Independence
Blue Cross

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Marc P. Volavka
Executive Director
Pennsylvania Health Care Cost Containment Council
Suite 400
225 Market Street
Harrisburg PA 17101

Dear Mr. Volavka:

Independence Blue Cross is pleased to continue working with the Pennsylvania Health Care Cost Containment Council in support of public reporting of meaningful performance data on health care in Pennsylvania. In particular we are pleased to participate in the publication of this report, *Measuring the Quality of Pennsylvania's HMOs* and we thank the Council for the opportunity to comment.

This report is a commendable beginning toward providing the public with information on health plan performance. However, we would like to clarify some information in the report, and offer some observations on how to interpret various performance indicators.

First, we want to clarify the financial data reported for Keystone Health Plan East in the document. We recognize that this information was obtained from information filed with the Pennsylvania Insurance Department. The information provided to the Council by the Insurance Department was from the Comprehensive columns, which did not allocate certain amounts (e.g. taxes and investment income) by product line. Therefore, we need to restate these data in order to present a clearer set of financial indicators for the commercial product line for Keystone Health Plan East. We have calculated the financial information for 1998, allocating monies appropriately across product line, and these calculations are consistent with the data in the annual filing with the Insurance Department. The restated financial information for KHPE's total commercial book of business (which excludes our Medicare and Medicaid members) in 1998 is as follows: Total Revenue: $801,771,211; Profit After Taxes: $25,854,868; Percent of Premium Revenue Spent on Health Care: 78.7%. The difference between these restated amounts and those shown on the insurance blank (NAIC filing), and used by the Council in its report, is due to the fact that Net Investment Income (line 4) and Provision for Federal Income Taxes (line 26) for all lines of business were included in the Council's numbers, and the restated numbers contain the appropriate allocation for the commercial product line. We are pleased to be able to offer this clarification, and note that the Council's report highlights the difficulty of interpreting complex financial data, particularly when only selected measures are used.

Our second set of comments pertains to the data on clinical and service indicators. We applaud the Council's desire to stimulate a quality improvement dialogue, and generally agree with the caveats and comments made by the Council in the introduction to the report. Specifically, we agree that caution is required in interpreting the data; that a plan's results in the specific areas addressed by this report cannot be used to generalize about the overall quality of services in a plan or for other clinical areas; and that for a number of reasons comparisons among HMOs may be problematic. We also commend the Council for attempting where possible to use nationally recognized and heavily validated measures, such as those taken from the National Committee on Quality Assurance's (NCQA) HEDIS measurement tool. Use of such established measures improves the usefulness of comparisons since data are measured and reported in the same way. However, we also have some concerns with certain measures and how they should be interpreted.

- The HEDIS indicators in this report are from 1998, and plans have already submitted 1999 data to NCQA. Thus the results used in this report are not the most current information available.
- The HEDIS benchmarks that are used, both National and PA, are from the 1998 NCQA Quality Compass Data but exclude data from HMOs with a POS component. KHPE offers a POS option, and our data include POS members. This may affect the validity of comparisons.
- While we are pleased that the Council included information from the CAHPS survey, and that KHPE performed very favorably against the benchmarks, we question the Council's decision to recalculate the measures rather than simply using the NCQA methodology. Specifically, the Council excluded certain responses in their

recalculations, and aggregated other responses differently than NCQA. This limits comparability to other data and benchmarks, such as those contained in NCQA's Quality Compass.

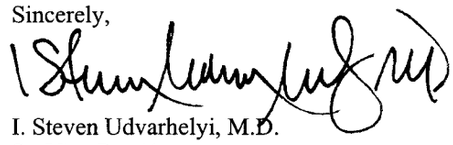
- We noted a number of measures that are reported with no context or benchmarks. In several cases, these may be meaningful, but their addition without reference points or benchmarks may lead the reader to inappropriate conclusions. One example is the number of Primary Care Physicians (or Specialists) per 1,000 Members. A plan such as ours with a very large membership base, even with a large network, can score quite differently than a smaller plan with a similar sized network. Network size is often driven by geographic considerations rather than purely by volume of membership.

Regarding the Hospitalization Outcome Data, we offer the following observations:

- We believe that certain measures in the report demonstrate that HMO based activities which focus on improving the health of members with chronic diseases have had a meaningful impact, since this conclusion is consistent with our own internal data. For example, KHPE has a lower than expected rate of readmission for adult patients with asthma. We attribute this in part to the effectiveness of our asthma disease management program.
- However, we are cautious about such conclusions. The Council's analyses of admission rates per 10,000 members did adjust for age and gender; however, the most relevant measure would be admission rates per 10,000 members with asthma. Each plan is different in the population it serves, and some plans have populations with a higher prevalence of certain diseases. Again noting asthma, this condition is more prevalent in large urban areas and the asthma admission rates for KHPE, which serves a large metropolitan area, are higher than expected. One would expect such variation since the analyses did not adjust for underlying differences in disease prevalence. At the same time, we applaud the Council for risk-adjusting length of stay, complication rate, and mortality rate measures.
- We also note that it can be difficult to interpret certain data. For example, for KHPE the Abdominal Hysterectomy Complication Rate after Admission is reported as statistically greater than expected. However, KHPE's rate of admission for this procedure is lower than expected. To the extent that the lower admission rate reflects fewer unnecessary hysterectomies, the case-mix of the hysterectomy patients in KHPE may be different than other plans, leading to a higher complication rate. However, the incidence of complicated admissions per 10,000 females in KHPE does not appear to be significantly higher (0.8 more admissions per 10,000 females) than would be expected if we had the HMO average admission rate and the same casemix of patients.
- Lastly, we believe that the Council's report continues to confirm the existence of geographical variation in procedure rates, a phenomenon that has been well documented for decades. Unfortunately, it remains unclear whether lower or higher rates are preferred. At a minimum, it does not appear that the variation in rates reported by the Council in this report is correlated with notable differences in outcomes. Hence we all have more work to do to understand if procedures are overused or underused in selected areas. As Mark Chassin and others have pointed out, both overuse and underuse are significant quality problems in the U.S. health care system.

Again, we applaud the Council for beginning a process of providing the public with information on health plan performance in an attempt to generate a dialogue aimed at quality improvement. We do urge caution in interpreting the data in this report due to the issues we raise above. Independence Blue Cross has been, and will remain, a strong supporter of performance measurement both within the State of Pennsylvania and nationally, and is committed to continuous improvement of our own processes and outcomes. We believe this is reflected in KHPE's recent accreditation rating by NCQA of "Excellent," a distinction given to only about 10% of health plans in the country. We are eager to continue to work with the Council in the future to improve the usefulness of performance data for residents in Pennsylvania.

Sincerely,



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