RI Health Plans' Performance Report (2007)

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Donald L. Carcieri
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Christopher F. Koller
Health Insurance Commissioner

March, 2009

To all Rhode Islanders:

We are pleased to present the 10th annual publication of the *RI Health Plans' Performance Report*. This Report, based on 2007 commercial health plan data, provides information on 34 separate measures covering 8 dimensions of performance (i.e., enrollment, costs, utilization, prevention, screening, treatment, access, and satisfaction). Health plan performance is trended over time, compared to regional averages, and benchmarked to the best 10% of health plans nationally.

Performance benchmarking serves to focus healthcare improvement efforts, and holds health plans accountable for the way services are provided. This information is also used by programs to gauge progress in improving the health status of Rhode Islanders, and may guide policy-makers in their efforts to create a healthcare delivery system promoting prevention and primary care.

Quality measures for Blue Cross and Blue Shield of RI and United Healthcare of NE compared fairly well to New England plans, in general. In addition, these two plans have historically been less expensive than their regional counterparts, and their favorable pricing continued in 2007.

Several measures in this report illustrate opportunities for plans to improve healthcare delivery in the state. For example, RI's 2007 commercial chlamydia screening rates were about 42 percent, and antidepressant medication management rates were under 28 percent. These and other measures demonstrate the need for targeted primary care for early detection and disease management.

The Department of Health and Office of the Health Insurance Commissioner appreciate RI's health plans' commitment to quality improvement, and their support in shaping RI's healthcare system to promote cost-effective, high quality services.

Sincerely,

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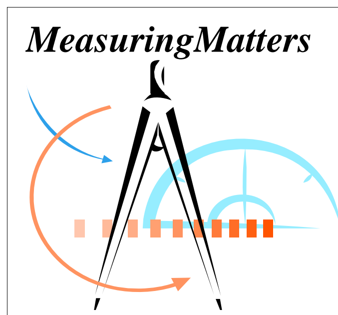

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I: EXECUTIVE SUMMARY

RI's two domestic commercial health insurers (Blue Cross and United) provided good value to their customers in 2007. Not only were their monthly premiums considerably less than their New England (N.E.) counterparts, but their quality measures were generally equivalent or superior to this cohort.

The 1996 Health Care Accessibility and Quality Assurance Act instituted the submission and analysis of health plan data in the state. This 2007 report fulfills the statutory reporting requirements of RIGL 23-17.13-3. It is the 10th edition to present health plan performance information, trended over time, and compared to regional averages, and national benchmarks.

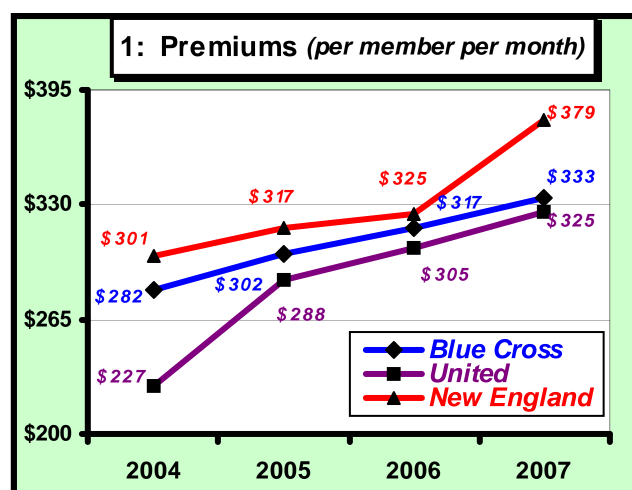
With a small state population, few commercial underwriters, and the market dominance of Blue Cross & Blue Shield of RI (Blue Cross), most Rhode Islanders have limited choice of carrier. The lack of selective contracting also means that most plans deliver services through the same network of caregivers (i.e., the majority of physicians, hospitals and other providers participate in most, if not all plans).

Therefore, the value in publishing this information is primarily in promoting accountability of the industry. Purchasers deserve to know how well the plans are performing and policymakers need empirical evidence to set effective policy. Healthcare programs also need tools to benchmark progress in improving health status. An added benefit is that plan performance may improve simply by making the results public.

Some 338,411 Rhode Islanders were commercially insured in 2007, and this report analyzes the two largest health plans, which together covered over 75.5% of this population (i.e., Blue Cross and UnitedHealthcare of New England (United)). In all, eight separate dimensions of performance are evaluated, ranging from enrollment, costs, utilization and prevention, to screening, treatment, access, and satisfaction. A separate, companion publication, *The Health of RI's Health Insurers (2006)*, provides a financial analysis of the state's domiciled insurers.

RI's health insurance market is concentrated in two carriers. Blue Cross had a share of 63.0% and United controlled 12.5% of the commercial market. The remainder (24.5%), consisted of a host of smaller plans, all incorporated out-of-state.[1]

Cost and quality are the two determinants of value. For Rhode Islanders to receive value from their investment in health insurance, that coverage should be equivalent or less expensive and deliver the same or better quality services than elsewhere. Chart 1 graphs the average 2004-2007 monthly premiums paid for commercial coverage.



Rhode Islanders have historically paid less than their regional counterparts for health insurance. In 2004, Blue Cross was 6% less expensive than the New England comparable, while United was 24% less expensive. In 2007, those differences were –12% and –14%, respectively.

RI's two commercial health plans performed fairly well when their quality measures were compared to their New England cohorts in 2007 (Table 1). For Blue Cross, 11 of its 19 quality measures were equivalent to the regional averages, five measures were better, and the remaining three were worse than these comparables. For United, 12 of its 19 quality measures were equivalent to the regional averages, four measures were better, and the remaining three were worse.

Irrespective of the overall favorable relative performance of the plans, the weak absolute val-

ues on some clinical measures is concerning. For example, *Chlamydia Screening* values of ~42%, and *Antidepressant Medication Management* values under 28%, underscore the continued need for improvement in these areas.

1: 2007 Health Plan Quality Performance

	Dimension/Measure	N.E. Averages	Relative to N.E. Averages[1] Blue Cross	Relative to N.E. Averages[1] United
	PREVENTION			
1	Childhood Immunization	73.5%	16%	13%
2	Adult Flu Shots	49.0%	=	-17%
3	Smokers Advised to Quit	79.6%	7%	=
4	Smokers Advised on Meds.	59.1%	-13%	20%
5	Smokers Advised on Methods	56.2%	=	7%
	SCREENING			
6	Colorectal Cancer Screening	63.3%	5%	-9%
7	Breast Cancer Screening	77.0%	=	=
8	Cervical Cancer Screening	83.5%	=	=
9	Chlamydia Screening	45.9%	-9%	-8%
10	Diabetic Eye Exams	62.7%	=	=
11	Diabetic HbA1c Testing	89.0%	=	=
	TREATMENT			
12	Persistent Beta Blocker Tx.	77.6%	-9%	=
13	Cholesterol Controlled	58.2%	6%	=
14	Appropriate Asthma Meds.	92.1%	=	=
15	Antidepressant Med. Mgmt.	25.8%	8%	=
	ACCESS			
16	Follow-up for Mental Illness	81.0%	=	=
17	Well Child Visits (1st 15 mos.)	81.9%	=	11%
18	Well Child Visits (3rd-6th yrs.)	82.8%	=	=
19	Adolescent Well-Care Visits	58.7%	=	=

[1] '=' indicates that the relative difference from the N.E. average was less than +/-5%

Chart 2 graphs plan members' satisfaction with their health plans and their healthcare.

Blue Cross' 2007 health plan satisfaction rate of 66% was 7% higher than the regional rate of 62%, while United's rate (44%) was 29% below that comparable. Blue Cross' healthcare satisfaction rate was not appreciably different from the New England value (77% vs 76%), but United was 11% below that comparable (68% vs 76%). In keeping with the experience in prior years, more members expressed satisfaction with their healthcare services than with their health plans, regardless of location.

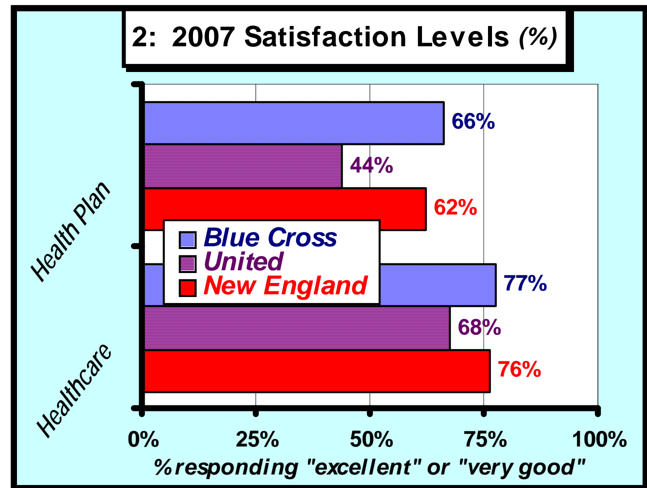
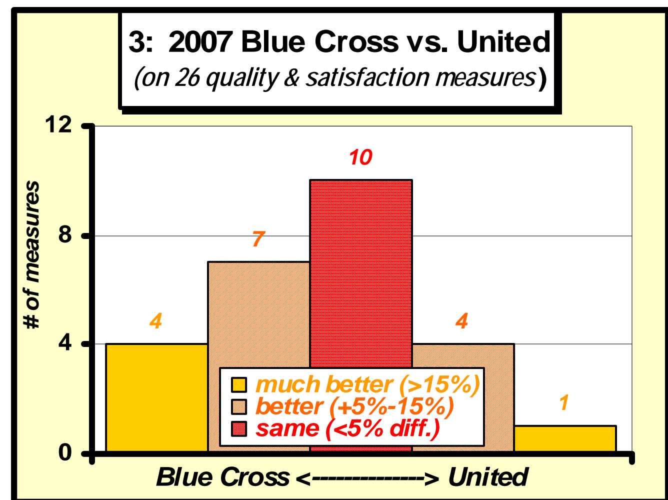


Chart 3 provides a Blue Cross/United comparison on 26 quality and satisfaction measures (#13-#38 in the appendices).



Blue Cross outperformed United on 11 measures, 10 measures were essentially similar between the two plans, and United outperformed Blue Cross on 5 measures.

II: INTRODUCTION

Increasingly, the public, purchasers, providers, and policy-makers are seeking meaningful information about commercial health insurers. This report provides the most comprehensive public source of data on plans certified to operate in Rhode Island.[1]

Consumers and purchasers may use this information to make informed choices among competing plans or to understand their chosen plan better. The plans themselves have comparative statistics to identify and focus improvement efforts, and policymakers may use this information to support their decision-making. Lastly, healthcare programs may use these data to benchmark their own performances.

A. Background

Not all health insurers are identical. They differ in how they keep members well and how they care for them when they are ill, even though their provider networks may be similar. They also differ in how they provide access to and deliver services. Most Rhode Islanders receive their health coverage through the two commercial plans in this report, so learning about how they perform is essential to determining if value is received from the premium dollars expended.

Consequently, in response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. One stipulation of this law was a requirement that health plans submit performance data to the RI Department of Health (RI-DOH). This report fulfills the statutory reporting requirements of the Act.

To consumers, the quality, and access to care provided by a plan may affect their health. To employers, these same issues may influence worker absenteeism, productivity and the company's personnel costs.

The *RI Health Plans' Performance Report (2007)* is the 10th annual publication of this information. For more assistance in choosing a particular commercial health plan, readers are referred to: http://hprc.ncqa.org/.

B. How to Use This Information

The report is divided into sections containing similar dimensions of performance. Section III examines enrollment and market share. Section IV provides cost information, and section V compares utilization statistics. Section VI looks at prevention measures, and section VII gives screening information. Section VIII presents treatment statistics and section IX shows access measures. Lastly, section X provides the results of member satisfaction surveys. Whenever possible, regional (New England) averages and national 90th percentile values are provided to assess the plans' performances relative to these comparables and benchmarks.

This report examines commercial health plans only, it does not include Medicaid or Medicare HMO plans. Information on the financial performance of RI's health insurers is presented in a companion publication, *The Health of RI's Health Insurers (2006)*.

The following guidelines should help improve the utility of this report.

