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, 2017

Public Employees Benefits Board Annual Report

Customer Service Complaints and Appeals

Washington State Health Care Authority

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Executive Summary

The Washington Legislature passed SSB 6584 in 2010, and it was codified as RCW 41.05.630. This statute requires the Health Care Authority (HCA) to capture customer service complaints for each health plan that provides medical coverage to the Public Employees Benefits Board (PEBB) Program, to summarize the complaints and appeals made by PEBB Program members related to these health plans, and to provide an analysis of any identifiable trends.

Per the directions of the statute, PEBB gathers data throughout the fiscal year (July 1-June 30) and reports its findings the following fall. The annual data cover half of two separate plan years, which follow the calendar year. This report, therefore, includes data on the latter half of 2016 and the first half of 2017. We separate Non-Medicare and Medicare employees in our findings because these populations are in separate risk pools. Risk pools are groups of subscribers formed by an insurer to spread risk equitably across a population of insured lives.

This annual report to the Legislature contains a summary of complaints and appeals for the previous twelve months and records annual trends related to the following categories:

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

During fiscal year 2017, total complaints rose from the previous year; however, appeals were proportionally low. This indicates that most issues in all three categories are being resolved at the plan customer service level and members are not forced to appeal to have situations remedied. The rise in complaints stemmed from two administrative issues within the Group Health/Kaiser Permanente of Washington plans.

Scope of the 2016-2017 Report

Each health plan provided the number of complaints and appeals related to the three categories described above. However, the data is limited by three factors.

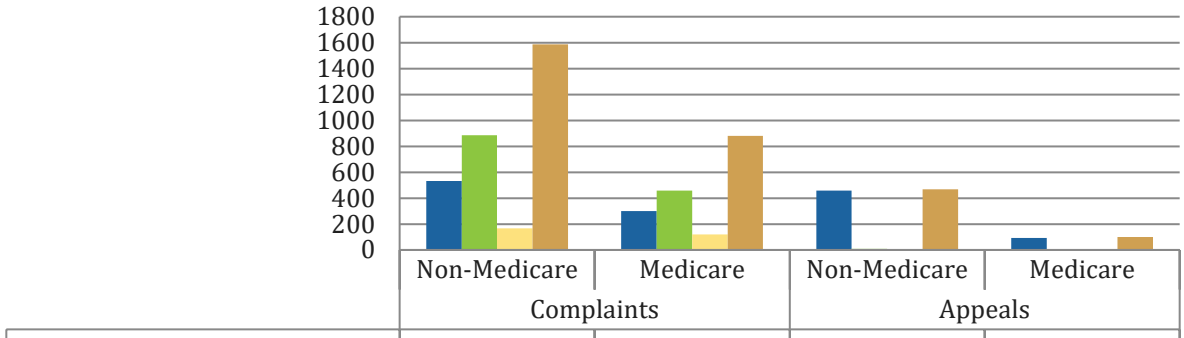
1. The plans do not use these three specific categories to track complaints internally or in other reports to the HCA. Each plan individually decides where to place complaints and appeals into these three categories. This may result in some variations in how the plans sort complaints.

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 into one of the three named categories are not included in this report.

3. Plans may change significantly between plan years. However, because of the fiscal year data collection period, improvements or worsening of complaints and appeals trends may not be discernable.

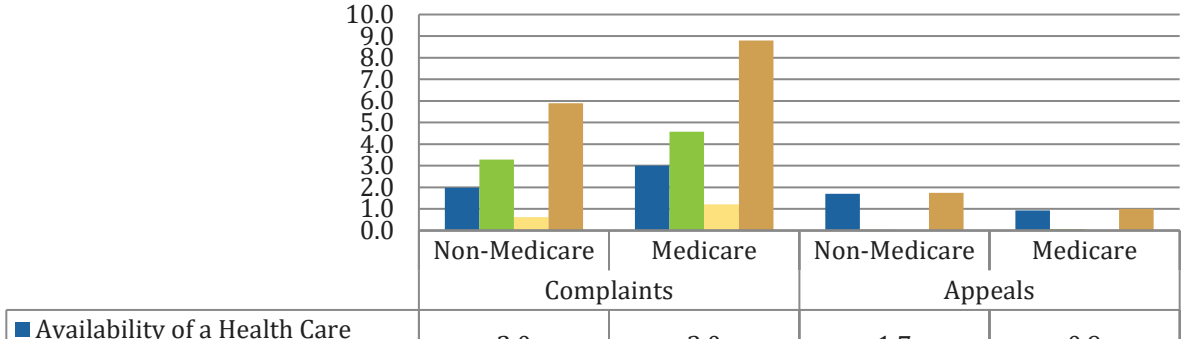
PEBB Health Plan Complaints and Appeals Data

