

Center for Data Insights and Innovation – Office of the Patient Advocate

Complaint Data Report Glossary for Measurement Year 2023

Term	Explanation
1095-A	An IRS tax form from Covered California to the consumer to report information on enrollment in a qualified health plan in the individual market through the Exchange marketplace, including – by month in the tax year – the premium of the qualified health plan, the premium of the second-lowest silver plan available, and the amount of advance payment of premium tax credit received by the consumer.
1095-B	An IRS tax form from the Department of Health Care Services to the consumer to report information on their enrollment in minimum essential coverage through Medi-Cal, including proof of coverage by month in the tax year.
Access to Care	Complaint that needed care is inaccessible due to refusal of primary care doctor to authorize specialist care or due to inadequate provider network.
Administrative Law Judge	A judge who resolves claims or disputes involving administrative law.
Advised Complainant	A complaint result indicating that the reporting entity informed the complainant of the state position, company status, agent status, or possible course of action.
Appeal	A kind of complaint in which a consumer asks for a review of a decision made by a health plan or coverage program.
Authorization Dispute	Complaint alleging that the insurer has improperly denied claim or assessed a penalty on the basis of required preauthorization not having been obtained.
Beneficiary	The person who benefits from an insurance policy or coverage program.
Billing/ Reimbursement Issue	Complaint reported by DHCS regarding a problem with billing or reimbursement. For DMHC, indicates a billing or reimbursement issue, such as requests for bills to be waived due to poor service or complaints about claim processing errors, which could not be categorized under another complaint reason.

Term	Explanation
Bronze	A product type indicating a level of coverage provided with 60 percent of the total allowed costs of benefits paid by the health plan.
CalAIM	California Advancing and Innovating Medi-Cal (CalAIM) is a broad transformation initiative by the California Department of Health Care Services focused on building a more coordinated, person-centered, and equitable health system for Medi-Cal members. CalAIM initiatives include a wide-range of significant system changes over multiple years, with the first reforms implemented in January 2022 and additional changes targeted to be phased in through 2027.
CalHEERS	The California Healthcare Enrollment, Eligibility, and Retention System is a web-based system that streamlines the eligibility and enrollment process for all products and programs available through Covered California.
California Children’s Services	A program administered by DHCS to provide diagnostic and treatments services, medical case management, and physical and occupational therapy services to children under age 21 with certain eligible medical conditions.
CalPERS (California Public Employees’ Retirement System)	A source of coverage data element indicating the organization that provides health and other benefits to California public employees, retirees, and their families.
Cancellation	Complaint alleging the insurer's improper cancellation of a policy and/or coverage before the expiration date.
Catastrophic	A product type indicating a health plan that meets all the requirements of a qualified health plan but that doesn’t cover any benefits other than three primary care visits per year before the plan’s deductible is met. These plans also are called minimum coverage plans. Covered California minimum coverage plans are only available to people under age 30.
CDI	California Department of Insurance
CDPH	California Department of Public Health
CDSS	California Department of Social Services

Term	Explanation
Claim	Request to a health plan or coverage program asking for payment based on the terms of the insurance policy.
Claim Delay	Complaint alleging that the insurer has unreasonably delayed the investigation and/or processing of a claim.
Claim Denial	Complaint alleging improper claim denial by insurer.
Claim Settled	Claim brought to conclusion, in whole or in part, and no other disposition is appropriate. CDI uses this result to indicate that the claim was settled in the consumer's favor.
Closed Complaint	A complaint that has been investigated by the state insurance department and given a resolution code. A complaint that has completed a complaint review process by a reporting entity or its official affiliate.
CMS	Centers for Medicare and Medicaid Services
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)	Employer-based coverage continued under COBRA, a U.S. statute that requires employers sponsoring group health plans to offer continuation of coverage under the group plan to employees and their dependents who have lost coverage because of the occurrence of a "qualifying event." Qualifying events include reduction in work hours, many types of termination of employment, death, and divorce. As a source of coverage indicates the consumer used COBRA to elect to continue their enrollment in the employer's group plan.
Co-Insurance	A share of the cost of a health care service. Co-insurance is a percent of the bill for a service.
Complaint	A written or oral complaint, grievance, appeal, independent medical review, hearing, or similar process to resolve a consumer problem or dispute.
Complaint Reason	A complaint data category indicating the primary reasons for the consumer complaint. For this report a single complaint case can have up to three reasons. Examples of complaint reasons include Cancellation, Medical Necessity Denial, and Claim Denial.
Complaint Result	A complaint data category indicating the outcome of the review of the consumer complaint. For this report a single complaint case can have up to three results. Examples of complaint results include Claim Settled and Upheld/Health Plan Position Substantiated.

