Annual Health Care Complaint Data Report

Report to the Legislature for Measurement Year 2021

STATE OF CALIFORNIA
Gavin Newsom, Governor

HEALTH AND HUMAN SERVICES AGENCY
Mark Ghaly, Secretary

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

Statutory Requirement

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

> (b) The center shall produce an annual report to be made publicly available on the center's internet website by December 31, 2022, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:
>
> (1) The types of calls received and the number of calls.
>
> (2) The call center's role with regard to each type of call, question, complaint, or grievance.
>
> (3) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.
>
> (4) The protocol for referring or transferring calls outside the jurisdiction of the call center.
>
> (5) The call center's methodology of tracking calls, complaints, grievances, or inquiries.
>
> (c) (1) The center may collect and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, insurer or plan data, appeals, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the center shall submit a report by December 31, 2022, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The format may be modified annually as needed based upon comments from the Legislature and stakeholders.
>
> (2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the center data concerning call centers to meet the reporting requirements in this section in the time, data elements, manner, and format requested by the center.
>
> (3) For the purpose of publicly reporting information as required in paragraph (1) and this paragraph about the problems faced by consumers in obtaining care and coverage, the center shall analyze data on consumer complaints, appeals, and grievances resolved by the agencies listed in subdivision (b), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.

This report and its accompanying documents (Detailed Methodology, Report Glossary) are available through the Center for Data Insights and Innovation webpage:

www.cdii.ca.gov/consumer-reports/complaint-data-reports/

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Section 1 – Executive Summary

The Center for Data Insights and Innovation (CDII) is statutorily required to produce an annual Complaint Data Report under the authority and specifications established by AB 172 (Chapter 696, Statutes of 2021). The reporting requirements transitioned to CDII from the Office of the Patient Advocate (OPA), which had originally been mandated to develop a baseline Complaint Data Report and annual report thereafter by AB 922 (Chapter 552, Statutes of 2011). The statute lists four state reporting entities that are required to provide data to CDII: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California).

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

This eighth annual Complaint Data Report catalogs 30,779 jurisdictional complaints for Measurement Year 2021 (complaints closed January 1 – December 31, 2021).

- DMHC submitted 16,025 complaints from its 27,668,250 plan enrollees.
    - The DMHC 2021 volume increased slightly (0.9%) compared to the prior year.
- DHCS submitted 4,825 complaints from its 13,824,018 beneficiaries.
    - The DHCS 2021 volume decreased slightly (2.7%) compared to the prior year.
- CDI submitted 3,608 complaints from its 2,203,105 plan enrollees.
    - The CDI 2021 volume increased by 12 percent (12.2%) compared to the prior year.
    - CDI reported 7,677 total complaints, including non-jurisdictional complaints that closed with a referral to an outside agency or department or similar result.
- Covered California submitted 6,321 complaints from its 1,580,130 plan enrollees and other applicants.
    - The Covered California 2021 volume significantly dropped compared to the prior year, with a nearly 43 percent (42.9%) decrease.
    - Covered California attributed the decrease primarily due to improvements in its Service Center training and issue escalation process.

The 2021 top five statewide complaint reasons:

1. Denial of Coverage (13.7%)
2. Medical Necessity Denial (12.0%)
3. Co-Pay, Deductible and Co-Insurance Issues (8.1%)
4. Eligibility Determination (6.9%)
5. Delays/ No Response (5.5%)

The 2021 top five statewide complaint results:

1. Upheld/ Health Plan Position Substantiated
2. Withdrawn/ Complaint Withdrawn
3. Compromise Settlement/ Resolution
4. Advised Complainant
5. Overturned/ Health Plan Position Overturned

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

The 2021 complaint resolution times:

- Statewide – 33 days on average (ranging from 0 [same day] to 783 days)
- DMHC – 26 days on average (ranging from 0 to 454 days)
- DHCS – 49 days on average (ranging from 0 to 703 days)
- CDI – 46 days on average (ranging from 0 to 783 days)
- Covered California – 30 days on average (ranging from 0 to 499 days)

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

Section 2 – Background and Methodology

The Center for Data Insights and Innovation (CDII) is statutorily charged under California Health and Safety Code section 130204 with the implementation of a multi-departmental complaint data reporting initiative. CDII took over this requirement from the Office of the Patient Advocate (OPA) in October 2021 after the enactment of AB 172 (Chapter 696, Statutes of 2021). CDII is now required to annually report health care complaint data and related consumer assistance information from four state entities – the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California) (collectively referred to as "reporting entities" within this report).

This eighth annual Complaint Data Report evaluates heath care complaints closed January 1 through December 31, 2021, and other information about the reporting entities' consumer assistance activities. For some comparisons, CDII also displays data previously collected by OPA for earlier measurement years.

DMHC, DHCS, CDI, and Covered California submitted to CDII non-aggregated complaint data through an annual submission process using standardized data categories and elements. The reporting entities also reported overall consumer assistance volumes, protocols details, and other service center information. The 2021 complaint types submitted were:

- DMHC – Standard Complaints, Independent Medical Reviews, Quick Resolutions, and Urgent Nurse Complaints
- DHCS – State Fair Hearings (conducted by the California Department of Social Services [CDSS])
- CDI – Standard Complaints and Independent Medical Reviews
- Covered California – State Fair Hearings (conducted by CDSS) and State Fair Hearings with Informal Resolutions (referred by CDSS for resolution by Covered California without a hearing)

CDII and the reporting entities remain dedicated to collaborating to standardize and enhance reporting. However, the data presented in this report may still provide an imperfect comparison between measurement years, reporting entities, coverage types, and similar categories. Because of the differences in complaint systems, many data categories are displayed in separate sections addressing each reporting entity rather than in an aggregated statewide display.

Additional details about the report methodology and the glossary of terms are available through the CDII website: www.cdii.ca.gov/consumer-reports/complaint-data-reports/

Section 3 – Statewide Complaint Data

A. Overview

The Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California) serve millions of Californians each year through health care coverage and regulatory oversight programs. The Center for Data Insights and Innovation (CDII) received data from these four reporting entities about consumer health care complaints and other information about their consumer assistance service centers. The service centers include help centers, call centers, ombudspersons, or other assistance centers that are operated or contracted by the entities.

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

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

Figure 3.1 Reporting Entity 2021 Complaints and Enrollment

Reporting Entity	Complaint Volume	Total Number of Enrollees
DMHC	16,025	28,378,102
DHCS	4,825	13,824,018
CDI	7,677	2,203,105
Covered California	6,321	1,580,130

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

B. Statewide Consumer Assistance Centers

The following state service centers reported 2021 consumer assistance data to CDII:

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

These service centers collectively received 5,763,069 requests for assistance from consumers in 2021. Nearly all (99.5%) of the statewide requests for assistance were inquiries from consumers who required information, referrals, or assistance other than with a complaint.

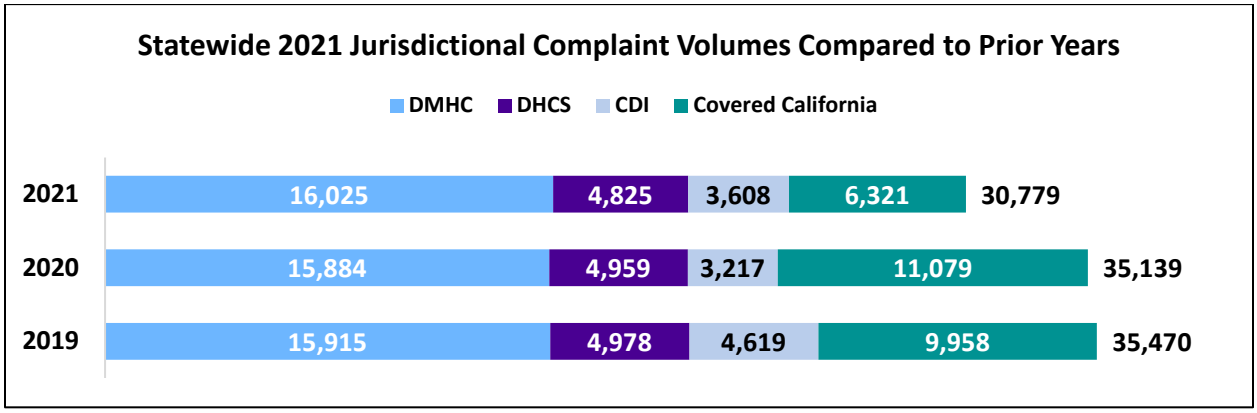
The 2021 requests for assistance volume was the lowest of all measurement years (reporting since 2014), with a 26 percent decrease from the 2020 high of 7,830,377.

- The decrease was largely driven by a 33 percent drop in the Covered California Service Center's inquiry volume compared to the prior year.
    - Covered California noted that the decrease was primarily due to improvements in its escalations process, ongoing training, and a focus on one-call resolution.
- DHCS was the only department with an increase in requests for assistance compared to the prior year.
    - The four percent overall increase can be attributed to a rise in inquiries to its Medi-Cal Dental Telephone Service Center after dental services resumed in 2021, which offset decreases in complaints and decreases in the inquiries made to the Office of the Ombudsman and Medi-Cal Telephone Service Center.
- DMHC's requests for assistance volume was similar to the prior year.
    - Regardless, the department experienced a slight increase in the number of complaints closed in 2021.
- CDI's requests for assistance volume fell for the third straight year, decreasing by 16 percent compared to the prior year.

C. Statewide Health Care Complaint Data

DMHC, DHCS, CDI, and Covered California submitted 30,779 jurisdictional complaints that were closed in 2021. The combined statewide volume has decreased each year since 2016.

Figure 3.2



Note: Due to methodology differences, the complaint figures shown may vary from complaint volumes published by the reporting entities in other reports. In addition, due to changes in reporting methodologies, year-over-year comparisons should be interpreted with caution. CDI's non-jurisdictional volumes were excluded from trend displays. DMHC totals include non-jurisdictional complaints.

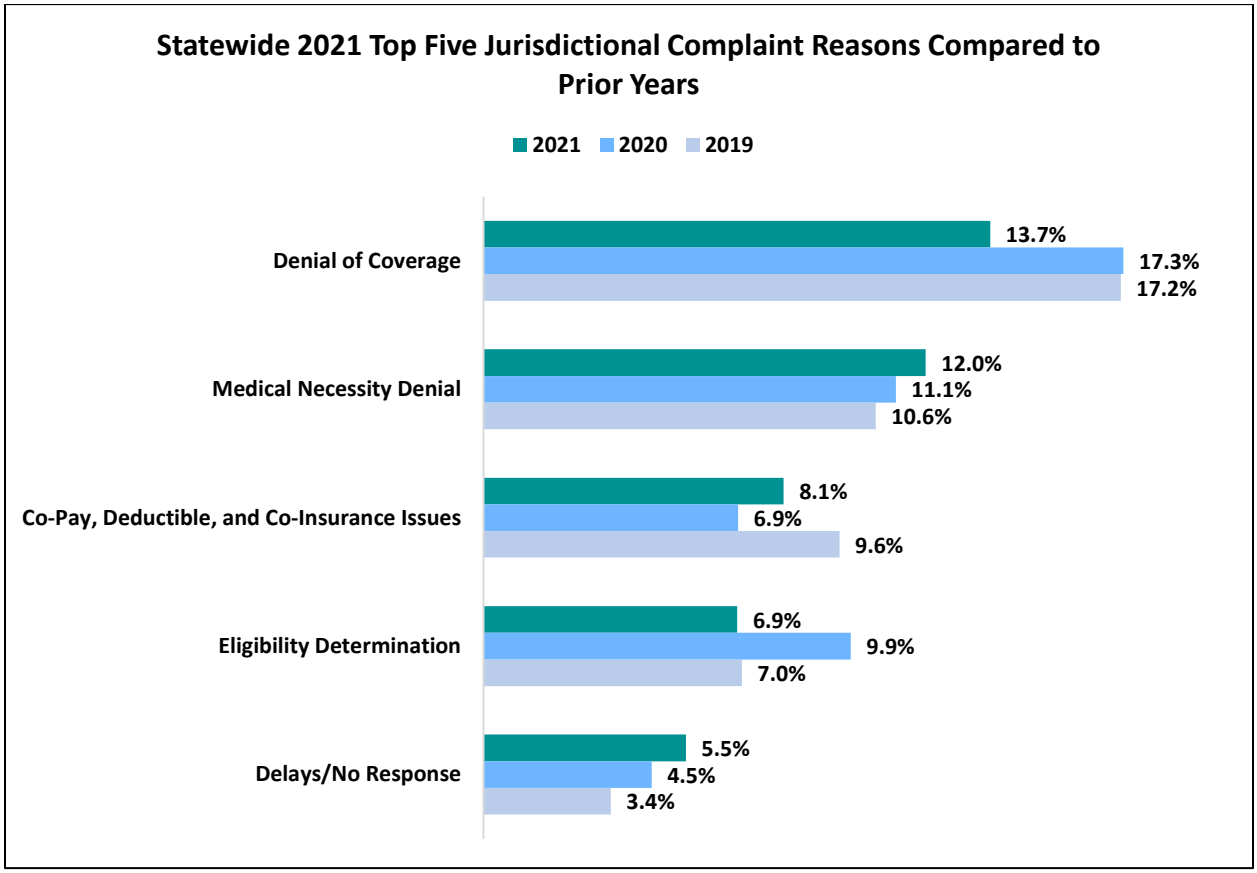
- Covered California's complaint volume decreased by about 43 percent from the prior year.
    - Covered California noted that in addition to helping to decrease the inquiry volume, its issue escalation process improvements and one-call resolution focus also helped to reduce the number of complaints in 2022.
- DHCS's complaint volume was similar to the prior year (decrease by about 3%)
- DMHC's complaint volume was similar to the prior year (increase under 1%)
- CDI's complaint volume increased by 12 percent over the prior year.
    - CDI indicated that the increase was primarily associated with medical services resuming in 2021 after the prior year's COVID-19-related delays and interruptions.

Complaint Reasons

The following chart displays the most common reasons for the 30,779 jurisdictional complaints closed in 2021, along with the 2019 and 2020 data for the same categories.

- Co-Pay, Deductible, and Co-Insurance Issues and Delays/No Response were the only two reasons in the top five that increased in volume from 2020 to 2021 (4.6% and 6.7% increases respectively).
- Denial of Coverage has been the top reason since 2015, although its volumes have continued to decrease each year since. There was a nearly 30 percent (29.8%) volume decrease from 2020 to 2021.

Figure 3.3



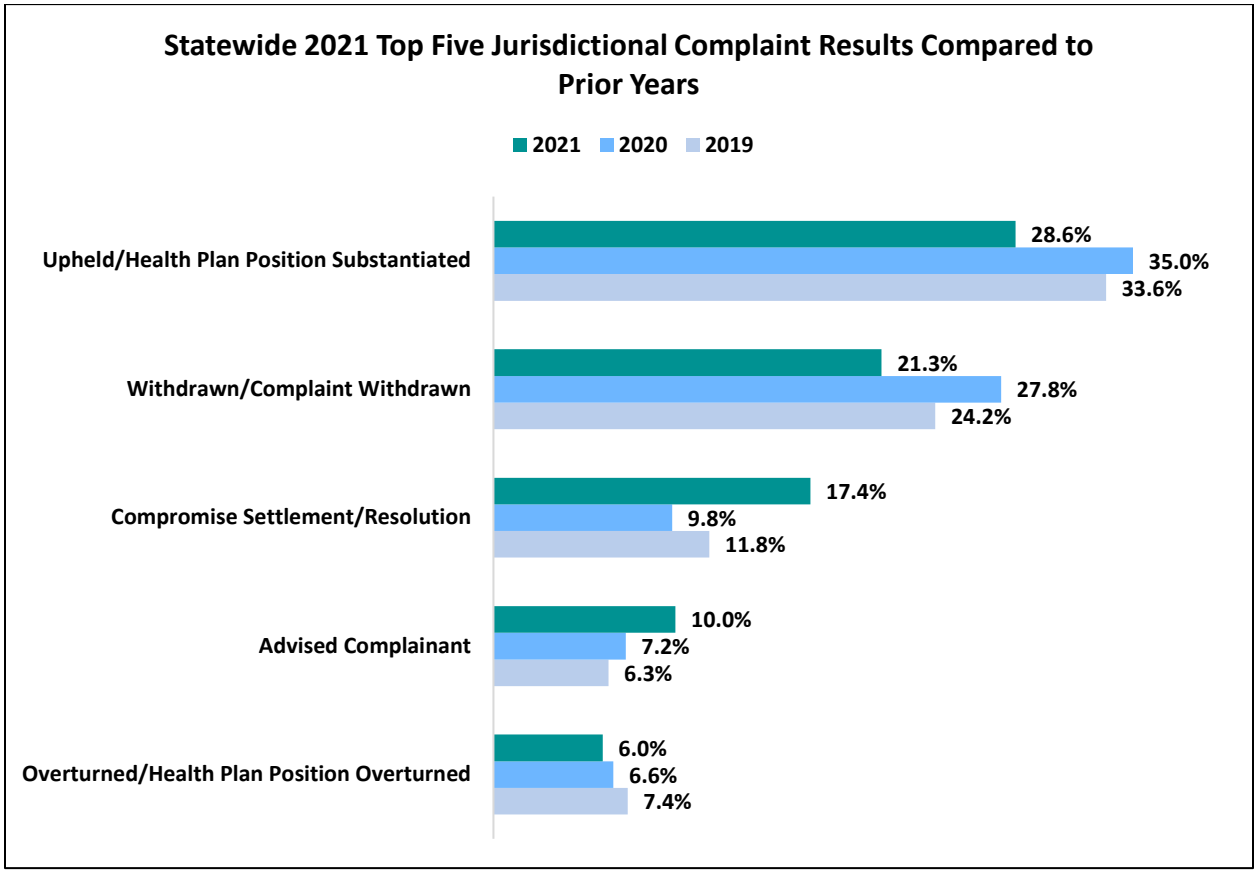
Note: The number of reasons exceeded the number of complaints because some cases had more than one reason submitted (38,299 reason entries from the 30,779 complaints in 2021). Differences between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Complaint Results

The following chart displays the most common results for the 30,779 jurisdictional complaints closed in 2021, along with the 2019 and 2020 data for the same categories.

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

Figure 3.4



Note: The number of results exceeded the number of complaints because some cases had more than one result reported (41,698 results from the 30,779 complaints in 2021).

Differences between measurement years for some results categories may be due in part to changes in data collection and reporting rather than changes in incidence.

Resolution Time

The 2021 statewide average complaint resolution time was 33 days, one day fewer than the 2020 average. The statewide average has decreased each year since 2016.

Figure 3.5 2021 Complaint Resolution Times (in Days) by Reporting Entity

Reporting Entity	Minimum Duration	Maximum Duration	Average Resolution Time
DMHC	0 (same day)	454	26
DHCS	0	703	49
CDI	0	783	46
Covered California	0	499	30

Note: The analysis excludes CDI's submitted non-jurisdictional complaints, which took four days on average to resolve in 2021.

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

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

Demographic and Other Complaint Categories

Sections 4-7 outline additional details about demographic and other complaint data elements submitted by each reporting entity.

The 2021 statewide complaint distributions by primary language of the complainant were similar to prior years, with English accounting for most complaints (83.9%), Spanish for five percent (5.0%) and Other Languages combined for around three percent (2.5%). Approximately nine percent of the complaints did not have a primary language identified (8.6% combined Refused and Unknown).

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

Figure 3.6 Statewide Top Five Complaint Reasons by Primary Language

Rank	English (% of English)	Spanish (% of Spanish)	Other Languages (% of Other)	Refused/Unknown (% of Refused/Unknown)
1 (most common)	Denial of Coverage 14.4%)	Denial of Coverage (18.3%)	Denial of Coverage (15.5%)	Pharmacy Benefits (27.7%)
2	Medical Necessity Denial (11.9%)	Eligibility Determination (14.9%)	Eligibility Determination (9.4%)	Claim Denial (20.8%)
3	Co-Pay, Deductible, and Co-Insurance Issues (8.8%)	Medical Necessity Denial (10.7%)	Co-Pay, Deductible, and Co-Insurance Issues (8.6%)	Medical Necessity Denial (14.5%)
4	Eligibility Determination (6.8%)	Quality of Care (7.5%)	Medical Necessity Denial (6.7%)	Information Requested (8.4%)
5	Delays/No Response (6.1%)	Co-Pay, Deductible, and Co-Insurance Issues (6.0%)	Scope of Benefits (6.3%)	Claim Delay (3.7%)

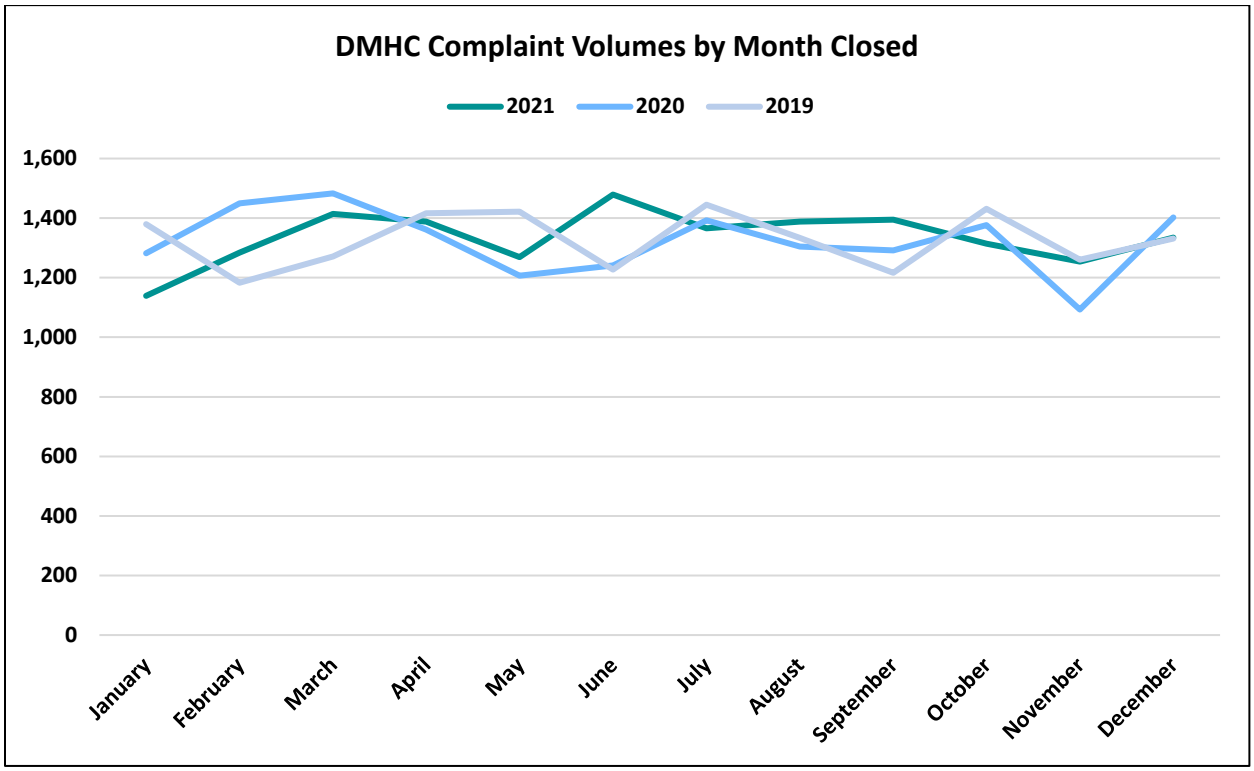
Section 4 – Department of Managed Health Care

A. Overview

The Department of Managed Health Care (DMHC) regulates 96 percent of enrollment in state-regulated health plans. DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services.

DMHC's Help Center received 130,197 requests for assistance from consumers in 2021, a similar volume to the previous year (130,233 in 2020). DMHC reported 16,025 complaints closed in 2021, a slight increase in volume (under 1%) from 2020.

Figure 4.1



The following table outlines DMHC's complaint standards for its four reported complaint types.

Most of DMHC's 2021 complaints were the Standard Complaint type (71.7% of the 16,025 complaints), followed by Independent Medical Review (25.7%), Quick Resolution (2.3%), and Urgent Nurse Case (0.3%).