Table 1. Total Number of Appeals and Complaints July 2016-June 2017



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
Availability of a Health Care Service	533	301	459	93
Customer Service	885	458	10	7
Quality of a Health Care Service	168	121	0	0
Total	1586	880	469	100

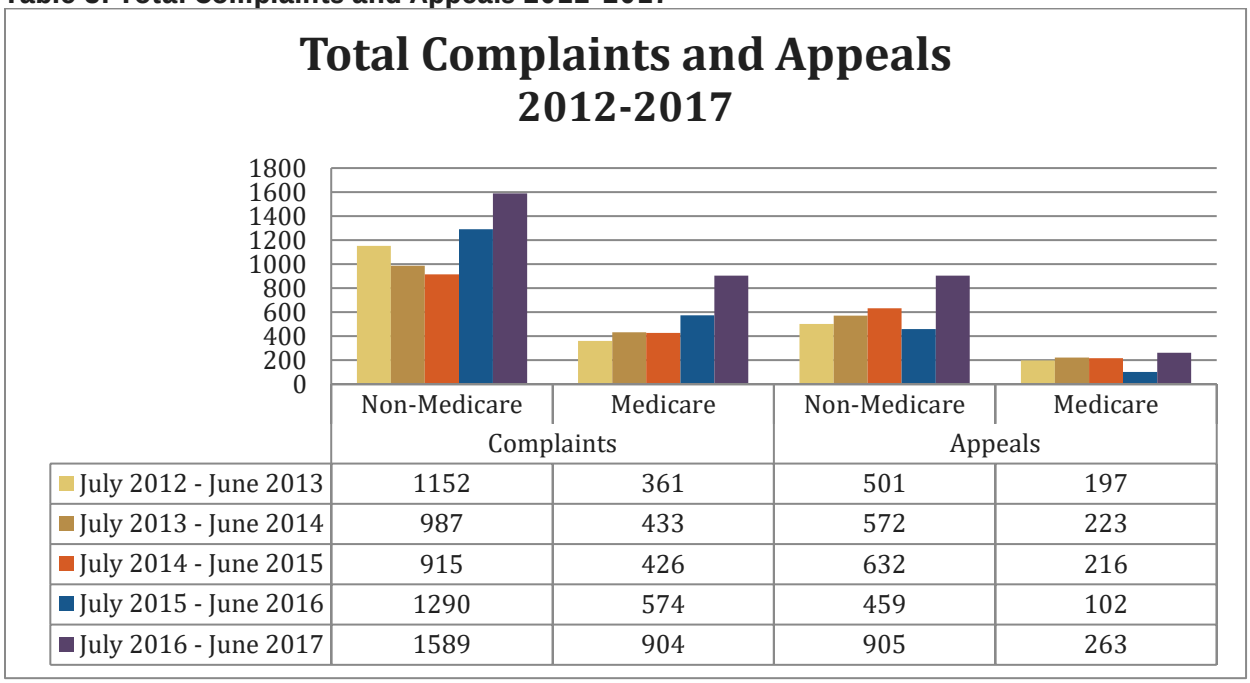
Table 2. Total Number of Appeals and Complaints Per 1,000 Members July 2016-June 2017



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
Availability of a Health Care Service	2.0	3.0	1.7	0.9
Customer Services	3.3	4.6	0.0	0.1
Quality of a Health Care Services	0.6	1.2	0.0	0.0
Total Number of Complaints and Appeals	5.9	8.8	1.7	1.0

