1999 RI Health Plan Performance Report

Rhode Island Department of Health

Lincoln Almond, Governor
Patricia A. Nolan, MD, MPH, Director of Health

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Table of Contents

I. Highlights 1

II. Introduction 2
- A. Background 2
- B. How to Use This Information -Limitations 2

III. Enrollment Information 4
- A. Rhode Island (Equivalent) Members 4
- *CHART 1. Health Plan RI Enrollment* *5*
- B. Rhode Island Market Share 5
- C. Total (Equivalent) Members 5
- D. RI Enrollment Percent of Total 5
- E. RI Enrollment Percent Female 6
- F. RI Enrollment Percent Male 6
- *TABLE 1. 1999 Enrollment Measures* *6*

IV. Financial Information 7
- A. Average Monthly Premium Revenue 7
- B. Medical Expense Ratio 7
- C. Total Profit Margin 7
- D. Hospital Expenses PMPM 8
- E. Physician Expenses PMPM 8
- F. Other Professional Expenses PMPM 8
- G. Pharmaceutical Expenses PMPM 8
- *CHART 2. 1999 Health Plan Expenses* *9*
- H. Substance Abuse Expenses PMPM 9
- I. Mental Health Expenses PMPM 9
- J. Health Education Expenses PMPM 9
- *TABLE 2. 1999 Financial Measures* *10*

V. Effectiveness of Care Information 11
- A. Childhood Immunization Status 11
- B. Adolescent Immunization Status 11
- C. Cholesterol Management After an Acute Cardiovascular Event 11
- D. Controlling High Blood Pressure 11
- *CHART 3. 1999 Effectiveness of Care Measures* *12*
- E. Beta Blocker Treatment After a Heart Attack 12
- F. Comprehensive Diabetes Care (Dilated Eye Exam Performed) 12
- *TABLE 3. 1999 Effectiveness of Care Measures* *13*

VI. Health Plan Stability Information 14
- A. Disenrollment 14
- B. Primary Care Practitioner Turnover 14
- CHART 4. 1999 Health Plan Stability Measures 15
- TABLE 4. 1999 Health Plan Stability Measures 15

VII. Access to, Availability of Care Information 16
- A. Children's Access to Primary Care Practitioners 16
- B. Adult's Access to Preventive Ambulatory Health Services 16

Table of Contents (Cont.)

CHART 5. 1999 Access to Care *17*
TABLE 5. 1999 Access/Availability of Care Measures *18*

VIII. Use of Services Information **19**
A. Hospital Days per 1,000 Members **19**
B. Hospital Discharges per 1,000 Members **19**
C. Average Length of Stay **19**
D. ER Visits per 1,000 Members **19**
CHART 6. 1999 Hospital Utilization *20*
E. Mental Health Utilization **20**
F. Chemical Dependency Utilization **20**
TABLE 6. 1999 Use of Services Measures *21*

IX. Member Satisfaction Information **22**
A. Rating of Personal Doctor or Nurse **22**
B. Rating of Specialist **22**
C. Rating of Health Care **22**
D. Rating of Health Plan **22**
CHART 7. 1999 Member Satisfaction Ratings *23*
E. Claims Processing **23**
F. Getting Needed Care **23**
G. Getting Care Quickly **23**
H. How Well Doctors Communicate **23**
I. Courteous & Helpful Office Staff **24**
J. Customer Service **24**
TABLE 7. 1999 Member Satisfaction Survey Measures *25*

X. Utilization Review Information **26**
A. Prior Authorizations **26**
CHART 8. Prior Authorization Denials (% Denied) *27*
TABLE 8. 1999 Prior Authorization Denials *28*
B. Adverse Decisions **29**
CHART 9. Adverse Decisions (% Denied) *30*
TABLE 9. 1999 Adverse Decisions *31*
C. Appeals **32**
CHART 10. Successful Appeals (% Overturned) *33*
TABLE 10. 1999 Appeals Overturned *34*

XI. Benchmarks -How Did RI Compare? **35**
A. Effectiveness of Care Measures **35**
B. Health Plan Stability Measures **35**
C. Access/Availability of Care Measures **35**
D. Use of Services Measures **36**
E. Member Satisfaction Survey Measures **36**
TABLE 11. 1999 Commercial Health Plan Benchmark Comparisons *37*

I: Highlights

This Report is the second year for which data were collected from the Health Plans in Rhode Island. Major findings for **Commercial Plans** in 1999 include:

RI Health Plans' profitability improved

Both Blue Cross and United returned to profitability in 1999, and CHP reduced its operating loss from –16.5 percent in 1998 to –7.4 percent in 1999.

In 1999, RI Plans spent less of each premium dollar on healthcare services

The average RI Plan spent 87 cents of each dollar in premiums on healthcare services in 1999 compared with 94 cents in 1998.

RI Plans scored higher on 'effectiveness of care' than Plans nationally

Effectiveness of care measures in RI, from childhood immunization to diabetes care, exceeded the national experience in 1999, however, there remains room for improvement in each of these measures.

Physician turnover was lower in RI Plans than in Plans nationally

Primary care physicians left RI Plans at an average rate 44 percent below the US rate (4.5 percent in RI versus 8 percent nationally).

Children's access to primary care in RI Plans was higher than in the nation

Children's access to primary care measures for RI Plans equaled or exceeded the national rates for all age groups.

RI Plans had lower inpatient utilization but higher ER use than Plans nationally

The average RI Plan hospital discharge rate was 16 percent less than the US rate but ER utilization was 18 percent higher in RI.

Member satisfaction was higher in RI Plans than in those nationally

RI Plans scored higher on patient satisfaction measures than their national counterparts in 1999.

Utilization review denials for services and payment were down in 1999

Even though RI Plan enrollment increased 8.5 percent in 1999, prior authorization denials fell 23 percent (535 to 413) and adverse decisions declined 41 percent (2,448 to 1,455). The number of appeals fell 43 percent (1,209 to 689) and the number of those appeals that were successful on the part of the member decreased 63 percent (617 to 231).

II: Introduction

Increasingly, the public, purchasers, providers, payors and policy makers are seeking meaningful information about Health Plans. This Report provides the most comprehensive source of data on Health Plans certified to operate in Rhode Island.[1] Purchasers may use this information to make better choices among competing Plans and the public may use it to understand their chosen Plan better. The Plans themselves now have comparative statistics to identify and focus performance efforts. Policy makers may use this empirical evidence to inform decision making and to aid accountability to constituents.

A. Background

Not all Health Plans are identical. They differ in how they keep members well and how they care for them when they are ill. They also differ in how they provide access to and deliver services. Over 595,000 Rhode Islanders receive their health coverage through the Health Plans in this Report, so learning about how the Plans perform is essential.

To consumers, the cost, 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.

Consequently, in response to this need for information, Rhode Island passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. This Law stipulates that, among other things,[2] Health Plans[3] submit performance data to the Department of Health (HEALTH).

The *1999 RI Health Plan Performance Report* is the second annual publication of this information. HEALTH, recognizing that this is an evolving process, remains committed to improving the Report and welcomes all input. For further information please contact the Office of Performance Measurement and Reporting.[4] To inspect the actual 1999 Health Plan filings, please contact the Office of Managed Care Regulation.[5] For more information on choosing a Health Plan, readers are referred to the following Web sites: http://hprc.ncqa.org/ and www.ahcpr.gov/consumer/qualguid.pdf.

B. How to Use This Information -Limitations

The Report is divided into Sections containing similar dimensions of performance. Sections III through X provide the statistics for each Plan participating in each product line (i.e., Commercial, Medicare[6], and Medicaid). Section III examines enrollment. Section IV provides financial data. Section V looks at effectiveness of care measures. Section VI reports Health Plan stability information. Section VII details access to and availability of care. Section VIII compares use of services. Section IX gives the results of member satisfaction surveys, and Section X assesses utilization review statistics. The final Section (XI) benchmarks the experience in RI with that in the Nation and New England region, whenever possible.

Different users will use this Report in different ways. However, the following guidelines should help improve its utility for everyone.

- **No one measure in and of itself can truly reflect Health Plan performance.** Therefore, the statistics should be viewed in combination and not in isolation. When the data are taken as a whole, a more complete picture emerges than if only a simple comparison is made based on a single indicator.

- **Readers should focus on large differences between Health Plans** that are less likely to be caused by random chance. Generally, relative differences less than 5 percent are not large enough to be significant.[7] Therefore, this Report focuses on changes or comparable differences that are 5 percent or more.

- **Readers should recognize there could be extraneous reasons why results vary.** Every Plan cares for a distinct set of members who may affect its performance. Some Plans may have an older membership and some may have a younger membership. Some memberships may be relatively healthy while others are more chronically ill. Some memberships may be more compliant with recommended treatments while others are less compliant. In addition, some Plan's may have a racial and ethnically diverse membership while others may be more homogeneous. Lastly, differences in covered benefits and provider networks could also influence outcomes. Therefore, there may be many reasons why performance could vary, even if the Plans were delivering care identically.

- **This Report examines both HMOs (Health Maintenance Organizations[8]) and PPOs (Preferred Provider Organizations[9]).** In general, HMOs use provider networks to deliver care through the member's primary care provider. PPOs generally allow access to any provider, with some cost savings to the member for using the providers in the network. From a technical standpoint, an HMO may have better control in managing certain aspects of members' care than a PPO. Hypothetically, this could give HMOs a comparative advantage in some of the performance indicators here, such as Effectiveness of Care, Access/Availability of Care, and Use of Services measures. However, examination of the data does not bear this out.[10] Further, as the line between HMOs and PPOs becomes further blurred as they each employ managed care techniques to varying degrees, this distinction will become less apparent and less important in the future.

- **This Report does not include any data on Harvard Pilgrim Health Care of NE**, a major Health Plan that ceased RI operations in December 1999 with about 107,000 members[11] and did not file for 1999. In addition, the smaller Health Plans[12] with less than 10,000 RI members were excluded from the analyses. The rationale is that these smaller Plans are exempt from filing in 2000, and the size of their membership is such that they are fairly inconsequential players in the RI marketplace at this time.

- **The information here is a 'snapshot in time'** of what happened in 1999. Care should be taken in not extrapolating too much from the experience in one year. Instead, performance should be examined over time (i.e., trended) to identify favorable or unfavorable patterns. Whenever possible, this Report presents the 1998 data (the first year collected) in addition to that for 1999.[13]

- **Finally, the Health Plans certified that the information they provided is complete and correct**. However, while not all of the data have been independently audited, they have been collected and analyzed with all due diligence, and are presented "as-is" for the benefit of interested parties.

III: Enrollment Information

This Section compares Health Plan membership information, including market share and gender based enrollment figures.

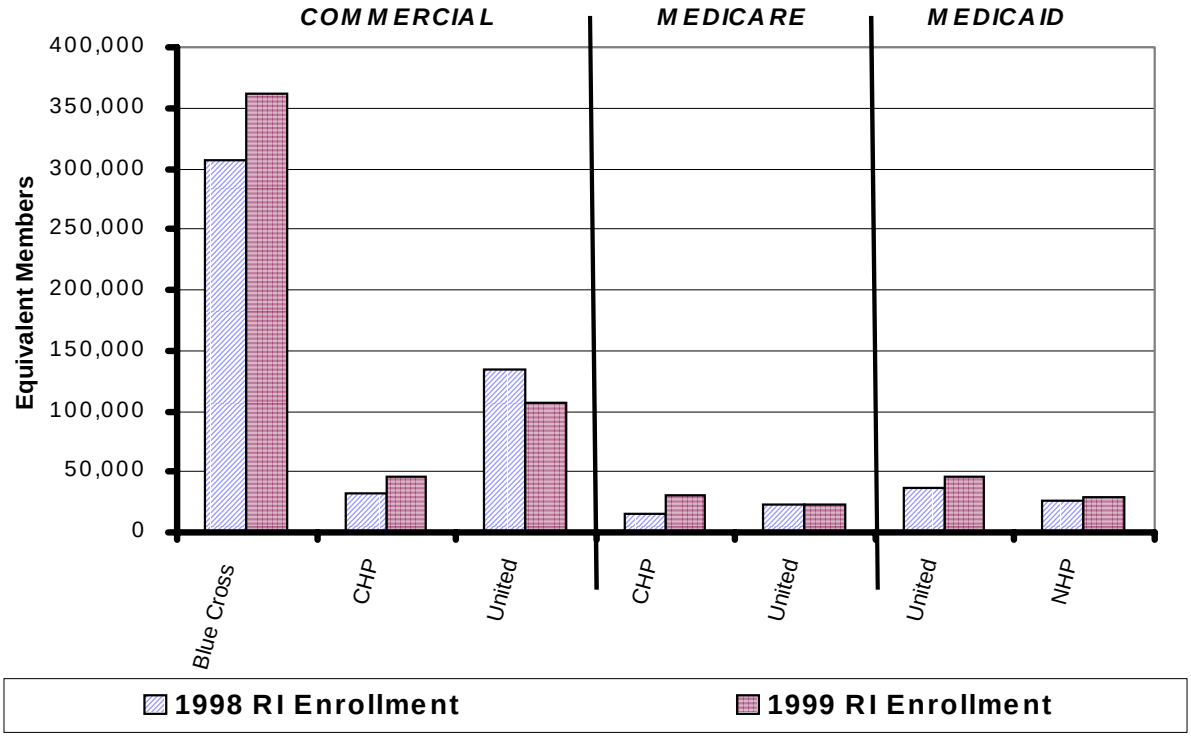
A. Rhode Island (Equivalent) Members are the computed RI resident enrollment in a Health Plan for the full year[14] (Chart 1 & Table 1). Increasing enrollment over time is important both in terms of "growing the business" and maintaining or increasing market share.

