

Public Employees Benefits Board Annual Report

Customer Service Complaints and Appeals

Substitute Senate Bill 6584, Chapter 293, Laws of 2010

RCW 41.05.630

September 30, 2019

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Executive Summary

During fiscal year 2019, complaints within the Public Employees Benefits Board (PEBB) Program health plans dropped by 29.4 percent among non-Medicare members, while appeals increased by 29.3 percent. Among Medicare members, complaints increased by 27.3 percent, and appeals dropped by 6.5 percent. While there is no direct connection between the numbers of complaints and appeals reported, if a complaint is denied, it can lead to an appeal. Leading categories of complaints are “Quality of a Health Care Service” and “Availability of a Health Care Service”.

During the 2019 fiscal year, Kaiser Permanente of Washington adjusted their methods of collecting data for Customer Service Complaints and Appeals and Quality of a Health Care Service Complaints and Appeals to match the methods used by Kaiser Foundation Health Plan of the Northwest. This change led to more granular data collection, which in turn created higher numbers in those categories (particularly in Quality of a Health Care Service). The new method of data collection is a significant cause of the increased number of Quality of a Health Care Service Complaints and Appeals, although the actual increase cannot be exactly quantified.

Because of the continued operational adjustments within the PEBB Program health plans, complaints and appeals data for 2019 continues to be unstable. This limits our ability to identify clear trends in the data from the last five years. Now that all plans are using similar collection methods, trends may be more readily apparent in future years.



Background

The Washington State Health Care Authority (HCA) administers the Public Employees Benefits Board (PEBB) Program, which aims to provide Washington public employees and retirees with high-quality, low-cost health care coverage. To help analyze PEBB Program Health Care Services, the Legislature passed SSB 6584 (2010), codified as RCW 41.05.630 measuring the complaints and appeals of PEBB members. The provision states,

Beginning in 2011, the HCA must capture customer service complaints and require each health plan that provides PEBB medical coverage to submit a summary of customer service complaints and appeals to the agency. The HCA must summarize the complaints and appeals processed in the preceding 12 months and report to the Legislature with an analysis of any trends by September 30 of each year.

The PEBB Program works with health plan partners to gather complaints and appeals data during the fiscal year (July 1 through June 30) and report the findings annually in September. However, the plan year runs from January 1 through December 31. Therefore, the complaints and appeals data in this report covers half of two calendar or plan years, twelve months of consecutive data, as required by RCW 41.05.630.

This report includes statistics collected from two separate PEBB risk pools: non-Medicare and Medicare members. Insurers form risk pools to spread risk evenly across a population of insured lives. Each health plan provided the number of complaints and appeals related to these three categories:

1. Availability of a health care service.
2. Customer service.
3. Quality of a health care service.

Data for this report is limited by three issues:

1. The plans do not use these three specific categories to track complaints internally or in other reports to the HCA. Each plan decides where to place their complaints and appeals in these three categories. This may result in some variation in how the plans sort complaints.
2. This report includes only those complaints and appeals that fit into one of the three named categories. Complaints and appeals that do not fit are not included in the medical plans' data.
3. Plan benefits may change significantly between plan years. Collecting data each fiscal year, which always captures two plan years, may obscure trends in complaint and appeals.

Findings

In the most recent fiscal year data, the total number of complaints shown in Table 1 (“Total Number of Appeals and Complaints July 2018-June 2019”) show that most complaints had to do with “Quality of a Health Care Service.” Among the Medicare population, though, “Availability of a Health

Care Service” complaints are equal to the “Quality of a Health Care Service” numbers. For Appeals, however, “Availability of a Health Care Service” leads all other categories (see Table 1).

It is worth noting that the fraction of complaints and appeals relative to the population size is quite low. Table 2 (“Total Number of Complaints Per 1,000 Members July 2018-June 2019”) offers some perspective. Customer Service complaints in the Medicare risk pool have the highest complaint rate at 4.5 per 1,000 members. Complaints about “Quality of a Health Care Service,” which seemed so high in Table 1, only register as 0.5 complaints per 1,000 non-Medicare members and 0.7 complaints per 1,000 Medicare members. Less than one person per 1,000 members submits a complaint about the “Quality of a Health Care Service” in the PEBB Program health plans.

Total complaints and appeals over the last five years

Table 3 (“Total Complaints and Appeals 2015-2019”) places the 2019 fiscal year results in a five-year perspective by comparing this year’s numbers to previously reported complaints and appeals. In this perspective, we see that Complaints for Non-Medicare members have fallen by 29.5 percent, a decrease of nearly 400 complaints.