- **No one measure in and of itself can accurately reflect health plan performance.** Therefore, the statistics should be viewed in combination and not in isolation.
- **Readers should focus on large differences between health plans** that are less likely to be caused by random chance. When comparing statewide performance to the regional values or national benchmarks, differences less than +/-5% usually do not signify any meaningful variations.[2]
- **Readers should recognize there may be reasons why results vary other than differences in quality or administration.** Every plan enrolls a distinct set of members with unique demographic characteristics that could affect performance (e.g., age, health status, race/ethnicity, socioeconomic status). In addition, differences in covered benefits may also influence outcomes.
- **This report examines all types of commercial health plans (i.e., HMO, POS and PPO).** HMOs are legally defined and, generally, use restricted networks to deliver

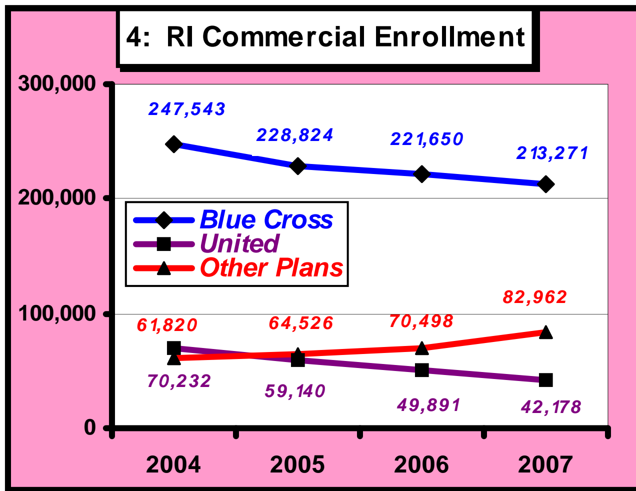
care through the member's primary care provider. In addition, they may employ a variety of managed care techniques to coordinate care and control costs (e.g., 'gatekeepers', second opinions, formularies, restricted networks, etc.). As other plans employ these same techniques, and as the popularity of traditionally-defined HMOs wanes, this distinction becomes less apparent and important.

- **This report excludes plans with fewer than 10,000 RI members.**[1] These insurers are fairly minor competitors in the RI marketplace at this time and, to reduce their reporting burden, they are exempt from filing. Also, given their smaller market shares, they do not influence providers' practices to any significant extent.
- **Comparable data** (i.e., the New England averages and the national 90th percentile values) are from other commercial health plans included in *Quality Compass* (National Committee for Quality Assurance). In the text, reference may be made to U.S. or national benchmarks. Those benchmarks are the cutoff values for the best-performing decile (10%) of health plans nationally (Appendix E). Therefore, these benchmarks are the 90th percentile national values (e.g., the 2007 *Childhood Immunization* benchmark of 88.1% means that 90% of plans across the country had values below 88.1%, and 10% had values above 88.1%). For the one measure in which lower values are preferred (i.e., *ED Visits*), the benchmark is the 10th national percentile value.

III: ENROLLMENT

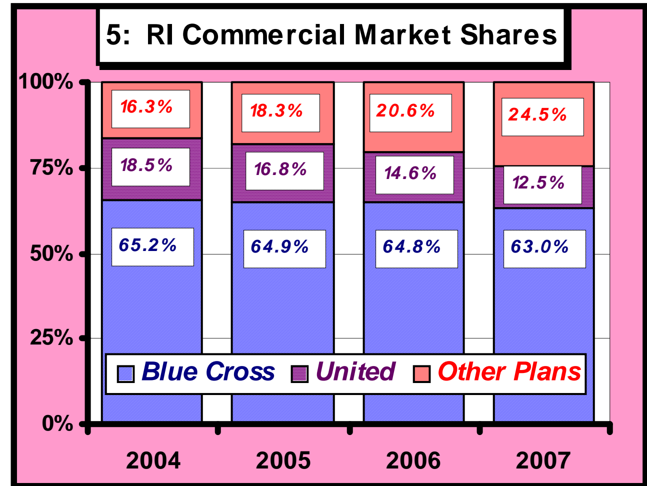
This section compares health plan membership information and market shares. Included is the fully-insured commercial book-of-business only, and not any self-insured members for which the plans provide third party administrators' (TPA) or administrative services only (ASO) services.

A. RI Enrollment is the computed RI resident enrollment in a health plan for the full year (Chart 4). Increasing enrollment over time is important both in terms of achieving economies of scale and increasing market share.



Blue Cross remained the largest commercial carrier with 213,271 fully-insured RI members, and United had 42,178 RI members. Total RI commercial enrollment fell every year, from 402,723 in 2004 to 338,411 in 2007, reflecting the general decline in insurance coverage and the switch to self-insurance by some larger companies.

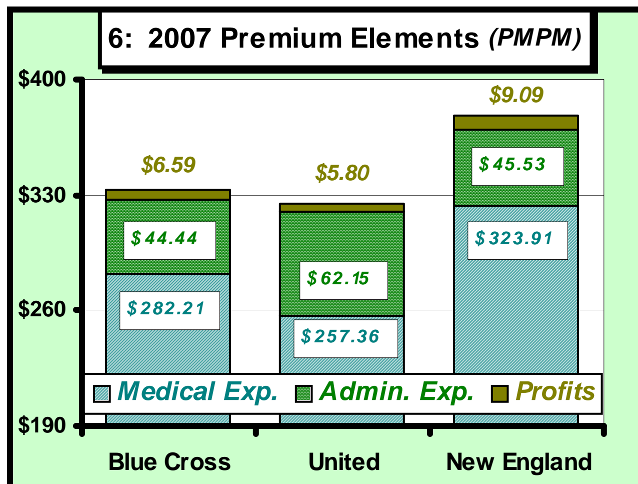
B. RI Market Shares calculates each plan's percentage of the total RI fully-insured enrollment (Chart 5). In many respects, market share is more important than simple enrollment (although the two are related). It is possible in a shrinking market such as RI, for a plan's enrollment to decline while its market share increases. Market share, to a large extent, determines how aggressively a plan can negotiate its provider contracts, rates and commissions.



Blue Cross' market shares were relatively stable since 2004, and it controlled 63.0% of the domestic commercial market in 2007. United's share has eroded over time to 12.5% of the market in 2007.

IV: COSTS

This section compares health plan cost information. Chart 6 presents the average costs of the insurance coverage in 2007, as well as the amounts spent on healthcare services, administrative expenses, and the profits remaining (on a per member per month (PMPM) basis).



In 2007, Blue Cross' PMPM premiums of $333.24 were 12% less than the New England value of $378.53, and United's premiums of $325.30 were 14% below that comparable.

Care should be exercised in comparing and interpreting premiums. One insurer may be less expensive than another, but that doesn't necessarily mean it is a better bargain. Different insurers may sell products with different benefits, co-pays or deductibles. Therefore, the total healthcare costs for a member in a less expensive plan may actually be greater than a more expensive plan that has fewer co-pays, lower deductibles, or more covered services the member needs.

Medical expenses are the amounts plans spend on healthcare services for their members. Consumers generally favor higher medical expenses (all else being equal), because they indicate more of the premium dollars going into their healthcare. However, lower medical expenses do not necessarily imply that an insurer restricts access to services. Lower expenses could instead mean that a plan's members are less ill, that the plan sells less expensive benefit plans with more cost sharing, that the plan is more effective at managing care for its members, or that its reimbursement rates to providers are lower than its competitors.

In 2007, Blue Cross' PMPM medical expenses of $282.21 were 13% less than the New England value of $323.91, and United's medical expenses of $257.36 were 21% below that comparable.

Administrative expenses are the amounts spent on operating the health plan, and marketing its products. Many administrative expenses are fixed, so controlling them is essential to maximizing profits. Generally, consumers favor lower administrative expenses as a matter of course, expecting that these monies could instead go into direct medical services to members.

In 2007, Blue Cross' PMPM administrative expenses of $44.44 were 2% less than the New England value of $45.53, while United's administrative expenses of $62.15 were 37% above that comparable.

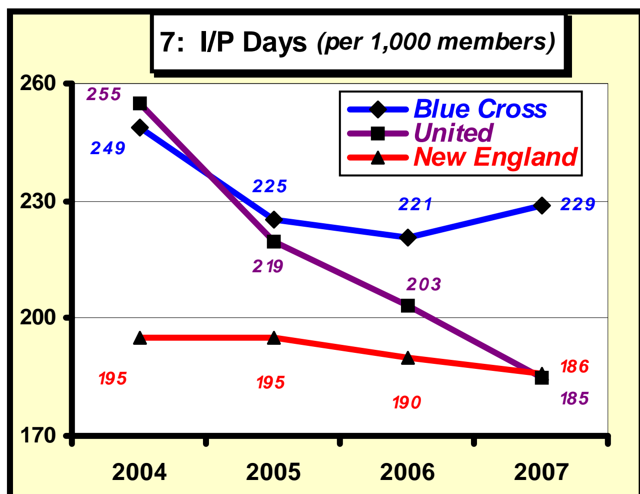
Profits are the monthly net amounts generated per member from underwriting the commercial book-of-business after all associated expenses have been paid. Profits are critical, even for non-profit insurers (e.g., Blue Cross), because they allow the organization to remain solvent (i.e., add to the reserves), to increase marketing, and to invest in new information systems. 'Excessive' profits, however defined, may be a particular risk in what is essentially a two insurer commercial market such as RI.

In 2007, Blue Cross' PMPM profits of $6.59 were 28% less than the New England value of $9.09, and United's profits of $5.80 were 36% below that comparable.

V: UTILIZATION

This section gives information[3] on the services utilized by members in a health plan.

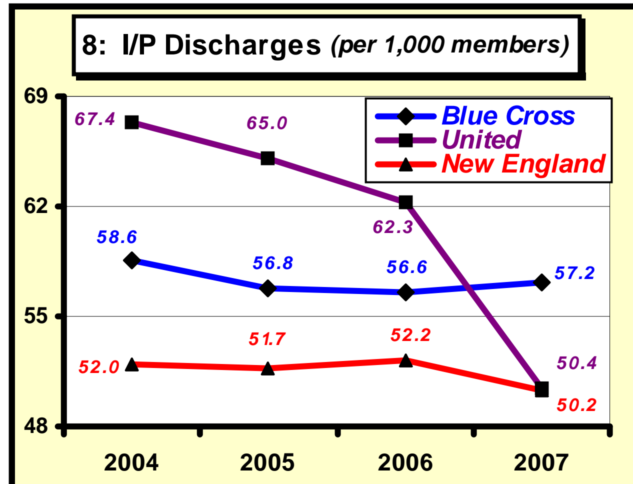
A. Hospital Inpatient Day Rates are the average number of acute-care hospital days used by every 1,000 members in a plan (Chart 7). Excluded are substance abuse, mental health and nursery days. Inpatient hospital expenses comprise 30%-40% of most insurers' medical expenses, but there is no desired trend or benchmark for this measure.



The two health plans consistently had higher hospital day rates than their regional counterparts, but United reduced its utilization to slightly below that comparable in 2007, while Blue Cross ended 23% above that rate (229 vs 186).

Relatively high hospital day rates are neither inherently favorable nor unfavorable, therefore, benchmarking to a desired goal is not possible. Assuming that all hospital utilization is appropriate, then high day rates may be acceptable given a sicker population requiring more services. However, relatively high day rates may also indicate the lack of preventive services or poor management of chronic diseases.

B. Hospital Inpatient Discharge Rates are the average number of acute-care hospital discharges (excluding substance abuse, mental health and nursery discharges) used per 1,000 members in a plan (Chart 8). There is no desired trend or benchmark for this measure.



Again, the two plans consistently had higher hospital discharge rates than their regional counterparts, but United reduced its utilization to a similar rate in 2007, while Blue Cross remained 14% above that comparable.

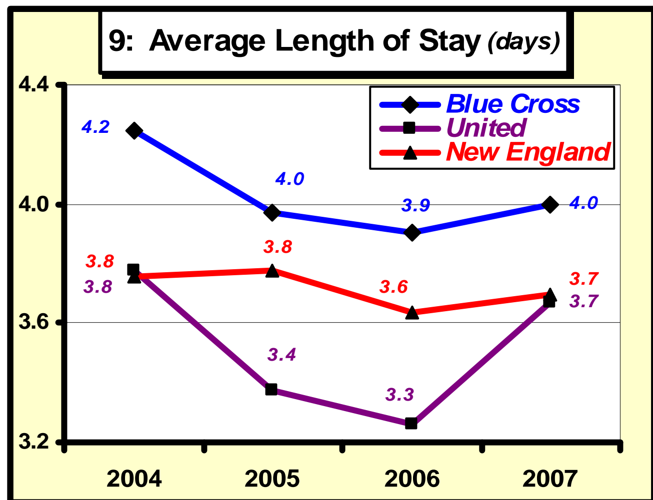
As with day use rates, relatively high discharge rates are neither inherently favorable nor unfavorable. Therefore, benchmarking to a desired goal is not possible. Assuming that all hospital utilization is appropriate, then high discharge rates may be acceptable given a sicker population requiring more services. However, relatively high discharge rates may also indicate the lack of preventive services or poor management of chronic diseases.

