Washington State Health Care Authority

REPORT TO THE LEGISLATURE

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, 2020

Public Employees Benefits Board Annual Report

Customer service complaints and appeals

Washington State Health Care Authority

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Executive summary

This 2020 report, submitted in response to ESSB 6584 (2010), details complaints and appeals in the Public Employee Benefits Board (PEBB) populations. The School Employees Benefits Board (SEBB) complaints and appeals data will be presented after data from a complete plan year is available, beginning with next year's report.

There is one substantive change in this year's report. Rather than reporting on data collected from July through June as has been done in all previous versions of this report, it was decided to align the data reporting period with the plan year (January through December) for PEBB. This change in reporting period will give a more complete overview of the complaints and appeals within a single plan year, rather than reporting on data from two different plan years. Additionally, this new reporting period better aligns with the PEBB health plan portfolio because new or revised benefit designs start in January and remain through the end of the year. Moving forward, future versions of the report will be based on data collected from the plan year for both PEBB and SEBB, which is January through December for both programs.

Data on PEBB complaints and appeals from the 2019 plan year (January 2019 through December 2019) was used for this report. The following are key findings from the 2019 plan year:

- PEBB Non-Medicare population:
    - Complaints show a significant downward trend year-over-year.
    - However, there seems to be an upward trend in appeals.
    - There does not appear to be a connection between the number of complaints and the number of appeals, so ERB will attempt to mitigate this increase in appeals by educating members about the complaint process.
- PEBB Medicare population:
    - There was an increase in complaints in 2019.
    - The increase in complaints may be related to the new data collection methodology that Kaiser Permanente Washington (KPWA) began using in 2018 that potentially duplicates complaints by logging one complaint into several different categories.
    - Many complaints may also be attributed to the design of Medicare benefits, which are not under the control of ERB.
    - The addition of more Medicare Advantage plans to the ERB portfolio may mitigate some complaints by increasing the number of choices Medicare members have for health care coverage.
    - Appeals remain low and steady year-over-year.
- ERB and its PEBB health plan carriers will continue to work on mitigating the causes of complaints and appeals, especially those related to accessing to health care services.

Data Reporting Period Change

Report Background

In 2010, the Legislature passed SSB 6584, codified as RCW 41.05.630, which called for measuring the complaints and appeals of PEBB members. The RCW states:

> *Beginning in 2011, the HCA must capture customer service complaints and require each health plan [carrier] 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.*

For the initial 2011 report, it was decided that complaints and appeals data would be collected for the twelve months *immediately preceding* the legislative effective date—July 1, 2010. This reporting period aligned with the State's fiscal year, but overlapped between the PEBB's plan years that run January through December of each year.

Addition of School Employees Benefits Board

When the SEBB population was added to ERB's book-of-business in 2017, it provided an opportunity to reconsider how the Complaints and Appeals Report is produced each year. Inclusion of SEBB in the report caused several challenges to emerge:

- Coverage under the SEBB health plans did not start until January 1, 2020.
- ERB had no access to pre-SEBB school district medical contracts, or the June—December 2019 complaints and appeals data for each school district.
- The SEBB data that *could be* reported would be only from 2020 Quarters 1 and 2, data that would be potentially skewed by the atypical issues that arise during complicated implementations of large programs with many new health plans, such as:
    - Hundreds of thousands of new members relatively unfamiliar with a new slate of enrollment procedures and benefit options;
    - Establishing initial eligibility;
    - Continuing coverage from previous plans; and
    - Issues concerning new service areas.

In response to these concerns, ERB made the decision to change the data reporting period to align with the PEBB and SEBB plan year, which runs from January to December of each year. Advantages of using the plan year for the data reporting period include:

- Aligning the data reporting period with the annual cycle of PEBB, SEBB, and its health plan carriers' operations;
- Capturing the entirety of SEBB's first plan year data when reported in the 2021 version of this report;
- Enabling ERB to identify impacts of:

- Specific benefit changes—which are implemented on a plan year basis—that may have resulted in more complaints and appeals, and
- Health plan carrier customer service activities aimed at reducing complaints and appeals.

Data Reporting Period Transition

Under the revised data reporting period, the annual Complaints and Appeals Report submitted during any calendar year will recap the complaints and appeals data for the plan year that ended in December of the previous year. As such, this report contains data from January through June 2019 that had been reported on in last year's report, as well as new data from July through December 2019. This was done to ensure there was no gap in the reported complaints and appeals. All charts in this report have been annotated to indicate the duplication in reported data from last year's report.

Categories and Cohorts

The legislation requires carriers to assign their complaints and appeals data to three categories outlined in the legislation: (1) dissatisfaction with customer service, (2) the quality of a health services, and (3) the availability of a health service. (RCW 41.05.630).

Data for this report is limited by two issues:

1. Carriers do not tend to use these three specific categories to track or report complaints, such that the appeals and complaints they receive are assigned to a category after-the-fact. This could result in some variation in the data, depending on how the carriers decide to sort their 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 carriers' data.

An additional note on the data categories: PEBB's fully-insured plan carriers—like Kaiser Permanente of Washington—tend to have higher overall numbers of complaints and appeals because it functions as both an insurer and a provider. When members have complaints about scheduling appointments or a disagreement with a provider, those complaints count against the carrier's overall numbers. In contrast, PEBB's self-insured plans, which are administered by Regence, function as an insurer only and not a provider (the self-insured plans are not the employer of the providers), and are therefore likely to just receive complaints about health care services.

PEBB has historically reported on two cohorts of data based on its two separate risk pools—non-Medicare and Medicare members. For the 2019 plan year, there were 274,425 non-Medicare members and 106,424 Medicare members.

Complaints and Appeals Data Tables

The following section contains tables of the data on complaints and appeals collected from the PEBB health plan carriers. As noted above, data from prior years reporting was collected on a fiscal year basis (from July through June), and for 2019 the reporting period aligns with the PEBB plan year (which runs January through December). This is noted by either "FY" for fiscal year or "CY" for calendar/plan year.