Among Medicare members, conversely, complaints increased by 202 or 14 percent (See Table 3). This increase is due, at least in part, to Kaiser Permanente of Washington (KPWA) changing their reporting requirements. After Kaiser Permanente acquired Group Health Cooperative (GHC) in early 2017, KPWA introduced a transition process to shift operational and reporting processes from GHC standards to KPWA standards. The change to data collection reached complaints and appeals reporting during the third quarter in 2018.

Under the new KPWA standards, the plan reviews each complaint to treat each concern as a separate complaint. For example, if members call in to complain about the wait time they had visiting their primary care physician and they then express dissatisfaction with how their PCP listened to them during the visit, the complaint is counted in two categories: Availability of a Health Care Service and Quality of a Health Care Visit. This could potentially double or triple the complaints attached to a single contact with a member because the complaint is counted in more than one category. Because KPWA did not previously report these categories, the new data has caused significant jumps in some categories, especially for Quality of a Health Care Service.

Table 4 (“Total Complaints and Appeals Per 1,000 members 2015-2019”) shows that complaints are declining among non-Medicare members. For 2019, the rate was 3.5 per 1,000, down from both 2018 and 2017. Among Medicare members, though, complaints have increased after last year’s drop-off from 7.2 per 1,000 in 2018 to 8.9 per 1,000 in 2019 (see Table 4). Again, much of this increase can be linked to the new reporting processes from KPWA.

Appeals among non-Medicare members increased by nearly 200 in 2019, but appeals among Medicare members for the same period held fairly steady (See Table 3). The overall rate of appeals remains low with 3.0 per 1,000 in the non-Medicare membership and 1.5 per 1,000 in the Medicare population on PEBB Program health plans (see Table 4).



Categories of complaints and appeals

As explained above, most complaints in 2019 had to do with Quality of a Health Care Service. Among the Medicare population, though, complaints about Availability of a Health Care Service reach similar numbers. For appeals, Availability of a Health Care Service leads all other categories (see Table 1).

A look at the 2019 findings for Availability of a Health Care Service in Table 5 shows that, among non-Medicare members, this category of complaint has decreased significantly. Since 2017, they have dropped by over 80 percent, to 178 per 1,000 members for 2019. For Medicare members, however, 2019 results erased the 2018 decrease and had 329 complaints (see Table 5). Table 6 (“Availability of a Health Care Service per 1,000 Members 2015-2019”) also reflects this change with 2019 complaints among non-Medicare members at 0.7 per 1,000, while among Medicare members, the rate is 3.1 per 1,000 members.

For Appeals for Availability of a Health Care Service among the non-Medicare members, there has been a year-over-year increase since 2016. This increase started small but has grown. From 2016 to 2019, the number of appeals have risen from 444 to 801, an 80.4 percent increase (See Table 5). For Medicare members, the increase over the same period has been less dramatic, from 92 to a high of 162, with a decrease this year to 155 (See Table 5). The overall change in these appeals for Medicare members is 68.5 percent.

When we compare these statistics in the per 1,000 member calculations, the changes are smaller, but also show an increase. In Table 6 (Availability of a Health Care Service per 1,000 Members 2015-2019”), non-Medicare appeals increased 70.6 percent, from 1.7 members to 2.9 members per 1,000. Medicare appeals in the same period moved from 0.9 per 1,000 to a high of 1.6 per 1,000 before a slight decrease to 1.5. Overall, that percentage increase is nearly 67 percent.

The Customer Service Complaints and Appeals category is one area where significant improvement appears in our five-year review. In Table 7, (“Customer Service 2015-2019”), the five-year trend seems to have peaked and begun to decline. From a high of 885 non-Medicare complaints about Customer Service in 2017, we had 365 complaints in the same category in 2019 for a 58.8 percent decrease. Similarly, Medicare member complaints have declined 38.8 percent from 461 last year (nearly steady after the 2017 surge to 458) to 282 in 2019. In Table 8, the corresponding drop in the non-Medicare complaints is from 3.3 complaints per 1,000 members to 1.3 complaints. Among Medicare members, the decrease is 41.3 percent from 4.6 to 2.7 complaints per 1,000 (See Table 8).

As mentioned before, Quality of a Health Care Service had a definite increase in complaints. The new data KPWA began to report in fiscal year 2019 resulted in this increase. Complaints grew by 172.7 percent between 2018 and 2019 among non-Medicare members, going from 150 to 409 complaints (See Table 9). In the Medicare population, a surge of complaints occurred, driving them from 75 to 329, for a 338.7-percent increase.



