Measuring the Quality of Pennsylvania's HMOs

A Managed Care Performance Report*

Pennsylvania Health Care Cost Containment Council

*Does not include Medicare or Medicaid HMO plans.

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FOREWORD

The Pennsylvania Health Care Cost Containment Council (PHC4) was established as an independent state agency by the General Assembly and the Governor of the Commonwealth of Pennsylvania in 1986. To help improve the quality and restrain the cost of health care, PHC4 promotes health care competition through the collection, analysis and public dissemination of uniform cost and quality-related information. Measuring the Quality of Pennsylvania's HMOs - A Managed Care Performance Report is one of a series of public reports designed to achieve this goal. Information related to this report is posted on the PHC4 Web site at www.phc4.org and in a separate Technical Report.

PURPOSE OF THE REPORT

Increasingly, purchasers, consumers, providers, payors and policy makers are seeking comparative information about health insurance plans. This report provides information related to the quality of health care services received by those patients belonging to Health Maintenance Organizations (HMOs) licensed to operate in Pennsylvania, but does not include Medicare or Medicaid HMOs. The information provided in this report can help purchasers of health care benefits and consumers make more informed choices among available HMO health insurance plans; it can provide physicians, hospitals and health insurance plans with meaningful comparative data about important health care issues; it can provide policy makers with information that can help them make more informed decisions and can serve as a tool to provide additional information to their constituents.

SOURCES OF THE DATA

Inpatient hospital data about treatment measures was submitted to PHC4 by Pennsylvania hospitals. The Pennsylvania Department of Health (DOH) supplied information such as the number of primary care physicians and enrollment figures. The Pennsylvania Insurance Department provided overall financial figures for reporting HMOs. The National Committee for Quality Assurance (NCQA), an independent

organization that reports information about managed care plans, was the source of the Health Plan Employer Data and Information Set (HEDIS) process measures and the Consumer Assessment of Health Plans Survey (CAHPS) member satisfaction measures.

LIMITATIONS OF THE DATA

This report is not intended to be a sole source of information in making choices about HMO plans since the measures included are important but limited indicators of quality. Hospital admissions, complications and death are at times unavoidable consequences of a serious medical condition. Hospitals, physicians and health insurance plans may do everything right and still the patient may die or experience other problems. In addition, an HMO's success in helping members to manage their health problems depends in part upon those members' willingness and ability to comply with their physicians' treatment decisions. While HMOs play an important role in the delivery of care and treatment decisions, it is hospitals and doctors who ultimately provide health care for patients.

This report may not provide exact comparisons for several reasons. Benefit plan designs differ among and within HMOs. Enrollment in HMOs is constantly changing. Furthermore, since this report includes data for one year, it is only a snapshot of what occurred during a limited period of time. Finally, the Council's risk-adjustment model may not completely capture some groups at higher risk due to social, economic, and behavioral differences.

All HMOs included in the report were given an opportunity to verify that records indicating the primary payor were correct. The Council would like to acknowledge all plans for their participation.

Since the methods to compare health plans are not yet well developed, this report addresses a limited number of indicators and are not intended to represent an HMO's *overall* performance. As with any new initiative, these data should be interpreted with caution.

The Council would like to emphasize that this report is about helping people make more informed choices and stimulating a quality improvement process where differences in important health care measures are identified and appropriate questions are raised and answered.

WHAT IS AN HMO?

Most Pennsylvanians receive their health care benefits through their employer or from a government-sponsored program such as Medicare or Medical Assistance. Traditionally, these health plans made arrangements that paid independent physicians and hospitals a fee for each service provided to the plan participants. These "fee-for-service" arrangements were thought to contribute to duplication of services, unnecessary services and escalating health care costs. One response to this problem was the creation of HMOs.

An HMO is an organized system that provides prepaid health benefits to a defined population of enrollees, or members. Unlike traditional insurers, HMOs typically offer and encourage members to take advantage of a host of educational materials, disease management programs, preventive health services coverage and other initiatives to keep their members healthy. HMO members usually are required to select Primary Care Physicians (PCPs) who have the responsibility to coordinate the various health services available to members. HMOs may share financial responsibility for the services provided to members with PCPs and other providers. "Point of Service" (POS) options offered by HMOs often combine the structure of HMOs (members select PCPs and usually access non-primary care services through referrals) with the flexibility to access services without referrals and the option to leave the network of participating providers.

WHY FOCUS ON HMOs?

More than five million Pennsylvanians were enrolled in 33 HMOs as of December 31, 1998. However, the number of plans covered in this report will be less since Medicare and Medicaid HMOs are not included.

In addition, the number of plans in each section will differ because data were not available for all HMOs in all report categories and because HealthAmerica and Highmark Blue Cross/Blue Shield reported their HMO and POS data separately. The number of Pennsylvanians covered by the plans in this report exceeded four million.

HMO membership has grown considerably in part because HMOs offer a number of attractive features. HMOs strive to:

- Keep their members healthy by emphasizing prevention and primary care services;
- Manage the health care process more efficiently;
- Hold down costs;
- Require small out-of-pocket payments from consumers.

While HMOs have delivered on many of these goals, there has been a growing concern about other issues such as the perceived lack of access to necessary services and medications. These perceptions have driven a national desire for more objective information about the cost and quality of health care for those in HMO plans.

Payors (insurers) have evolved from the traditional approach of financing the delivery of health care to one of influencing the organization of the delivery system. This takes the form of quality improvement efforts, recertification, utilization management, promulgation of physician practice guidelines, development of select physician and hospital networks and financial incentives - the increasing "management" of care.

HOW THE REPORT IS ORGANIZED

SECTION 1 – TREATMENT MEASURES

To most people, the outcome or result of their treatment is the most important factor in judging health care quality. Section 1 is focused on the outcome of treatment for patients in four medical and surgical categories: asthma (adult and pediatric), heart attack, heart failure and hysterectomy. The first three disease categories are ones where prevention, solid primary care and timely access to services can make a difference. Hysterectomy was also chosen because it is a procedure performed on many women. HMOs can play a positive role in making sure that women receive appropriate treatment.

In addition to the HMO information reported, overall figures have been calculated for the 67 largest fee-for-service plans in Pennsylvania. These figures can provide comparisons regarding the quality of care and services according to different types of health plans.

