California Office of the Patient Advocate

Complaint Data Report Glossary for Measurement Year 2018

Term	Explanation
1095-A	An IRS tax form from Covered California to the consumer to report information on enrollment in a qualified health plan in the individual market through the Exchange marketplace, including – by month in the tax year – the premium of the qualified health plan, the premium of the second-lowest silver plan available, and the amount of advance payment of premium tax credit received by the consumer.
Access to Care	Complaint that needed care is inaccessible due to refusal of primary care doctor to authorize specialist care or due to inadequate provider network.
Appeal	A kind of complaint in which a consumer asks for a review of a decision made by a health plan or coverage program.
Beneficiary	The person who benefits from an insurance policy or coverage program.
Billing/ Reimbursement Issue	Complaint reported by DHCS regarding a problem with billing or reimbursement.
Bronze	A Covered California health plan product type. Bronze tier indicates a level of coverage provided by a health plan with 60 percent of the total allowed costs of benefits paid by the health plan.
CalPERS (California Public Employees' Retirement System)	A source of coverage data element indicating the organization that provides health and other benefits to California public employees, retirees, and their families.
Cancellation	Complaint alleging the insurer's improper cancellation of a policy and/or coverage before the expiration date.
Catastrophic	Health plans that meet all the requirements of a qualified health plan but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met. These plans also are called minimum coverage plans. Covered California minimum coverage plans are only available to people under age 30.
Claim	Request to a health plan or coverage program asking for payment based on the terms of the insurance policy.
Claim Delay	Complaint alleging that the insurer has unreasonably delayed the investigation and/or processing of a claim.
Claim Denial	Complaint alleging improper claim denial by insurer.
Claim Reopened	Regulated entity or individual has reopened claim for further investigation or settlement negotiation. A final resolution of the claim has not been determined.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate. CDI uses this result to indicate that the claim was settled in the consumer's favor.
Closed Complaint	A complaint that has been investigated by the state insurance department and given a resolution code. A complaint that has completed a complaint review process by a reporting entity or its official affiliate.
Co-Insurance	A share of the cost of a health care service. Co-insurance is a percent of the bill for a service.
Complaint	A written or oral complaint, grievance, appeal, independent medical review, hearing, or similar process to resolve a consumer problem or dispute.
Complaint Ratio	The number of complaints closed during the calendar year divided by the number of enrollees during the same year. Some complaint ratios are based on the number of health plan complaints divided by the number of health plan enrollees. Some complaint ratios are based on the number of coverage complaints in a county divided by the number of county enrollees. The report displays complaint ratios as complaints per 10,000 members.
Complaint Reason	A complaint data element indicating the primary reasons for the consumer complaint. For this report a single complaint case can have up to three reasons. Examples of complaint reasons include cancellation, medical necessity denial, and claim denial.

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Complaint Result	Primary outcome of the review of the consumer complaint.
Complaint Type	A data category for complaints reported to OPA that identifies the complaint review process used by the reporting entity, such as Standard Complaint, State Fair Hearing, Independent Medical Review, Quick Resolution, and Urgent Nurse.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.
Compromise Settlement/ Resolution	Complaint resolved voluntarily by an insurer or regulated entity, via additional payment, restored benefit or policy status, and/or other means. No finding that the regulated entity or individual was in violation or otherwise at fault.
Consumer Received Requested Service	A complaint result indicating that the consumer received the requested service after the complaint was filed.
Continuity of Care	Complaint regarding the transition plan of continuing care.
Co-Pay	A fixed charge (flat fee) for a health care service. You usually pay the co-pay when you get the service. You pay the same fee each time.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible, or co-insurance amount has been applied to a claim.
County Organized Health System (COHS) Model	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the county. In a COHS county, all Medi-Cal members are in the same managed care plan.
Coverage Question	Complaint alleging insurer’s inadequate response to insured’s request for information on policy status or coverages, or for interpretation of policy provisions.
Covered California/ Exchange	Coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. Covered California is California's state-run exchange.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
Customer Service Representative (CSR)	A person who answers telephone calls in a service center (or communicates with customers through other modes of contact, such as email).
Deductible	The amount you must pay each year for health care before your health plan starts to pay.
Denial of Coverage	Complaint that coverage was improperly denied.
Denied Services	Complaint alleging that the complainant was improperly refused health-related services.
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
Eligibility Determination	Complaint is about a problem with eligibility for health care coverage, typically through a public program.
Enrollment	The process of a health plan initiating coverage for a new member or renewing a policy. Enrollment generally occurs after a coverage program or employer determines eligibility. Enrollment can also refer to the number of members who are a part of a health plan or coverage program.
EPO (Exclusive Provider Organization)	An EPO is a kind of health plan that requires its members to use an exclusive network of contracted providers, but typically allows members to see network providers without a referral.
Ethnicity	A demographic data element for the Complaint Data report consisting of categories Hispanic or Latino, Not Hispanic or Latino, Unknown, and Refused.