Term	Explanation
Complaint Type	A data category for complaints reported to the Center for Data Insights and Innovation (previously the Office of the Patient Advocate) that identifies the complaint review process used by the reporting entity, such as Standard Complaint, State Fair Hearing, Independent Medical Review, Quick Resolution, and Urgent Nurse.
Complaint Withdrawn	Complainant requested that the complaint be withdrawn.
Compromise Settlement/ Resolution	Complaint resolved voluntarily by an insurer or regulated entity, via additional payment, restored benefit or policy status, and/or other means. No finding that the regulated entity or individual was in violation or otherwise at fault.
Conlan	A type of Medi-Cal out-of-pocket expense reimbursement. As the result of a court order issued on November 17, 2006, in the case of <i>Conlan v. Shewry</i> , Medi-Cal may be required to reimburse certain covered medical and dental expenses paid by eligible Medi-Cal members. This term also is sometimes used to reference the DHCS claims process to request this type of reimbursement.
Consumer Received Requested Service	A complaint result indicating that the consumer received the requested service after the complaint was filed.
Co-Pay	A fixed charge (flat fee) for a health care service. You usually pay the co-pay when you get the service. You pay the same fee each time.
Co-Pay, Deductible, and Co-Insurance Issues	Complaint alleging that the incorrect co-pay, deductible, or co-insurance amount has been applied to a claim.
County Organized Health System (COHS) Model	A Medi-Cal managed care model approved by the federal government under an 1115 Waiver. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors. The health plan is run by the county. In a COHS county, all Medi-Cal members are in the same managed care plan.
Covered California Position Overturned	A Covered California complaint result identifying a complaint was resolved by Covered California to ensure compliance with applicable state law/requirement. Also see Health Plan Position Overturned.

Term	Explanation
Covered California/Exchange	A source of coverage indicating that coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. The California Health Benefit Exchange (Covered California) is California's state-run exchange.
Covered California/MAGI Medi-Cal	A source of coverage element indicating an appeal of a dual agency determination regarding eligibility for Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California.
Covered Lives	Policyholders, subscribers, enrollees, or other individuals participating in a health benefit plan.
CRM (Customer Relationship Management)	A call center technology system to manage and record interactions with people who contact the call center.
Customer Service Representative (CSR)	A person who answers telephone calls in a service center or communicates with customers through other modes of contact, such as email. The reporting entities may use different titles to refer to their staff who provide CSR services and related consumer assistance.
DCA	California Department of Consumer Affairs
Deductible	The amount you must pay each year for health care before your health plan starts to pay.
Delays/No Response	Complaint alleging untimely response to, or failure to respond to, policyholder request for information.
Delivery System	A system for providing health care services. DHCS reported its delivery systems for its dental, fee-for-service, managed care, long term care, mental health, Medi-Cal Coordinated Care, and California Children's Services programs under Product Type.
Denial of Coverage	Complaint that coverage was improperly denied.
Denied Services	Complaint alleging that the complainant was improperly refused health-related services.

