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Puget Sound Community Checkup:

Health Plans

COLLABORATION • ACCOUNTABILITY • ACTION

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Introduction

The Puget Sound Health Alliance (the Alliance) is the one place in this region where all stakeholders – employers, unions, doctors, hospitals, health plans, patients and others – have come together to work on constructive ways to improve the value of local health care. A centerpiece of that collaborative work is the creation and expansion of the *Community Checkup*, a report to the public about health care quality and value.

This report is the first time that health plan results are included in the *Community Checkup*. Alliance participants, including many large purchasers (i.e., public and private employers and union trusts), are committed to promoting the use of national, evidence-based standards and public sharing of information on *all* aspects of the health care system. The *Community Checkup* report uses available data sources and draws from national standards, resulting in different approaches to evaluating the services provided through medical groups, hospitals, and health plans. Data related to medical group or ambulatory care is drawn from the Alliance’s large multi-payer database of claims data supplied by health plans and self-insured purchasers. Hospital-related data is drawn from state and national sources such as the federal Department of Health and Human Services “Hospital Compare” reporting process. For measuring health plan activities, this report is based on scores from the national eValue8™ tool owned and maintained by the National Business Coalition on Health (NBCH).

The Alliance, on behalf of its members, worked with NBCH to conduct a rigorous evaluation of health plans in Washington state using the eValue8™ tool, first in 2008 and then again in 2009. By sponsoring eValue8™ in the Puget Sound region, Alliance participants have these shared objectives:

1. Generate consistency in health plan assessment that enables transparency of health plan performance and permits comparison within and across markets over time, including national benchmarks and best practices;
2. Stimulate improved performance from health plans, with a particular focus on information, systems and tools within the control of the plan that can be used to encourage and support improved performance from providers and delivery systems, as well as promote consumer behavior for wellness and informed decision-making;
3. Enable purchasers and plans to work collaboratively to structure programs to reward value; and
4. Inform purchasers’ procurement decisions about health insurance for their employees and dependents.

Thus far, six health plans have participated in the eValue8™ process in this region: three national PPO plans, two regional PPO plans and one regional HMO plan. These health plans committed to participation in the process, including completing the extensive eValue8™ Request for Information, which required a significant time and resource commitment. In 2008 and again in 2009, ten purchasers sponsored the eValue8™ process in this region. These 16 organizations each provided funding to the Alliance to cover a portion of the cost of the eValue8™ process, which was also supported financially by two generous grants from Merck, Inc.

Laying the Foundation for Reporting Over Time

The Alliance has communicated to each of the six health plans that took part in the eValue8™ process in this region in 2008 and 2009 that participating purchasers and others hope that each health plan will continue to participate in eValue8™ in future years. With ongoing participation, health plans can use the tool to clearly demonstrate to employers and to local consumers how the health plan's actions and programs are helping to promote health and provide value in the Puget Sound region. Each health plan will be able to show their commitment to public accountability and transparency regarding their continuous improvement in key areas, as measured by a process based on evidence and national standards that enables the community to compare across health plans in this market and with other health plans nationally. This kind of health plan accountability and transparency is important to purchasers and individuals throughout the region.

This is the first *Community Checkup* report on health plan performance based on results calculated by the eValue8™ program, which the Alliance believes to be the best approach currently and consistently available to measure performance across all health plans that choose to participate in eValue8™. Given the complexity of health care and health plan products and programs, there is no "perfect" approach to measuring and reporting on the quality, cost-effectiveness and value provided by health plans. We recognize that what is measured may not equate to the actual experience members have with their health plan. Fortunately, the willingness of health plans to participate in this project is a strong first step in the journey toward creating an evidence-based comparison of health plan activities, based upon national standards and accreditation processes, that gets useful information to health plans, purchasers and the public. The continued evolution of the *Community Checkup* report reflects a shared commitment among health plans, employers, union trusts, doctors, hospitals, patients and others to improve health care measurement and public reporting over time.

Focus Areas in eValue8™

eValue8™ asks health plans to submit online annual standardized reports, along with extensive documentation, that describe their performance in a number of clinical and administrative areas. The information is then assessed and scores tabulated so purchasers can compare the health plans against each other as well as to national benchmarks. The areas covered by eValue8™ include:

1. **Plan Profile** – health plans are asked about: national accreditation status and participation in quality reporting; design of benefit package offerings; flexible reporting capabilities that reveal opportunities for purchaser plan design and improved health management; proactive management of provider network and contracts; use and promotion of data inter-operability and electronic exchange of health information in a collaborative manner; and activities to address health equity and disparities.
2. **Consumer Engagement** – health plans are asked about: electronic provider directories available to members that include quality and patient experience information; availability of performance information about hospitals and other facilities; encouraging member access to personal health records; information and tools to help members understand the benefits and risks of treatment alternatives as well as the costs involved; fielding the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey and reporting those results publicly.
3. **Provider Measurement** – health plans are asked about: partnering with other health plans in the community to measure and improve physician and hospital performance; use of tools to identify members with potential gaps in care; differentiation among primary care physicians, specialty care physicians, and facilities using clinical process and clinical outcome measures; evaluation of patient experience, utilization, efficiency and use of health information technology; and, use of incentives, benefits design and information to promote high performing providers and facilities.
4. **Pharmaceutical Management** – health plans are asked about: promotion and use of generic drugs; monitoring and influencing the cost-effective use of pharmaceuticals; the e-prescribing capabilities of providers in the health plan's contracted network; programs to address cost and appropriate utilization of specialty pharmaceuticals; Healthcare Effectiveness Data and Information Set (HEDIS) reporting and performance; use information under health plan's control to influence patient safety and encourage members to stay on prescribed medications.
5. **Prevention and Health Promotion** – health plans are asked about: partnering with employers on worksite health promotion and education about the risk factors associated with chronic diseases; providing and promoting the use of a health risk assessment (HRA) for members; cancer screening programs; child, adolescent and adult immunizations with emphasis on member-specific interventions; programming to address the prevention and treatment of tobacco use and obesity; promoting pre-conception counseling and tracking of high-risk pregnancies and interventions.

6. **Chronic Disease Management** – health plans are asked about: disease management programs that facilitate the coordination of care that may involve more than one health condition, depression, alcohol and tobacco screening, and prescription drugs; use of interventions involving direct contact with members to address their specific needs, including staying on prescribed medication; monitoring clinical indicators with the goal of providing actionable clinical data to doctors and other practitioners; proactively engaging providers in the health plan’s disease management program; HEDIS reporting and the monitoring of non-HEDIS indicators including absenteeism.

7. **Behavioral Health** – health plans are asked about: whether they offer coverage for behavioral health in an accredited program to all of their members; identification and tracking of members who require treatment for alcohol use and/or depression; providing and monitoring the use of screening tools for alcohol use and depression; interventions with members in areas such as staying on prescribed medications; identification and treatment of members with multiple behavioral health and medical conditions; use of clinical guidelines and patient-specific reports for depression and alcohol overuse; HEDIS reporting and monitoring of non-HEDIS indicators including absenteeism.

eValue8™ in the Puget Sound Region

2008

During the first year of involvement with eValue8™, in 2008, the Alliance shared results privately with each participating health plan and the ten sponsoring purchasers. During site visits with each health plan, the purchasers reviewed the eValue8™ process and results and discussed the purchasers' highest priority expectations, which were:

1. **Transparency and Collaboration.** Specifically, increase community-wide availability and use of information to motivate improvement in health system performance, and enhance plan provider directories.
2. **Focus to Continually Improve Quality.** Specifically, engage in HEDIS reporting, using information available to the plans to help promote and improve prevention and chronic disease management, and expand focus on risk reduction, obesity and tobacco cessation.
3. **Design Benefits and Reimbursement to Promote Value.** Specifically, address 'Never Events'*, health care associated infections, reducing avoidable hospital readmissions, and promoting the use of generic prescription drugs instead of higher-cost brand name drugs.

