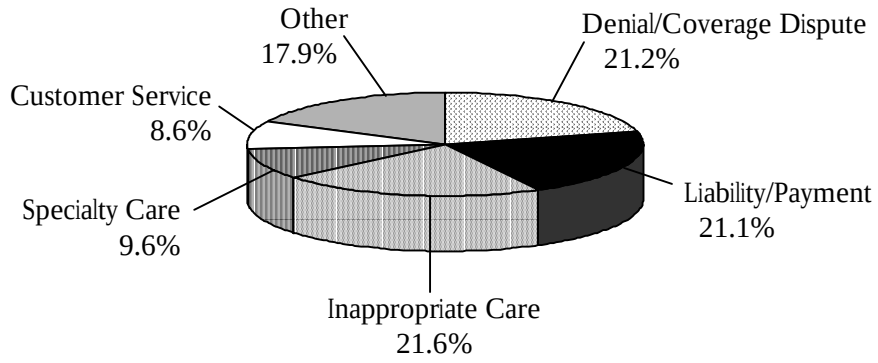


Chart 2. Alternate Grouping of Complaints by Type of Issue for Comparative Analysis, 1997
(for full-service health plans)



6. Collect and report data by medical groups, whether or not the medical group is a limited licensee. Increasingly, medical groups are the locus of responsibility for organizing patient care; they are also increasingly the locus of patients' problems. The Department acknowledges this reality in its current complaint categories, with three categories specifically referencing actions taken by a "provider entity," in contrast to actions taken by the "plan." The Department needs to go beyond this simple acknowledgment and assess how it can best collect and report on the experiences of consumers in medical groups that may contract with multiple HMOs.

7. Include data in the Annual Hotline Report on complaints that are pending and unresolved with the Department for 60 or more days. Just as HMOs are held accountable for their grievance handling by filing reports on delayed grievances (see Section III, *infra*), the Department should prepare and make public data on hotline complaints that have been pending and unresolved with it for 60 or more days. This information could be reported in 60 day intervals (*e.g.*, pending and unresolved for more than 60 days; pending and unresolved for more than 120 days; pending and unresolved for more than 180 days, etc.). The State Auditor's recent report on the Department found serious backlogs in the Department's complaint resolution beyond the 60 day deadline.[35] The reporting of this information would make the Department more accountable for delays in resolving consumers' problems.

[35] Auditor's Report, *supra* note 24, Table 3 at p. 19 & pp. 20 – 21.

III. LATE GRIEVANCE REPORTS

State law requires each HMO to maintain a grievance system for its members.[36] HMOs must resolve grievances within 30 days, whenever possible, and must provide the enrollee at least a written statement on the status of the grievance within 30 days of the HMO's receipt of it.[37] In cases involving an imminent and serious threat to the patient's health, the grievance system must provide expedited review and a written statement of disposition or pending status within five days.[38]

Grievances that remain unresolved for long periods of time can be enormously frustrating to consumers who have unsuccessfully sought relief from their HMOs and may increase the risk of injury to consumers who are denied needed care pending the review. A survey commissioned by California's Managed Health Care Improvement Task Force found that significant proportions of California consumers have had difficulties getting grievances resolved. In that survey, 42% of Californians who reported a problem with their HMO in the prior 12 months said that their problem had not been resolved.[39] Some of the problems least likely to be resolved relate to HMO denial of care or treatment (60% unresolved) and refusal to cover important benefits (62% unresolved).[40] Regarding HMO handling of grievances, 29% who reported having a problem with their HMOs in the prior 12 months were either dissatisfied (18%) or very dissatisfied (11%).[41]

Beginning January 1, 1997, HMOs were required to file "a quarterly report to the commissioner of complaints pending and unresolved for 30 or more days, with separate categories of complaints for Medicare enrollees and Medi-Cal enrollees."[42] If effectively implemented, this reporting requirement should help the Department and the public monitor how well HMOs are meeting the goal of resolving grievances within 30 days.[43] This report refers to the grievances consumers file with HMOs that are pending and unresolved for 30 days or more as "late grievances" and the report of late grievances filed with the Department by an HMO as a "Late Grievance Report."

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[36] CAL. HEALTH & SAFETY CODE § 1368 (a)(1) (West Supp. 1998).

[37] CAL. HEALTH & SAFETY CODE § 1368.01 (a) (West Supp. 1998).

[38] CAL. HEALTH & SAFETY CODE § 1368.01 (b) (West Supp. 1998).

[39] Task Force Report, *supra* note 5, Vol. 2 at p. 31.

[40] *Id.*

[41] *Id.* at pp. 31 – 32.

[42] CAL. HEALTH & SAFETY CODE § 1368 (c) (West Supp. 1998).

[43] Medical Survey Reports can be another source for the Department and the public to monitor HMOs' performance in grievance resolution. In some Medical Survey Reports we reviewed (see Section IV, *infra*), the Department found deficiencies by HMOs in their grievance handling.

In the first two years of reporting, Late Grievance Reports showed wide variation in both the information HMOs provided to the Department and in the format of the reports.[44] Some reports were only one page long and provided minimal information. Other reports exceeded 60 pages, with summary information contained in a few pages and detailed listings of individual cases comprising the bulk of the report. The longer reports contained information for each individual grievance, such as the opening date, notations of grievance updates, and how long the grievance has been open.

