CANARY IN THE COAL MINE

Consumer Health Plan Complaints As Early Warning System

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ABOUT THIS REPORT

This report describes the importance of consumer health insurance complaint systems and suggests improvements to the system in California. It relies on Consumer Reports' groundbreaking 2015 nationally representative, and California-specific, survey of adults enrolled in private health coverage to describe the dimensions of the problem.* Senior Staff Attorney Julie Silas was the primary author. You can find out more about how to file a complaint in your state here: https://consumersunion.org/insurance-complaint-tool/. For further information on this paper contact Betsy Imholz, Special Projects Director, at 415-431-6747.

* Consumer Reports National Research Center, Surprise Medical Bill Survey (2015).

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Canary in the Coal Mine: Consumer Health Plan Complaints As Early Warning System

In the first two years of expanded coverage as a result of the Affordable Care Act (ACA), millions of Californians obtained access to health coverage through Covered California and the expansion of Medi-Cal, California's Medicaid program. With California's budget action to expand full-scope Medi-Cal to all California children regardless of immigration status (beginning May 2016 or later), the number of insured Californians will continue to rise.

Along with expanded health coverage, the ACA brought major changes to the health coverage system.[1] No longer can most health plans discriminate against people with disabilities or chronic illnesses, nor can they impose annual or lifetime limits. Most plans must provide a set of comprehensive benefits. The state health insurance Exchange, Covered California, was created and all its plans must provide a standard cost-sharing benefit design—meaning that products at each tier level must have the same co-payments, deductibles or co-insurance for specific services—making it easier for consumers to shop and compare.

The evolving health system isn't without its complications. To stay competitive, many insurers are offering plans with narrower provider networks, highlighting the importance of consumers' access to clear information about which providers are in the plan's network. And for those Californians who have limited or no experience with health insurance, terms used to describe their plans, plan rules, and the process for getting care are new and often confusing.

The health insurance system has had to make significant adaptations to fully integrate changes brought about by the ACA. Much energy has been spent at both the federal and state level creating consumer-facing websites for plan shopping. In addition, California policymakers have turned their attention to developing statutes and regulations to effectively implement and improve upon the ACA in the state. Health insurers have had to update their policies and practices to conform to these changes, establishing new networks, redesigning websites, and interfacing with other online systems, as well as marketing to a new, more diverse lower income population.

One area that has not received enough attention during this re-invention of the health system is the process for collecting and tracking consumer complaints. With broadly expanded coverage and substantial new consumer protections in place as a result of the ACA, there is a greater need for tracking complaints and monitoring provider and health plan activity to ensure consumers benefit from the full value of their premium dollars and get access to high quality, affordable health care. A well-utilized and monitored consumer complaint system can ensure ACA compliance and expose previously unknown and recurring issues that need to be addressed by policymakers; for example, triggering non-routine surveys and enforcement actions. It can also serve as another metric in the regulators' evaluation of mergers and acquisitions, highlight needs for new statutory authority and gaps in regulation, and point to opportunities for greater coordination among state purchasers and regulators.[2]

A well-established body of research shows that health care consumer complaints can provide valuable indicators of systemic problems. Creating complaint codes that best reflect issue areas, and coordinating them across agencies, will allow complaint systems to be most useful in bringing problem patterns to the surface.

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1 California law distinguishes between health insurance and pre-paid health services plans. Herein, the terms are used interchangeably, unless otherwise noted.

2 California has two regulators for health insurance and health plans: the California Department of Insurance and the Department of Managed Health Care. Each has its own consumer complaints system.

The benefits of consumer complaints as an early warning of problems in the health care system

A strong consumer complaint system is an important component of any health insurance system, all the more so in a system undergoing dramatic transformation. Though the majority of consumers in California (and across the country) do not complain about health insurance problems to state regulators,[3] a substantial proportion of complaints filed with California regulators are resolved in favor of consumers.[4] Moreover, tracking consumer health insurance inquiries and complaints helps policymakers identify patterns and practices and better understand how the current insurance system is working, or not, for consumers.