C. Average Length of Stay (ALOS) is the average number of inpatient days for each acute-care hospital discharge (Chart 9). There is no desired trend or benchmark for this measure.

Blue Cross had ALOS values regularly above the regional values, and remained 8% above this comparable in 2007. United both started and ended the period equivalent to the N.E. values after dropping below those comparables in 2005 and 2006.

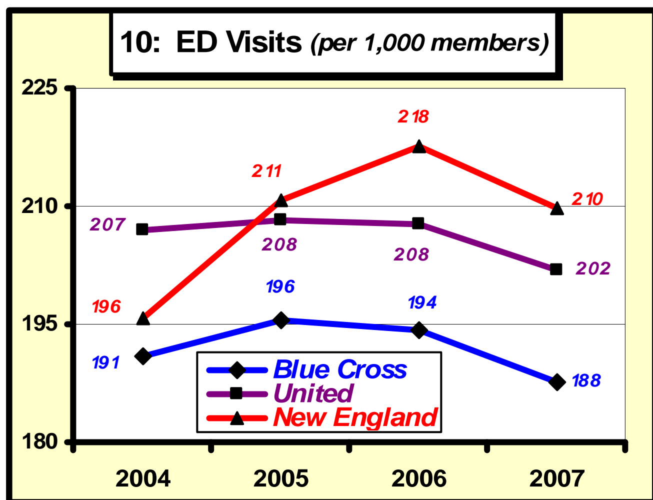
Again, higher length of stay values are neither inherently desirable nor undesirable without case-mix adjusting the different patient populations. A longer length of stay may be warranted because of the case-mix complexity or demo-

graphics of a particular plan's members requiring more intensive inpatient services.



D. Emergency Department Visits are the number of visits to hospital emergency departments (excluding behavioral health visits and those that resulted in the patient being admitted) for every 1,000 members in a plan (Chart 10).

Emergency departments are often used to provide primary or secondary care that could be delivered more inexpensively and more appropriately elsewhere. Therefore, lower values on this measure are preferred.



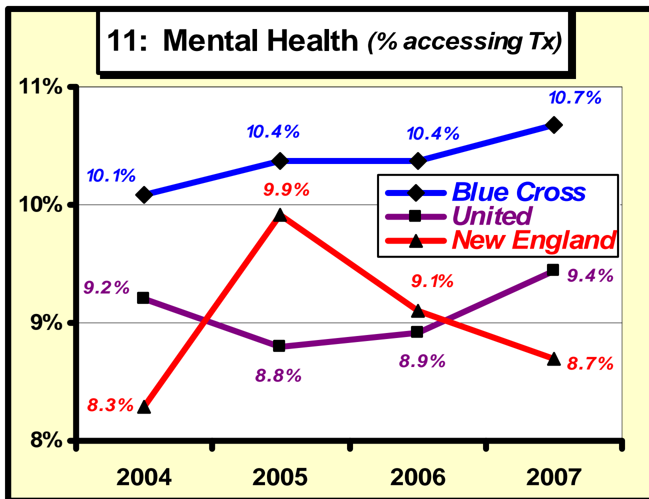
Blue Cross outperformed United by –7% on this measure in 2007. Even though the absolute ED utilization rates for both plans were fairly consistent since 2004, they both experienced significant relative improvement as the regional rates increased. In 2007, Blue Cross was 10% favorably below the N.E. value, while United was slightly below this comparable (ie., 4% lower).

Regardless of these favorable relative gains, neither plan approached the national benchmark in 2007. Blue Cross was 32% unfavorably above the benchmark of 142, and United was 43% above that value.

RI clearly needs to expand its primary care delivery system to further reduce inappropriate ED utilization.

E. Mental Health Utilization is the percentage of members with a mental health benefit that received any mental health treatment (i.e., inpatient, intermediate or ambulatory) during the year (Chart 11).

Mental illness is widely under-diagnosed and a major quality-of-life determinant, thus an argument could be made that trends should be increasing. However, without knowing the respective disease incidences, one cannot conclude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



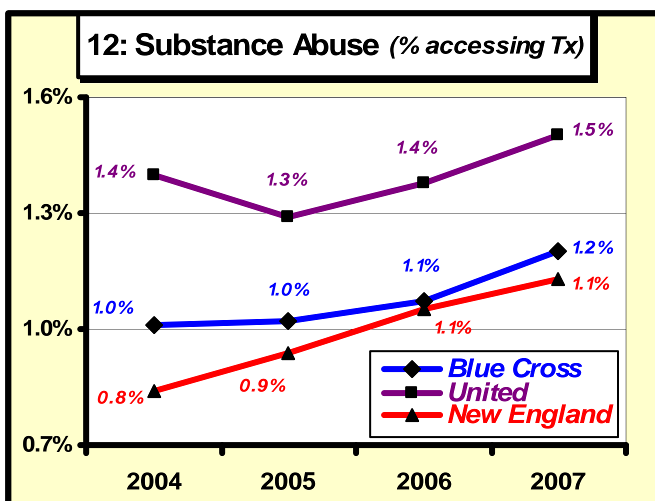
Absolute values for both plans rose slightly over the period, with Blue Cross ending 23% above the regional average, and United was 9% above that comparable.

Without knowing the comparative mental illness incidence rates, the actual utilization of services, and outcomes, one cannot determine if

mental health treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a plan with a higher value accessed these services (at least once).

F. Substance Abuse Tx. Utilization is the percentage of members filing an alcohol and/or other drug claim for substance abuse treatment services (i.e., inpatient, day or outpatient) during the year (Chart 12).

Substance abuse is very expensive in terms of personal and societal costs. Treatment, even with recidivism, remains the most cost-effective response to this disease. However, as with mental health, without knowing the respective disease incidences, one cannot conclude that a higher value is necessarily preferable to a lower one. Therefore, there is no desired trend or benchmark for this measure.



Absolute values for both plans rose over the period, and remained above the N.E. average. In 2007, Blue Cross was 6% above the regional value, and United was 33% above that comparable.

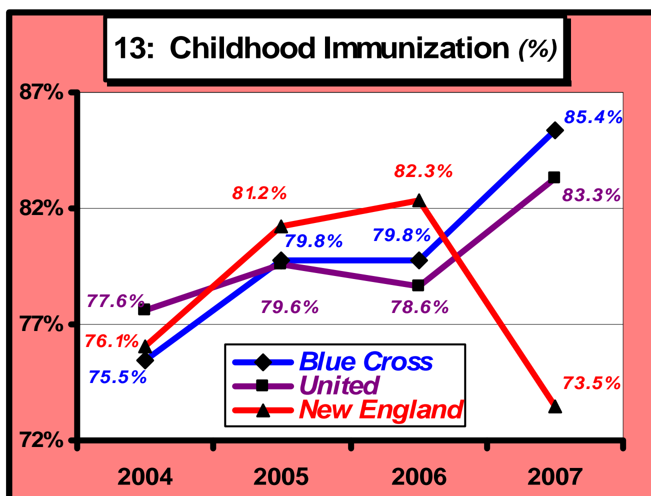
However, and similar to the mental health utilization measure, without knowing the comparative substance abuse incidence rates, the utilization of services, and outcomes, one cannot conclude that substance abuse treatment was any better in one plan than another (or in RI than elsewhere). One may only state that a greater percentage of members in a plan with a higher value accessed these services (at least once).

V: PREVENTION

This section contains measures[3] that look at how effectively a plan delivers preventive services to keep its members healthy.

A. Childhood Immunization is the percentage of children in the plan that received the appropriate immunizations by age 2 (Chart 13).[4] As immunization protects children against vaccine-preventable and sometimes devastating and costly disease, it is one of the most cost-effective examples of high-quality primary care. Therefore, higher values on this measure are preferred.

To enhance immunization levels in the state, the RI-DOH Immunization Program[5] tracks this measure and provides vaccines consistent with the CDC's *Recommended Childhood and Adolescent Immunization Schedule*, free of charge to pediatricians and other select providers. The Program has adopted a target of 85% compliance on this measure by 2010.

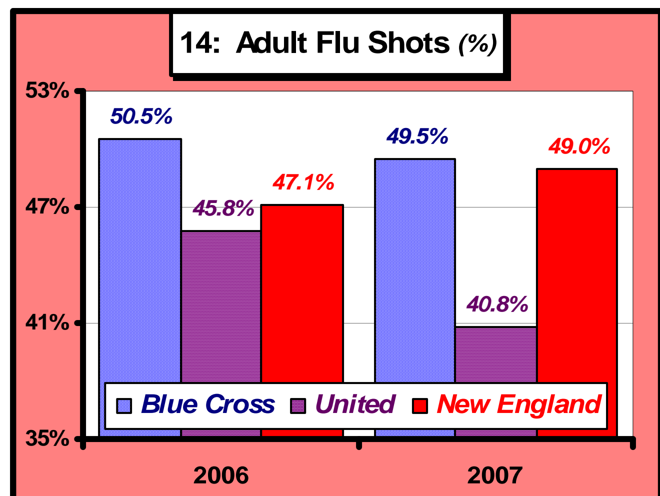


Absolute values for both plans improved over time, and ended the period above the regional value (16% higher for Blue Cross and 13% higher for United).

The U.S. benchmark was 88.1% in 2007. Blue Cross did not significantly differ from that value (i.e., less than a -5% variance), and United was slightly below that cutoff (i.e., -6%).

Regardless of both plans' favorable relative performances, with approximately 15% of eligible children in both plans not receiving their vaccinations within the recommended timeframes, there needs to be renewed effort to reach this population.

B. Adult Flu Shots is the percentage of members (aged 50-64) who received an influenza vaccination during the year (Chart 14).[6] Every year, up to 20% of Americans contract influenza, with more than 200,000 people hospitalized for flu-related complications. Vaccination is the most effective way to prevent severe illness and death related to influenza, so higher values on this measure are preferred.



Blue Cross outperformed United by +21% on this measure in 2007. That year, Blue Cross was equivalent to the regional average, while United was 17% below that comparable.

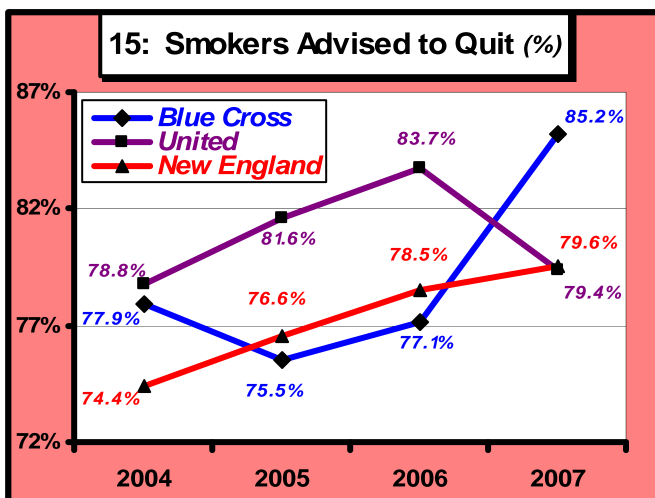
Neither plan approached the national benchmark of 57.1% in 2007. Blue Cross was 13% below that value, and United was 29% below that cutoff.

Both plans needs to improve their performances on this measure when over 50% of their eligible members are not being inoculated.

C. Smokers Advised to Quit is the percentage of members (ages 18+) who are smokers and who received advice to quit within the past year (Chart 15).[6] An estimated 21% of adult Americans are smokers and it is the leading preventable cause of death in the nation

(~440,000 deaths per year). Seventy percent of smokers are interested in stopping, and getting advice to quit is associated with a 30% increase in success rates. Therefore, higher values on this measure are preferred.

This measure is tracked by the RI-DOH Tobacco Control Program[7] as part of its efforts to reduce smoking in the state. Tobacco Control has adopted a target level of 95% compliance on this metric.