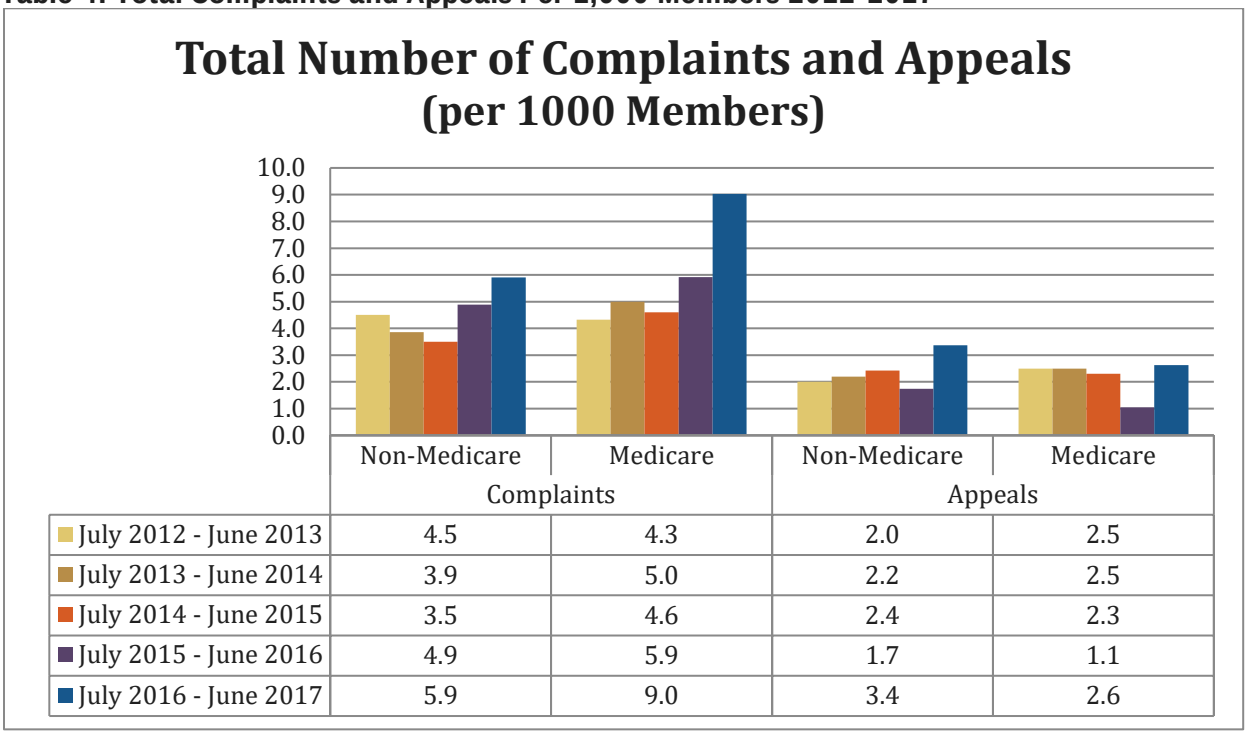
Complaints and Appeals Data 2012-2017

Table 3: Total Complaints and Appeals 2012-2017



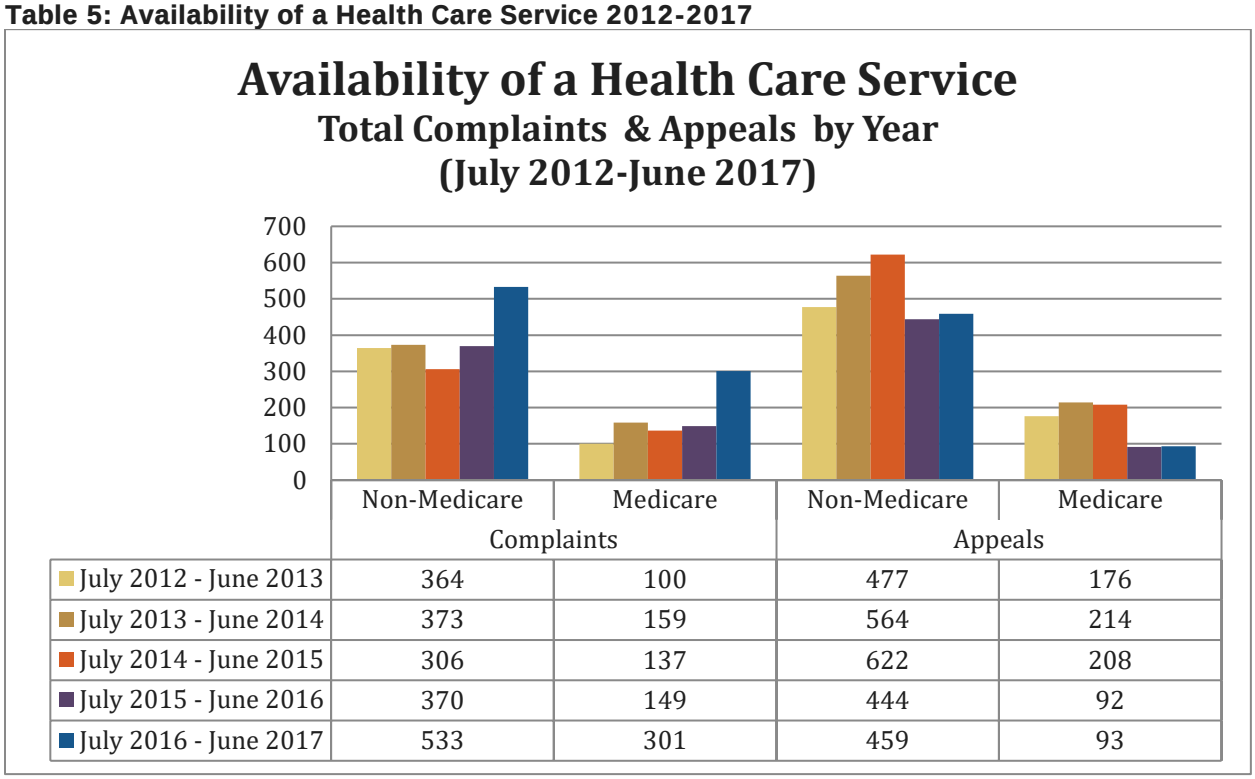
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	1152	361	501	197
July 2013 - June 2014	987	433	572	223
July 2014 - June 2015	915	426	632	216
July 2015 - June 2016	1290	574	459	102
July 2016 - June 2017	1589	904	905	263