In 2013, as the state and federal actors began the bold steps to implement the ACA, Consumer Representatives to the National Association of Insurance Commissioners (NAIC), undertook research on health insurance market oversight. The study identified that:

> [o]ne of the primary sources of information for both market conduct reviews and enforcement investigations is the [regulator's] consumer complaint data. Regulators have long relied on information obtained from complaints to identify business practices or unusual trends among individual insurers as well as industry-wide patterns that warrant investigation. Complaints are also one of the earliest indicators used by [regulators] to identify companies for market conduct examinations since they are the primary method of communication for consumers with problems.[5]

A more recent survey of state insurance commissioners found wide recognition that consumer complaints are an important tool that is used to monitor network adequacy.[6] In the fall of 2014, Consumer Representatives to the NAIC fielded a survey of all 50 state insurance commissioners to assess their work on network adequacy. The commissioners reported that consumer complaints are one of the strongest resources state agencies have for monitoring network adequacy issues: "States place a high value on consumer complaint data and commonly rely on complaint data as a tool for identifying potential problems and monitoring health plan compliance."[7]

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3 Consumer Reports National Research Center. (2015). Californians Face Out-of-Network Bills, Don't Know Where to Turn for Help. Available from http://consumersunion.org/wp-content/uploads/2015/05/Surprise-Bills-Survey-CA.pdf. Full national survey available from http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf

4 While neither California health insurance regulator publicly reports the number of all complaints resolved in favor of consumers, both provide public information about their Independent Medical Review process. For 2013, the Department of Managed Health Care (DMHC) granted enrollees the requested services more than 54% of the time. California Department of Managed Health Care. (2013). California Department of Managed Health Care 2013 Independent Medical Review Summary Report Overview. Available from https://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf. California Department of Insurance (CDI) statistics for 2013 and 2014 Independent Medical Review reports showed that CDI overturned approximately 50% of insurance company denials for both years. Available from https://interactive.web.insurance.ca.gov/IMR/faces/search?_adf.ctrl-state=14pj3qvzov_4

5 NAIC Consumer Representatives to the National Association of Insurance Commissioners. (2013). Strengthening the Value and Performance of Health Insurance Market Conduct Examination Programs: Consumer Recommendations for Regulators and Lawmakers. Available from http://www.naic.org/documents/committees_conliaison_related_health_mce.pdf

6 NAIC Consumer Representatives to the National Association of Commissioners. (2014). Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market. Available from http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf

7 *Id.*

There is a well-established body of research on consumer complaints in the patient safety arena as well, which indicates the link between patient complaints and broader system improvements (most often in this case, quality improvements). Patient complaints in hospital settings have been used to identify and resolve patient safety issues, both for the specific patient and systemically.[8]

Experts have found that a standardized system for collecting, aggregating and analyzing complaints is needed to take advantage of complaint data as a means to understand and improve the system of patient care and safety. Researchers have also recognized the prophylactic value of patients' complaints if they are "matched by adequate mechanisms for dealing with what has been complained about."[9] By collecting data and analyzing complaints, regulators can prevent the "acts or omissions that are likely to lead to patient complaints in the first instance."[10]

California's current system already surfacing some systemic issues

In California, regulators use two approaches to resolve health insurance and health plan complaints, depending upon the nature of the problem: Independent Medical Review and complaint handling systems. Independent Medical Review (IMR) deals with situations when a health care service or treatment has been denied, modified or delayed because the insurance company has determined the service is either not medically necessary or is experimental or investigational. Complaints issues, on the other hand, include topics such as balance billing, disputes about the amount paid on a claim, a co-pay dispute, cancellation of coverage, and customer service issues.

California's regulators responsible for the oversight of the health insurance market have used the complaint system to identify patterns and practices that are harmful to consumers through the traditional complaints mechanisms that are already in place. Both California's Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) have used their regulatory authority to bring enforcement actions to remedy systemic practices based on consumer complaints.[11]

For example, after receiving a series of complaints about inaccurate provider directories, DMHC used its regulatory authority to initiate non-routine surveys of two of California's largest insurers. These surveys identified serious defects in the two health plans' provider directories.[12] The Department required corrective action by both health plans and fined them a total of $600,000.[13] The Department continues to monitor the plans to ensure correction of the inaccuracies. In the meantime, consumers negatively impacted by the inaccurate directories have received restitution of nearly $40 million to date.[14]

Additionally, based on consumer complaints filed with its Help Center, DMHC fined Anthem Blue Cross more than $1.5 million for the insurer's failure to pay for an important screening for pregnant women when the only provider able to conduct that screening was out-of-network.[15]

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8 See, e.g. Pichert, J.W., Hickson, G., & Moore, I. (2008). Using Patient Complaints to Promote Patient Safety. In Henriksen, K., Battles, J.B., Keyes M.A., & Grady, M.L. (Eds.), *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign).* Rockville, MD: Agency for Healthcare Research and Quality. Available from http://www.ncbi.nlm.nih.gov/books/NBK43703/pdf/Bookshelf_NBK43703.pdf