Figure 4.2 DMHC Help Center Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2021
Standard Complaint	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework Legal Affairs Branch: Casework for more complex legal cases	30 days, from receipt of a completed complaint application	28 days
Independent Medical Review (IMR)	Contact Center: Intake and routing Independent Medical Review/Complaint Branch: Casework IMR Contractor (MAXIMUS): External Review decision Legal Affairs Branch: Legal review if needed	45 days, from receipt of a completed IMR application 7 days for cases that qualify for an expedited IMR	23 days
Quick Resolution	Contact Center: Intake and casework to resolution	N/A	4 days
Urgent Nurse	Contact Center: Intake, initial casework, and routing Independent Medical Review/Complaint Branch: Casework, opens an IMR if an external review is needed	N/A	11 days

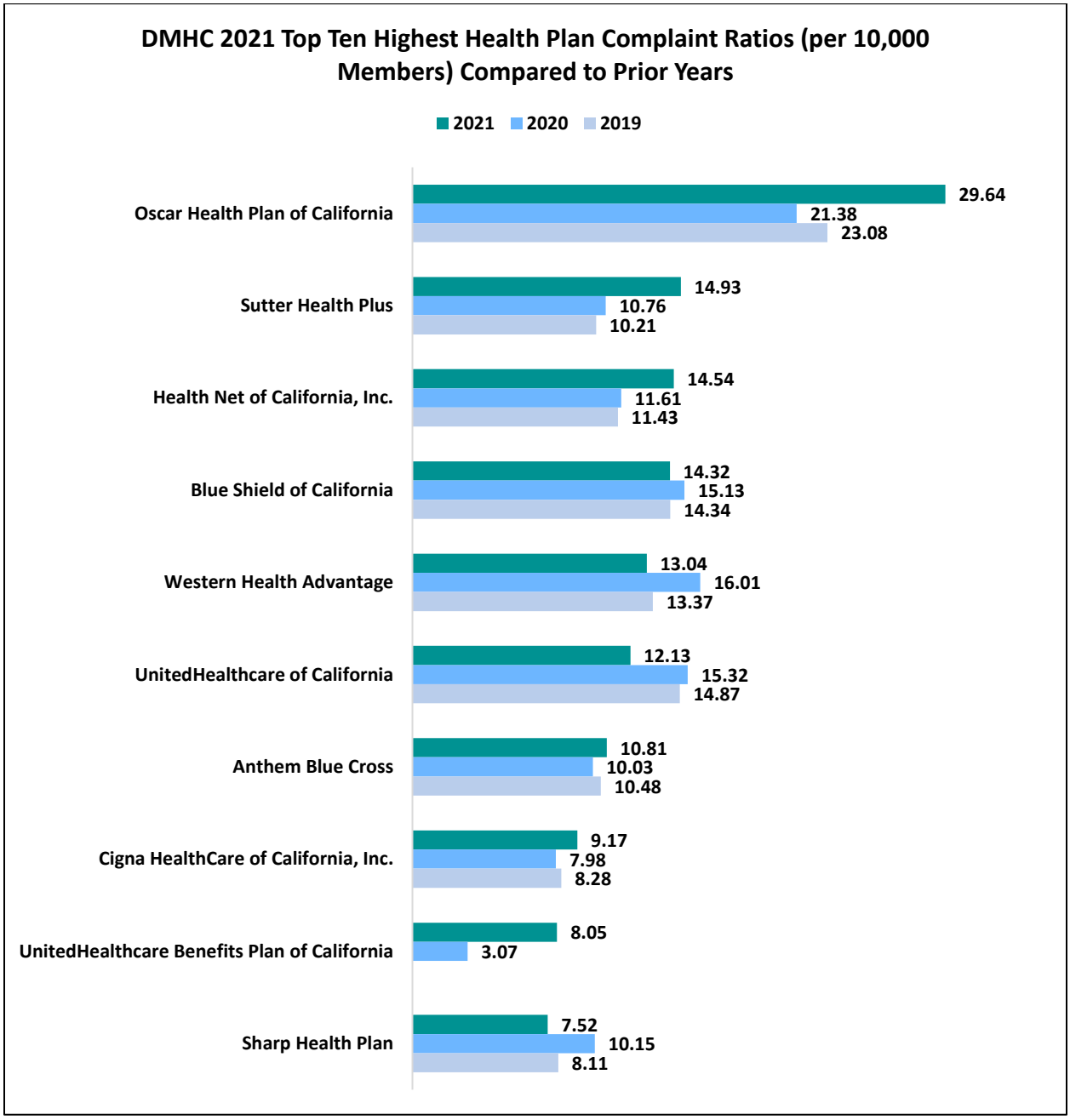
Note: The timeframes for DMHC's time standards are based on the date the department receives a completed complaint/IMR application. DMHC may review complaints involving consumers with urgent clinical issues as Urgent Nurse Case complaints, or through expedited IMR or Standard Complaint processes.

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays the DMHC-regulated full-service health plans with the highest complaint ratios in 2021 among plans with enrollment over 70,000 members.

Figure 4.3



Note: The display excludes health plans with enrollment under 70,000 members in 2021. The 2020 and 2021 figures for Anthem Blue Cross consist of data reported for Blue Cross of California and Blue Cross of California Partnership Plan. For the trend comparisons, the data was not separated. UnitedHealthcare Benefits Plan of California did not have any active products or enrollees for MY 2019.

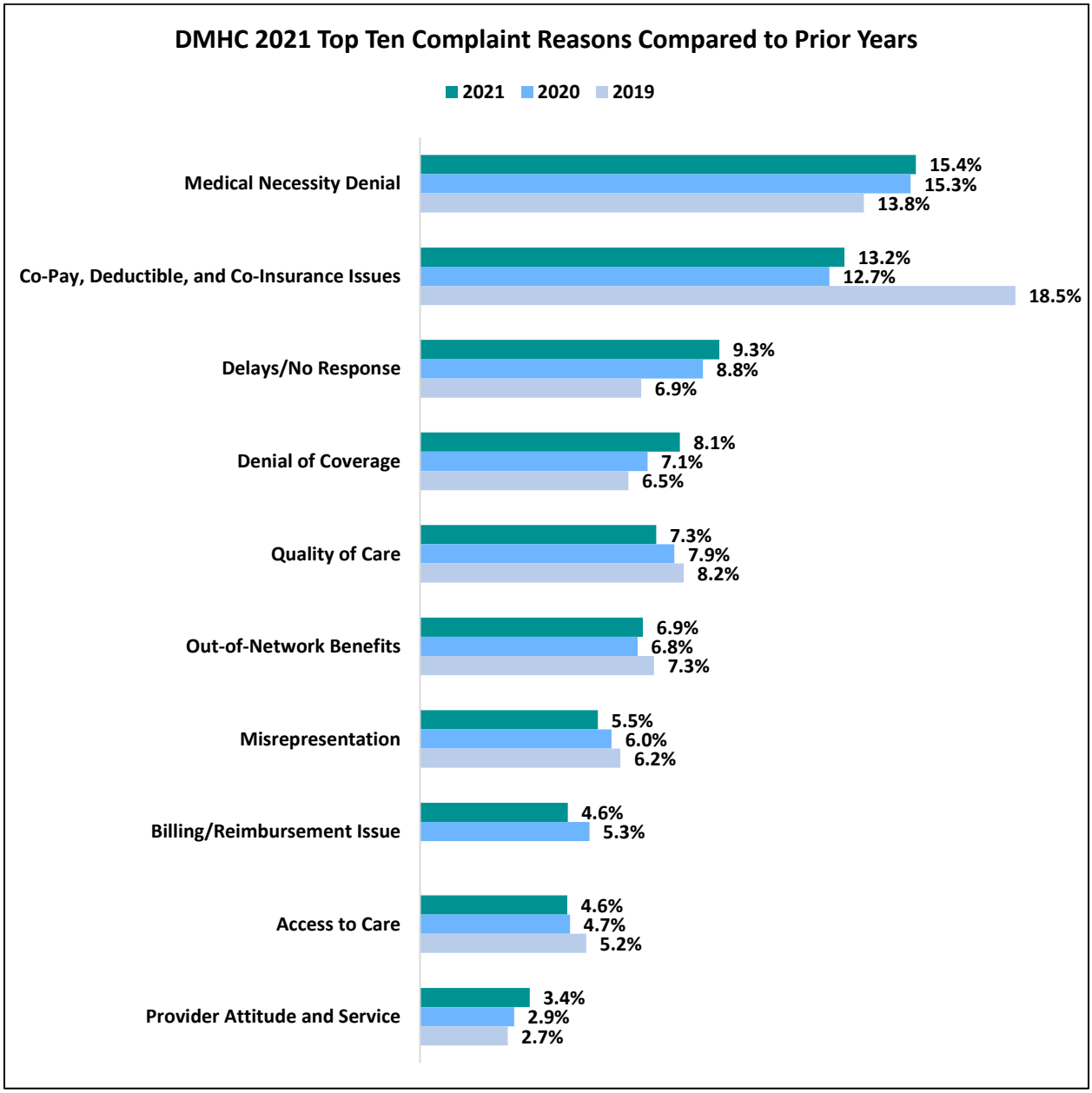
Complaint Reasons

The following chart displays the most common complaint reasons reported by DMHC for measurement year (MY) 2021, as well as the 2019 and 2020 data for those same

reason categories. Some differences between measurement years may be due in part to data collection and reporting changes. For example:

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

Figure 4.4



Note: Differences between measurement years may be due in part to reporting changes rather than changes in incidence. The volume of reasons exceeded the number of complaints because some cases had more than one reason reported (22,319 reason entries from 16,025 complaints in 2021).

Inquiry Topics and Referrals

The following table displays the most common topics of consumer inquiries in 2021, including complaints that were outside of DMHC's jurisdiction to address. For each inquiry topic, referral organizations are listed in order of most common to least common referral.

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

Figure 4.5 DMHC Help Center 2021 Top Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Volume	Organization(s) Referred To
1 (most common)	General Inquiry/ Information	4,027	Department of Health Care Services (DHCS), Covered California, Other, Health Insurance Counseling and Advocacy Program (HICAP), California Department of Insurance (CDI), Centers for Medicare and Medicaid Services (CMS), U.S Department of Labor (DOL)-South, DOL-USA
2	Provider Service/ Attitude	818	Department of Consumer Affairs (DCA), California Department of Public Health (CDPH), HICAP, Other, DHCS, federal Health and Human Services (HHS)
3	Claims/ Financial	692	CDI, HICAP, DCA, Out of State Department of Insurance (DOI), Covered California, Other, DHCS, DOL-USA, CMS, DOL-South, CDPH
4	Access Complaints	368	DHCS, DCA, HICAP, CMS, California Department of Social Services (CDSS), Other, HHS, Covered California
5	Coverage/ Benefits Dispute	363	HICAP, DHCS, DCA, CDI, CMS, CDSS, Out of State DOI, Covered California
6	Enrollment Disputes	354	Covered California, DHCS, HICAP, Other, CDI, DOL-South, CDSS
7	Plan Service/ Attitude	140	HICAP, HHS, DHCS, DCA, CMS, Other, CDI, Covered California
8	Coordination of Care	136	HICAP, DHCS, DCA, CMS, Other, CDPH, CDSS, Out of State DOI
9	Appeal of Denial – Independent Medical Review	49	CDI, DCA, DHCS, CDSS, HICAP, Other, Out of State DOI, California Public Employees' Retirement System (CalPERS), CMS

Note: The volume is a count of issues within a call case. In the Help Center's Customer Relationship Management system, a case can record up to three issues. As a result, the total number of inquiry issues is greater than the total number of non-jurisdictional call cases reported later in Figure 4.16.

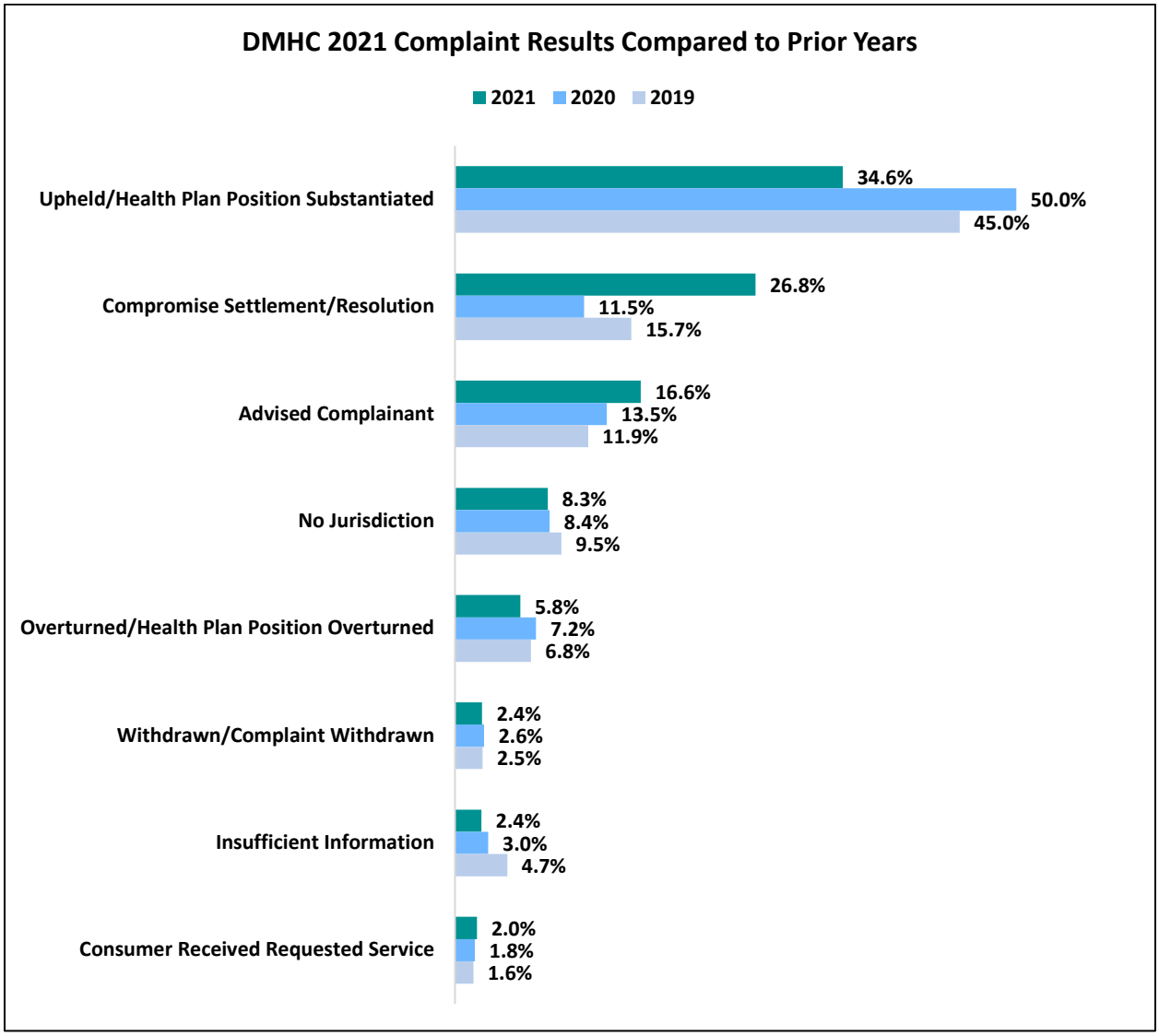
Complaint Results

The following chart displays DMHC's 2021 complaint results, along with the 2019 and 2020 data for those same results categories.

Some differences between measurement years may be due in part to changes in data collection and reporting. For example:

- Due to a collection change starting in MY 2021, DMHC more accurately identified cases with multiple complaints where part of the complainant's case resulted in a benefit provided. Therefore, certain complaints that would have previously been reported as Upheld/Health Plan Position Substantiated, Claim Settled, or Insufficient Information, were reported as Compromise Settlement/Resolution.

Figure 4.6



Note: Three results categories with low volumes (under 1%) were excluded from the display: Referred to Other Division for Possible Disciplinary Action, Claim Settled, and Policy Not in Force. Results categories considered to be favorable to the consumer complainant include: Overturned/Health Plan Position Overturned; Consumer Received Requested Service; Compromise Settlement/Resolution; and Referred to Other Division for Possible Disciplinary Action. Results considered to be favorable to the health plan include: Upheld/Health Plan Position Substantiated. The favorability of the other categories shown is neutral or cannot be determined. For some categories, favorable to the complainant does not necessarily mean that the complaint was substantiated against the health plan but indicates that the consumer received services or a similar positive outcome.

DMHC noted that the increase in Compromise Settlement/Resolution and the decrease in Upheld/Health Plan Position Substantiated from 2020 to 2021 were primarily due to the data collection and reporting change noted above.

DMHC also indicated that the multi-year increase in the Advised Complainant result was driven by an increase in the number of complaints that were returned to the health plan to complete the first level complaint resolution process before appealing to the DMHC.

The following three figures display the 2021 results for DMHC's most commonly reported complaint reasons.

Figure 4.7

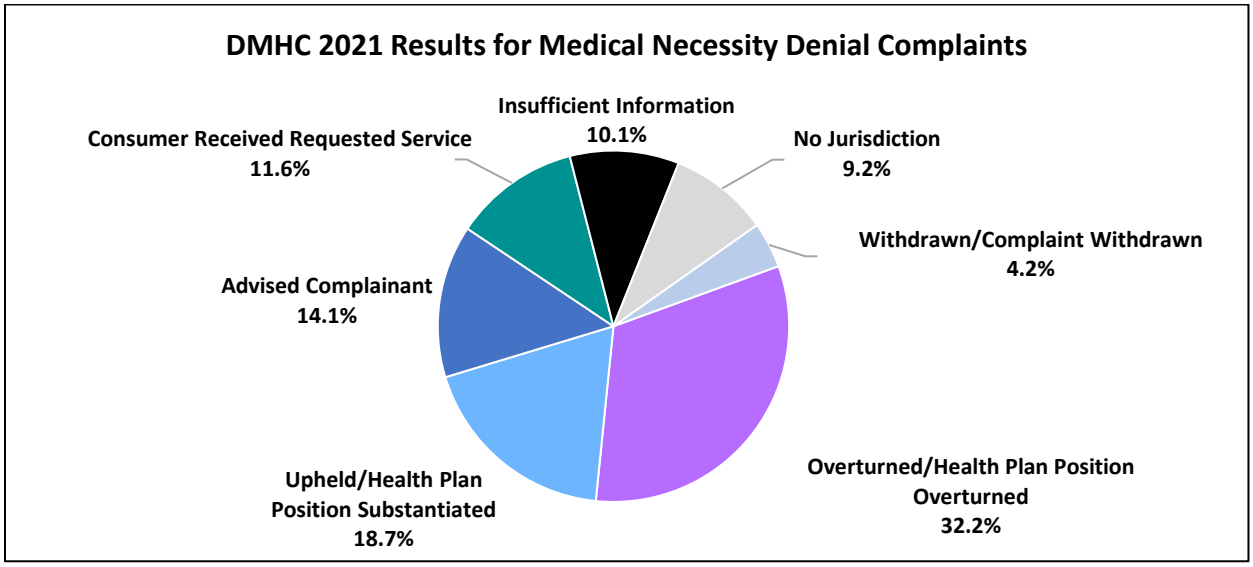


Figure 4.8

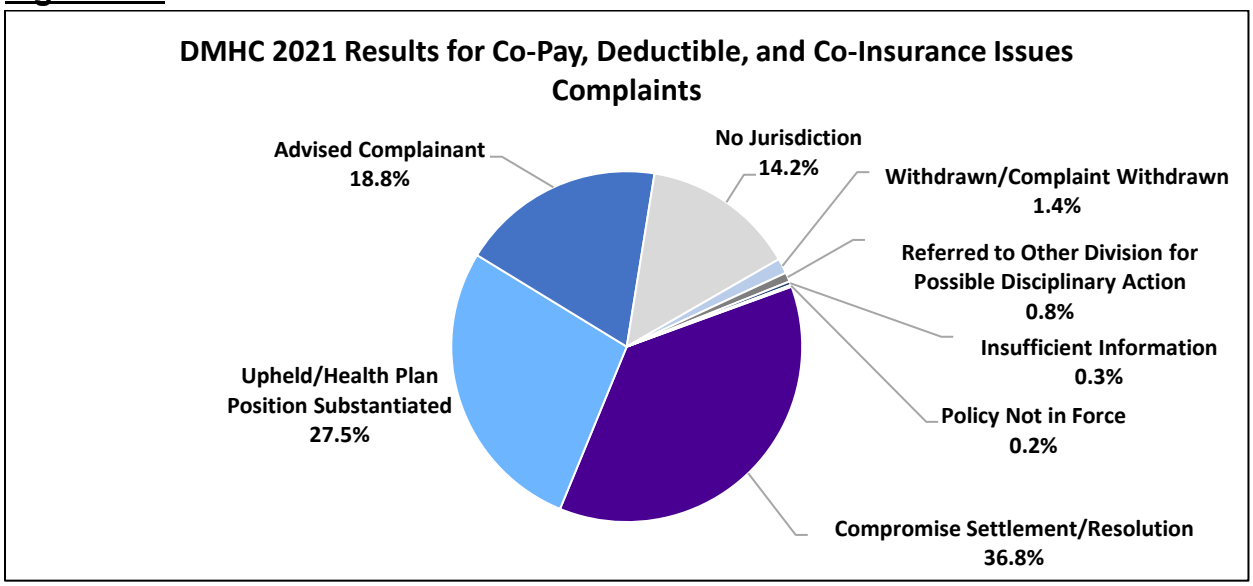
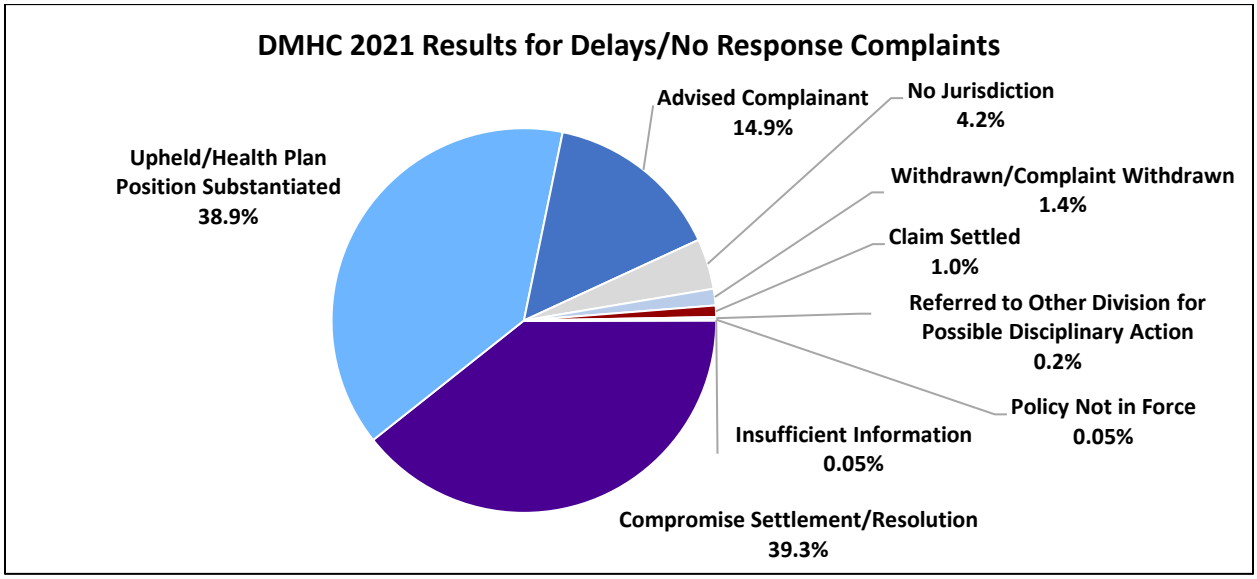


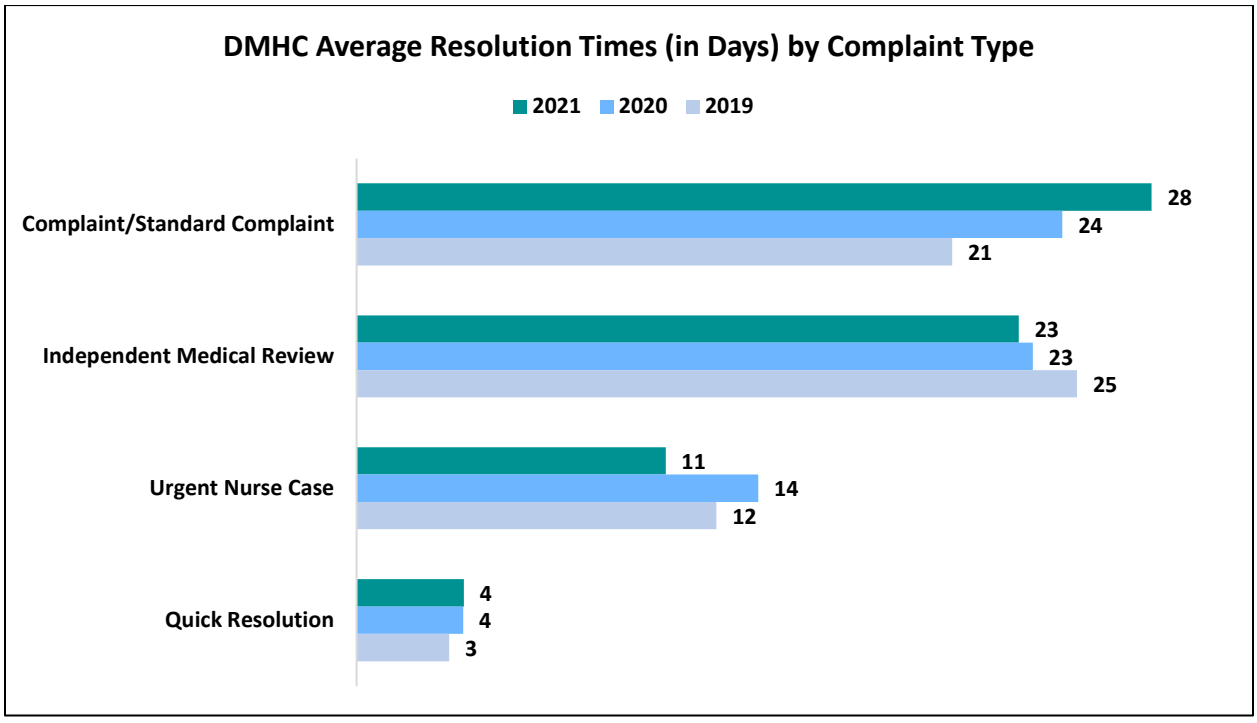
Figure 4.9



Resolution Time

The overall average resolution time of the complaints DMHC closed in 2021 was 26 days. The following chart shows the average resolution times by complaint type for 2019-2021.

Figure 4.10



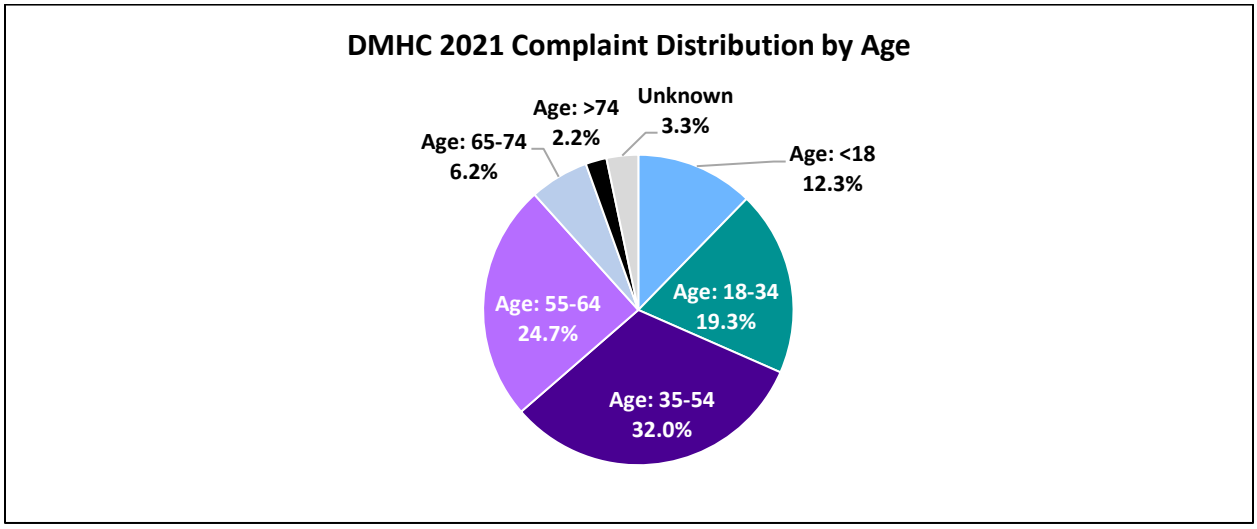
Note: The timeframes for DMHC's time standards are based on the date that the department receives a completed complaint/IMR application. Figures detailing average resolution times include case durations with time prior to the completion of the complaint/IMR application.