* see www.psnet.ahrq.gov/primer.aspx?primerID=3

2009

In the second year, six health plans and ten sponsoring purchasers participated in the eValue8™ process again, with the shared understanding that high level summary results would be shared publicly. During site visits with each health plan, the group of purchasers and the health plan representatives again discussed the purchasers' priority expectations and the health plan's strengths and opportunities for improvement. In 2009, these purchasers' priority expectations for health plans are:

1. **Health Plan Accreditation.** Engage in external review and oversight of health plan operations through accreditation from one or more organizations such as the National Committee for Quality Assurance (NCQA). This accreditation signifies that there is external oversight of health plan activities, assures that there are appropriate organizational and technological structures in place, stimulates quality improvement practices and promotes greater value within the health plan.
2. **HEDIS Measurement and Reporting.** Participate in measuring and reporting HEDIS, which includes specific quality metrics used by more than 90 percent of America's health plans to measure

performance on important dimensions of care and service. HEDIS provides a ‘common language’ and a basis for comparison of performance across health plans within the market and against top performers nationally. The purchasers want to have access to HEDIS results by health plan and encourage plans to submit their audited results to NCQA and the Quality Compass, an interactive, web-based comparison tool that allows users to view plan results and benchmark information on important dimensions of care and service.

3. **CAHPS Measurement and Reporting.** Conduct the CAHPS survey, which is a nationally-developed and standardized survey that assesses patient experience with their health plan. The purchasers are encouraging health plans to report their results publicly through Quality Compass.
4. **Aggregation of Claims Data for Performance Reporting.** Continue to work with the Alliance to expand the data set available for reporting to the public via the *Community Checkup* report and to enable measurement of resource use and efficiency. They also want health plans to use the *Community Checkup* report for business purposes as the common, region-wide tool for health care value measurement and incentives.
5. **Strategies to Address Waste and the Medical Cost Trend.** Provide information to purchasers about health plan initiatives to lower the medical cost trend in the Puget Sound market and how purchasers can support these efforts. They are particularly interested in actions to reduce unnecessary medical consultations, procedures and tests in addition to emergency room visits and hospitalizations that are preventable.

Other strong areas of interest for health plan actions communicated by the sponsoring purchasers are:

6. **Health Plan Price Transparency and Cost Calculators for Members.** Build the capacity to provide ongoing, real-time information to health plan members regarding the cost of care, including the member’s out-of-pocket expense.
7. **Link Medical/Lab/Pharmacy Claims and Proactively Identify Gaps in Care.** Leverage their information about member-specific gaps in preventive and chronic-care services by using that information to motivate plan members, their doctors, and other health plan resources to close those gaps and improve members’ health status.

8. **Support Members to Change Behaviors to Achieve Better Health and Health Care Value (Health Risk Assessments, Benefit and Program Design).** Partner with purchasers to increase members' completion and use of health risk assessments, with particular interest in assistance from the health plans in analyzing data and designing benefits and programs to encourage and support individual behavior change.
9. **Physician and Hospital Directories.** Expand the content and functionality of provider directories to better meet individual member needs. This includes information that is searchable, detailed and regularly audited. Emphasis should be placed on information related to access, clinical quality, patient safety, and patient experience. Ideally, health plans will integrate clinic, medical group and hospital results from the Alliance's *Community Checkup* report into their physician and hospital directories for use by members.
10. **Screening for Depression and Substance Abuse.** Given that depression and substance abuse often go undiagnosed and untreated and yet have profound effects on employee productivity and absenteeism, actively promote the use of effective screening tools and then monitor whether and how providers use those tools with their patients.

Participating Employers and Health Plans in 2009

As a show of continued leadership and an expansion of their commitment to health care transparency and accountability, between December 2008 and February 2009, six health plans in Washington state completed the detailed eValue8™ Request for Information (RFI). Between March and May 2009, the National Business Coalition on Health reviewed and scored the RFI submissions from each health plan. Then, in June 2009, the Alliance and representatives from ten major employers (purchasers) conducted individual site visits with each of the six participating health plans. In the site visits, the groups discussed the perceived strengths and weaknesses of the individual health plan, as reflected by eValue8™ scores, and identified areas for improvement and collaboration.

The ten participating purchasers are:

- Alaska Air Group
- The Boeing Company
- City of Seattle
- King County
- Pierce County
- Port Blakeley Companies
- Puget Sound Energy
- Recreational Equipment, Inc.
- Snohomish County
- Washington State Health Care Authority

The six participating health plans are:

- Aetna (PPO)
- CIGNA HealthCare (PPO)
- Group Health Cooperative (HMO)
- Premera Blue Cross (PPO)
- Regence Blue Shield (PPO)
- United Healthcare (PPO)

Health Plan Information

Aetna

Year founded

1853

Number of members

18.9 million (350K – Washington)

Products

Comprehensive Health and Productivity programs offered on a fully integrated and stand-alone basis

Health Plan's View on Their Market Approach

Aetna is focused on supporting plan sponsors in achieving their health and productivity goals through comprehensive program offerings. A cornerstone of the Aetna programs is the focus on evidence based medicine and technology to support both the provider and member. This technology support is fully integrated across Aetna's systems to support all aspects of the operations, including member engagement. Member engagement is enhanced via tools and resources designed to create informed health care consumers. Among others, available tools include provider transparency, information resources, personal health records and wellness coaching.

More about Aetna online: www.aetna.com

CIGNA

Year founded

1865

Number of members

140,000 in Washington state; 12,000,000 nationally

Products

PPO, OAP, Consumer Driven Products with HRAs and HSAs, Dental, Life and disability policies, behavioral health, Pharmacy and EAP

Health Plan's View on Their Market Approach

CIGNA's mission is to improve the health, well-being and security of the people we serve.

We do this by using the data available to us to understand our members and to identify health risks as early as possible. This is done through a sophisticated trend management system.

We then take these results and use our wide-ranging array of clinical programs to outreach to our members to support them through their care needs and behavioral change programs that will improve their health and productivity.

We have developed best practices for sharing data with our network providers to help them improve care. We are developing value-based reimbursement to pay for outcomes rather than activity. We report on quality and efficiency of our network to help members with their selection process.

We have customized support programs for workplace wellness that allows us to support the goals of our customers to improve the health and wellbeing of their employees.

We subject ourselves to multiple quality oversight processes such as NCQA, URAC, JD Powers in addition to eValue8™ to be sure we know what to work on next to keep us at the top of quality and performance.

More about CIGNA online: www.cigna.com

Group Health Cooperative

Year founded

1947

Number of members

560,000 in Washington state

Products

Plans offered by Group Health include HMO, PPO, Point-of-Service, Health Savings Accounts, and Health Reimbursement Arrangements. We offer plans for individuals and families as well as for groups of two or more. In addition, our plans include Medicare Advantage, Basic Health (State of Washington plan) and Healthy Options (Medicaid).

Health Plan's View on Their Market Approach

While most of our plans offer choice, allowing our members to keep their own doctors, many of our members choose Group Health because of the quality and convenience offered at our 26 owned and operated medical centers where they can get an exam, lab work or an X-ray and fill prescriptions all at the same location. Group Health also offers free consulting nurse hotlines, available to most members 24/7.

Group Health's focus is on wellness and preventive care through education, screenings, immunizations, and an award-winning tobacco cessation program. Group Health uses nationally respected treatment guidelines developed from comprehensive, physician-led reviews of best-available research. Among the many features available on Group Health's website, www.ghc.org, members have the added convenience of e-mailing their doctors, checking lab results, checking deductible levels, ordering prescriptions and scheduling appointments.

At Group Health we listen to the voice of the customer. We are piloting value-based benefits with the goal of improved member health, reduced health care costs, and increased productivity and presenteeism. The benefit designs include a combination of incentives and plan components to reduce barriers to care and encourage member engagement in improving their own health.

Group Health's successful Medical Home pilot resulted in fewer emergency room visits and hospitalizations—outcomes linked to improvements in primary care and reducing costs. As a result, we are expanding Medical Home to all 26 Group Health medical centers. Supporting the expansion of this initiative is our advanced secure electronic clinical information system that supports greater accessibility, coordination, and patient confidentiality.

More about Group Health online: www.ghc.org

Premera Blue Cross

Year founded

1933

Number of members

>1,500,000

Products

Premera Blue Cross provides health insurance and related services to customers – from individuals to *Fortune 100* companies. Coverage options are designed to meet the varying financial and healthcare needs of members and include: Preferred Provider Organization (PPO); Traditional; Dental, Vision, and Pharmacy; Exclusive Provider Organization (EPO); and Medicare Supplement.