9 Montini, T., Noble, A.A., & Stelfox, H.T. (2008). Content analysis of patient complaints. *International Journal for Quality in Health Care,* 20(6), 412-420. Available from http://intqhc.oxfordjournals.org/content/intqhc/20/6/412.full.pdf

10 *Id.*

11 Though not the subject of this paper, an additional source of data for regulators is their capacity to audit health plans and insurers. DMHC is required to conduct "routine medical surveys" of health plans every three years. CDI is empowered to conduct "market conduct studies." Both of these processes may also surface systemic problems.

12 California Department of Managed Health Care. (2014). Final Report: Non-routine Survey of Blue Shield of California, a Full Service Health Plan. Available from http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043_nr_provider directory_111814.pdf and Final Report: Non-routine Survey of Anthem Blue Cross, a Full Service Health Plan. Available from http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303_nr_provider directory_111814.pdf

13 Department of Managed Health Care. (2015). DMHC Fines Blue Shield and Anthem for Inaccurate Provider Directories: Enrollees Reimbursed Nearly $40 Million in Costs, More Expected. Available from https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/NewsRoom/pr110315.pdf

14 *Id.*

15 California Department of Managed Health Care. (2015). Letter of Agreement between DMHC and Anthem Blue Cross, Enforcement Action 11-371. Available from http://wpso.dmhc.ca.gov/enfactions/docs/2294/1432760550987.pdf The Department leveraged a $1.5 million administrative penalty against the insurer for failing to cover alpha fetal protein (AFP) testing at in-network rates.

CDI entered into settlement agreements with several insurance plans to require that they cover Applied Behavioral Analysis services for enrollees diagnosed with pervasive development disorder or autism, now known collectively as "autism spectrum disorder." These enforcement actions were the result of widespread consumer complaints.[16]

Immediate improvements can be made to California's health insurance complaint system

To maximize the effectiveness of California's complaint databank as an early warning system, there are a number of improvements policymakers can make to the existing complaint system:

1. Require more robust public information about the right to complain and about the process to file complaints;
2. Standardize meaningful complaint codes and update them as frequently as needed, including the creation of new complaint categories to surface ACA compliance issues;
3. Track and report comprehensive inquiry and complaint data and make data publicly available; and
4. Collaborate across departments.

Require more robust public information about the right to complain

In Spring 2015, the Consumer Reports National Research Center conducted a survey of 825 privately-insured English-speaking Californians to learn more about their experience with surprise medical bills, one of the myriad health insurance issues confronting consumers today.[17] One of the most striking findings of the survey was that most California consumers do not understand that they have recourse to complain to a state agency about health insurance. The results indicate that only a small percentage of Californians understand that they have the right to file complaints with a state agency about insurance company behavior.[18]

Specifically, the results indicate that **85%** of privately insured Californians do not know which State agency is tasked with handling complaints about health insurance. And only a small percentage (11%) surveyed believe that a state agency is responsible for resolving health insurance billing issues. Moreover, more than two-thirds of Californians (71%) are unaware of their right to appeal to the state or an independent medical expert if a health plan refuses coverage for medical services they think they need, though the right to "Independent Medical Review" has been in California law since 2001. Survey findings suggest that consumers overall are confused when it comes to their right to challenge health insurance company decisions.

This tells us that the vast majority of consumers are ***not*** complaining to California health plan regulators. Yet, we know that when consumers do bring their health insurance problems to regulators, insurers' denials of coverage are often overturned.[19] In fact, on average approximately one-half of the insurers' denials of coverage that went through Independent Medical Review with either DMHC and CDI were overturned in favor of the consumer.[20] If more consumers were aware of their right to complain and about the process to file complaints, it is likely that consumers would have greater access to care and could save or possibly recoup millions of dollars.[21]

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16 See, e.g. "In the matter of Blue Shield of California Life and Health Insurance Company, Settlement agreement," OAH No. 2011080142. Available from http://www20.insurance.ca.gov/ePubAcc/Graphics/168951.pdf

17 Consumer Reports National Research Center Surprise Medical Bill Survey, *Ibid.*

18 *Id.*

19 In 2013, on average close to half of the insurance plan denials of coverage that went through Independent Medical Review with both DMHC and CDI were overturned in favor of the consumer. See footnote 4, supra.