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- **Table 5b: "Availability of a health care service" complaints and appeals per 1,000 members, FY2016-CY2019**
- **Table 6a: Total "customer service" complaints and appeals, FY2016-CY2019**
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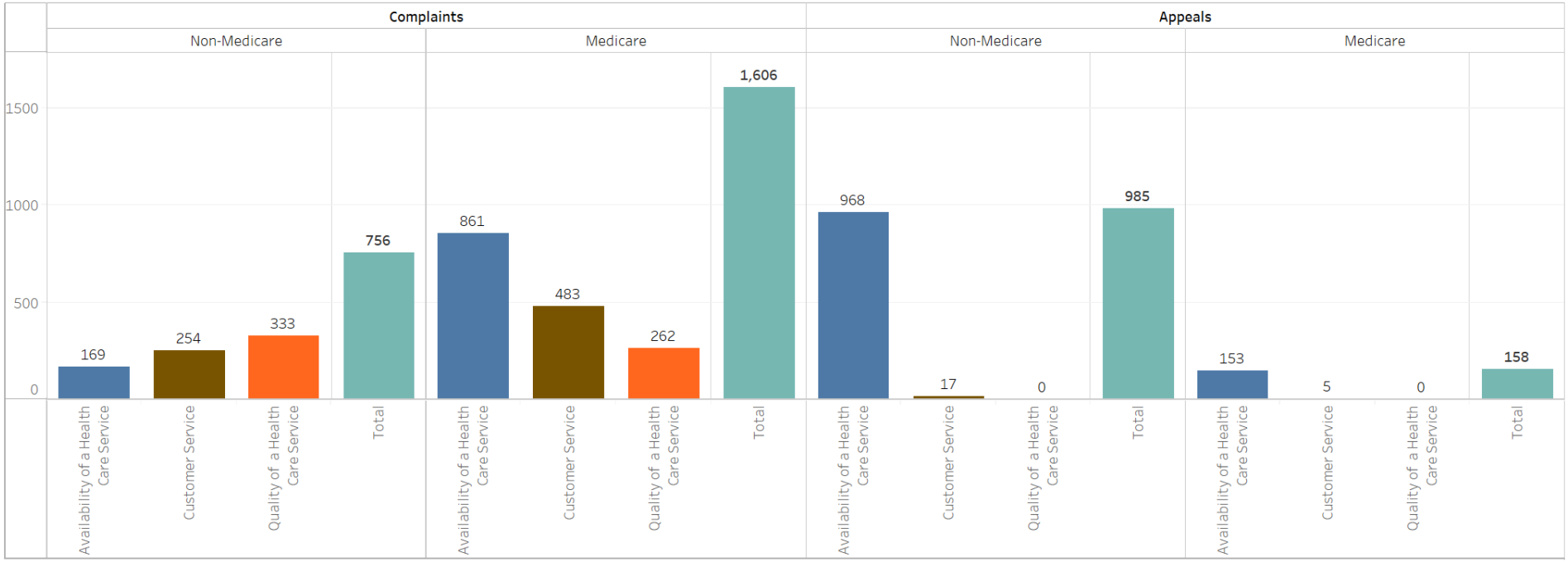
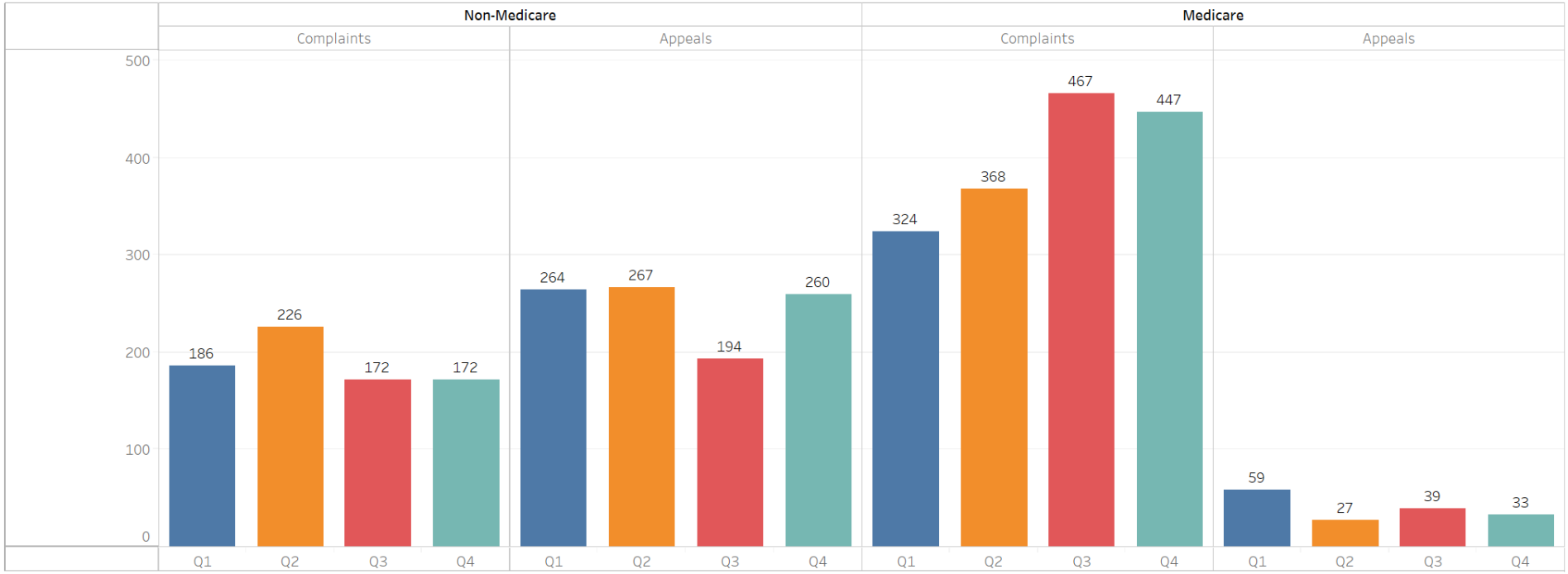
- **Table 7b: "Quality of a health care service" complaints and appeals per 1,000 members, FY2016-CY2019**