Term	Explanation
Dental or Dental Only	A product type indicating a line of business providing dental only coverage; coverage can be on a stand-alone basis or as a rider to a medical policy. If the coverage is as a rider, deductibles or out-of-pocket limits must be set separately from the medical coverage. For commercial coverage, does not include self-insured business as well as Federal Employees Health Benefits Program or Medicare and Medicaid programs. For DHCS, includes its service delivery system for Medi-Cal dental benefits.
Dental Stand Alone	Coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan.
DHCS	Department of Health Care Services
Dis/Enrollment	Complaint regarding issues related to enrollment in coverage.
DMHC	Department of Managed Health Care
DOI	A department of insurance. For the purpose of this report, DOI is typically used to reference an out-of-state department of insurance.
DOL	United States Department of Labor
Eligibility Determination	Complaint is about a problem with eligibility for health care coverage, typically through a public program.
Emergency Services	Complaint regarding coverage, with respect to an emergency medical condition, arising out of a medical screening examination that is within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize a patient.
Enrollment	The process of a health plan initiating coverage for a new member or renewing a policy. Enrollment generally occurs after a coverage program or employer determines eligibility. Enrollment can also refer to the number of members who are a part of a health plan or coverage program.
EPO (Exclusive Provider Organization)	A product type indicating a kind of health plan that requires its members to use an exclusive network of contracted providers, but typically allows members to see network providers without a referral.

Term	Explanation
Ethnicity	A demographic data element for the Complaint Data report consisting of categories Hispanic or Latino, Not Hispanic or Latino, Unknown, and Refused.
Exchange	A product type indicating coverage provided by a plan issued through a governmental agency or non-profit entity that meets the applicable standards of Title 45 of the Federal Register and makes qualified health plans available to qualified individuals and/or qualified employers. The California Health Benefit Exchange (Covered California) is California’s state-run Exchange.
Fee for Service	A product type indicating a service delivery method in which health care providers are paid for each service performed. Also see Medi-Cal Fee-for-Service.
FI (Fiscal Intermediary)	A contracted company that serves as the government’s agent for claims processing and managing related systems for administering a public health care program.
Full-Service License	A full-service license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides a full range of basic health care services, including preventive and routine care, physician and hospital services, and emergency and urgent care.
Geographic Managed Care (GMC) Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In GMC counties, DHCS contracts with several commercial plans to provide more choices for beneficiaries. GMC serves Medi-Cal beneficiaries in two counties: Sacramento and San Diego.
Gold	A product type indicating a health plan with a level of coverage provided with 80 percent of the total allowed costs of benefits paid by the health plan.
Grandfathered	A product type indicating coverage provided by a group health plan, or a group or individual health insurance issuer, in which the individual was enrolled on March 23, 2010, for as long as it maintains that status under the rules of section 147.140 of Title 45 (Code of Federal Regulations). Grandfathered plans were made exempt from some provisions of the federal Affordable Care Act.
Grievance	A complaint that you make to your health plan. In a grievance, you ask your health plan to solve a problem or change a decision they made about your care.

Term	Explanation
Group	A source of coverage indicating a health insurance coverage policy purchased by an employer or other employee organization and offered to eligible employees as a benefit. Insurance that is issued against sickness or injury where the group is the policyholder and the individual insured is the certificate holder.
Health Benefit Exchange Board	The Exchange is an independent public entity within state government with a five-member board appointed by the Governor and the Legislature. Two members are appointed by the Governor; one by Senate Rules Committee; and one by Speaker of the Assembly. The Secretary of the Health and Human Services Agency or another designee serves as an ex-officio voting member of the Board. Appointed members serve four year terms.
Health Care Options	Health Care Options (HCO) is a program in the California Department of Health Care Services. HCO's role is to assure access to health care through an enrollment broker contractor. The contractor gives information to Medi-Cal members about managed care plans. This helps members make informed choices about their Medi-Cal benefits. The plans may include medical and dental care services.
Health Only	A product type indicating insurance covering sickness only. This can include an HMO (Health Maintenance Organization), which provides basic health care services to enrollees on a prepaid basis except for enrollees' responsibility for co-payments, deductibles, and a PPO (Preferred Providers Organization).
Health Plan Position Overturned	Complaint resolved by a regulated entity to ensure compliance with applicable state law/requirement, via additional payment, restored benefit or policy status, and/or other means. Reporting entity found the regulated entity to be in violation or otherwise at fault.
Health Plan/ Health Insurer	A health plan or insurer is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members or policy holders for a fixed, prepaid premium. Health plans are licensed to operate in California by the Department of Managed Health Care. Health insurers are licensed by the California Department of Insurance. For this report, health plan may be used to refer to both health plans and health insurers.