20 *Id.*

21 In November 2015, DMHC fined two insurers $600,000 for provider directory violations, Anthem Blue Cross $250,000 and Blue Shield of California $350,000. Blue Shield enrollees also received restitution of close to $40 million.

And as NAIC Consumer Representatives stated, "[b]ecause regulators rely heavily on complaints as an indicator of potential problems with a health plan's network, it is imperative that consumers are aware of the ability to file complaints with [the regulator] and the process for so doing."[22] In fact, the absence, or a relatively small number, of complaints on an issue may lead regulators to draw the incorrect conclusion that there is no significant consumer problem. In reality, however, a dearth of complaints is likely due to the fact that consumers do not know they can complain or which agency to complain to.

Even when consumers are aware of the complaint system, it does not always work as effectively as it should. For example, the Department of Health Care Services' Medi-Cal Managed Care Office of the Ombudsman has the authority to investigate and resolve complaints by Medi-Cal beneficiaries about health plans. Yet, a report by the State Auditor, commissioned in 2015 at the request of the Joint Legislative Audit Committee, found substantial shortcomings in the Office's handling of such complaints, with its telephone system unable to respond to 7,000 to 45,000 calls from consumers per month.[23] During the audit period, the Ombudsman Office chief stated that due to staffing limitations at that time it could not handle 50–70% of the calls it received[24] and that the Office was losing data due to hardware inadequacies.[25]

Without a robust bank of consumer experience data derived from complaints, and adequate staffing and follow through to handle the complaints, regulators and other policymakers will not have a full picture of how well our health system is functioning for real people. The problems are likely exacerbated for non-English speakers. While California's insured population is extremely diverse, DMHC, for example, indicates that more than 85% of callers to its Help Center are English speakers.

While insurance companies and providers remain important actors for resolving complaints, the consumer experience with those avenues for recourse has not resulted in satisfactory consumer outcomes. Consumer Reports' 2015 survey found that only 26% of the privately insured Californians with billing issues were satisfied with the resolution by the insurer, health plan or provider. More than half (56%) of Californians with surprise medical bills reported that the issue was either not resolved as they liked or not resolved at all, with a majority of this group (60%) ending up paying the bill in full.

Filing a complaint with the relevant state agency is a proven way to resolve individual's problems as well as to surface systemic issues for regulators. The public just needs to know that recourse is available through a formal complaint filing system with the appropriate state department.

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22 NAIC Consumer Representatives, *Ensuring Access to Care.* (2014). *Ibid.*

23 California State Auditor. (2015). California Department of Health Care Services: Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care. Available from https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf

24 While some of the attempted contacts to the Ombudsman Office, and the county offices that also receive calls from beneficiaries, may involve Medi-Cal eligibility issues, these calls also "include calls from Medi-Cal beneficiaries who have concerns related to their access to health care or complaints regarding the services provided by the health plan." *Id,* p. 34. We found no public-facing data describing such complaints.

25 We understand that additional staffing has been obtained and that data system upgrades have been undertaken in an attempt to transform the system. But in the meantime, there are grounds for concern about missing data points on Medi-Cal beneficiaries' experiences with their health plans, as well as about such individuals' frustrated efforts to resolve complaints and questions through the designated state agency.

RECOMMENDATIONS:

- Require health insurers to include the relevant Department's complaint website and telephone number on the enrollee's identification card, and in other key documents such as the Explanation of Benefits (EOB);
- Publicize how to complain through Public Service Announcements, on-the-ground outreach, and outreach to other key constituencies;
- Ensure DHCS' Medi-Cal Managed Care Office of the Ombudsman has the needed staffing and technical capacity to fulfill its complaint handling responsibilities to Medi-Cal beneficiaries;
- Undertake outreach efforts in communities of color, rural areas, and to underserved and low-income populations and to those who provide assistance and guidance to those populations including to groups that serve as "information intermediaries" who have broader service networks and communication channels (newsletters, blogs, webinars, training seminars, etc.), such as navigators, certified enrollment counselors, unions, and others;
- Increase language access by requiring complaint resources, including materials noted above, to be translated into all Medi-Cal threshold languages;
- Ensure websites of all departments are available in at least English and Spanish;
- Require translation and interpreter support for complaint filing with the relevant agencies in any geographic area that health plans market to in languages other than English, to ensure limited English proficient enrollees are able to register complaints with the State; and
- Update all template notices that explain consumer options for complaint filing, including those used for private insurance, Covered California, and Medi-Cal.