Based upon reports submitted to the Department by HMOs, we performed a preliminary analysis of the late grievance rates for Second Quarter 1997.[45] The rate of late grievances varied enormously, with some HMOs reporting a rate of late grievances more than 20 times higher than other HMOs (range of 0.44 to 9.56 late grievances per 10,000 enrollees – see Table 5). However, it is impossible to tell from the Late Grievance Reports whether the variation is the result of underlying differences among HMOs, differences in the timing of which grievances are included and when grievances are considered closed, or differences in how HMOs define grievances.

Table 5. Late Grievance Rates for Second Quarter 1997

HMO	Enrollees*	Second Quarter 1997 Late Grievances†	Late Grievances per 10,000 Enrollees
Aetna	454,205	28	0.62
Blue Cross	3,064,456	554	1.81
Blue Shield	1,628,111	1,144	7.03
CareAmerica	251,040	25	1.00
Cigna	654,885	29	0.44
FHP	884,108	738	8.35
Foundation	748,267	166	2.22
Health Net	1,397,605	1,336	9.56
Kaiser	5,422,957	2,210	4.08
Lifeguard	216,813	34	1.57
Maxicare	221,911	35	1.58
PacifiCare	1,431,274	243	1.70
Prudential	820,531	283	3.45
Total	17,196,163	6,825	3.97

* Source: California Department of Corporations 1997 Annual Hotline Report.

† Source: Second Quarter 1997 Late Grievance Reports submitted by HMOs to the California Department of Corporations.

[44] The source of much of the data for Section III is the Department's responses to the authors' Public Records Act requests.

[45] We chose Second Quarter 1997 because it was the only quarter for which Late Grievance Reports filed by all the HMOs reviewed were available.

A new state regulation effective October 18, 1998, amended and standardized the format for the Late Grievance Reports starting 4th Quarter 1998.[46] HMOs must now include the following information:

- Categories for grievances included in the report (commercial, Medicare Risk, Medicare Supplement, and Medi-Cal).[47]
- Levels of appeal allowed by the HMO (Initial Grievance Only, One-Level Appeal, Two-Level Appeal, and Multi-Level (three or more) Appeal).
- A list of the reasons for the number of pending and unresolved grievances (awaiting additional information from enrollee, awaiting additional information from provider, awaiting the HMO's review and determination, and other).
- The number of grievances within each of the reasons listed above.[48]

When an HMO's grievance system allows multiple opportunities for internal appeal, the new regulations state that an enrollee's grievance is considered unresolved and must be included in the HMO's Late Grievance Report until the enrollee has exhausted all opportunities for appeal, or the time for appeal under the grievance system has expired.[49] The regulations also specify that grievances filed or processed "outside the plan's grievance system in other complaint resolution procedures, such as arbitration, voluntary mediation and the Department of Corporations" are not to be included in the Late Grievance Report.[50]

Findings

1. The Department does not prepare its own summary report that would allow consumers to compare grievance handling by HMOs. Without a plainly stated comparison of late grievances that synthesizes the HMOs' reports, consumers have no meaningful way to compare HMOs. The Knox-Keene Act states that, "[i]f requested by a plan, the commissioner shall include [a statement that pending complaints may reflect

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[46] Under the recent amendments to Regulation 1300.68 that specify the format of Late Grievance Reports, the Department estimates that the average length of Late Grievance Reports under the new format will be three pages. "Economic and Fiscal Impact Statement, Calculations for Costs and Savings Associated with Proposed Changes to Rule 1300.68," Department of Corporations (January 29, 1998). The first reports required to be filed under the new format were due to the Department by January 30, 1999. According to Department counsel, these reports will not be available for public inspection until the Department completes its review.

[47] Commercial plans include employer- or individual-based coverage; Medicare Risk plans are full-service HMOs that provide coverage to Medicare enrollees; Medicare Supplement plans are additional to fee-for-service Medicare plans, with coverage provided by HMOs; and Medi-Cal plans provide coverage to Medi-Cal enrollees, who meet low-income guidelines.

[48] CAL. CODE REGS. tit. 10, § 1300.68 (i)(6) (1998).

[49] CAL. CODE REGS. tit. 10, § 1300.68 (i)(1) (1998).

[50] *Id.* As discussed later in this section, there are separate handling issues for Medicare and Medi-Cal enrollees.

enrollees pursuing Medicare and Medi-Cal appeal rights] in a written report made available to the public and prepared by the commissioner that describes or compares complaints that are pending and unresolved for 30 days or more."[51] In response to our requests for such a written report, the Department indicated that no such document prepared by the Commissioner exists and that the "report" consists of a packet with a Department cover letter attached to the individual HMOs' Late Grievance Reports. This is not a comparison based on the Department's own analysis of the data. Although the Knox-Keene Act does not explicitly mandate the Department to prepare its own comparison of internal grievance handling delays, without such a comparison, the Late Grievance Reports filed by individual HMOs have little utility for consumers.

2. There are inadequate guidelines for late grievance reporting by HMOs.

a. **Variations may exist in how HMOs define a "grievance."** Currently, each HMO appears to be able to create its own definition of a grievance. California's Managed Health Care Improvement Taskforce found "lack of consistency, ineffective communication, [and] variable reporting" in HMOs' grievance processes.[52] The Department confirmed this observation in Medical Survey Reports we reviewed in which the Department identified problems regarding which consumer problems HMOs considered grievances.[53]

b. **Inconsistency in whether HMOs include pending or only closed grievances in reports hinders comparisons**. Most HMOs were not specific about the timing criteria used for the grievances included in their reports. However, among those HMOs that explicitly defined the time period for late grievances, two broad categories were used:

   1. Grievances more than 30 days old that were ***pending and unresolved*** at any time during the quarter (for example, used by Foundation Health).
   2. Grievances more than 30 days old that were ***resolved*** during the reporting quarter (for example, used by Cigna).[54]

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[51] CAL. HEALTH & SAFETY CODE § 1368 (c) (West Supp. 1998).