Table 1: Complaints and appeals by category, CY2019



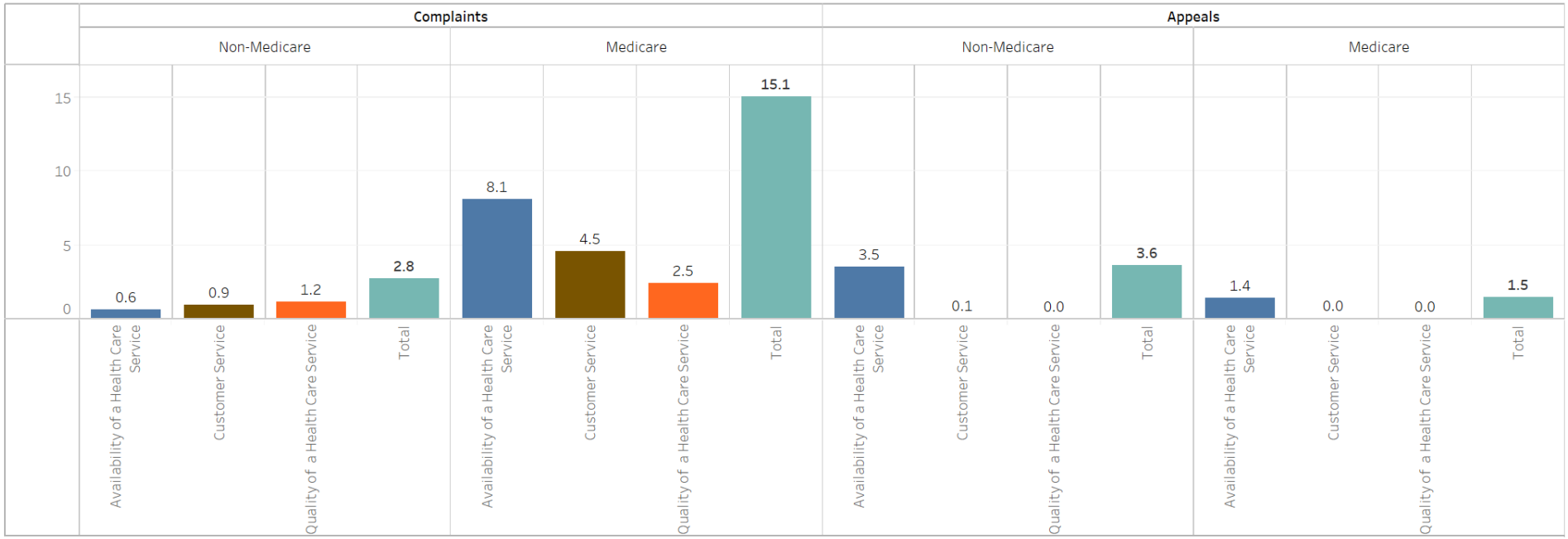
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
Availability of a Health Care Service	169	861	968	153
Customer Service	254	483	17	5
Quality of a Health Care Service	333	262	0	0
Grand Total	**756**	**1,606**	**985**	**158**

Table 2: Total of all categories of complaints and appeals by quarter, CY2019



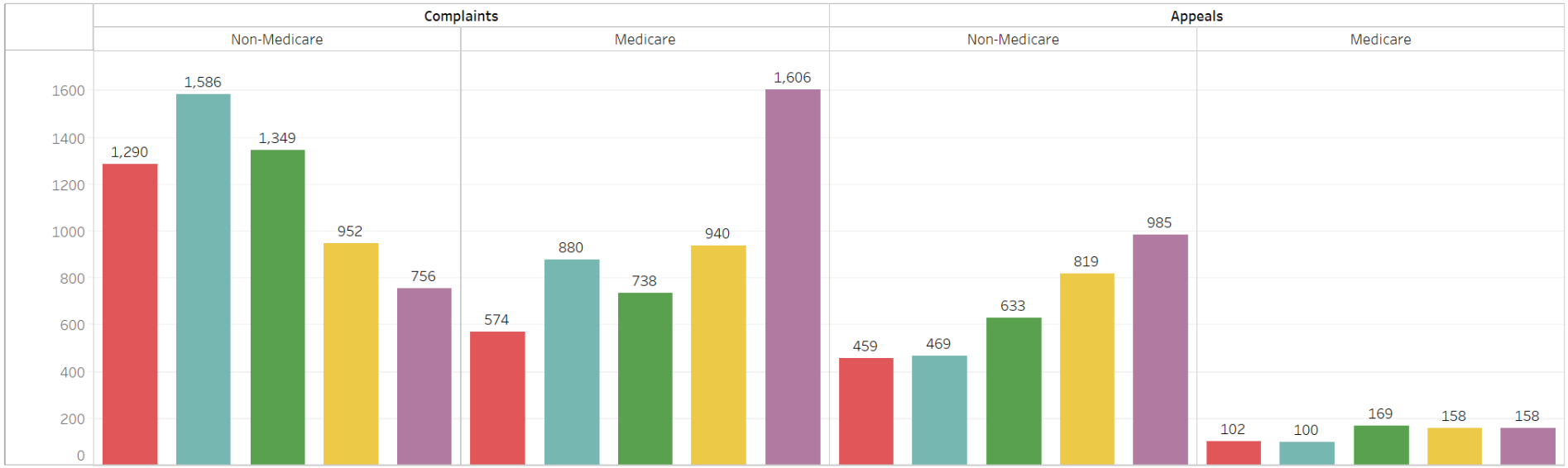
	Non-Medicare		Medicare	
	Complaints	Appeals	Complaints	Appeals
Q1	186	264	324	59
Q2	226	267	368	27
Q3	172	194	467	39
Q4	172	260	447	33

Table 3: Complaints and appeals by category per 1,000 members, CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
Availability of a Health Care Service	0.6	8.1	3.5	1.4
Customer Service	0.9	4.5	0.1	0.0
Quality of a Health Care Service	1.2	2.5	0.0	0.0
Grand Total	**2.8**	**15.1**	**3.6**	**1.5**