Sources of the data - This section includes inpatient hospital data submitted by Pennsylvania hospitals to PHC4 and subsequently verified by the HMOs. The figures for Beta Blockers and Cervical Cancer Screening are HEDIS measures obtained directly from NCQA.

Data Period - July 1, 1998 through June 30, 1999 for treatment measures and January 1, 1998 to December 31, 1998 for HEDIS

SECTION 2 – ACCESS, SERVICE AND PREVENTION

HMOs contract with certain physicians, hospitals and other types of health care providers to create a provider network. This section includes information on provider networks, member satisfaction results as well as each participating HMO's current NCQA accreditation rating: excellent, commendable, accredited, provisional, denied and suspended or under review. Participation in the NCQA accreditation process is voluntary. Updates on plan ratings can be found on the NCQA Web site: www.NCQA.org.

When you enroll in an HMO, most of your health care services will be coordinated through that plan and your PCP. HMOs differ in the number and types of providers in their networks. Network composition may change frequently. Your options for accessing PCPs, specialists and other health care services are determined by the plan's selected network,

so it is important to know whether plan members are satisfied with the services received through their HMO.

Data Period - January 1 through December 31, 1998

SECTION 3 – FINANCIAL INDICATORS

Source of the data - Each HMO is required to file an annual audited financial statement containing a variety of financial indicators with the Pennsylvania Insurance Department.

Data Period - January 1 through December 31, 1998

SECTION 4 – YOUR PERSONAL WORKSHEET

If you have decided that an HMO plan is right for you, the next step is generally to identify those plans available to you through your employer. HMOs offer basic information to assist potential members including:

- member handbooks;
- lists of doctors, facilities, and services available to members;
- information about special educational programs;
- newsletters;
- and other information to help in the selection of an HMO.

See your employer or HMO for specific information about required monthly premiums, co-payments, deductibles and coverage limitations because the types of coverage and benefits contracted from an HMO can differ.

The personal worksheet on the back page of this report can help you organize the information in this report, as well as other information provided by your employer and the HMOs, to help choose the plan that best fits your needs.

As you do that, consider the following issues:

- Does the HMO cover the services and health care providers needed by you or your family?
- What are the major differences among the HMOs presented in this report?
- Which cost and quality considerations are most important to you?

Try to use the overall information presented; avoid looking at results for single measures.

ACKNOWLEDGMENTS

PHC4 wishes to acknowledge and thank the individual HMOs and Pennsylvania hospitals that participated in the data verification process, as well as the leadership of the Insurance Federation of Pennsylvania, Managed Care Association of Pennsylvania and Blue Cross/Blue Shield - related plans. Their cooperation, advice and constructive criticism were invaluable to the Council in the completion of this report.

PHC4 also thanks the Pennsylvania Department of Health, Secretary Robert S. Zimmerman, Jr., the Pennsylvania Insurance Department and Insurance Commissioner M. Diane Koken, for their assistance in compiling this report.

PHC4 wishes to thank its Data Systems Committee, chaired by Richard C. Dreyfuss, its Payor Advisory Group, chaired by Daniel R. Tunnell, and its Technical Advisory Group, chaired by David B. Nash, MD, MBA for their contributions to this report.

UNDERSTANDING THE TABLES

Adjusting for risk, severity of illness, age and sex

PHC4 compiles "expected" rates for many of the measures in this report based on a complex mathematical formula that assesses the degree of illness or risk for patients. In other words, HMOs that have sicker members or a higher percentage of high-risk members are given "credit" in the formula; more patients can be expected to be admitted, have longer lengths of stay, complications or to die because they are more seriously ill or at greater risk.

Age and sex adjustments are similar. For example, the methods account for the fact that a particular HMO might have a higher proportion of older patients in comparison to a plan that has younger members. PHC4's system "expects" more health problems in HMOs with older populations and makes adjustments for that.

HMO information in this report is displayed and defined in several ways:

Actual Hospitalization, In-hospital Mortality, Readmission and Complication Rates – The hospitalization rate is the actual number of hospital admissions per 10,000 members. Actual mortality, readmission and complication rates are reported as percentages and not as rates per 10,000 members.

Expected Hospitalization, In-hospital Mortality, Readmission and Complication Rates – Using a mathematical formula that accounts for severity of illness factors as well as age and sex, PHC4 predicts the rate of hospitalizations per 10,000 members. Expected mortality, readmission and complication rates are reported as percentages and not as rates per 10,000.

Statistical Rating – Symbols representing statistical significance or importance are used to measure hospitalization rates, readmission rates, mortality rates and complication rates. These symbols tell you if the difference between the actual and expected rates was statistically:

- ○ less than expected,
- ⊙ same as expected,
- ● greater than expected.

NR (Not Rated) – Certain plans are not rated due to small numbers.

Length of Stay (risk-adjusted) – Length of stay means the average number of days spent in the hospital after accounting for severity of illness and other risk factors.

Cardiac Catheterizations, Percutaneous Transluminal Coronary Angioplasty (PTCA)/Stent Procedures and Coronary Artery Bypass Graft (CABG) surgery – These data refer to the percent of heart attack patients who received these procedures within 30 days of their hospital admission for heart attack.

Beta Blockers – This is a HEDIS measure and relates to the percent of plan members who received a prescription for Beta Blockers following a heart attack hospitalization.

Cervical Cancer Screening – Also a HEDIS measure that reports the percent of plan members (women 18 years of age and older) that received a screening for cervical cancer.

Average Number of Days Hospitalized – The average number of days hospitalized indicates time spent in the hospital(s) for heart attack treatment during a 30 day episode beginning with the initial hospitalization. An episode of care consists of one or more related hospitalizations and is defined for each condition.

A COMPREHENSIVE DESCRIPTION OF THESE AND OTHER ISSUES CAN BE FOUND IN THE TECHNICAL REPORT AVAILABLE IN HARD COPY AND ON THE PHC4 WEB SITE - WWW.PHC4.ORG.