Plan's View on Their Market Approach

Premera is committed to the health of our members and, together, to creating a sustainable healthcare system for our children and grandchildren.

The current rate of U.S. healthcare cost growth is not sustainable. The solution is in addressing the true drivers of rising healthcare costs: maintaining health and preventing illness where possible, and improving the quality and cost-effectiveness of healthcare when we need it.

Nobody can do this alone. We can achieve it together through education and collaboration with members and employers who rely on us for coverage; the brokers and consultants who advise them; physicians and hospitals who deliver needed care; and the extended healthcare community.

At Premera, we provide tools and health support resources that work together, empowering our members to take greater control of health and healthcare dollars. We're also determined to deliver responsive customer service for our members, and a locally based, experienced account team for employers who rely on Premera.

Everybody has a role in achieving a lasting solution that brings costs in line with general economic growth. Premera is working with others in the healthcare system to take action – from consumers, employers, brokers and consultants to healthcare professionals and government.

More about Premera online: www.premera.com

Regence Blue Shield

Year founded

1917

Number of members

>1,000,000

Products

Regence medical product suite offers plans focused around value-based benefit design including:

- *Innova* – Up-front coverage; personalized wellness programs
- *Engage* – Single coinsurance level; personalized wellness programs
- *Activate* – Employees can earn up to \$600 annually for healthy behaviors.
- *H.S.A. Healthplan 2.0* – Comprehensive health plan; tax-free savings account
- *RegenceRx* – Pharmacy Benefit Manager (PBM)

Plan's View on Their Market Approach

Regence is committed to developing products and providing resources that engage members in health care decisions. The value-based benefit design options offered in Regence products are based on a multifaceted approach – providing incentives and support to reward healthy behavior; reducing the cost of evidence-based services and treatments; and offering programs to encourage and drive meaningful behavior change.

Regence is proud to support the activities of the Puget Sound Health Alliance. In 2008, the Regence Foundation gave the Alliance a grant to implement performance reports for use in patient care improvement programs. Regence is also committed to eValue8™ and has found the opportunity to receive feedback directly from our purchaser community of great value in supporting the design of products and services that meet their needs. In early 2009, Regence reviewed its eValue8™ module scores and developed action plans designed to improve future eValue8™ results. Targeted prevention mailings were completed. Enhancements to myRegence.com continue. In March 2009 Regence launched the Treatment Cost Estimator, which enables members to access regional average cost for a range of treatment options and conditions. In addition, members on select products are also able to view out-of-pocket expense estimates.

Regence acknowledges that despite equal health benefits, disparities in care exist and need to be addressed. Regence is currently developing a process to encourage members to voluntarily share race and ethnicity information during the welcome process. This data will help us offer targeted outreach to members vulnerable to health disparities to ensure they receive the highest quality care.

More about Regence online: www.wa.regence.com

United Healthcare

Year founded

1977

Number of members

610,000 in Washington state; 26 million nationally

Products

UnitedHealthcare offers a diversified set of products that include PPO, HSA, HRA, POS, High Deductible, and HMO offerings.

Plan's View on Their Market Approach

We believe in the missions of the Puget Sound Health Alliance and the National Business Coalition on Health of increasing transparency and driving towards evidence based medicine. This philosophy aligns well with our mission/philosophy to improve healthcare by supporting and encouraging evidence based guidelines. To support our approach, we are developing infrastructure such as our Premium Designation program that emphasizes quality and efficiency and reporting that provides actionable information to all stakeholders. Premium Designation addresses waste and the increasing medical cost trend while at the same time providing transparency which allows for more informed decision making. This, combined with our extensive integration through technology, provides an end to end solution that allows us to connect the dots and provide higher levels of engagement, better outcomes, and reduced costs.

More about United Healthcare online: www.uhc.com

Using This Report

As one aspect of the Alliance's commitment to increasing accountability and transparency in health care, high level summary results from the eValue8™ process are being shared with the public for the first time in 2009. The most detailed eValue8™ data continues to be confidential, only shared with each health plan and the sponsoring purchasers. This is similar to the approach the Alliance takes with respect to medical group measurement: summary results for each clinic and medical group measure are publicly available on the *Community Checkup* website, while detailed results are shared privately only with each medical group.

Given that 2009 is the first year of publicly sharing comparative summary results for each eValue8™ module, the following rules apply to using the information in this report:

1. Each health plan may communicate about their own summary-level eValue8™ results; however, health plans are prohibited from using any eValue8™ results that reference or compare to another health plan's results in any public communication or promotional materials.
2. All organizations are encouraged to direct people to the *Community Checkup* report website to see the comparison of summary-level results from eValue8™.
3. Any communication regarding eValue8™ results must follow the media guidelines of the National Business Coalition on Health (see http://www.nbch.org/eValue8/Media_Protocol).

In the future, these rules may change per direction from the Alliance Board or NBCH.

Note: The *Community Checkup* report is the opinion of the Alliance. While this is the first attempt to measure and report on health plans in this region, it is important to recognize that the health plan scores are determined based on information submitted directly by the health plans and a combination of quantitative and qualitative assessments that required the judgment of numerous experts. And, yes, even experts sometimes disagree about the best approach. Others who use their own processes to assess the quality, cost-effectiveness and value offered by health plans in this region may reach different conclusions than the results shown in this report.

The *Community Checkup* report is not a substitute for independent decision-making that incorporates other pertinent information not included in this report. If you have concerns or questions about your medical care, health plan coverage, services or other related programs, always consult your health care provider, health plan or employer directly. Do not disregard information or advice from your health care provider, health plan or employer because of something you read in this report.

Health Plan Results in the Puget Sound Region

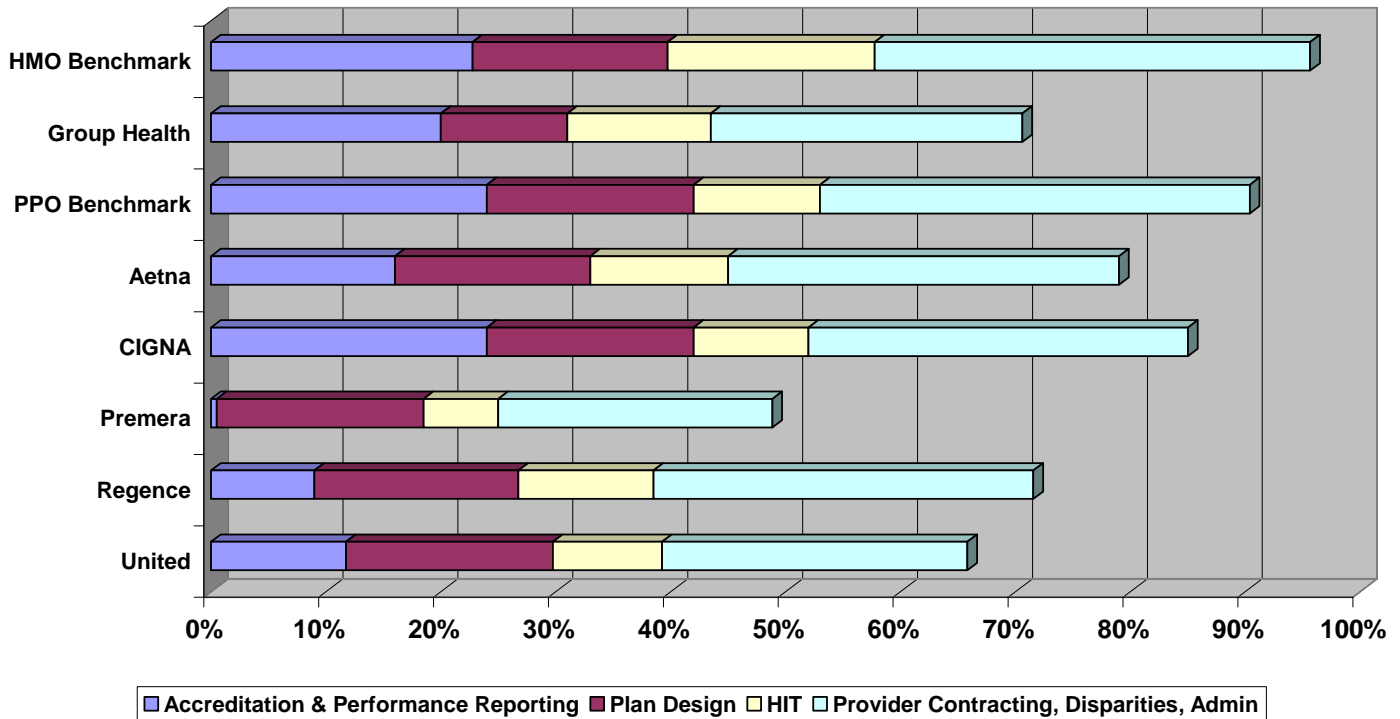
Participating health plans submitted online information via eValue8™, describing their performance in a number of clinical areas and administrative practices. The information was interpreted, scored and tabulated by eValue8™ experts at the National Business Coalition on Health. Summaries of the scores for each module are presented in the following pages to enable community comparison of eValue8™ results for health plans in this region. The graphs show the high level summary scores for the six participating health plans that operate in this market, as well as the score for the PPO or HMO health plan that earned the highest eValue8™ score in the country.