Standardize and make complaint codes meaningful, including the creation of new complaint categories to surface ACA compliance issues

There is no rule under the ACA requiring all monitoring agencies to use, as applicable, a set of health insurance or plan complaint categories. While the NAIC has developed a template for insurance complaints, the template covers all lines of insurance, not just health insurance. As a result, the NAIC template categories for health insurance are broad and often fail to capture specific, systemic health coverage issues affecting consumers. Furthermore, these codes are geared toward traditional insurance rather than pre-paid health service plans such as those covered by the Knox-Keene Act, which governs more than 90% of covered lives in California.

California has a rich, but fragmented, repository of complaint information with two regulators of health plan and insurance coverage; a state-based Exchange, Covered California; the Medi-Cal managed care Ombudsman (which handles complaints for enrollees in plans that contract with the state's Medicaid program); and the Office of the Patient Advocate (OPA). Disparate coding and categorization of complaints for each body means the opportunity for getting an accurate, full picture of the consumer experience is lost. California needs a comprehensive and overarching list of complaint codes that can be used across agencies, as applicable. In addition, regular, periodic updating of the complaint coding and categorization system would ensure its currency and relevance.

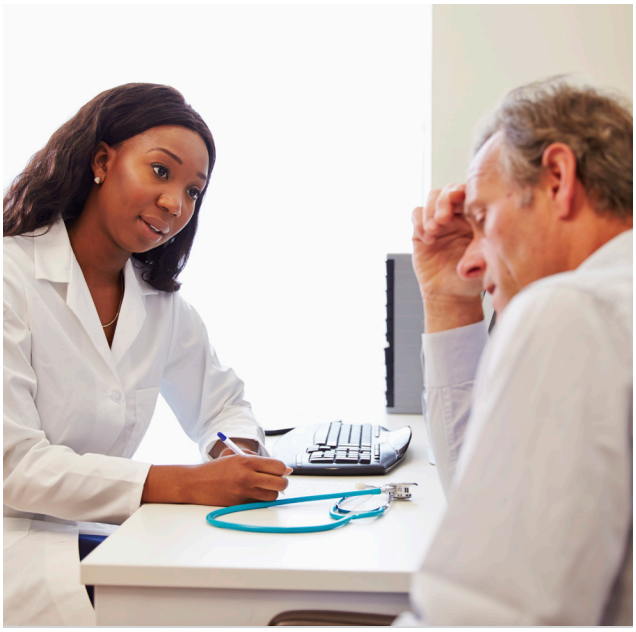
Jointly coordinating amongst the relevant agencies would

be useful to enable them to share and align their protocols for categorizing complaints, responses to inquiries, and investigations, develop common procedures, and communicate and train their staffs similarly, thus improving the quality of the databank. A natural offshoot of this would include development of a shared understanding of the systemic issues faced by consumers, regardless of where they originally lodge their inquiry or complaint. As the 2014 survey of state insurance commissioners emphasized, "this process must take into account complaint data received by other agencies such as the health insurance exchange, or consumer ombudsman program."[26] The anticipated report from the Office of the Patient Advocate for four complaint-handling divisions (DMHC, CDI, Covered California, the Department of Health Care Services) is expected to be a first step in that direction.

The NAIC template and complaint categories currently used by most state agencies do not fully reflect changes in policy stemming from the ACA. NAIC has made some updates to reflect post-ACA categories, but the updates are not as comprehensive as they need to be.

An NAIC Market Conduct Examination Working Group established to strengthen market surveys has recommended a number of changes to surveys to reflect ACA compliance issues. A similar review and update of the *complaints systems* should be undertaken so that regulators can capture, track and address consumers' experiences with the new health coverage system. Some specific ACA policy changes that necessitate updates to market conduct examinations, and thus likely complaint categories as well, raised by the NAIC Working Group include:

- Coverage of, and cost-sharing requirements for, preventive services;
- Restrictions on lifetime and annual limits;
- Restrictions on limitations or exclusions of benefits based on pre-existing conditions;
- Restrictions on policy rescissions;
- Extension of coverage for adult dependent children;
- Uniform explanation of coverage documents and standardized definitions;
- Compliance with requirements to provide public information on certain items including claims payment policies and practices, financial disclosures, enrollment and disenrollment data, rating practices, out-of-network cost sharing and payments;
- Establishment of an internal claims appeal process and external review process;
- Compliance with patient protections related to designation of a primary care physician, coverage of emergency services, and access to care for obstetrics or gynecological care for women; and
- Compliance with nondiscrimination requirements in benefit plan designs.[27]