ASTHMA - Adult and Pediatric (Under 18 Years of Age)

Asthma is a chronic inflammatory disease of the lung airways which makes breathing difficult and causes patients to wheeze and cough. In unusual cases, acute attacks can be fatal. Most asthma cases appear to be related to allergies. Once a person becomes sensitive to an allergen, even a small amount can trigger an asthma attack. Other factors such as upper respiratory diseases, air pollution, or exercise may trigger asthma, making it difficult to determine the cause.

Nationally, between 1980 and 1998 the number of people affected by asthma increased from 6.7 million to 17.3 million – an increase of more than 150 percent. It is the most common chronic childhood disease, affecting an estimated 5.3 million children. Inner city children are more likely to be asthmatic, especially those of African or Hispanic heritage. People with asthma collectively have more than 100 million days of restricted activity and 470,000 hospitalizations annually, the ninth leading cause of admission. More than 5,000 people die from asthma every year. Yet, its severity can be managed with appropriate medical treatment, education and environmental changes.

What we measured...

- Hospital Admissions - Adult and Pediatric
- Hospitalization Rate per 10,000 Members (age/sex-adjusted) and Statistical Rating
- Length of Stay (risk-adjusted)
- Readmission Rate within 90 days (adults only) - Actual Rate, Expected Rate and Statistical Rating

Why are these measures important?

Nationally, the total estimated annual cost of asthma is approximately $7.5 billion, with hospitalization accounting for half of all expenditures. Studies have shown that hospitalizations, repeat hospitalizations and emergency room visits can be decreased and quality of life improved when patients are taught how to control their disease and are helped to follow established asthma management guidelines. Studies have also suggested that appropriate access to an allergy specialist (allergist) can result in better patient outcomes. Aggressive and consistent implementation of asthma management programs and clinical practice guidelines are excellent ways for HMOs to optimize the health of their members.

The Expert Panel of the National Heart, Lung and Blood Institute has recommended the following four components of an effective asthma management program:

- Use of objective measures of lung function to assess the seriousness of the disease and to monitor the course of therapy;
- Environmental control measures to avoid or eliminate potential triggers of asthma;
- Comprehensive drug therapy designed to reverse and prevent the airway inflammation associated with asthma;
- Patient education that fosters a partnership among patients, their families and clinicians.

Furthermore, the Expert Panel of the National Heart, Lung and Blood Institute has emphasized that young children, adolescents and older adults have different needs to consider in their asthma therapy.

People are more likely to outgrow asthma if treatment begins soon after diagnosis, according to the American Lung Association. The chance of becoming symptom-free has also been correlated to younger age and less severe cases with twenty-five percent of asthmatic children eventually outgrowing the disease.

ASTHMA - Adult and Pediatric (Under 18 Years of Age)

HMO	ADULT Hospital Admissions	ADULT Hospitalization Rate per 10,000	ADULT Statistical Rating	ADULT Length of Stay (Days) Risk-Adjusted	ADULT Readmission Rate Actual (%)	ADULT Readmission Rate Expected (%)	ADULT Statistical Rating	PEDIATRIC Hospital Admissions	PEDIATRIC Hospitalization Rate per 10,000	PEDIATRIC Statistical Rating	PEDIATRIC Length of Stay (Days) Risk-Adjusted
Aetna USHC	350	5.8	○	3.4	8.5	15.3	○	233	9.3	○	2.0
Alliance	24	6.9	◉	2.7	4.3	14.1	◉	13	8.5	◉	2.1
CIGNA	27	8.2	◉	2.6	11.5	17.0	◉	18	11.2	◉	2.1
First Priority	103	8.9	◉	3.9	15.8	14.0	◉	52	9.8	◉	2.3
HealthAmerica HMO	124	8.4	◉	3.5	12.8	16.1	◉	56	8.6	◉	2.0
HealthAmerica POS	77	13.2	●	3.6	5.5	14.7	○	37	14.3	◉	2.2
HealthCentral	35	12.2	●	3.8	14.3	13.8	◉	19	15.5	◉	2.3
HealthGuard	26	4.1	○	3.4	3.8	14.8	◉	32	12.1	◉	2.2
Horizon	0	NR	NR	NR	NR	NR	NR	2	NR	NR	NR
KHP Central	98	6.8	◉	3.7	15.2	15.3	◉	45	6.8	○	2.1
KHP East	388	9.4	●	3.1	11.4	17.3	○	293	15.9	●	2.0
KHP West	146	8.0	◉	3.4	8.7	14.7	○	69	10.3	◉	2.0
PS/Geisinger	72	4.5	○	2.9	4.3	14.0	○	35	6.0	○	2.1
PruCare	29	13.4	●	3.2	3.6	15.0	◉	29	27.5	●	2.1
QualMed East	31	18.8	●	2.9	20.7	19.5	◉	13	25.5	●	2.2
QualMed West	11	12.6	◉	NR	NR	NR	NR	2	NR	NR	NR
Select Blue	429	6.8	◉	3.2	10.5	14.5	○	228	9.8	◉	1.9
UPMC	60	13.3	●	3.1	14.3	14.9	◉	24	16.0	◉	1.4
HMO Total/Average	2,030	7.5		3.3	10.5	15.4		1,200	10.8		2.0
Fee-For-Service Sample	1,099	NA		3.5	11.4	14.7		579	NA		2.1
State Total/Average	9,231	12.9		3.4	16.4	16.4		6,666	23.0		2.1

○	Less than Expected
◉	Same as Expected
●	Greater than Expected
NR	Not Rated
NA	Not Available

Source: PHC4

HEART ATTACK

A heart attack (Acute Myocardial Infarction) occurs when there is sudden insufficient blood supply to an area of heart muscle. Normally, the body supplies blood to the heart muscle through vessels known as coronary arteries. A heart attack occurs when an obstruction in one of the coronary arteries blocks the blood supply to part of the heart muscle. Most often, the cause of the blockage is a blood clot formed in a coronary artery already narrowed by atherosclerosis. Heart muscle cells may suffer irreversible damage and die if the blood supply is cut off drastically. This can result in disability or death.

What we measured...