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Experimental/ Investigational Denial	Complaint regarding denial of coverage for a treatment or service that the health plan has determined is experimental.
Full-Service License	A full-service license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides a full range of basic health care services, including preventive and routine care, physician and hospital services, and emergency and urgent care.
Geographic Managed Care (GMC) Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In GMC counties, DHCS contracts with several commercial plans to provide more choices for beneficiaries. GMC serves Medi-Cal beneficiaries in two counties: Sacramento and San Diego.
Gold	A Covered California health plan product type. The gold tier indicates a level of coverage provided by a health plan with 80 percent of the total allowed costs of benefits paid by the health plan.
Grandfathered	A product type indicating coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations). Grandfathered plans were made exempt from some provisions of the ACA.
Grievance	A complaint that you make to your health plan. In a grievance, you ask your health plan to solve a problem or change a decision they made about your care.
Group Health Plan	Health insurance coverage policy purchased by an employer or other employee organization and offered to eligible employees as a benefit. Insurance that is issued against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Care Delivery	The provision of health care services to members enrolled in a health plan or coverage program. Health care delivery complaints include those related to provider access, quality of care, and payment for services.
Health Only	Insurance covering sickness only. This can include an HMO (Health Maintenance Organization), who provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments, deductibles, and a PPO (Preferred Providers Organization).
Health Plan or Insurer	A health plan or insurer is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members or policy holders for a fixed, prepaid premium. Health plans are licensed to operate in California by the Department of Managed Health Care. Health insurers are licensed by the California Department of Insurance. For this report, health plan may be used to refer to both health plans and health insurers.
HMO (Health Maintenance Organization)	A kind of managed care health plan that requires its members to use a network of contracted providers to get health care services.
Hospitalization	Complaint regarding coverage for expenses arising out of services provided during confinement in a hospital as a patient for diagnostic study and/or treatment.
Independent Medical Review (IMR)	An Independent Medical Review is an external review process for addressing certain qualifying complaints about treatment or service denials or delays. Doctors who aren't part of the complainant's health plan or insurance company conduct the review and make a determination. Under law an IMR must be resolved within 30 days.
Individual Health Plan or Individual/ Commercial	Insurance that is issued to an individual insuring one (and one's dependents if on the same policy) against sickness or injury.

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Inquiry	A request for assistance made by a consumer to a consumer assistance service center that does not initiate a complaint with the associated reporting entity. For this report, the general category of inquiry is used to refer to jurisdictional inquiries and non-jurisdictional inquiries/complaints.
Insufficient Information	Complainant failed to provide sufficient information/documentation to warrant further investigation.
Interactive Voice Response (IVR)	A technology system used by telephone service centers that interacts with callers by allowing them to input information using their phone keypad and/or their voice. IVR systems often are used to gather information needed to route the call to the right customer service representative or to provide appropriate pre-recorded information.
Jurisdictional	Within the authority of a consumer assistance service center to address or resolve.
Large Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and sometimes their dependents) through a group health plan maintained by a large employer, unless otherwise provided under state law.
Limited Benefits Plan	A health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary. These policies usually limit the services the plan will cover and have a low maximum amount the plan will pay out. Limited-benefits plans include critical illness plans, indemnity plans, and “hospital cash” policies.
Long Term Care	A product type indicating a range of services and support for personal care needs. Most long-term care isn't medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living.
Managed Care	Health plans that contract with health care providers and medical facilities to provide care for members at reduced costs. HMOs, PPOs, EPOs, and POS plans are all managed care plans.
Medi-Cal	California's Medicaid program to provide health coverage to low-income individuals. The Medi-Cal program is administered and overseen by DHCS.
Medi-Cal Coordinated Care	A product type indicating a Medi-Cal managed care model approved by the federal government under an 1115 Waiver. The Coordinated Care Initiative’s Cal MediConnect demonstration project in certain counties provided beneficiaries with both Medicare and Medi-Cal (dual eligible) the option to receive all benefits in a single organized delivery system for medical, long-term care, and behavioral health services. The other major part of the initiative required all beneficiaries to join a Medi-Cal managed care plan to receive their Medi-Cal benefits, even if they opted out of Cal MediConnect or were not in a demonstration county.
Medi-Cal Fee-for-Service	A health care delivery system of the Medi-Cal program. Under this model, providers render services to Medi-Cal beneficiaries and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
Medi-Cal Managed Care	A health care delivery system of the Medi-Cal program. Under managed care models, the Medi-Cal program contracts with managed care plans to provide services to beneficiaries through established networks of organized systems of care.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medi-Cal/Medicare	A source of coverage category indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medicare	A source of coverage indicating the consumer has Medicare, a federal government health insurance program for people age 65 years and older and for some people with disabilities.