C. Demographics and Other Complaint Elements

Age

The average age of the DMHC complainants in 2021 was 43 years old.

Figure 4.11



Medical Necessity Denial was the most common complaint reason for age groups under 65. For ages 65-74, 75 and older, and Unknown, the top reason was Co-Pay, Deductible, and Co-Insurance Issues.

Gender

Most of the DMHC 2021 complaints were submitted with gender as Female (53.1%), followed by Male (37.6%), Unknown (8.6%), and Other (0.7%).

DMHC noted that the department changed its demographic collection process starting in MY 2021 to be more reflective and respectful of complainants' gender identity. As a result, there was an increase in the volume of cases with gender submitted as Unknown compared to prior years. The impact of the increase in cases without gender identified on the known categories cannot be determined.

Race and Ethnicity

More than a third of the DMHC 2021 complaints did not have race or ethnicity identified (35.7% Refused). Distributions of complaints with race identified were similar to prior years, with White accounting for the most cases (36.0%), followed by Asian (6.6%), Black or African American (4.3%), Other (4.2%), Other Pacific Islander (0.6%), American Indian or Alaska Native (0.5%), and Native Hawaiian (0.1%). Nearly 12 percent (11.9%) of the cases identified the complainant's ethnicity as Hispanic or Latino.

Language

The distribution of DMHC's 2021 complaints by the complainant's primary language was similar to the prior two years. Most (94.0%) complaints had English identified, followed by Spanish (3.8%), and Other languages combined (2.1%).

Medical Necessity Denial was the top complaint reason for English-speaking complainants (15.8% of English). Quality of Care was the top reason for Spanish-speaking complainants (14.8% of Spanish). Co-Pay, Deductible, and Co-Insurance Issues was the top reason for Other languages (15.7% of Other).

Mode of Contact

The Online mode of contact was the most common way complaints were initiated with DMHC (accounting for 58.2% of the 2021 complaints), followed by Mail (21.9%), Fax (10.5%), Email (6.6%), and Telephone (2.8%).

The Online and Email modes of contact both increased in volume for the third straight year. The volume of complaints initiated by Mail fell for the fifth straight year. The volume initiated by Fax decreased by 20 percent from the prior year.

Regulator

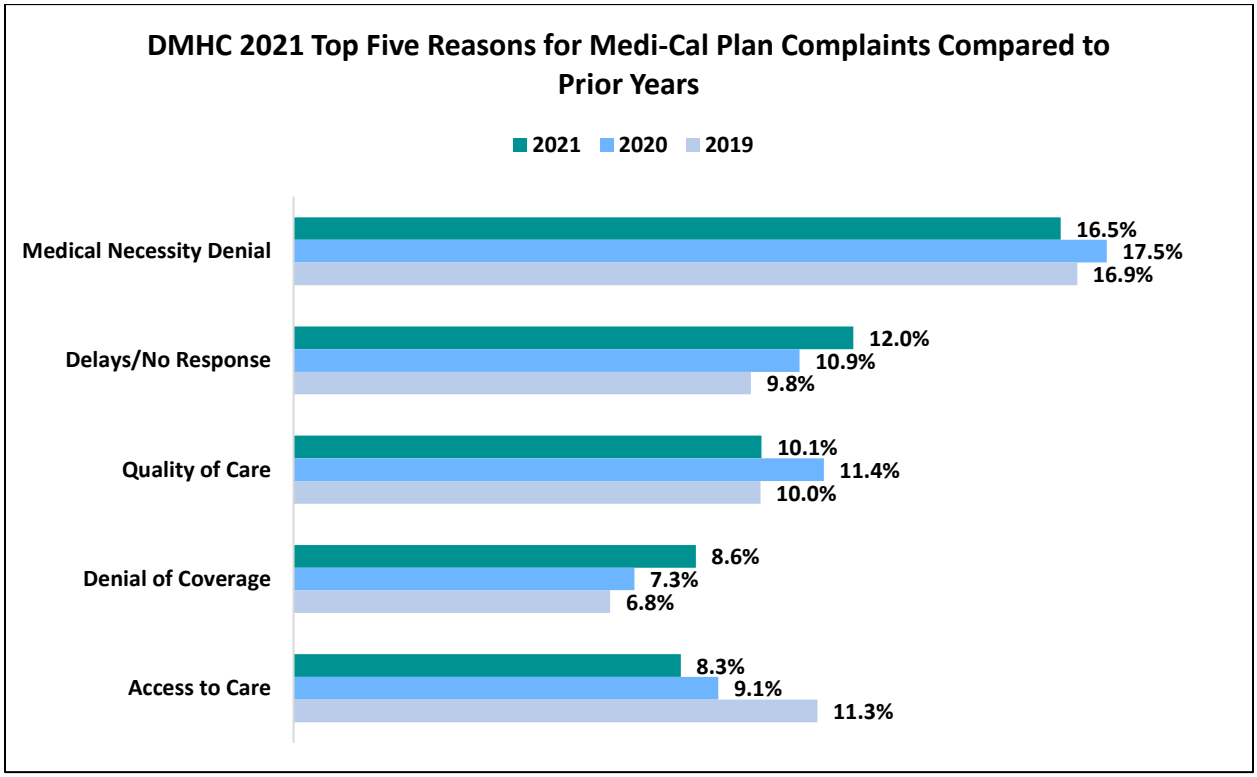
The distribution of DMHC's 2021 complaints by regulator was similar to prior years. DMHC was the regulator identified for ninety percent (90.3%) of the complaints, followed by the U.S. Department of Labor (2.5%), Centers for Medicare and Medicaid Services (2.1%), Other (1.5%), California Department of Insurance (1.4%), Out-of-State Department of Insurance (0.9%), No Regulator (0.8%), U.S. Office of Personnel Management (0.3%), and Unknown (0.1%).

Source of Coverage

Half of DMHC's 2021 complaints involved the Group source of coverage (50.5% of the 16,025 complaints). Other reported sources of coverage: Medi-Cal (16.0%), Individual/Commercial (12.8%), Covered California/Exchange (12.2%), CalPERS (3.0%), Medicare (2.5%), Medi-Cal/Medicare (1.4%), Unknown (1.0%). Three categories accounted for under one percent: COBRA, State Specific (Other), and Uninsured.

For 2021, DMHC reported 2,571 complaints with Medi-Cal identified as the source of coverage. The following chart displays the top reasons for these Medi-Cal plan complaints, along with the 2019 and 2020 data for the same categories.

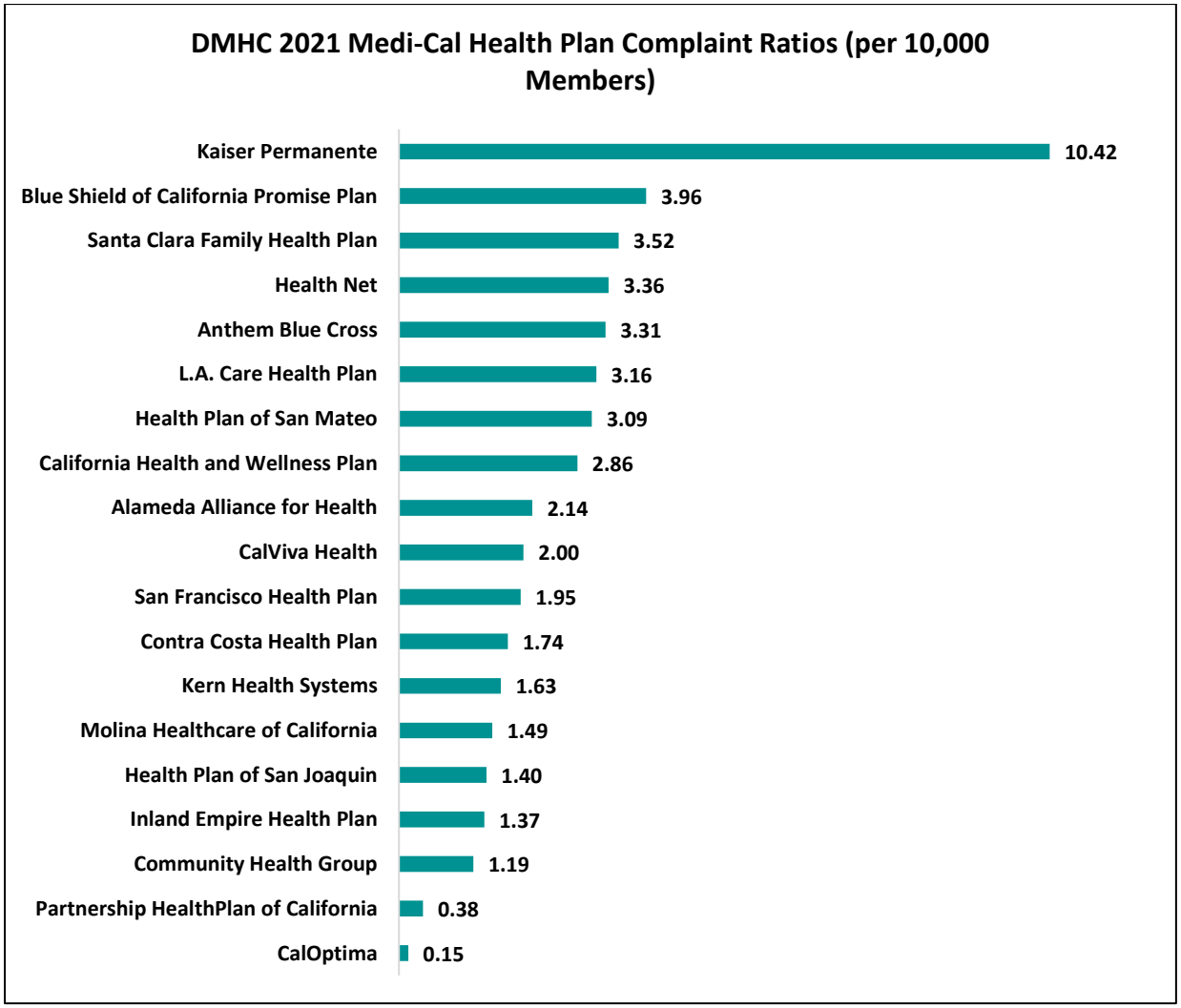
Figure 4.12



Note: The number of Medi-Cal plan reasons exceeded the number of complaints because some cases had more than one reason reported (3,746 reasons from 2,571 complaints in 2021). Difference between measurement years may be due in part to changes in data reporting rather than changes in incidence.

The following chart displays ratios of complaints per 10,000 plan members for Medi-Cal managed care plans with complaints closed by DMHC in 2021.

Figure 4.13 DMHC 2021 Medi-Cal Plan Complaint Ratios (per 10,000 Members)

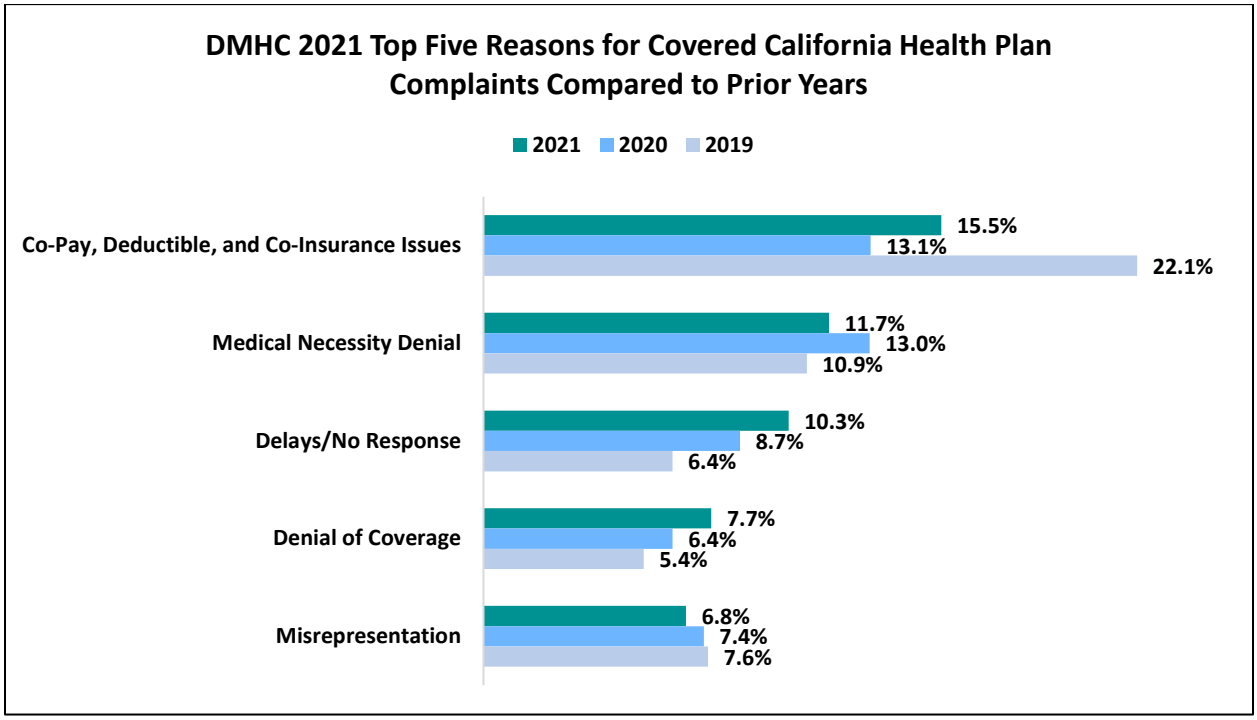


Note: The display excludes Medi-Cal managed care plans with enrollment under 70,000 members and/or 10 or fewer complaints in 2021.

For 2021, DMHC reported 1,954 complaints with Covered California/Exchange identified as the source of coverage. DMHC regulates most of the health plans offered through the Covered California marketplace.

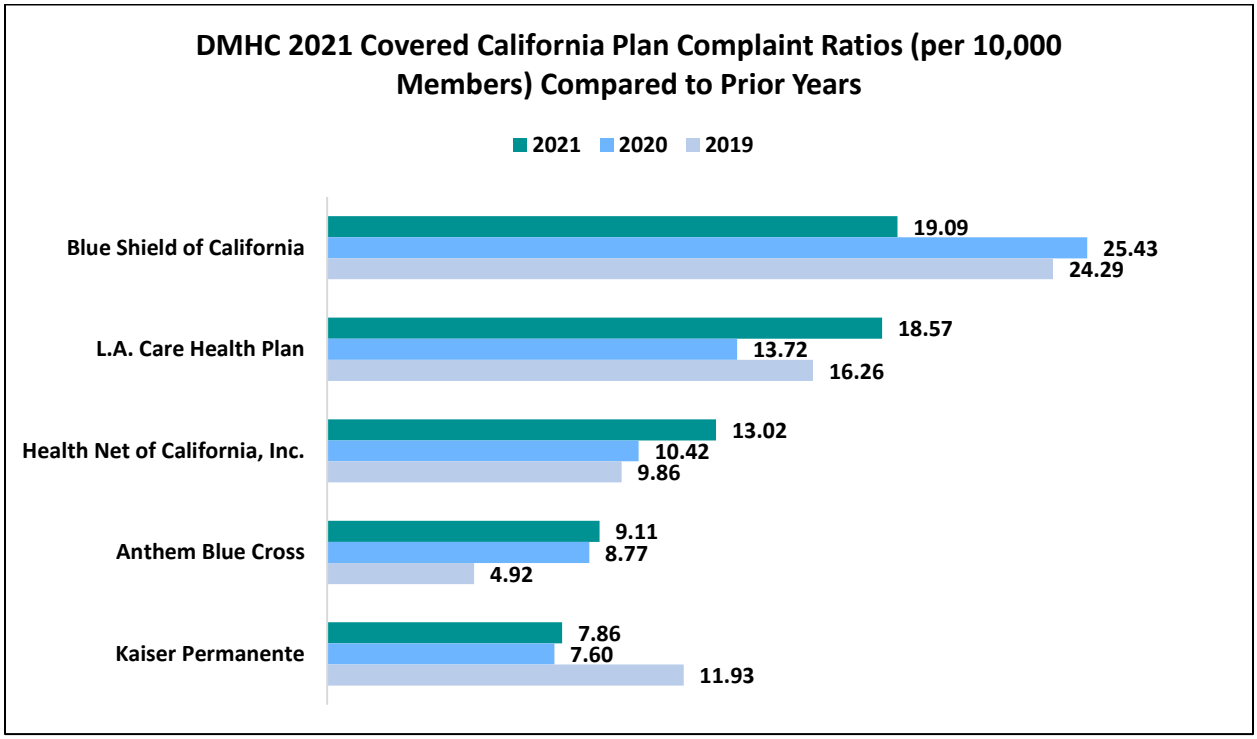
Figures 4.14-4.15 address these Covered California plan complaints.

Figure 4.14



Note: The number of reasons exceeded the number of complaints because some cases had more than one reason reported (2,794 reasons from 1,954 complaints in 2021). Differences between measurement years may be due in part to changes in reporting rather than changes in incidence.

Figure 4.15



Note: The display excludes Covered California plans with enrollment under 70,000 members and/or 10 or fewer complaints in 2021.

Product Type

DMHC reported health plan models under product type. The distribution of DMHC's 2021 complaints by product type was similar to prior years. HMO continued to account for most of the complaints (61.3% in 2021), followed by PPO (30.6%), EPO (3.5%), POS (2.8%), and Other product types combined (0.7%). Approximately one percent did not have a product type identified (1.1% Unknown).

D. Consumer Assistance Center Details

The DMHC Help Center received 130,197 requests for assistance from consumers in 2021, including 106,641 requests by telephone.

Figure 4.16 DMHC Help Center – 2021 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	3,120
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	70,988
Number of Jurisdictional Inquiry Calls*	16,352
Number of Non-Jurisdictional Calls*	6,650
Average Number of Calls Received per Jurisdictional Complaint Case (including follow-up calls after a complaint is filed)	2.44
Average Wait Time to Reach a CSR	04:51
Average Length of Talk Time (time between a CSR answering and completing a call)	09:04
Average Number of CSRs Available to Answer Calls (during Service Center hours)	8 per day

**The Help Center agents handled 32,533 calls in 2021, of which 23,002 were inquiries recorded as jurisdictional (16,305) and non-jurisdictional (6,697).*

Consumer Assistance Protocols and Systems

DMHC reported the following updates made in 2021 by the Help Center's Independent Medical Review and Complaint Branch to improve staff training and tools related to its complaint protocols and systems:

- Updated staff training on the collection of complainant demographic information in its record-keeping system.
- Created a new customer service policy document outlining expectations of Help Center staff related to telephone contacts, voicemail and email box management, and written interactions.
- Updated, and adapted to an electronic format, its audit tool for internally reviewing a Help Center analyst's handling of a Standard Complaint case.
- Revised its training manual for processing an IMR.
- Developed a new policy and procedure for the review of IMR case documents prior to dispatch to the contracted review organization.

Section 5 – Department of Health Care Services

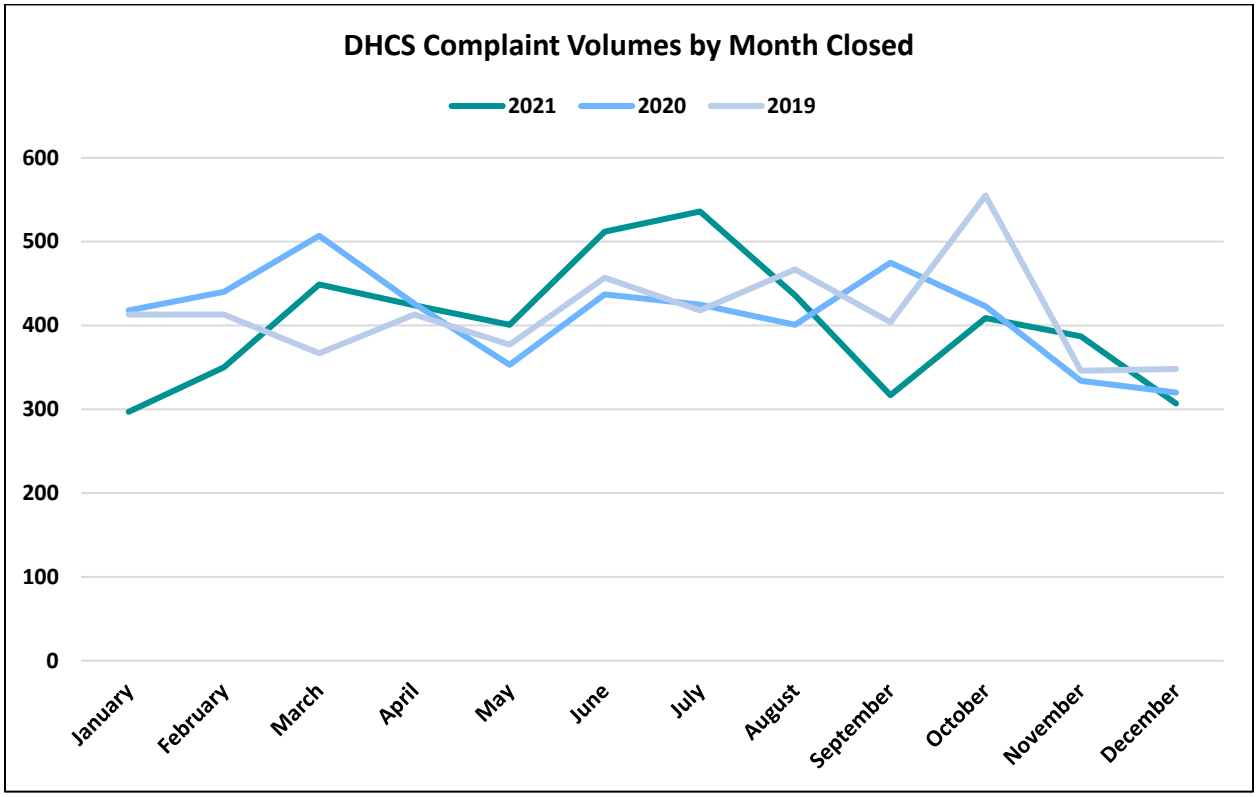
A. Overview

The Department of Health Care Services (DHCS) operates the Medi-Cal program, which is a public health care program that provides comprehensive health care services at no or low-cost for low-income Californians. In 2021, approximately 14 million people received services from the Medi-Cal program. At the time of this report publication, this number is nearly 15 million.

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

DHCS reported 1,305,157 requests for assistance from consumers in 2021, including 4,825 State Fair Hearings and 1,300,332 inquiries to the three DHCS service centers. The following chart displays the monthly volumes for the 4,825 complaints in 2021, the 4,959 complaints in 2020, and the 4,978 complaints in 2019.

Figure 5.1



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

Figure 5.2 Medi-Cal State Fair Hearing Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2021
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on Medi-Cal appeals. Administrative Law Judges make decisions. Urgent clinical issues may qualify for an expedited hearing.	90 days from the hearing request date	49 days

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

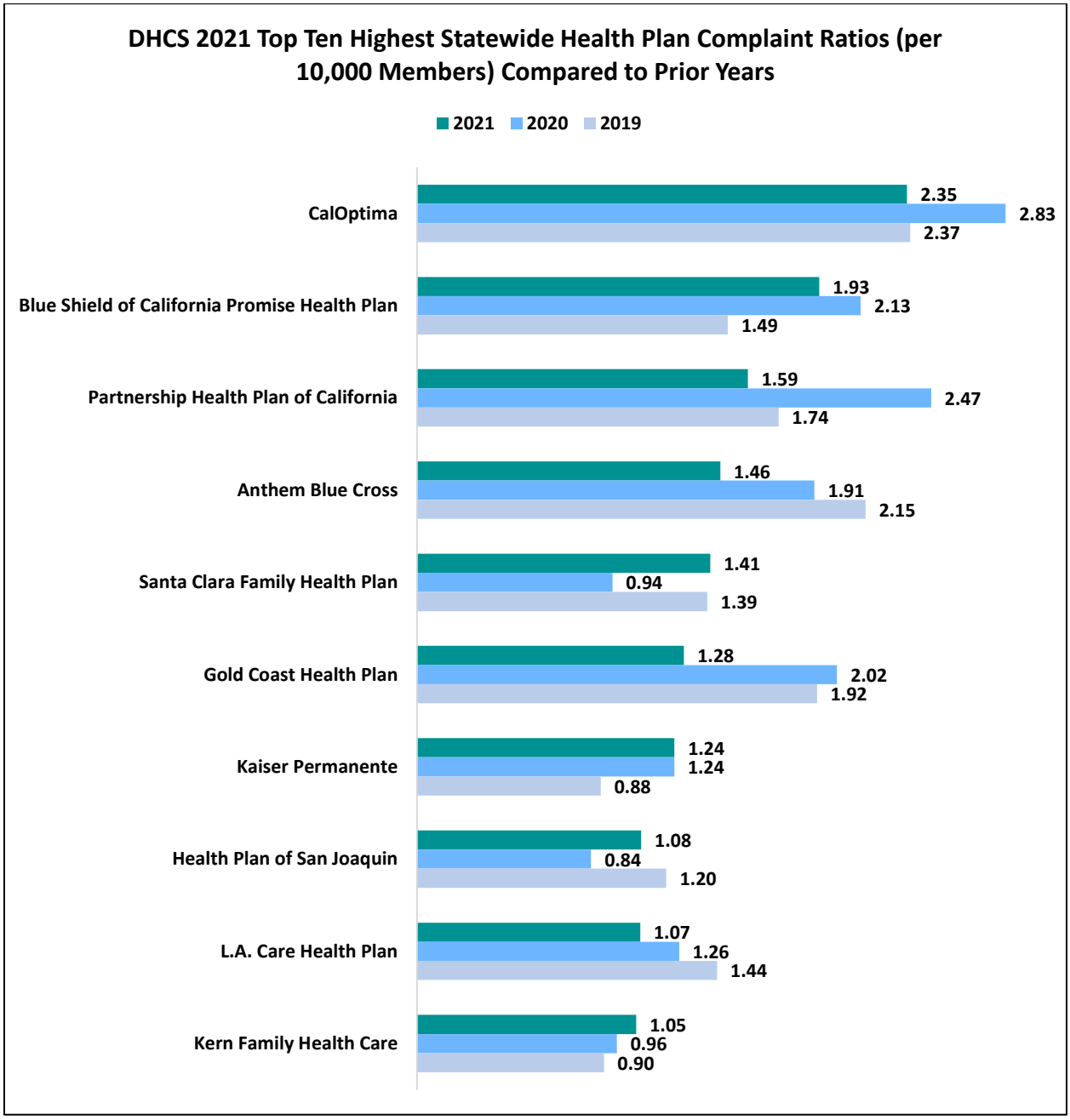
B. Complaint Ratios, Reasons, and Results

DHCS reported State Fair Hearings for the California Children's Services program for the first time in 2021. These complaints accounted for less than one percent of the department's overall complaint volume.