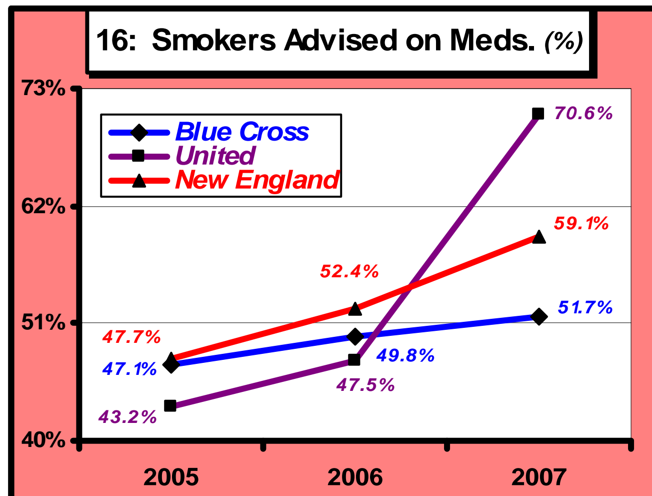
Blue Cross outperformed United by +7% on this measure in 2007. Both plans started the period above the regional average in 2004, but Blue Cross ended 7% above this metric in 2007, while United ended equivalent to that value.

Blue Cross was among the best 10% of health plans nationally on this measure in 2007, and United was not significantly below the benchmark of 83.0% (i.e., less than a -5% variance).

Given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when ~15% of Blue Cross' and ~20% of United's affected members were not properly advised to quit.

D. Smokers Advised on Cessation Medications is the percentage of members (ages 18+) who are smokers and who received advice on cessation medications (Chart 16).[6] Research has shown that provider advice on cessation medications doubles quit rates. Therefore, higher values on this measure are preferred.

This measure is also tracked by the RI-DOH Tobacco Control Program. It has adopted a target level of 95% compliance on this metric.



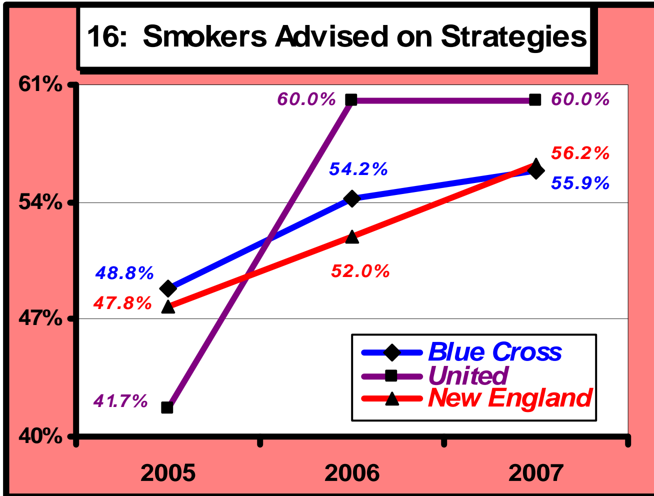
United outperformed Blue Cross by +37% on this measure in 2007. That year, Blue Cross was 13% below the regional average, while United was 20% above that comparable.

Blue Cross was also below the national benchmark of 60.2% in 2007, while United was 17% above that cutoff putting it among the best 10% of plans across the country.

Again, given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when over 48% of Blue Cross' and 29% of United's affected members were not properly advised on cessation medications.

E. Smokers Advised on Cessation Strategies is the percentage of members (ages 18+) who are smokers and who received advice on cessation strategies (Chart 17).[6] Due to the effectiveness of provider advice in routine clinical encounters, it is important that smokers are consistently advised on a combination of cessation strategies, including counseling and pharmacotherapy. Therefore, higher values on this measure are preferred.

This is a third measure tracked by the RI-DOH Tobacco Control Program. The Program has adopted a target level of 95% compliance on this metric.



United outperformed Blue Cross by +7% on this measure in 2007. Both plans posted favorable absolute gains over time, with Blue Cross ending the period essentially equivalent to the regional value (i.e., less than a –5% variance), and United was 7% above that comparable.

The U.S. benchmark was 57.6% in 2007. Blue Cross was not significantly different from this value (i.e., less than a -5% variance), and United was among the best 10% of health plans nationally on this measure.

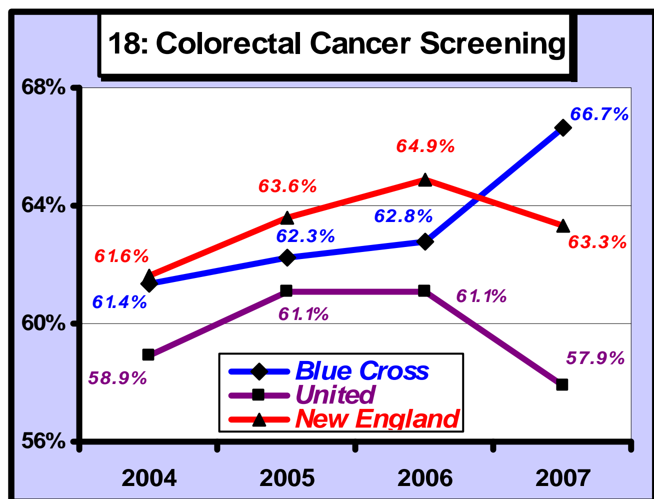
Once again, given the marginal cost of providing medical advice on smoking, further gains should be made on a statewide basis when over 40% of the affected members were not properly advised on cessation strategies.

VI: SCREENING

This section contains information[3] on how effectively a health plan screens its members for possible medical problems. Screening is the second most cost-effective activity (behind prevention) to reduce the adverse effects of disease.

A. Colorectal Cancer Screening is the percentage of members (ages 50-80) who were screened for colorectal cancer (Chart 18). Colorectal cancer is the third most common cancer in the U.S, resulting in ~52,000 deaths annually. Early stages of the disease are often asymptomatic so regular screening becomes the only way to detect it. In addition, colorectal screening can prevent the disease through removal of pre-malignant polyps, and early-stage detection and treatment produce a 90% 5-year survival rate. Therefore, higher values on this measure are preferred.

This measure is tracked by the RI-DOH Comprehensive Cancer Control Program[8] as part of its efforts to increase colorectal cancer screening in the state. The Program has adopted a target level of 85% compliance on this metric.



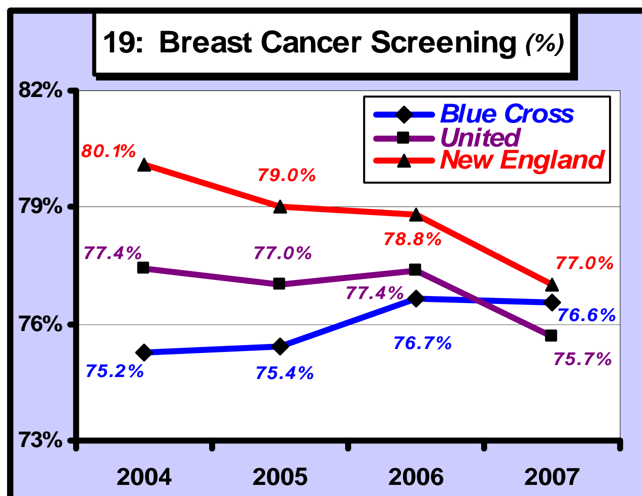
Blue Cross outperformed United by +15% on this measure in 2007. Absolute values for Blue Cross rose over the period, while United's performance was flat in 2006 and declining in 2007. That year, Blue Cross was 5% above the regional average and United was 9% below that metric.

In 2007, the national benchmark was 65.7%. Blue Cross was among the best 10% of health plans nationally on this measure, and United was 12% below this value.

Regardless of the relatively strong showing of Blue Cross, there needs to be further improvement in this measure when over 33% of its affected members, and over 42% of United's affected members were unscreened.

B. Breast Cancer Screening is the percentage of women members (ages 52-69) who had a mammogram within the last two years (Chart 19). Breast cancer is the second most prevalent cancer among U.S. women, with over 178,000 new cases per year resulting in approximately 40,000 deaths annually. Mammography screening reduces mortality 30% for women 50 and older, so higher values on this measure are preferred.

This measure is tracked by the RI-DOH Women's Cancer Screening Program,[9] which provides breast and cervical cancer screening to RI uninsured, program-eligible women. Because the Program is targeted to the uninsured, it does not have an adopted target level of compliance for this measure, which reflects the commercially insured population.

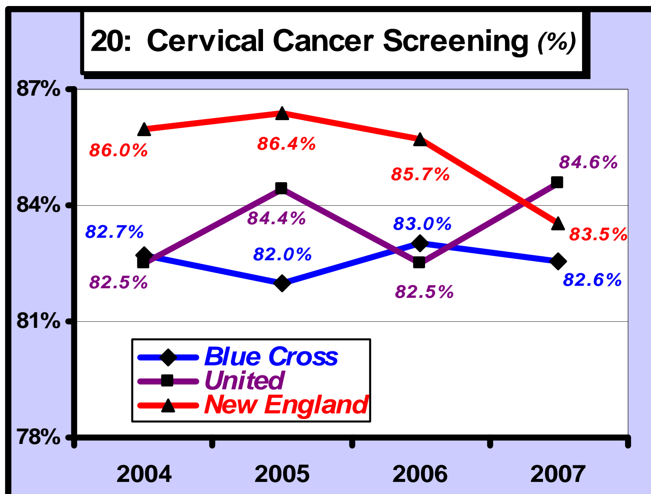


Breast cancer screening rates declined over the period but finished relatively favorably. In 2007, neither Blue Cross nor United was significantly

different from the regional average of 77.0% or the national benchmark of 79.1% (i.e., less than –5% variances for both).

C. Cervical Cancer Screening is the percentage of women (ages 21-64) who received a Pap test within three years (Chart 20). Cervical cancer is one of the most successfully treated cancers when diagnosed early, and screening has led to declining mortality rates over the past 30 years. Nonetheless, an estimated 11,000 new cases are diagnosed each year resulting in nearly 4,000 deaths nationally; therefore, higher values on this measure are preferred.

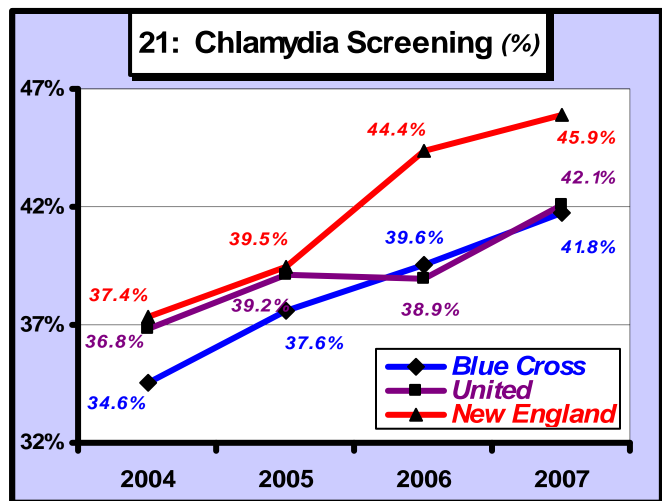
This is another measure tracked by the RI-DOH Women's Cancer Screening Program that provides breast and cervical cancer screening to RI uninsured, program-eligible women. Because the Program is targeted to the uninsured, it does not have an adopted target level of compliance for this measure, which reflects the commercially insured population.



In 2007, neither health plan deviated substantially from the regional average (i.e., less than –5% variances), or the U.S. benchmark of 86.0%.

D. Chlamydia Screening is the percentage of (sexually active) women members (ages 16-25) having a chlamydia test during the year (Chart 21). Chlamydia is a leading cause of infertility, and the most common sexually transmitted disease (STD) in the U.S. with approximately 2.8 million new infections per year. Screening is essential because the disease is usually asymptomatic and easily treated with antibiotics, so higher values on this measure are preferred.

The RI-DOH's STD Prevention and Control Program[10] follows this measure to monitor Chlamydia screening in the commercially insured population. Because the Program targets the under/uninsured, it does not have an adopted target level of compliance for this measure (which reflects the commercially insured population).



Both health plans improved their values on this measure, but the N.E. average increased at a faster pace, compromising their relative performances. In 2007, Blue Cross ended 9% below the regional average, and United was 8% below that comparable.