- Hospital Admissions
- Hospitalization Rates per 10,000 Members (age/sex-adjusted) and Statistical Rating
- Average # of Days Hospitalized (risk-adjusted) - within 30 days
- In-Hospital Mortality within 30 Days - Actual Rate, Expected Rate and Statistical Rating
- Percent of Heart Attack Patients Receiving a Cardiac Catheterization within 30 days
- Percent of Heart Attack Patients Receiving a Percutaneous Transluminal Coronary Angioplasty (PTCA)/Stent within 30 days
- Percent of Heart Attack Patients Receiving Coronary Artery Bypass Graft Surgery (CABG) within 30 days
- Percent Receiving a Prescription for Beta-Blockers after Heart Attack (HEDIS)

Why are these measures important?

Heart attack is among the most common reasons for hospital admission in the United States. In a recent study, 50 percent of all patients who survived an initial hospitalization for heart attack were rehospitalized within three years; 20 percent experienced a repeat heart attack.

People who have had a heart attack are at high risk for another one, and the mortality rates are high for these patients. Therefore, prevention of the second or subsequent attacks should be a high priority. One important medical therapy that has been shown to lower the risk of a second heart attack is the use of beta-blockers, which reduce how hard the heart has to work and lowers blood pressure. A recent study demonstrated that HMO-insured patients receive aspirin and beta-blockers as often as fee-for-service patients.

High mortality rates also exist for heart patients with diabetes. The New England Journal of Medicine has noted that the number of people affected by type 2 diabetes is rising and that the rate of death due to coronary heart disease has not fallen for diabetics, as it has for the general population.

Ultimately, treatment of a heart attack must address the underlying coronary heart disease that led to the attack. There are several types of treatment including medication, angioplasty and coronary artery bypass graft surgery. Angioplasty involves the insertion of a catheter with a balloon tip, which inflates to compress the plaque build-up in the artery. Sometimes a stent, a wire mesh tube, is used in angioplasty to support and permanently hold the artery open. CABG surgery creates an alternate route (bypass) for the blood to flow by taking a blood vessel from another part of the body and attaching it around the blocked artery. Determining which of these treatments is the best course of action is a complicated decision based on many factors. You should make that choice based on the advice of a qualified physician. Prevention and lifestyle changes can also play a key role in reducing the risk of heart disease. HMOs play an important part in educating and encouraging their members to reduce their risk of heart disease, and to ensure that they receive the appropriate treatment for their conditions.

HEART ATTACK

HMO	Hospital Admissions	Hospitalization Rate per 10,000	Statistical Rating	Avg. # of Days Hospitalized	Mortality Rate Actual (%)	Mortality Rate Expected (%)	Statistical Rating	% Receiving Catheterization	% Receiving PTCA/Stent	% Receiving CABG	% Beta Blockers Prescribed[1]
Aetna USHC	509	8.5	○	5.9	3.4	3.4	◉	89.4	52.8	16.9	92.2
Alliance	55	16.0	●	5.7	1.8	4.7	◉	96.4	61.8	23.6	NA
CIGNA	22	7.6	○	8.0	0.0	1.6	◉	81.8	27.3	31.8	NA
First Priority	176	15.7	●	7.3	2.4	4.0	◉	85.8	56.3	20.5	92.2
HealthAmerica HMO	174	10.9	◉	6.2	2.4	2.4	◉	90.2	59.8	14.9	75.0
HealthAmerica POS	169	26.7	●	5.5	2.4	3.2	◉	87.0	56.2	14.2	NA
HealthCentral	35	14.9	◉	5.3	0.0	1.8	◉	91.4	62.9	11.4	NA
HealthGuard	72	10.3	◉	5.2	1.4	2.3	◉	97.2	68.1	15.3	95.2
Horizon	2	NR	NR	NR	NR	NR	NR	NR	NR	NR	NA
KHP Central	166	11.6	◉	6.5	1.3	3.2	◉	89.2	46.4	18.1	90.2
KHP East	387	10.1	○	6.2	4.9	3.7	◉	82.2	49.1	11.9	94.9
KHP West	242	13.6	●	5.9	4.3	2.9	◉	91.3	59.5	21.5	90.4
PS/Geisinger	162	9.8	○	5.8	2.6	3.1	◉	79.6	35.2	22.2	93.7
PruCare	47	26.8	●	5.6	4.8	2.9	◉	89.4	61.7	17.0	NA
QualMed East	22	14.5	◉	5.1	0.0	2.4	◉	95.5	63.6	9.1	NA
QualMed West	11	11.8	◉	NR	9.1	2.1	◉	90.9	45.5	27.3	NA
Select Blue	904	13.6	●	6.3	1.8	2.9	◉	88.5	57.7	19.5	89.8
UPMC	41	10.4	◉	5.5	5.4	4.4	◉	80.5	61.0	7.3	NA
HMO Total/Average	3,196	11.8		6.1	2.8	3.2		87.8	54.5	17.6	87.4
Fee-For-Service Sample	2,866	NA		6.3	3.2	3.7		89.0	52.6	20.2	NA
State Total/Average	12,138	16.8		6.2	3.8	3.8		83.7	49.6	17.3	NA

○	Less than Expected
◉	Same as Expected
●	Greater than Expected
NR	Not Rated
NA	Not Available

Source: PHC4

[1] NCQA, HEDIS, Calendar Year 1998 - Does not relate to Hospital Admissions column.

HEART FAILURE

Congestive heart failure is an abnormal accumulation of fluid due to the heart's inability to pump a normal amount of blood. Generally, damage first occurs to the left side of the heart but may involve the right side or both sides at once. Heart failure develops over time, most often as a result of other cardiac diagnoses such as atherosclerosis, heart attack or untreated hypertension. This disabling chronic illness is a major public health problem affecting 4.8 million Americans, 70 percent of whom are 60 years of age or older. As more individuals survive other cardiac conditions and the elderly population expands, heart failure is expected to become a more extensive problem.

What we measured...

- Hospital Admissions
- Hospitalization Rate per 10,000 Members (age/sex-adjusted) and Statistical Rating
- Length of Stay (risk-adjusted)
- In-Hospital Mortality within 30 days - Actual Rate, Expected Rate and Statistical Rating
- Readmission Rate within 90 days - Actual Rate, Expected Rate and Statistical Rating

Why are these measures important?