Term	Explanation
HICAP (Health Insurance Counseling and Advocacy Program)	A consumer assistance program that provides counseling and education to Medicare members about Medicare coverage, other health insurance, and long-term care. In California, the program is administered by the Department of Aging and is supported by state funds and federal State Health Insurance Assistance Program (SHIP) funds.
HMO (Health Maintenance Organization)	A product type indicating a kind of managed care health plan that requires its members to use a network of contracted providers to get health care services.
Independent Medical Review (IMR)	An Independent Medical Review is an external review process for addressing certain qualifying complaints about treatment or service denials or delays. Doctors who aren't part of the complainant's health plan or insurance company conduct the review and make a determination. Under law an IMR must be resolved within 30 days.
Individual/ Commercial or Individual plan	A source of coverage indicating insurance that is issued to an individual insuring one (and one's dependents if on the same policy) against sickness or injury.
Information Furnished/ Expanded	Supplied requested, missing, or additional information to consumer
Information Requested	Complaint reason used when a complainant requests information from a health plan or the reporting entity.
Inquiry	A request for assistance made by a consumer to a consumer assistance service center that does not initiate a complaint with the associated reporting entity. For this report, the general category of inquiry is used to refer to jurisdictional inquiries and non-jurisdictional inquiries/complaints.
Insufficient Information	Complainant failed to provide sufficient information/documentation to warrant further investigation.
Interactive Voice Response (IVR)	A technology system used by telephone service centers that interacts with callers by allowing them to input information using their phone keypad and/or their voice. IVR systems often are used to gather information needed to route the call to the right customer service representative or to provide appropriate pre-recorded information.

Term	Explanation
Jurisdictional	Within the authority of a consumer assistance service center to address or resolve.
Jurisdictional Complaint	Complaint that falls under the authority of the service center to address or resolve.
Large Group	A product type indicating coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and sometimes their dependents) through a group health plan maintained by a large employer, unless otherwise provided under state law.
Limited Benefits or Limited Benefits Plan	A product type indicating a health insurance policy with limited benefit payments where all benefits have been paid to the beneficiary. These policies usually limit the services the plan will cover and have a low maximum amount the plan will pay out. Limited-benefits plans include critical illness plans, indemnity plans, and “hospital cash” policies.
Long-Term Care	A product type indicating a range of services and support for personal care needs. Most long-term care isn't medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living.
Managed Care	A product type indicating a health plan that contracts with health care providers and medical facilities to provide care for members at reduced costs. HMOs, PPOs, EPOs, and POS plans are all managed care plans.
Measurement Year (MY)	The annual period from January 1 through December 31 during which time complaints were closed.
Medicaid	Medicaid is a Federal-State jointly-funded program that provides health care coverage to eligible children and adults with low incomes, including seniors and people with disabilities. Medicaid also provides long term care and related services to beneficiaries who qualify. California’s Medicaid program is called Medi-Cal and is administered by the California Department of Health Care Services.
Medi-Cal	A source of coverage indicating California's Medicaid program to provide health coverage to low-income individuals. The Medi-Cal program is administered and overseen by DHCS.

Term	Explanation
Medi-Cal Fee-for-Service	A health care delivery system of the Medi-Cal program. Under this model, providers render services to Medi-Cal beneficiaries and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.
Medi-Cal Managed Care	A health care delivery system of the Medi-Cal program. Under managed care models, the Medi-Cal program contracts with managed care plans to provide services to beneficiaries through established networks of organized systems of care.
Medical Necessity Denial	Complaint alleging that the insurer has improperly denied covered services as not medically necessary.
Medi-Cal Rx	Medi-Cal Rx is the name DHCS has given to the collective pharmacy benefits and services that are administered through a fee-for-service delivery system, provided via a pharmacy. Under the CalAIM transformation reforms, this pharmacy benefits delivery system came into full operation in January 2022.
Medi-Cal/Medicare	A source of coverage indicating the consumer has dual coverage through the Medi-Cal and Medicare programs.
Medically Necessary	Care that you need in order to prevent, find, or treat a health problem. In general, health plans only cover medically necessary care. This care must meet accepted standards of medicine. There should be evidence that you need the treatment and that it can help problems like yours.
Medicare	A source of coverage indicating the consumer has Medicare, a federal government health insurance program for people aged 65 years and older and for some people with disabilities.
Medicare Prescription Drug	A product type indicating a stand-alone, Medicare Part D plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Savings Account Plans.
Medicare Supplement	A product type indicating coverage that provides for accident and health expenses not covered under Medicare. There are various types of standard policy form choices available for Medicare supplemental insurance coverage. Medicare supplemental insurance is sometimes referred to as Medigap.