Conclusion

Most, if not all, of the increase in complaints and appeals in 2019 result from new data KPWA began to report in fiscal year 2019. Because of the influx of new data, we are not able to identify trends across years. New reporting processes make the data appear volatile; only after a few years will it stabilize enough to allow us to spot clear trends. Nevertheless, it seems that a decrease in complaints and appeals began in 2017 that will hopefully continue after this adjustment for new reporting methods.



Data

Here is a list of the tables:

- **Table 1. Total Number of Appeals and Complaints July 2018-June 2019**
- **Table 2. Total Number of Appeals and Complaints Per Thousand Members July 2018-June 2019**
- **Table 3: Total Complaints and Appeals 2014-2019**
- **Table 4: Total Complaints and Appeals Per 1,000 Members 2014-2019**
- **Table 5: Availability of a Health Care Service 2014-2019**
- **Table 6: Availability of a Health Care Service per 1,000 Members 2014-2019**
- **Table 7: Customer Service 2014-2019**
- **Table 8: Customer Service per 1,000 Members 2014-2019**
- **Table 9: Quality of a Health Care Service 2014-2019**
- **Table 10: Quality of a Health Care Service per 1,000 Members 2014-2019**



PEBB Health Plan Complaints and Appeals Data

Table 1. Total Number of Appeals and Complaints July 2018-June 2019

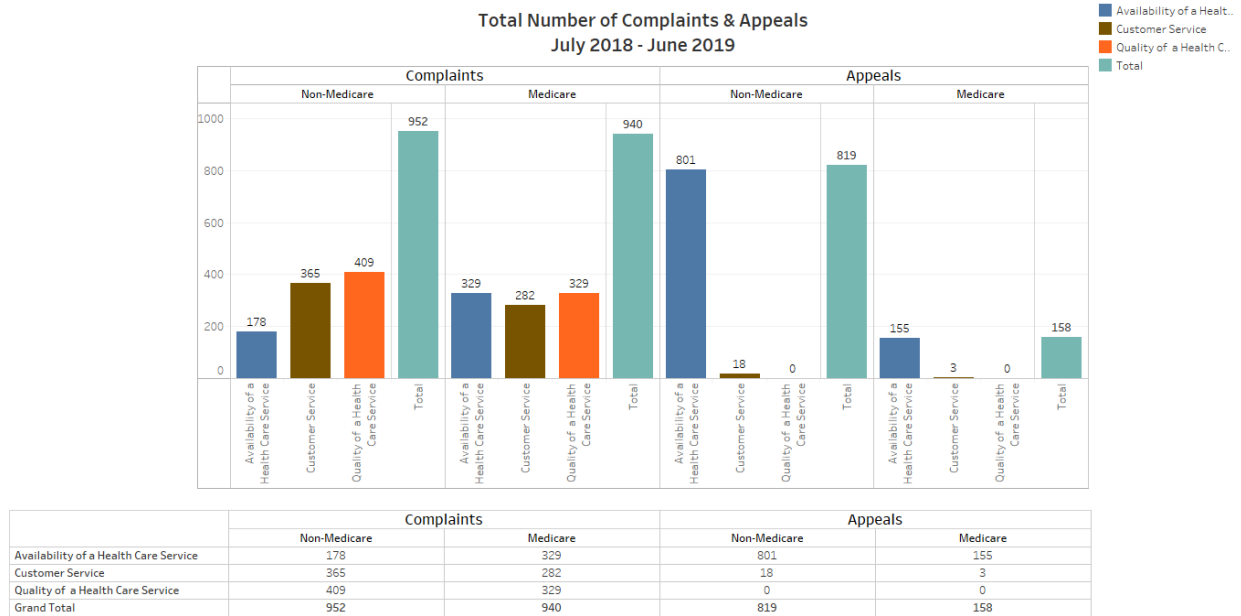
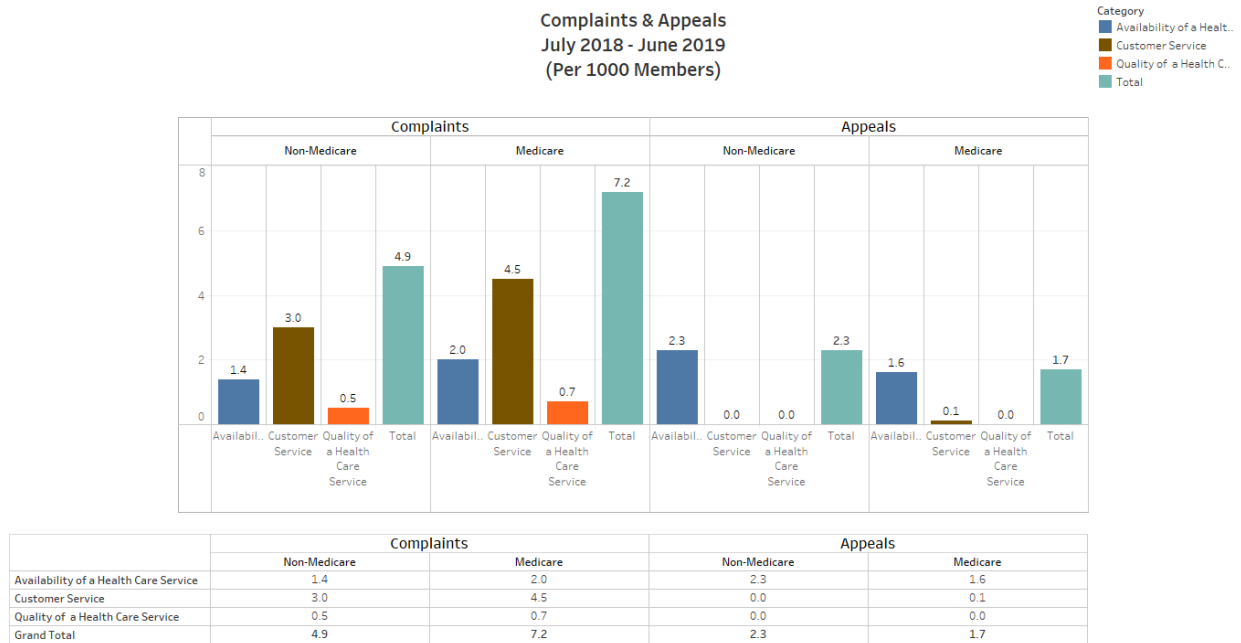