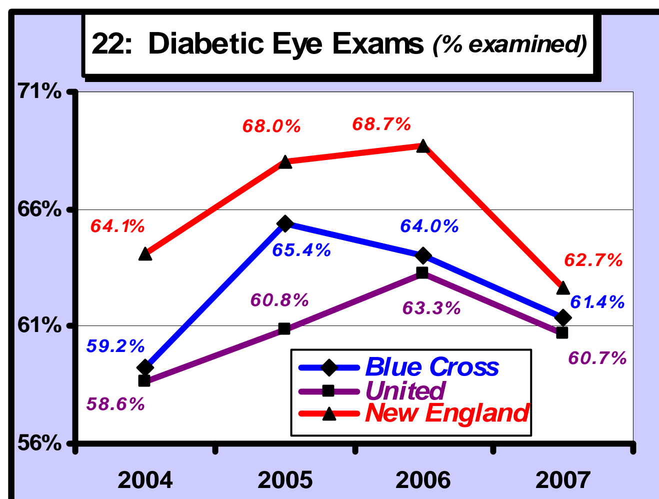
Neither plan approached the U.S. benchmark of 48.7% in 2007. Blue Cross was 14% below that value, and United was 13% below that cutoff.

Regardless of the recent improvements in chlamydia screening rates, the low absolute values illustrate the need for further improvement as ~58% of the affected members in these plans are not being screened.

E. Diabetic Eye Exams is the percentage of diabetic members (ages 18-75) that received an eye exam for retinal disease (Chart 22). Diabetes is the leading cause of adult blindness in the U.S., so regular examinations are important to diagnose and treat problems as early as possi-

ble. Therefore, higher values on this measure are preferred.

This is a measure tracked by the RI-DOH Diabetes Prevention and Control Program[11] as part of its efforts to reduce the incidence of and improve the quality of care for the disease. The Program has adopted a target goal of 85% for diabetic eye exam screening.



22: Diabetic Eye Exams *(% examined)*

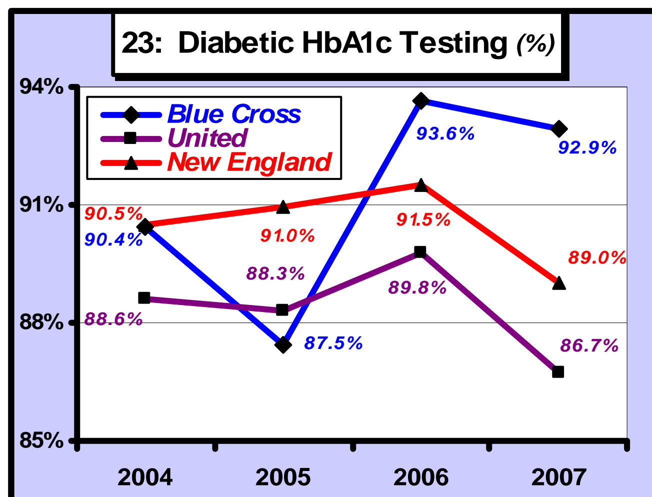
Both plans experienced declining values in 2007, but ended not significantly different from the N.E. average of 62.7% (i.e., less than –5% variances).

The U.S. benchmark was 67.7% in 2007. Blue Cross was 9% lower than this value and United was 10% below that cutoff.

Regardless of the relatively strong showing of both plans, eye exam screening rates should be improved when over 38% of the eligible members remain unscreened.

F. Diabetic HbA1c Testing is the percentage of diabetic members (ages 18-75) who had their hemoglobin A1c tested (Chart 23). Diabetes is one of the most costly (~$100 billion annually), and prevalent diseases in the U.S. (~21 million persons), causing 20% of all deaths in adults over 25. Diabetic complications (amputations, kidney failure, blindness) may be prevented if diagnosed and addressed early, so higher values on this measure are preferred.

This is another measure tracked by the RI-DOH Diabetes Prevention and Control Program and it has adopted a target goal of 95% for HbA1c testing.



23: Diabetic HbA1c Testing *(%)*

Blue Cross outperformed United by +7% on this measure in 2007. Neither plan deviated significantly from the regional average in 2007 (i.e., less than +/–5% variances).

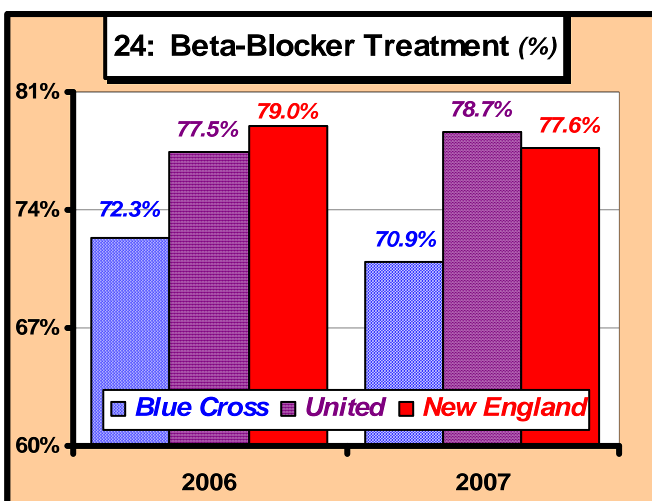
The U.S. benchmark was 92.0% in 2007. Blue Cross was among the best 10% of health plans nationally, while United was 6% below that cutoff.

VII: TREATMENT

This section contains measures[3] that look at the clinical quality of care provided within a health plan, how well it treats its members who are ill and whether that care is effectively managing the disease.

A. Persistent Beta-Blocker Treatment is the percentage of members (18 and older) discharged after an acute myocardial infarction (AMI) who received persistent beta-blocker treatment for six months after discharge (Chart 24). Given the prevalence and costs of heart disease in the U.S. (i.e., over 1 million AMIs at a cost of ~$111 billion, annually), beta-blocker therapy has proven an effective medical treatment to reduce the risk of having another attack. Higher values on this measure are, therefore, preferred.

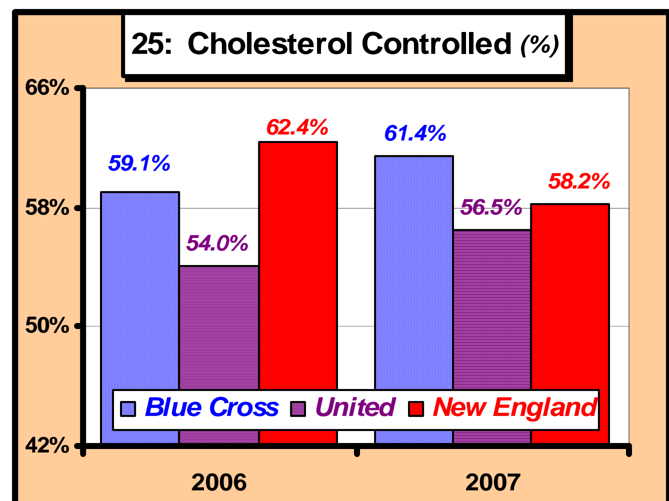
This measure is tracked by the RI-DOH Heart Disease and Stroke Prevention Program[12] to improve the current heart disease and stroke prevention system in RI. The Program has adopted a target level of 100% compliance on this measure.



United outperformed Blue Cross by +11% on this measure in 2007. That year, Blue Cross ended 9% below the N.E. median while United was equivalent to that comparable (i.e., less than a +5% difference).

Neither plan was among the best performing plans in 2007. Blue Cross was 15% below the national benchmark value of 83.1%, and United was 5% below that cutoff.

B. Cholesterol Controlled is the percentage of members (ages 18-75) discharged after an acute cardiac event whose low-density lipoprotein component of blood cholesterol (LDL-C) was controlled to <100mg/dL (Chart 25). It is estimated that one in three Americans have some form of cardiovascular disease, including coronary heart disease, hypertension, heart failure and stroke. High blood cholesterol is directly related to coronary heart disease, so management of this causative factor is important in controlling the disease. Therefore, higher values on this measure are preferred.



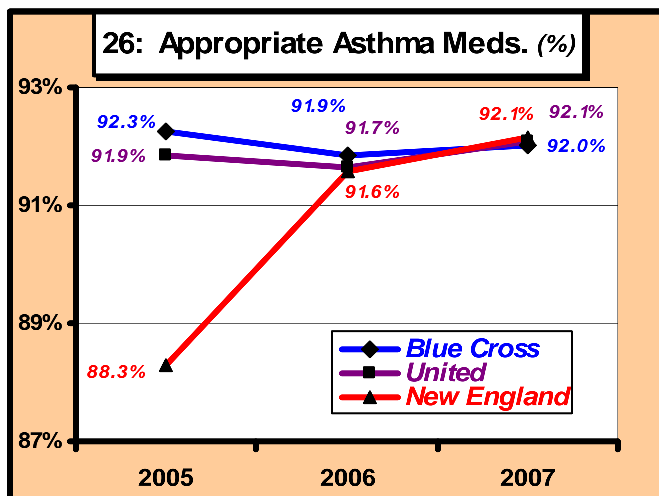
Blue Cross outperformed United by +9% on this measure in 2007. Both plans improved that year, and Blue Cross ended 6% above the regional average, while United was not significantly different from that comparable (i.e., less than a –5% variance).

The national benchmark was 68.8% in 2007. Blue Cross was 11% below that value, and United was 18% lower than that cutoff.

Regardless of the 2007 improvements realized by both health plans, over 40% of their affected members are not having this risk-factor controlled.

C. Appropriate Asthma Medications is the percentage of persistent asthmatic members (ages 5-56) prescribed the appropriate medications during the year (Chart 26). Over 30 million Americans, including 8.5 million children suffer from asthma. In Rhode Island, over 10% of the population is affected, including 83,000 adults and 27,000 children. In 2005 and 2006, there were 1,511 hospital discharges where asthma was the primary diagnosis (in patients ages 5-56), 30% of which were covered by Blue Cross and United. Some of these admissions could have been avoided had the disease been more effectively managed.

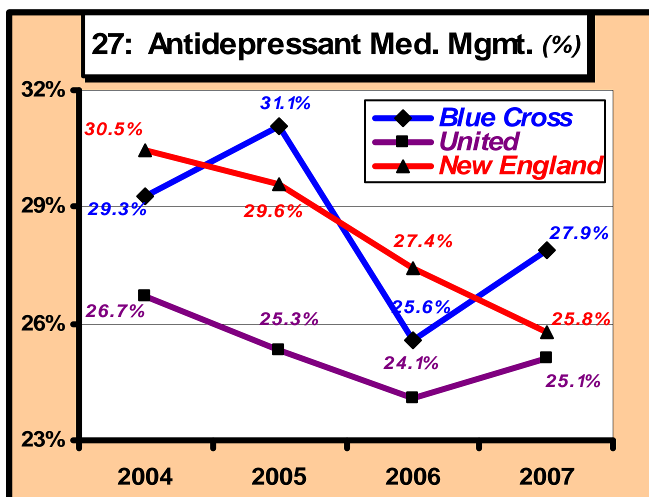
This measure is tracked by the RI-DOH Asthma Control Program[13] as part of its efforts to improve the quality of asthma care and patient education to, in part, reduce asthma hospitalizations. The Program has adopted a target of 95% compliance on this measure, so higher values on this measure are preferred.



Both Blue Cross and United performed well on this measure, with values virtually indistinguishable from each other and equivalent to the regional average in 2007.

In 2007, neither plan was significantly different from the U.S. benchmark of 95.3% (i.e., less than –5% variances).

D. Antidepressant Medication Management measures the percentage of members (ages 18+) with a new episode of depression who received medication and at least three provider contacts within 12 weeks (Chart 27). Almost 21 million Americans suffer from a depressive disorder annually, and it is a major quality of life factor, with huge societal costs in terms of worker absenteeism and lost productivity. Therefore, higher values on this measure are preferred.



Blue Cross outperformed United by +11% on this measure in 2007. RI health plans' low values were matched by equally low regional values, so Blue Cross ended 8% above the N.E. average in 2007, and United was essentially equivalent to that comparable (i.e., less than a –5% variance).

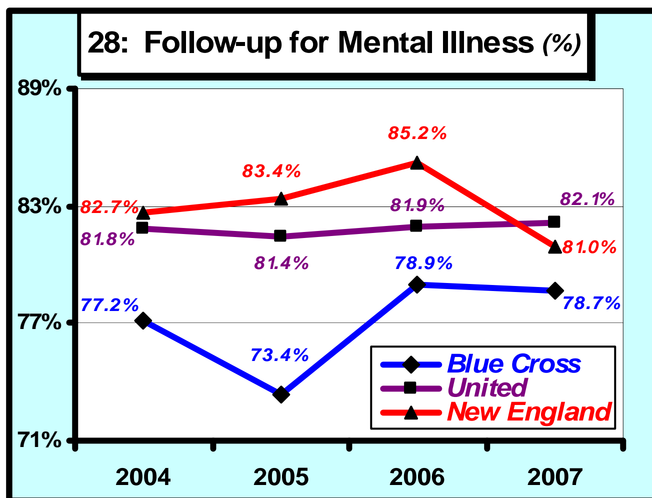
In 2007, the U.S. benchmark was 28.8%. Blue Cross was not significantly off that value (i.e., less than a –5% variance), and United was 13% below that value.