Commercial Plans: Blue Cross Blue Shield of Rhode Island (Blue Cross) remained the largest RI commercial insurer with 362,000 RI members (up from 307,629 in 1998). Following were United Healthcare of New England (United) with 107,130 RI members (down from 134,853 in 1998) and Coordinated Health Partners[15] (CHP) with 45,438 RI members (up from 31,637 in 1998). Overall, Commercial coverage in the State increased from 600,438 members in 1998 to 641,347 in 1999 (+7 percent).

Medicare Plans: CHP leads the Medicare managed-care market in the State with 29,913 RI members (up from 15,442 in 1998). United followed with 22,267 RI members (down slightly from 22,691 in 1998). Total Medicare Health Plan enrollment increased from 43,684 members in 1998 to 52,180 in 1999 (+19 percent).

Medicaid Plans: United remained the largest RI Medicaid insurer with 45,098 RI members (up from 36,529 in 1998). Neighborhood Health Plan of Rhode Island (NHP) followed with 29,008 RI members (up from 26,281 in 1998). Statewide, Medicaid Health Plan enrollment increased from 75,845 members in 1998 to 79,155 in 1999.

CHART 1. Health Plan RI Enrollment



B. Rhode Island Market Share calculates each Plan's percentage of the total RI enrollment in each product line, Commercial, Medicaid, and Medicare (Table 1). In many respects, market share is more important than enrollment (although the two are related). It is possible in a shrinking market for enrollment to decline while market share actually increases. Market share, to a significant extent, determines how competitive a company can be and how much control it can exert over its fiscal environment.

Commercial Plans: Blue Cross continued to be the dominant RI Commercial Health Plan with 56 percent market share compared to 51 percent in 1998. United followed with 17 percent (versus 22 percent in 1998) and CHP was third with 7 percent (up from 5 percent in 1998).

Medicare Plans: CHP was the leading Medicare Health Plan with 57 percent market share (up from 35 percent in 1998). United followed with a 43 percent share, down from 52 percent in 1998.

Medicaid Plans: United led the RI Medicaid market with a 57 percent share (versus 48 percent in 1998). NHP followed with 37 percent market share (up from 35 percent in 1998).

C. Total (Equivalent) Members are the computed total enrollment in a Health Plan, regardless of residence, for a full year[16] (Table 1).

D. RI Enrollment Percent of Total (enrollment) is the proportion of a Plan's total enrollment that are RI residents (Table 1).

E. RI Enrollment Percent Female calculates how many of the Plan's RI members are female (Table 1).

F. RI Enrollment Percent Male calculates how many of the Plan's RI members are male (Table 1).

TABLE 1. 1999 ENROLLMENT MEASURES

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS [1]				
1) RI (Equivalent) Members	362,000	45,438	107,130	
2) RI Commercial Market Share [2]	56%	7%	17%	
3) Total (Equivalent) Members	404,410	49,693	139,497	
4) RI Enrollment Percent of Total	90%	91%	77%	
5) RI Enrollment Percent Female	52%	50%	51%	
6) RI Enrollment Percent Male	48%	50%	49%	
B) MEDICARE HEALTH PLANS [1]				
1) RI (Equivalent) Members		29,913	22,267	
2) RI Medicare Market Share		57%	43%	
3) Total (Equivalent) Members		29,913	37,307	
4) RI Enrollment Percent of Total		100%	60%	
5) RI Enrollment Percent Female		59%	57%	
6) RI Enrollment Percent Male		41%	43%	
C) MEDICAID HEALTH PLANS [1]				
1) RI (Equivalent) Members			45,098	29,008
2) RI Medicaid Market Share [3]			57%	37%
3) Total (Equivalent) Members			45,422	29,008
4) RI Enrollment Percent of Total			99%	100%
5) RI Enrollment Percent Female			62%	61%
6) RI Enrollment Percent Male			38%	39%

KEY:

[1] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)

[2] Based on total 1999 Commercial RI enrollment which included: Harvard Pilgrim Health Care of NE (~107,000 estimated RI members), Tufts Health Plan of NE (ceased RI operations in 1999 with 7,545 RI members), Blue Cross -MA (7,253 RI members), Aetna US Healthcare (2,656 RI members), Connecticut General Life Insurance Company (~1,800 estimated RI members), and Aetna Life Insurance Company (525 RI members)

[3] Based on total 1999 Medicaid RI enrollment which included Coordinated Health Partners (5,049 RI members)

IV: Financial Information

This Section allows users to compare information on Health Plan operations. Included are the average costs of the plans, how much they spend on healthcare services for their members, and how financially strong (i.e., profitable) they are. Readers should note that the specific allocations of dollars to the measures in Section IV were not audited.

A. Average Monthly Premium Revenue is the average monthly amount the Health Plan receives in payment for each member covered (Table 2). This is the average cost[17] to the member of the Health Plan (either directly through purchase or indirectly through wages foregone). However, great care should be taken in comparing these statistics between Plans (or with single Plans over time). One Plan may be less expensive than another but that doesn't necessarily mean it is a better value. Different Plans (or the same Plan over time) may have different benefits, co-pays and deductibles. Therefore, the total healthcare cost to a member for a less expensive Plan may actually be greater than a more expensive Plan that has fewer co-pays, lower deductibles and more covered services the member needs.

In 1999, the average Commercial monthly premium revenue remained basically static (from $145 in '98 to $150 in '99). That same year, the average Medicare monthly premium revenue increased 5 percent (from $422 to $442), and the average Medicaid monthly premium revenue fell slightly, from $124 to $122.

B. Medical Expense Ratio is the percentage of total premium revenue received that the Health Plan spends on healthcare services for its members (Table 2). Consumers generally favor a high Medical Expense Ratio (or Loss Ratio) in that it indicates a higher portion of their premium dollars are actually going into their healthcare. However, a lower Medical Expense Ratio does not necessarily imply that a Plan restricts access to healthcare. It could mean that the Plan's members are less ill (i.e., need less services) or that the Plan is more effective in managing needed care for its enrollees (all else being equal). In any case, the Medical Expense Ratio should not be considered in isolation, it should be viewed as only one component of many.

In 1999, the average Commercial Medical Expense Ratio decreased 8 percent (from 94.1 percent in '98 to 87 percent in '99). That same year, the average Medicare Loss Ratio decreased 5 percent (from 101.8 to 97.2 percent), and the average Medicaid Loss Ratio decreased slightly (from 87.4 to 84.4 percent).

C. Total Profit Margin is the net income (after all expenses and applicable taxes) expressed as a percentage of total operating revenue (Table 2). This statistic is important in evaluating the financial solvency of a Health Plan. Consumers depending on a financially weak Health Plan may find themselves with reduced coverage, less access to providers, and compromised customer service as the Plan tries to regain profitability. Likewise, providers may experience delinquent payments or outright default from a troubled Plan. Certainly no Plan can lose money for any length of time without corrective action. Such remedial steps may be as (descriptively) simple as raising premiums, cutting costs, or, as drastic as leaving a particular market altogether.

In 1999, both Blue Cross[18] and United made money in their Commercial products while CHP lost 6.6 percent. Both United and CHP lost money on their Medicare products. United and NHP each posted small profits in their Medicaid Plans.

D. Hospital Expenses PMPM[19] are the (per member per month) Health Plan expenses for all inpatient and outpatient services provided by licensed hospitals, with the exception of substance abuse and mental health services provided by the specialty behavioral health hospitals (Chart 2 & Table 2).

For Commercial Health Plans, the average PMPM hospital expenses decreased 6 percent in 1999 ($57.13 to $53.51). That year, the average Medicare Health Plan PMPM hospital expenses decreased 9 percent ($233.85 to $212.72), and the average Medicaid health Plan PMPM hospital expenses decreased 8 percent ($55.02 to $50.42).

E. Physician Expenses PMPM are the (per member per month) Health Plan expenses for all services provided by physicians and physician practices (Chart 2 & Table 2).

The average Commercial Health Plan PMPM physician expenses held steady ($41.60 in '98 to $41.48), Medicare Health Plan PMPM physician expenses increased 10 percent ($94.01 to $103.88), and Medicaid Health Plan PMPM physician expenses decreased 30 percent ($27.51 to $19.37).

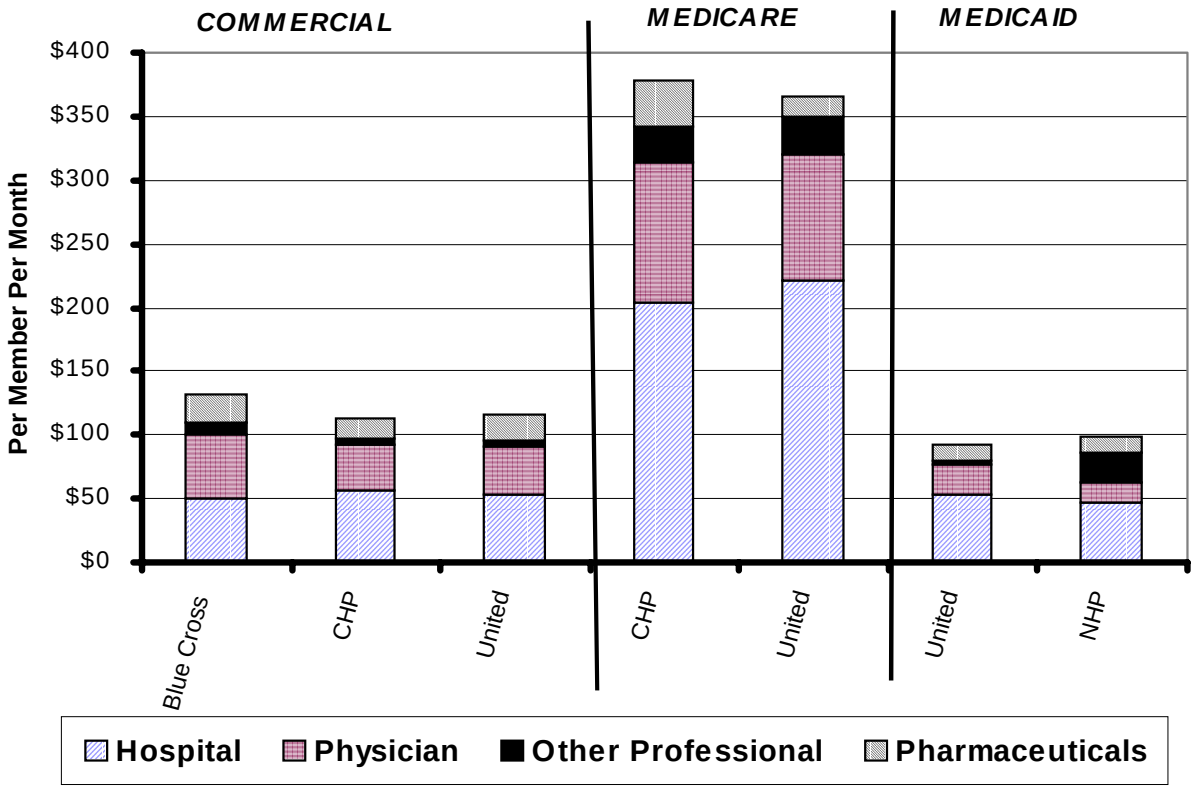
F. Other Professional Expenses PMPM are the (per member per month) Health Plan expenses for the services of dentists, optometrists, nurses, and other clinical personnel (e.g., technicians, technologists, therapists, vocational and rehab professionals, etc. – Chart 2 & Table 2).

The average Commercial Health Plan PMPM other professional expenses decreased 32 percent in 1999 ($8.37 to $5.71), they increased 44 percent for Medicare Plans ($20.56 to $29.56), and increased 113 percent for Medicaid Plans ($6.26 to $13.33).

G. Pharmaceutical Expenses PMPM are the (per member per month) Health Plan expenses for prescription drugs and other proprietary medications (Chart 2 & Table 2).

The average PMPM pharmaceutical expenses rose 13 percent in 1999 for Commercial Plans ($17.34 to $19.57), they decreased 13 percent for Medicare Plans ($29.81 to $25.89), and increased 16 percent for Medicaid Plans ($11.38 to $13.20).

CHART 2. 1999 Health Plan Expenses



H. Substance Abuse Expenses PMPM are the (per member per month) Health Plan expenses for inpatient and outpatient substance abuse services, supplies, and medications for treatment of chemical dependency (Table 2).

The average PMPM substance abuse expenses decreased 10 percent in 1999 for Commercial Plans ($0.70 to $0.63), and increased 77 percent for Medicare Plans ($0.51 to $0.90). Comparable 1998 statistics for the Medicaid Plans were not available because NHP did not report its data.

I. Mental Health Expenses PMPM are the (per member per month) Health Plan expenses for inpatient and outpatient mental health services, supplies, and medications for treatment of mental health problems (Table 2).

The average PMPM mental health expenses increased 7 percent in 1999 for Commercial Plans ($4.14 to $4.41), and increased 52 percent for Medicare Plans ($3.51 to $5.33). Comparable 1998 statistics for the Medicaid Plans were not available because NHP did not report its data.

J. Health Education Expenses PMPM are the (per member per month) Health Plan expenses for services for enrollee health education (e.g., health fairs/seminars for health risk information, preventive services, lifestyle modifications, treatment compliance, and subsidies for health clubs, etc. –Table 2). Excluded are individual provider-patient consults.