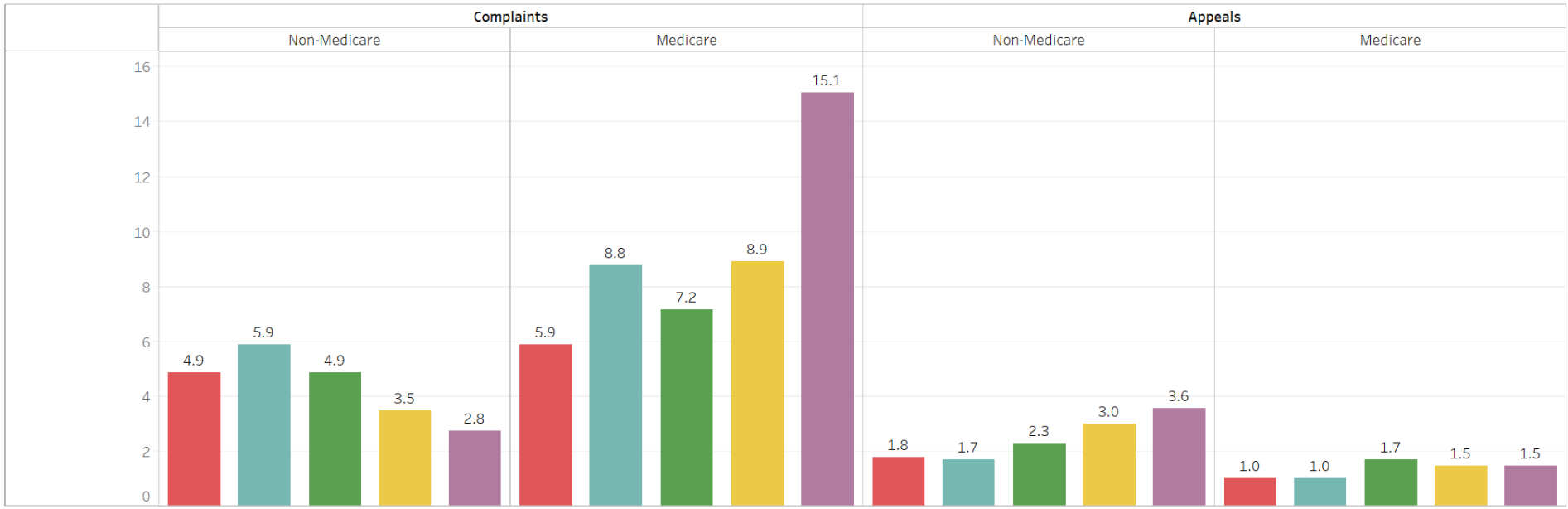
Table 4a: Total of all categories of complaints and appeals, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	1,290	574	459	102
FY 2017	1,586	880	469	100
FY 2018	1,349	738	633	169
FY 2019	952	940	819	158
* CY 2019	756	1,606	985	158

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

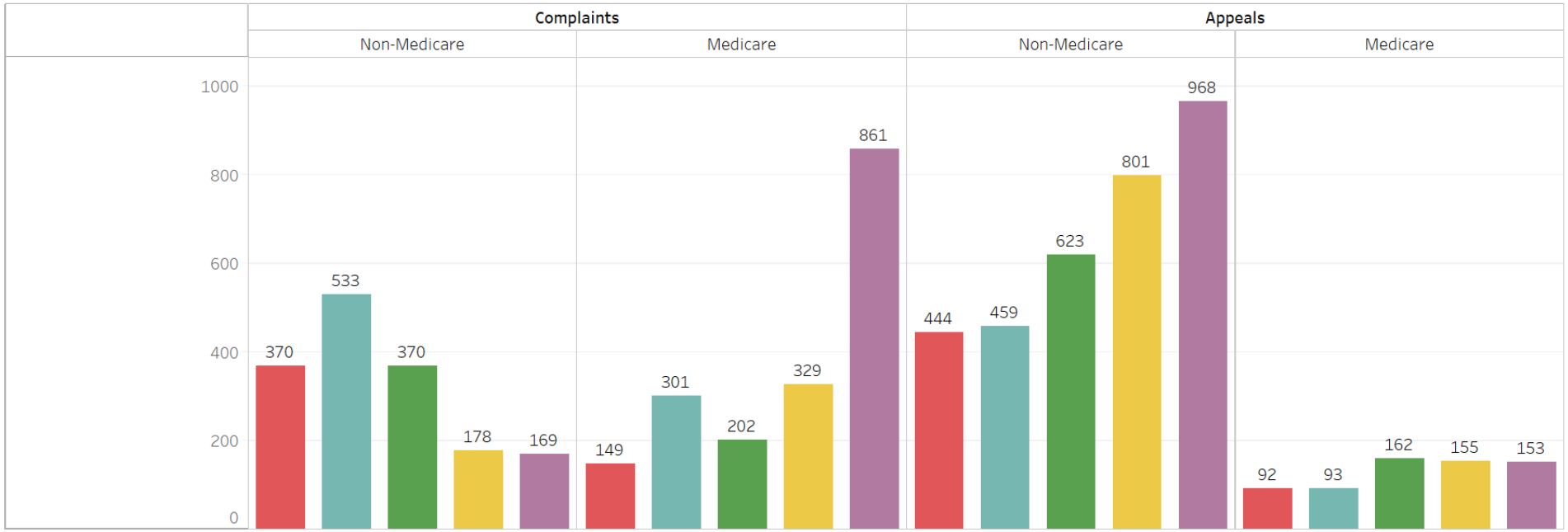
Table 4b: All categories of complaints and appeals per 1,000 members, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	4.9	5.9	1.8	1.0
FY 2017	5.9	8.8	1.7	1.0
FY 2018	4.9	7.2	2.3	1.7
FY 2019	3.5	8.9	3.0	1.5
* CY 2019	2.8	15.1	3.6	1.5