Table 4: Total Complaints and Appeals Per 1,000 Members 2012-2017



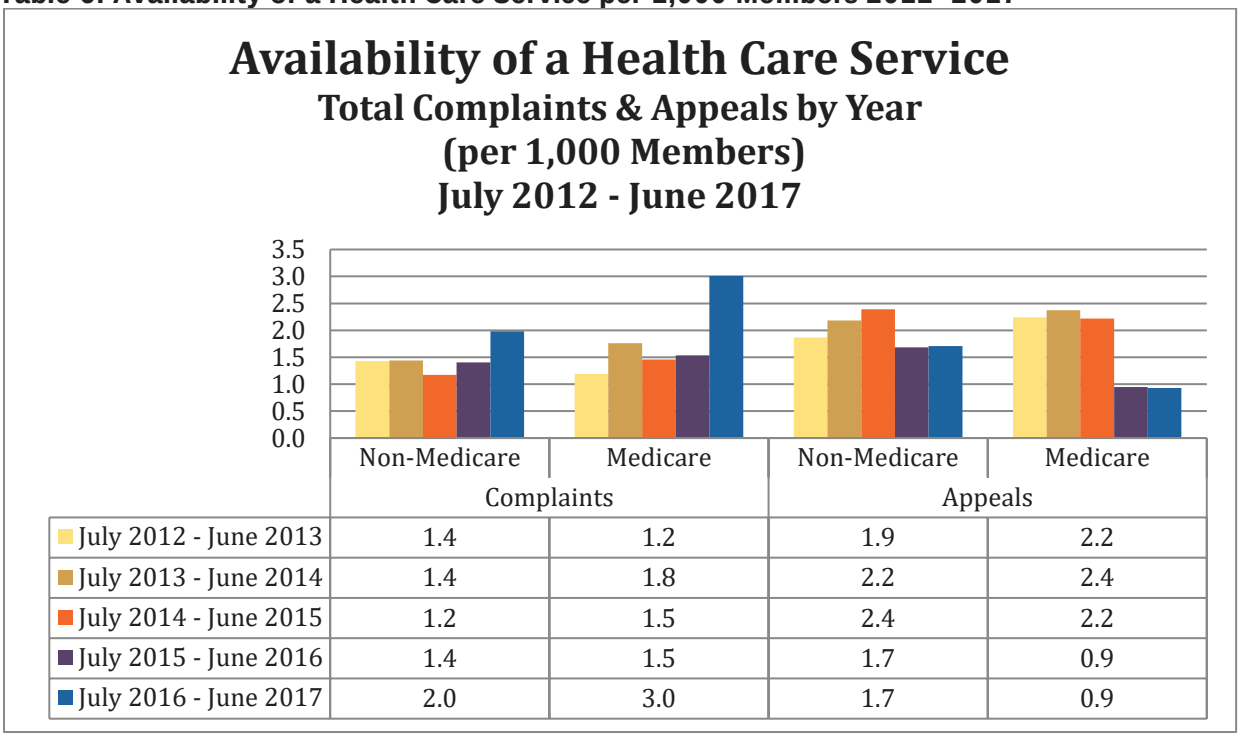
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	4.5	4.3	2.0	2.5
July 2013 - June 2014	3.9	5.0	2.2	2.5
July 2014 - June 2015	3.5	4.6	2.4	2.3
July 2015 - June 2016	4.9	5.9	1.7	1.1
July 2016 - June 2017	5.9	9.0	3.4	2.6