Health Plan Complaint Ratios

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

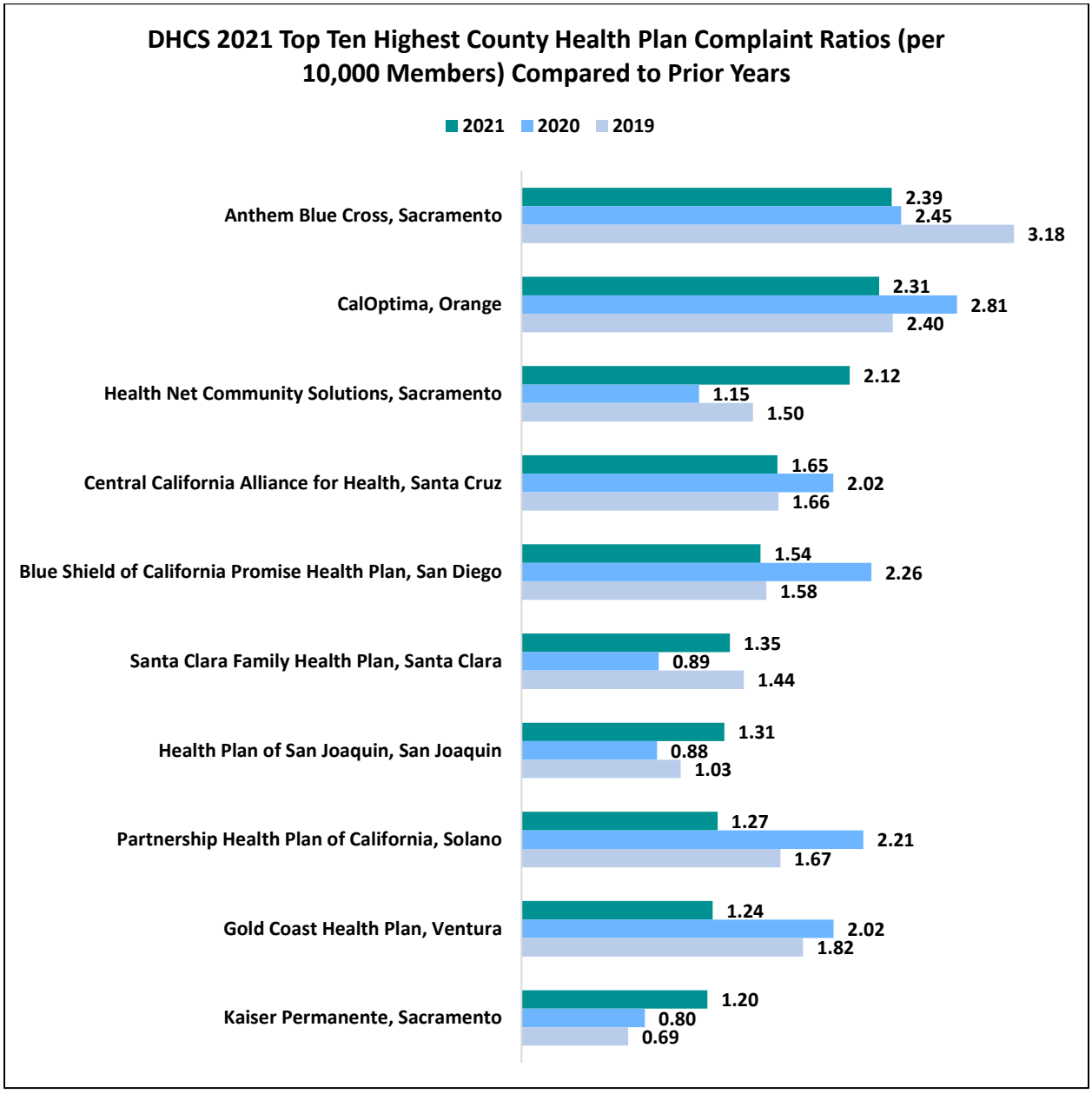
Figure 5.3



Note: The display excludes Medi-Cal plans with 2021 statewide enrollment under 70,000 members. CDII combined data for plans that serve multiple counties, including under different Medi-Cal contract models. DHCS reports may vary because the department typically monitors quality issues by county contract.

The following chart shows ratios of the Medi-Cal managed care plans' State Fair Hearings per 10,000 plan members in the top ten highest counties.

Figure 5.4

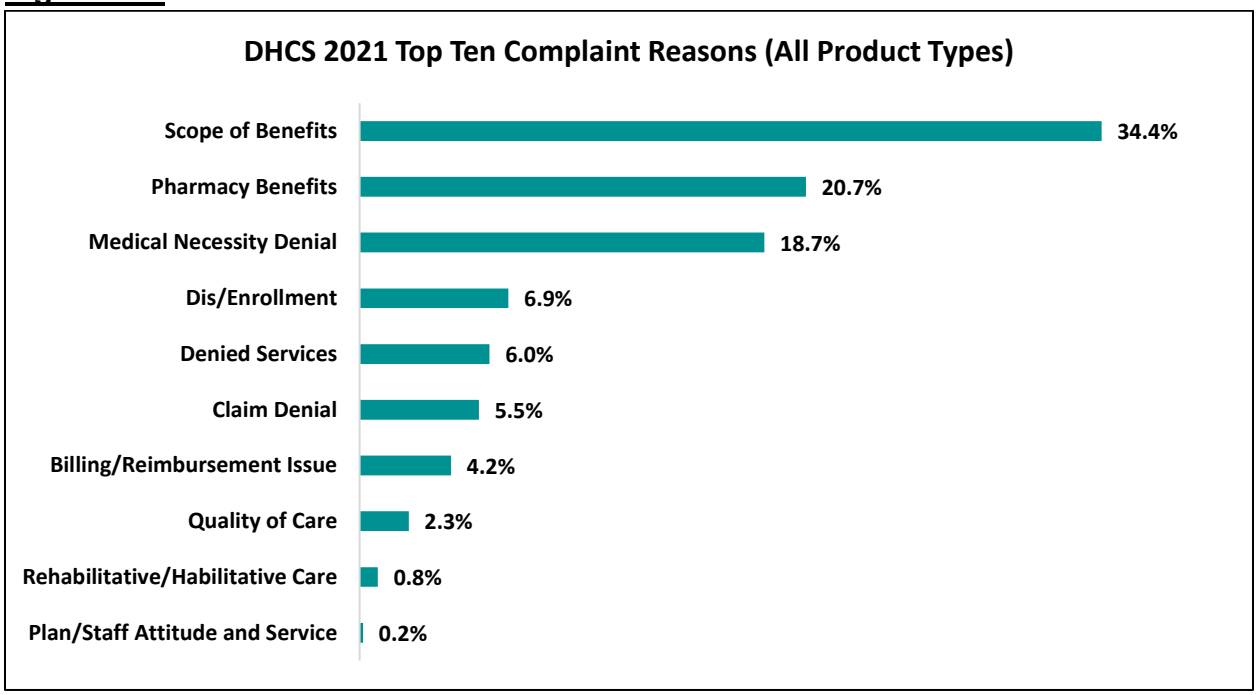


Note: The display excludes plans with 2021 county Medi-Cal enrollment under 70,000 members. Three Medi-Cal managed care contract models are represented. County Organized Health System (COHS) model: CalOptima in Orange County, Central California Alliance for Health in Santa Cruz County, Partnership Health Plan of California in Solano County, and Gold Coast Health Plan in Ventura County. Geographic Managed Care model: Anthem Blue Cross in Sacramento County, Health Net Community Solutions in Sacramento County, Blue Shield of California Promise Health Plan in San Diego County, and Kaiser Permanente in Sacramento County. Two-Plan model: Santa Clara Family Health Plan in Santa Clara County and Health Plan of San Joaquin in San Joaquin County. None of the plans under the Imperial, Regional, or San Benito models met the enrollment threshold for display consideration.

Complaint Reasons

The following chart displays the top complaint reasons in 2021 for all submitted DHCS delivery systems, which were reported to CDII as product types. Difference between measurement years may be due in part to changes in reporting rather than changes in incidence.

Figure 5.5



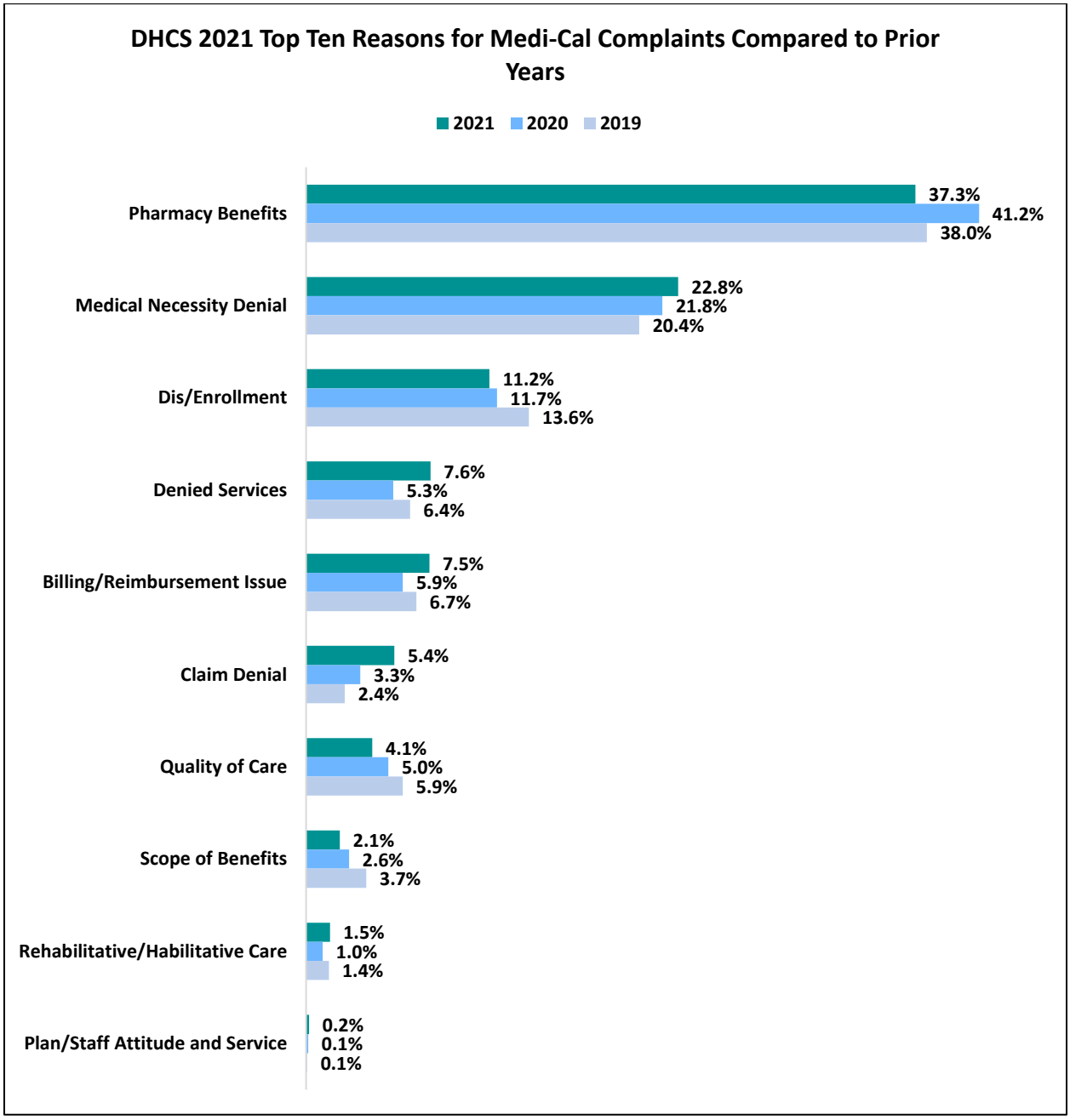
Note: The number of complaint reasons exceeded the number of complaints because some cases had more than one reason reported (4,835 reasons from 4,825 complaints in 2021).

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

- Dental – Scope of Benefits (79.4%)
- Fee-for-Service – Pharmacy Benefits (54.6%)
- Managed Care – Pharmacy Benefits (37.3%)
- Long Term Care – Dis/Enrollment (50.0%)
- Mental Health – Denied Services (100.0%)
- Medi-Cal Coordinated Care – Denied Services (36.4%)
- California Children's Services – Denied Services (70.0%)

The following figure shows the most common complaint reasons in 2021 for Medi-Cal Managed Care and Fee-for-Services, as well as the 2019 and 2020 data for those same reason categories.

Figure 5.6



Note: This display shows Medi-Cal Managed Care and Fee-for-Service delivery systems only, and excludes volumes submitted with product types of Medi-Cal Dental, Medi-Cal Behavioral Health, Medi-Cal Coordinated Care, Long Term Care, and California Children's Services. Difference between measurement years may be due in part to reporting changes rather than changes in incidence.

Inquiry Topics and Referrals

Figures 5.7-5.9 display the most common inquiry topics consumers contacted the DHCS service centers about in 2021, as well as the department or other service center to which the consumers were referred.

Figure 5.7 Office of the Ombudsman 2021 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	2021 Volume	Organization(s) Referred To
1 (most common)	Medi-Cal Eligibility	43,048	County Medi-Cal Office
2	Fee-For-Service	7,242	Medi-Cal Telephone Service Center
3	Health Care Options	4,404	Health Care Options
4	Medicare	4,106	Medicare
5	Mental Health	3,224	County Mental Health Program
6	Covered California	2,770	Covered California
7	Medi-Cal Dental	1,830	Medi-Cal Dental
8	State Fair Hearings	1,053	California Department of Social Services

Figure 5.8 Medi-Cal Telephone Service Center 2021 Top Topics for Non-Jurisdictional Inquiries

Ranking	Inquiry Topic	Organization(s) Referred To
1 (most common)	Beneficiary Inquiry/Eligibility	County Medi-Cal Office
2	Beneficiary Inquiry/Eligibility	Managed Care Plan
3	Beneficiary Inquiry/Eligibility	Medi-Cal Dental
4	Beneficiary Inquiry/Eligibility	Medicare
5	Beneficiary Inquiry/Coverage	Pharmacies
6	Beneficiary Inquiry/Coverage	Medicare Part D
7	Beneficiary Inquiry/Coverage	Other Coverage
8	Beneficiary Inquiry/Coverage	Medicare Part D Prescription Low Income Subsidy

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

Figure 5.9 Medi-Cal Dental Telephone Service Center 2021 Top Topics for Non-Jurisdictional Inquiries

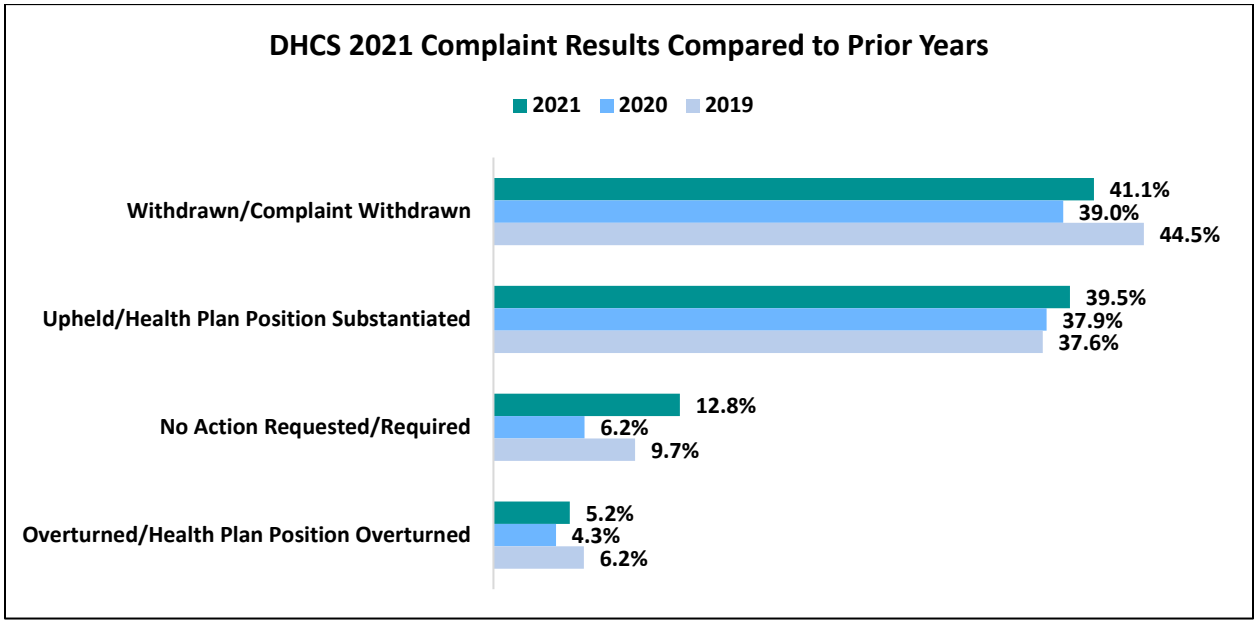
Ranking	Inquiry Topic	2021 Volume	Organization(s) Referred To
1 (most common)	Complaint about Care or Treatment Performed	5,503	California Dental Board
2	Complaint about Provider Office Conduct	1,194	California Dental Board
3	Complaint about Office or Staff	342	California Dental Board
4	Complaint about a Clinical Screening Dentist	227	California Dental Board
5	Complaint - Beneficiary Website	180	Member Outreach
6	Mail not Received	95	Correspondence
7	Received Records	57	Correspondence
8	Medical Necessity	16	California Department of Social Services, State Hearing
9	Excessive long wait time/ appointment schedule time	15	Care Coordination
10	Lack of primary care provider availability	13	Care Coordination

Note: The 2021 volumes are reported through the DHCS dental contractor's Customer Relationship Management system based on system inputs. Data rankings based on the inquiry topic and referral organization is representative of actual captured informational elements.

Complaint Results

The following chart displays the most common complaint results submitted by DHCS for 2021, as well as the 2019 and 2020 data for the same results categories.

Figure 5.10 DHCS 2021 Top Complaint Results Compared to Prior Years



Note: The number of results exceeded the number of complaints because some cases had more than one result reported (4,830 results from the 4,825 complaints in 2021). The display excludes seven results categories with low volumes (under 1%) in 2021. Some differences between measurement years may be due in part to reporting changes rather than changes in incidence. The result category considered as favorable to the complainant is Overturned/Health Plan Position Overturned. The result category considered favorable to the health plan is Upheld/Health Plan Position Substantiated. The favorability of the other categories is neutral or cannot be determined. For DHCS, No Action Requested/Required indicates that the case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.

DHCS indicated that many of the Withdrawn/Complaint Withdrawn cases involve a deferred services issue resolved by the complainant's medical provider before the hearing date and with a favorable outcome for the complainant.

The department also noted that the increase in No Action Requested/Required may reflect a change in the categorization of Fee-for-Service Pharmacy case dismissals rather than a change in incidence.

Figures 5.11-5.13 display the 2021 results for the most common complaint reasons reported by DHCS.

Figure 5.11

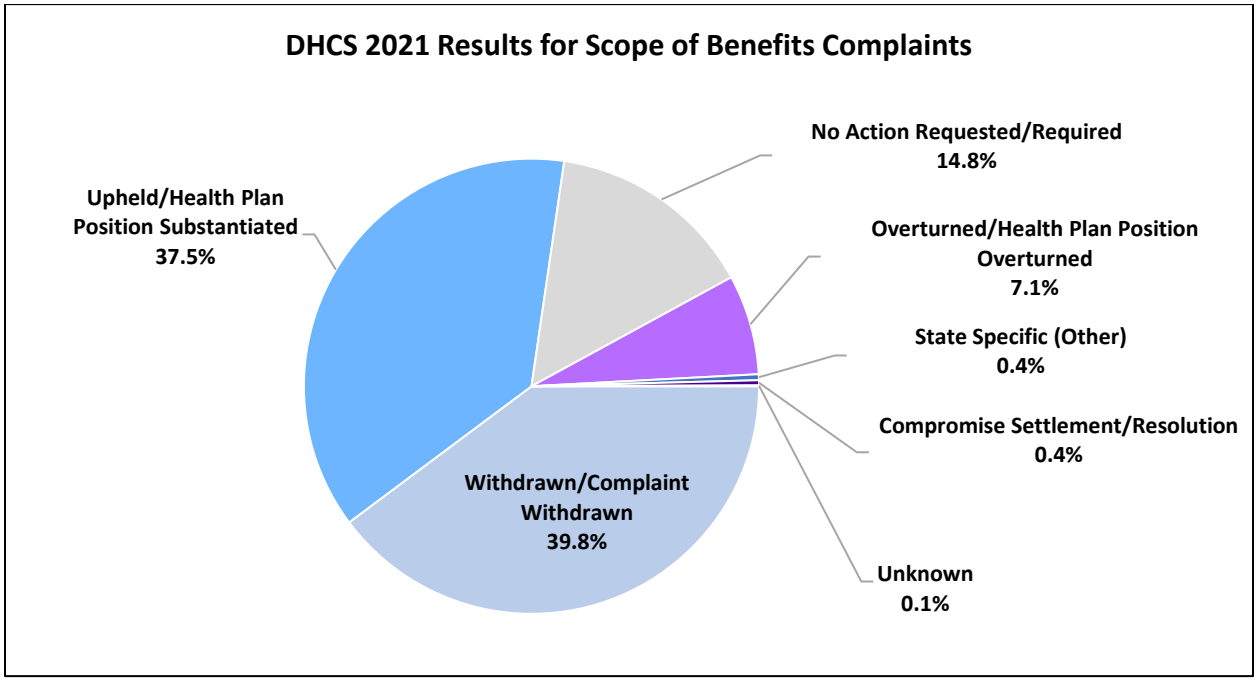


Figure 5.12

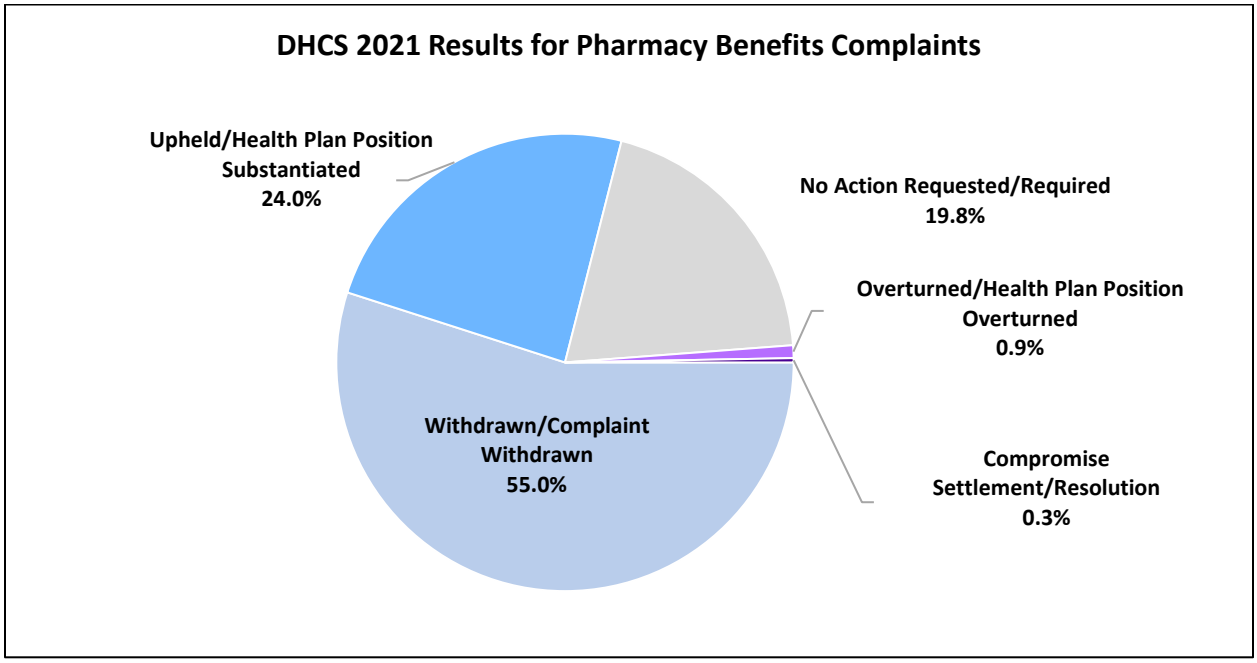
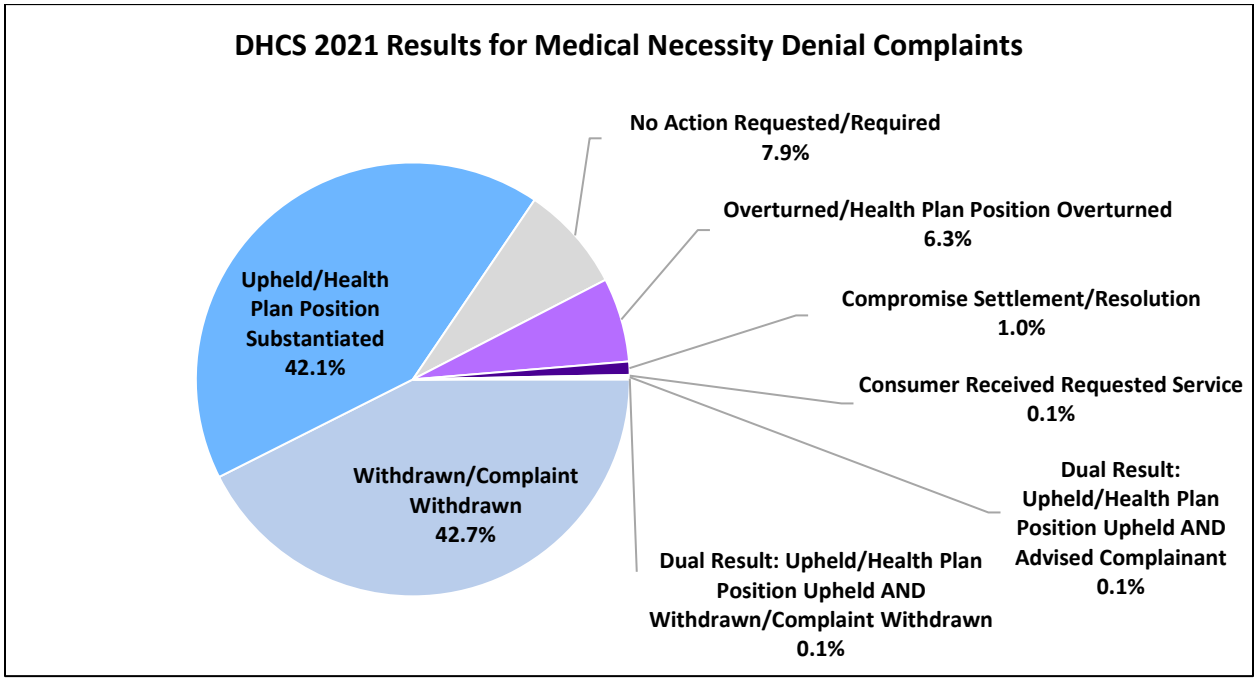