Table 2. Total Number of Appeals And Complaints per 1,000 Members July 2018-June 2019



Complaints and Appeals Data 2015-2019

Table 3: Total complaints and Appeals 2015-2019

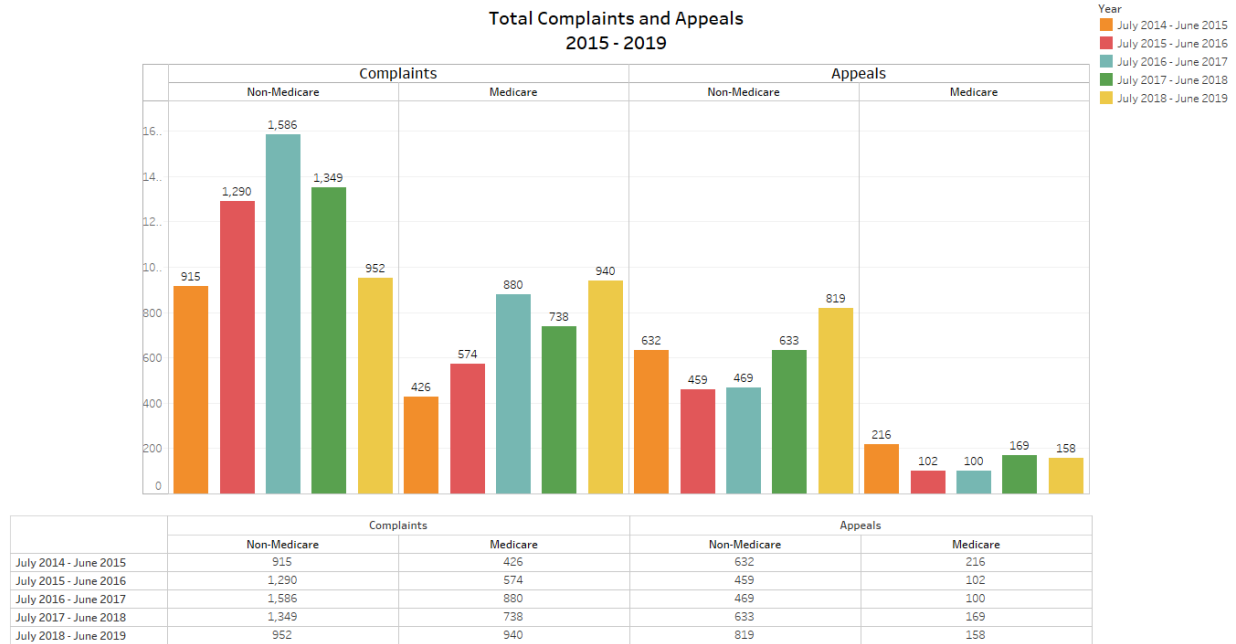