Importance of National Accreditation and Performance Reporting

A number of nationally-recognized health plan accreditation and reporting tools exist in the United States today. The eValue8™ tool awards points to health plans that engage in external review and oversight of the health plan operations by the National Committee for Quality Assurance (NCQA) and by URAC. Health plans that have chosen to participate in other evaluation systems instead or have not been nationally accredited receive a lower score in the “Plan Profile” module. The sponsoring purchasers acknowledge that becoming nationally accredited is a time and resource intensive process for health plans; however, they also believe that the national accreditation process: (1) provides a needed nationally-recognized external, independent review of a health plan’s programs and policies; (2) stimulates a health plan to refine its structure and processes to focus on improving quality, customer service and value, and, (3) creates a way for purchasers and others to make “apples-to-apples” comparisons among health plans in this region and with top performers across the country.

NCQA accreditation by itself represents only about ten percent of the points in the Plan Profile module and no points in the other six scored modules; therefore, its overall impact on total eValue8 scoring is minimal (i.e., approximately one percent of the total points available). However, if a health plan does not measure and report key quality indicators through the Healthcare Effectiveness Data and Information Set (HEDIS) to NCQA and Quality Compass, the impact on scores is larger. The eValue8™ tool heavily credits plans for HEDIS participation (approximately sixteen percent of the total points available) because it provides a standard set of condition-specific process and outcome measures that are audited and reported nationally. The eValue8™ tool awards the most points for health plans that have achieved HEDIS results at or above the 90th percentile nationally. The eValue8™ scoring break points are based on the national distribution of HEDIS results calculated from a total pool of more than 400 public and private health plan products covering about 100 million people. Health plans that have not measured and reported HEDIS, or that do not have satisfactory HEDIS results, typically earn lower scores in up to five of the seven of the eValue8™ modules. It is possible for health plans to use other approaches to operationally achieving the outcomes measured by eValue8™. In that case, the health plan must fully describe its activities so evaluators at NBCH are able to apply the eValue8™ criteria appropriately.

Health Plan Profile / Overview



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plan products and services can directly influence health care decisions made by patients and providers. This module considers health plan actions to offer plan designs that promote health behaviors as well as reduce financial barriers to patient adherence, advice to employers about using health benefits to promote safe and effective care, and providing culturally appropriate services that reflect members' race, ethnicity or primary language. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Accreditation & Performance Reporting

Health plans are asked whether they participate in formalized external review and oversight through one or more types of national accreditation. One common accreditation comes from an independent health care accrediting body called the National Committee for Quality Assurance (NCQA). This organization collects data and checks patient records to determine various levels of accreditation. Other recognized accreditation is

through URAC or the Joint Commission. Health plans with accreditation at both the plan and program levels receive the highest scores on this measure.

Plan Design

Health plans are evaluated on efforts to promote value-based benefit designs (i.e., safe, effective and affordable care). Health plans are expected to offer and administer (often complex) benefit plan designs that promote healthy behaviors as well as reduce financial barriers to encourage patients to receive effective care.

Health Information Technology (HIT)

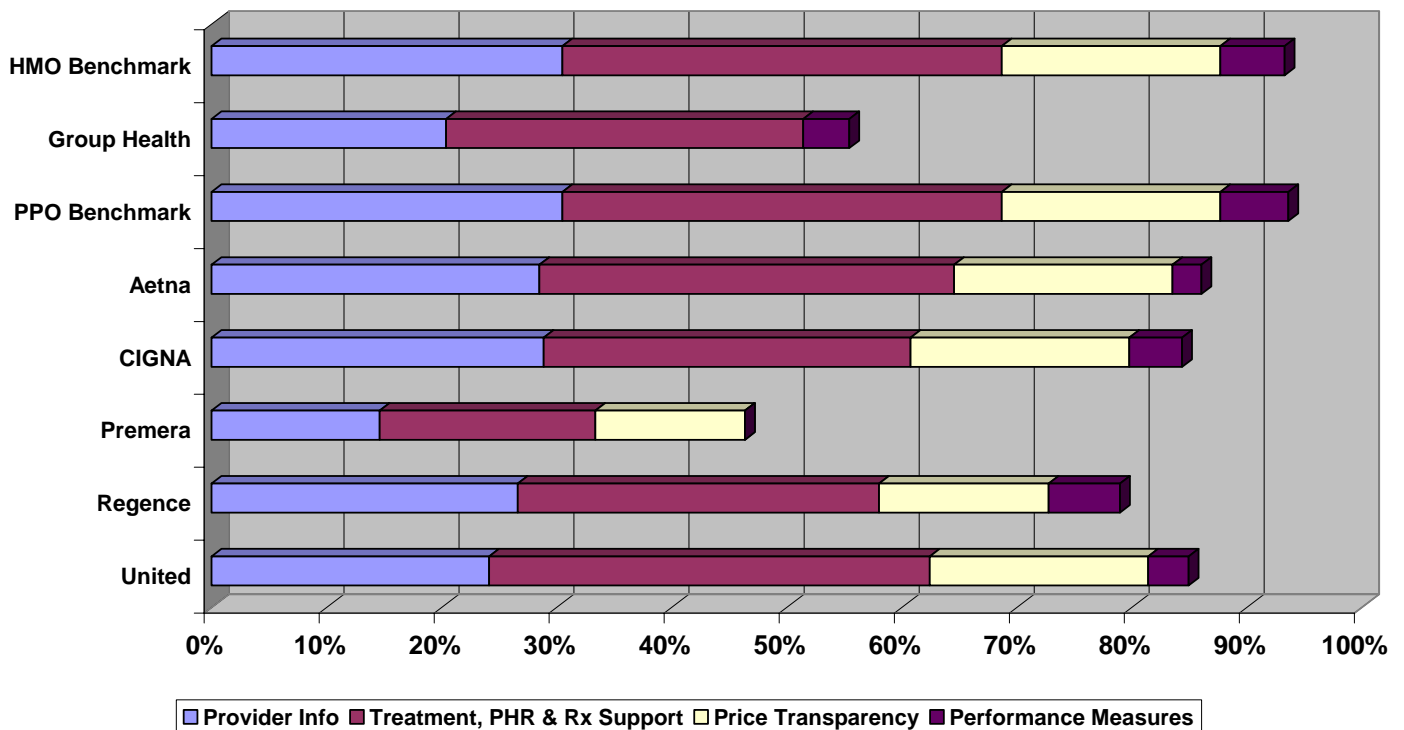
Health plans are evaluated on the degree to which they use and promote health information exchange and health information technology that is interoperable (i.e., computer systems that can share data with each other) in a collaborative manner to improve care, safety and patient satisfaction.