[52] Task Force Report, *supra* note 5, Vol. 2 at p. 72.

[53] For example, in 1997, the Department found that Health Net did not "ensure that complaints regarding quality of care or access are considered as grievances by medical groups." Health Net did not appear to count as grievances those filed by enrollees with their medical groups, but not with Health Net. This also prolonged the grievance process for enrollees who first submitted the grievance to a medical group, then submitted the grievance to Health Net (failing to capture the time spent at the medical group grievance level in the system of aging of grievances). Department of Corporations Medical Survey Report for Health Net, pp. 77 – 78 (March 31, 1997). Furthermore, the Department found Blue Cross Pharmacy Plan's grievance system "fragmented and confusing" and that grievances were not logged or maintained in any orderly way. Department of Corporations Medical Survey Report for Blue Cross Pharmacy, p. 51 (May 1, 1998).

[54] Foundation's report listed "grievances and appeals pending and unresolved over 30 days at any time during this quarter." Cigna's report listed "all member complaints and grievances resolved more than 30 days after receipt."

The first approach most closely tracks the requirement that HMOs resolve grievances within 30 days whenever possible.[55] The second standard includes only grievances resolved during the quarter. HMOs using this basis for deciding what to include do not report late grievances that are still open at the end of the quarter.

Despite ample notice that HMOs held conflicting interpretations, the Department has not issued clear guidelines on whether Late Grievance Reports should include all grievances pending more than 30 days at any time during the quarter or only those more than 30 days old that were resolved during the quarter. Almost a year before the current regulation took effect, one HMO commented that the reference to cases that "are pending and unresolved" for 30 days or more was ambiguous.[56]

c. **Variation in defining a grievance as "closed" makes it difficult to compare HMOs.** On the Late Grievance Reports we reviewed from the past two years, few HMOs defined the closing date of grievances. However, a review of the reports from those HMOs that did define closing dates indicates there is significant variation. For instance, some Medicare HMOs counted grievances referred for appeal as "closed" when those grievances are sent to another entity for review, while other HMOs consider those same grievances as pending.[57] A consistent definition for "closing date" is critical to providing consumers with comparable information about the length of time HMOs take to resolve grievances.

New regulations effective for the last quarter of 1998 appear to impose uniformity on closing dates for Late Grievance Reports. These regulations specify that HMOs shall not include late grievances filed or processed "outside the plan's grievance system in other complaint resolution procedures, such as arbitration, voluntary mediation and the Department of Corporations."[58] On their face, the new regulations apparently allow HMOs to stop reporting late grievances from Medicare enrollees when those grievances are sent to the Medicare external appeal agency, the Center for Health Dispute Resolution (CHDR), for automatic review. However, we have been informed by multiple Department representatives that HMOs are expected to report as unresolved grievances from Medicare enrollees until CHDR renders a decision and

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[55] CAL. HEALTH & SAFETY CODE § 1368.01 (a) (West Supp. 1998).

[56] Letter from Diana L. Bendix, Associate Attorney, Lifeguard, Inc., to Timothy L. LeBas, Senior Corporations Counsel (October 30, 1997).

[57] FHP Health Care, before its 1997 merger with PacifiCare, counted days for its Medicare grievances from the date the consumer filed the grievance with FHP until the date the grievance was sent to the Center for Health Dispute Resolution (CHDR). The federal Health Care Financing Administration has contracted with CHDR for automatic reviews of Medicare grievances not resolved in a consumer's favor. In contrast, PacifiCare counted days for Secure Horizons, its Medicare product, from the consumer's filing date until the date CHDR rendered a decision. This disparity gave the misleading appearance that PacifiCare took substantially longer to resolve grievances from its Medicare HMO enrollees than did FHP.

[58] CAL. CODE REGS. tit. 10, § 1300.68 (i)(1) (1998).

from Medi-Cal enrollees until their Fair Hearing has been decided, though the regulations do not explicitly mention this requirement. So, even with regulations that appear to set a uniform definition, ambiguity still exists.[59]

3. The reports produced by HMOs do not allow for comparisons among HMOs. The Late Grievance Reports prepared by each HMO have several weaknesses that do not enable consumers to compare HMOs or fully understand each HMO's grievance handling. These limitations include the following:

- While each HMO's report shows the number of cases pending, by reporting only raw numbers of late grievances but not enrollment, making comparisons among HMOs is difficult.[60]
- The reports fail to provide a frame of reference by listing only late grievances, but not total number of grievances received or late grievances as a percentage of all grievances received. The number of grievances an HMO receives may impact its effectiveness in resolving grievances quickly. Two HMOs with identical numbers of enrollees and late grievances may appear to be resolving grievances with equal efficiency. However, if one HMO received twice as many grievances as the other HMO, then only half as large a percentage of its grievances are late. The first HMO may do a better job at resolving grievances quickly, though the fact that it received twice as many grievances may raise other issues.

  The reports fail to provide a frame of reference by listing only late grievances, but not…late grievances as a percentage of all grievances received.
- Some HMOs included in their reports precisely how long each late grievance has been pending in their grievance systems, but many do not. Even among those HMOs that do list the length of unresolved grievances, there is variation in how that length is indicated. For some HMOs, a grievance filed 70 days ago, for example, would show up as 40 days late, while other HMOs would report that same grievance as pending for 70 days. This variation needlessly confuses anyone trying to compare HMOs on the basis of the length of late grievances pending.