Term	Explanation
Mental Health	A product type indicating coverage for professional mental health services, including psychologist, crisis centers, rehabilitative therapy, etc. Can also refer to health conditions regarding psychological and emotional wellbeing or services related to an emotional or organic mental impairment (usually excluding senility, retardation or other developmental disabilities, and substance addiction); a psychoneurotic or personality disorder; any psychiatric disease identified in a medical manual (American Psychiatric Association's Diagnostic and Statistical Manual).
Metal Tier	A term associated with the level of coverage for Covered California health plans and other plans in the individual and small-group markets. As the metal category increases in value, so does the percentage of medical expenses that a health plan covers compared with what the plan member is expected to pay in co-pays and deductibles. Four metal tiers - Bronze, Silver, Gold, and Platinum – are reported under product type for this report.
Misrepresentation	Complaint alleging that the insurer or representative made misleading or untrue statements about policy terms, benefits, or about insurance during the marketing/sales process.
Mode of Contact	A report data element indicating the communication platform used by a consumer to contact a consumer assistance service center. Examples of modes of contact include telephone, mail, email, online, and fax.
Modified Adjusted Gross Income (MAGI)	A specified methodology defining households and counting income used for determining eligibility for the most common forms of Medi-Cal and for financial assistance through Covered California.
No Action Requested/ Required	Complaint result indicating that the complaint review organization received only a copy of a complaint that the complainant sent directly to the company, or there was no direct request for assistance. For DHCS, this result indicates that the State Fair Hearing case either was dismissed because the complainant did not appear for the hearing or was dismissed administratively.
No Jurisdiction	Complaint does not fall under the regulatory authority or oversight of the reporting entity, and was not referred to any outside agency, Department, or court system. Includes Action Suspended for litigation and/or formal arbitration.
Non-Jurisdictional	Not within the authority of a consumer assistance service center to address or resolve.

Term	Explanation
Non-Jurisdictional Inquiry/ Complaint	A request for assistance to a consumer assistance service center from a consumer who requires education and a referral to another entity to address a question or resolve a complaint about a non-jurisdictional topic.
Other	Indicating a category not fitting into any specific standardized report category.
Out-of-Network Benefits	Complaint regarding dissatisfaction with the administration or determination of benefits, on a claim for services that have been requested, received, or determined to be, out-of-network.
Participating Provider Availability/ Timely Access to Care	Complaint alleging that no in-network provider available, and that a claim processed at the out-of-network benefit level should be reprocessed as an in-network claim.
Pharmacy Benefits	As a complaint reason, indicates a complaint regarding coverage for expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician. As a product type, indicates coverage for pharmacy benefits, covering expenses for charges made by a pharmacy, for medically necessary prescription drugs or related supplies ordered by a physician.
Plan/Staff Attitude and Service	Complaint alleging unacceptable attitude or treatment from a health plan's staff.
Platinum	A product type indicating a health plan with a level of coverage provided with 90 percent of the total allowed costs of benefits paid by the health plan.
POS (Point of Service)	A product type indicating a kind of managed care health plan. A POS plan combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).
PPO (Preferred Provider Organization)	A product type indicating a kind of managed care health plan. A PPO has a network of contracted providers but offers its members options to go outside of the network for care. In addition, members can usually see providers without prior approval from the plan.
Premium	The amount you pay each month to keep your health plan. For many people, their employer or the government may pay all or part of the premium.