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

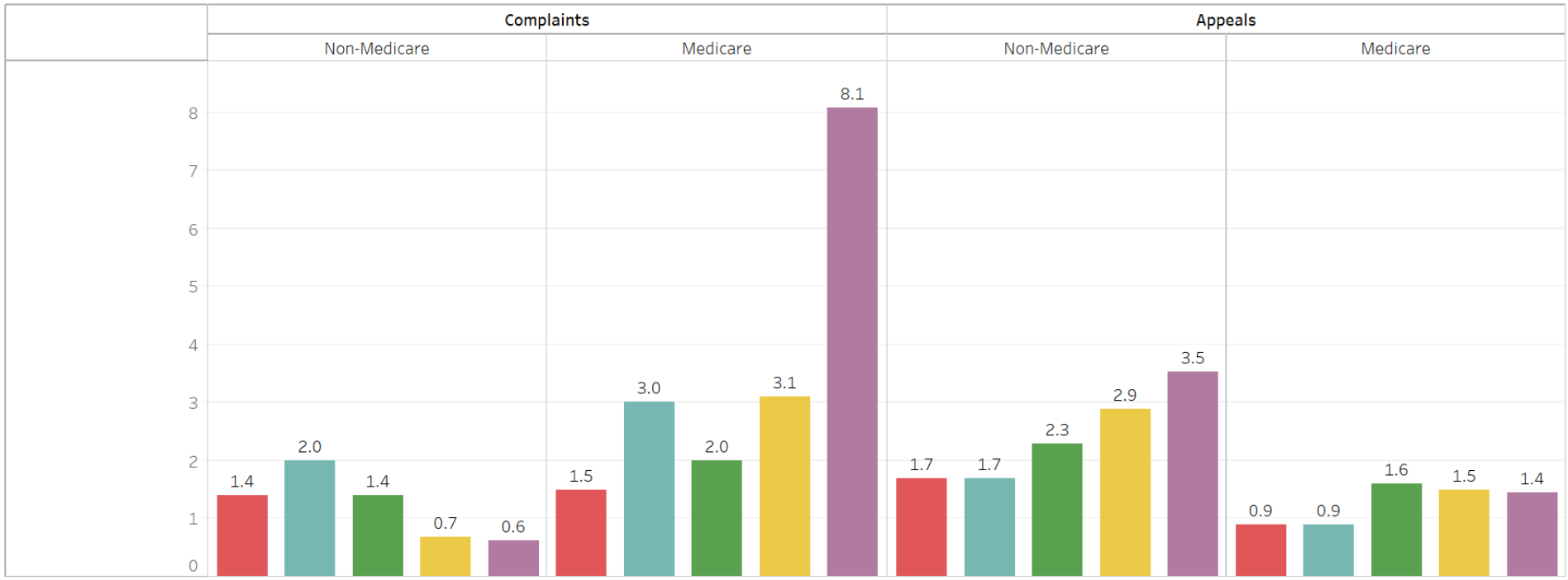
Table 5a: Total of "Availability of a Health Care Service" complaints and appeals, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	370	149	444	92
FY 2017	533	301	459	93
FY 2018	370	202	623	162
FY 2019	178	329	801	155
* CY 2019	169	861	968	153

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

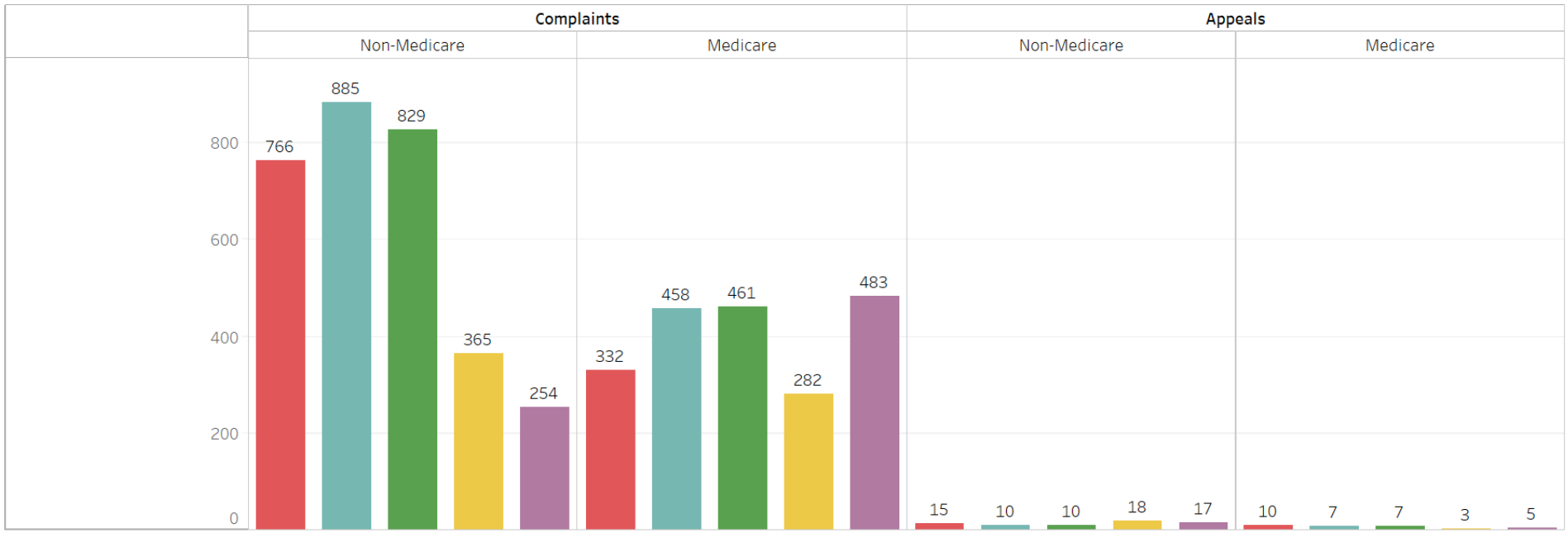
Table 5b: "Availability of a Health Care Service" complaints and appeals per 1,000 members, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	1.4	1.5	1.7	0.9
FY 2017	2.0	3.0	1.7	0.9
FY 2018	1.4	2.0	2.3	1.6
FY 2019	0.7	3.1	2.9	1.5
* CY 2019	0.6	8.1	3.5	1.4