Provider Contracting, Disparities & Administration

Health plans are assessed on their reporting capabilities to determine whether the health plans target reporting for purchasers in ways that identify opportunities for employers to improve the benefit plan design and health management activities. The health plans are also evaluated as to whether they gather information on member race, ethnicity, and primary language, and the ways in which the health plan uses that information to better meet the needs of its members. Health plans are asked about the ways in which they proactively manage their provider network and contracts (negotiated rates, board certification) with a focus on quality and efficiency. For example, health plans earn a higher score if they require their network physicians to be board certified.

NOTE: This type of reporting is new in this region, so what is measured may not equate to the actual experience of health plan members. Scores may be affected by whether the health plan has pursued NCQA or other national accreditation, measurement and reporting of HEDIS and CAHPS, completeness of the narrative submitted by the health plan, how that description and data were scored, and other information submitted by the health plan before draft scores were finalized.

Consumer / Member Engagement



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plans provide a tremendous amount of information and support to their members, as health care consumers, employees and dependents, and as patients. This module looks at the types of support that are important to consumers, such as the content of a health plan's electronic provider directories, availability of performance information about hospitals and other facilities, personal health records, information and tools to help members understand the benefits and risks of treatment alternatives, and patient experience survey results. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Provider Information

Health plans are assessed regarding the extent to which they offer consumers detailed information about doctors and other health care providers in their network. Health plans are scored on their provider information listed in their online provider directories. This may include information on a provider's years in practice, board certifications and disciplinary actions, in addition to quality and patient experience information

on specific providers. Health plans are also expected to enable convenient methods of communication between doctors and patient, including web-based visits. This section assesses whether the health plan makes available and encourages members to use hospital performance information, including both clinical quality and patient safety.

Treatment, Personal Health Records, and Pharmaceutical (Rx) Support

Health plans are evaluated on whether they provide well-researched and objective resources to support members in making decisions about treatment options. Health plans are asked whether these tools and resources incorporate information about benefits, coverage and cost. In addition, health plans are expected to provide a variety of technology-based tools to members, including personal health records (PHRs) that are populated with claims transactions, medication history, etc., that don't require the patients to enter that information themselves. Ideally, patients are allowed to add other content such as over-the-counter drug use and immunizations. Health plans are expected to offer PHRs that can be "activated" as self-management tools incorporating features like outbound email reminders about gaps in care (e.g., due or overdue HbA1c / blood sugar tests for health plan members who have diabetes). This section also reflects the degree to which health plans provide information and tools to help members manage their prescription drug use and other elements covered by a pharmacy benefit, including cost comparisons and alternative choices.

Price Transparency

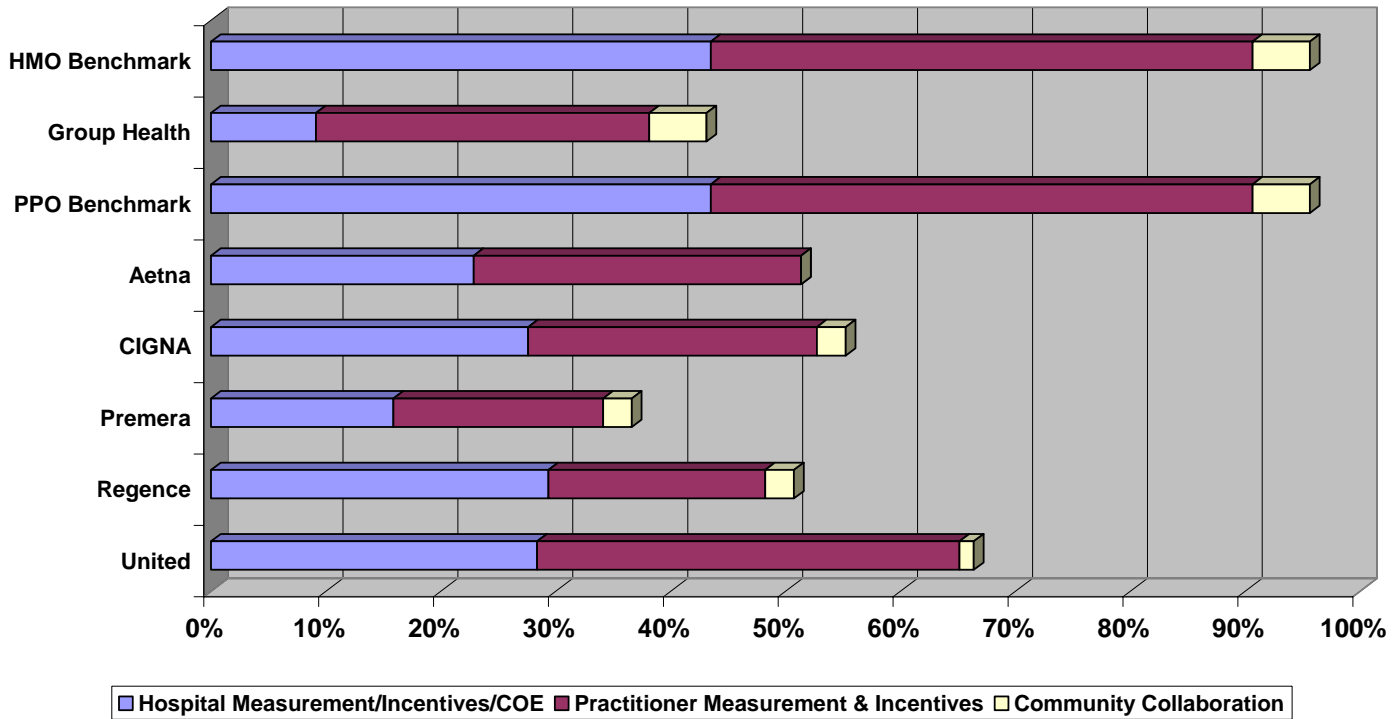
Efforts to help members become more involved in the financial aspects of their health care are encouraged. In this case, the more specific the information provided to the member by the health plan, and the more interactive the information, the better. As such, searchable information is more valued than display-only information.

Performance Measurement

This section assesses how health plan members rate their plan in areas like overall satisfaction, customer services and ability to access and receive needed care. Ideally, health plans field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey and report results publicly.

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Provider Measurement



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plans routinely interact with physicians and other practitioners in clinics, hospitals and other health care settings. This module considers health plan actions to: work with others in the community to measure and improve physician and hospital performance (e.g., the *Community Checkup* report), identify members with potential gaps in care and communicate that to providers; use clinical measures to differentiate among providers; and, use incentives to promote high performing providers. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Hospital Measurement, Incentives and Centers of Excellence

This section asks health plans about the ways in which the health plan differentiates among hospitals using various measures (i.e., clinical, patient experience, utilization, efficiency and use of health information technology) and reimbursement strategies to motivate the avoidance of serious events and health care

associated infections. This section examines how the health plan uses incentives, benefit design and information to promote high performing hospitals and other health care facilities.