Regardless of Blue Cross' favorable performance on this measure in 2007, almost 75% of the affected members in both plans were not receiving the recommended treatment.

VIII: ACCESS

The statistics[3] in this section examine if members are obtaining needed services from the healthcare system. Access is one of the most difficult concepts to measure. It is more than simply making healthcare services available. Access means the right patients get the right care in the right amounts at the right time. Most of these measures are proxies for gauging access to particular services.

A. Follow-up for Mental Illness measures the percentage of members (ages 6+) who were discharged from hospitals for mental health treatment and received a follow-up visit within 30 days (Chart 28). Most mental disorders have their onset in childhood and adolescence, and affect about 25% of adult Americans. They are a leading factor in suicides. Follow-up to hospitalization for mental illness is important in transitioning the patient out of the inpatient setting and for evaluating medications, so higher values on this measure are preferred.

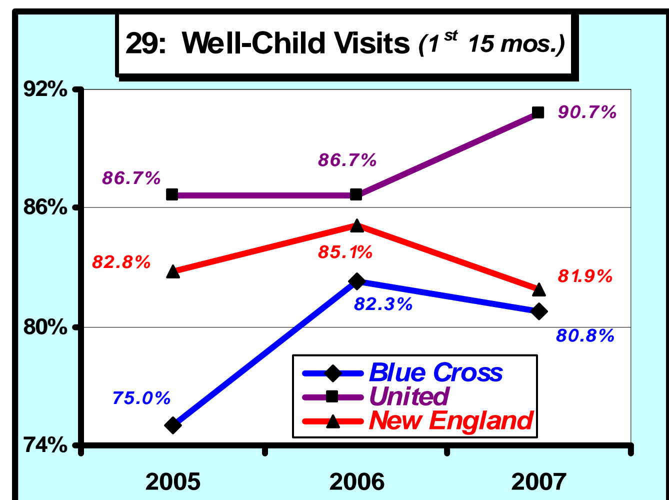


Both plans maintained consistent values in 2007, while the regional average declined 5%. That year, neither Blue Cross nor United were significantly different from the N.E. experience (i.e., less than +/–5% variances).

The U.S. benchmark was 85.5% in 2007. Blue Cross was 8% below the benchmark, while United was not significantly different from that cutoff (i.e., less than a –5% variance).

B. Well-Child Visits (1st 15 mos.) measures the percentage of members (to 15 mos.) who received six or more primary care visits during the year (Chart 29). Early primary care allows an opportunity for a child's developmental delay or disability to be detected, which can lead to treatment, lessening the future impact on both the child and family. In addition, it provides parents guidance in basic areas of childrearing.

This measure is tracked by the RI-DOH Perinatal and Early Childhood Health Team[14] as part of its efforts to promote health among children (birth to 6 years), and their families. The various programs within the Team target individual provider practices, so they have no adopted target level for this measure of statewide performance.



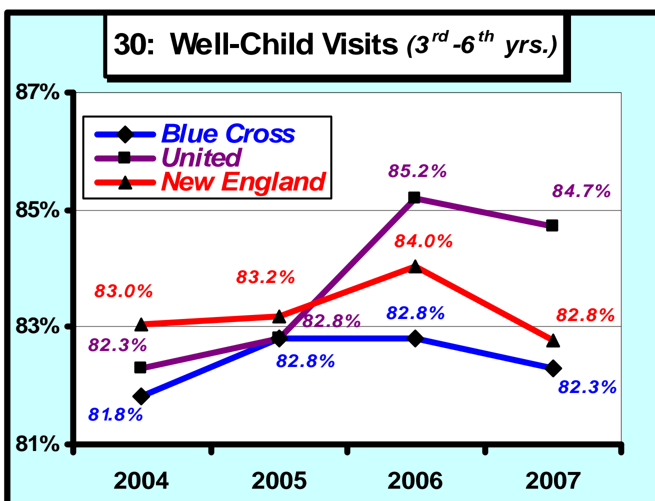
United outperformed Blue Cross by +12% on this measure in 2007. That year, Blue Cross was equivalent to the N.E. average (i.e., less than a –5% variance), while United was 11% above that comparable.

The U.S. benchmark was 87.1% in 2007. Blue Cross was 7% below that threshold, while United was among the best 10% of health plans across the nation in this measure.

C. Well-Child Visits (3-6 yrs.) measures the percentage of members (ages 3-6) who received a primary care visit during the year (Chart 30). Well-child visits are critical in detecting vision, speech and language problems early to help each child reach his or her full po-

tential. Therefore, higher values on this measure are preferred.

This measure is also tracked by the RI-DOH Perinatal and Early Childhood Health Team as part of its efforts to promote health among children (birth to 6 years), and their families. The various programs within the Team target individual provider practices, so they have no adopted target level for this measure of statewide performance.

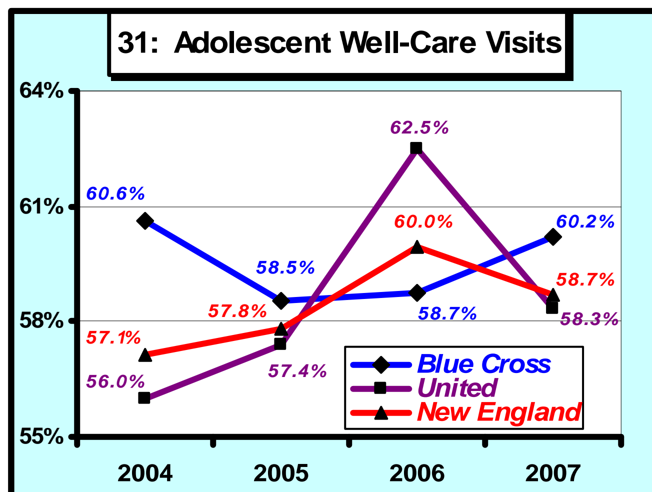


In 2007, both Blue Cross and United were essentially equivalent to the regional average of 82.8% (i.e., less than +/-5% variances).

The U.S. benchmark was 82.4% in 2007 (i.e., less than the N.E. average). Blue Cross was not appreciably than that value (i.e., less than a –5% variance, while United was among the best 10% of health plans in the U.S. on this measure.

D. Adolescent Well-Care Visits measures the percentage of members (ages 12-21) who received a comprehensive well-care visit during the year (Chart 31). Well-care visits are key to addressing the physical, emotional and social aspects of development in this population transitioning from childhood to adulthood. Therefore, higher values on this measure are preferred.

This measure is tracked by the RI-DOH Initiative for Healthy Youth Program[15] as part of its efforts to improve the health of adolescents through the development of medical homes. The Program has adopted a target level of 75% compliance on this measure.



In 2007, both Blue Cross and United were essentially equivalent to the regional average of 82.8% (i.e., less than +/-5% variances).

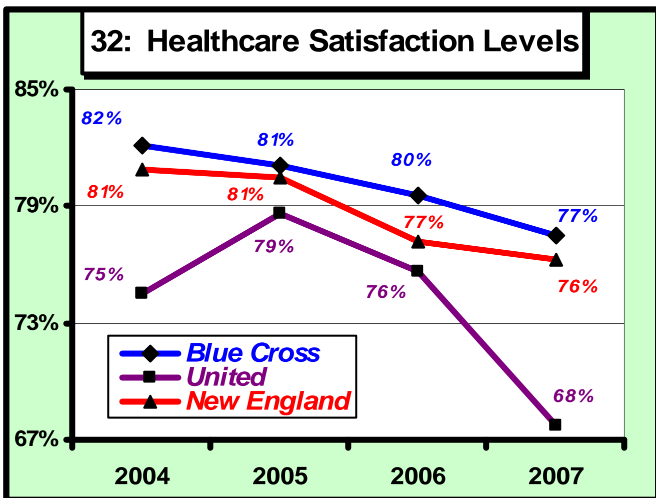
The U.S. benchmark was 58.2% in 2007 (i.e., less than the N.E. average). Both Blue Cross and United were among the best 10% of health plans in the U.S. on this measure.

Regardless of the favorable, relative performances of both health plans, approximately 40% of their eligible members were not accessing these services on a timely basis.

IX: SATISFACTION

This section provides information[6] on the percentage of members who were satisfied with their experience of care, including both the healthcare services and the health plan itself.

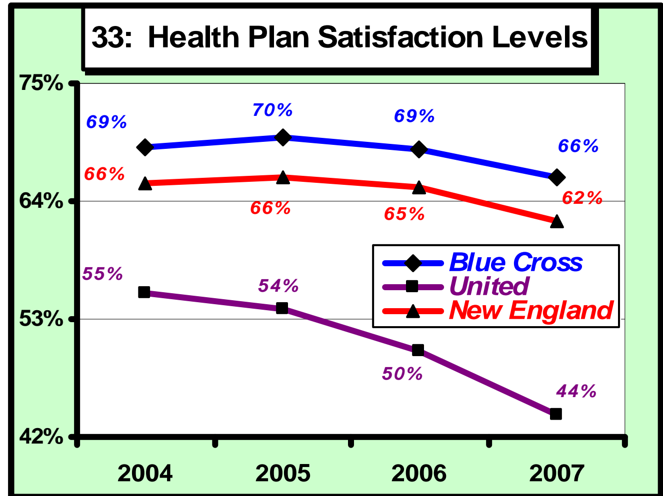
A. Satisfaction with Healthcare is the percentage of members rating the healthcare services received in the past year as "excellent" or "very good" (Chart 32). This is a significant satisfaction measure in that it provides a composite score of overall satisfaction with all of the healthcare services a member receives. Perception is an important aspect of quality in that members must believe they are receiving quality services for them to be effectively provided, so higher values are preferred.



Blue Cross outperformed United by +14% on this measure in 2007. That year, Blue Cross was essentially equivalent to the regional average (i.e., less than a +5% variance), while United was 11% below that value.

The national benchmark was 79.4% in 2007. Blue Cross was not appreciable different than that value (i.e., less than a –5% variance), while United was 15% below that threshold.

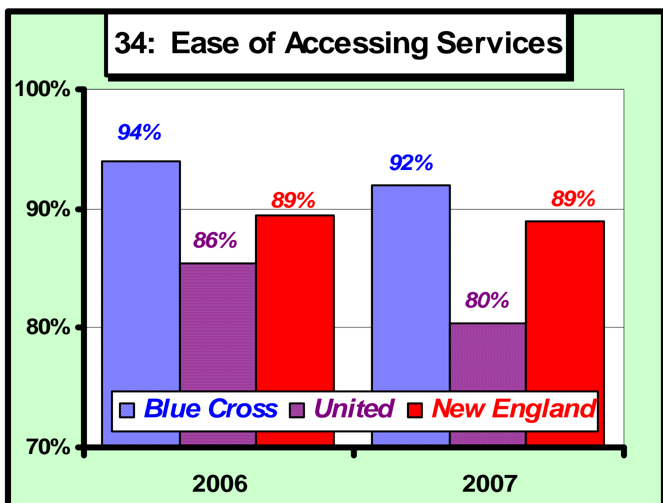
B. Satisfaction with Health Plans is the percentage of members rating the health plan as "excellent" or "very good" (Chart 33). This is another composite measure of satisfaction examining how members viewed the health plan itself. This measure and the previous one may be used as marketing and improvement tools indicating how the so-called 'customers' view the 'product'. Therefore, higher values are preferred.



Blue Cross outperformed United by +51% on this measure in 2007. That year, Blue Cross was 7% above the N.E. average, while United was 29% below that value.

In 2007, the national benchmark was 71.2%, and both plans fell short of that cutoff (i.e., 7% lower for Blue Cross and 38% lower for United).

C. Ease of Accessing Services is the percentage of members responding they were "usually" or "always" able to access the healthcare services they thought they needed in the past year (Chart 34). Higher values on this measure are preferred.



Blue Cross outperformed United by +14% on this measure in 2007. That year, Blue Cross was essentially equivalent to the regional average (i.e., less than a +5% variance), while United was 10% below that value.

United exhibited a large discrepancy between its 2007 healthcare and health plan satisfaction levels (68% vs 44%, respectively). This measure may illustrate one factor contributing to the disparity. The perception of some members that services were not easily accessible could partially explain its low health plan satisfaction rate when a majority of its members were generally well satisfied with their healthcare services.