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Medicare Prescription Drug	A source of coverage indicating a stand-alone drug plan that adds prescription drug coverage to Original Medicare and some other Medicare plans.
Medicare Supplement	A product type indicating coverage that provides for accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage. Medicare supplemental insurance is sometimes referred to as Medigap.
Mental Health	Coverage for professional mental health services. Including psychologist, crisis centers, rehabilitative therapy, etc. An emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addition); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual (American Psychiatric Association's Diagnostic and Statistical Manual).
Mode of Contact	A report data element indicating the communication platform used by a consumer to contact a consumer assistance service center. Examples of modes of contact include telephone, mail, email, chat, and fax.
Modified Adjusted Gross Income (MAGI)	A specified methodology defining households and counting income used for determining eligibility for the most common forms of Medi-Cal and for financial assistance through Covered California.
No Action Requested/ Required	Complaint Result indicating that the complaint review organization received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance. For DHCS, this result indicates that the State Fair Hearing case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.
No Jurisdiction	Complaint does not fall under the regulatory authority or oversight of the reporting entity, and was not referred to any outside agency, Department, or court system. Includes Action Suspended for litigation and/or formal arbitration.
Non-Jurisdictional	Not within the authority of a consumer assistance service center to address or resolve.
Other	Indicating a category not fitting into any specific standardized report category.
Out-of-Network Benefits	Complaint regarding dissatisfaction with the administration or determination of benefits, on a claim for services that have been requested, received, or determined to be, out-of-network.
Overturned/Health Plan Position Overturned	Complaint resolved by a regulated entity or individual to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Reporting entity found the regulated entity or individual to be in violation or otherwise at fault.
Pharmacy Benefits	Complaint regarding coverage for expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician. As a product type, indicates a plan that provides coverage for pharmacy benefits.
Plan/Staff Attitude and Service	Complaint alleging unacceptable attitude or treatment from a health plan's staff.
Platinum	A Covered California health plan product type. The platinum tier indicates a level of coverage provided by a health plan with 90 percent of the total allowed costs of benefits paid by the health plan.
POS (Point of Service)	A POS plan is a kind of managed care health plan. It combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).
PPO (Preferred Provider Organization)	A PPO is a kind of managed care health plan. A PPO has a network of contracted providers but offers its members options to go outside of the network for care. In addition, members can usually see providers without prior approval from the plan.

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Term	Explanation
Premium	The amount you pay each month to keep your health plan. For many people, their employer or the government may pay all or part of the premium.
Premium Notice/Billing	Complaints alleging insurer’s failure to send notice regarding premium due date, premium increase/decrease, policy lapse, etc.
Primary Care Physician Referral	Complaint regarding consent given by a designated health care provider to visit another physician or healthcare provider.
Primary Language	The language a person was exposed to from birth or a very early age, or the main language a person uses to communicate. For the Complaint Data Report, primary language response options include Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Refused, Russian, Spanish, Tagalog, Unknown, and Vietnamese.
Product Type	A complaint data element used to identify details about specific areas of coverage, such as the health plan's model, structure, benefits, and/or other distinguishing characteristics. In this report, most product types align with NAIC's Type of Coverage/Accident & Health Second Level codes. Examples of product types include HMO, PPO, Silver, Platinum, Health Only, Dental, and Small Group.
Protocols	Performance standards, policies and procedures, and other system requirements that determine a service center's response to a consumer request for assistance.
Provider	A health professional or heath practitioner who provides preventative, curative, promotional, or rehabilitative health care services. For this report, provider may refer to an individual or a hospital, clinic, medical group, or other group of professionals that provide medical services.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Quality of Care	Complaint alleging that the health care provided was not appropriate for their health needs or the provider did not possess sufficient competency.
Question of Fact/ Contract/ Provision/ Legal Issue	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority or oversight of the reporting entity.
Quick Resolution (QR)	A complaint type reported by DMHC. DMHC staff use the QR process for certain issues that can be resolved without standard complaint or urgent nurse processes, such as requests to file a grievance/appeal, expedited review of a grievance/appeal, access to providers, out of network referrals, second opinion consultation, quality of care complaints, or refill of medication(s).
Race	A demographic data element for the Complaint Data report consisting of categories White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Other, Unknown, and Refused.
Referred to Other Division for Possible Disciplinary Action	Complaint referred elsewhere within regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.
Referred to Outside Agency/Dept.	Complaint was referred to a different state agency/department.
Refused/Unknown	A data element indicating that the complainant either was not asked for or refused to provide this information.