Table 4: Total Complaints and Appeals per 1,000 Members 2015-2019

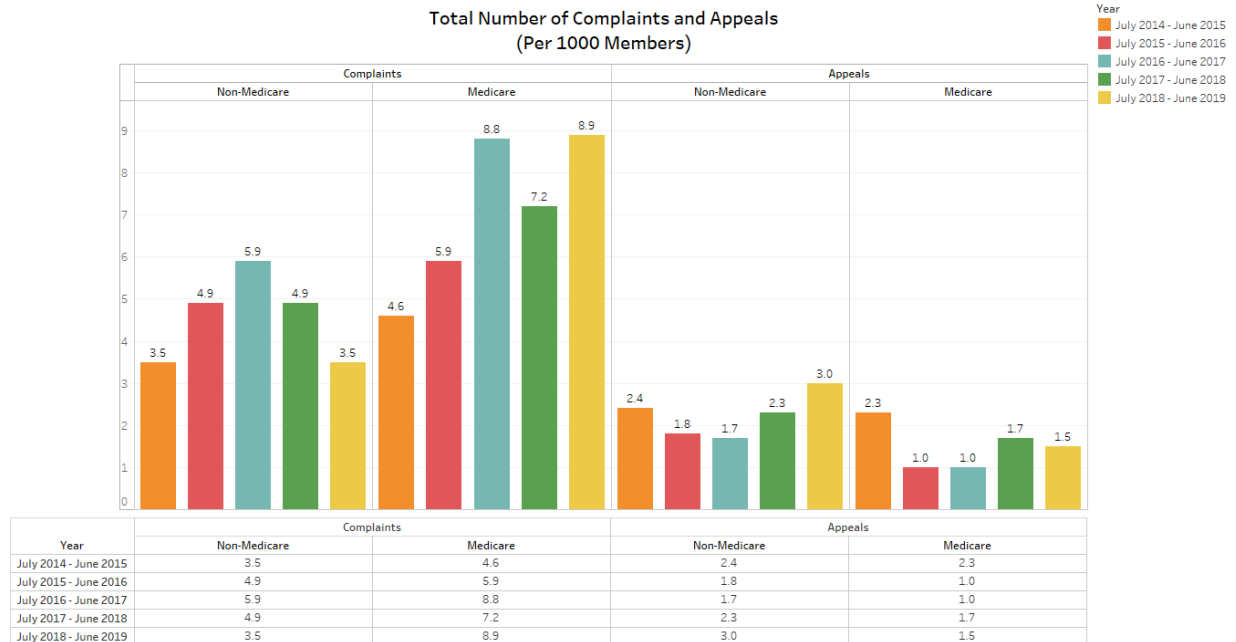


Table 5: Availability of a Health Care Service 2015-2019

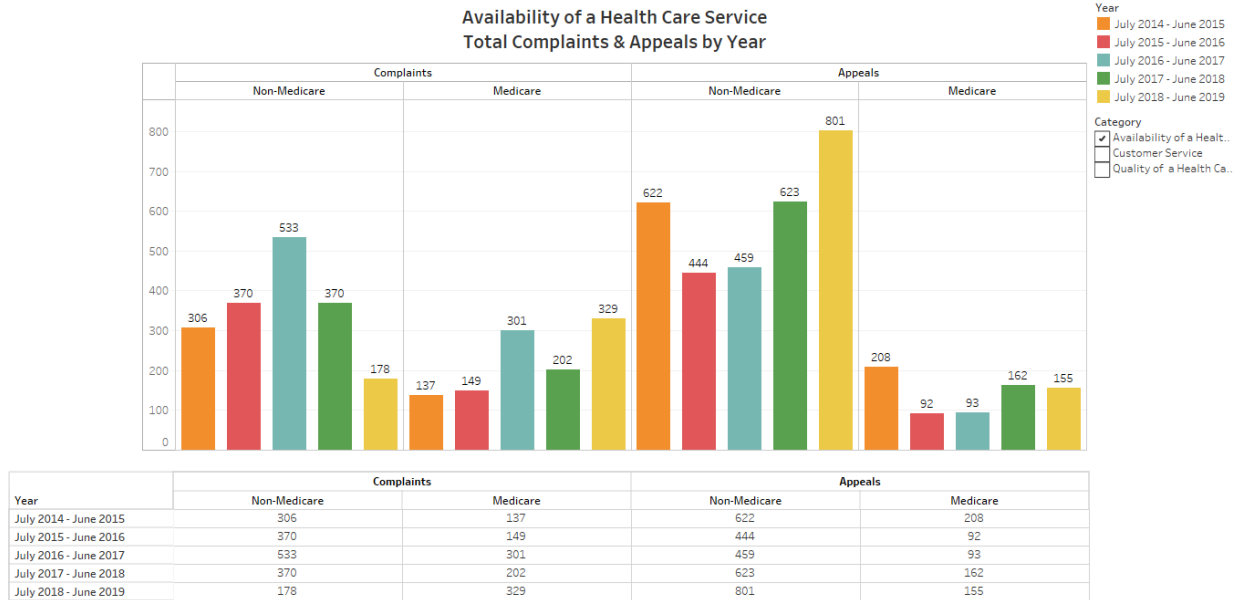