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[59] Our understanding is that the basis for this exception is an inference drawn from the statutory disclaimer HMOs may include in Late Grievance Reports that "Medicare and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees." CAL. HEALTH & SAFETY CODE § 1368 (c) (West Supp. 1998). HMOs may request this disclaimer to be included in any report prepared by the Commissioner that describes or compares grievances unresolved for 30 days or more. *Id.*

[60] California HMOs have widely varying enrollments, ranging from 5.7 million to less than 500. California Association of Health Plans website (http://www.calhealthplans.com/members/enrollment.html), visited Feb. 24, 1999. Even among the ten largest HMOs in the state, the largest HMO's enrollment is more than 25 times the enrollment of the tenth largest HMO. Kaiser was the largest HMO in 1998 with 5,659,679 enrollees; Lifeguard, the tenth largest HMO, had 232,378 enrollees in 1998. *Id.*

- The reports lack information on how late grievances were resolved. Generally, neither raw numbers nor rates of grievances sustained or overturned are provided. While some HMOs included in their reports the outcome or determination of individual cases,[61] no HMO provided overall rates of reversals in its Late Grievance Reports.

Recommendations

1. Issue a Department-prepared summary report based on an independent analysis of the HMO data with comparative measures. The Department should prepare an annual Late Grievance Report, including an easy-to-read comparison of HMO performance in grievance resolution. The Department's current practice of reissuing HMO-prepared Late Grievance Reports does not provide meaningful, comparative information. The Department should consider using graphics, such as pie charts, to display visually the reasons for delay in grievance resolution or bar charts comparing rates of late grievances.[62]

2. Define uniform criteria for which grievances are included in the Late Grievance Reports. Comparisons among HMOs must be based on all HMOs using the same criteria, ones that are clearly specified by the Department. The Department's definition of a grievance should be consistent across HMOs. As the Department conducts medical surveys, it must ensure that HMOs comply with its definition of a grievance. The Department should also establish a uniform standard regarding the timing of grievances to be covered by the report. Current regulations do not do so. We recommend the following standard for inclusion as a late grievance: pending and unresolved over 30 days *at any time during the quarter*. This definition is the simplest and adheres most closely to HMOs' statutory duty to resolve grievances within 30 days, whenever possible.

The Department should also standardize the definition, for reporting purposes, of when grievances are "closed." Although various Department officials told the authors that HMOs must report grievances from Medicare and Medi-Cal enrollees until those grievances are resolved by CHDR or by Fair Hearing, there is no specific written instruction in statute or regulation. Until there is an explicit statement of what appears to be informal Department policy, HMOs will lack clear guidance, and the Department's enforcement of compliance will be weak. Ultimately, comparisons among HMOs will be unreliable as long as HMOs inconsistently report grievances after they have been sent to CHDR or the enrollee files for a Medi-Cal Fair Hearing.

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[61] Lifeguard and Maxicare were two HMOs that listed outcomes of individual cases.

[62] For example, Late Grievance Reports from the Kaiser Foundation Health Plan used pie charts to display the reasons for delay in grievance resolution. We make no evaluation of Kaiser's categories of reasons for delay; we simply note that Kaiser's use of the pie chart is unique among the HMOs examined and may be a useful tool for broader consumer information in comparing HMOs' grievance handling.

3. Require HMOs to adopt standardized measures to facilitate comparisons. Valid comparisons among HMOs are possible only if the Late Grievance Reports include standard measures and if the Department summarizes those measures. The following are some recommended indicators the Department should include in any report it generates or requires of HMOs:

- **Late grievances per 10,000 enrollees**. Three measures that the Department uses in its Annual Hotline Report are the raw number of complaints, HMO enrollment, and complaints per 10,000 enrollees.[63] The advantage of using these types of measures is that they allow for comparisons of HMOs with significantly different enrollments.[64] Similarly, measures such as enrollment, the number of grievances filed, and late grievances per 10,000 enrollees would allow consumers to compare the timeliness of HMOs' grievance resolution.
- **Reasons for late grievances per 10,000 enrollees**. A measure indicating the reasons grievances are pending per 10,000 enrollees would enable consumers to distinguish, for example, between those HMOs whose late grievances are largely caused by provider delays in presenting requested information and HMOs whose delays are primarily attributable to the HMO.
- **Relation of late grievances to all grievances filed**. Another simple indicator the Department could provide is the percentage rate of late grievances compared to all grievances filed with the HMO. This figure could provide a picture of HMOs' performance in meeting their statutory duty to resolve grievances within 30 days whenever possible.
- **Degree of lateness of reported grievances**. Measures that describe the average length and distribution of late grievances by HMO could be useful.[65] For example, the mean and median lengths of grievances reported provides an indication of how quickly HMOs respond to grievances. A broader picture of grievance resolution could be provided by showing the number of grievances open by 30 day intervals (*e.g.*, between 30 – 59 days, 60 – 89 days, with successive 30 day intervals).

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[63] The Annual Hotline Report uses the term "Request for Assistance" or "RFA" to describe complaints that it formally opens. *See, e.g.*, Appendix 1 for sample pages from the 1997 Annual Hotline Report.

[64] In public comment to proposed regulations, one HMO suggested adding the number of enrollees and the number of late grievances per 10,000 enrollees to Late Grievance Reports because these measures provide a measure of perspective. This HMO later added this information to its own Late Grievance Reports submitted to the Department. Letter from Patricia C. Ernsberger, Associate General Counsel, Blue Shield of California, to Timothy L. LeBas, Senior Corporations Counsel (October 30, 1997).