TABLE 2. 1999 FINANCIAL MEASURES

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS [1]				
1) Avg. Monthly Premium Revenue	$160	$142	$148	
2) Medical Expense Ratio	84.8%	92.5%	83.7%	
3) Total Profit Margin	3.9%	-6.6%	0.8%	
4) Hospital Expenses PMPM	$49.61	$56.88	$54.04	
5) Physician Expenses PMPM	$51.49	$36.40	$36.53	
6) Other Professional Exp. PMPM	$7.99	$3.42	$5.72	
7) Pharmaceutical Expenses PMPM	$22.45	$16.40	$19.87	
8) Substance Abuse Exp. PMPM	$0.43	$0.60	$0.85	
9) Mental Health Expenses PMPM	$3.57	$4.05	$5.62	
10) Health Education Exp. PMPM	n/r	n/r	$0.56	
B) MEDICARE HEALTH PLANS [1]				
1) Avg. Monthly Premium Revenue		$453	$431	
2) Medical Expense Ratio		102.0%	92.4%	
3) Total Profit Margin		-7.5%	-1.8%	
4) Hospital Expenses PMPM		$204.18	$221.26	
5) Physician Expenses PMPM		$108.82	$98.93	
6) Other Professional Exp. PMPM		$29.05	$30.06	
7) Pharmaceutical Expenses PMPM		$35.94	$15.83	
8) Substance Abuse Exp. PMPM		$0.22	$1.58	
9) Mental Health Expenses PMPM		$6.40	$4.25	
10) Health Education Exp. PMPM		n/r	$0.62	
C) MEDICAID HEALTH PLANS [1]				
1) Avg. Monthly Premium Revenue			$123	$121
2) Medical Expense Ratio			83.6%	85.3%
3) Total Profit Margin			0.8%	0.7%
4) Hospital Expenses PMPM			$53.19	$47.64
5) Physician Expenses PMPM			$23.75	$14.99
6) Other Professional Exp. PMPM			$3.46	$23.21
7) Pharmaceutical Expenses PMPM			$12.84	$13.57
8) Substance Abuse Exp. PMPM			$1.87	n/r
9) Mental Health Expenses PMPM			$5.90	$7.41
10) Health Education Exp. PMPM			$0.45	n/r

KEY:
[1] *Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)*
PMPM (per member per month)
n/r Not Reported (statistic was required but not reported)

V. Effectiveness of Care Information

This Section contains HEDIS®[20] measures that look at the clinical quality of care provided within a Health Plan. These indicators examine how effectively a Plan delivers preventive services to keep its members healthy, and how well it treats members who are already sick. Starting in 1999, certain Commercial and Medicaid HEDIS measures in this domain were on a rotation schedule, meaning they may be based on biennial (2 year) data collection, and so reported. Three statistics in this Report[21] are on this rotation and are not scheduled to be collected again for year 2000.

A. Childhood Immunization Status is the percentage of children in the Plan who received the appropriate immunizations[22] by age 2 (Chart 3 & Table 3). This statistic is applicable to the Commercial and Medicaid populations only. As immunizations protect children against preventable and sometimes devastating disease, they are one of the most cost-effective examples of high-quality primary care.

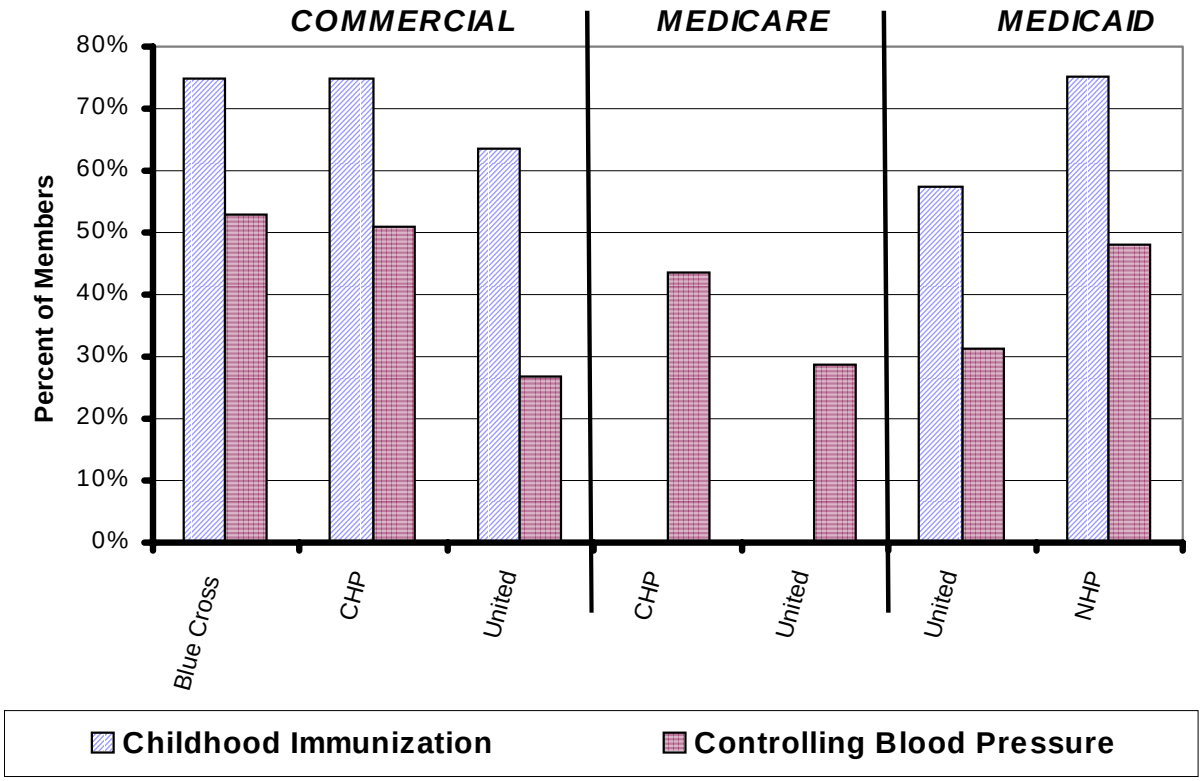
In 1999, the average Commercial Health Plan childhood immunization rate decreased 5 percent (74.6 to 71.1 percent), and the average Medicaid Health Plan rate remained essentially static (65.6 to 66.3 percent).

B. Adolescent Immunization Status is the percentage of adolescents (who turned 13) that received the appropriate immunizations[23] within the past year (Table 3). This statistic is also applicable to the Commercial and Medicaid populations only. As with the previous measure, immunizing adolescents is a proven cost-effective defense against serious illness. This measure was not collected in 1998 so a trend analysis is not possible.

C. Cholesterol Management After an Acute Cardiovascular Event is the percentage of members (age 18 through 75 years) discharged after an acute cardiac event and/or procedure with clinical screening and control of cholesterol (Table 3). This measure was not collected in 1998 so a trend analysis is not possible.

D. Controlling High Blood Pressure is the percentage of diagnosed hypertensive members (age 46 through 85 years) whose blood pressure was under control (Chart 3 & Table 3). This measure was not collected in 1998 so a trend analysis is not possible.

CHART 3. 1999 Effectiveness of Care Measures



E. Beta Blocker Treatment After a Heart Attack is the percentage of members (age 35 years and older) diagnosed and discharged with acute myocardial infarction who received a beta blocker prescription at discharge (Table 3). Given the prevalence and cost of heart disease in the US, beta blocker therapy has proven an effective medical treatment to reduce the risk of having another attack. This measure was not collected in 1998 so a trend analysis is not possible.

F. Comprehensive Diabetes Care (Dilated Eye Exam Performed) is the percentage of members (age 18 through 75 years) with diabetes who received an eye exam for diabetic retinal disease (Table 3). Diabetes is the leading cause of adult blindness in the US, so regular examinations are important to diagnose problems as early as possible. This measure was not collected in 1998 so a trend analysis is not possible.

TABLE 3. 1999 EFFECTIVENESS OF CARE MEASURES

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[1]				
1) Childhood Immunization Status	74.9%	74.8%	63.5%	
2) Adolescent Immunization Status	49.6%	44.1%	44.0%	
3) Cholesterol Management after an Acute Cardiovascular Event	76.9%	73.7%	81.6%	
4) Controlling High Blood Pressure	52.9%	51.1%	26.7%	
5) Beta Blocker Treatment After a Heart Attack	89.2%	80.0%	93.3%	
6) Comprehensive Diabetes Care (Dilated Eye Exam Performed)	47.4%	52.3%	48.9%	
B) MEDICARE HEALTH PLANS[1]				
1) Childhood Immunization Status		n/a	n/a	
2) Adolescent Immunization Status		n/a	n/a	
3) Cholesterol Management after an Acute Cardiovascular Event		81.8%	69.0%	
4) Controlling High Blood Pressure		43.5%	28.7%	
5) Beta Blocker Treatment After a Heart Attack		95.0%	98.0%	
6) Comprehensive Diabetes Care (Dilated Eye Exam Performed)		70.1%	64.2%	
C) MEDICAID HEALTH PLANS[1]				
1) Childhood Immunization Status			57.4%	75.2%
2) Adolescent Immunization Status			38.4%	44.5%
3) Cholesterol Management after an Acute Cardiovascular Event			n/a	n/a
4) Controlling High Blood Pressure			31.4%	48.1%
5) Beta Blocker Treatment After a Heart Attack			80.0%	n/a
6) Comprehensive Diabetes Care (Dilated Eye Exam Performed)			39.0%	37.7%

KEY:
[1] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/a Not Applicable (statistic was not required or not statistically significant)

VI: Health Plan Stability Information

This Section contains HEDIS measures that examine two aspects of how stable a Plan is in terms of its enrollment and provider base. All else being equal, high turnover in either area is not desirable and may indicate other problems. Continuity of care is a highly valued attribute of good healthcare and this may be problematic if primary care providers are leaving a Plan.

A. Disenrollment measures the percentage of members who left the Plan during the year (Chart 4 & Table 4). This statistic is calculated for the Commercial and Medicare enrollment only and serves strictly as a measure of the stability of the Plan's membership. It should not be viewed as a proxy for members' satisfaction with a Plan because it does not differentiate between voluntary and involuntary disenrollment (e.g., an employer drops a particular Plan). However, a high disenrollment rate could be a predictor of declining revenue and future insolvency if those members are not replaced with new subscribers (or expenses are not commensurately reduced).

In 1999, the average Commercial Health Plan disenrollment decreased 5 percent (28.5 to 27.1 percent), and the average Medicare Health Plan disenrollment increased 251 percent (3.5 to 12.3 percent).

B. Primary Care Practitioner Turnover is the percentage of the Plan's primary care practitioners at the beginning of the year that left the Plan by year's end (Chart 4 & Table 4). Most people like to see the same practitioner over time and this continuity may result in more effective care. While some turnover is normal, it is difficult to provide high quality care if the doctor/patient relationship is disrupted. United did not provide this information for 1999, so a statewide comparison with 1998 is not possible.

CHART 4. 1999 Health Plan Stability Measures

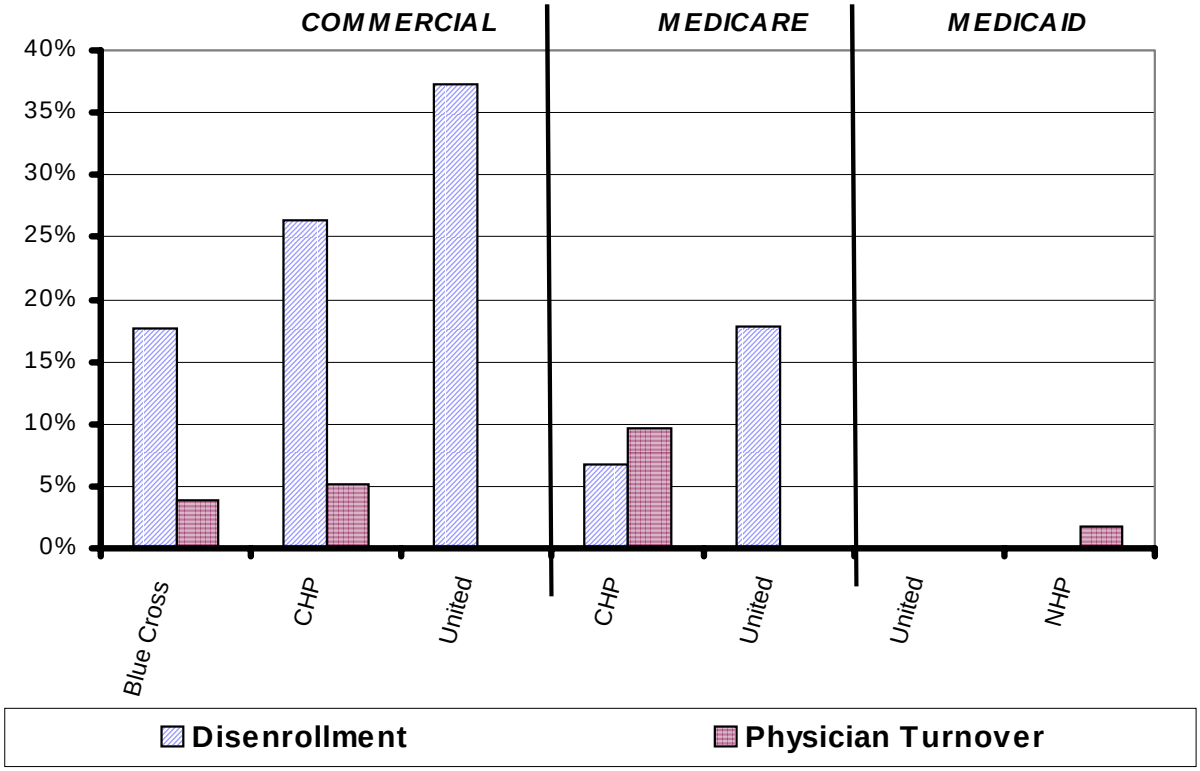


TABLE 4. 1999 HEALTH PLAN STABILITY MEASURES	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[1]				
1) Disenrollment	17.7%	26.3%	37.3%	
2) Primary Care Practitioner Turnover	3.8%	5.1%	n/r	
B) MEDICARE HEALTH PLANS[1]				
1) Disenrollment		6.8%	17.8%	
2) Primary Care Practitioner Turnover		9.6%	n/r	
C) MEDICAID HEALTH PLANS[1]				
1) Disenrollment			n/a	n/a
2) Primary Care Practitioner Turnover			n/r	1.8%

KEY:
[1] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/r Not Reported (statistic was required but not reported)
n/a Not Applicable (statistic was not required or not statistically significant)

VII: Access to, Availability of Care Information

HEDIS measures in this Section examine if members are obtaining needed services from the healthcare system. Access means not only that healthcare is available, but that patients know of this availability, and they know how to actually get the care when they need it.