Figure 5.13



Resolution Time

The overall 2021 average resolution time for the DHCS-reported State Fair Hearings was 49 days, a two-day increase from the prior year but still well below the 2015-2019 averages. The 2021 average resolution times by DHCS delivery system:

- Long Term Care – 102 days
- California Children's Services – 75 days
- Managed Care – 73 days
- Mental Health – 72 days
- Medi-Cal Coordinated Care – 65 days
- Fee-for-Service – 45 days
- Dental – 35 days

C. Demographics and Other Complaint Elements

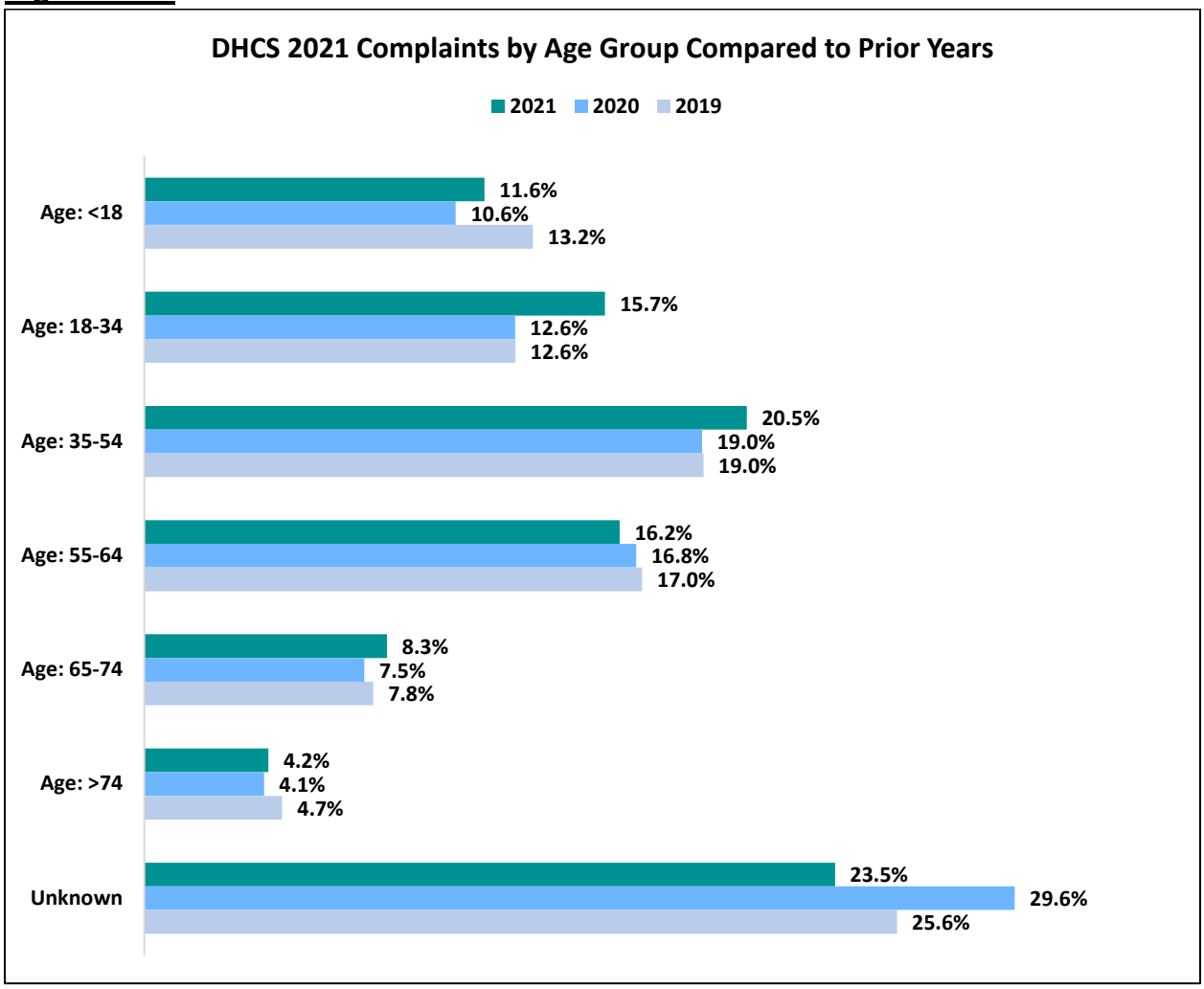
Difference in findings between measurement years may be due in part to changes in data collection and reporting rather than changes in incidence.

Age

Compared to 2020 volumes, the 2021 DHCS complaint volumes increased for all known age groups except for Ages 55-64 and for age Unknown. It cannot be determined how much the decrease in Unknown affected the distributions among the known ages. All

cases with age submitted as Unknown were associated with the Fee-for-Service delivery system.

Figure 5.14



Pharmacy Benefits was the top reason for age Unknown (68% of the reasons for cases with age Unknown). The Under 18 age group's top complaint was Medical Necessity Denial (52% of the Under 18 reasons), while Scope of Benefits was the most common reason reported in 2021 for known age groups 18 and over (accounting for between 46-56% of the age groups' reasons).

DHCS noted that the difference in top reasons for Under 18 compared to the other age groups may be attributable to the Medi-Cal Dental program, which accounts for the largest segment of State Fair Hearing filings and has a high level of age data capture. Within Medi-Cal Dental:

- Some types of dental services are more limited for adults than for children, resulting in more adults facing denials due to the scope of covered benefits.

- Laws such as Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) inherently provide children more rights to dental services than adults, resulting in more cases for medical necessity denial issues as the covered benefits are used.

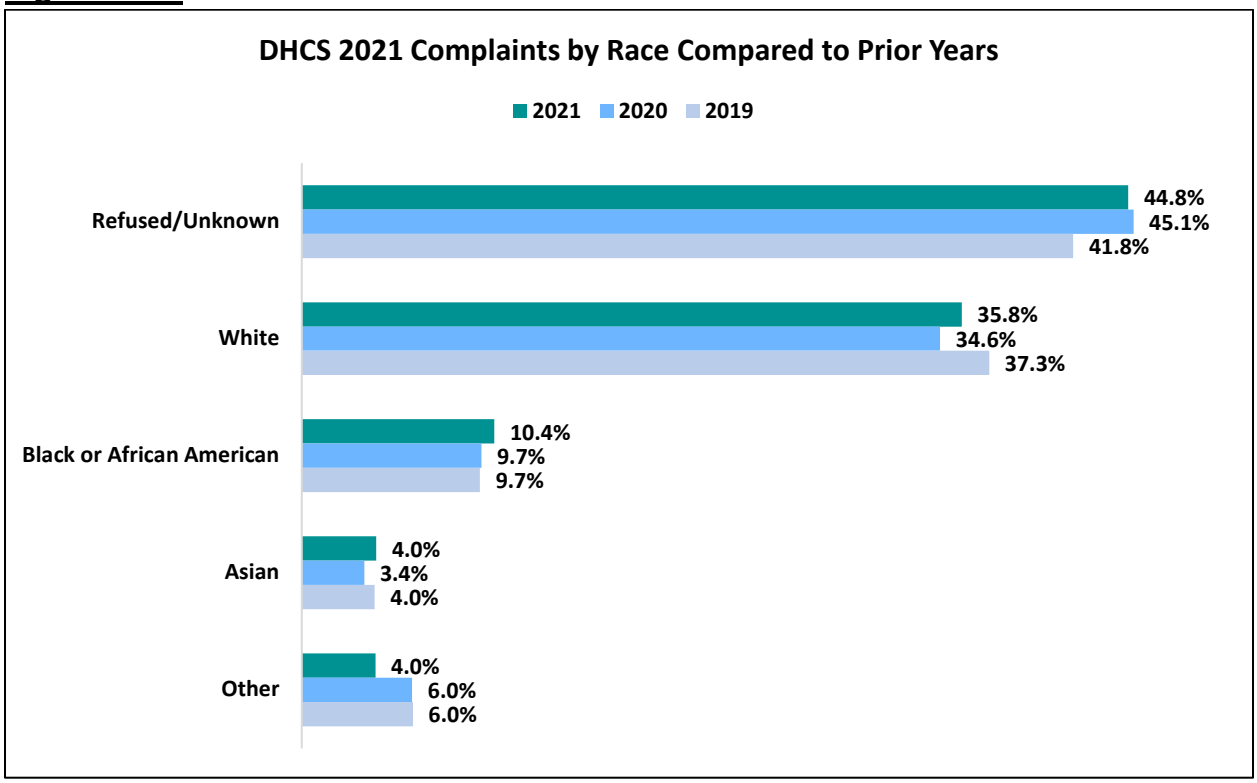
Gender

DHCS and CDSS do not collect gender data as part of the Medi-Cal enrollment process or for State Fair Hearing filings. The data submitted to CDII under gender represents data collected about sex. Nearly half (47.2%) of the 2021 complaints were submitted listing the complainant as Female and about 29 percent as Male (29.3%). The remainder did not have gender identified (23.5% Unknown).

Race

Nearly 45 percent (44.8%) of the 2021 DHCS complaints did not have race identified (40.4% Unknown and 4.4% Refused).

Figure 5.15



Note: The display excludes the following reported race categories with low volumes (each under 1% for all three years shown): American Indian or Alaska Native, Other Pacific Islander, and Native Hawaiian or Other Pacific Islander.

Ethnicity

Approximately 42 percent of the DHCS 2021 complaints did not have ethnicity identified (37.9% Unknown and 4.4% Refused). Around 39 percent (39.2%) of the 2021 complaints listed the complainant's ethnicity as Not Hispanic or Latino. Hispanic or Latino accounted for over 18 percent (18.5%) of the complaints, with a slight increase (3%) in complaint volume compared 2020.

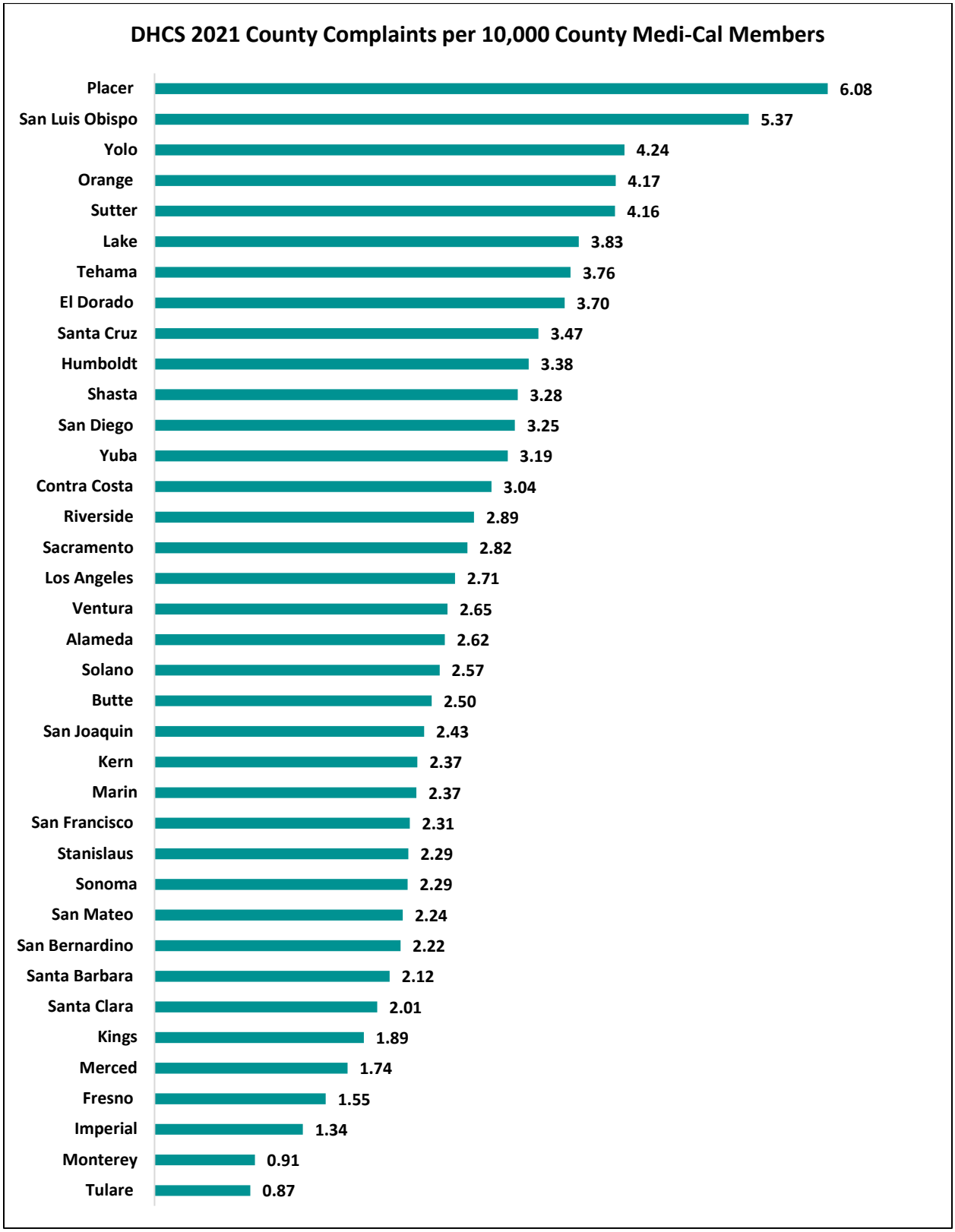
Language

From 2020 to 2021, there was a nearly 26 percent decrease in the volume of complaints without the complainant's primary language identified (Refused/Unknown). English continued to be reported as the primary language for most of the complainants (66.4% of the 4,825 complaints in 2021). Spanish accounted for approximately seven percent (7.1%). Other languages combined accounted for nearly three percent (2.9%). For the Other combined distribution, the 13 reported languages included each had low volumes under one percent in 2021.

County of Residence

The following chart displays county ratios based on each county's 2021 volume of complaints divided by the number of Medi-Cal beneficiaries in the county that year.

Figure 5.16



Note: The above display excludes counties with fewer than 10,000 Medi-Cal beneficiaries and/or 10 or fewer complaints in 2021.

Most of the California counties (42 out of 58) had a lower complaint ratio in 2021 than the prior year.

Mode of Contact

Mail continued to be the most common mode of contact for initiating DHCS complaints in 2021 (36.6% of the 4,825 complaints), followed by Telephone (32.6%) and Online (under 1%). Approximately 30 percent did not have the mode of contact identified (30.2% Unknown).

Regulator

The distribution of the 2021 complaints by regulator was similar to prior years, with Other accounting for most complaints (73.1% of the 4,825 complaints) and DMHC for the remainder (26.9%).

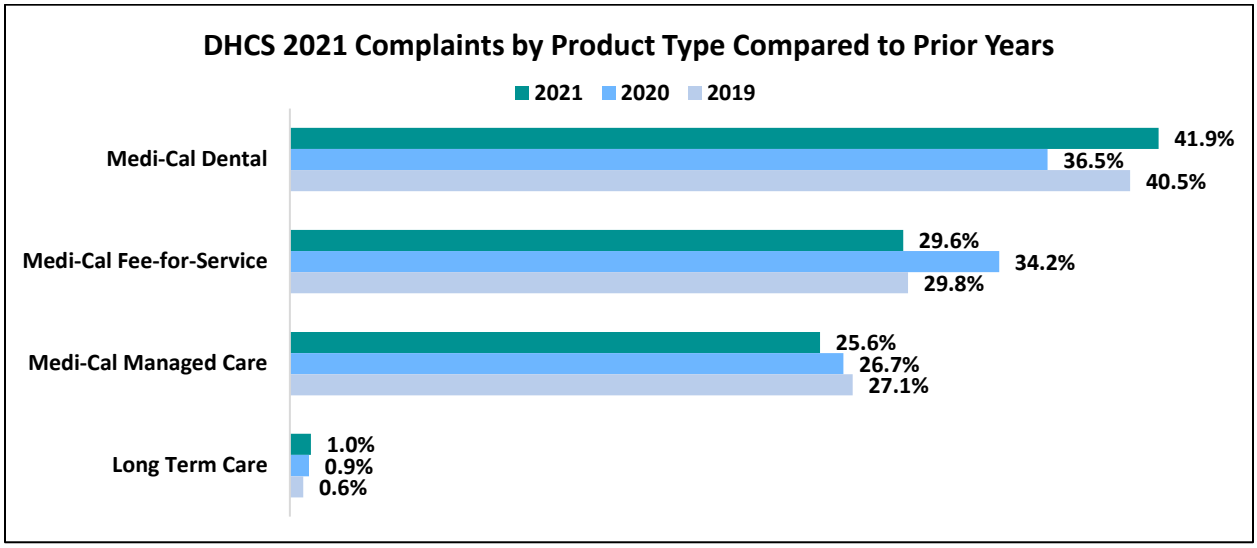
Source of Coverage

Nearly all (98.8%) of the DHCS 2021 complaints involved the Medi-Cal source of coverage. Approximately one percent (1.2%) were for Medi-Cal/Medicare.

Product Type

DHCS reports its health care delivery systems under product type. Starting with measurement year 2021, DHCS submitted State Fair Hearings data about California Children's Services for the first time. This program provides diagnostic and treatments services, medical case management, and physical and occupational therapy services to children under age 21 with certain eligible medical conditions.

Figure 5.17



Note: The chart excludes the following product types with low reported volumes (under 1%) in 2021: Mental Health, Medi-Cal Coordinated Care, and California Children's Services.

D. Consumer Assistance Center Details

DHCS reported that there were 1,300,332 consumer inquiries made in 2021 to its three service centers: the Office of the Ombudsman, Medi-Cal Telephone Service Center, and Medi-Cal Dental Telephone Service Center. All the requests for assistance to these service centers are categorized as inquiries because the service centers do not make determinations for the complaints submitted by DHCS for this report.

- The Office of the Ombudsman received 168,285 inquiries in 2021, a nearly 10 percent decrease from the prior year and the sixth straight annual decrease.
- The Medi-Cal Telephone Service Center received 621,714 inquiries from beneficiaries in 2021, a slight decrease (0.5%) from the prior year.
    - The reported inquiry volumes do not include calls addressed by the service center's Interactive Voice Response system, which also receives requests for assistance from Medi-Cal providers (volumes that could not be separated).
- The Medi-Cal Dental Telephone Service Center received 510,333 inquiries in 2021, an 18 percent increase from the prior year. DHCS reported that this increase may be related to dental offices resuming treatment of patients in 2021 after COVID-19-related closures and limitations in 2020.

Figures 5.18-5.20 show the service centers' monthly inquiry volumes in 2021 compared to the 2019 and 2020 volumes.