Nationally, more than one-third of patients affected by heart failure are advanced stage, often characterized by progressive deterioration and frequent hospital admissions and readmissions. Heart failure patients consume a considerable amount of health care resources, and annual expenditures for the condition have been estimated to be as high as $38 billion, of which $23 billion is for hospital stays.

Since most heart failure cases stem from previous cardiac conditions, heart failure prevention efforts should focus on reducing risk factors associated with coronary artery disease. Particularly important is the prevention and treatment of high blood pressure and heart attack, which are the specific conditions most often correlated with higher risk of the disease.

Once patients develop heart failure, the goals are to decrease disability, prolong life and control resource use. These objectives can be enhanced by comprehensive heart failure management, which incorporates patient education, control of sodium and water use and careful drug therapy. Studies have shown that involvement in these programs leads to improved functional status and decreased admission rates. If patients at higher risk for readmission can be identified, they can be encouraged to participate in comprehensive heart failure management programs and obtain appropriate treatment that can help to improve the quality of life and reduce costs. The success of these programs depends on the active participation of the patient in lifestyle and behavior modification, following the treatment plan, and collaborating with the physician.

By providing comprehensive heart failure management programs, HMOs may play an important role in promoting appropriate care resulting in improved quality of life and fewer hospitalizations.

The American Heart Association provides a valuable online resource, called Living with Heart Failure, for heart failure patients, their caregivers and their families. As the title suggests, the guide offers information and support, on topics such as diet, lifestyle and exercise, and understanding the disease, to help individuals live with the condition. It is available on their Web site at www.americanheart.org/chf.

HEART FAILURE

HMO	Hospital Admissions	Hospitalization Rate per 10,000	Statistical Rating	Length of Stay (Days) Risk-Adjusted	Mortality Rate Actual (%)	Mortality Rate Expected (%)	Statistical Rating	Readmission Rate Actual (%)	Readmission Rate Expected (%)	Statistical Rating
Aetna USHC	317	5.3	○	4.8	1.4	1.9	◉	14.1	20.2	○
Alliance	19	5.5	◉	3.5	0.0	1.5	◉	10.5	16.8	◉
CIGNA	11	3.9	◉	6.2	0.0	1.8	◉	0.0	22.5	◉
First Priority	91	8.1	◉	6.2	1.1	2.2	◉	14.0	19.1	◉
HealthAmerica HMO	113	7.1	◉	5.2	0.9	2.2	◉	16.5	20.0	◉
HealthAmerica POS	51	8.2	◉	6.5	2.0	2.0	◉	12.8	18.3	◉
HealthCentral	12	5.0	◉	5.2	0.0	2.1	◉	16.7	20.0	◉
HealthGuard	31	4.4	○	4.4	3.2	2.2	◉	16.7	19.7	◉
Horizon	1	NR	NR	NR	NR	NR	NR	NR	NR	NR
KHP Central	68	4.8	○	5.7	0.0	1.7	◉	15.4	19.8	◉
KHP East	416	10.8	●	4.8	1.9	1.7	◉	17.5	21.7	◉
KHP West	143	7.9	●	5.2	1.4	1.6	◉	14.7	19.0	◉
PS/Geisinger	55	3.3	○	4.3	1.9	1.8	◉	13.7	18.3	◉
PruCare	23	13.3	●	4.7	4.5	4.5	◉	10.0	19.1	◉
QualMed East	36	23.1	●	3.6	0.0	1.1	◉	17.9	22.9	◉
QualMed West	6	NR	NR	NR	NR	NR	NR	NR	NR	NR
Select Blue	376	5.6	○	5.3	2.2	1.8	◉	11.1	19.5	○
UPMC	29	7.1	◉	3.4	0.0	1.4	◉	7.7	19.7	◉
HMO Total/Average	1,798	6.6		5.0	1.6	1.9		14.2	20.1	
Fee-For-Service Sample	1,474	NA		5.2	2.3	2.1		14.3	19.6	
State Total/Average	12,245	17.0		5.2	2.1	2.1		21.0	21.0	

○	Less than Expected
◉	Same as Expected
●	Greater than Expected
NR	Not Rated
NA	Not Available

Source: PHC4

HYSTERECTOMY (Non-Cancerous)

What is a Hysterectomy?

Hysterectomy, the most common non-pregnancy related surgical procedure among American women, is the surgical removal of the uterus. It is a procedure that has a number of complications associated with it, the most common being hemorrhage, infection and injuries to nearby organs. Nearly 600,000 women in the U.S. have a hysterectomy every year (by age 65, more than 37 percent of all women will have undergone this procedure) with an estimated overall cost of more than $5 billion. In addition to cancer, common reasons for performing a hysterectomy include uterine fibroids, uterine prolapse, abnormal bleeding, endometriosis and chronic pelvic pain.

Three different approaches are used to perform a hysterectomy: abdominal, vaginal and laparoscopic (laparoscopically assisted vaginal hysterectomy, LAVH). Abdominal hysterectomy involves an incision in the abdomen and removal of the uterus through the incision; the vaginal approach involves removal of the uterus through the vaginal canal. LAVH is a relatively new procedure in which the uterus is detached by laparoscopic instruments while the doctor monitors the procedure through a camera. About 50 percent of women who undergo a hysterectomy also have their ovaries removed (oophorectomy).

What we measured...

- Only non-cancerous hysterectomies
- Hospital Admissions - Total, Abdominal and Vaginal (includes LAVH)
- Cervical Cancer Screening (HEDIS)
- Hospitalization Rate per 10,000 Female Members (age-adjusted) and Statistical Rating
- Length of Stay (risk-adjusted)
- Complications - Actual Rate, Expected Rate and Statistical Rating