[65] One HMO suggested that reporting the duration of each appeal would be adequate to determine how well an HMO handles an appeal. Letter from Katherine L. Watts, Senior Counsel, Delta Dental Plan, to Timothy L. LeBas, Senior Corporations Counsel (February 20, 1998).

- **Percentage of grievances upheld or overturned**. Another important question for consumers is the rate at which grievances are upheld or overturned. Listing reversal rates, which indicate an HMO's ultimate agreement with the consumer, and the level of internal appeal[66] can provide additional comparative information to consumers and to the Department.

[66] An HMO may have more than one level of appeal within its grievance system.

IV. MEDICAL SURVEYS

"Medical survey" describes the Department's Knox-Keene Act-mandated review of the health care delivery system of HMOs. These surveys, if done properly and reported in a timely fashion, can be one way the Department protects consumers from the risk that HMOs provide inadequate care. Medical surveys are required to review "the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees,"[67] and must include a discussion of the HMO's record for handling grievances.[68] Although the Department contracts with two organizations, the Institute for Medical Quality and the Joint Commission on Accreditation of Healthcare Organizations, to collect background data for these surveys on California's full-service HMOs,[69] the Department retains sole discretion to determine if, and to what extent, corrective actions are required.[70]

Consumers Union's 1996 report on the Department, "A Shot in the Dark," found that the Department did not conduct the surveys in a timely manner; that Medical Survey Reports were released, on average, nearly one year after the survey's completion; and that the focus on deficiencies and widespread use of cross-references was confusing. This section of the report re-examines these areas and, regrettably, finds the Department's performance, for the most part, unimproved since 1996.

Since the effective date of Senate Bill 689 (Rosenthal) on January 1, 1996, the Department has been required to conduct onsite medical surveys at least every three years (36 months), a change from the previous five-year requirement.[71] A Medical Survey Report must be publicly available no later than 180 days after the survey's completion,[72] and a consumer is entitled to a free summary of the Medical Survey Report's findings describing compliance efforts, corrected deficiencies, and proposed remedial actions.[73] Furthermore, within 18 months of the Medical Survey Report's release, the Department is required to conduct a follow-up review to

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[67] CAL. HEALTH & SAFETY CODE § 1380 (a) (West Supp. 1998).

[68] CAL. HEALTH & SAFETY CODE § 1380 (f) (West Supp. 1998). Medical surveys, which examine the health delivery system of an HMO, differ from the fiscal and administrative audits that are also authorized under the Knox-Keene Act. *See* CAL. HEALTH & SAFETY CODE § 1382 (West Supp. 1998). This report does not examine the Department's fiscal and administrative audits of HMOs.

[69] The Institute for Medical Quality and the Joint Commission on Accreditation of Healthcare Organizations evaluate full-service HMOs only, but not specialty HMOs that provide dental, vision, psychological, or chiropractic care.

[70] *See, e.g.*, Letter from Judith A. Imel, Senior Counsel, Department of Corporations to Mary V. Anderson, Regional Counsel, Aetna Health Plans of California, Inc., p. 2 (May 13, 1998).

[71] CAL. HEALTH & SAFETY CODE § 1380 (c) (West Supp. 1998).

[72] CAL. HEALTH & SAFETY CODE § 1380 (h)(1) (West Supp. 1998).

[73] CAL. HEALTH & SAFETY CODE § 1380 (h)(4) (West Supp. 1998).

The Department's average time between surveys for the HMOs reviewed was nearly 5 years (57 months), almost two years beyond the statutory timeframe.

determine and report on the status of the HMO's efforts to correct deficiencies.[74] For this report, we obtained copies of the Medical Survey Reports and summaries for the ten largest HMOs [75] publicly released after August 1995, when research for "A Shot in the Dark" had ended, and through December 31, 1998. The availability and presentation of these Medical Survey Reports and summaries is the focus of this section.[76]

Findings

1. The medical surveys have not been conducted within the statutory timeframe. The Department's average time between surveys for the HMOs reviewed was nearly 5 years (57 months), almost two years beyond the statutory timeframe.[77] The Department met the mandated 3-year timeframe in only 1 of 12 instances for full-service HMOs reviewed for this report.[78] (See Table 6 for a list of survey completion dates.)

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[74] CAL. HEALTH & SAFETY CODE § 1380 (i)(2) (West Supp. 1998).

[75] These ten largest HMOs represent 90% of the state's enrollment in full-service HMOs. We obtained Medical Survey Reports and summaries for these HMOs by Public Records Act requests to the Department.

[76] Beyond how and when the information is made public, the value of the surveys rests in the underlying quality of the survey, how deficiencies are identified, and the extent to which the Department follows up on HMOs' responses to the surveys to ensure that deficiencies have been corrected. While critical, these issues are beyond the scope of this report.