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

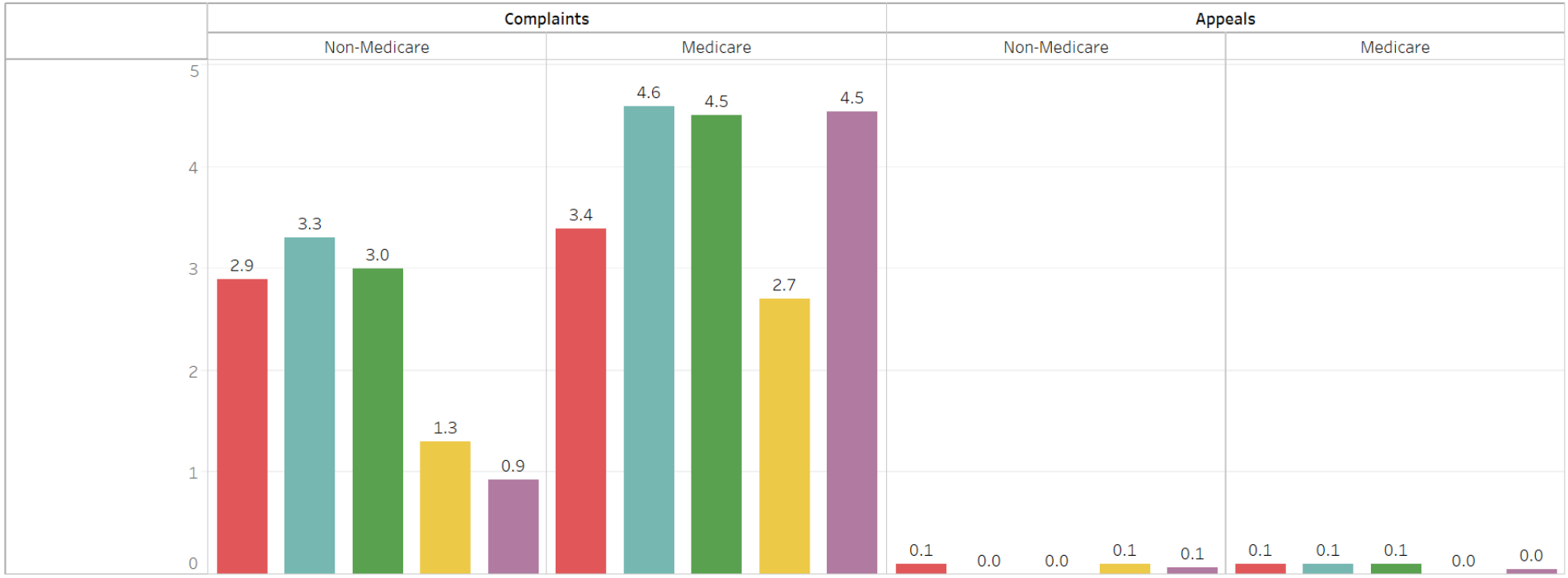
Table 6a: Total "Customer Service" complaints and appeals, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	766	332	15	10
FY 2017	885	458	10	7
FY 2018	829	461	10	7
FY 2019	365	282	18	3
* CY 2019	254	483	17	5

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

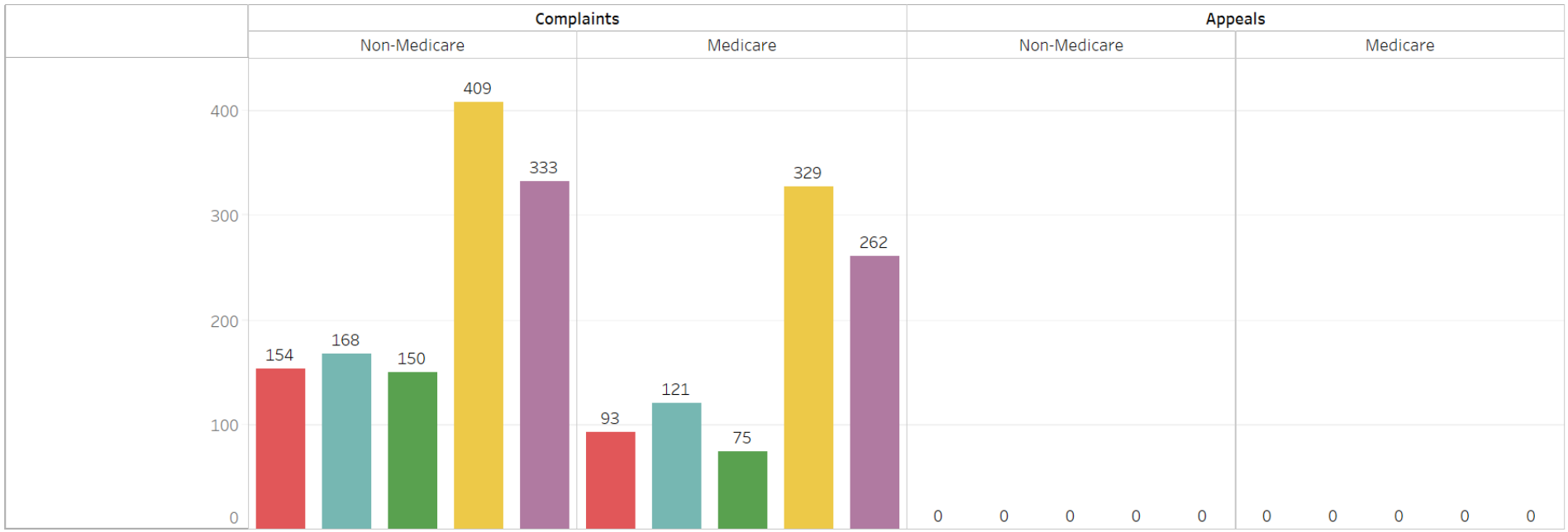
Table 6b: "Customer Service" complaints and appeals per 1,000 members, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	2.9	3.4	0.1	0.1
FY 2017	3.3	4.6	0.0	0.1
FY 2018	3.0	4.5	0.0	0.1
FY 2019	1.3	2.7	0.1	0.0
* CY 2019	0.9	4.5	0.1	0.0