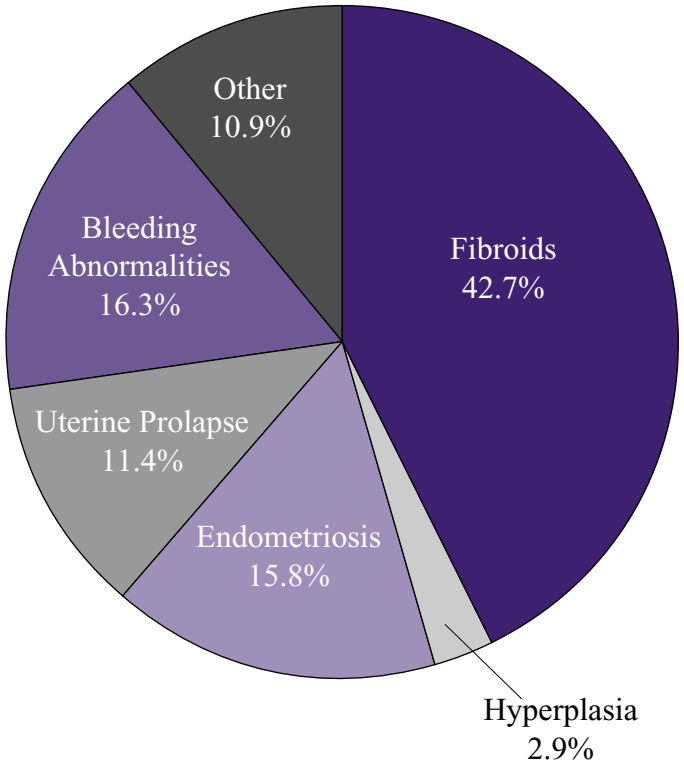
Why are these measures important?

Procedure selection by physicians, complicated medical illnesses and diagnoses related to abdominal hysterectomy result in increased lengths of stay and increased complication rates, due to the difference in the type of surgery. Vaginal hysterectomies tend to be performed in cases where patients have smaller uteruses and/or fewer medical complications, such as endometriosis or pelvic adhesions. With abdominal hysterectomies, the likelihood of removal of the ovaries is increased compared to those with a vaginal hysterectomy.

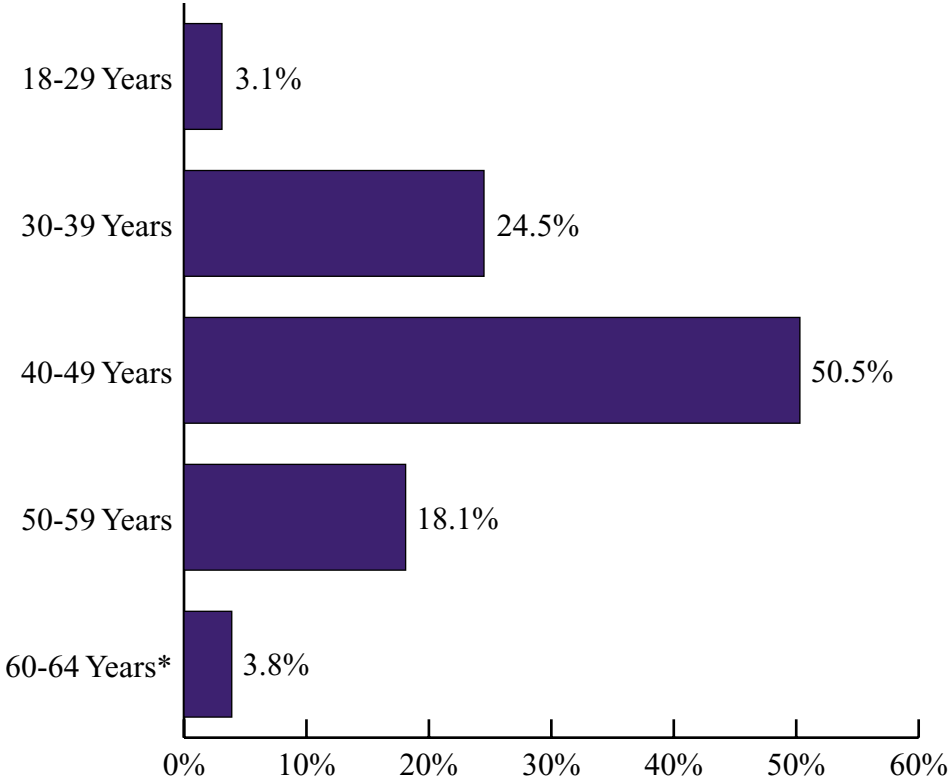
Studies have observed that hysterectomies are performed in varying percentages for reasons that may be clinically inappropriate. Heavy bleeding, endometriosis and fibroid tumors, all major reasons for hysterectomies, can often be treated by other less traumatic methods. The American College of Obstetricians and Gynecologists advises that hysterectomy be a treatment of last resort performed only after proper diagnostic tests confirm the underlying condition; conservative treatments have failed to improve the condition and fertility is not an issue; and proper counseling has informed the woman of the risks and benefits of the procedure. Given these issues, women should fully research the available options and discuss their concerns with their physicians. The data on the following pages, broken down by procedure, can help in that process.

HYSTERECTOMY

COMMON REASONS FOR ELECTIVE HYSTERECTOMIES



HYSTERECTOMIES PERFORMED ACCORDING TO AGE



Source: PHC4

* This report does not include patients over 65 years of age.

HYSTERECTOMY - Abdominal

HMO	TOTAL Hospital Admissions	ABDOMINAL Hospital Admissions	Hospitalization Rate per 10,000 women	Statistical Rating	Length of Stay (Days) *Risk-Adjusted*	Complication Rate *Actual (%)*	Complication Rate *Expected (%)*	Statistical Rating
Aetna USHC	927	631	19.8	○	2.9	16.6	12.8	●
Alliance	149	98	52.8	●	2.8	10.3	11.1	◉
CIGNA	58	42	24.4	◉	2.4	2.4	13.9	○
First Priority	381	269	44.1	●	3.3	9.0	11.4	◉
HealthAmerica HMO	381	255	33.5	●	3.0	15.0	13.0	◉
HealthAmerica POS	355	214	71.1	●	3.0	12.0	12.5	◉
HealthCentral	109	78	48.4	●	3.2	12.8	11.8	◉
HealthGuard	171	125	37.1	●	2.7	8.2	12.2	◉
Horizon	4	2	NR	NR	NR	NR	NR	NR
KHP Central	441	302	39.8	●	3.0	7.8	11.9	○
KHP East	769	577	26.2	○	2.9	19.8	14.9	●
KHP West	461	305	31.4	◉	3.0	15.2	12.1	◉
PS/Geisinger	276	220	26.2	◉	2.7	8.1	11.7	◉
PruCare	79	55	46.4	●	2.8	13.0	13.0	◉
QualMed East	55	41	45.8	●	3.0	17.5	15.2	◉
QualMed West	18	11	22.8	◉	2.8	0.0	10.8	◉
Select Blue	1,350	851	26.2	○	2.9	13.2	11.8	◉
UPMC	107	80	31.9	◉	3.0	17.7	12.4	◉
HMO Total/Average	6,091	4,156	29.1		2.9	13.6	12.6	
Fee-For-Service Sample	5,220	3,414	NA		3.0	12.1	11.9	
State Total/Average	18,888	12,831	34.8		3.0	13.6	12.5	