Practitioner / Physician Measurement and Incentives

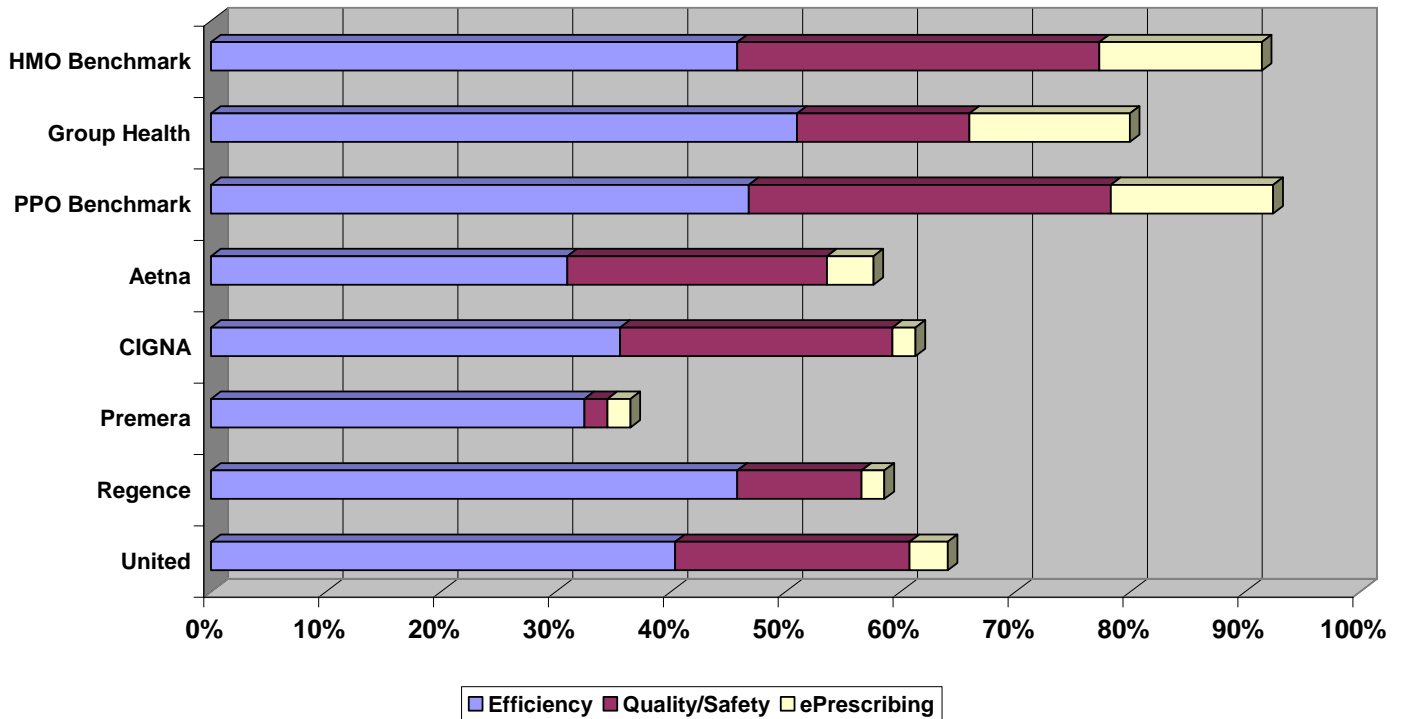
Health plans are asked about the ways in which they support physicians and other practitioners by providing tools to identify members with needed services or potential gaps in care. An important element is the promotion of interoperable electronic health information and adoption of health information technology. The practitioner performance section asks health plans about the performance measures the health plan uses to track physicians and physician groups. The measures eValue8™ asks about include quality, utilization, and efficiency. Health plans are also asked about whether they measure physician patient experience and use of health information technology. Health plans disclose the ways in which they use incentives, benefit design, and information to promote and reward high-performing providers.

Community Collaboration for Provider Measurement

This section evaluates health plans on their collaboration with other health plans in the market to measure and improve medical group (physician) and hospital performance. This includes whether the health plan pools data with others for provider benchmarking, reporting and rewards. Regionally this includes participation in the *Aligning Forces for Quality* initiative, which is coordinated by the Puget Sound Health Alliance in Washington state

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Pharmaceutical Management



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plans benefits and services focus on prescription drugs as an increasingly important part of health care today. This module considers health plan actions to: promote greater use of generic drugs when appropriate; monitor and influence cost-effective use of pharmaceuticals; understand and support providers' e-prescribing capabilities; address cost and appropriate utilization of specialty pharmaceuticals; and use information under the health plan's control to promote patient health and safety. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Efficiency

Health plans are asked how they promote the use of generic instead of brand-name pharmaceuticals, and whether they demonstrate high rates of prescriptions being filled with generics. Health plans describe how they monitor and influence the cost-effective use of pharmaceuticals. Health plans are assessed in terms of programs to address the cost and appropriate utilization of specialty pharmaceuticals, which are typically very expensive and for which there is no generic substitution.

Quality and Safety

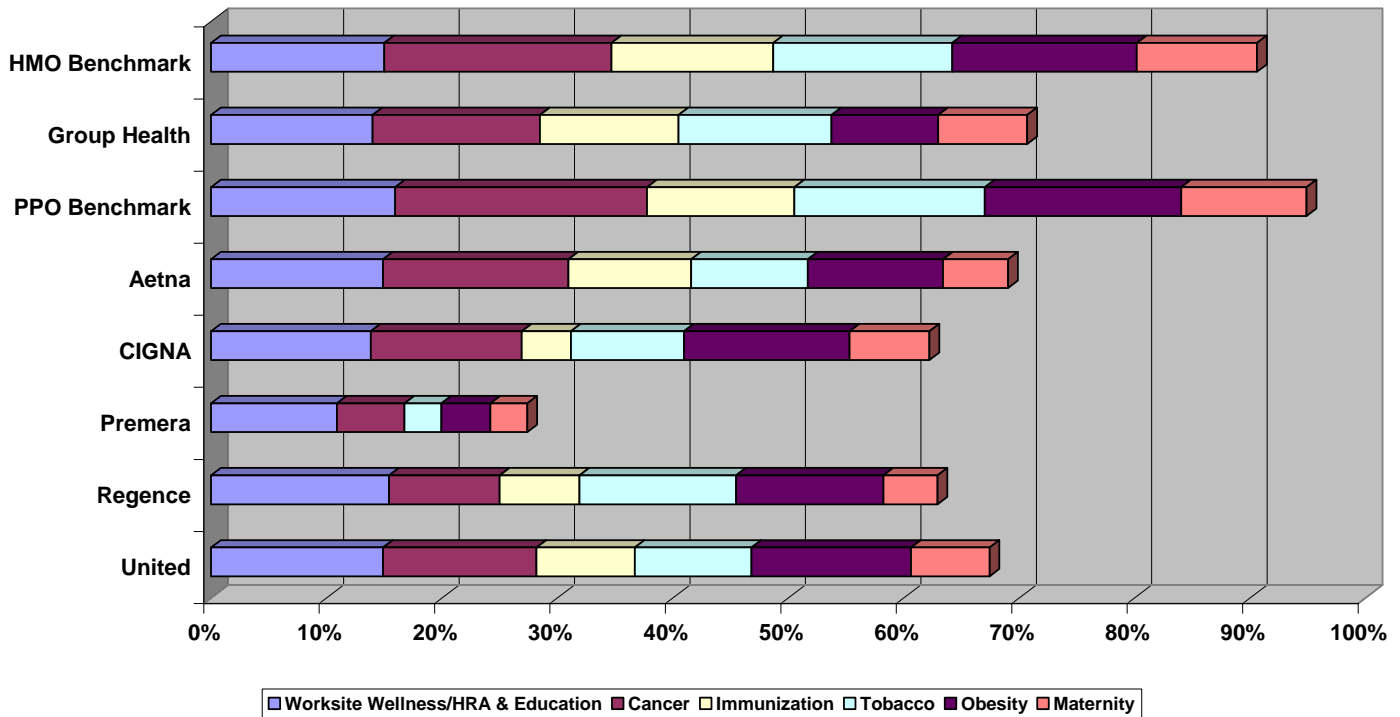
Health plans are expected to measure and report HEDIS and other pharmaceutical indicators and to use information under the health plan's control to promote patient safety and support patients staying on medications as prescribed. Nationally, the number of important pharmaceutical measures is growing, including those that reveal the extent to which there are gaps in care or safety problems.

E-Prescribing

Health plans describe whether and how they know the e-prescribing capabilities of their contracted network, as electronic prescribing has been found to increase efficiency and safety of prescribing pharmaceuticals. Health plans are also expected to comply with the national health data management standards that support information system interoperability.

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Prevention and Health Promotion



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plans provide benefits and services that influence health care decisions made by members, including actions that affect an individual's current and future health. This module considers health plan actions to: partner with employers on worksite health promotion and education about risk factors associated with chronic diseases; provide and promote the use of health risk assessments; and offer programs to address cancer screening, immunizations, tobacco use, obesity and high-risk pregnancy. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Worksite Wellness Programs, Health Risk Assessments (HRA) and Related Education

This assesses a health plan's capabilities and history in offering employers on-site health promotion programs such as health fairs, customized printed materials, on-site screenings (blood pressure, weight, etc.) and presentations on health topics, with emphasis on follow-up for health plan members needing assistance with things like tobacco cessation and management of chronic conditions. eValue8™ assesses whether health plans offer a health risk assessment (HRA) to members and the health plan's strategies to motivate and maximize

members to complete and use the HRAs. Health plans are expected to educate their members on chronic disease risk factors such as family history, diet, physical inactivity, weight, cholesterol levels and tobacco use. There is a particular interest in education for children and their care givers about the risk factors associated with *developing* chronic disease..