[77] Wherever possible, we measured time between surveys, as did the State Auditor's recent report on the Department, by the number of months between completion of surveys. *See* Auditor's Report, *supra* note 24, at p. 30. Untimeliness was determined in one of four ways, depending upon the circumstances:

- The time between completion of the two most recent surveys for the HMO exceeded three years. For example, more than 5 years (63 months) passed between Blue Shield's surveys, while Aetna's surveys were nearly 5 years (55 months) apart.
- No survey had been completed for the HMO in the last three years. As of December 31, 1998, Cigna had not been surveyed since June 1993 (67 months), Kaiser – Southern California's last survey was completed April 1992 (80 months), Lifeguard's most recent survey concluded February 1994 (58 months), and Maxicare's previous survey was finished on November 1994 (49 months).
- More than three years elapsed between the date of the last survey for an HMO that merged with another HMO and the date of merger. From CareAmerica's last completed survey on January 1994 to its merger with Blue Shield in June 1998, for example, 53 months passed.
- More than three years had passed from an HMO's licensure until completion of its initial survey. For instance, the Department's survey on Health Net, completed June 1996, was the first for that HMO since it received its Knox-Keene license in March 1991, 63 months earlier.

[78] The delay in producing Medical Survey Reports for full-service HMOs extends to specialty HMOs as well. The State Auditor has noted that of 40 Medical Survey Reports the Department has delayed issuing, 22 are for dental HMOs. Auditor's Report, *supra* note 24, at p. 30.

Table 6. Timeliness of Conducting Medical Surveys

HMO	Survey Completion Date	Months Between Full-Scope Surveys (36 months is statutorily mandated)
Aetna	July 17, 1992 Feb. 21, 1997	55
Blue Cross (Pharmacy)	Apr. 15, 1997	Unknown (No surveys found for Blue Cross' full-service HMO before or after Blue Cross' August 1997 reorganization.)*
Blue Shield	Oct. 25, 1991 Jan. 10, 1997	63
CareAmerica	Jan. 26, 1994	46 (Measured from Jan. 26, 1994 to Nov. 10, 1997 merger date with Blue Shield)
Cigna	June 9, 1993	67†
FHP	Oct. 19, 1995	Not applicable (FHP merged with PacifiCare on February 14, 1997, less than 36 months after its last survey completion date)
Foundation Health	Nov. 5, 1998	47¥
Health Net	June 4, 1996	63 (Measured from Mar. 7, 1991, date of licensure)
Kaiser Foundation Health Plan		
Northern California	Aug. 14, 1996	81¥
Southern California	Apr. 30, 1992	80†
Lifeguard	Feb. 21, 1994	58†
Maxicare	Nov. 29, 1994	49†
PacifiCare	May 12, 1993 Mar. 1, 1996	34
Prudential	Dec. 6, 1995	37†

* In August 1997 Blue Cross of California, Wellpoint Dental Plan, Wellpoint Health Networks, and Wellpoint Pharmacy Plan (each a Knox-Keene licensed HMO under the same parent company) reorganized into a single Knox-Keene licensed health plan, Blue Cross of California.

† Measured from completion of last survey to December 31, 1998. For the five HMOs in this category, the ultimate period between surveys could be far greater.

¥ Because the completion dates of these surveys were not available, we estimated the time between surveys by the number of months between publication dates. From the previous Medical Survey Report of Foundation Health (published December 9, 1994) and its most recent Medical Survey Report (published November 5, 1998), 47 months passed. Similarly, 81 months elapsed between the previous Medical Survey Report for Kaiser Northern California (published November 17, 1989) and its most recent Medical Survey Report (published August 14, 1996).

2. The Department fails to issue Medical Survey Reports within the required time. "A Shot in the Dark" found that, on average, the Department took nearly 12 months from the point the medical surveys were completed until the Medical Survey Reports were released to the public. We found no improvement on timeliness of Medical Survey Report release. Of the Medical Survey Reports obtained for this report, not one was issued within the 180-day timeframe; instead, they took, on average, over twice that long (12.4 months) from the survey's completion to public issuance. (See Table 7 for Medical Survey Report publication.)[79] Although the Commissioner of the Department may extend the 180-day deadline if additional time is reasonably necessary to fully and fairly report the survey results,[80] there is no indication of such an extension in the files for any of the Medical Survey Reports that we reviewed.[81] Several of these Medical Survey Reports were started before the effective date of the 180-day requirement. Even examining only surveys that began after January 1, 1996, the effective date for SB 689, the average time between completion of the survey and release of the Medical Survey Report was 13 months. In other words, even after the statutorily mandated 6 month limit became effective, the Department took over a year to issue the reports. The late release of Medical Survey Reports frequently compounded the initial lag in conducting the medical survey. For instance, in the case of Health Net, the Medical Survey Report was released 10 months after its completion, leaving the public without access to a Medical Survey Report for the first six years of Health Net's existence. Late issuance of reports not only denies consumers access to timely HMO information, it also undercuts the credibility of the Department's regulatory efforts.

Of the Medical Survey Reports obtained for this report, not one was issued within the 180-day timeframe; instead, they took, on average, over twice that long (12.4 months) from the survey's completion to public issuance.

[79] For the purpose of measuring timeliness, we excluded the Foundation and Kaiser Northern California surveys because these Medical Survey Reports did not list the survey dates. The State Auditor has found that 44 of 45 reports issued from January 1996 to December 1998 were issued late. Similar to our finding, the State Auditor found that on average, Medical Survey Reports were issued 12 ½ months after survey completion (*i.e.*, 197 days late). Auditor's Report, *supra* note 24, at p. 14.

[80] CAL. HEALTH & SAFETY CODE § 1380 (h)(1) (West Supp. 1998).

[81] While we did not find any examples in the files of any individual extensions, the former Commissioner reportedly provided "blanket approval" for an extension of the 180-day timeframe because of the backlog of surveys the Department's Health Plan Division had to complete. Auditor's Report, *supra* note 24, at p. 15.