○ Less than Expected
◉ Same as Expected
● Greater than Expected
NR Not Rated
NA Not Available

Source: PHC4

HYSTERECTOMY - Vaginal

VAGINAL

HMO	Hospital Admissions	Hospitalization Rate per 10,000 women	Statistical Rating	Length of Stay (Days) Risk-Adjusted	Complication Rate Actual (%)	Complication Rate Expected (%)	Statistical Rating	Cervical Cancer Screening [1]
Aetna USHC	296	9.3	○	2.1	9.2	11.8	◉	69.6
Alliance	51	27.4	●	2.1	17.6	11.1	◉	NA
CIGNA	16	9.2	◉	2.2	13.3	12.4	◉	64.6
First Priority	112	18.3	●	2.5	4.5	11.6	○	69.4
HealthAmerica HMO	126	16.6	●	2.3	10.3	11.9	◉	82.5
HealthAmerica POS	141	46.9	●	2.2	11.5	11.2	◉	77.0
HealthCentral	31	19.2	◉	2.4	12.9	11.4	◉	73.2
HealthGuard	46	13.7	◉	2.1	4.4	11.2	◉	78.7
Horizon	2	NR	NR	NR	NR	NR	NR	NA
KHP Central	139	18.3	●	2.1	7.3	11.6	◉	78.1
KHP East	192	8.7	○	2.0	13.0	13.1	◉	61.7
KHP West	156	16.1	●	2.2	11.0	11.3	◉	81.1
PS/Geisinger	56	6.7	○	2.1	7.7	11.4	◉	80.1
PruCare	24	20.0	◉	2.0	16.7	12.3	◉	NA
QualMed East	14	15.7	◉	2.1	0.0	14.3	◉	NA
QualMed West	7	NR	NR	NR	NR	NR	NR	NA
Select Blue	499	15.4	●	2.2	11.5	11.3	◉	81.2
UPMC	27	10.8	◉	2.1	14.8	12.2	◉	NA
HMO Total/Average	1,935	13.6		2.2	10.4	11.7		71.5
Fee-For-Service Sample	1,806	NA		2.2	7.9	11.3		NA
State Total/Average	6,057	16.4		2.2	9.3	11.6		NA

○	Less than Expected
◉	Same as Expected
●	Greater than Expected
NR	Not Rated
NA	Not Available

Source: PHC4

[1] NCQA, HEDIS, Calendar Year 1998 - Does not relate to Hospital Admissions columns.

ACCESS, SERVICE AND PREVENTION

HMO	Area Served	Number of Members* (as of December 31, 1998)	Change in Enrollment (between 12/31/97 and 12/31/98)	Number of Primary Care Physicians (PCPs)	Number of PCPs (per 1,000 Members)
Aetna USHC	Eastern and Western PA	866,107	-12.2%	5,202	6.0
Alliance	Erie Area	50,716	24.4%	324	6.4
CIGNA	Philadelphia Area	50,534	23.8%	1,377	27.2
First Priority	Northeastern PA	172,583	13.3%	518	3.0
HealthAmerica HMO	Central and Western PA	218,736	-10.9%	2,628	8.6
HealthAmerica POS	Central and Western PA	86,445	NA	2,628	20.8
HealthCentral	Southcentral PA	39,729	103.4%	942	23.7
HealthGuard	Southeastern PA (except Philadelphia)	91,727	13.5%	832	9.1
Horizon	Philadelphia Area	9,100	NA	1,572	172.7
KHP Central	Central PA and Lehigh Valley	213,183	3.6%	1,531	7.2
KHP East	Philadelphia Area	603,730	9.4%	2,812	4.7
KHP West	Western and Northwestern PA	268,177	6.7%	2,380	8.9
PS/Geisinger	Central, Northcentral and Northeastern PA	224,230	12.2%	1,224	5.5
PruCare	Philadelphia Area	32,277	2.9%	2,639	81.8
Select Blue	Western and Northwestern PA	895,703	-1.0%	2,380	2.7
QualMed East	Philadelphia Area and Northeastern PA	22,054	-29.5%	2,034	92.2
QualMed West	Pittsburgh Area	10,364	-16.9%	678	65.4
UPMC	Western PA	61,798	NA	952	15.4

Source: Pennsylvania Department of Health
NA- Not Available
* Does not include Medicare/Medical Assistance.

ACCESS, SERVICE AND PREVENTION

HMO	Number of Specialists in the Network	Number of Specialists (per 1,000 Members)	Number of General Acute Care (GAC) Hospitals in the Service Area	Percent of all GAC Hospitals in the Plan's Service Area	Additional GAC Hospitals in Network[2]	NCQA Accreditation Status (as of June 2000)
Aetna USHC	19,164	22.1	138	80%	53	Excellent
Alliance	598	11.8	9	100%	3	Accredited
CIGNA	3,061	60.6	NA	NA	NA	NA
First Priority	1,578	9.1	24	92%	4	Excellent
HealthAmerica HMO	6,849	31.3	69	70%	2	Commendable
HealthAmerica POS	6,849	31.3	69	70%	2	Commendable
HealthCentral	2,283	57.5	19	68%	1	NA
HealthGuard	1,732	18.9	13	52%	1	Commendable
Horizon	4,320	474.7	55	98%	4	NA
KHP Central	3,955	18.6	33	94%	6	Excellent
KHP East	7,915	13.1	55	98%	64	Excellent
KHP West	5,420	20.2	79	100%	1	Commendable
PS/Geisinger	1,923	8.6	35	52%	5	Excellent
PruCare	8,497	263.3	48	79%	0	Commendable
Select Blue	5,420	6.1	79	100%	1	Commendable
QualMed East	4,544	206	56	85%	5	Provisional
QualMed West	1,826	176.2	24	30%	0	Provisional
UPMC	2,199	35.6	18	33%	1	NA