A. Children's Access to Primary Care Practitioners measures the percentage of members in different age groups who saw a primary care practitioner during the past year[24] (Chart 5 & Table 5). This statistic is applicable to the Commercial and Medicaid populations only. Children without access to preventive care are more likely to incur advanced disease at higher personal and financial cost. This measure was not collected in 1998 so a trend analysis is not possible.

B. Adults' Access to Preventive Ambulatory Health Services measures the percentage of members in different age groups who had an ambulatory or preventive care visit in the past 3 years[25] (Chart 5 & Table 5). As with the previous measure, low rates may indicate access problems and/or the need for Plans to inform members of the importance of preventive care, both from a clinical and financial standpoint.

In 1999, the average Commercial Health Plan adults' access improved for all age categories (+5 percent) for ages 20-44, and held essentially steady for ages 45-64, and ages 65+. There were no significant changes in the average Medicare or Medicaid Health Plans' adults' access.

CHART 5. 1999 Access to Care

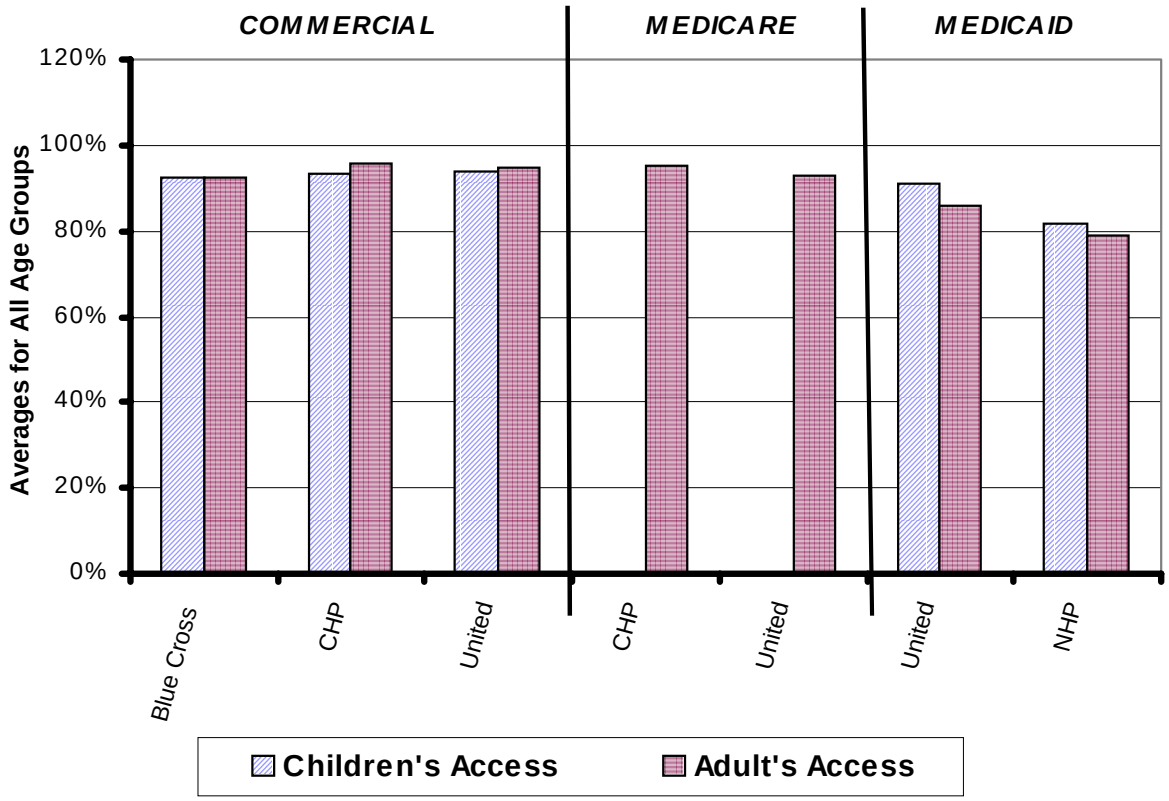


TABLE 5. 1999 ACCESS/AVAILABILITY OF CARE MEASURES

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[1]				
Children's Access to Primary Care Practitioners:				
1) **Age 12 Through 24 mos.**	95.3%	97.1%	96.6%	
2) **Age 25 mos. Through 6 yrs.**	90.6%	91.1%	91.3%	
3) **Age 7 Through 11 yrs.**	91.3%	92.6%	93.2%	
Adults' Access to Preventive/ Ambulatory Health Services:				
4) **Age 20 Through 44 yrs.**	93.9%	93.5%	93.6%	
5) **Age 45 Through 64 yrs.**	94.1%	96.0%	95.6%	
6) **Age 65+**	89.4%	97.6%	95.0%	
B) MEDICARE HEALTH PLANS[1]				
Children's Access to Primary Care Practitioners:				
1) **Age 12 Through 24 mos.**		n/a	n/a	
2) **Age 25 mos. Through 6 yrs.**		n/a	n/a	
3) **Age 7 Through 11 yrs.**		n/a	n/a	
Adults' Access to Preventive/ Ambulatory Health Services:				
4) **Age 20 Through 44 yrs.**		90.9%	89.3%	
5) **Age 45 Through 64 yrs.**		97.6%	93.3%	
6) **Age 65+**		97.8%	95.9%	
C) MEDICAID HEALTH PLANS[1]				
Children's Access to Primary Care Practitioners:				
1) **Age 12 Through 24 mos.**			90.9%	90.1%
2) **Age 25 mos. Through 6 yrs.**			90.1%	76.7%
3) **Age 7 Through 11 yrs.**			92.5%	78.0%
Adults' Access to Preventive/ Ambulatory Health Services:				
4) **Age 20 Through 44 yrs.**			84.1%	79.7%
5) **Age 45 Through 64 yrs.**			87.7%	77.7%
6) **Age 65+**			n/a	n/a

KEY:
[1] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/a Not Applicable (statistic was not required or not statistically significant)

VIII: Use of Services Information

This Section gives HEDIS information on the services a Health Plan provides to its members. Because so many demographic factors can influence utilization and because each Plan's enrollment is different, readers are urged to interpret the data with care. Further, these statistics are not age, gender or risk-adjusted.

A. Hospital Days per 1,000 Members is the average number of acute-care hospital days used by every 1,000 members[26] in the Plan (Table 6). Excluded are substance abuse, mental health and newborn days.

In 1999, the average Commercial Health Plan hospital days utilization decreased slightly, from 188.3 to 182.9 days per 1,000 members. Likewise, the average Medicare Health Plan days utilization decreased from 1,428.1 to 1,415 days per 1,000, and the average Medicaid Health Plan days utilization fell 5 percent (294.7 to 279.2 days per 1,000).

B. Hospital Discharges per 1,000 Members is the average number of acute-care hospital discharges (excluding substance abuse, mental health and newborn discharges) used by every 1,000 members[27] in the Plan (Chart 6 & Table 6).

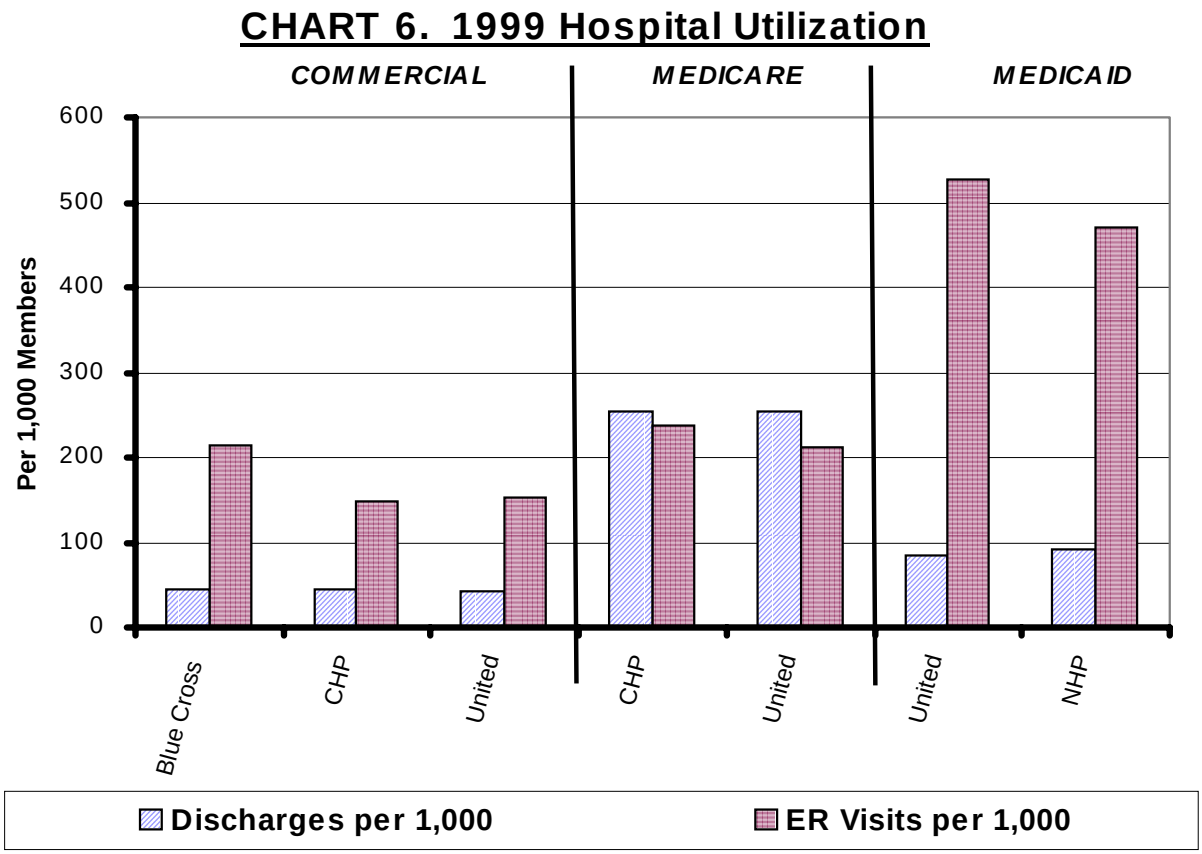
In 1999, the average Commercial Health Plan hospital discharge rate decreased slightly, from 45.2 to 44.2 discharges per 1,000 members. By contrast, the average Medicare Health Plan discharge rate increased 8 percent (235.8 to 253.6 discharges per 1,000), and the average Medicaid Health Plan discharge rate increased from 87.4 to 89.2 discharges per 1,000.

C. Average Length of Stay is the average number of days each acute-care hospital admission lasted (Table 6).

In 1999, the average Commercial Health Plan length of stay remained basically static at 4.2 days, while the average Medicare Health Plan length of stay decreased 7 percent (6 to 5.6 days), and the average Medicaid Health Plan length of stay decreased 8 percent (3.4 to 3.1 days).

D. ER Visits per 1,000 Members is the number of visits to the Emergency Department (that did not result in the patient being admitted) for every 1,000 members[28] in the Plan (Chart 6 & Table 6). All else being equal, higher ER rates could indicate a lack of primary care.

In 1999, the average Commercial Health Plan ER utilization decreased 12 percent (194.7 to 172 visits per 1,000). The average Medicare Health Plan ER utilization rate remained essentially steady (228.2 to 225.8 visits per 1,000), and the average Medicaid Health Plan ER utilization held constant at 498 visits per 1,000. ER use by Medicaid Plan members was 190 percent greater than for Commercial Plans (498.4 versus 172 visits per 1,000 members), suggesting there could be a community-based primary care access problem for this population.



E. Mental Health Utilization is the percentage of members receiving mental health services during the year (Table 6). Mental illness is often under-diagnosed, so higher rates on this indicator could mean the Plan offers better access to these services.

In 1999, the average Commercial Health Plan mental health utilization declined slightly (7.5 to 7.2 percent). The average Medicare Health Plan mental health utilization decreased 7 percent (4.5 to 4.2 percent), and the average Medicaid Health Plan mental health utilization fell from 7.1 to 6.9 percent.

F. Chemical Dependency Utilization is the percentage of members receiving chemical dependency services during the year (Table 6). As with mental illness, substance abuse may be under-diagnosed. Therefore, higher rates may indicate that more members are being identified and treated.