Consumers Union reviewed the coding/categories currently used by DMHC, the Medi-Cal Ombudsman, and CDI (the latter of which uses the NAIC standard template for insurance coding, with some enhancements based on specific California state law requirements). Some of the important health insurance rules in effect today are not reflected in the current complaint collection data. For example, neither DMHC nor CDI currently specifically tracks complaints regarding an insurer's failure to adequately monitor compliance with out-of-pocket maximums for consumers, or these complaints are bundled together under a broad category, preventing understanding of whether consumers are truly benefitting from this legal protection. As another example, DMHC

26 NAIC Consumer Representatives, *Ensuring Access to Care.* (2014). *Ibid.*

27 NAIC Consumer Representatives, *Strengthening the Value and Performance,* (2013), *Ibid.* pp18–19.

may categorize surprise out-of-network bills—where a consumer goes to an in-network hospital for a procedure by an in-network surgeon, but gets a bill from an out-of-network anesthesiologist—under various categories such as a billing or benefit dispute, making it impossible to track this problem area effectively.

RECOMMENDATIONS:

- Review and regularly update codes and categories to reflect current state and federal law and the California managed care environment. A starting point set of initial recommendations for consideration and further development of complaint categories can be found in Appendix A; and
- Ensure that a system for coding and categorizing enrollee inquiries and complaints is used consistently throughout all relevant California complaint-handling entities at all points where consumers might seek assistance.

Track and report comprehensive complaint data and make it publicly available

With wholesale changes to the health insurance system under the ACA and related new state laws, the transition to updated standards may take some time to run smoothly. In the midst of implementation, strong oversight and vigilance can ensure that consumer protections are in place and adhered to.

California regulators are tasked with enforcing a myriad of important consumer protections, such as ensuring that plans and insurers do not exceed consumers' out-of-pocket maximums, that consumers have access to adequate provider directories to determine which providers are in the plan's network, and that consumers are afforded the opportunity to enroll in coverage during "special enrollment periods" if they experience one of the defined triggering events.

At the federal level, through the NAIC, data is collected via the NAIC Complaint Database System (CDS) and reported publicly through the Consumer Information Source (CIS). Information that describes what data goes into CDS is paltry.[28] Public reports for each state identify only the broad categories of "complaints" and "inquiries." Based on information gleaned from the NAIC website, the scope of "complaints" identified is unclear, but it explicitly states that the reporting is not comprehensive. "Complaints" appear to include only those that have been officially closed, but do not include withdrawn complaints or active, open ones.

In its report on Consumer Services and Antifraud, NAIC documents for each state the number of consumer complaints and the number of consumer inquiries.[29] This compilation includes all insurance issues, not just ***health*** insurance ones. For California, in 2014, NAIC reported more than 210,000 complaints and inquiries from the Department of Insurance. Of the total reported by NAIC, only 18% were complaints; the remaining 82% were categorized as inquiries. Moreover, the NAIC data contains *only data received from CDI,* which has jurisdiction over just a small fraction of California's commercial health insurance market.[30]

Neither CDI nor DMHC publicly report on categories of "inquiries" received. Inquiries may result in advice to consumers about how to solve the problems themselves—which could prove efficient and empowering. Categorizing them by issue area, if feasible, and reporting the topic areas would also provide a more complete picture of recurring areas of consumer confusion or dissatisfaction that may not have risen to the level of a complaint investigation, but nonetheless surface concerns to be addressed.

28 According to the NAIC, CDS "data is voluntarily supplied by state insurance departments and compiled and coded by the NAIC. Not all states provide complaint data to the Consumer Information Source. Please note that this database does not contain a complete record of all complaints filed and should not be used as the sole basis for insurance decisions." NAIC website.

29 National Association of Insurance Commissioners. (2014). Insurance Department Resources Report, Volume 1. Available from http://www.naic.org/documents/prod_serv_naic_state_sta_bb_1.pdf

30 As of 2014, DMHC regulated enrollment in 91% of the large group, 77% of the small group, and 82% of the individual market. Wilson, K. (2015). Enrollment in Individual Health Plans Up 47% in 2014. Available from http://www.chcf.org/articles/2015/05/enrollment-individual-up

RECOMMENDATIONS:

- Require all agencies to collect and report complaint data broken out by source of coverage (e.g., Medi-Cal, Medicare), plan, product, type of problem, geographic region, demographic data, resolution of complaints, and time frame of resolution, including complaint data for all Medi-Cal plans in each county;
- Encourage all agencies to broadly categorize inquiries by issue area; and
- At least annually, identify and report publicly on systemic problems and communicate steps the regulator is taking to investigate and resolve them.