Figure 5.18

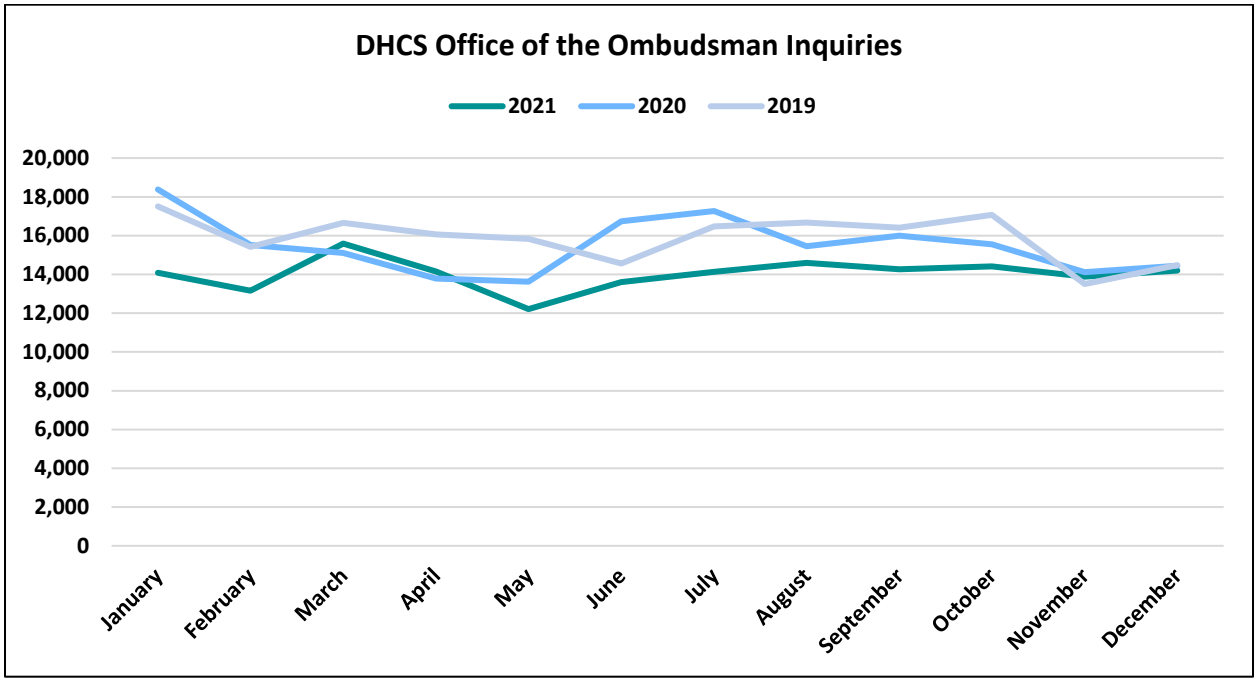


Figure 5.19

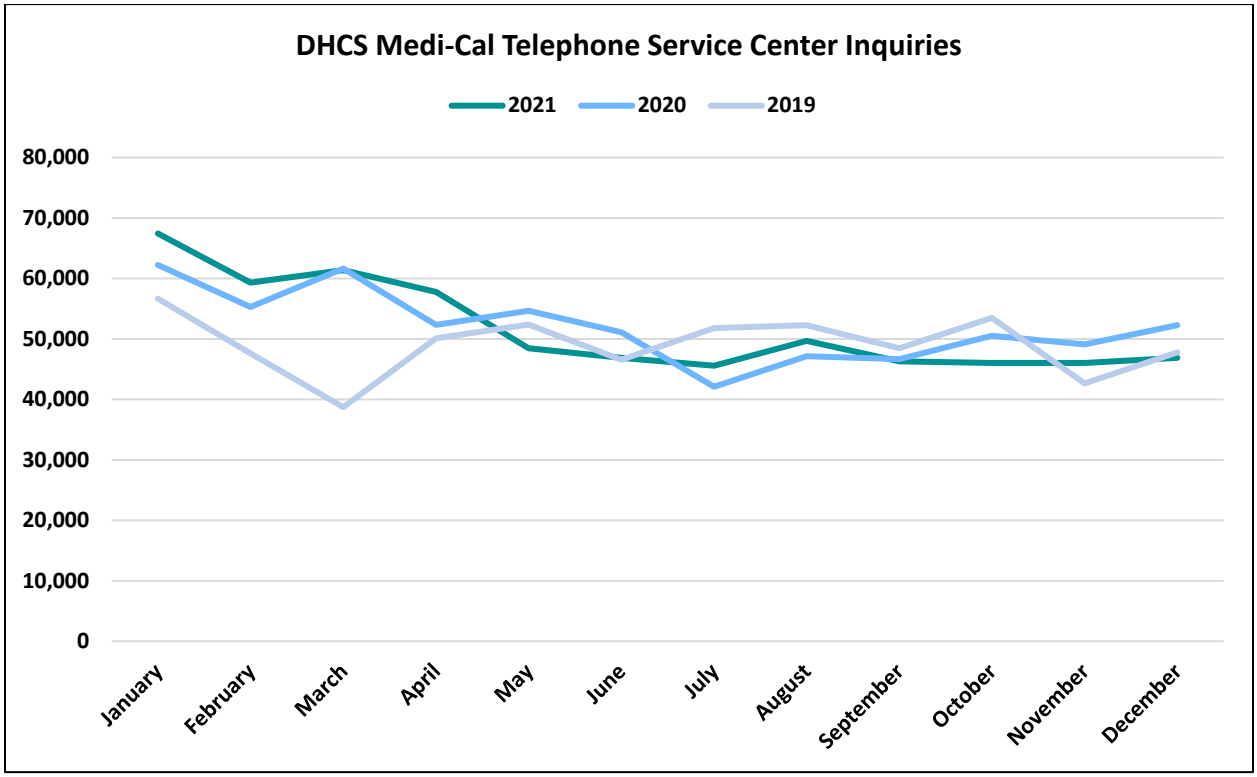


Figure 5.20

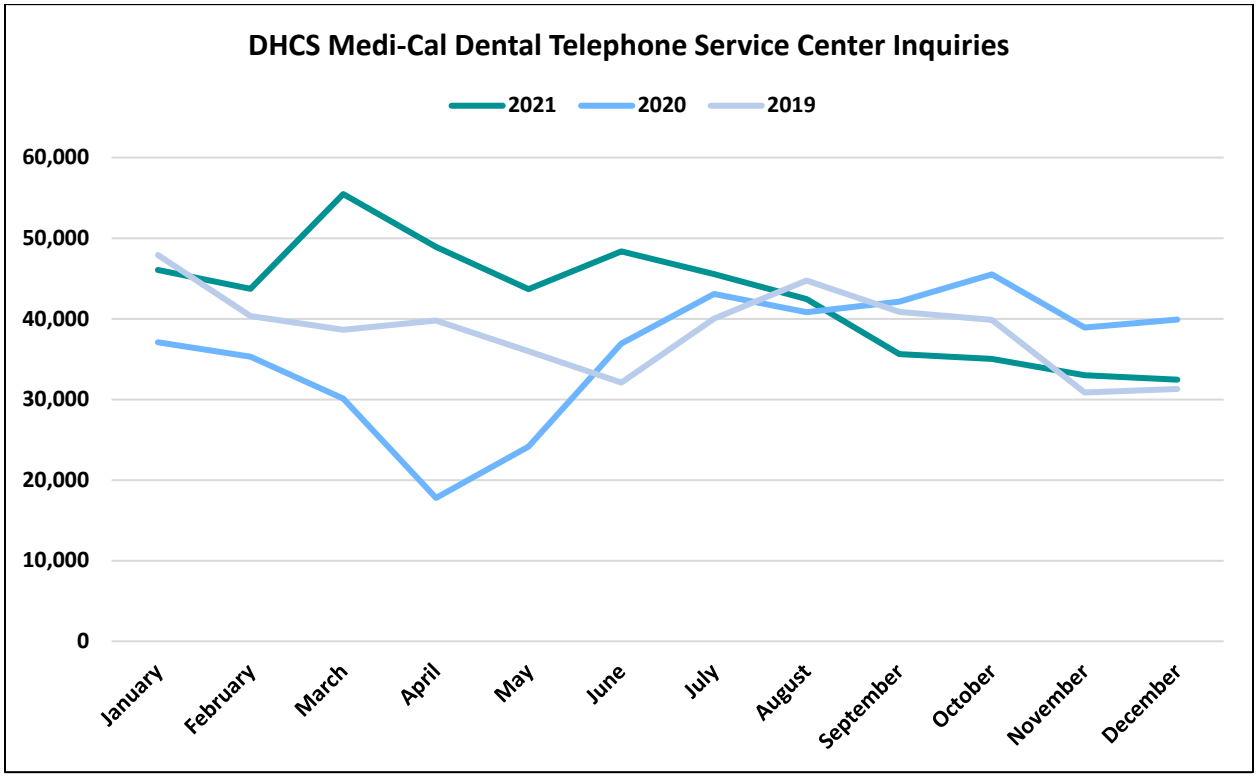


Figure 5.20 shows a marked increase in the number of inquiries in March 2021 and call volumes remaining higher than usual for several months after. DHCS noted that this increase may be related to dental offices reopening and members resuming treatment after COVID-19 closures and limitations, as noted previously. After June 2021, the volume of calls to the Medi-Cal Dental Telephone Service Center returned to more typical levels.

The following table displays the telephone metrics for the three DHCS service centers that reported data to CDII. Like previous years, nearly all of the service centers' inquiries received in 2021 were by telephone (95% of the Office of the Ombudsman inquiries, 100% of the Medi-Cal Telephone Service Center inquiries, and 99% of the Medi-Cal Dental Telephone Service Center inquiries).

Figure 5.21 DHCS Service Centers' 2021 Telephone Metrics

Metric	Office of the Ombudsman	Medi-Cal Telephone Service Center	Medi-Cal Dental Telephone Service Center
Telephone Call Volume	160,130	621,714*	504,965
Number of Abandoned Calls (incoming calls ended by callers prior to reaching a Customer Service Representative-CSR)	8,245	16,691	27,475
Number of Calls Resolved by the Interactive Voice Response (IVR)/ Phone System	67,677	2,689,625**	177,570
Number of Jurisdictional Inquiry Calls	84,208	621,714	499,597
Number of Non-Jurisdictional Calls	Considered the same as calls resolved by IVR	Not available	5,368
Average Wait Time to Reach a CSR	3 minutes	01:00	02:01
Average Length of Talk Time (Between a CSR answering and completing a call)	8 minutes	06:10	09:38
Average Number of CSRs Available to Answer Calls (during service center hours)	18	50 estimated	153

**The Medi-Cal Telephone Service Center telephone call volume includes only jurisdictional inquiries from beneficiaries.*
***The indicated category includes calls from both Medi-Cal beneficiaries and Medi-Cal providers. The beneficiary data could not be separated for reporting.*

Consumer Assistance Protocols and Systems

DHCS did not report any changes to its service centers' protocols or systems for 2021.

Section 6 – California Department of Insurance

A. Overview

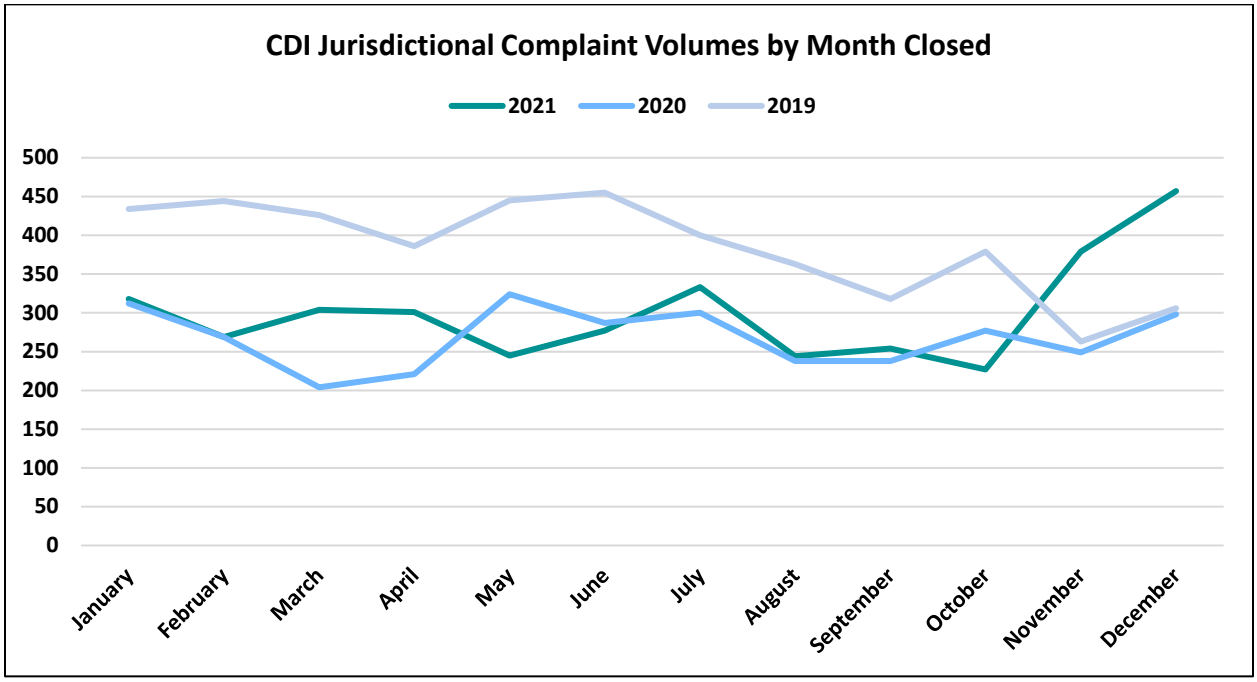
The California Department of Insurance (CDI) licenses and regulates more than 1,400 insurance companies and more than 485,000 insurance agents, brokers, adjusters, bail agents, and business entities. The Consumer Services Division (CSD), within CDI's Consumer Services and Market Conduct Branch, is responsible for responding to consumer inquiries and complaints regarding insurance companies or producers.

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

CDI reported 23,455 requests for assistance from health care consumers in 2021, including 3,608 jurisdictional complaints and 4,069 non-jurisdictional complaints.

The following chart compares CDI's monthly volumes for jurisdictional complaints in 2021 compared to prior years, accounting for 4,619 complaints in 2019, 3,217 complaints in 2020, and 3,608 complaints in 2021.

Figure 6.1



CDI indicated that the 12 percent increase in 2021 complaint volumes compared to the prior year was associated with medical services resuming following COVID-19-related delays and interruptions.

The following table addresses the two different complaint types reported by CDI: Standard Complaint and Independent Medical Review (IMR). The average resolution times noted were based on durations of jurisdictional complaints closed in 2021.

- CDI's complaint duration reflects the date from initial receipt of the complaint to the date the complaint was closed after completion of the final regulatory review.

Figure 6.2 CDI Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Roles	Time Standard	Average Resolution Time in 2021
Standard Complaint	Consumer Communications Bureau: Assistance to callers Health Claims Bureau and Underwriting Services Bureau: Compliance Officers respond to written complaints Consumer Law Unit: Legal review (if needed)	30 working days, or 60 days if reviewed concurrently with the health plan review	43 days Calculation includes time for regulatory review after the case is closed to the complainant
Independent Medical Review (IMR)	Consumer Communications Bureau: Assistance to callers Health Claims Bureau: Intake and casework IMR Organization (contractor – MAXIMUS): Case review and decision Consumer Law Unit: Legal review (if needed) Urgent clinical issues that qualify are addressed through an expedited IMR process	30 working days, or 60 days if reviewed concurrently with the health plan review	62 days Calculation includes time for regulatory review after the case is closed to the complainant

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

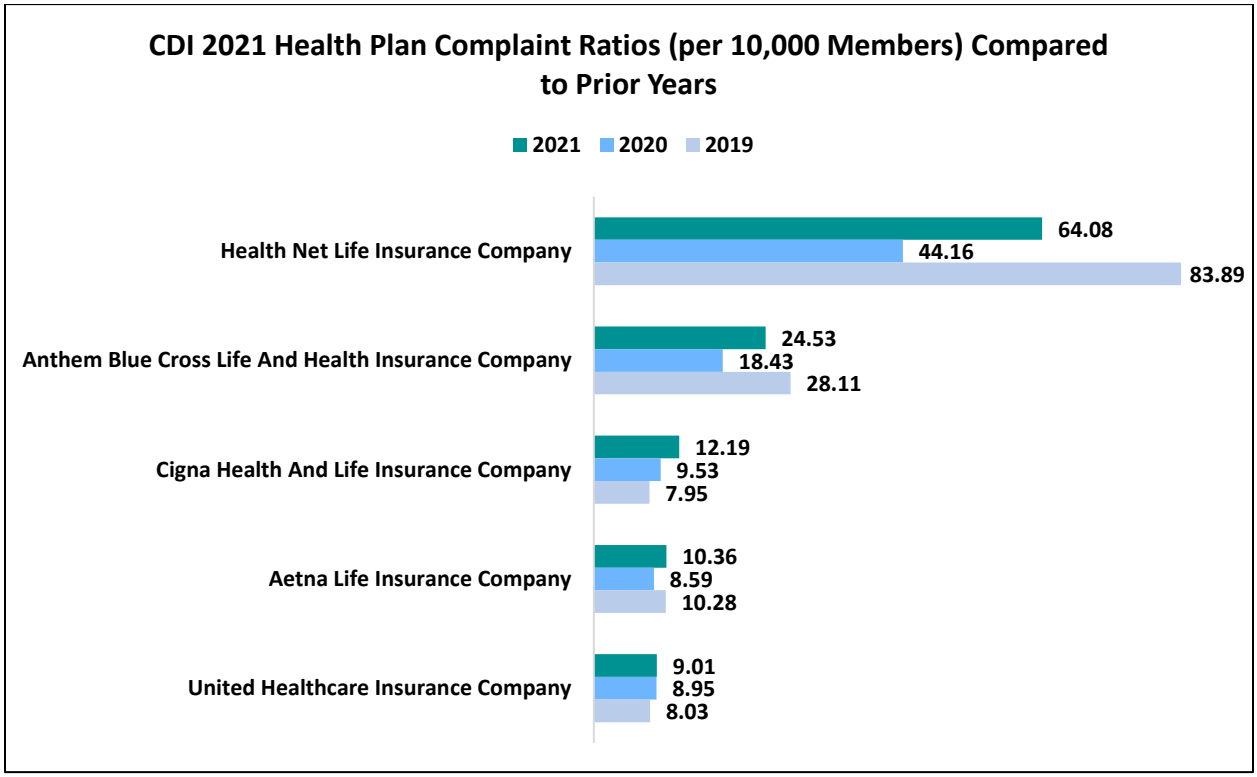
B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

The following chart displays health plan complaint ratios for the plans with at least 25 complaints closed by CDI and with enrollment exceeding 70,000 members in 2021.

CDI noted that the ratio increases from 2020 to 2021 were largely associated with overall complaint volume increases as medical services resumed after COVID-19-related postponements.

Figure 6.3



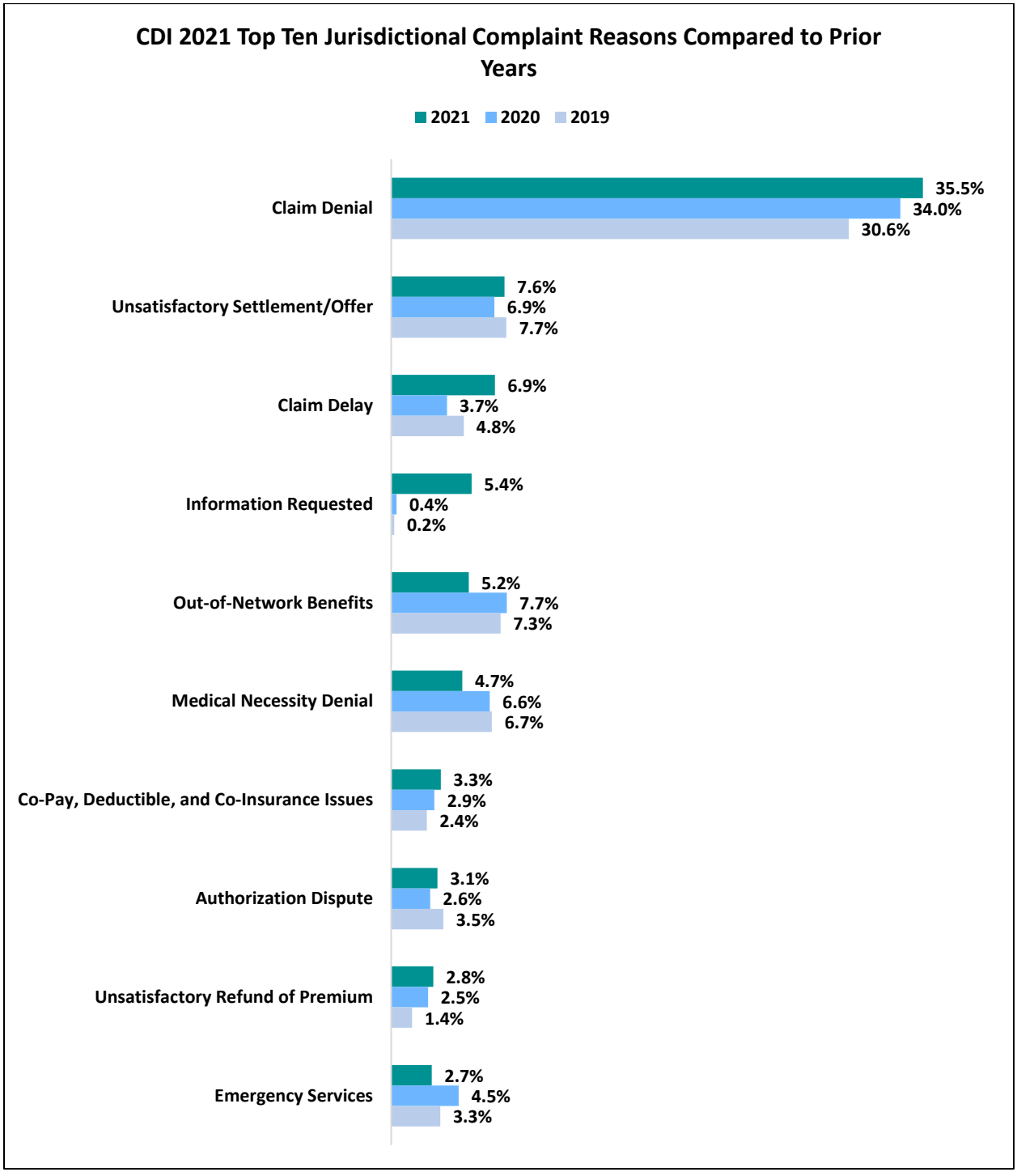
Note: Health Net Life Insurance's 2019 complaint ratio calculation included a significant number or cases initiated in 2016 and 2017 that were held open until 2019 for regulatory purposes. This may affect comparisons between measurement years.

Complaint Reasons

The following chart displays the most common reasons for CDI's jurisdictional complaints in 2021, along with the 2019 and 2020 data for the same categories.

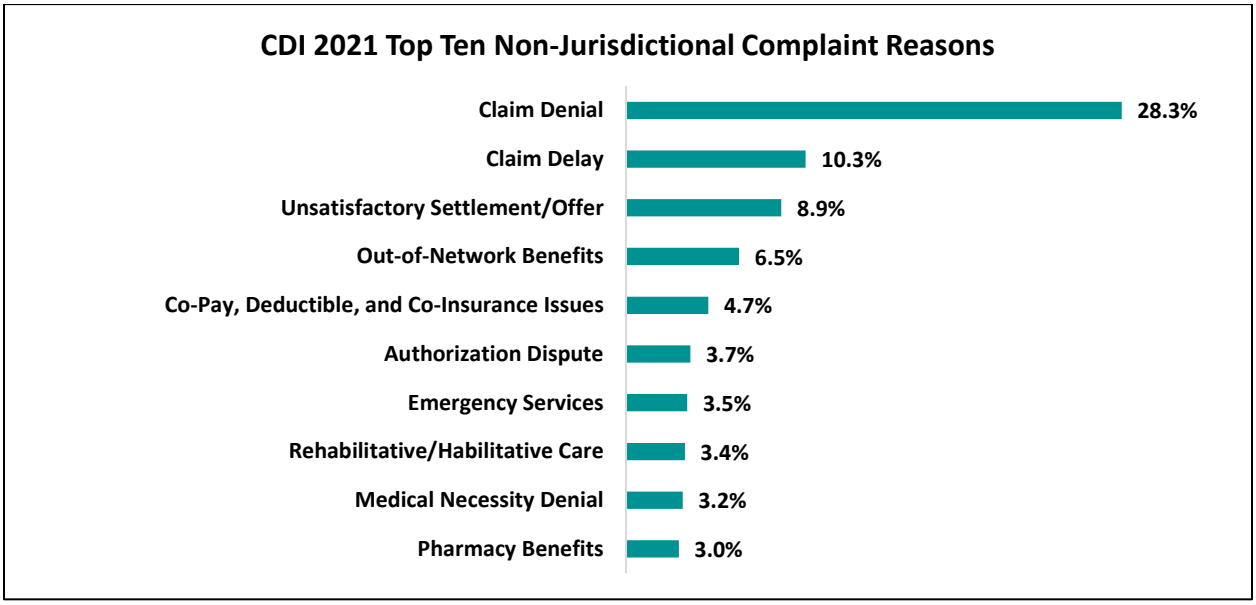
The number of complaint reasons exceed the number of complaints because some cases have more than one reason reported. There were 4,824 reasons from the 3,608 jurisdictional complaints in 2021.

Figure 6.4



The following chart shows CDI's most common reasons for non-jurisdictional complaints in 2021. There were 5,750 reasons submitted for the 4,069 non-jurisdictional complaint cases. CDI refers most non-jurisdictional complaints to a different agency or department.

Figure 6.5



Inquiry Topics and Referrals

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

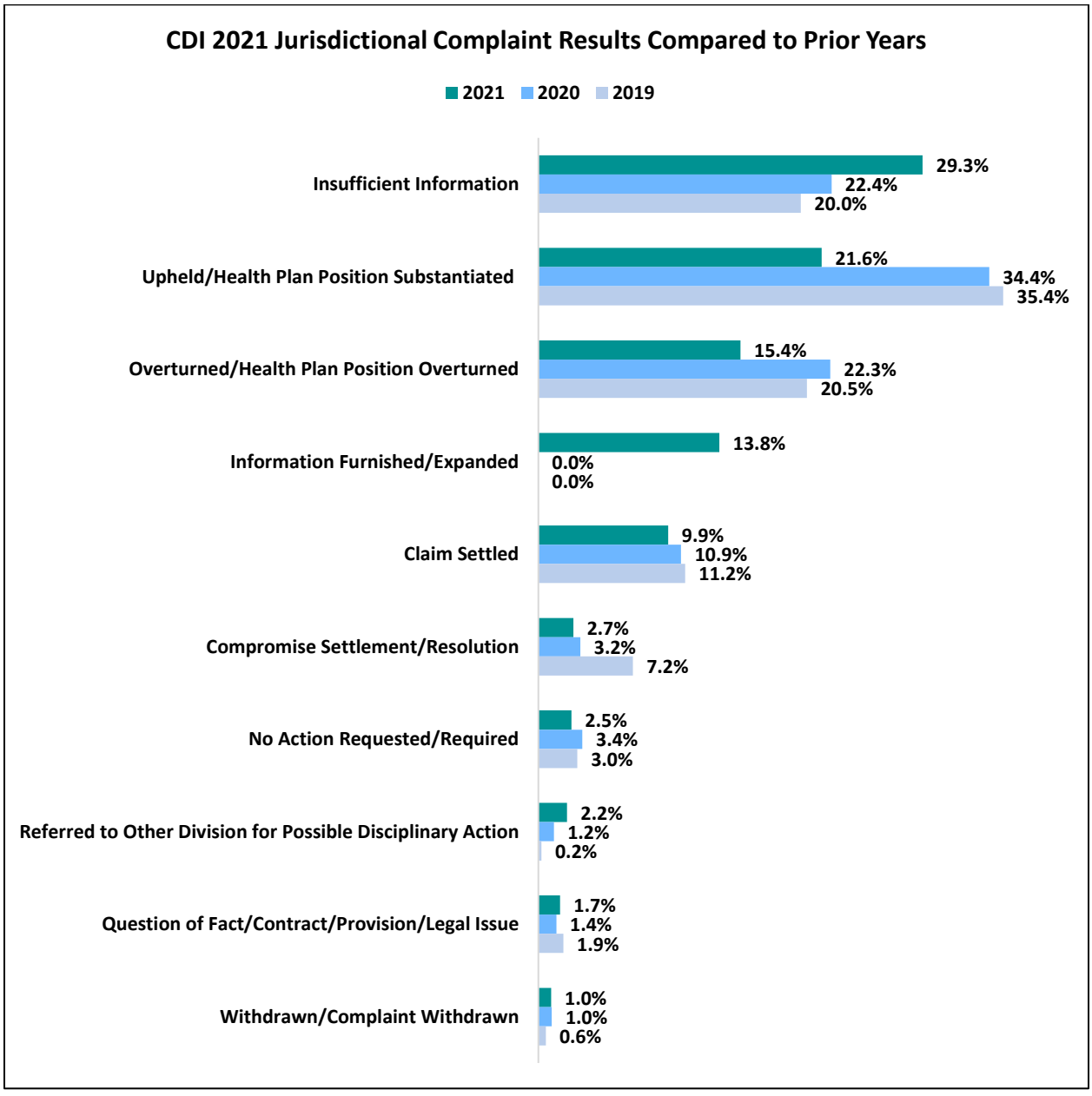
Figure 6.6 CDI Top Ten Topics for Non-Jurisdictional Inquiries

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

Complaint Results

The following chart shows the 2021 results for CDI's 3,608 jurisdictional complaints, along with the 2019 and 2020 data for the same categories.

Figure 6.7 CDI 2021 Jurisdictional Complaint Results Compared to Prior Years



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

For CDI's non-jurisdictional complaints in 2021, most (92.8% of the 4,069 complaints) had the result of Referred to Outside Agency/Department. The rest were submitted with the result of No Jurisdiction.