Table 6: Availability of a Health Care Service per 1,000 Members 2015-2019

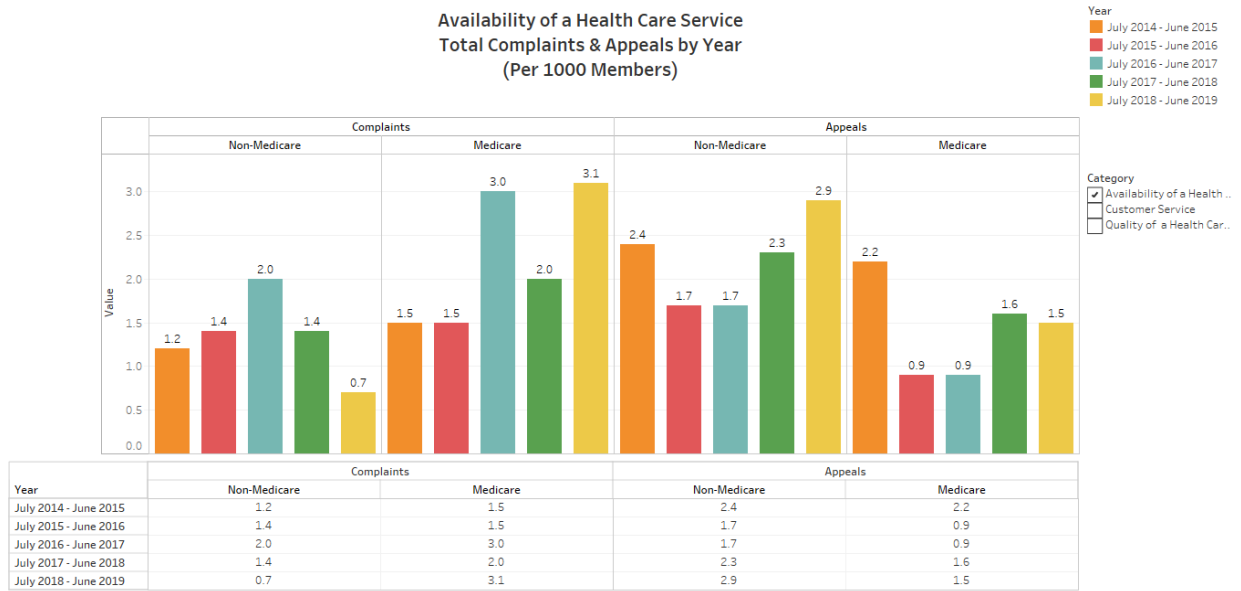


Table 7: Customer Service 2015-2019

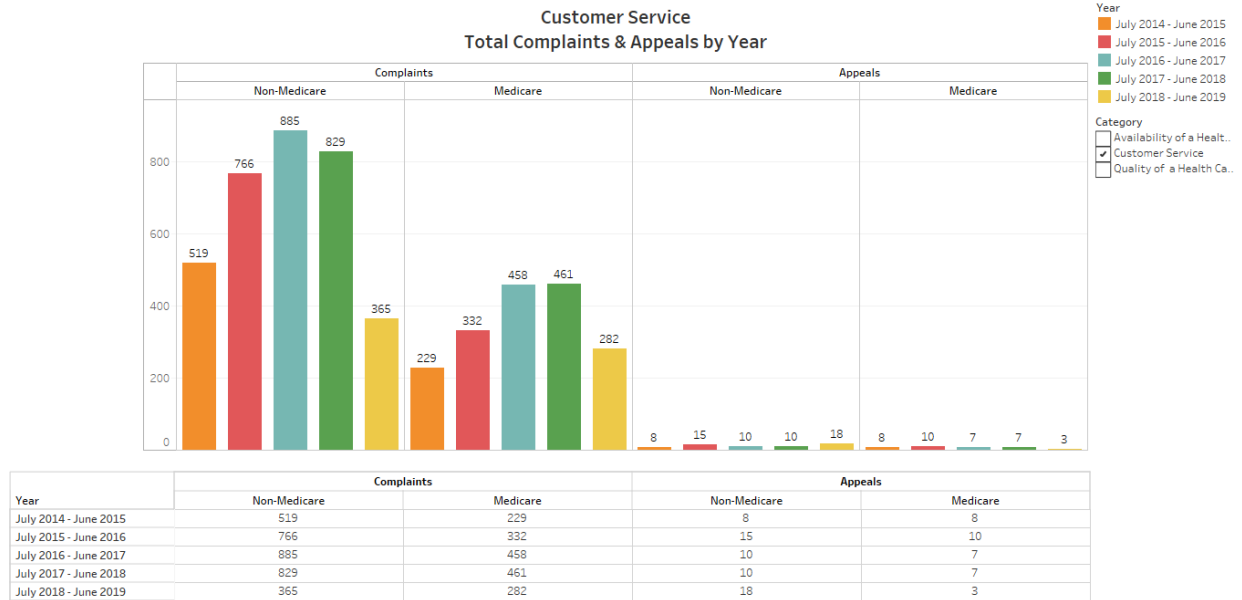