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

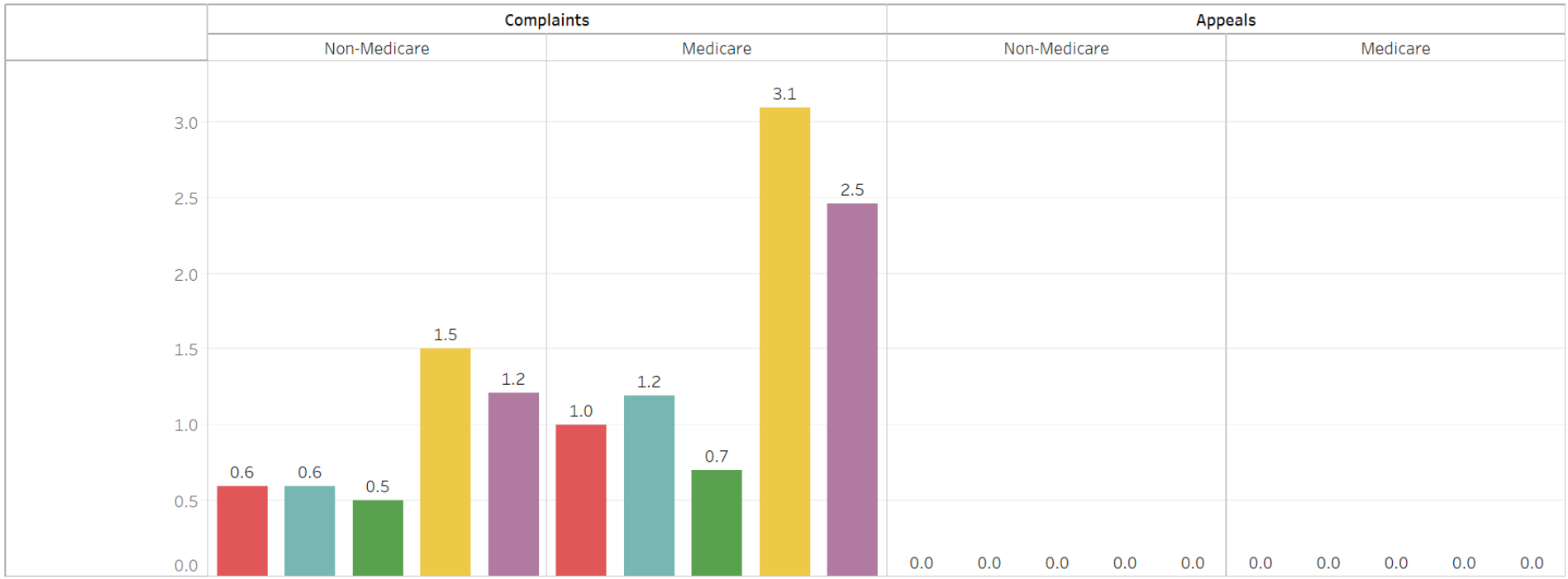
Table 7a: Total of "Quality of a Health Care Service" complaints and appeals, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	154	93	0	0
FY 2017	168	121	0	0
FY 2018	150	75	0	0
FY 2019	409	329	0	0
* CY 2019	333	262	0	0

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

Table 7b: "Quality of a Health Care Service" complaints and appeals per 1,000 members, FY2016-CY2019



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
FY 2016	0.6	1.0	0.0	0.0
FY 2017	0.6	1.2	0.0	0.0
FY 2018	0.5	0.7	0.0	0.0
FY 2019	1.5	3.1	0.0	0.0
* CY 2019	1.2	2.5	0.0	0.0

* Note: Reporting by plans changed to Calendar Year beginnning January 2019.
The 1st two quarters of CY 2019 are reported in both FY 2019 and CY 2019.

Discussion

Medicare Cohort for 2019

The number of complaints in the Medicare cohort was nearly double that of the non-Medicare cohort for 2019, despite being much smaller in total population. For the Medicare cohort, 54 percent of complaints were for issues with "Availability of a Health Care Services", 30 percent for Customer Service", and 16 percent for the "Quality of a Health Care Service".

The increase of complaints is likely related to a particular finding from last year's Complaints and Appeals Report. During the 2019 fiscal year, KPWA adjusted its method of collecting data for customer service and quality of a health care service complaints and appeals to match the methods used by the Kaiser Foundation Health Plan of the Northwest (KPNW). While this change led to more granular data collection, it also created higher numbers of complaints and appeals in all categories. More specifically, KPWA now reviews each complaint and may assign it to multiple categories. For example, if a member calls to complain about the wait time when visiting their physician and also expresses dissatisfaction with how their physician listened to them during the visit, the complaint is counted in both the "Availability of a Health Care Service" and the "Quality of a Health Care Visit" categories. This in turn increases the number of actual complaints reported. Because KPWA had not previously report these complaints in this method, the new data resulted in an increase in some categories, especially for "Quality of a Health Care Service."

In contrast, Regence, the Administrator for the UMP health plans, does not perform this kind of "multi-categorizing" of the complaints it receives, so complaint data remains relatively steady year-over-year.

Aside from the changes by KPWA, data seems to generally indicate that Medicare members may be facing difficulties in accessing desired health care services, even if the only difficulty is the wait time for an appointment with their physician. ERB and its health plan carriers will continue to address this issue, to ensure that barriers to access and quality care are lowered or removed where possible, as well as working to improve the customer service experience.

As for appeals, data shows a relatively low number of appeals for availability of a health care service. Only nine percent of Medicare complaints moved on to the appeal process, which indicates many issues were resolved at the complaint stage for the Medicare population.