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Term	Explanation
Regulator	A government entity with the authority to oversee and enforce health insurance laws and regulations, including those related to licensing, product regulation, financial regulation, and market conduct. For the Complaint Data Report, plan regulator options include California Department of Insurance (CDI), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), Department of Labor (DOL), Out of State Department of Insurance, Other, and Unknown.
Rehabilitative/ Habilitative Care	Health care services that help a person keep, get back, or improve skills and functioning for daily living that did not develop at a typical age, or that have been lost or impaired because a person was sick, hurt, or disabled. As a complaint reason, a complaint regarding coverage for rehabilitative and/or habilitative services and/or devices.
Reporting Entity	For this report, a state health care department or entity that is statutorily required to provide consumer complaint data and other consumer assistance information to the Office of the Patient Advocate (per Health and Safety Code section 136000). Reporting entities are the Department of Managed Health Care, Department of Health Care Services, Department of Insurance, and the Exchange (Covered California).
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report, this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Service Center	Health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers. For this report, service centers refer to those operated or contracted by the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California.
Share of Cost	An inquiry type reported by DHCS indicating the amount in health care costs certain Medi-Cal beneficiaries must pay each month before Medi-Cal pays for their care. The Share of Cost is determined by a beneficiary’s income.
Silver	A Covered California health plan product type. The Silver tier indicates a level of coverage provided by a health plan with 70 percent of the total allowed costs of benefits paid by the health plan.
Small Group	Coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.
Source of Coverage	A complaint data element used to identify a category of a health plan's contracting/purchasing mechanism, which is associated with an insurance market segment and related laws. Examples of coverage sources include Individual/Commercial, Group, Medi-Cal, and COBRA.
Specialty License	A specialized license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides health care services in a single area such as dental, vision, or mental health.

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Term	Explanation
Stand Alone Dental	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan. This type of dental plan is not a part of the medical plan.
Standard Complaint	A report data element indicating a complaint type used for complaints that undergo the reporting entity's typical complaint review process. Examples of issues that may be addressed as a Standard Complaint include billing problems, cancellation of coverage, and a provider's attitude. Complaints that are urgent or require the intervention of a health care provider may also be addressed as Standard Complaints.
State Fair Hearing	A formal complaint process to adjudicate appeals from California residents who have applied for, have received, or are currently receiving benefits or service from an assistance program administered by the State of California. The California Department of Social Services is authorized to conduct State Fair Hearings for appeals regarding Covered California applications and eligibility determinations, as well as for all Medi-Cal appeals. A State Fair Hearing is sometimes called a State Hearing, Fair Hearing, or Medi-Cal Fair Hearing.
State Fair Hearing: Informal Resolution	A complaint type used by Covered California that identifies a complaint that went as an appeal to the California Department of Social Services for a State Fair Hearing but was resolved before the State Fair Hearing took place.
State Specific (Other)	A complaint data element indicating an element that is state-specific and cannot be conveyed with other available options. Reporting entities use further internal coding to track data as needed.
Uninsured	A product type and source of coverage data element reported by DMHC indicating that the complainant was not enrolled in a health plan or public coverage program at the time of filing the complaint. Other reporting entities may categorize product type and source of coverage by the coverage the uninsured complainant lost and/or was seeking.
Unknown	A complaint data category indicating data was not identified. Data listed as Unknown were for fields submitted as Unknown or blank (without data), either because the data was not collected by a reporting entity (CDI, Covered California, DHCS, or DMHC) or because there were complainants who did not provide information to a reporting entity.
Unsatisfactory Settlement/Offer	Complaint that insurer's payment or settlement offer is less than or below the amount expected by the insured or claimant.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Urgent Nurse Complaint (or Urgent Nurse Case)	A complaint type reported by DMHC. DMHC's Urgent Nurse process identifies and addresses complaints involving a potential health risk to the complainant and that may need immediate attention and expedited resolution by DMHC clinical staff, who are experienced in both health care and managed care systems.
Withdrawn/ Complaint Withdrawn	Complainant requested that the complaint be withdrawn.