Resolution Time

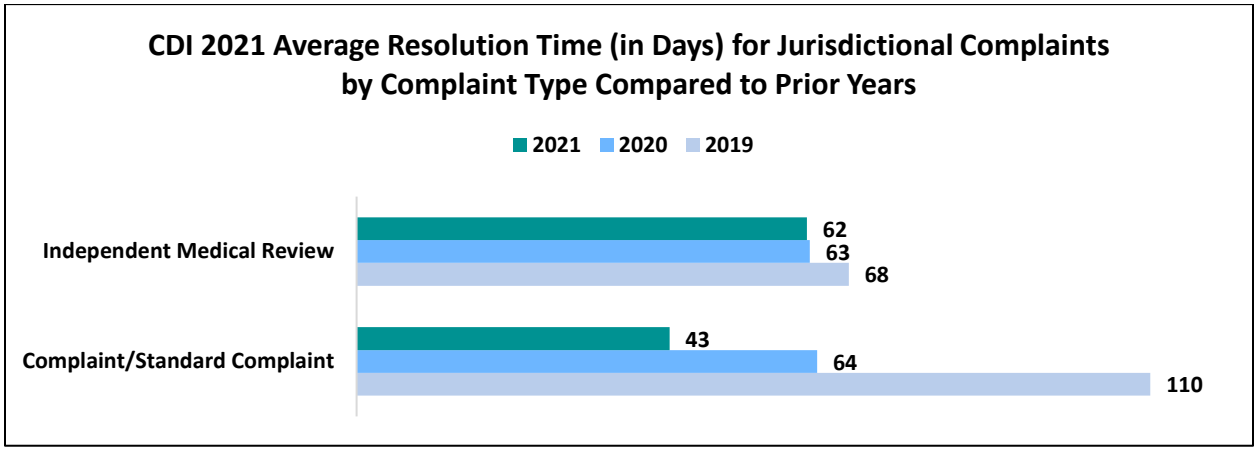
CDI's average resolution time for jurisdictional complaints in 2021 was 46 days, the department's lowest annual average over the last eight measurement years (all reports to date). The department had a 28 percent decrease in the average duration from the prior year (64 days in 2020) even with a 12 percent increase in the volume of jurisdictional complaints over the same period. Non-jurisdictional complaints took four days on average for CDI to close in 2021.

- CDI noted that the faster review times in 2021 likely reflected a combination of factors, including consumers' increased use of electronic communications (which reduce some time-consuming manual processes) as well as staff productivity gains with the establishment of the Consumer Services Division's 5-day telecommute program.

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

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

Figure 6.8



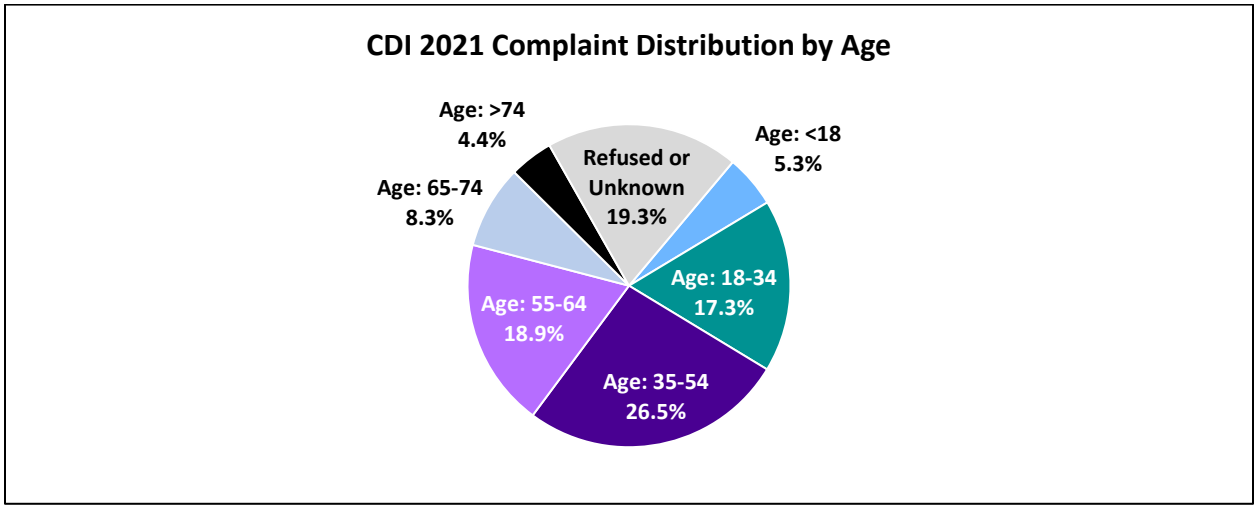
C. Demographics and Other Complaint Elements

The analyses within the Demographics and Other Complaint Elements subsections address CDI's jurisdictional complaints unless otherwise indicated. Multiple demographic categories had significantly increased volumes of complaints reported as Unknown.

Age

The average age of the CDI complainants increased slightly from 46 years old in 2020 to 47 years old in 2021. There was a 168 percent increase in complaints reported without age identified compared to the prior year. The effect of that increase in Unknown on the distributions for the known age groups cannot be determined.

Figure 6.9



Gender

Female complainants continued to account for most of CDI's complaints, with over half (52.1%) of the 3,608 complaints in 2021. Male was identified for the rest of the complaints (47.9% in 2021).

Race

Most of CDI's 2021 complaints did not have the complainant's race identified (40.4% Refused and 17.0% Unknown). The Unknown volume significantly increased from the prior year (955% increase in volume).

Of the categories with race identified in 2021, White was the most commonly reported (28.3%), followed by Asian (6.4%), Other (5.2%), and Black or African American (2.0%). Two categories accounted for under one percent of the 2021 complaints: American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.

Ethnicity

Most of the 2021 complaints did not have the complainant's ethnicity identified (40.4% Refused and 17.0% Unknown). Not Hispanic or Latino accounted for over 37 percent (37.3%) and Hispanic or Latino accounted for approximately five percent (5.3%) of the 2021 complaints.

Both categories without ethnicity identified had increased volumes of complaints in 2021 compared to the prior year (a 1033% increase in Unknown and a 10% increase in Refused). Both known ethnicity categories had decreased volumes over the same period.

Language

Most of CDI's 2021 complaints reported the complainant's primary language as English (58.9% of the 3,608 complaints). Twelve other languages combined accounted for approximately three percent of the complaints. None of the other known language categories exceeded one percent.

Nearly 38 percent of the complaints did not have the primary language identified (22.3% Refused and 15.6% Unknown). There was a 766% increase in volume of complaints with the primary language submitted as Unknown from 2020 to 2021.

Mode of Contact

Half (50.2%) of CDI's complaints in 2021 were initiated through the Online mode of contact. Mail accounted for over 36 percent (36.4%), followed by Other (11.8%) and Telephone (1.6%). Other was reported for the first time by CDI for the 2021 measurement year, capturing consumer complaint emails that were initiated with other CDI divisions rather than through the usual online portal.

Regulator

CDI continued to be the reported regulator for all the department's complaints.

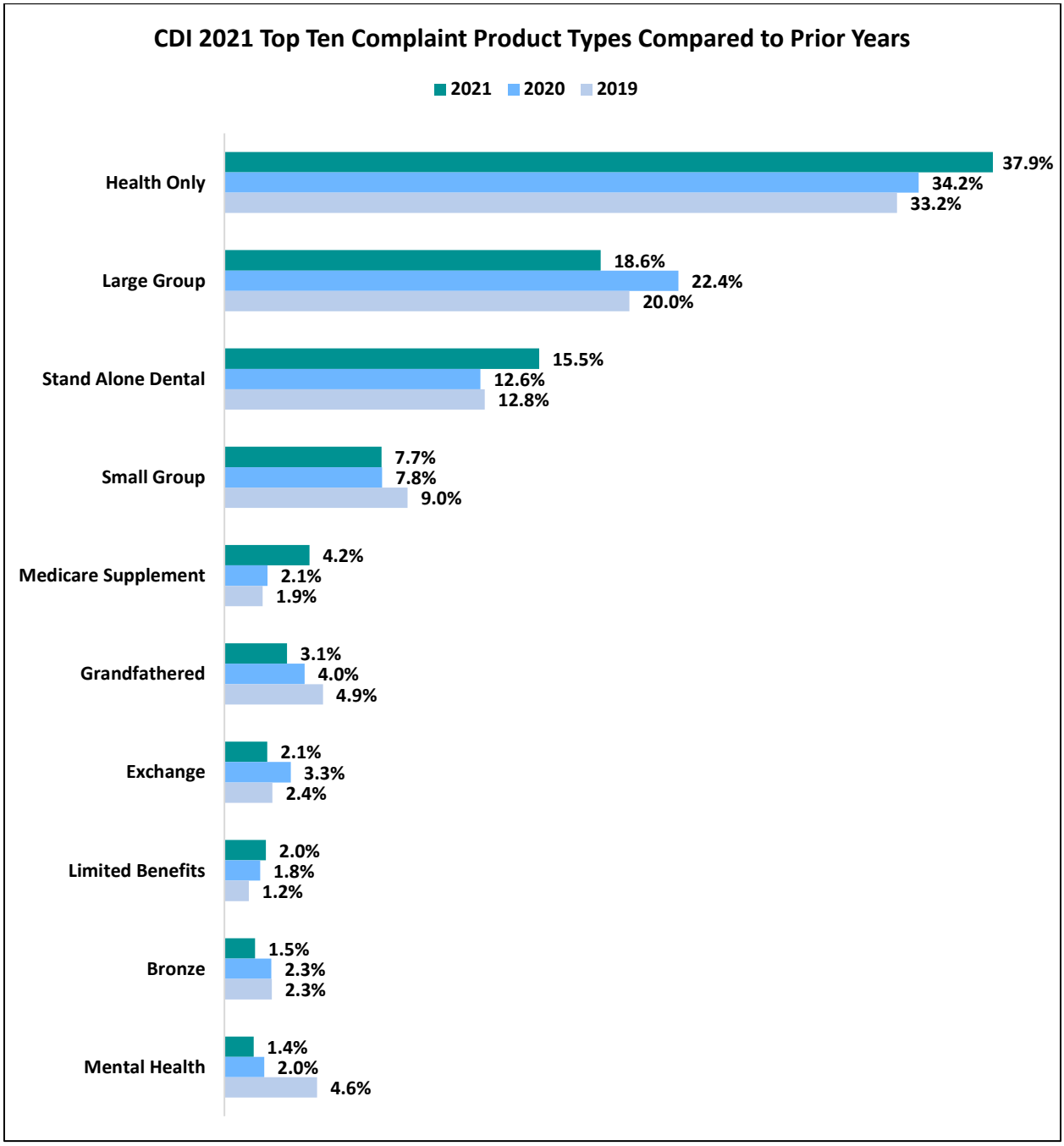
Source of Coverage

The Group source of coverage continued to account for most of CDI's complaints (50.7% in 2021). Individual/Commercial coverage accounted for 49 percent (49.3%), its highest distribution level in the annual report's eight years. Compared to the previous year, the 2021 volume of complaints for Individual/Commercial coverage increased by nearly 40 percent while complaints for Group coverage fell slightly.

Product Type

CDI submitted 26 different product type categories for its 2021 complaints. The product type volume exceeded the volume of complaints because some CDI complaint cases had more than one product type submitted (5,536 product type entries from the 3,608 complaints in 2021).

Figure 6.10



D. Consumer Assistance Center Details

CDI's Consumer Services Division reported 23,455 requests for assistance from consumers in 2021, including 15,175 contacts by telephone. Most requests for assistance were consumer inquiries rather than a complaint initiation.

The following table outlines the metrics for CDI's 2021 telephone calls to its service center.

Figure 6.11 CDI Consumer Services Division – 2021 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	196
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	254
Number of Jurisdictional Inquiry Calls	10,142
Number of Non-Jurisdictional Calls	4,674
Average Wait Time to Reach a CSR	00:12
Average Length of Talk Time (time between a CSR answering and completing a call)	05:18*
Average Number of CSRs Available to Answer Calls (during Service Center hours)	Varied based on need**

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

Consumer Assistance Protocols and Systems

CDI did not report any changes to its service center's protocols or systems for 2021.

Section 7 – Covered California

A. Overview

The California Health Benefit Exchange (Covered California) provides a state-based health insurance marketplace for consumers to buy health insurance and quality for financial assistance to help pay their insurance costs. This report includes information reported by Covered California regarding:

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

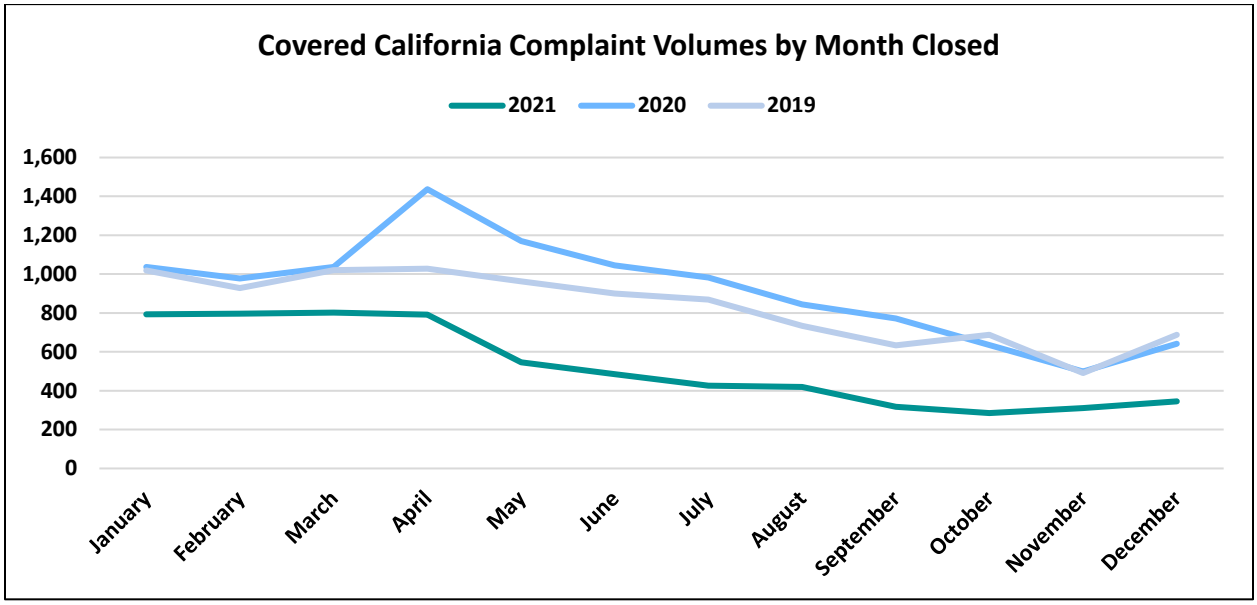
With 4,304,260 requests for assistance in 2021, Covered California's annual consumer assistance volume decreased by 33 percent from 2020, falling to the lowest level in eight years. Most requests for assistance were inquiries about Covered California coverage rather than contacts to initiate a complaint (4,297,939 inquiries).

Covered California reported that its consumer assistance volume decreased from 2020 to 2021 primarily due to improvements in its escalation process, including ongoing Service Center and Appeals staff training and a focus on one-call resolution. Its Service Center was able to more effectively address issues that may have previously resulted in an applicant or enrollee making a follow-up inquiry or filing a request for a State Fair Hearing.

Covered California reported 6,321 complaints closed in 2021, including 998 adjudicated State Fair Hearings and 5,323 State Fair Hearings resolved informally.

The following figure displays volumes by month closed for the 6,321 complaints in 2021, 11,079 complaints in 2020, and 9,958 complaints in 2019.

Figure 7.1



Covered California noted that 39 percent of its 2021 complaints were dual agency appeals to address eligibility determinations for Covered California and Modified Adjusted Gross Income (MAGI) Medi-Cal coverage.

The following table outlines the two complaint types reported by Covered California, State Fair Hearing and State Fair Hearing: Informal Resolution. Complaint volumes decreased from 2020 to 2021 for both complaint types.

- Formal State Fair Hearings volumes decreased for the fourth straight year.
- The volume of informally resolved State Fair Hearings decreased by over 40 percent from 2020 to 2021.

Figure 7.2 Covered California Complaint Standards

Complaint Type	Primary Unit(s) Responsible and Role	Time Standard	Average Resolution Time in 2021
State Fair Hearing	CDSS State Hearings Division: Conducts hearings on eligibility appeals. Administrative Law Judges make decisions. Expedited appeal status may be granted for certain appeals involving urgent health issues.	90 days from the date the hearing request was filed	67 days
State Fair Hearing: Informal Resolution	CDSS State Hearings Division: Reviews hearing request and refers some complaints to Covered California for resolution instead of conducting a hearing with an Administrative Law Judge	45 days from the date the appeal was filed	23 days

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

B. Complaint Ratios, Reasons, and Results

Health Plan Complaint Ratios

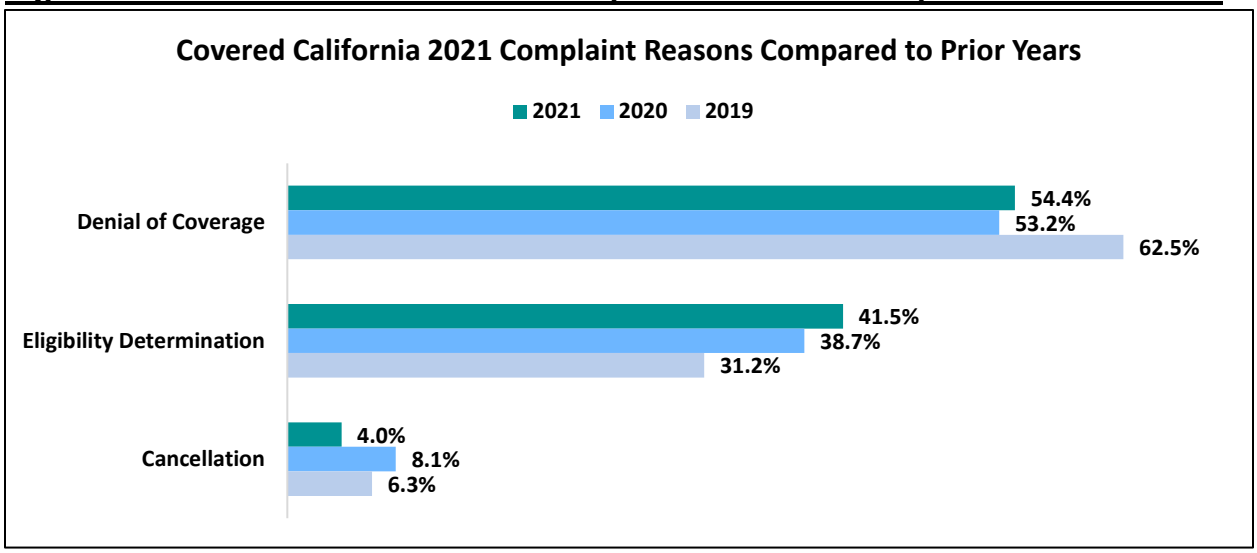
Covered California health plan complaints are addressed through health plan grievance and insurance regulator complaint review processes rather than through a State Fair Hearing. See Section 4.C for information about Covered California health plan complaints resolved by the Department of Managed Health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

Complaint Reasons

The following chart displays the complaint reason distribution for all 6,321 complaints in 2021, 11,079 complaints in 2020, and 9,958 complaints in 2019.

Complaint volumes for all three reported reasons fell from 2020 to 2021.

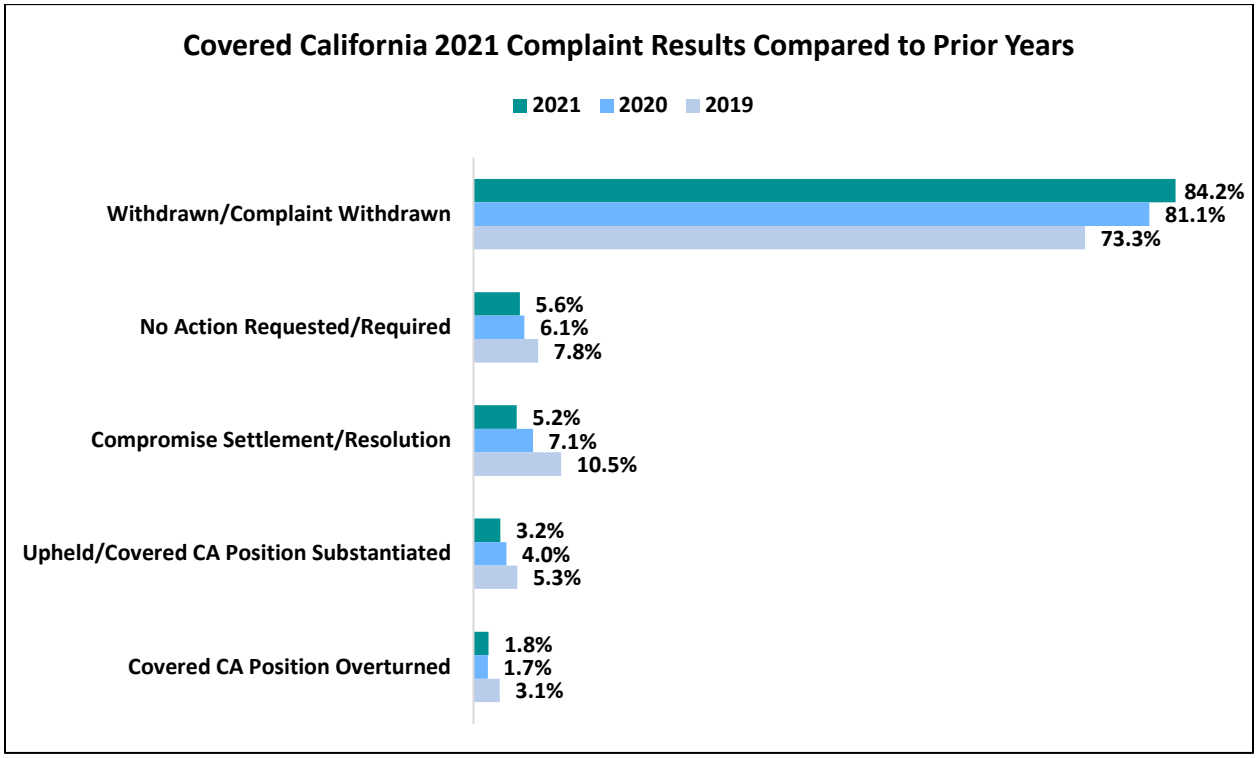
Figure 7.3 Covered California 2021 Complaint Reasons Compared to Prior Years



Complaint Results

The following chart shows the results distribution for all 6,321 complaints in 2021, as well as the 2019 and 2020 data for the same results categories.

Figure 7.4 Covered California 2021 Complaint Results Compared to Prior Years



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

- Volumes for all of Covered California's reported complaint results categories decreased from 2020 to 2021.
- Covered California noted that the Withdrawn/Complaint Withdrawn result, its most commonly reported result, was submitted for cases where the complainant's issue was resolved informally prior to the completion of the State Fair Hearing.

Figures 7.5-7.7 display the 2021 results distributions for each of the three complaint reasons reported by Covered California compared to prior years distributions.