Table 5: Availability of a Health Care Service 2012-2017



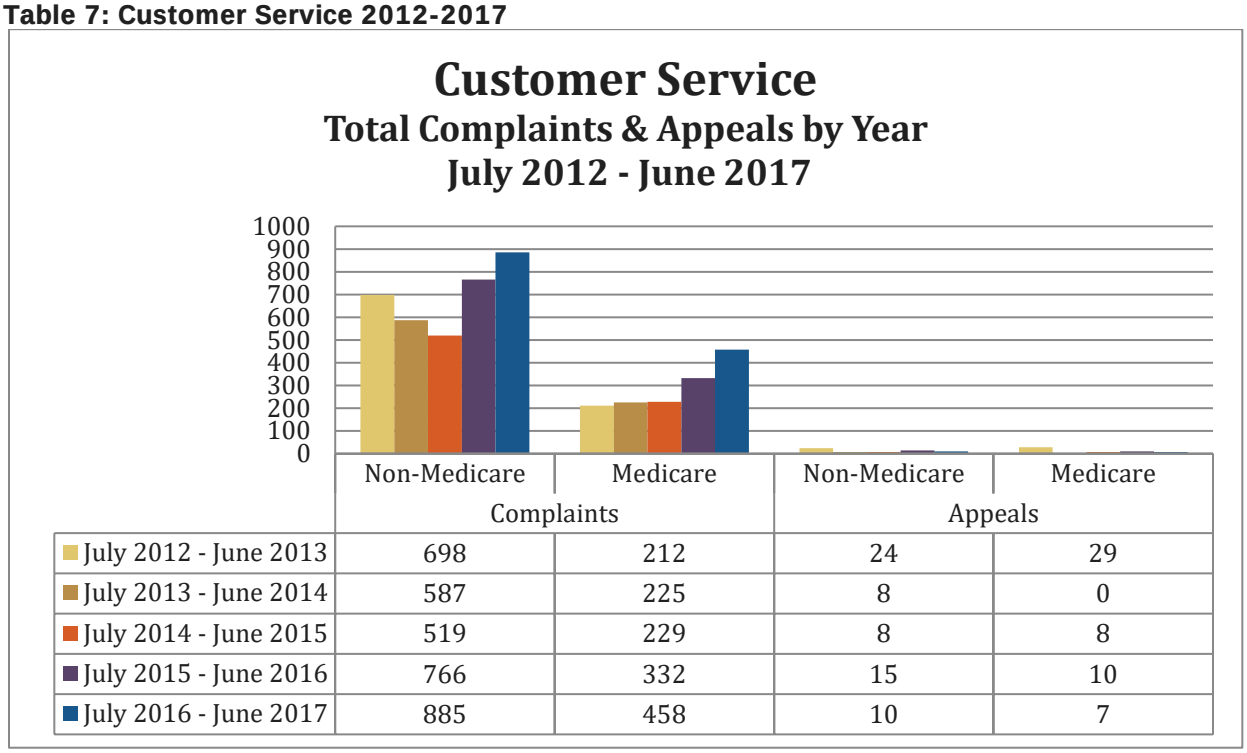
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	364	100	477	176
July 2013 - June 2014	373	159	564	214
July 2014 - June 2015	306	137	622	208
July 2015 - June 2016	370	149	444	92
July 2016 - June 2017	533	301	459	93