Changes in the average chemical dependency utilization were inconsistent across Health Plans. The average 1999 Commercial Health Plan chemical dependency utilization decreased 29 percent (0.9 to 0.6 percent). The average Medicare Health Plan chemical dependency utilization decreased 50 percent (0.4 to 0.2 percent), and the average Medicaid Health Plan chemical dependency utilization increased 21 percent (1.1 to 1.3 percent).

TABLE 6. 1999 USE OF SERVICES MEASURES

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[1]				
1) Hospital Days per 1,000 Members	192.6	185.2	170.8	
2) Hosp. Discharges per 1,000 Members	45.0	44.4	43.2	
3) Average Length of Stay	4.3	4.2	4.0	
4) ER Visits per 1,000 Members	214.3	149.0	152.6	
5) Mental Health Utilization	8.3%	6.1%	7.3%	
6) Chemical Dependency Utilization	0.7%	0.7%	0.5%	
B) MEDICARE HEALTH PLANS[1]				
1) Hospital Days per 1,000 Members		1,374.1	1,456.0	
2) Hosp. Discharges per 1,000 Members		253.1	254.0	
3) Average Length of Stay		5.4	5.7	
4) ER Visits per 1,000 Members		238.7	212.8	
5) Mental Health Utilization		4.3%	4.1%	
6) Chemical Dependency Utilization		0.2%	0.2%	
C) MEDICAID HEALTH PLANS[1]				
1) Hospital Days per 1,000 Members			266.5	291.9
2) Hosp. Discharges per 1,000 Members			85.7	92.8
3) Average Length of Stay			3.1	3.1
4) ER Visits per 1,000 Members			526.4	470.4
5) Mental Health Utilization			8.4%	5.3%
6) Chemical Dependency Utilization			1.1%	1.6%

KEY:
[1] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)

IX: Member Satisfaction Information

This Section provides CAHPS[29] information on the percentage of members who were satisfied with their experience of care (Table 7). CAHPS data were not collected in 1998 so a trend analysis is not possible. Also, with the exception of the *Getting Needed Care* and *Customer Service* measures, the methodology used in calculating the measures for the Medicare Plans is different than that used for the Commercial and Medicaid Plans. Therefore, it is not possible to make comparisons between the Medicare and either the Commercial and/or the Medicaid Plans.

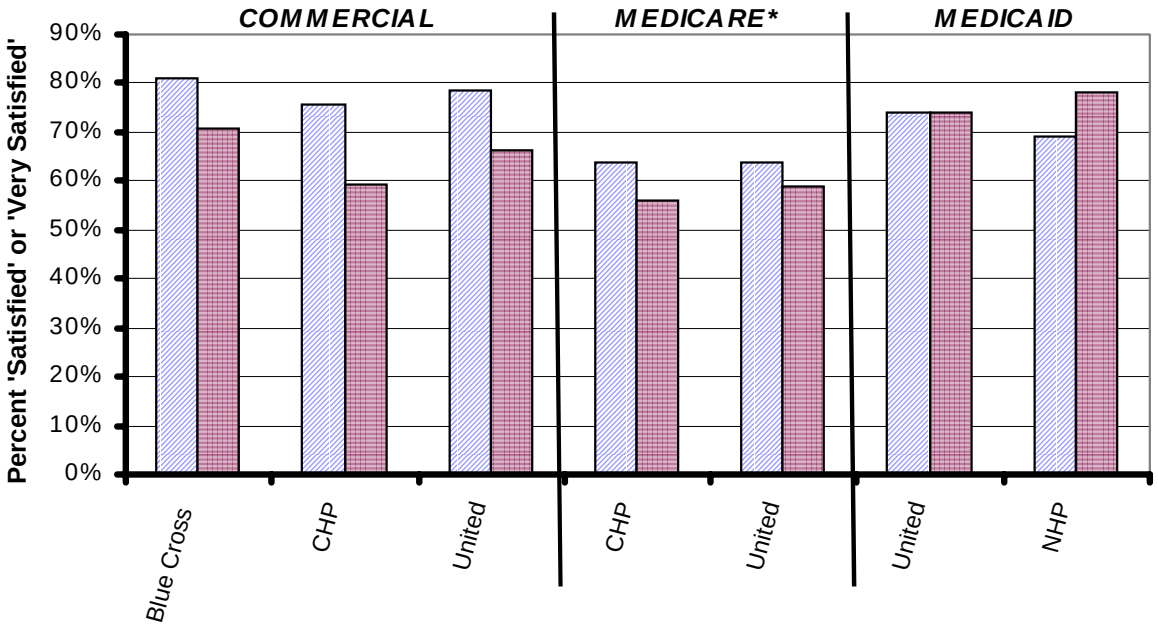
A. Rating of Personal Doctor or Nurse is the percentage of members indicating general satisfaction with their own doctors or nurses. In 1999, the average Health Plan scores on this measure were not appreciably different for the Commercial Plans (80.1 percent) versus the Medicaid Plans (78.7 percent). The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

B. Rating of Specialist is the percentage of members indicating satisfaction with the specialists seen most frequently in the past year. In 1999, the average Health Plan scores on this measure ranked higher for the Commercial Plans (82.1 percent) than the Medicaid Plans (77.9 percent). The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

C. Rating of Health Care is the percentage of members indicating overall satisfaction with all of the healthcare received in the past year (Chart 7). In 1999, the average Health Plan scores on this measure ranked higher for the Commercial Plans (78.4 percent) than the Medicaid Plans (71.6 percent). *Rating of Health Care* was the lowest rated of all measures for the Medicaid Plans. The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

D. Rating of Health Plan is the percentage of members indicating overall satisfaction with the Health Plan (Chart 7). In 1999, the average Health Plan scores on this measure ranked higher for the Medicaid Plans (76.1 percent) than the Commercial Plans (65.3 percent). *Rating of Health Plan* was the lowest rated of all measures for the Commercial Plans. The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible. *Rating of Health Plan* was the lowest rated of all measures for the Medicare Plans.

CHART 7. 1999 Member Satisfaction Ratings



** Medicare Measures are Calculated Differently Than Commercial or Medicaid Measures*

With the Health Care Received | With the Health Plan Itself

E. Claims Processing is a composite rating of 2 questions involving the members' satisfaction with how efficiently their claims were handled. This measure is only applicable to Commercial Health Plans.

F. Getting Needed Care is a composite rating of 4 questions involving the members' satisfaction with how effectively they could access care. *Getting Needed Care* is one satisfaction measure (along with *Customer Service*), that is calculated the same way across produce lines so a comparison is possible. In 1999, Medicare Plans posted the highest average satisfaction (91.0 percent) followed by the Commercial Plans (84.4 percent) and the Medicaid Plans (75.9 percent). *Getting Needed Care* was the highest rated of all the measures for the Medicare Plans.

G. Getting Care Quickly is a composite rating of 4 questions involving the members' satisfaction with how quickly they could access care. In 1999, the average Health Plan scores on this measure ranked higher for the Commercial Plans (83.5 percent) than the Medicaid Plans (74.3 percent). The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

H. How Well Doctors Communicate is a composite rating of 4 questions involving the members' satisfaction with how their doctors communicated with them. On average, Commercial members were most satisfied on this measure (92.1 percent) than Medicaid members (87.1 percent). The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

I. Courteous and Helpful Office Staff is a composite rating of 2 questions relating to the members' satisfaction with how well the physicians' staff interacted with them. Again, Commercial members were most satisfied (93.5 percent) than Medicaid members (88.3 percent). *Courteous and Helpful Office Staff* was the highest rated of all the measures for the Commercial and Medicaid Plans. The Medicare Plans use a different methodology in calculating this measure so a comparison with the Commercial and Medicaid Plans is not possible.

J. Customer Service is a composite rating of 3 questions relating to the members' satisfaction with how well the Health Plans interacted with them. *Customer Service* is one satisfaction measure (along with *Getting Needed Care*), that is calculated the same way across produce lines so a comparison is possible. On average, there was no appreciable difference between the Medicare Plans (73.0 percent), the Medicaid Plans (72.2 percent) or the Commercial Plans (69.7 percent).

TABLE 7. 1999 MEMBER SATISFACTION SURVEY MEASURES[1]

	Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[2]				
1) Rating of Personal Doctor or Nurse	83.0%	76.5%	80.9%	
2) Rating of Specialist	85.2%	80.6%	80.5%	
3) Rating of Health Care	81.2%	75.6%	78.5%	
4) Rating of Health Plan	70.7%	59.2%	66.1%	
5) Claims Processing	88.1%	81.5%	84.0%	
6) Getting Needed Care	89.9%	79.8%	83.6%	
7) Getting Care Quickly	83.6%	83.4%	83.4%	
8) How Well Doctors Communicate	92.8%	90.9%	92.7%	
9) Courteous & Helpful Office Staff	94.9%	92.9%	92.7%	
10) Customer Service	70.7%	67.9%	70.4%	
B) MEDICARE HEALTH PLANS (SEE BELOW)				
C) MEDICAID HEALTH PLANS[2]				
1) Rating of Personal Doctor or Nurse			77.3%	80.0%
2) Rating of Specialist			80.8%	75.0%
3) Rating of Health Care			74.1%	69.0%
4) Rating of Health Plan			74.2%	78.0%
5) Claims Processing			n/a	n/a
6) Getting Needed Care			79.7%	72.0%
7) Getting Care Quickly			78.6%	70.0%
8) How Well Doctors Communicate			88.2%	86.0%
9) Courteous & Helpful Office Staff			89.5%	87.0%
10) Customer Service			80.4%	64.0%

B) MEDICARE HEALTH PLANS[2]	***NOTE: With the exceptions of #6 (Getting Needed Care) and #10 (Customer Service), Medicare scores are calculated differently than those for Commercial and Medicaid Health Plans, so it is not possible to make comparisons between Medicare and the other types of Health Plans***			
1) Rating of Personal Doctor or Nurse		68.0%	66.0%	
2) Rating of Specialist		68.0%	67.0%	
3) Rating of Health Care		64.0%	64.0%	
4) Rating of Health Plan		56.0%	59.0%	
5) Claims Processing		n/a	n/a	
6) Getting Needed Care		91.0%	91.0%	
7) Getting Care Quickly		71.0%	67.0%	
8) How Well Doctors Communicate		80.0%	75.0%	
9) Courteous & Helpful Office Staff		89.0%	87.0%	
10) Customer Service		70.0%	76.0%	

KEY:
[1] *Generally defined as the percentage of enrollees responding they are satisfied or very satisfied with the service(s) in each particular category*
[2] *Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)*
n/a Not Applicable (statistic was not required or not statistically significant)

X: Utilization Review Information

Utilization Review (UR) is the process Health Plans use to determine if services to members are medically necessary and appropriate. Most Health Plans will only pay for covered services if they are medically necessary and/or appropriate. This Section provides statistics for UR enrollees of Health Plans, who are defined as Rhode Island resident members or members who reside elsewhere and receive healthcare services in the state. The service categories are the same as those defined in Section III.

A. Prior Authorization Denials

Some Health Plans require members to get prior authorization for covered services before they will pay for them. If a Plan determines the service is not medically necessary, it will deny the request (Chart 8 & Table 8). Health Plans employ a variety of delivery models and benefits designs, so caution should be used when making comparisons between Plans for *Prior Authorization Denial* data. For example, one Plan may require notification of all physician services while another Plan may only require notification of certain physician services. In both cases, these notifications constitute a request for service. Therefore, while the population based rates[30] of *Prior Authorization Denials* may be the same for these two Health Plans, the number of requests and the percentage of those requests denied at each Plan may be quite different.

Commercial Plans: In 1999, the total requests (including all service categories) for prior authorizations decreased 23 percent (59,491 to 45,847) while the percentage of those requests that were denied remained steady at 0.9 percent. During that same period, RI Commercial enrollment increased from 600,438 members in 1998 to 641,347 members in 1999 (+7 percent).

Requests for hospital services declined 33 percent (13,449 to 8,950) while the percentage of those denied increased 29 percent (1.1 to 1.4 percent). Requests for physician services decreased 42 percent (2,498 to 1,448) but the percentage of those denied increased 251 percent (1.6 to 5.6 percent). Requests for other professional services decreased 76 percent (24,357 to 5,907) while the percentage denied increased 27 percent (0.6 to 0.8 percent). Requests for pharmaceuticals increased 139 percent (2,053 to 4,914) but the percentage denied decreased 92 percent (1.7 to 0.1 percent). Requests for substance abuse services increased 16 percent (2,345 to 2,720) and the percentage of those denied decreased 13 percent (2.2 to 1.9 percent). Requests for mental health services increased 45 percent (14,270 to 20,754) but the denial rate decreased 52 percent (0.5 to 0.2 percent).

Medicare Plans: In 1999, the total requests (including all service categories) for prior authorizations increased 16 percent (24,411 to 28,384) while the percentage of those requests that were denied decreased 33 percent (1.6 to 1.1 percent). During that same period, RI Medicare enrollment increased from 43,684 members in 1998 to 52,180 members in 1999 (+19 percent).

Requests for hospital services increased 10 percent (4,085 to 4,481) while the percentage of those denied decreased 59 percent (6.1 to 2.5 percent). Requests for physician services decreased 90 percent (9,063 to 865) but the percentage of those denied increased from 0.1 percent to 2.8 percent. Requests for other professional

services increased 86 percent (8,045 to 14,974) and the percentage denied increased 261 percent (0.2 to 0.7 percent). Requests for pharmaceuticals increased from 45 to 1,108 requests and the percentage denied went from 0 percent in 1998 to 0.5 percent in 1999. Requests for substance abuse services increased 350 percent (213 to 959) but the denial rate remained at 0.0 percent. Requests for mental health services increased 82 percent (2,271 to 4,125) but the denial rate also remained at 0.0 percent.