The national benchmark was 92.5% in 2007. Blue Cross was not appreciable different than that value (i.e., less than a –5% variance), while United was 13% below that threshold.

APPENDIX A: Blue Cross -RI *(Commercial Data)*

#	Measure	2004	2005	2006	2007
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	247,543	228,824	221,650	213,271
2	**RI Commercial Market Shares**	65.2%	64.9%	64.8%	63.0%
	COSTS				
3	**Premiums** *(per member per month)*	$281.69 [1]	$301.94 [1]	$316.72 [1]	$333.24 [1]
4	**Medical Expenses** *(per member per month)*	$238.35 [1]	$258.49 [1]	$269.67 [1]	$282.21 [1]
5	**Administrative Expenses** *(per member per month)*	$36.53 [1]	$36.13 [1]	$38.57 [1]	$44.44 [1]
6	**Profits** *(per member per month)*	$6.81 [1]	$7.32 [1]	$8.48 [1]	$6.59 [1]
	UTILIZATION				
7	**Hospital Days** *(per 1,000 members)*	248.8 [2]	225.4 [2]	220.8 [2]	228.8 [2]
8	**Hospital Discharges** *(per 1,000 members)*	58.6 [2]	56.8 [2]	56.6 [2]	57.2 [2]
9	**Average Length of Stay**	4.25 [2]	3.97 [2]	3.90 [2]	4.00 [2]
10	**ED Visits** *(per 1,000 members)*	190.9 [2]	195.6 [2]	194.1 [2]	187.7 [2]
11	**Mental Health Utilization** *(% accessing care)*	10.1% [2]	10.4% [2]	10.4% [2]	10.7% [2]
12	**Substance Abuse Tx. Utilization** *(% accessing care)*	1.01% [2]	1.02% [2]	1.07% [2]	1.20% [2]
	PREVENTION				
13	**Childhood Immunization** *(combo 2; to 2 yrs.)*	75.5% [3]	79.8% [3]	79.8% [3,5]	85.4% [3]
14	**Adult Flu Shots** *(50-64 yrs., Q.44)*	---	---	50.5% [4]	49.5% [4]
15	**Smokers Advised to Quit** *(18+ yrs., Q.46)*	77.9% [4]	75.5% [4]	77.1% [4]	85.2% [4]
16	**Smoking Cessation Meds Discussed** *(18+ yrs., Q.47)*	---	47.1% [4]	49.8% [4]	51.7% [4]
17	**Smoking Cessation Strategy Discussed** *(18+ yrs., Q.48)*	---	48.8% [4]	54.2% [4]	55.9% [4]
	SCREENING				
18	**Colorectal Cancer Screening** *(51-80 yrs.)*	61.4% [3]	62.3% [3]	62.8% [3]	66.7% [3]
19	**Breast Cancer Screening** *(52-69 yrs.)*	75.2% [3]	75.4% [3]	76.7% [3]	76.6% [3]
20	**Cervical Cancer Screening** *(21-64 yrs.)*	82.7% [3]	82.0% [3]	83.0% [3]	82.6% [3]
21	**Chlamydia Screening** *(16-25 yrs.)*	34.6% [3]	37.6% [3]	39.6% [3]	41.8% [3]
22	**Diabetic Eye Exams** *(18-75 yrs.)*	59.2% [3]	65.4% [3]	64.0% [3]	61.4% [3]
23	**Diabetic HbA1c Testing** *(18-75 yrs.)*	90.4% [3]	87.5% [3]	93.6% [3]	92.9% [3]
	TREATMENT				
24	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	42.2% [3]	39.2% [3]
25	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	65.2% [3]	65.2% [3,5]
26	**Persistent Beta Blocker Treatment** *(after AMI; 18+ yrs.)*	---	---	72.3% [3]	70.9% [3]
27	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	59.1% [3]	61.4% [3]
28	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	92.3% [3]	91.9% [3]	92.0% [3]
29	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	29.3% [3]	31.1% [3]	25.6% [3]	27.9% [3]
	ACCESS				
30	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	77.2% [3]	73.4% [3]	78.9% [3]	78.7% [3]
31	**Prenatal Care Access** *(w/in 1st trimester)*	94.8% [3]	94.8% [3,5]	93.0% [3]	93.0% [3,5]
32	**Postpartum Care Access** *(w/in 21-56 days)*	81.3% [3]	81.3% [3,5]	89.8% [3]	89.8% [3,5]
33	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	75.0% [3]	82.3% [3]	80.8% [3]
34	**Well-Child Visits** *(3rd-6th years)*	81.8% [3]	82.8% [3]	82.8% [3]	82.3% [3]
35	**Adolescent Well-Care Visits**	60.6% [3]	58.5% [3]	58.7% [3]	60.2% [3]
	SATISFACTION				
36	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	82.1% [4]	81.1% [4]	79.5% [4]	77.5% [4]
37	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	69.1% [4]	70.0% [4]	68.9% [4]	66.3% [4]
38	**Ease of Accessing Services** *(Q.27)*	---	---	93.9% [4]	92.0% [4]

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

[1] Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database

[2] Sourced from HEDIS data, a combined rate (i.e., sum of the numerators over sum of the denominators) for Blue Cross' commercial PPO and HMO products

[3] Sourced from HEDIS data, a weighted-average (based on the eligible populations) of the values for Blue Cross' commercial PPO and HMO products

[4] Sourced from CAHPS data, a weighted-average (based on the RI commercial enrollments) of the values for Blue Cross' commercial PPO and HMO products

[5] Plan "rotated" the measure(s) (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX B: UnitedHealthcare -NE *(Commercial Data)*

#	Measure	2004	2005	2006	2007
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	70,232	59,140	49,891	42,178
2	**RI Commercial Market Shares**	18.5%	16.8%	14.6%	12.5%
	COSTS				
3	**Premiums** *(per member per month)*	$227.00 [1]	$287.84 [1]	$305.18 [1]	$325.30 [1]
4	**Medical Expenses** *(per member per month)*	$170.01 [1]	$224.10 [1]	$234.57 [1]	$257.36 [1]
5	**Administrative Expenses** *(per member per month)*	$45.66 [1]	$50.96 [1]	$55.54 [1]	$62.15 [1]
6	**Profits** *(per member per month)*	$11.33 [1]	$12.78 [1]	$15.07 [1]	$5.80 [1]
	UTILIZATION				
7	**Hospital Days** *(per 1,000 members)*	254.7	219.5	203.2	184.8
8	**Hospital Discharges** *(per 1,000 members)*	67.4	65.0	62.3	50.4
9	**Average Length of Stay**	3.78	3.37	3.26	3.67
10	**ED Visits** *(per 1,000 members)*	207.0	208.2	207.8	202.0
11	**Mental Health Utilization** *(% accessing care)*	9.2%	8.8%	8.9%	9.4%
12	**Substance Abuse Tx. Utilization** *(% accessing care)*	1.40%	1.29%	1.38%	1.50%
	PREVENTION				
13	**Childhood Immunization** *(combo 2; to 2 yrs.)*	77.6%	79.6%	78.6%	83.3%
14	**Adult Flu Shots** *(50-64 yrs., Q.44)*	---	---	45.8%	40.8%
15	**Smokers Advised to Quit** *(18+ yrs., Q.46)*	78.8%	81.6%	83.7%	79.4%
16	**Smoking Cessation Meds Discussed** *(18+ yrs., Q.47)*	---	43.2%	47.5%	70.6%
17	**Smoking Cessation Strategy Discussed** *(18+ yrs., Q.48)*	---	41.7%	60.0%	60.0%
	SCREENING				
18	**Colorectal Cancer Screening** *(51-80 yrs.)*	58.9%	61.1%	61.1% [2]	57.9%
19	**Breast Cancer Screening** *(52-69 yrs.)*	77.4%	77.0%	77.4%	75.7%
20	**Cervical Cancer Screening** *(21-64 yrs.)*	82.5%	84.4%	82.5%	84.6%
21	**Chlamydia Screening** *(16-25 yrs.)*	36.8%	39.2%	38.9%	42.1%
22	**Diabetic Eye Exams** *(18-75 yrs.)*	58.6%	60.8%	63.3%	60.7%
23	**Diabetic HbA1c Testing** *(18-75 yrs.)*	88.6%	88.3%	89.8%	86.7%
	TREATMENT				
24	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	38.9%	41.6%
25	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	47.2%	61.0%
26	**Persistent Beta Blocker Treatment** *(after AMI; 18+ yrs.)*	---	---	77.5%	78.7%
27	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	54.0%	56.5%
28	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	91.9%	91.7%	92.1%
29	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	26.7%	25.3%	24.1%	25.1%
	ACCESS				
30	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	81.8%	81.4%	81.9%	82.1%
31	**Prenatal Care Access** *(w/in 1st trimester)*	93.7%	93.8%	84.6%	90.2%
32	**Postpartum Care Access** *(w/in 21-56 days)*	76.6%	76.6% [2]	72.5%	72.1%
33	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	86.7%	86.7% [2]	90.7%
34	**Well-Child Visits** *(3rd-6th years)*	82.3%	82.8%	85.2%	84.7%
35	**Adolescent Well-Care Visits**	56.0%	57.4%	62.5%	58.3%
	SATISFACTION				
36	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	74.5%	78.7%	75.7%	67.7%
37	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	55.4%	53.9%	50.0%	44.0%
38	**Ease of Accessing Services** *(Q.27)*	---	---	85.5%	80.4%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

[1] Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database

[2] Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX C: Blue Cross -MA *(Commercial Data)*

		2004	2005	2006	2007
ENROLLMENT					
1	**RI Commercial Enrollment** *(RI member months/12)*	32,408	33,557	34,850	33,866
2	**RI Commercial Market Shares**	8.5%	9.5%	10.2%	10.0%
COSTS					
3	**Premiums** *(per member per month)*	$270.95 [1]	$299.01 [1]	$327.07 [1]	$352.69 [1]
4	**Medical Expenses** *(per member per month)*	$239.57 [1]	$265.02 [1]	$288.93 [1]	$313.58 [1]
5	**Administrative Expenses** *(per member per month)*	$31.38 [1]	$33.99 [1]	$38.14 [1]	$40.46 [1]
6	**Profits** *(per member per month)*	$11.62 [1]	$5.57 [1]	$1.47 [1]	($1.35) [1]
UTILIZATION					
7	**Hospital Days** *(per 1,000 members)*	213.7	214.4	211.0	214.9
8	**Hospital Discharges** *(per 1,000 members)*	51.9	51.9	53.6	53.7
9	**Average Length of Stay**	4.12	4.13	3.94	4.00
10	**ED Visits** *(per 1,000 members)*	199.5	208.7	214.4	216.5
11	**Mental Health Utilization** *(% accessing care)*	10.9%	11.1%	11.5%	11.7%
12	**Substance Abuse Tx. Utilization** *(% accessing care)*	1.00%	1.07%	1.24%	1.31%
PREVENTION					
13	**Childhood Immunization** *(combo 2; to 2 yrs.)*	86.2%	83.5%	87.3%	87.8%
14	**Adult Flu Shots** *(50-64 yrs., Q.44)*	---	---	49.0%	52.3%
15	**Smokers Advised to Quit** *(18+ yrs., Q.46)*	74.2%	79.7%	85.3%	80.3%
16	**Smoking Cessation Meds Discussed** *(18+ yrs., Q.47)*	---	46.8%	54.8%	57.3%
17	**Smoking Cessation Strategy Discussed** *(18+ yrs., Q.48)*	---	46.1%	50.0%	55.0%
SCREENING					
18	**Colorectal Cancer Screening** *(51-80 yrs.)*	63.8%	68.5%	69.4%	69.2%
19	**Breast Cancer Screening** *(52-69 yrs.)*	83.3%	82.2%	82.3%	81.4%
20	**Cervical Cancer Screening** *(21-64 yrs.)*	87.8%	87.8%	86.9%	86.9% [2]
21	**Chlamydia Screening** *(16-25 yrs.)*	44.0%	46.7%	49.1%	50.7%
22	**Diabetic Eye Exams** *(18-75 yrs.)*	67.4%	74.7%	76.6%	75.4%
23	**Diabetic HbA1c Testing** *(18-75 yrs.)*	93.2%	93.2%	92.7%	92.9%
TREATMENT					
24	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	53.0%	51.1%
25	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	68.4%	70.3%
26	**Persistent Beta Blocker Treatment** *(after AMI; 18+ yrs.)*	---	---	84.3%	84.0%
27	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	64.2%	69.5%
28	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	89.0%	89.6%	89.9%
29	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	38.2%	37.8%	33.1%	31.0%
ACCESS					
30	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	84.3%	85.5%	87.5%	85.3%
31	**Prenatal Care Access** *(w/in 1st trimester)*	98.0%	98.0% [2]	100.0%	100.0% [2]
32	**Postpartum Care Access** *(w/in 21-56 days)*	91.3%	91.3% [2]	89.8%	89.8% [2]
33	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	95.4%	95.4% [2]	94.8%
34	**Well-Child Visits** *(3rd-6th years)*	95.9%	92.4%	97.3%	92.4%
35	**Adolescent Well-Care Visits**	72.6%	71.9%	71.9% [2]	76.3%
SATISFACTION					
36	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	81.6%	80.4%	75.3%	75.6%
37	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	74.0%	75.7%	70.2%	73.3%
38	**Ease of Accessing Services** *(Q.27)*	---	---	92.2%	92.4%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

[1] Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database and an aggregate of the commercial product-lines of BCBS of MA, and BCBS of MA HMO Blue, Inc.