Collaborate across multiple departments

In 2011, the California Legislature passed a statute broadening the mandate of California's Office of the Patient Advocate (OPA). Prior to 2011, the office was primarily tasked with producing quality report cards for private health insurance plans. The new legislation, however, tasked OPA with an additional important coordinating role—to collect and report out health insurance complaint information.[31]

The authority granted to OPA offers the potential to greatly enhance California's ability to collect, analyze and report out consumers' experiences through more comprehensive health insurance and health plan complaint information. It also creates the opportunity to improve collaboration amongst the agencies responsible for complaint data, including DMHC, CDI, Covered California, and the Department of Health Care Services program.[32]

Currently, DMHC and CDI categorize consumer health insurance inquiries and complaints including such broad categories as non-covered benefits, payment issues, cancellation of coverage issues, and complaints about insurer or provider behavior.

DMHC's complaints fall within five broad categories:

- **Accessibility**—the category includes: long wait times for appointments, lack of availability of primary or specialty physicians, delay or failure to respond to requests for authorization or referrals;
- **Coverage and Benefit Disputes**—the category includes: disagreement about whether a service is covered under the plan, refusals to refer to a specialist, or out-of-network providers or denials of ancillary services on the basis that benefit maximums have been met;
- **Billing, claims and enrollment disputes**—the category includes: disenrollment or termination of coverage, false or misleading marketing information, claims disputes (slow payment or insufficient payment), premium disputes (refunds and premium increases), refusals to pay for medical services or equipment, denials of payment for emergency or urgent care;
- **Attitude and Service of Health Plan**—the category includes: health plan staff behavior and slow responses to inquiries; and
- **Attitude and Service of Provider**—the category includes: physician or office staff behavior, physical condition of facility or provider office, inappropriate care (including failure to diagnose or treat) and slow responses.[33]

Within each of the main categories, DMHC also organizes complaints by a subset of categories to capture enrollees' experiences.

CDI uses the NAIC template to code its complaint data and provides that data to the NAIC, but the Department does not provide this coded information about their complaints on their own public-facing website. For health complaints, both NAIC and CDI only report publicly the number of decisions in favor of enrollees/members for Independent Medical Review cases.

Although CDI and DMHC are responsible for complaints for most health insurers—including those doing business through the Medi-Cal program, Covered California, the non-group and group market—both DHCS and Covered California also get consumer complaints through Covered California's Service Center and through the Medi-Cal Ombudsman office.

DHCS categorizes its Medi-Cal managed care plan-reported grievances under five broad categories: accessibility, benefits, referral, quality of care/services, and

31 Assembly Bill 922, amending §13975 of the Government Code and §§1341 and 1368.02 of the Health & Safety Code.

32 California Government Code §136000(a).

33 California Department of Managed Health Care. (2002). California HMO Help Center Annual Report 2002. Available from https://www.dmhc.ca.gov/Portals/0/FileaComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2002.pdf

other.[34] Covered California, as the newest entity handling complaints, in the first two years of operation has not publicly reported out complaint data.

OPA's first annual analysis of complaints across four agencies (DMHC, CDI, DHCS, and Covered California) is expected in the near future. Its forthcoming baseline complaint data review represents an opportunity for the relevant stakeholders to analyze and reconsider the coding and categorization of complaints they collected, as well as patterns observed.

RECOMMENDATIONS:

- Establish uniform tracking and monitoring of complaints across all agencies, including specific demographics such as location and language spoken;
- Coordinate amongst agencies to share data by plan quarterly;
- Create a cross-agency task force that meets regularly to share information about inquiries and complaints, including identification of patterns and practices;
- Twice per year, including as part of the OPA annual report, combine data and analyze complaint patterns and develop action plans (joint or several); and
- Expand the use of health coverage intermediaries, such as clinics, navigators, certified enrollment counselors, agents/brokers and other state agencies to publicize and encourage consumers to use the relevant complaint systems.

Conclusion

Strengthening consumer complaint systems will help ensure that consumers are getting the coverage they need, when they need it, at a price that is affordable. More robust consumer complaint systems will also improve data collection efforts, which can enable stronger monitoring of health plan and insurer behavior and enforcement of important consumer protections. OPA is charged with aggregating and analyzing health consumer complaints to help surface systemic issues. But without a cohesive reporting system, embraced by all parties, the benefit that could be gleaned from this analysis is minimized and the opportunities to ferret out overall policy problems will continue to be hampered.