Table 6: Availability of a Health Care Service per 1,000 Members 2012–2017



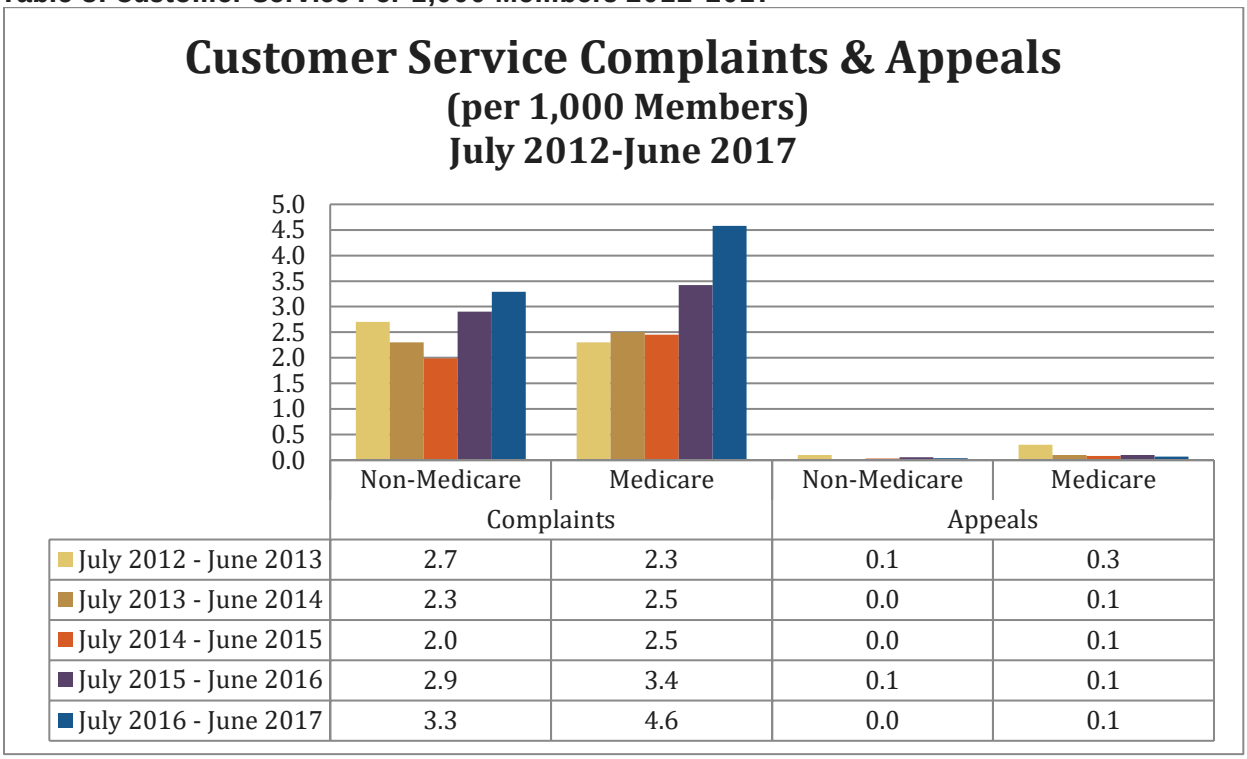
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	1.4	1.2	1.9	2.2
July 2013 - June 2014	1.4	1.8	2.2	2.4
July 2014 - June 2015	1.2	1.5	2.4	2.2
July 2015 - June 2016	1.4	1.5	1.7	0.9
July 2016 - June 2017	2.0	3.0	1.7	0.9

Table 7: Customer Service 2012-2017



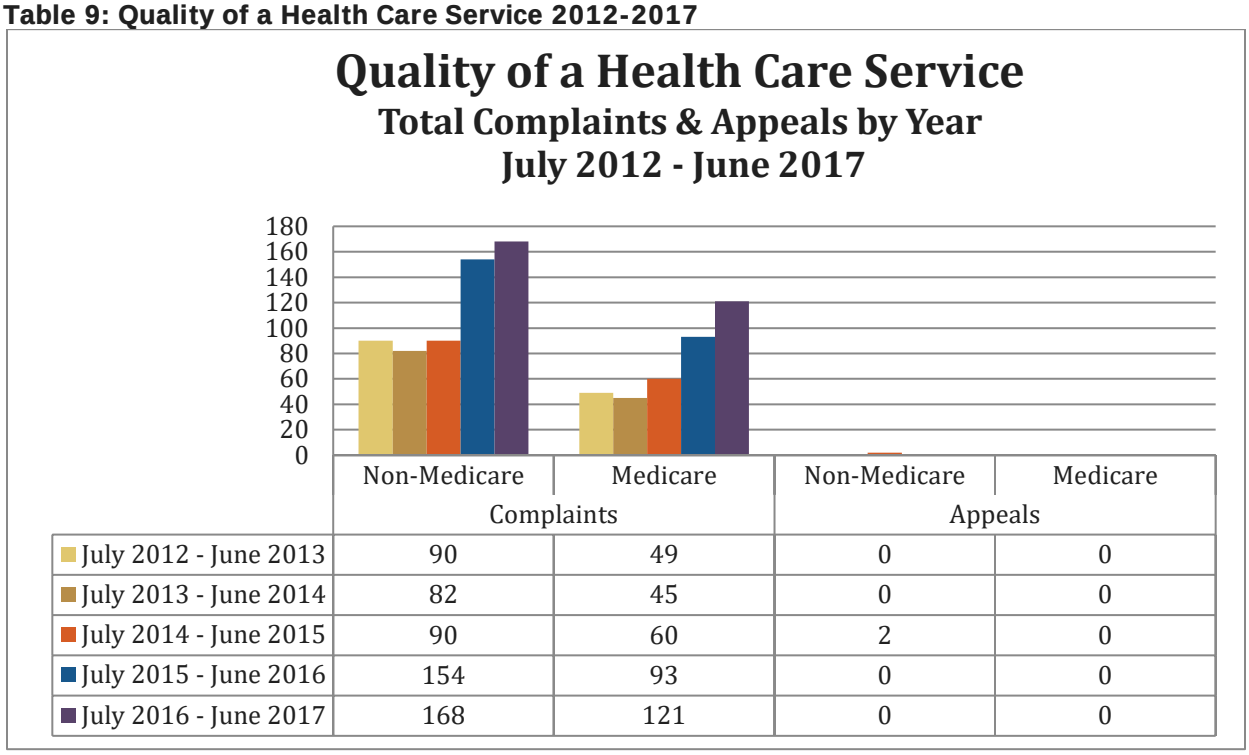
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	698	212	24	29
July 2013 - June 2014	587	225	8	0
July 2014 - June 2015	519	229	8	8
July 2015 - June 2016	766	332	15	10
July 2016 - June 2017	885	458	10	7