Cancer Screening Programs and Results

Health plans are asked to describe their comprehensive cancer screening program, if any, and the screening rates for breast, cervical and colorectal cancer; health plans are expected to report this as part of the national HEDIS survey.

Immunization Programs

Health plans are assessed as to how they address child, adolescent and adult immunizations, with emphasis on member-specific interventions such as reminders when specific services are needed. Health plans are expected to report this as part of the national HEDIS survey.

Prevention and Treatment of Tobacco Use

Health plans are expected to offer a comprehensive program to address prevention and treatment of tobacco use. This includes identifying members, offering a variety of intervention opportunities, and measuring member participation.

Obesity

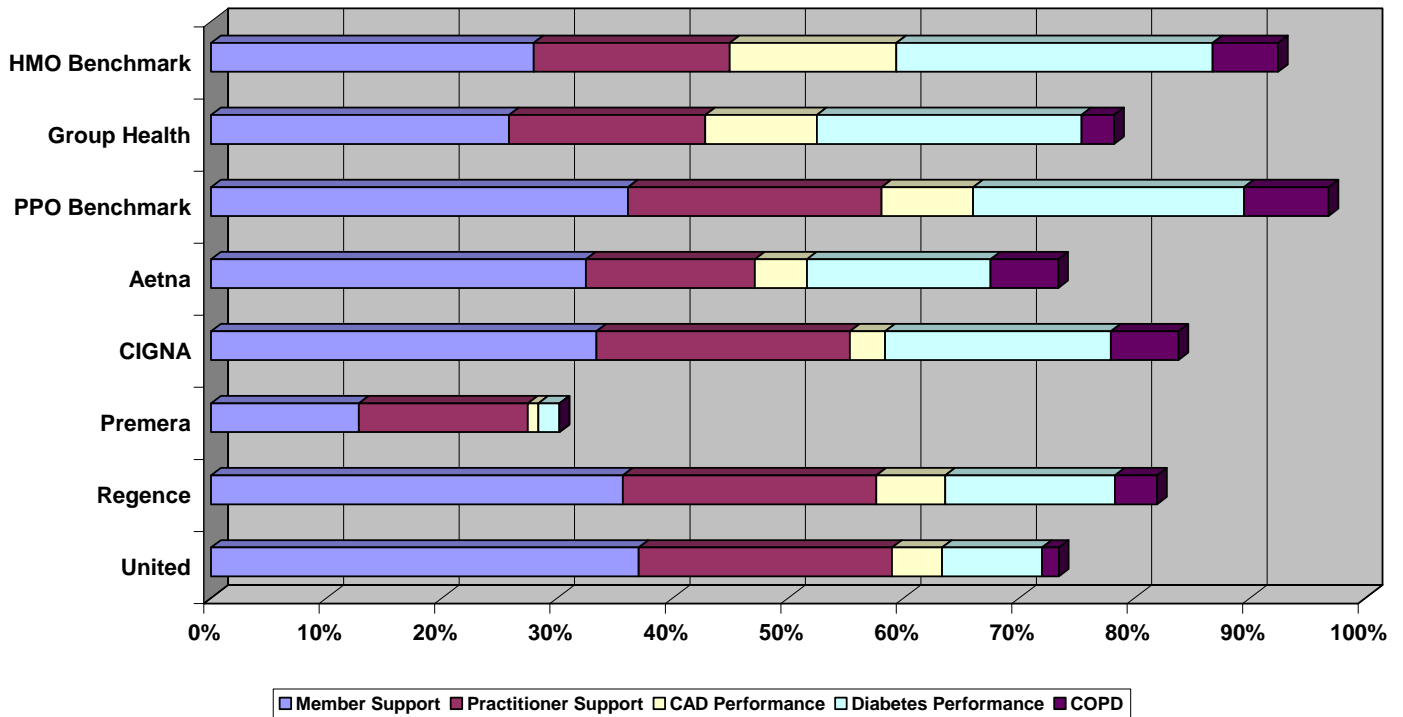
Health plans are expected to educate their members on the health risks of obesity. This includes identifying and targeting members who can benefit from treatment and tracking results from obesity-related programs.

Maternity and Obstetrics

Health plans are expected to promote pre-conception counseling and track high-risk pregnancies and interventions. This includes encouraging providers to screen pregnant women for alcohol and for tobacco use.

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Chronic Disease Management



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plan services focus on preventing and managing chronic disease, as it is one of the largest cost drivers in health care. This module considers health plan actions to: provide disease management programs that enable coordination of care across multiple health conditions while addressing depression, alcohol and tobacco use and prescription drugs; use interventions that involve direct contact with members to address the member's specific needs, including staying on needed medication; and proactively engage providers in the health plan's disease management program to support effective patient care. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Member Support

Health plans are assessed on their performance in providing assistance to members who have chronic conditions. For instance, health plans are scored on whether they offer general reminders to diabetic patients to schedule routine visits and lab tests. Health plans are also asked if they provide follow-up reminders to patients who have missed appointments or tests, or are not filling prescriptions for needed medications. Other

services looked for include one-to-one counseling, live, outbound phone calls to members, and programs that facilitate coordination of care beyond the specific individual disease. This might include depression, alcohol and tobacco screening for members, and pharmacy expertise to address medication compliance.

Practitioner Support

Health plans are evaluated regarding whether they provide physicians and other health care practitioners with patient-specific reports on adherence to clinical guidelines appropriate to the patient's condition and reports that compare practitioners' results with their peers. Health plans are expected to proactively engage providers in disease management programs.

Coronary Artery Disease (CAD) Management

Health plans are assessed regarding the breadth of the disease management programs offered to members suffering from coronary artery (heart) disease. It is expected that such disease management programs also facilitate coordination of care *across* chronic conditions and include depression, alcohol and tobacco screening. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

Diabetes Disease Management

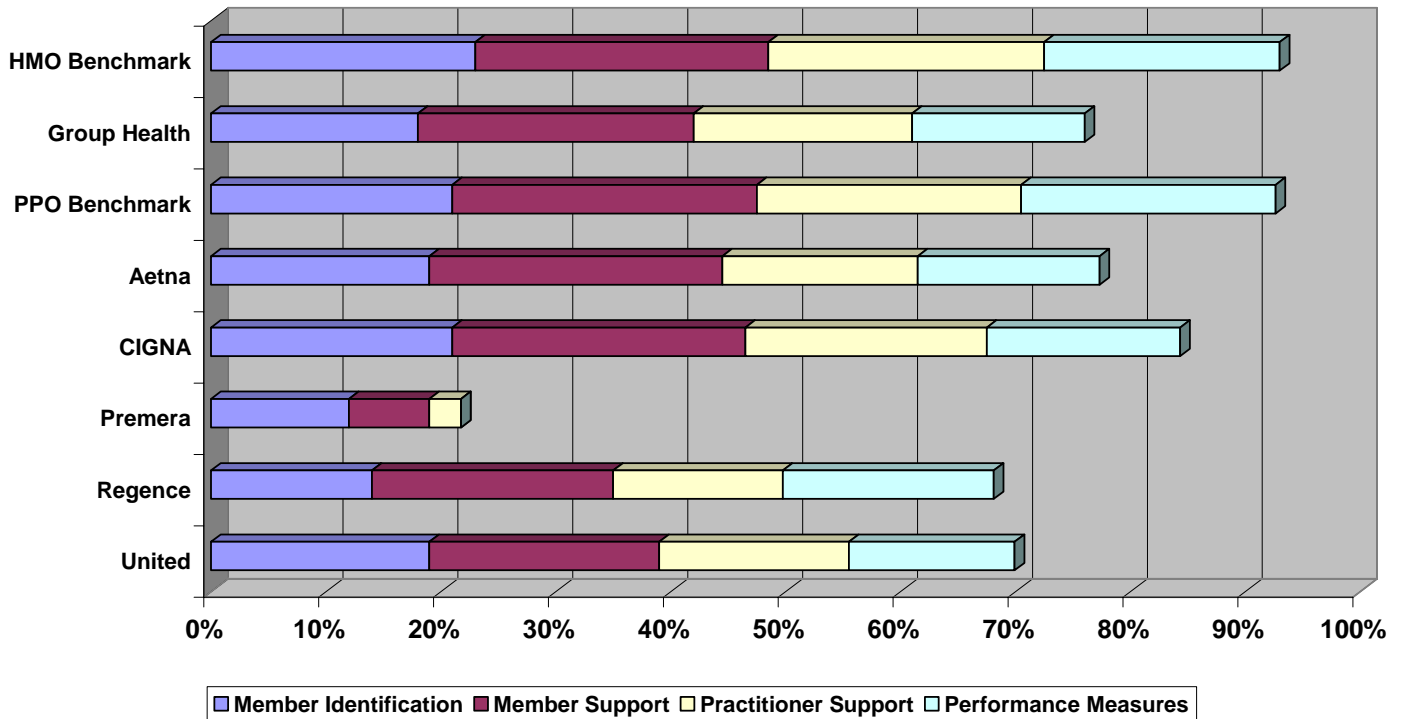
Health plans are assessed regarding the breadth of the disease management programs offered to members who have diabetes. It is expected that such disease management programs also facilitate coordination of care *across* chronic conditions and include depression, alcohol and tobacco screening. This also looks at whether the health plan measures outcomes of its chronic disease program in addition to employee absenteeism, productivity, program return on investment and patient experience with the program. Health plans are also invited to communicate other measures that they have determined to be important. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