Table 8: Customer Service per 1,000 members 2015-2019



Table 9: Quality of a Health Care Service 2015-2019

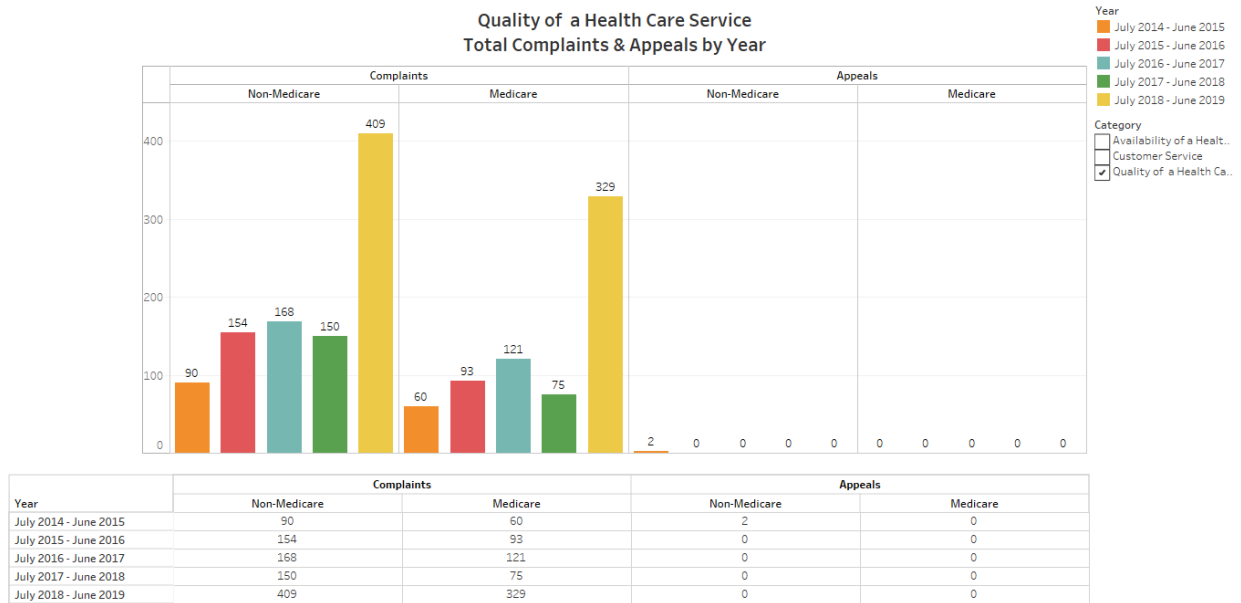
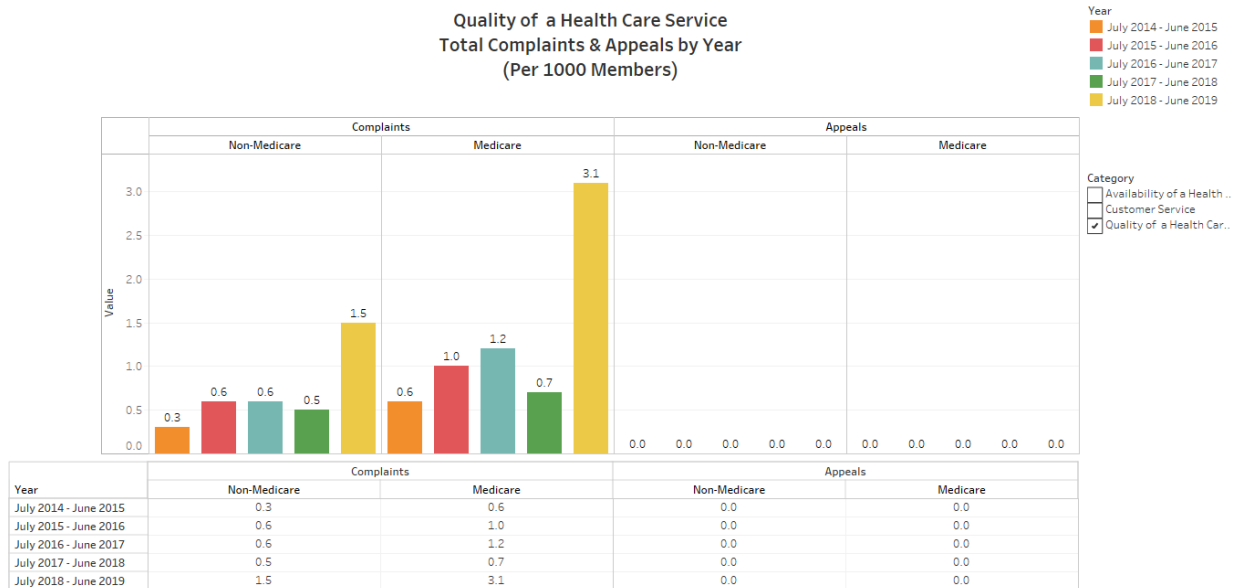