Table 7. Medical Survey Report Publication

HMO	Survey Start Date	Survey Completion Date	Medical Survey Report Release Date	Report Publication (months)*
Aetna	Feb. 17, 1997	Feb. 21, 1997	May 13, 1998	15
Blue Cross (Pharmacy)	Mar. 13, 1997	Apr. 15, 1997	May 1, 1998	13
Blue Shield	Jan. 6, 1997	Jan. 10, 1997	Apr. 20, 1998	15
FHP	Oct. 2, 1995	Oct. 19, 1995	June 17, 1996	8
Foundation	Not Available	Not Available	Nov. 5, 1998	Not Available
Health Net	Feb. 13, 1996	June 4, 1996	Mar. 31, 1997	10
Kaiser Northern California	Not Available	Not Available	Aug. 14, 1996	Not Available
PacifiCare	Jan 24, 1996	Mar. 1, 1996	Feb. 21, 1997	12
Prudential	Nov. 6, 1996	Dec. 6, 1995	Feb. 14, 1997	14

* Report publication time is measured from the completion of the survey to the release of the Medical Survey Report. If an HMO did not have a Medical Survey Report published after January 1, 1996, the effective date of the statute requiring publication within 180 days, it is not listed on this table (*e.g.*, Kaiser Foundation Health Plan – Southern California, Lifeguard, and Maxicare).

3. The Department appears not to conduct timely follow-up reviews. No later than 18 months after the release of the Medical Survey Report, the Department is required to conduct a follow-up review on the status of the HMO's efforts to correct deficiencies identified in the Medical Survey Report.[82] Of the surveys we reviewed, all had deficiency findings and, based on the time period reviewed, five should have had follow-up reviews by the closure of our study period.[83] There were only two follow-up reports on file, however.[84] It is impossible to

[82] CAL. HEALTH & SAFETY CODE § 1380 (i)(2) (West Supp. 1998). The Knox-Keene Act is silent about how soon after completion of follow-up reviews the Department must release the results.

[83] Because our cut-off for the Medical Survey Reports file review was December 31, 1998, we counted back 18 months from that date to determine which of the Medical Survey Reports we examined should have had a follow-up review by our cut-off date. Thus, Medical Survey Reports issued from January 1, 1996, the date the follow-up requirement took effect, through June 30, 1997 comprise the pool. Only five Medical Survey Reports were published within the January 1, 1996 – June 30, 1997 timeframe. (See Table 7 for release dates of Medical Survey Reports.)

[84] In one Medical Survey Report for Kaiser Foundation Health Plan, the Department indicated that it would conduct a follow-up review six months from August 14, 1996, or by February 14, 1997. The follow-up review was not completed until May 20, 1998, 21 months after the release of the Medical Survey Report.

tell if the other three follow-up reviews were ever conducted. A failure to conduct timely follow-up reviews may be especially harmful to the public because a follow-up review targets identified deficiencies. Moreover, timely follow-up reviews are essential to sending the message to HMOs that the Department will hold them accountable to correct deficiencies identified in the Medical Survey Report.

4. The summaries provided free to the public are too long for most consumers to use. For a summary to be useful to consumers, it should present a brief digest of the major findings. Yet, some summaries were more than half the length of the remainder of the report. For example, the summary for the Health Net report was 37 pages long; the non-summary report was 67 pages.

5. The summaries are not written in plain language. Many summaries list findings and corrective actions with extensive citations to code and regulatory references, but with inadequate plain-language explanations of the standards and how the HMO met or failed to meet those standards. Without giving a clear explanation of the standards and their importance, consumers are hard-pressed to understand the significance of findings described in the summaries and the Department's corrective actions required of HMOs.

6. The Medical Survey Reports are not presented in a format that is accessible to consumers. While the primary audience for Medical Survey Reports are HMOs and the Department itself, Medical Survey Reports should, nonetheless, be comprehensible to consumers. Those consumers who want more information than is provided in a summary may wish to see the full Medical Survey Report. However, the Medical Survey Reports had several weaknesses that make them difficult for consumers to understand:

- The Medical Survey Reports generally describe only how the HMO falls short of meeting its Knox-Keene requirements. References to compliance with the Knox-Keene Act typically are raised in the context of whether an HMO's response to a deficiency is acceptable to the Department. In other areas, the Department is silent about Knox-Keene compliance, so it is unclear whether the survey examined those areas or whether the HMO met or exceeded those requirements.
- The Medical Survey Reports made extensive use of cross-references of deficiencies and corrective actions, usually to indicate that the Department had reached similar conclusions and suggested remedies at more than one point in the report. Not only does this force a reader to refer to other sections of the report, it leaves open the question of whether one corrective action by the HMO is adequate to rectify multiple problems.

7. Consumers receive conflicting directions from the Department about gaining access to summaries and Medical Survey Reports. When we attempted to obtain summaries, which are free to the public, we encountered contradictory instructions. Calls to

each of the four Department statewide offices resulted in incorrect and sometimes conflicting directions.[85] Consumers should not have to make numerous telephone calls to obtain what should be readily available documents.

Both the summaries and the Department's website include instructions regarding how to view the Medical Survey Reports. The instructions in the summaries indicate that Medical Survey Reports may be viewed at any of the Department's offices by appointment; however, the website indicates that Medical Survey Reports "are available for public viewing by appointment in the Department's Los Angeles and Sacramento offices,"[86] implying that the reports are not available in the San Francisco or San Diego offices. In fact, we did get access to Medical Survey Reports in the San Francisco office. A consumer who wants to view the Medical Survey Reports in San Francisco, however, may be discouraged from doing so after consulting the Department's website.