Table 8: Customer Service Per 1,000 Members 2012-2017



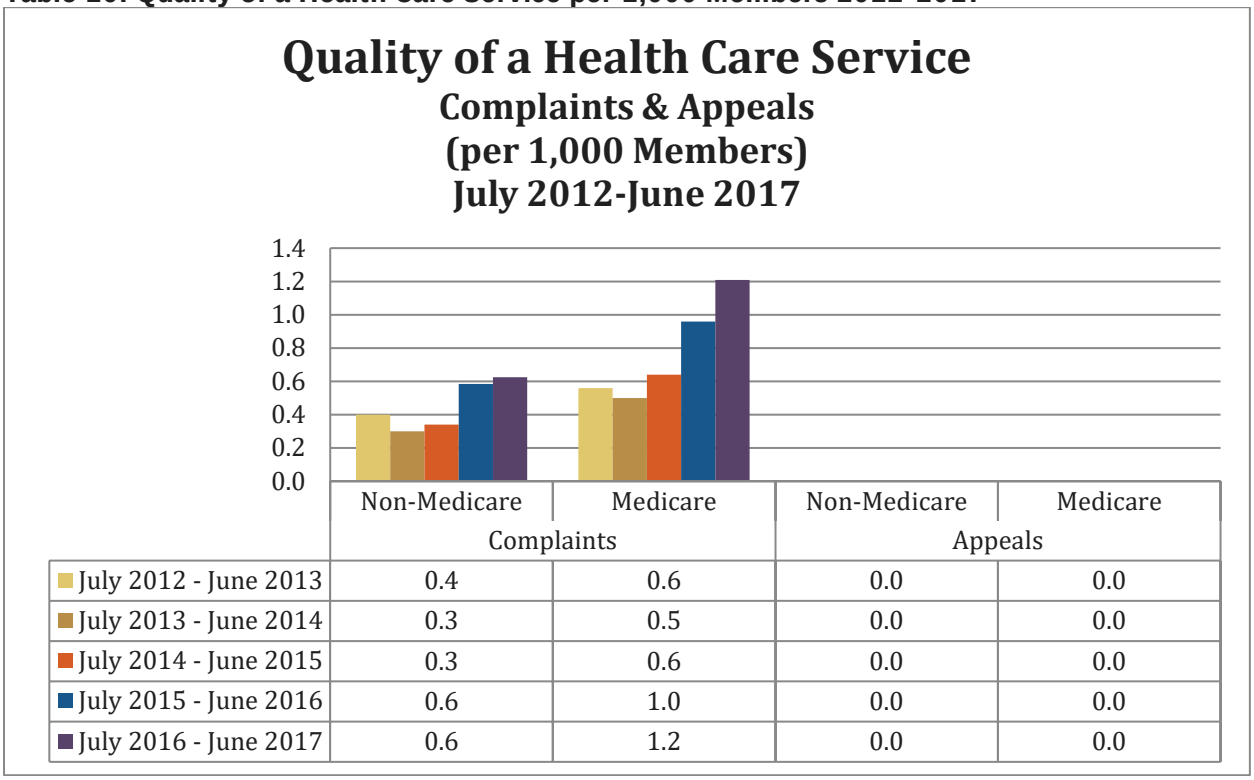
	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	2.7	2.3	0.1	0.3
July 2013 - June 2014	2.3	2.5	0.0	0.1
July 2014 - June 2015	2.0	2.5	0.0	0.1
July 2015 - June 2016	2.9	3.4	0.1	0.1
July 2016 - June 2017	3.3	4.6	0.0	0.1