Non-Medicare Cohort for 2019

In the non-Medicare cohort, complaints were highest for "Quality of a Health Care Service" with 44 percent of complaints, followed by 34 percent for "Customer Service", and 22 percent for "Availability of a Health Care Service". This indicates that non-Medicare members are generally receiving the requested services, but may not be as satisfied with the quality of the service they receive. Concern over quality of health care services is a primary focus that ERB continues to addresses with its health plan carriers. This includes a focus on quality improvements, some of which have been linked to performance guarantees in the contracts with the health plan carriers.

During 2019, appeals by the non-Medicare cohort were higher than complaints. This may indicate that members did not attempt to first follow the complaint process, but moved directly to the appeal process. The vast majority of the appeals were about availability of a health care service, which, by contrast, had a lowest number of complaints. This disconnect between complaints and appeals may indicate that members are unclear about how the complaint process works or what their rights are in the complaint process, so that they bypassed complaints entirely and filed an appeal. More effort to communicate the complaint process to members may solve this anomaly in the data and could prevent an increase in the number of appeals.

2019 Plan Year

Reporting on the plan year allows for a view of complaints and appeals as they happen throughout the plan year cycle. Table 2 lays out the timing of all complaints and appeals during each quarter of the 2019 plan year. Complaints and appeals were distributed relatively equally across all four quarters of the year for the non-Medicare cohort. For the Medicare cohort, complaints generally increased throughout the plan year, while appeals were relatively stable throughout.

In contrast to the relative stability of appeals received by the health plan carriers, eligibility appeals (which are handled internally by ERB) usually peak in late February and early March as members realize that there is an issue with their enrollment. Those cases typically drop off sharply after the end of Quarter 2, usually by as much as 70 percent. This annual trend for eligibility appeals is in contrast to the 2019 data on complaints and appeals received by the health plan carriers.

It is premature to draw any further conclusions about trends within the plan year cycle based on a single year of data. In future reports there will be an opportunity to further explore cyclical trends of complaints and appeals from plan year to plan year.

2019 Complaints and Appeals per 1,000 Members

Table 3 shows the rate of complaints and appeals per 1,000 members of each cohort. For the non-Medicare cohort, complaints were 2.8 per 1,000 members, while appeals were 3.8 per 1,000. These figures represent just under 0.3 percent and 0.4 percent respectively for the entire non-Medicare population of 274,425 members.

For the Medicare cohort, the rate of complaints was significantly higher, while the rate of appeals was lower than the non-Medicare cohort. Complaints for the Medicare cohort per 1,000 members were 15.1 in this population, which is just over 1.5 percent of Medicare's 106,424 members. Appeals, however, were nearly insignificant at less than 0.1 percent of the Medicare cohort. The numbers of complaints, again, may be linked to the new methodology used by KPWA to sort member complaints into the multiple categories, with many complaints counted more than once.

Total Complaints and Appeals 2016-2019

The remainder of the data tables must be prefaced with a reminder of the overlap in data caused by transitioning to data reporting on the plan year starting in 2019, as opposed to having used the

State's fiscal year for prior year reports. The results for earlier years in this "look back" are based on fiscal year data, while the 2019 data is based on the 2019 plan year. Because of this transition in reporting period, there is an overlap of data for Quarters 1 and 2 of 2019, which were previously reported as part of fiscal year 2018 as well. Nevertheless, there are some inferences that can be made about the last five years of data.

Table 4a shows the total complaints and appeals from FY2016 to CY2019. Overall, complaints trended downward for the non-Medicare cohort overall—a 52.3 percent drop in complaints since 2017, which suggests an increased satisfaction with PEBB's health plans. However, appeals have continued to trend upwards, which may indicate these members are unclear about how the complaint process works so they bypass complaints entirely to file an appeal.

For the Medicare cohort, complaints have been more variable over the last few years, but again there was a significant increase in the total appeals for CY2019. These complaints may relate to Medicare as a plan, which is federally designed and regulated; ERB has very limited ability to change the Medicare plan designs in order to address these complaints. However, the appeals have remained steadily low throughout the years.

Table 4b further highlights the nearly four-fold increase in complaints from the Medicare cohort, as well as an increase in appeals by non-Medicare members. ERB will continue to provide communications to inform members of their rights regarding complaints and appeals and will follow the data for changing trends.

Individual Categories of Complaints and Appeals 2016-2019

The "Availability of Health Care Services" category (Tables 5a & 5b) continues to be the major source of appeals for both cohorts, with a notable upward trend over the last few years for the non-Medicare cohort. However, this trend is in contrast to the downward trend of complaints, which bolsters the assumption that non-Medicare members are skipping the complaint process and instead going straight to appeals. As for the significant increase in the number of Medicare complaints for 2019, it is unknown what in particular has driven this increase.

The "Customer Service" category (Tables 6a & 6b) has remained low for appeals for both cohorts, and remained relatively steady on complaints for the Medicare cohort. The complaints for this category for the non-Medicare cohort has experienced a significant decrease over the last four reporting years. Member experience is a key metric for PEBB's health plan carriers, and ERB continually encourages carriers to improve direct customer service interactions in order to continue the downward trend.

The "Quality of a Health Care Service" category (Tables 7a & 7b), which saw a significant increase in the last reporting year, saw a modest decline for 2019 complaints, decreasing 18.5 and 20.3 percent for the non-Medicare and Medicare cohorts respectively. The overall numbers are still high to the relative to earlier years, but the efforts of the last year will be continued in hopes of seeing a recovery after last year's spike.

Appendix A: PEBB medical plan types

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

Consumer-directed health plans (CDHP)

CDHP plans generally have a lower monthly premium than most other plans, but also have a higher deductible and a higher out-of-pocket limit. These plans also allow a member to contribute pre-tax money to a health savings account (HSA), which can be used to pay for out-of-pocket medical expenses.

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

Managed-care

Managed care health plans may require a member to select a primary care provider within its network to fulfill or coordinate health services. The plan may not cover (in full or in part) services received by a member from non-contracted or out-of-network provider.

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

Preferred provider organization (PPO)

PPO health plans allows a member to self-refer to any approved provider. The plan provides a higher level of coverage if the provider that the member chose 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.