8. Incomplete files undermine the usefulness of the Medical Survey Reports.

Consumers and consumer groups that want to research HMO performance and monitor Department follow-up to the medical surveys may find their task next to impossible. In both the Sacramento and San Francisco offices, there appear to be no indices of Medical Survey Reports. Tracking medical surveys and subsequent action by HMOs and the Department is possible, if at all, only by endless hours of sifting through uncategorized or misfiled documents.

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Despite longstanding promises to improve the way it gathers and disseminates information,[87] some of the files in the Department's San Francisco office are missing key documents, (including HMO or Department correspondence regarding HMO deficiencies, corrective action reports, or follow-up reports). For example, the Blue Cross file in the San Francisco office mentions a letter from that HMO to the Department concerning proposed corrective action, yet there is no copy of this letter in the file.[88] A persistent inability to maintain files

[85] For example, we were told by one office that there were no free summaries and by another that the summaries were only available from the Department's Duty Counsel in Sacramento. In fact, we obtained the statutorily required free summaries from the Department's Los Angeles and San Francisco offices and the Health Care File Room, not the Duty Counsel, in Sacramento.

[86] Department of Corporations Health Plan Division website (http://www.corp.ca.gov/pub/hpdpub.htm), visited April 28, 1999.

[87] The Department stated a year ago that document management is one of its top priorities. "New DOC Commissioner Outlines Priorities," *California Health Law Monitor*, p. 1 (May 4, 1998).

[88] Similarly, several Medical Survey Reports mention corrective action reports to be completed by HMOs. Corrective action reports indicate an HMO's progress in addressing problems identified in the survey. These reports are sometimes, but not always, found in the file, so it is difficult to know if the HMO has filed the report – and more importantly, to know if the HMO has executed the corrective action. For example, the FHP Medical Survey Report required regular corrective action reports, but two of the required reports

undermines confidence that the Department is doing a good job as regulatory overseer of HMOs, that the documents represent an accurate picture of the Department's regulatory efforts, and that the Department cares about the well-being of consumers.

Recommendations

1. Perform the surveys in a timely fashion. The Department should conduct medical surveys at least once every three years, in accordance with its mandate under the Knox-Keene Act. To provide consumers with current information, and itself with information for enforcement purposes, the Department should conduct timely follow-up reviews based on deficiencies previously identified in corresponding Medical Survey Reports. Delays between medical surveys undermine consumer protection because of the increased risks of stale information, uncorrected deficiencies, and inappropriate care. Furthermore, undue delays frustrate consumers seeking current information from the State about an HMO. More frequent surveys are particularly appropriate if there are indications of problems with a specific HMO.

2. Release Medical Survey Reports in a timely manner. The Department should make the survey results publicly available within the 180-day period mandated by law.

3. Standardize the Medical Survey Report and summary formats. Medical Survey Reports and summaries should have a consistent format, comprehensible to consumers seeking to evaluate HMOs. Standard elements should include a clear description of the survey's procedure (*e.g.*, the facilities visited, persons interviewed, and records reviewed), background of the HMO surveyed (*e.g.*, date of licensure, enrollment, tax status, service area, scope of services, date of last survey, and a summary of the last survey), identified deficiencies and HMO responses, and areas of HMO compliance. The summary available to the public should be written concisely, in plain easy-to-understand language, highlighting major findings and corrective actions, as well as including clear instructions on how to get more information, such as the Medical Survey Report.

The Department should conduct medical surveys at least once every three years and publish Medical Survey Reports within 180 days, in accordance with its mandate under the Knox-Keene Act.

4. Promote the availability of summaries and make them more readily available to public. As discussed in Section I, the Department's lack of visibility to consumers results in inadequate public awareness of its HMO regulatory role and its services and products. Summaries of Medical Survey Reports would convey an informative picture of HMOs if only consumers knew such reports were available, free, and easily obtainable.

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were not found in the San Francisco office's files, and there is no indication that the Department ever received these reports.

- In recognition of the Internet's increased role in providing information, the Department should post summaries on its website or on another website that is promoted to health care consumers. Consumers and advocacy groups are more likely to access this information through a website than by making a written request for the summary. If the entire summary is too lengthy to post on-line (and even if it is not), instructions should be given on how consumers can obtain the full summary or see the Medical Survey Report.
- The Department should issue press releases that announce the publication of Medical Survey Reports and summaries. The release of Medical Survey Reports offer an important opportunity to highlight the Department's work and the extent to which HMOs are in and out of compliance with their obligations.
- In addition to our recommendations in Section I for the Department's promotional efforts, the Department should consider requiring HMOs to describe in enrollee materials a consumer's right to obtain a summary of the HMO's most recent Medical Survey Report and view Medical Survey Reports by providing both the Department's website and telephone number.

5. Improve the Department's information management. Missing documents and misfiling of existing documents hampers the Department's oversight of HMOs and creates a barrier to public access. With the large volume of reports and correspondence each survey generates, a comprehensive index of the files is required for effective Department regulation and assurance of quality care. Clearly, the Department must better educate its staff and develop a streamlined, universally understood process for giving consumers access to these documents. This is a long-standing problem that must be made a top priority.

CONCLUSION

The Department of Corporations' past efforts to produce information for health care consumers have been sporadic and of poor quality. The Department must make an effort to become more visible to consumers by promoting itself and the information it is obligated by law to provide. The Department should also improve the products and services available to the public. These measures are necessary if consumers are to take advantage of the Department's offerings, monitor the Department's regulatory efforts, and obtain information so crucial to making informed health care choices for themselves and their families.