Medicaid Plans: In 1999, the total requests (including all service categories) for prior authorizations increased 17 percent (30,971 to 36,144) but the percentage of those requests that were denied fell 62 percent (0.3 to 0.1 percent). During that same period, RI Medicaid enrollment increased from 75,845 members in 1998 to 79,155 members in 1999 (+4 percent).

Requests for hospital services increased 42 percent (1,192 to 1,688) but the denial rate fell 95 percent (4.9 to 0.2 percent). Requests for physician services increased 40 percent (12,399 to 17,418) but the percentage of those denied remained at 0.0 percent. Requests for other professional services increased 4 percent (7,298 to 7,556) and the percentage of those denied increased 112 percent (0.1 to 0.2 percent). Requests for pharmaceuticals jumped 188 percent (349 to 1,005) and the denial rate increased 9 percent (1.1 to 1.2 percent). Requests for substance abuse services decreased 24 percent (713 to 544) and the percentage of those denied declined 89 percent (3.4 to 0.4 percent). Lastly, requests for mental health services decreased 12 percent (8,762 to 7,740) but the percentage of those denied increased from 0.0 percent in 1998 to 0.1 percent in 1999.

CHART 8. Prior Authorization Denials (% Denied)

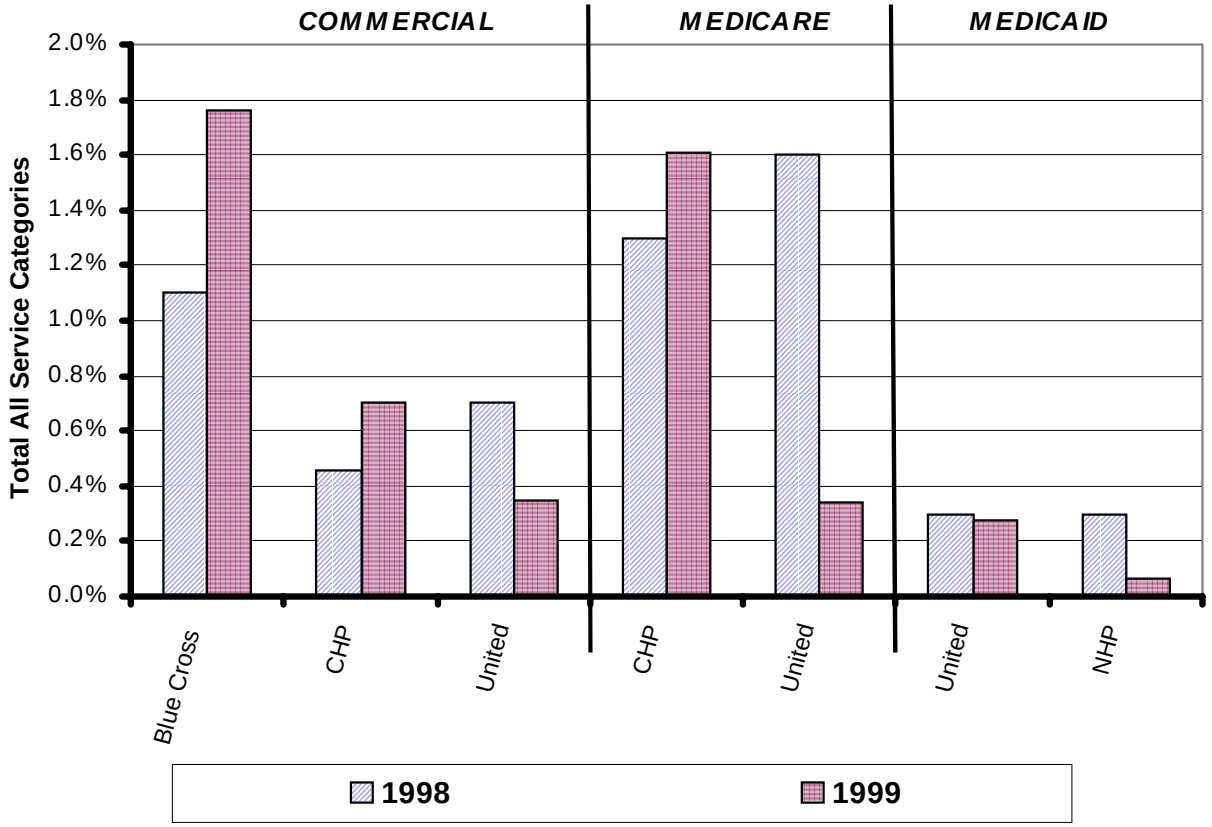


TABLE 8. 1999 PRIOR AUTHORIZATION DENIALS[1]

			Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[2]						
1)	Hospital	# of Requests:	4.112	659	4.179	
		% Denied:	1.8%	2.9%	0.8%	
2)	Physician	# of Requests:	505	87	851	
		% Denied:	14.1%	6.9%	0.5%	
3)	Other Professional	# of Requests:	2.894	407	2.606	
		% Denied:	0.2%	0.2%	1.4%	
4)	Pharmaceuticals	# of Requests:	93	14	4.807	
		% Denied:	6.5%	7.1%	0.0%	
5)	Substance Abuse	# of Requests:	1.488	636	596	
		% Denied:	3.3%	0.2%	0.3%	
6)	Mental Health	# of Requests:	6.400	3.830	10.524	
		% Denied:	0.7%	0.0%	0.1%	
7)	Health Education	# of Requests:	0	0	0	
		% Denied:	n/a	n/a	n/a	
8)	Total (All)	# of Requests:	16.442	5.842	23.563	
		% Denied:	1.8%	0.7%	0.3%	
B) MEDICARE HEALTH PLANS[2]						
1)	Hospital	# of Requests:		1.867	2.614	
		% Denied:		5.6%	0.3%	
2)	Physician	# of Requests:		216	649	
		% Denied:		8.8%	0.8%	
3)	Other Professional	# of Requests:		8.476	6.498	
		% Denied:		1.0%	0.4%	
4)	Pharmaceuticals	# of Requests:		28	1.080	
		% Denied:		17.9%	0.0%	
5)	Substance Abuse	# of Requests:		932	27	
		% Denied:		0.0%	0.0%	
6)	Mental Health	# of Requests:		3.175	950	
		% Denied:		0.0%	0.1%	
7)	Health Education	# of Requests:		0	0	
		% Denied:		n/a	n/a	
8)	Total (All)	# of Requests:		16.566	11.818	
		% Denied:		1.6%	0.3%	
C) MEDICAID HEALTH PLANS[2]						
1)	Hospital	# of Requests:			796	892
		% Denied:			0.5%	0.0%
2)	Physician	# of Requests:			81	17.337
		% Denied:			2.5%	0.0%
3)	Other Professional	# of Requests:			557	6.999
		% Denied:			2.0%	0.1%
4)	Pharmaceuticals	# of Requests:			878	127
		% Denied:			0.0%	9.4%
5)	Substance Abuse	# of Requests:			422	122
		% Denied:			0.5%	0.0%
6)	Mental Health	# of Requests:			5.648	2.092
		% Denied:			0.1%	0.0%
7)	Health Education	# of Requests:			0	193
		% Denied:			n/a	0.0%
8)	Total (All)	# of Requests:			8.382	27.762
		% Denied:			0.3%	0.1%

KEY:
[1] A Health Plan denies a request for a covered service because it deems it not medically necessary
[2] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/a Not Applicable (statistic was not required or not statistically significant)

B. Adverse Decisions

A decision by a Health Plan not to pay for a covered service it deems is not medically necessary or appropriate is called an adverse decision (Chart 9 & Table 9). Unlike Prior Authorizations (above), these decisions are made concurrently with or retrospectively to treatment. Health Plans employ a variety of delivery models and benefits designs, so caution should be used when making comparisons between Plans for *Adverse Decisions* data. For example, one Plan may require notification of all physician services while another Plan may only require notification of certain physician services. In both cases, these notifications constitute a request for service. Therefore, while the population based rates[28] of *Adverse Decisions* may be the same for these two Health Plans, the number of requests and the percentage of those requests denied at each Plan may be quite different.

Commercial Plans: In 1999, the total requests for payment for services (including all service categories) decreased 13 percent (135,989 to 118,705) and the percentage of those requests that were denied fell 32 percent (1.8 to 1.2 percent). During that same period, RI Commercial enrollment increased from 600,438 members in 1998 to 641,347 members in 1999 (+7 percent).

Requests for payment for hospital services remained steady at 53,000, but the percentage that were denied fell 20 percent (3.0 to 2.4 percent). Requests for payment for physician services decreased 68 percent (2,733 to 874) but the percentage of those denied increased 276 percent (0.7 to 2.6 percent). Requests for payment for other professional services decreased 10 percent (7,824 to 7,007) and the percentage of those denied decreased 63 percent (0.5 to 0.2 percent). Requests for payment for pharmaceuticals decreased 77 percent (15,538 to 3,528) and the percentage denied decreased 63 percent (3.8 to 1.4 percent). Requests for payment for substance abuse services increased 7 percent (4,737 to 5,068) but the percentage of those denied decreased 33 percent (0.8 to 0.5 percent). Requests for payment for mental health services decreased 7 percent (52,220 to 48,752) and the percentage denied decreased 47 percent (0.2 to 0.1 percent).

Medicare Plans: In 1999, the total requests for payment for services (including all service categories) decreased 31 percent (43,958 to 30,527) but the percentage of those requests that were denied increased 51 percent (1.1 to 1.7 percent). During that same period, RI Medicare enrollment increased from 43,684 members in 1998 to 52,180 members in 1999 (+19 percent).

Requests for payment for hospital services grew 34 percent (14,431 to 19,298) and the percentage denied increased 37 percent (1.8 to 2.5 percent). Requests for payment for physician services decreased 96 percent (11,587 to 463) but the percentage denied remained at 0.0 percent. Requests for payment for other professional services decreased 13 percent (9,493 to 8,236) but the percentage of those denied increased 27 percent (0.2 to 0.3 percent). Requests for payment for pharmaceuticals decreased 99 percent (4,779 to 59) and the percentage of those denied decreased from 1.9 to 0.0 percent. Requests for payment for substance abuse services decreased 29 percent (206 to 146) but the percentage of those denied increased from 0.0 to 0.7 percent. Requests for payment for mental health services decreased 11 percent (2,584 to 2,292) but the denial rate increased from 0.0 to 0.2 percent.

Medicaid Plans: In 1999, the total requests for payment for services (including all service categories) decreased 1 percent (64,098 to 63,530) and the percentage of those requests that were denied decreased 98 percent (4.1 to 0.1 percent). During that same period, RI Medicaid enrollment increased from 75,845 members in 1998 to 79,155 members in 1999 (+4 percent).

Requests for payment for hospital services increased 18 percent (44,552 to 52,643) but the percentage denied decreased from 5.8 to just over 0.0 percent. Requests for payment for physician services decreased 98 percent (6,091 to 106) but the percentage denied remained at 0.0 percent. Requests for payment for other professional services decreased 67 percent (4,923 to 1,615) but the percentage denied increased from 0.0 to 0.2 percent. Requests for payment for pharmaceuticals decreased from 1,706 in 1998 with a denial rate of 3.9 percent to 0 requests in 1999. Requests for payment for substance abuse services increased 229 percent (613 to 2,017) but the percentage of those denied decreased 17percent (0.3 to 0.2 percent). Requests for payment for mental health services increased 15 percent (6,209 to 7,144) and the denial rate increased 68 percent (0.2 to 0.3 percent).