Chronic Obstructive Pulmonary Disease (COPD) Management

Health plans are assessed regarding the breadth of the disease management programs offered to members suffering from chronic obstructive pulmonary disease. It is expected that such disease management programs facilitate coordination of care *across* chronic conditions and include depression, alcohol and tobacco screening. Significant emphasis is placed on HEDIS results with the maximum credit given to those health plans whose HEDIS scores are in the 90th percentile nationally.

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Behavioral Health



Note: The "benchmarks" above show the scores earned by the nation's best performing health plan (HMO and PPO) that participated in this same evaluation process in 2009.

What Does This Tell Us About How Health Plans Affect Health and Health Care Value?

Overall, health plan programs to address depression management and alcohol treatment are essential to promoting health and health care value. This module considers health plan actions to: cover behavioral health in an accredited program for all members; identify, track and support members who need treatment for alcohol use and/or depression; provide and monitor provider use of patient screening tools for alcohol use and depression; and use related clinical guidelines and patient-specific reports. Read on for more specifics.

What is Being Measured in Each Color Segment in the Chart?

Member Identification and Screening

Health plans are expected to identify and track members requiring treatment for alcohol use disorders and depression as a percent of total members enrolled. Health plans are assessed as to whether they recommend tools to screen members for depression and alcohol overuse and to monitor the use of these tools.

Member Support

Health plans are assessed as to whether they offer behavioral health (BH) services *in an accredited program*, as a part of all of their benefit plans. Health plans are expected to provide timely clinical support 24 hours per day, 7 days per week. Similar to chronic disease management, emphasis is on the use of clinical guidelines and adherence to prescribed medications, recommendation of effective screening tools, and supporting provider use of clinical data registries. Health plans are asked how they support interventions that involve a direct member contact for specific needs, including medication compliance. The health plan is expected to identify and treat members who have behavioral health and medical conditions in a coordinated fashion.

Practitioner Support

In contrast to the Chronic Disease Management module above, for this element, health plans are asked about the support they provide to both medical practitioners such as primary care physicians and behavioral health practitioners including psychiatrists, psychologists and other professionals who provide behavioral health services. Health plans are asked which screening tools it recommends to these practitioners, whether the health plan tracks the use of those tools, and if they provide patient-specific and comparative reports for practitioners.

Performance Measurement

Similar to the Chronic Disease Management module above, the health plan's HEDIS results specific to depression and alcohol use disorders are used for this score. Health plans also disclose their use of non-HEDIS measures and are allowed to specify their own measures. Measures include the number of members diagnosed with depression and alcohol disorders who stay with treatment programs and the level of patient and provider satisfaction with the health plan's depression and alcohol treatment management programs.

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More About eValue8™

The eValue8™ tool is a nationally-recognized health care quality improvement assessment process developed by the National Business Coalition on Health (NBCH) to help purchasers buy health care products and services. It was created in collaboration with concerned employers and union trusts that purchase health care (“purchasers”). In 2002, several coalitions and large employers across the country gathered to develop a means by which purchasers could evaluate health plans based on real value, not just on price. The concept of quality was introduced and has become the overarching principle in the eValue8™ process. The eValue8™ tool conveys purchaser expectations for health plans, based on the best available evidence and expert agreement on innovative approaches to improving health and health care. Today, more than 20 coalitions and more than 100 health plans across the country participate in this process.

Using a standard request for information based on national standards, eValue8™ asks health plans to submit information about clinical quality and administrative efficiency so purchasers (i.e., public and private employers and union trusts) can compare plans against one another and against national benchmarks. Hundreds of benchmarks are gathered in critical areas such as:

- Health information technology
- Member and provider communications and support
- Disease management
- Provider performance measurement, transparency and rewards
- Patient safety
- Pharmaceutical management
- Behavioral health
- Prevention and health promotion

The following organizations work with NBCH to develop and update the eValue8™ tool and scoring method:

- Centers for Disease Control (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Agency for Healthcare Research and Quality (AHRQ)
- National Committee on Quality Assurance (NCQA)
- The Joint Commission
- URAC
- American Board of Internal Medicine (ABIM)
- eHealth Initiative (eHI)
- The Leapfrog Group
- The Pharmacy Quality Alliance
- Pennsylvania State University
- George Washington University

Once the health plans have electronically submitted their data, a certified eValue8™ scoring team verifies the information to ensure that all the information is accurate and comparable, and then scores the information. In the local region, purchasers review the information in meetings with each of the health plans to discuss strengths, best practices and opportunities for improvement. Purchasers, working through coalitions such as the Puget Sound Health Alliance, also use the information to discuss community-wide opportunities for health improvement through collaboration.

Purchasers ultimately use the information gathered through eValue8™ - the comparative charts, detailed health plan responses and the knowledge gained through site visits with the health plans - to compare health plan value, based on their own criteria. In other parts of the country, some purchasers use the information to negotiate pricing with health plans or set the employee share of premiums, with employees paying less when they choose a health plan that the purchaser considers to be higher quality. Equally important to pricing, purchasers working with coalitions use the information and the subsequent feedback with health plans as a unique opportunity to stimulate market-wide improvements in health care quality.

Acknowledgements

Special thanks to the 16 health plans and sponsoring purchasers listed below. Each provided funding to help cover the cost of the eValue8™ process, which was also supported by two generous grants from Merck, Inc.

Participating Health Plans

- Aetna (PPO)
- CIGNA HealthCare (PPO)
- Group Health Cooperative (HMO)
- Premera Blue Cross (PPO)
- Regence Blue Shield (PPO)
- United Healthcare (PPO)

Sponsoring Purchasers

- Alaska Air Group
- The Boeing Company
- City of Seattle
- King County
- Pierce County
- Port Blakeley Companies
- Puget Sound Energy
- Recreational Equipment, Inc.
- Snohomish County
- Washington State Health Care Authority

Alliance Staff Contact

Susie Dade, Director of Quality Improvement and Administration
Puget Sound Health Alliance
2003 Western Avenue, Suite 600
Seattle WA 98121
(206) 448-2570 ext. 117 sdade@pugetsoundhealthalliance.org

NBCH Staff Contact

Dennis White, Vice President, Value-Based Purchasing
National Business Coalition on Health
1015 18th St NW, Suite 730
Washington DC 20036
202.775.9300 ext 18 DWhite@nbch.org

The Puget Sound Health Alliance (www.pugetsoundhealthalliance.org) is a non-profit organization made up of those who provide, pay for and use health care, working together to improve quality of care at a price more people can afford. More than 150 organizations, plus individuals, have joined the Alliance, including many employers, clinics, hospitals, consumer groups, unions and trusts, health plans and others. The Alliance produces the *Community Checkup*, a report on health care performance in the region. For the full report, go to www.WACommunityCheckup.org.