Table 10: Quality of a Health Care Service per 1,000 members 2015-2019



Conclusion

During fiscal year 2019, complaints within PEBB Program health plans dropped among non-Medicare members, while total appeals increased. Complaints among Medicare members increased by 27.3 percent, and appeals dropped by 6.5 percent.

Kaiser Permanente of Washington revised their data collection methods for 2019. In particular, they added data for Customer Service Complaints and Appeals and Quality of a Health Care Service complaints and appeals. In past years, that data remained uncounted. Better data collection led to higher numbers in those categories. The major cause for the increased number of Quality of a Health Care Service complaints and appeals is this new data collection method.

With the introduction of the new data collection methodology for fiscal year 2019, the overall data for the last five years remain too volatile for us to identify trends. Now that all the PEBB health plans are using similar collection methods, trends may be more obvious in future years.



Appendix A: Three types of PEBB medical plans

The PEBB Program offers three types of medical plans (value-based plans noted in **bold**):

Consumer-directed health plans

These plans let you use a health savings account to help pay for out-of-pocket medical expenses tax-free, have a lower monthly premium than most other plans, and a higher deductible and a higher out-of-pocket limit.

- **Kaiser Permanente NW CDHP***
- **Kaiser Permanente WA CDHP**
- UMP CDHP

Managed-care plans

Managed care plans may require you to select a primary care provider within its network to fulfill or coordinate all of your health needs. The plan may not pay benefits if you see a noncontracted provider.

- **Kaiser Permanente NW Classic***
- **Kaiser Permanente WA Classic**
- **Kaiser Permanente WA SoundChoice**
- **Kaiser Permanente WA Value**

Preferred provider organization (PPO) health plans

PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan.

- UMP Classic
- **UMP Plus–Puget Sound High Value Network**
- **UMP Plus–UW Medicine Accountable Care Network**

*Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.



Appendix B: Exhibits

The PEBB Program's complaints and appeals demonstrated by UMP and Kaiser Permanente plans from state fiscal year 2019.

- **Kaiser Permanente Northwest**
- **Kaiser Permanente Washington**
- **Uniform Medical Plan**