CHART 9. Adverse Decisions (% Denied)

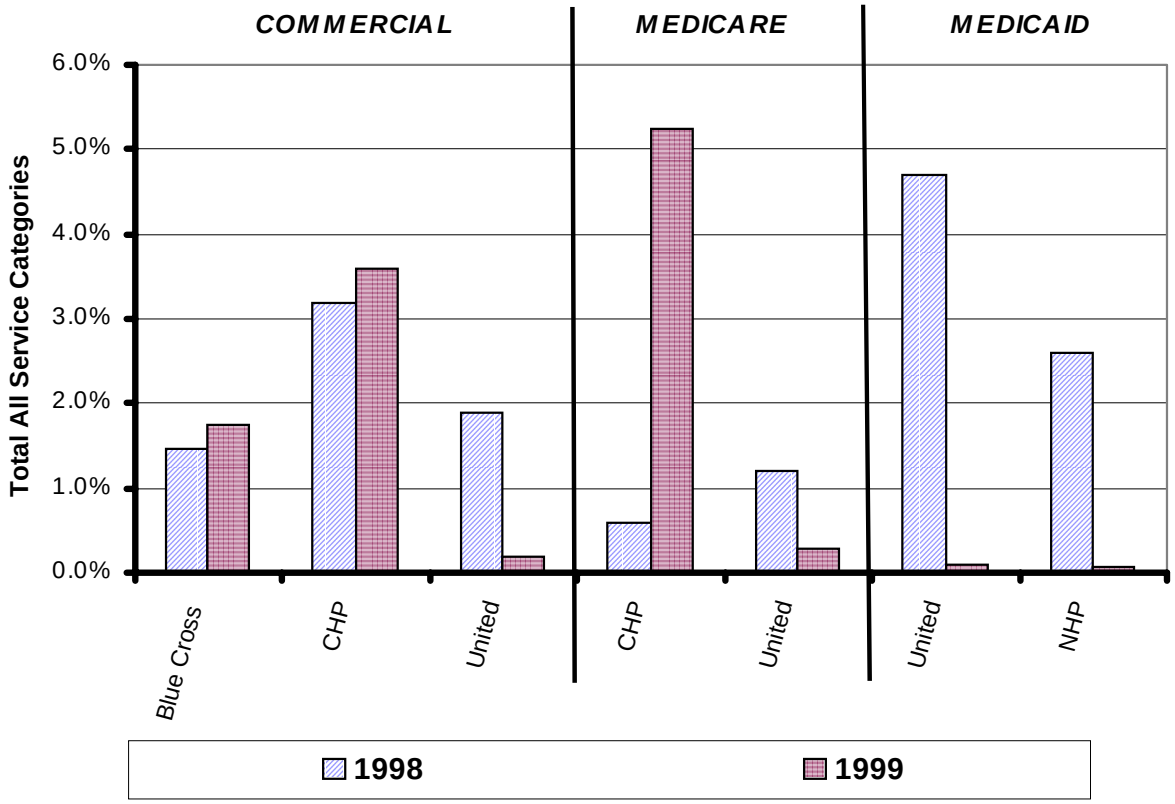


TABLE 9. 1999 ADVERSE DECISIONS[1]

			Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[2]						
1)	Hospital	# of Requests:	13.201	5.870	33.795	
		% Denied:	6.8%	5.9%	0.1%	
2)	Physician	# of Requests:	279	2	593	
		% Denied:	7.9%	50.0%	0.0%	
3)	Other Professional	# of Requests:	2.725	262	4.020	
		% Denied:	0.3%	0.8%	0.1%	
4)	Pharmaceuticals	# of Requests:	96	66	3.366	
		% Denied:	0.0%	0.0%	1.5%	
5)	Substance Abuse	# of Requests:	3.264	467	1.337	
		% Denied:	0.7%	0.2%	0.3%	
6)	Mental Health	# of Requests:	37.009	3.303	8.440	
		% Denied:	0.1%	0.2%	0.2%	
7)	Health Education	# of Requests:	0	0	0	
		% Denied:	n/a	n/a	n/a	
8)	Total (All)	# of Requests:	57.167	9.987	51.551	
		% Denied:	1.8%	3.6%	0.2%	
B) MEDICARE HEALTH PLANS[2]						
1)	Hospital	# of Requests:		7.040	12.258	
		% Denied:		6.0%	0.4%	
2)	Physician	# of Requests:		20	443	
		% Denied:		0.0%	0.0%	
3)	Other Professional	# of Requests:		142	8.094	
		% Denied:		11.3%	0.1%	
4)	Pharmaceuticals	# of Requests:		59	0	
		% Denied:		0.0%	n/a	
5)	Substance Abuse	# of Requests:		66	80	
		% Denied:		0.0%	1.3%	
6)	Mental Health	# of Requests:		1.158	1.134	
		% Denied:		0.2%	0.2%	
7)	Health Education	# of Requests:		0	0	
		% Denied:		n/a	n/a	
8)	Total (All)	# of Requests:		8.518	22.009	
		% Denied:		5.2%	0.3%	
C) MEDICAID HEALTH PLANS[2]						
1)	Hospital	# of Requests:			33.869	18.774
		% Denied:			0.0%	0.1%
2)	Physician	# of Requests:			106	0
		% Denied:			0.0%	n/a
3)	Other Professional	# of Requests:			1.615	0
		% Denied:			0.2%	n/a
4)	Pharmaceuticals	# of Requests:			0	0
		% Denied:			n/a	n/a
5)	Substance Abuse	# of Requests:			1.781	236
		% Denied:			0.3%	0.0%
6)	Mental Health	# of Requests:			3.918	3.226
		% Denied:			0.6%	0.0%
7)	Health Education	# of Requests:			0	0
		% Denied:			n/a	n/a
8)	Total (All)	# of Requests:			41.289	22.241
		% Denied:			0.1%	0.1%

KEY:
[1] A Health Plan does not pay for a covered service because it deems it not medically necessary
[2] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/a Not Applicable (statistic was not required or not statistically significant)

C. Appeals

When a Health Plan determines a covered service is not medically necessary or appropriate and denies payment, a member may appeal that decision according to state law. When such an appeal is overturned (Chart 10 & Table 10), it means that the original decision to deny payment was reversed (i.e., the appeal was successful on the part of the member).

Commercial Plans: In 1999, the total appeals (for all service categories) decreased 43 percent (1,209 to 689) and the percentage of those appeals that were overturned decreased 34 percent (51.0 to 33.5 percent). During that same period, RI Commercial enrollment increased from 600,438 members in 1998 to 641,347 members in 1999 (+7 percent).

Appeals for hospital services fell 59 percent (806 to 332) and the percentage overturned fell 47 percent (57.7 to 30.7 percent). Appeals for physician services increased 55 percent (58 to 90) but the percentage overturned decreased 39 percent (34.5 to 21.1 percent). Appeals for other professional services decreased 65 percent (57 to 20) but the percentage of those overturned increased 35 percent (33.3 to 45.0 percent). Appeals for pharmaceuticals increased 100 percent (6 to 12) and the percentage of those overturned increased 150 percent (16.7 to 41.7 percent). Appeals for substance abuse services decreased 6 percent (80 to 75) while the percentage overturned increased 47 percent (36.3 to 53.3 percent). Appeals for mental health services decreased 30 percent (179 to 126) and the percentage of those overturned also decreased 13 percent (43.0 to 37.3 percent).

Medicare Plans: In 1999, the total appeals (for all service categories) increased from 16 to 221 and the percentage of those appeals that were overturned increased 3 percent (37.5 to 38.5 percent). During that same period, RI Medicare enrollment increased from 43,684 members in 1998 to 52,180 members in 1999 (+19 percent).

Appeals for hospital services increased from 1 (which was overturned) to 101 (with an overturned rate of 19.8 percent). Appeals for physician services increased from 0 to 19 (with an overturned rate of 10.5 percent). Appeals for other professional services increased from 2 (none overturned) to 20 (45.0 percent overturned). Appeals for pharmaceuticals increased from 0 to 18 (with 100 percent overturned). Appeals for substance abuse services remained at 0, and appeals for mental health services increased from 0 to 1 (which was not overturned).

Medicaid Plans: In 1999, the total appeals (for all service categories) decreased 76 percent (248 to 59) and the percentage of those appeals that were overturned decreased 27 percent (56.0 to 40.7 percent). During that same period, RI Medicaid enrollment increased from 75,845 members in 1998 to 79,155 members in 1999 (+4 percent).

Appeals for hospital services fell 97 percent (214 to 7) and the percentage overturned fell 53 percent (61.2 to 28.6 percent). Appeals for physician services increased from 0 to 6 (with none overturned). Appeals for other professional services decreased 56 percent (9 to 4) but the percentage of those overturned increased from 0.0 percent to 50.0 percent. Appeals for pharmaceuticals decreased 44 percent (9 to 5) but the

percentage of those overturned increased from 0 percent to 60.0 percent. Appeals for substance abuse services decreased from 11 (the 1998 overturned rate was not available) to 6 (with 33.3 percent overturned). Appeals for mental health services increased 182 percent (11 to 31) and the percentage overturned also increased 6 percent (45.5 to 48.4 percent).

CHART 10. Successful Appeals (% Overturned)

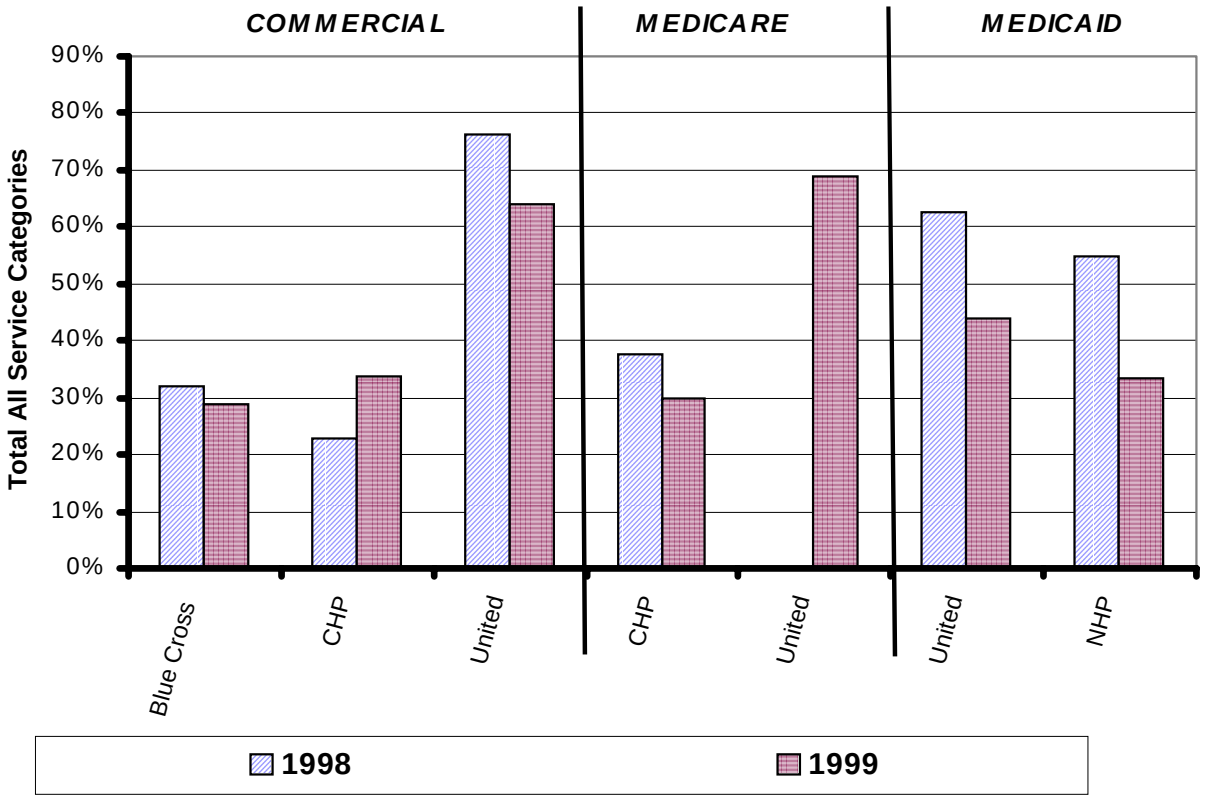


TABLE 10. 1999 APPEALS OVERTURNED[1]

			Blue Cross RI	Coordinated Health Partners	United Healthcare NE	Neighbor-hood Health Plan RI
A) COMMERCIAL HEALTH PLANS[2]						
1)	Hospital	# of Appeals:	202	96	34	
		% Overturned:	16.8%	40.6%	85.3%	
2)	Physician	# of Appeals:	68	16	6	
		% Overturned:	20.6%	18.8%	33.3%	
3)	Other Professional	# of Appeals:	14	0	6	
		% Overturned:	50.0%	n/a	33.3%	
4)	Pharmaceuticals	# of Appeals:	12	0	0	
		% Overturned:	41.7%	n/a	n/a	
5)	Substance Abuse	# of Appeals:	67	0	8	
		% Overturned:	55.2%	n/a	37.5%	
6)	Mental Health	# of Appeals:	101	6	19	
		% Overturned:	36.6%	0.0%	52.6%	
7)	Health Education	# of Appeals:	0	0	0	
		% Overturned:	n/a	n/a	n/a	
8)	Total (All)	# of Appeals:	486	128	75	
		% Overturned:	28.8%	33.6%	64.0%	
B) MEDICARE HEALTH PLANS[2]						
1)	Hospital	# of Appeals:		93	8	
		% Overturned:		15.1%	75.0%	
2)	Physician	# of Appeals:		19	0	
		% Overturned:		10.5%	n/a	
3)	Other Professional	# of Appeals:		11	9	
		% Overturned:		36.4%	55.6%	
4)	Pharmaceuticals	# of Appeals:		18	0	
		% Overturned:		100.0%	n/a	
5)	Substance Abuse	# of Appeals:		0	0	
		% Overturned:		n/a	n/a	
6)	Mental Health	# of Appeals:		1	0	
		% Overturned:		0.0%	n/a	
7)	Health Education	# of Appeals:		0	0	
		% Overturned:		n/a	n/a	
8)	Total (All)	# of Appeals:		173	48	
		% Overturned:		30.1%	68.8%	
C) MEDICAID HEALTH PLANS[2]						
1)	Hospital	# of Appeals:			4	3
		% Overturned:			25.0%	33.3%
2)	Physician	# of Appeals:			0	6
		% Overturned:			n/a	0.0%
3)	Other Professional	# of Appeals:			4	0
		% Overturned:			50.0%	n/a
4)	Pharmaceuticals	# of Appeals:			0	5
		% Overturned:			n/a	60.0%
5)	Substance Abuse	# of Appeals:			5	1
		% Overturned:			40.0%	0.0%
6)	Mental Health	# of Appeals:			28	3
		% Overturned:			46.4%	66.7%
7)	Health Education	# of Appeals:			0	0
		% Overturned:			n/a	n/a
8)	Total (All)	# of Appeals:			41	18
		% Overturned:			43.9%	33.3%

KEY:
[1] A Health Plan approves payment for a covered service as a result of a review of an appeal
[2] Health Plans w/10,000 or more RI (equivalent) members only (except for Harvard Pilgrim Health Care of NE which did not file and ceased RI operations in 1999 with ~107,000 estimated RI Commercial members)
n/a Not Applicable (statistic was not required or not statistically significant)

XI: Benchmarks -How Did RI Compare?