Term	Explanation
Primary Language	The language a person was exposed to from birth or a very early age, or the main language a person uses to communicate. For the Complaint Data Report, primary language response options include Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Hmong, Japanese, Korean, Mandarin, Other, Other Chinese, Refused, Russian, Spanish, Tagalog, Unknown, and Vietnamese.
Product Type	A complaint data element used to identify details about specific areas of coverage, such as the health plan's model, structure, benefits, and/or other distinguishing characteristics. In this report, most product types align with NAIC's Type of Coverage/Accident & Health Second Level codes. Examples of product types include HMO, PPO, Silver, Platinum, Health Only, Dental, and Small Group.
Program of All-Inclusive Care for the Elderly (PACE)	A model of care provided through a DHCS program to coordinate health care, long term care, and other social services to help older adults who would otherwise reside in nursing facilities to remain in their own homes. A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).
Protocols	Performance standards, policies and procedures, and other system requirements that determine a service center's response to a consumer request for assistance.
Provider	A health professional or health practitioner who provides preventative, curative, promotional, or rehabilitative health care services. For this report, provider may refer to an individual or a hospital, clinic, medical group, or other group of professionals that provide medical services.
Provider Attitude and Service	Complaint alleging rude, threatening, or other coercive or unprofessional behavior by a provider or their representative.
Quality of Care	Complaint alleging that the health care provided was not appropriate for their health needs or the provider did not possess sufficient competency.
Question of Fact/ Contract/ Provision/ Legal Issue	Complaint involves a question of fact, or a question of law involving a contract provision or interpretation thereof, and therefore falls outside the regulatory authority or oversight of the reporting entity.

Term	Explanation
Quick Resolution (QR)	A complaint type reported by DMHC. DMHC staff use the QR process for certain issues that can be resolved without standard complaint or urgent nurse processes, such as requests to file a grievance/appeal, expedited review of a grievance/appeal, access to providers, out of network referrals, second opinion consultation, quality of care complaints, or refill of medication(s).
Race	A demographic data element for the Complaint Data report consisting of categories White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian, Native Hawaiian or Other Pacific Islander, Other, Other Pacific Islander, Unknown, and Refused.
Referred to Other Division for Possible Disciplinary Action	Complaint referred elsewhere within regulating agency (Legal, Agent Services, Investigations, etc.) based on apparent or suspected violations of state law, etc.
Refused	A data element indicating that the complainant refused to answer or identify information in a collected data category.
Refused/Unknown	A composite data element indicating that the complainant either was not asked for or refused to provide this information. This element combines complaints reported as Refused and Unknown under a category.
Regulator	A government entity with the authority to oversee and enforce health insurance laws and regulations, including those related to licensing, product regulation, financial regulation, and market conduct. For the Complaint Data Report, plan regulator options include California Department of Insurance (CDI), Department of Managed Health Care (DMHC), Centers for Medicare and Medicaid Services (CMS), Office of Personnel Management (OPM), Department of Labor (DOL), Out of State Department of Insurance, Other, and Unknown. (Also see Plan Regulator)
Reporting Entity	A state health care department or organization that is statutorily required to provide consumer complaint data and other consumer assistance information for this reporting initiative. Reporting entities are the Department of Managed Health Care, Department of Health Care Services, Department of Insurance, and the California Health Benefit Exchange (Covered California).