[2] Plan "rotated" the measure (i.e., reported the previous year's value as allowed by the NCQA)

APPENDIX D: New England Commercial Averages[1]

		2004	2005	2006	2007
ENROLLMENT					
1	**RI Commercial Enrollment** *(RI member months/12)*	---	---	---	---
2	**RI Commercial Market Shares**	---	---	---	---
COSTS					
3	**Premiums** *(per member per month)*	$300.64 [2]	$317.14 [2]	$324.50 [2]	$378.53 [2]
4	**Medical Expenses** *(per member per month)*	$255.03 [2]	$264.85 [2]	$274.45 [2]	$323.91 [2]
5	**Administrative Expenses** *(per member per month)*	$35.20 [2]	$38.05 [2]	$40.45 [2]	$45.53 [2]
6	**Profits** *(per member per month)*	$10.41 [2]	$14.24 [2]	$9.60 [2]	$9.09 [2]
UTILIZATION					
7	**Hospital Days** *(per 1,000 members)*	195.2	195.2	189.8	185.8
8	**Hospital Discharges** *(per 1,000 members)*	52.0	51.7	52.2	50.2
9	**Average Length of Stay**	3.75	3.78	3.64	3.70
10	**ED Visits** *(per 1,000 members)*	195.7	210.8	217.6	209.6
11	**Mental Health Utilization** *(% accessing care)*	8.3%	9.9%	9.1%	8.7%
12	**Substance Abuse Tx. Utilization** *(% accessing care)*	0.84%	0.94%	1.05%	1.13%
PREVENTION					
13	**Childhood Immunization** *(combo 2; to 2 yrs.)*	76.1%	81.2%	82.3%	73.5%
14	**Adult Flu Shots** *(50-64 yrs., Q.44)*	---	---	47.1%	49.0%
15	**Smokers Advised to Quit** *(18+ yrs., Q.46)*	74.4%	76.6%	78.5%	79.6%
16	**Smoking Cessation Meds Discussed** *(18+ yrs., Q.47)*	---	47.7%	52.4%	59.1%
17	**Smoking Cessation Strategy Discussed** *(18+ yrs., Q.48)*	---	47.8%	52.0%	56.2%
SCREENING					
18	**Colorectal Cancer Screening** *(51-80 yrs.)*	61.6%	63.6%	64.9%	63.3%
19	**Breast Cancer Screening** *(52-69 yrs.)*	80.1%	79.0%	78.8%	77.0%
20	**Cervical Cancer Screening** *(21-64 yrs.)*	86.0%	86.4%	85.7%	83.5%
21	**Chlamydia Screening** *(16-25 yrs.)*	37.4%	39.5%	44.4%	45.9%
22	**Diabetic Eye Exams** *(18-75 yrs.)*	64.1%	68.0%	68.7%	62.7%
23	**Diabetic HbA1c Testing** *(18-75 yrs.)*	90.5%	91.0%	91.5%	89.0%
TREATMENT					
24	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	---
25	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	63.1%	66.6%
26	**Persistent Beta Blocker Treatment** *(after AMI; 18+ yrs.)*	---	---	79.0%	77.6%
27	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	62.4%	58.2%
28	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	88.3%	91.6%	92.1%
29	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	30.5%	29.6%	27.4%	25.8%
ACCESS					
30	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	82.7%	83.4%	85.2%	81.0%
31	**Prenatal Care Access** *(w/in 1st trimester)*	95.3%	95.6%	96.1%	86.0%
32	**Postpartum Care Access** *(w/in 21-56 days)*	84.9%	85.6%	85.5%	77.8%
33	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	82.8%	85.1%	81.9%
34	**Well-Child Visits** *(3rd-6th years)*	83.0%	83.2%	84.0%	82.8%
35	**Adolescent Well-Care Visits**	57.1%	57.8%	60.0%	58.7%
SATISFACTION					
36	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	80.9%	80.5%	77.2%	76.2%
37	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	65.8%	66.3%	65.3%	62.2%
38	**Ease of Accessing Services** *(Q.27)*	---	---	89.5%	89.0%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

[1] Unless otherwise stated, data are sourced from NCQA's Quality Compass, editions 2005-2008

[2] Source: RI Department of Business Regulation (Jack Broccoli, Chief Insurance Examiner, 401-462-9606); extracted from the NAIC Health Database, data are aggregates (totals) and not averages

APPENDIX E: National Commercial Benchmarks *('best' decile [1])*

#	Measure	2004	2005	2006	2007
	ENROLLMENT				
1	**RI Commercial Enrollment** *(RI member months/12)*	---	---	---	---
2	**RI Commercial Market Shares**	---	---	---	---
	COSTS				
3	**Premiums** *(per member per month)*	---	---	---	---
4	**Medical Expenses** *(per member per month)*	---	---	---	---
5	**Administrative Expenses** *(per member per month)*	---	---	---	---
6	**Profits** *(per member per month)*	---	---	---	---
	UTILIZATION				
7	**Hospital Days** *(per 1,000 members)*	---	---	---	---
8	**Hospital Discharges** *(per 1,000 members)*	---	---	---	---
9	**Average Length of Stay**	---	---	---	---
10	**ED Visits** *(per 1,000 members)*	130.9 [2]	138.4 [2]	138.9 [2]	141.7 [2]
11	**Mental Health Utilization** *(% accessing care)*	---	---	---	---
12	**Substance Abuse Tx. Utilization** *(% accessing care)*	---	---	---	---
	PREVENTION				
13	**Childhood Immunization** *(combo 2; to 2 yrs.)*	81.7%	86.5%	87.7%	88.1%
14	**Adult Flu Shots** *(50-64 yrs., Q.44)*	---	---	55.2%	57.1%
15	**Smokers Advised to Quit** *(18+ yrs., Q.46)*	77.3%	78.4%	80.2%	83.0%
16	**Smoking Cessation Meds Discussed** *(18+ yrs., Q.47)*	---	48.0%	53.0%	60.2%
17	**Smoking Cessation Strategy Discussed** *(18+ yrs., Q.48)*	---	48.2%	52.8%	57.6%
	SCREENING				
18	**Colorectal Cancer Screening** *(51-80 yrs.)*	61.8%	63.5%	65.1%	65.7%
19	**Breast Cancer Screening** *(52-69 yrs.)*	81.2%	80.1%	80.1%	79.1%
20	**Cervical Cancer Screening** *(21-64 yrs.)*	87.2%	87.9%	87.1%	86.0%
21	**Chlamydia Screening** *(16-25 yrs.)*	43.1%	45.5%	48.6%	48.7%
22	**Diabetic Eye Exams** *(18-75 yrs.)*	66.2%	69.3%	71.2%	67.7%
23	**Diabetic HbA1c Testing** *(18-75 yrs.)*	92.5%	92.7%	92.9%	92.0%
	TREATMENT				
24	**Diabetic HbA1c Controlled** *(<7%; 18-75 yrs.)*	---	---	---	---
25	**Hypertension Controlled** *(<140/90; 18-85 yrs.)*	---	---	68.1%	70.3%
26	**Persistent Beta Blocker Treatment** *(after AMI; 18+ yrs.)*	---	---	82.7%	83.1%
27	**Cholesterol Controlled** *(LDL-C<100 mg/dL; 18-75 yrs.)*	---	---	66.2%	68.8%
28	**Appropriate Asthma Medications** *(5-56 yrs.)*	---	94.1%	94.8%	95.3%
29	**Antidepressent Med. Mgmt.** *(optimal contacts; 18+ yrs.)*	31.9%	31.1%	31.0%	28.8%
	ACCESS				
30	**Follow-up for Mental Illness** *(w/in 30 days; 6+ yrs.)*	86.2%	86.4%	87.6%	85.5%
31	**Prenatal Care Access** *(w/in 1st trimester)*	96.9%	97.1%	97.5%	97.4%
32	**Postpartum Care Access** *(w/in 21-56 days)*	88.3%	89.0%	89.1%	89.0%
33	**Well-Child Visits** *(1st 15 months; 6+ visits)*	---	85.9%	88.7%	87.1%
34	**Well-Child Visits** *(3rd-6th years)*	82.8%	83.2%	83.3%	82.4%
35	**Adolescent Well-Care Visits**	55.2%	55.0%	57.8%	58.2%
	SATISFACTION				
36	**Satisfaction with Healthcare** *(Q.12; #s8-10)*	83.4%	83.4%	80.0%	79.4%
37	**Satisfaction with Health Plan** *(Q.42; #s8-10)*	73.9%	75.3%	73.2%	71.2%
38	**Ease of Accessing Services** *(Q.27)*	---	---	92.5%	92.4%

Blank cells (without values), indicate that the measure was either not available (it was not yet developed by the NCQA), not reportable (it did not pass auditing standards), or not collected by the RI-DOH

[1] Benchmarks are the best decile of health plans nationally (i.e., the 90th percentile values, because higher values are preferred), and are sourced from NCQA's Quality Compass, editions 2005-2008

[2] Benchmarks are the best decile of health plans nationally (i.e., the 10th percentile values, because lower values are preferred), and are sourced from NCQA's Quality Compass, editions 2005-2008

Endnotes:

[1] *Blue Cross and Blue Shield of Massachusetts, domiciled in Massachusetts, is included in this group and its performance data are included in Appendix C (but not analyzed in the body of the report), and United Healthcare Insurance Company (UHIC), a Connecticut domiciled insurer and 'sister' corporation to UnitedHealthcare of NE (UHCNE), is also included in this group but its data were not included because it was granted a waiver from reporting separate HEDIS and CAHPS measures from the RI-DOH Office of Managed Care Regulation (i.e., for the HEDIS and CAHPS measures, its data are identical to that for UHCNE). UHIC had the following RI members: 13,279, 11,652, 22,738, and 20,742 for 2004-2007, respectively. All other health plans in this group had fewer than 10,000 fully-insured RI members, and were exempt from filing any data (to reduce their reporting burdens). In addition, this report excludes members enrolled in self-insured plans administered by these and other carriers that are exempt from state regulation.*

[2] *Confidence intervals were not calculated for Blue Cross' clinical, access, and satisfaction measures because they are a composite of the HEDIS and CAHPS values for its commercial PPO and HMO products (see endnotes 3 and 6), therefore, differences in values for these measures that are less than +/-5% are considered to be too small to be significant.*

[3] *These values are sourced from HEDIS data. HEDIS (Health Plan Employer Data and Information Set) is a set of performance measures for the health insurance industry, administered by the National Committee for Quality Assurance (NCQA). The values reported for Blue Cross –RI are a weighted-average (based on the eligible populations) of the individual HEDIS values reported for its commercial PPO and HMO products. For the utilization measures in Section V (Utilization), the values reported for Blue Cross –RI are a combined rate (i.e., sum of the numerators over the sum of the denominators) of the individual HEDIS rates reported for its commercial PPO and HMO products.*

[4] *So-called Combo 2 immunizations include: four DTaP/DT, three IPV, one MMR, three HIB, three hepatitis B, and one VZV vaccination*

[5] *For more information contact Patricia Raymond, RN at 401-222-5921, patricia.raymond@health.ri.gov; see also http://www.health.ri.gov/immunization/data/ChildhoodVaccinationCoverageReport.pdf*

[6] *These values are sourced from CAHPS data. CAHPS (Consumer Assessment of Healthcare Providers & Systems) is a set of standardized surveys administered by the NCQA. The values reported for Blue Cross –RI are a weighted-average (based on RI membership) of the individual CAHPS values reported for its commercial PPO and HMO products.*

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