Benchmarks are reference points to evaluate a measure compared to a peer group (or to a desired level of performance). Included here is a comparison of RI **Commercial**[31] Health Plans with their national and regional peers in 1999 (Table 11).

A. Effectiveness of Care Measures

RI Health Plans compared favorably to the national experience on the 5 effectiveness of care measures but somewhat less favorably when compared to the regional group. On all of these statistics, higher comparative values are preferred. Even though RI's comparative performance on these measures was favorable, it was far from acceptable. Given the importance of these public health indicators, professionals in the field would view rates approaching 100 percent as optimal.

RI's *Childhood Immunization Status* rate of 71.1 percent was 8 percent above the national rate (65.5 percent), but 6 percent less than New England's rate (75.8 percent). The *Adolescent Immunization Status* rate (45.9 percent) was 48 percent greater than the US rate (31 percent) and 5 percent greater than the New England rate (43.9 percent). *Cholesterol Management* (77.4 percent) was 11 percent above the US statistic (69.6 percent) but equivalent to the regional experience (76.3 percent). *Beta Blocker After a Heart Attack* (87.5 percent) was not appreciably different from the US rate (84.9 percent) or the regional rate (91.2 percent). Finally, the *Comprehensive Diabetes Care (Eye Exam)* measure (49.5 percent) was 9 percent above the US rate (45.4 percent), but 13 percent less than the New England rate (57.1 percent).

B. Health Plan Stability Measures

In general, RI Health Plans compared favorably on the 2 stability measures. For these statistics, lower comparative values are preferred.

RI's *Disenrollment* rate of 27.1 percent was equivalent to the national rate (27.4 percent), but 9 percent higher than the New England rate (24.9 percent). The *Primary Care Practitioner Turnover* rate of 4.5 percent was 44 percent lower than the US rate (8.0 percent) and 27 percent lower than the regional rate (6.1 percent).

C. Access/Availability of Care Measures

On every one of the measures, RI Health Plans exceeded and/or matched the national and regional experience of other Health Plans. Higher comparative values in this domain are preferred.

RI's *Children's Access to Primary Care Practitioners* rates were equivalent to the national rate for the 12 through 24 months age group, 10 percent greater for the 25 months through 6 years age group, and 11 percent greater for ages 7 through 11 years. RI Plans were not significantly different from their regional counterparts on this measure. RI's *Adult's Access to Preventive ambulatory Services* rates were essentially similar to both the national and regional rates for all age groups.

D. Use of Services Measures

With the exception of inpatient admissions, RI Health Plan members generally used more health services than their national or regional counterparts. However, neither higher nor lower comparative values in this domain are necessarily preferred. Greater healthcare utilization is no more favorable than less healthcare utilization (as long as all members are accessing needed services).

RI's *Hospital Discharges per 1,000 Members* rate of 44.2 was 16 percent less than the national rate (52.8) and 5 percent less than the New England rate (46.5). However, the *Average Length of Stay* in RI (4.2 days) was 16 percent greater than the national experience (3.6 days) and 10 percent greater than the New England experience (3.8 days). RI's *ER Visits per 1,000 Members* rate (172.0) was 18 percent higher than the national rate (145.7) and 13 percent higher than the regional rate (152.5). *Mental Health Utilization* in RI (7.2 percent) was 72 percent higher than the US rate (4.2 percent) and 11 percent higher than the New England rate (6.5 percent). Lastly, *Chemical Dependency Utilization* (0.6 percent) was 112 percent greater than in the US (0.3 percent) and 59 percent greater than in New England (0.4 percent).

E. Member Satisfaction Survey Measures

RI Commercial Health Plans bested, or tied, their national and New England peers on every satisfaction measure. For the indicators in this domain, higher comparative values are preferred.

RI's *Rating of Personal Doctor or Nurse* satisfaction rate of 80.1 percent, was 10 percent above the national rate (72.7 percent) and 8 percent above the regional rate (74.2 percent). The *Rating of Specialist* in RI (82.1 percent), was 9 percent above the US rate (75.1 percent) and 6 percent above the New England rate (77.4 percent). RI's *Rating of Health Care* (78.4 percent), was 11 percent above the national rate (70.4 percent) and equivalent to the regional rate (75.3 percent). RI's *Rating of Health Plan* (65.3 percent), the lowest rated of all the measures, still exceeded the US rate (56.0 percent) by 17 percent, and exceeded the regional rate (57.8 percent) by 13 percent. RI's rating of *Claims Processing* (84.5 percent), was 9 percent above the national rate (77.8 percent) and 7 percent above the regional rate (78.7 percent). The rating for *Getting Needed Care* in RI (84.4 percent), was 13 percent above the US rate (74.5 percent) and 8 percent above the New England rate (78.1 percent). RI's rating for *Getting Care Quickly* (83.5 percent), was 6 percent above the national rate (78.6 percent) and similar to the regional rate (83.1 percent). RI's rating for *How Well Doctors Communicate* (92.1 percent) was not significantly different from the US rate (89.5 percent) or the New England rate (91.9 percent). RI's rating for *Courteous & Helpful Office Staff* (93.5 percent), was also similar to the national rate (91.3 percent) and regional England rate (93.5 percent). Finally, RI's rating for *Customer Service* (69.7 percent), was 9 percent above both the national rate (63.8 percent) and the regional rate (64.2 percent).

TABLE 11. 1999 COMMERCIAL HEALTH PLAN BENCHMARK COMPARISONS				
	Rhode Island Weighted Averages[2]	HEALTH PLAN AVERAGES[1]		
		Rhode Island	United States	New England
A. EFFECTIVENESS OF CARE MEASURES				
1) Childhood Immunization Status	72.5%	71.1%	65.5%	75.8%
2) Adolescent Immunization Status	47.9%	45.9%	31.0%	43.9%
3) Cholesterol Management	77.6%	77.4%	69.6%	76.3%
4) Controlling High Blood Pressure	47.3%	43.6%	n/a	n/a
5) Beta Blocker Treatment After a Heart Attack	89.2%	87.5%	84.9%	91.2%
6) Comprehensive Diabetes Care (Eye Exam)	48.1%	49.5%	45.4%	57.1%
B. HEALTH PLAN STABILITY MEASURES				
1) Disenrollment	22.5%	27.1%	27.4%	24.9%
2) Primary Care Practitioner Turnover	3.1%	4.5%	8.0%	6.1%
C. ACCESS/AVAILABILITY OF CARE MEASURES				
Children's Access to Primary Care Practitioners:				
1) Age 12 Through 24 mos.	95.7%	96.3%	92.4%	96.4%
2) Age 25 mos. Through 6 yrs.	90.8%	91.0%	82.8%	90.3%
3) Age 7 Through 11 yrs.	91.8%	92.4%	83.5%	91.6%
Adult's Access to Preventive Ambulatory Services:				
4) Age 20 Through 44 yrs.	93.8%	93.7%	89.7%	92.3%
5) Age 45 Through 64 yrs.	94.6%	95.2%	92.2%	93.7%
6) Age 65+	91.3%	94.0%	92.9%	94.3%
D. USE OF SERVICES MEASURES				
1) Hospital Discharges per 1,000 Members	44.6	44.2	52.8	46.5
2) Average Length of Stay	4.2	4.2	3.6	3.8
3) ER Visits per 1,000 Members	195.7	172.0	145.7	152.5
4) Mental Health Utilization	7.9%	7.2%	4.2%	6.5%
5) Chemical Dependency Utilization	0.7%	0.6%	0.3%	0.4%
E. MEMBER SATISFACTION SURVEY MEASURES				
1) Rating of Personal Doctor or Nurse	82.0%	80.1%	72.7%	74.2%
2) Rating of Specialist	83.8%	82.1%	75.1%	77.4%
3) Rating of Health Care	80.1%	78.4%	70.4%	75.3%
4) Rating of Health Plan	68.7%	65.3%	56.0%	57.8%
5) Claims Processing	86.7%	84.5%	77.8%	78.7%
6) Getting Needed Care	87.7%	84.4%	74.5%	78.1%
7) Getting Care Quickly	83.5%	83.5%	78.6%	83.1%
8) How Well Doctors Communicate	92.6%	92.1%	89.5%	91.9%
9) Courteous & Helpful Office Staff	94.3%	93.5%	91.3%	93.5%
10) Customer Service	70.4%	69.7%	63.8%	64.2%

KEY:

[1] Comparative statistics are simple averages for Commercial Health Plans, source of US and NE data is NCQA's 'Quality Compass 2000'

[2] Weighted averages (based on RI enrollment) for RI Commercial Health Plans

n/a National and regional benchmmarks are not available

Endnotes:

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[1] *Includes full-service Health Plans with 10,000 or more RI members, excludes: all single-service Health Plans (i.e., vision and dental) and the following full-service Health Plans: Harvard Pilgrim Health Care of NE (ceased operations in RI in 1999 with ~107,000 estimated RI Commercial members), Tufts Health Plan of NE (ceased operations in RI in 1999 with 7,545 RI Commercial members and 86 RI Medicare members), Blue Cross –MA (7,253 RI Commercial members), Aetna US Healthcare (2,656 RI Commercial members), Aetna Life Insurance Company (525 RI Commercial members), Connecticut General Life Insurance Company (<1,800 estimated RI Commercial members), and Coordinated Health Partners (5,049 RI Medicaid members)*

[2] *The HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT of 1996 (RIGL 23-17.13) also provides for the certification of all RI Health Plans, the credentialing of network providers in a Plan, due cause process for appealing adverse changes for non-institutional Plan providers, and disclosure on members' appeals rights, coverage provisions, financial arrangements and the like.*

[3] *A Health Plan is defined in RIGL 23-17.13-2, as a plan operated by a health care entity, that provides for the delivery of care services to persons enrolled in such plan through: arrangements with selected providers to furnish health care services; and/or financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. The functional definition of a Health Plan is along product lines (e.g., the entity ABC Insurance Company may operate 4 Health Plans consisting of 2 Commercial Plans, 1 Medicare Plan and 1 Medicaid Plan)*

[4] *Bruce Cryan, #407, 3 Capitol Hill, Providence, RI 02908, (401) 222-5123, (401) 273-4350 fax, brucec@doh.state.ri.us*

[5] *Linda Johnson, Chief, #410, 3 Capitol Hill, Providence, RI 02908, (401) 222-6015*

[6] *Refers to Medicare managed care products, not to traditional Medicare fee-for-service*

[7] *Generally the measures derived from sampling have a margin of error of +-5 percent*

[8] *United Healthcare –NE, Coordinated Health Partners, and Neighborhood Health Plan –RI*

[9] *Blue Cross –RI*

[10] *With the exception of ER Visits per 1,000 Members, Blue Cross –RI, a PPO, scored very favorably on performance measures that could be directly influenced by whether the Plan is a HMO or a PPO.*

[11] *Extrapolation of 1999 Quarterly filing with the Office of Managed Care Regulation in HEALTH*

[12] *see [1] above*

[13] *When 1998 data are reported on a state-wide or aggregate level, they are calculated to only include those Plans that also reported (and are included here) for 1999 (to allow for a valid year-to-year comparison).*

[14] *This statistic is calculated by dividing the RI Resident Member Months by 12.*

[15] *Coordinated Health Partners is a wholly owned, for-profit subsidiary of Blue Cross Blue Shield of Rhode Island*

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[16] *This statistic is calculated by dividing the Total Member Months by 12.*

[17] *This is an average amount of all premiums collected and, therefore, not equivalent to what one particular member pays for coverage.*

[18] *Blue Cross and Blue Shield of RI is a not-for-profit corporation and technically does not identify its net income as 'profit', however, the 'profit margin' is the standardized measure (with the same calculation) used by industry analysts (e.g., A.M. Best Company) to report the profitability of any health plan, regardless of tax-status*

[19] *Per member per month (PMPM) reporting is a standardized way to present Health Plan expenses on a comparative basis.*

[20] *HEDIS (Health Plan Employer Data and Information Set) is the most widely used set of performance measures in the managed care industry. HEDIS was developed and maintained by the National Committee for Quality Assurance (NCQA), a non-profit organization for assessing, reporting on and improving the quality of care provided by organized delivery systems*

[21] *Childhood Immunization Status, Adolescent Immunization Status, and Beta Blocker Treatment After a Heart attack*

[22] *Immunizations include: four DPT or DtaP vaccinations and three OPV or IPV vaccinations and one MMR and two HiB vaccinations, and three hepatitis B vaccinations*

[23] *Immunizations include: the second MMR and three hepatitis B vaccinations*

[24] *For children age 7 through 11 years this measure counts visits within the past 2 years.*

[25] *For Medicaid and Medicare enrollees this measure counts visits within the past 1 year.*

[26] *For Medicaid Plans only, HEDIS calculates the statistic as the rate per 1,000 Member Months. However, for ease of comparison with the Commercial and Medicare Plans, it is reported it as the rate per 1,000 Members. To convert the statistic one multiplies the rate per 1,000 Member Months by 12.*

[27] *see [25] above*

[28] *see [25] above*

[29] *CAHPS (Consumer Assessment of Health Plans) are a set of standardized surveys assessing patient satisfaction. CAHPS is sponsored by the Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research) which worked in conjunction with the NCQA to develop the assessment tools.*

[30] *Population based rates cannot be calculated because the denominator, a subset of total enrollment based on RI members and others who access care in RI, is unknown*

[31] *Medicare and Medicaid benchmarks are not available*