Figure 7.5

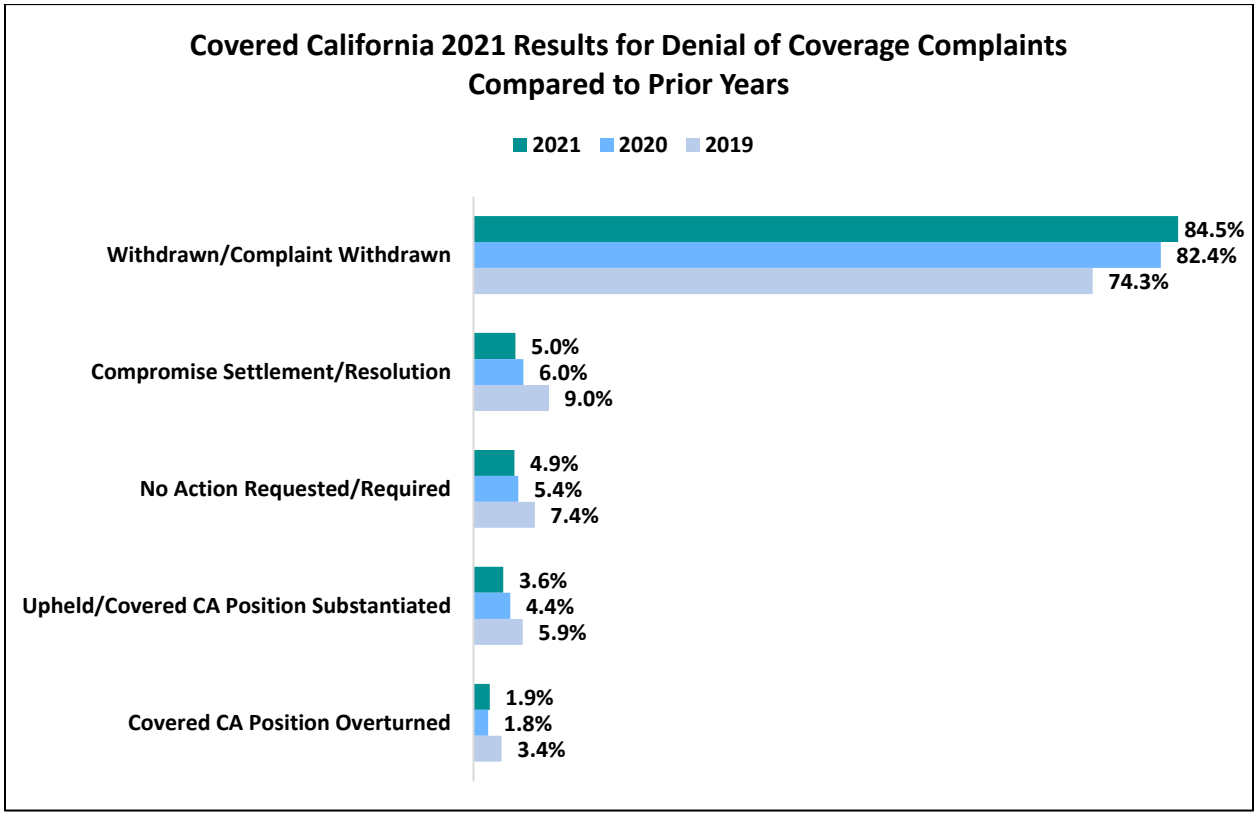


Figure 7.6

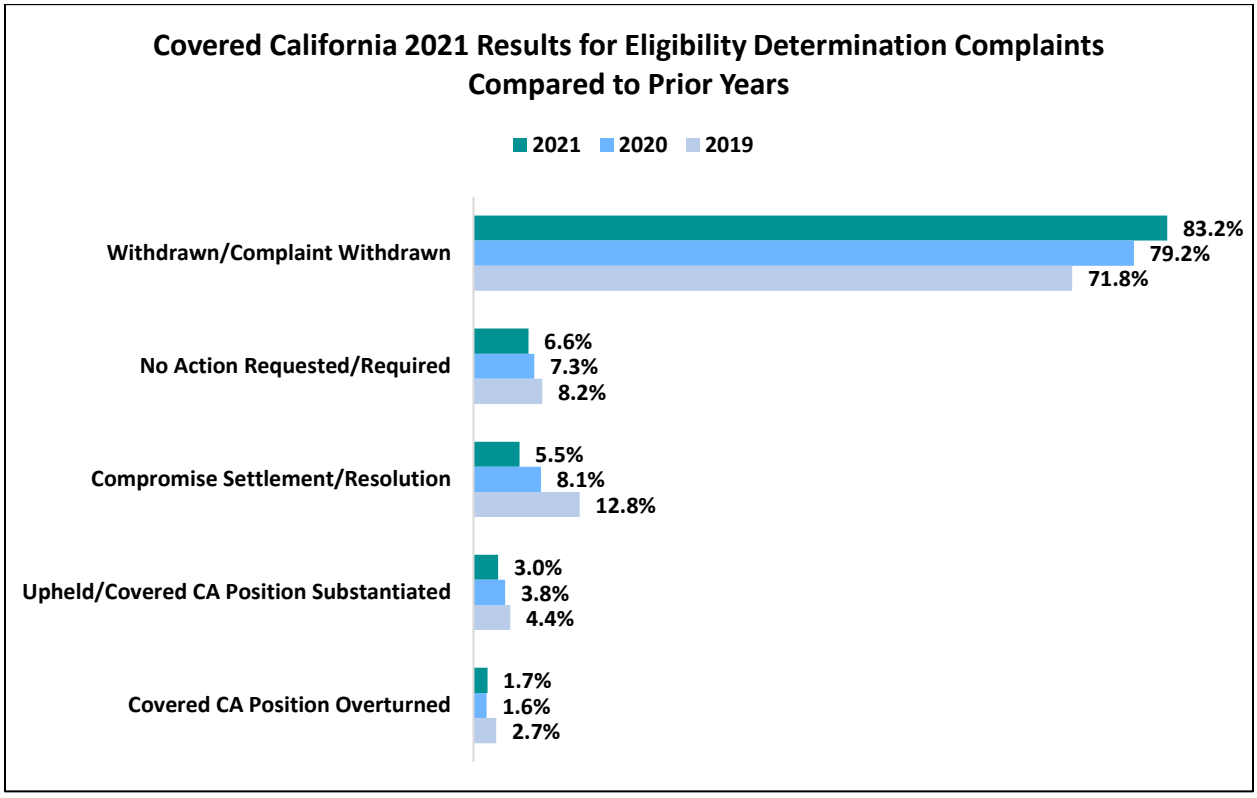
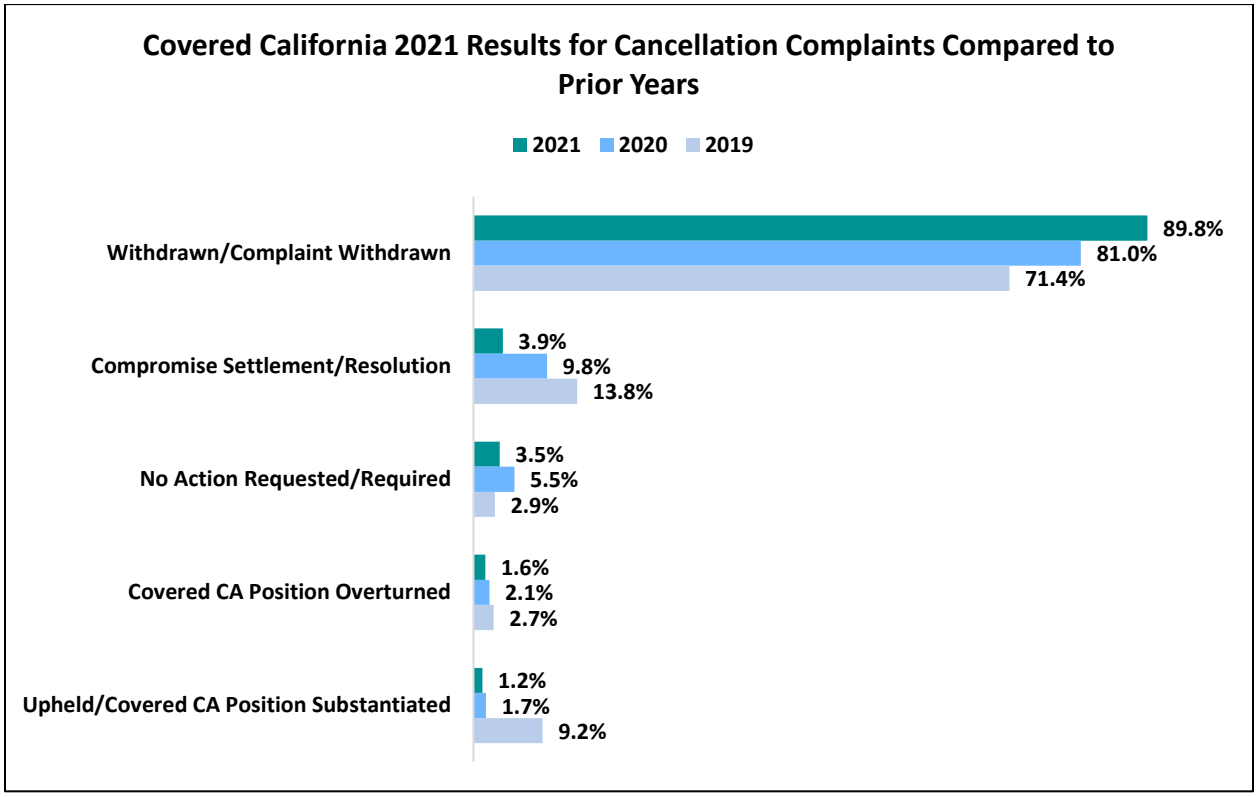


Figure 7.7

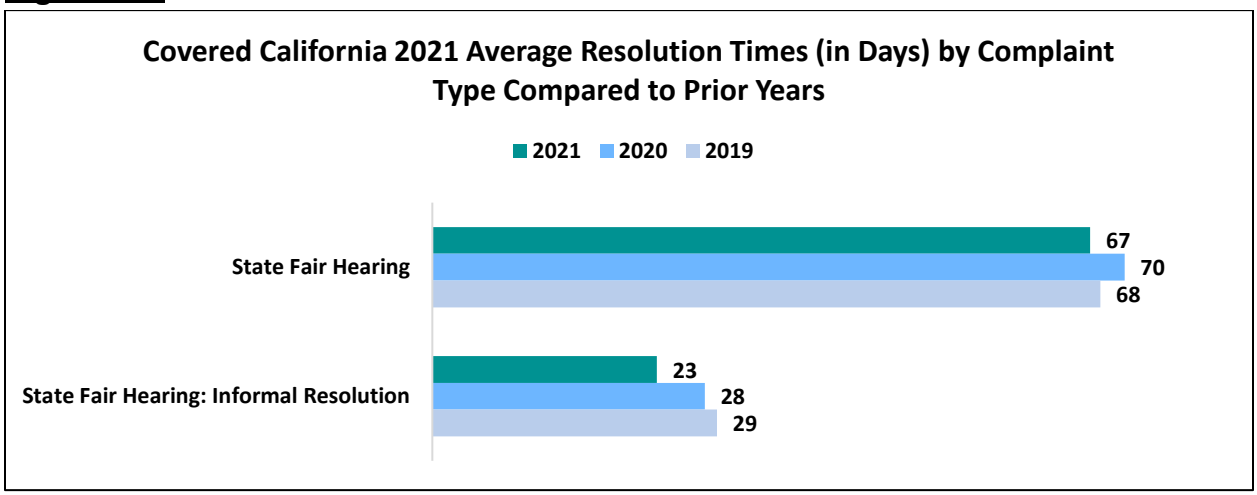


Resolution Time

Covered California's average complaint resolution time fell for the fourth straight year, with an average duration of 30 days in 2021.

The following chart shows the 2021 average resolution times for Covered California's two complaint types, along with the 2019 and 2020 data for the two types.

Figure 7.8



The 23-day average for informally resolved State Fair Hearings is the shortest average duration since Covered California first began reporting that complaint type in 2015.

Covered California credits the multi-year decreases in the informal review times to the ongoing improvements to the Service Center's escalations process, including staff training and a focus on one-call resolution. In addition to resulting in fewer appeals filed as a State Fair Hearing, the Service Center improvements have reduced the time it takes for the Covered California staff to conduct research, prepare for hearings, and resolve complaint issues.

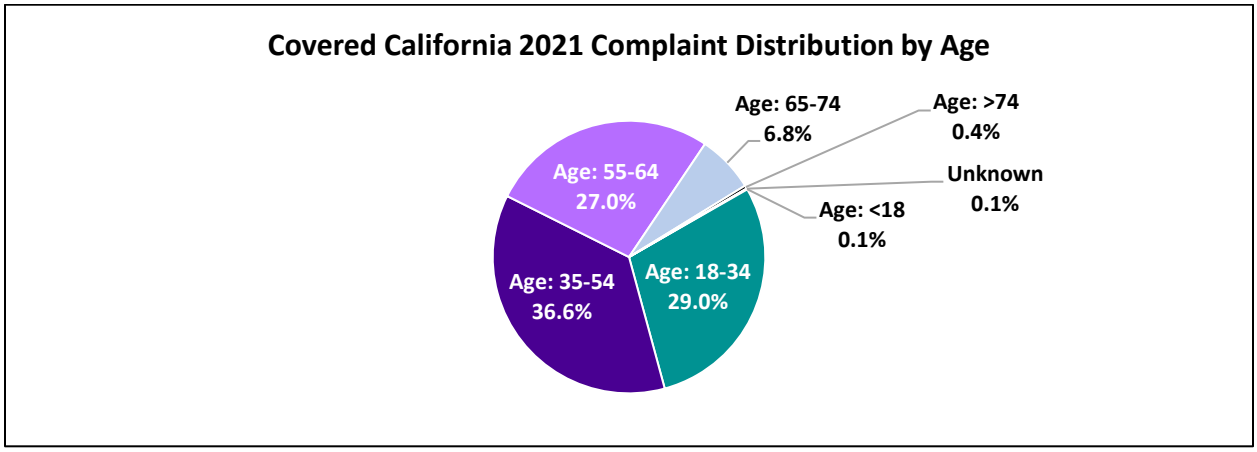
C. Demographics and Other Complaint Elements

Covered California noted that information for some demographic categories is collected but is optional for applicants to provide.

Age

The average age of Covered California's complainants in 2021 was 46 years old. The 2021 complaint distribution by age group was similar to previous years.

Figure 7.9



Gender

The distribution of Covered California's complaints by the complainant's gender was similar to prior years, with Female continuing to account for most complaints (54.0% of the 6,321 complaints in 2021), followed by Male (44.2%) and Unknown (1.8%).

Race

Approximately 34 percent of Covered California's complaints in 2021 did not have the race of the complainant identified (33.7% Unknown). The 2021 distribution was similar to the prior year, with White reported for the most complainants (37.9% of the 6,321 complaints in 2021), followed by Other (11.9%), Asian (11.9%), and Black or African

American (4.1%). Two categories accounted for under one percent combined: American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander.

Ethnicity

The distribution of Covered California's 2021 complaints by ethnicity was similar to the prior year. The majority of complaints identified the complainant's ethnicity identified as Not Hispanic or Latino (66.9% of the 6,321 complaints in 2021). Hispanic or Latino accounted for nearly 24 percent (23.7%). Approximately 10 percent of the complaints did not have the complainant's ethnicity identified (10.3% Unknown).

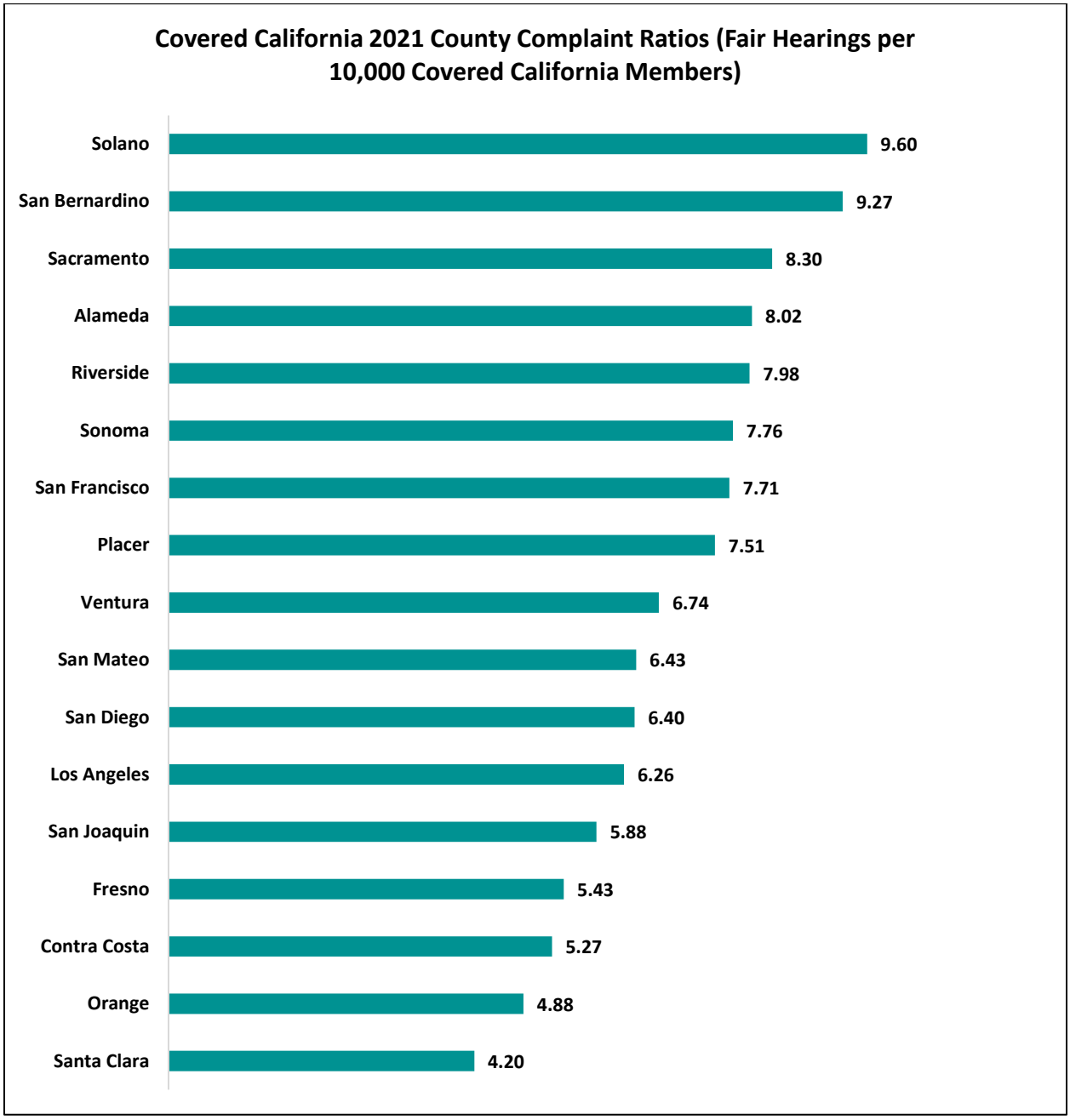
Language

Most of Covered California's complaints continued to be from complainants whose primary language was identified as English (85.8% of the 6,321 complaints in 2021). Spanish was identified for nearly nine percent (8.8%) of the complaints. Other languages, nine categories each with low volumes under one percent, combined to account for three percent (3.3%). Two percent did not have the complainant's language identified (2.1% Unknown). Complaint volumes decreased for all reported primary language categories from 2020 to 2021.

County of Residence

The following chart displays ratios of Covered California's formal State Fair Hearings per 10,000 county residents enrolled in a Covered California plan. The complaint volumes used for this calculation were determined based on the complainants' identified county of residence and exclude volumes for the State Fair Hearing: Informal Resolution complaint type.

Figure 7.10



Note: The above display excludes counties with fewer than 10,000 Covered California plan members and/or 10 or fewer State Fair Hearings in 2021.

Most counties had a lower complaint ratio in 2021 than the prior year (48 out of 58 counties).

Mode of Contact

Most of Covered California's 2021 complaints were reported as being initiated by Telephone (52.6% of the 6,321 complaints), with Email (35.5%) and Online (11.9%)

also identified as modes of contact for the complaints. Complaint volumes decreased for all submitted modes of contact from 2020 to 2021.

Regulator

Covered California's complaints do not address health plan issues and so do not have attributed regulator information. For 2021, Covered California indicated that 97 percent of its members were enrolled in plans regulated by DMHC and three percent in plans regulated by CDI.

Source of Coverage

Most of Covered California's complaints continued to indicate Covered California as the source of coverage (79.4% of the 6,321 complaints in 2021). Unknown was reported for cases where the consumers had not selected a Covered California plan when they filed their appeals (20.6% in 2021).

Product Type

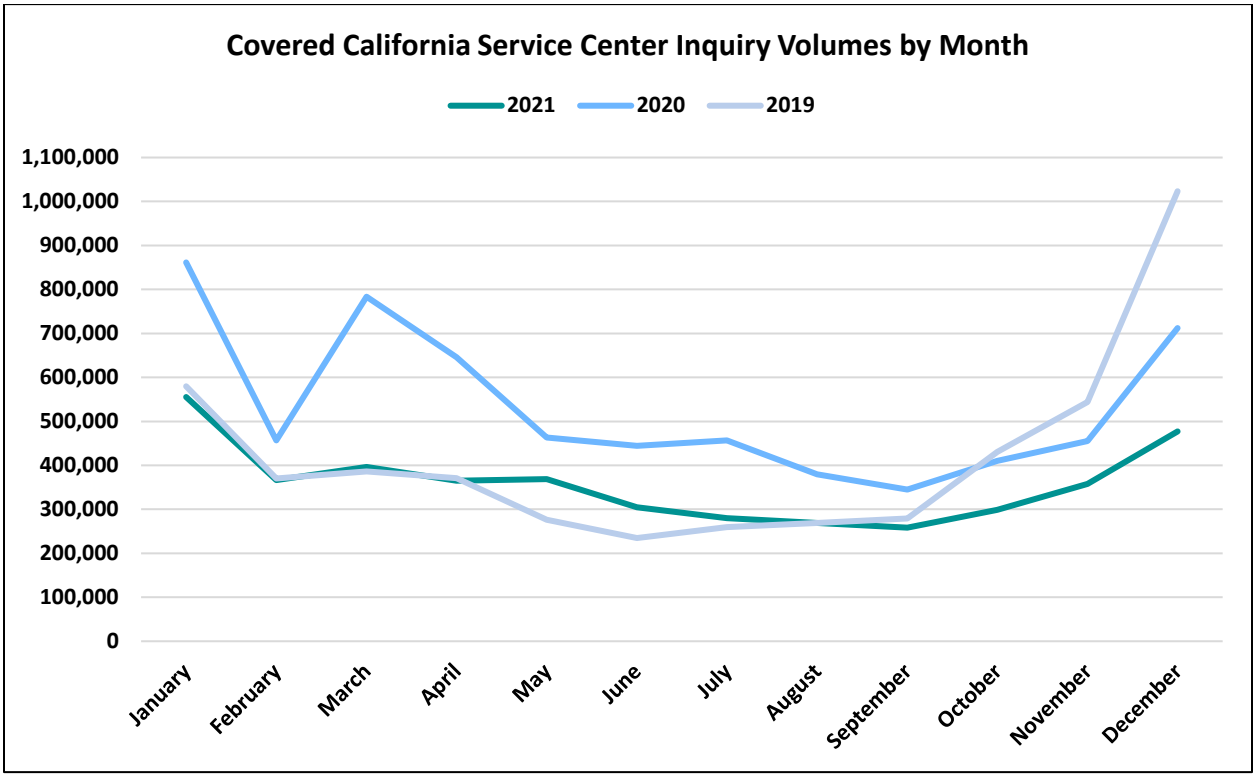
Covered California submitted complaints with product types pertaining to the metal tier associated with the complainant's level of coverage. Unknown was reported for cases where the consumers had not selected a Covered California plan when they filed their appeals (20.6% of the 6,321 complaints in 2021). Silver continued to account for the most complaints (44.6% in 2021), followed by Bronze (20.3%), Gold (9.3%), Platinum (4.5%), and Catastrophic (under 1%).

- The order corresponds to the popularity of the metal tier product types, with the highest number of Covered California members choosing Silver-level plans and the fewest members qualifying for and choosing Catastrophic (minimum coverage) plans.
- Covered California noted that, when comparing complaints and membership tier distribution, members who have selected the higher actuarial value plans (higher metal tier) are slightly more likely to file complaints.

D. Consumer Assistance Center Details

The Covered California Service Center received 4,297,939 inquiries from consumers in 2021, a decrease of nearly 33 percent from the prior year volume.

Figure 7.11 Covered California Service Center Inquiry Volumes by Month



The following table displays the top ten inquiries to the Covered California Service Center in 2021 for both jurisdictional and non-jurisdictional topics. Most consumer contacts with the Service Center are jurisdictional inquiries that do not have to be referred to another organization.

Figure 7.12 Covered California Service Center Top Ten Topics for Inquiries

Ranking	Inquiry Topic	Volume	Organizations(s) Referred to
1 (most common)	Case Status Inquiry	492,247	Not referred
2	Provided County Contact Information	191,757	Medi-Cal program
3	Enrollment	180,007	Not referred
4	Inquiry about Covered California	162,385	Not referred
5	Online Account Assistance Inquiry	160,559	Not referred
6	Report a Change - Income Change	121,216	Not referred
7	Renewal Assistance	113,134	Not referred
8	Payment Inquiry	104,385	Not referred
9	Enrollment Status	81,045	Not referred
10	Reset Password	67,950	Not referred

Nearly 93 percent of the consumer inquiries to the Covered California Service Center in 2021 were made by telephone (3,999,673 calls). Approximately seven percent were online chat inquiries.

The following table displays metrics for the Covered California Service Center's telephone calls in 2021. The information was based on tracked data unless indicated as an estimate.

Figure 7.13 Covered California Service Center – 2021 Telephone Metrics

Yearly Metrics	Measurement
Number of Abandoned Calls (terminated by callers prior to reaching a Customer Service Representative – CSR)	48,218
Number of Calls Resolved by the Interactive Voice Response (IVR)/Phone System (caller's needs addressed without involving a CSR)	1,482,053
Average Wait Time to Reach a CSR	00:46
Average Length of Talk Time (time between a CSR answering and completing a call)	19:46
Average Number of CSRs Available to Answer Calls (during Service Center hours)	511 Full-Time Equivalent (estimated)

Consumer Assistance Protocols and Systems

Other than the ongoing improvements to its Service Center's escalation process and training, Covered California did not report any changes to its consumer assistance protocols or systems in 2021.

Section 8 – Conclusion

This section highlights issues that were noteworthy for the eighth year of this Annual Health Care Complaint Data Report. The Center for Data Insights and Innovation (CDII) reviewed data about complaints closed in 2021 submitted by four reporting entities: the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), California Department of Insurance (CDI), and the California Health Benefit Exchange (Covered California). CDII continues to urge caution in making comparisons between reporting entities and measurement years due to complaint system differences and reporting changes.

Volume of Complaints

DMHC, DHCS, CDI, and Covered California reported 30,779 jurisdictional complaints closed in 2021. The combined statewide volume has dropped annually since the high of 55,923 complaints in 2016.

- After a 2020 spike in applications and associated increase in complaints, Covered California's complaint volume decreased by nearly 43 percent in 2021 (11,079 complaints in 2020 to 6,321 complaints in 2021). Covered California attributed the decrease in 2021 from the prior year to Service Center improvements to its escalation process, staff training, and a focus on one-call resolution.
- With 4,825 complaints in 2021, DHCS's complaint volumes have decreased annually since the 2016 high of 6,770.
- For the two state health insurance regulators:
    - DMHC's 16,025 complaints in 2021 represented a slight increase (0.9%) from the prior year.
    - With 3,608 jurisdictional complaints in 2021, CDI's annual volume increased by more than 12 percent compared to 2020 but stayed below 2017-2019 levels. CDI noted that the increase was primarily associated with medical services resuming in 2021 after the prior year's COVID-19-related delays and interruptions.

Complaint Reasons

Denial of Coverage continued to be the most common statewide reason (13.7% of the combined entity volumes in 2021) and Covered California's top complaint reason (54.4% of Covered California's complaints in 2021).

In 2021, Medical Necessity Denial was the second most common statewide reason and:

- DMHC's top complaint reason (15.4% of the DMHC volume).
- DHCS's third most common reason overall (18.7% of the DHCS volume), but the top reason for its Medi-Cal Managed Care delivery system complaints.

Scope of Benefits has been the most common reason for DHCS complaints since 2018 (34.4% of the DHCS 2021 volume).

- Most Scope of Benefits complaints reported by DHCS involve the Medi-Cal Dental delivery system.

Claim Denial has been CDI's most commonly reported reason for eight years, since this annual report's initiation, accounting for between 24 to 36 percent of the department's complaints each year since 2014 (35.5% in 2021).

Complaint Results and Resolution Time

Accounting for over 28 percent of the 2021 results, Upheld/Health Plan Position Substantiated has been the top statewide complaint result since 2015.

- Upheld/Health Plan Position Substantiated was DMHC's top result.
- Insufficient Information replaced Upheld/Health Plan Position Substantiated for the first time to become CDI's top result in 2021 (29.3% of CDI's jurisdictional complaints).
- Withdrawn/Complaint Withdrawn remained the most common result for complaints reported by DHCS (41.1% in 2021) and by Covered California (84.2% in 2021). Both indicated that many complaints were closed with this result when the complainant's issue was resolved before the State Fair Hearing occurred.

Complaints took the four state entities 33 days on average to resolve in 2021, continuing the annual decrease in the statewide average since 2016.

The 2021 average complaint durations per entity (with comparison to the 2020 average noted) were:

- DMHC – 26 days (increase of 2 days)
- DHCS – 49 days (increase of 2 days)
- CDI – 46 days (decrease of 18 days)
- Covered California – 30 days (decrease of 6 days)

Data Limitations

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

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