Term	Explanation
Request for Assistance	A call, email, or other contact made to a state reporting entity from a consumer who is looking for help resolving a problem or complaint or who has a question regarding his/her health care coverage. For this report, this category includes all consumer contacts for jurisdictional and non-jurisdictional complaints and inquiries.
Resolution Time	The time from the date a complaint was filed by a consumer with a reporting entity to the date that a complaint was closed by that reporting entity. Reporting entities may have different protocols for when they register the opening and closing of a complaint case.
Scope of Benefits	A complaint reason reported by DHCS that encompasses multiple complaint reasons regarding the delivery of services, including access to care, quality of care, medical necessity denials, and others. DHCS indicated that their data currently cannot be separated into more specific standardized report reasons.
Sent to Company Quality Assurance	A complaint result indicating that the complaint was referred to the regulated entity's quality assurance for further investigation, and the complaint has been closed within the regulating agency.
Service Center	Health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers. For this report, service centers refer to those operated or contracted by the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California.
Silver	A product type indicating a health plan with a level of coverage provided with 70 percent of the total allowed costs of benefits paid by the health plan.
Small Group	A product type indicating coverage provided by a health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.
Source of Coverage	A complaint data element used to identify a category of a health plan's contracting/purchasing mechanism, which is associated with an insurance market segment and related laws. Examples of coverage sources include Individual/Commercial, Group, Medi-Cal, and COBRA.

Term	Explanation
Specialty License	A specialized license is issued by DMHC to a health plan that meets requirements under the Knox-Keene Act and provides health care services in a single area such as dental, vision, or mental health.
Stand Alone Dental	A product type indicating coverage provided by a limited scope dental benefits plan through an exchange or in conjunction with a qualified health plan. This type of dental plan is not a part of the medical plan.
Standard Complaint	A report data element indicating a complaint type used for complaints that undergo the reporting entity's typical complaint review process. Examples of issues that may be addressed as a Standard Complaint include billing problems, cancellation of coverage, and a provider's attitude. Complaints that are urgent or require the intervention of a health care provider may also be addressed as Standard Complaints.
State Fair Hearing	A formal complaint process to adjudicate appeals from California residents who have applied for, have received, or are currently receiving benefits or service from an assistance program administered by the State of California. The California Department of Social Services is authorized to conduct State Fair Hearings for appeals regarding Covered California applications and eligibility determinations, as well as for all Medi-Cal appeals. A State Fair Hearing is sometimes called a State Hearing, Fair Hearing, or Medi-Cal Fair Hearing.
State Fair Hearing: Informal Resolution	A complaint type used by Covered California that identifies a complaint that was filed as an appeal to the California Department of Social Services for a State Fair Hearing but was resolved before the State Fair Hearing took place.
State Specific (Other)	A complaint data element indicating an element that is state-specific and cannot be conveyed with other available options. Reporting entities use further internal coding to track data as needed.

Term	Explanation
Two-Plan Model	A Medi-Cal managed care plan model approved by the federal government under an 1115 Waiver. In this Medi-Cal managed care model, DHCS contracts with a local initiative plan (county organized) and a commercial plan. The Two-Plan Model serves Medi-Cal beneficiaries in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.
Unknown	A complaint data category indicating data was not identified. Data listed as Unknown were for fields submitted as Unknown or blank (without data), either because the data was not collected by a reporting entity (CDI, Covered California, DHCS, or DMHC) or because there were complainants who did not provide information to a reporting entity. If a reporting entity can distinguish Refused from Unknown, Unknown indicates that the complainant was not asked for the information.
Unsatisfactory Refund of Premium	Complaint alleging insurer or their representative failed to properly refund an unearned premium.
Unsatisfactory Settlement/Offer	Complaint that insurer's payment or settlement offer is less than or below the amount expected by the insured or claimant.
Upheld/Covered California Position Substantiated	A Covered California Complaint Result indicating that Covered California's original position appears to be in compliance with applicable statutes/regulations. Also see Upheld/Health Plan Position Substantiated.
Upheld/Health Plan Position Substantiated	The regulated entity upheld its original position, and appears to be in compliance with applicable statutes/regulations.
Urgent Nurse Complaint (or Urgent Nurse Case)	A complaint type reported by DMHC. DMHC's Urgent Nurse process identifies and addresses complaints involving a potential health risk to the complainant and that may need immediate attention and expedited resolution by DMHC clinical staff, who are experienced in both health care and managed care systems.

Term	Explanation
Utilization Review	Complaint regarding a technique for controlling medical expenses by reviewing utilization patterns reflected in claims information. Type, quantity, and charges related to medical services are evaluated to identify problem areas responsible for increasing cost. Specific diagnoses, procedures, service providers, and claimant group responsible for increasing cost are identified.