As California continues to lead in successfully implementing the ACA, we urge the Department of Insurance, the Department of Managed Health Care, Covered California, and the Department of Health Care Services to work together to enhance the state's consumer health insurance and plan complaint systems. Updating consumer complaint categories to reflect ACA features, creating uniform complaint codes, and engaging in a concerted campaign to increase public awareness of how to complain about health plan issues will give policymakers a better handle on which parts of the health care environment are working well and which need to be refined. At the same time, such actions will educate and provide recourse to health care consumers, fulfilling the promise of the ACA and fostering confidence in government's ability to protect consumer interests.

34 California Department of Health Care Services. (2015). Medi-Cal Managed Care Performance Dashboard. Available from http://www.dhcs.ca.gov/services/Documents/MMCD/December152015Release.pdf. Note: this dashboard does not include complaints received by DHCS' Ombudsman.

APPENDIX A:
RECOMMENDATIONS FOR UPDATED COMPLAINT CATEGORIZATION[1]

In California, those entities that collect consumer complaints about health coverage should reconsider the current complaint categories in light of the Affordable Care Act and related state legislation, and consider adding categories to capture consumer experiences with:

- **Provider network directory inaccuracies** that result in denial of coverage, higher cost-sharing, balance billing or surprise medical bills—subcategories to be tracked and reported out are:
  - Inaccurate information on accepting new patients; and
  - Inaccurate listing of provider network participation.

- **In-network tiering** issues, which would include subcategories:
  - Insufficient labeling of network tiers in provider directory;
  - Insufficient or inaccurate information about co-pay/deductibles for tier cost-sharing; and
  - No disclosure from plan or provider on what tier a provider is associated with.

- **Prescription drug coverage**
  - Exceeding the prescription medication out-of-pocket dollar cap;
  - Failure to count prescription co-pays/co-insurance toward deductibles;
  - Applying the wrong cost-sharing to formulary tiers;
  - Formulary accuracy issues; and
  - Challenges to use of generic drugs for specific conditions or situations.

- **Payments issues**
  - Requiring payments in excess of the deductibles limit or out-of-pocket maximums;
  - Failure to apply cost-sharing reductions;
  - Insufficient or delayed payments and/or reimbursements;
  - Delays in claim processing;
  - Inaccurate cost-sharing; and
  - Problems with individual v. family deductible.

- **Preventive service violations**
  - Cost-sharing applied inappropriately; and
  - Coverage denials for services that should be preventive care.

- **Open enrollment issues**

- **Special enrollment issues**
  - Failure to grant special enrollment; and
  - Denied special enrollment because of failure to produce documents.

- **Surprise medical bills**—would include such subcategories as:
  - In-network facility, out-of-network provider;
  - Balance billing violations for emergency room care; and
  - Denial of coverage for out-of-network provider when no in-network provider is available.

1 See also, NAIC Consumer Representatives, Strengthening the Value and Performance, (2013), *Ibid.*

- **Access issues**
  - Failure to make referrals or authorizations;
  - Issues with waiting times for and geographic access to network providers;
  - Lack of availability of primary care or specialist physicians;
  - Mental health parity issues;
  - Continuity of care;
  - Coordination of care;
  - Appropriateness of care;
  - Transition between coverage;
  - Network change mid-year; and
  - Withdrawal from service.

- **Benefit and coverage issues**
  - Applying lifetime or annual limits;
  - Waiting periods or imposing pre-existing condition exclusions or limitation;
  - Exclusion of essential health benefits;
  - Rescission;
  - Failure to cover dependent children up to age 26; and
  - Disenrollment or termination from coverage.

- **Upholding rights, marketing and communication issues**
  - Absence of, inaccurate, or inconsistent Summary of Benefits and Coverage (SBC), Explanation of Benefits, and other consumer-facing materials;
  - Marketing materials in other languages, but failure to support enrollees who are Limited English proficient;
  - Failure to establish and make transparent internal grievance and complaint system; and
  - Failure to inform consumers about external right to complain and/or appeal.

- **Premium issues,** which would include:
  - Failure to apply premium tax credits;
  - Excess premium increases;
  - Failure to provide rebates from MLR review; and
  - Failure to provide premium refunds.

- **Attitude and Service issues** (for both plans and providers)