Table 9: Quality of a Health Care Service 2012-2017



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	90	49	0	0
July 2013 - June 2014	82	45	0	0
July 2014 - June 2015	90	60	2	0
July 2015 - June 2016	154	93	0	0
July 2016 - June 2017	168	121	0	0

Table 10: Quality of a Health Care Service per 1,000 Members 2012-2017



	Complaints		Appeals	
	Non-Medicare	Medicare	Non-Medicare	Medicare
July 2012 - June 2013	0.4	0.6	0.0	0.0
July 2013 - June 2014	0.3	0.5	0.0	0.0
July 2014 - June 2015	0.3	0.6	0.0	0.0
July 2015 - June 2016	0.6	1.0	0.0	0.0
July 2016 - June 2017	0.6	1.2	0.0	0.0

Analysis

During fiscal year 2017, total complaints and appeals within the PEBB health plans rose from the previous year: Total complaints among Non-Medicare enrollees increased from 1290 to 1598. Total complaints among Medicare enrollees increased from 574 to 904. Appeals were also higher compared to the previous four years: Non-Medicare enrollee appeals rose by 97.17 percent and Medicare enrollee appeals rose by 157.84 percent.

PEBB Analysts believe that the rise in the number of complaints may be traced to two primary factors:

- A change in Pharmacy Benefit Managers (PBM) at Kaiser Permanente of Washington (KPWA) (formerly Group Health Cooperative) in September of 2016; and
- The Kaiser Permanente acquisition of KPWA which took place in February 2017.

The initial switch in PBMs created long delays at KPWA facility pharmacies. Previous wait times for prescription fills, which averaged 15-45 minutes, ballooned to 6 or more hours because of data exchange issues with their new PBM. Further, the mail order pharmacy process experienced longer fulfillment times for refills. Medicare member complaints about Availability of a Health Care Service—in this case, pharmacy—rose 154.95 percent. These data about complaints reflects the frustration members felt regarding increased wait and fulfillment times. KPWA immediately resolved these pharmacy operations issues.

The acquisition of Group Health Cooperative (GHC) by Kaiser Permanente and the rebranding of GHC as Kaiser Permanente Health Plan of Washington also occurred this past fiscal year. Though communicated widely to GHC members, the transition required members to learn new processes and procedures for getting services and appointments. This seems to have driven a 12.95 percent increase in Customer Service complaints for the Non-Medicare population and a 50.88 percent spike in Customer Service complaints among the Medicare population. However, complaints regarding Quality of Health Care Services at KPWA stayed steady for both Non-Medicare members and Medicare members.

Uniform Medical Plan (UMP) also experienced some increased complaints and appeals, but the numbers were not as high as KPWA. UMP increases were mainly in the Availability of a Health Care Service and Customer Service categories; however, complaints and appeals in both categories fell after January 1, 2017. Analysts agree the increased complaints and appeals were attributable to the introduction of the UMP accountable care plan (ACP) as members learned the limitations of the new ACP networks. Availability of a Health Care Service complaints increased when members learned providers they sought were not participating in the network they had chosen. PEBB and UMP had to manage the learning curve of members new to narrower networks.

When complaints are high, appeals numbers also tend to be high. However, this is not the case with year-over-year numbers of PEBB appeals for both Medicare and Non-Medicare populations.

Appeals in all categories stayed nearly the same or dropped by as much as 10 percent. This encourages us to conclude that plan customer service are handling complaints in a manner satisfactory to our members, thereby preventing the number of appeals from rising at the same rate as complaints.

Conclusion

During this reporting period, PEBB customer service complaints and appeals significantly increased. However, the reasons for the increase have been identified as unique operational/administrative issues mainly experienced by a single health plan carrier. Complaints and appeals for members of the unaffected plans did not show significant changes beyond what should be expected with increased enrollment.

Additionally, the increase in complaints did not drive a similar increase in appeals. This leads us to conclude that the majority of member issues are being handled at the plan customer service level; members are not forced to appeal to find a remedy for issues they encounter.

PEBB will continue to closely monitor complaints and appeals from our members, and we will seek satisfactory resolution from the health plan carriers when situations arise that cause member complaints or appeals to rise.