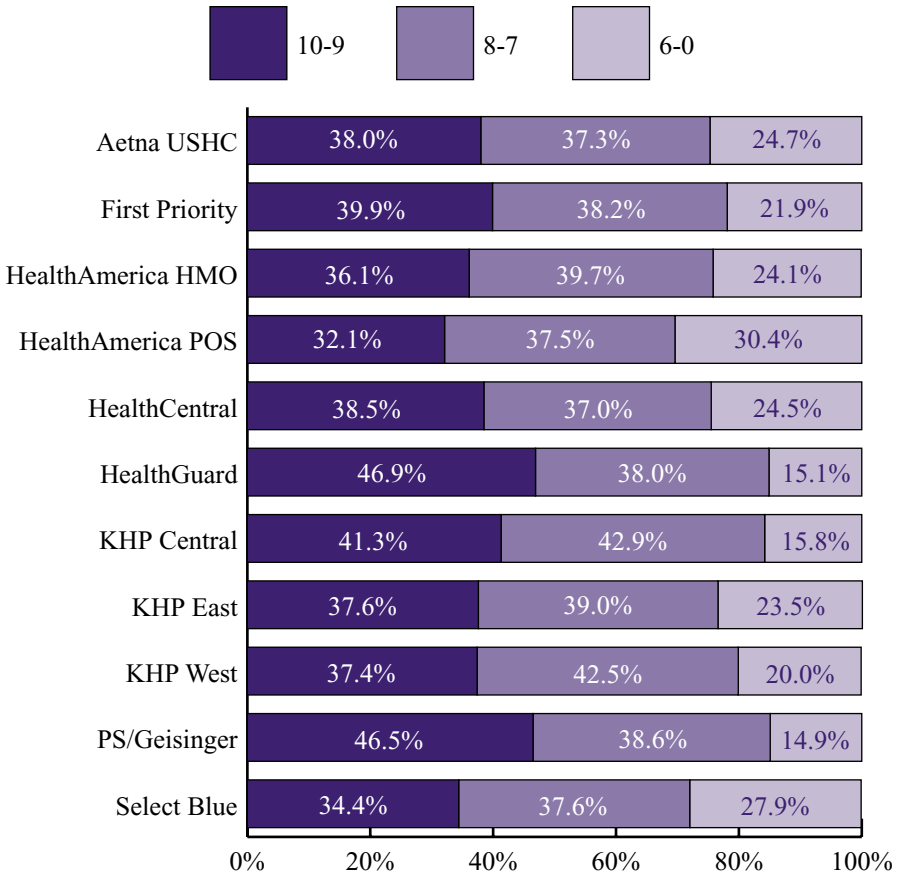
Source: Pennsylvania Department of Health
NA - Not Available
[2] This column represents GAC hospitals that are in the network but are not located within the plan's service area.

ACCESS, SERVICE AND PREVENTION

HOW WOULD YOU RATE YOUR HEALTH PLAN NOW?

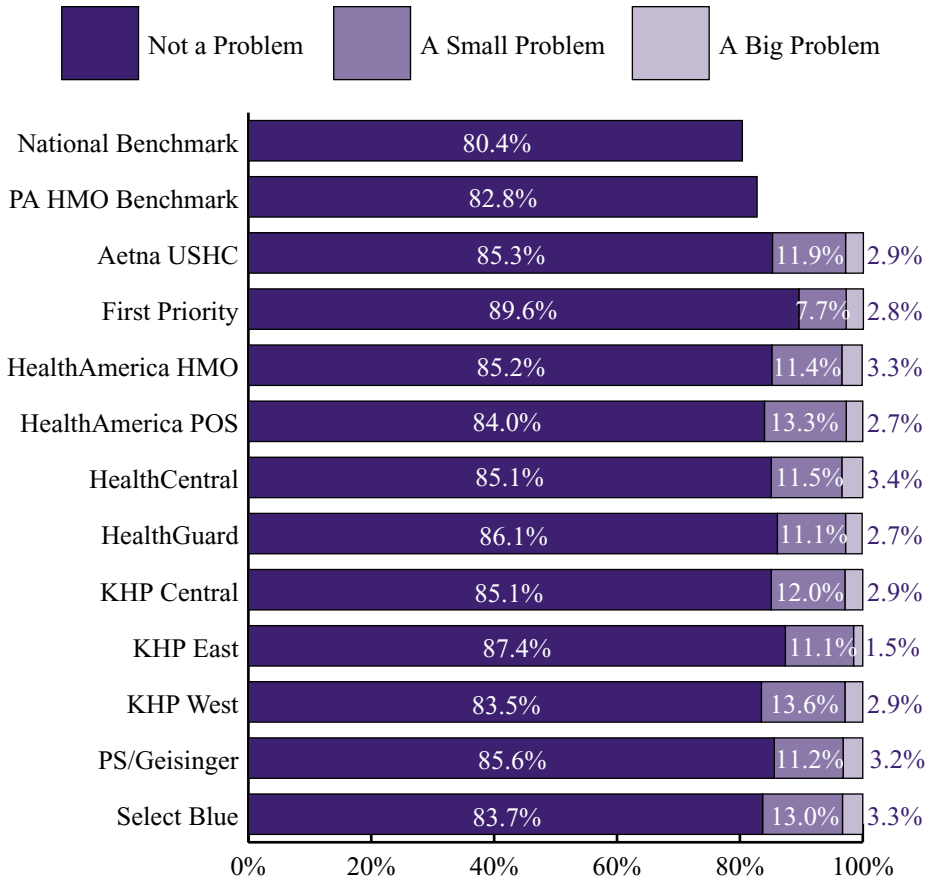
10 = "extremely satisfied with the plan" or
0 = "not satisfied with the plan."

Percentage who gave their plan a rating of:



IN THE LAST 12 MONTHS, HOW MUCH OF A PROBLEM, IF ANY, WAS IT TO GET THE CARE YOU OR A DOCTOR BELIEVED NECESSARY?

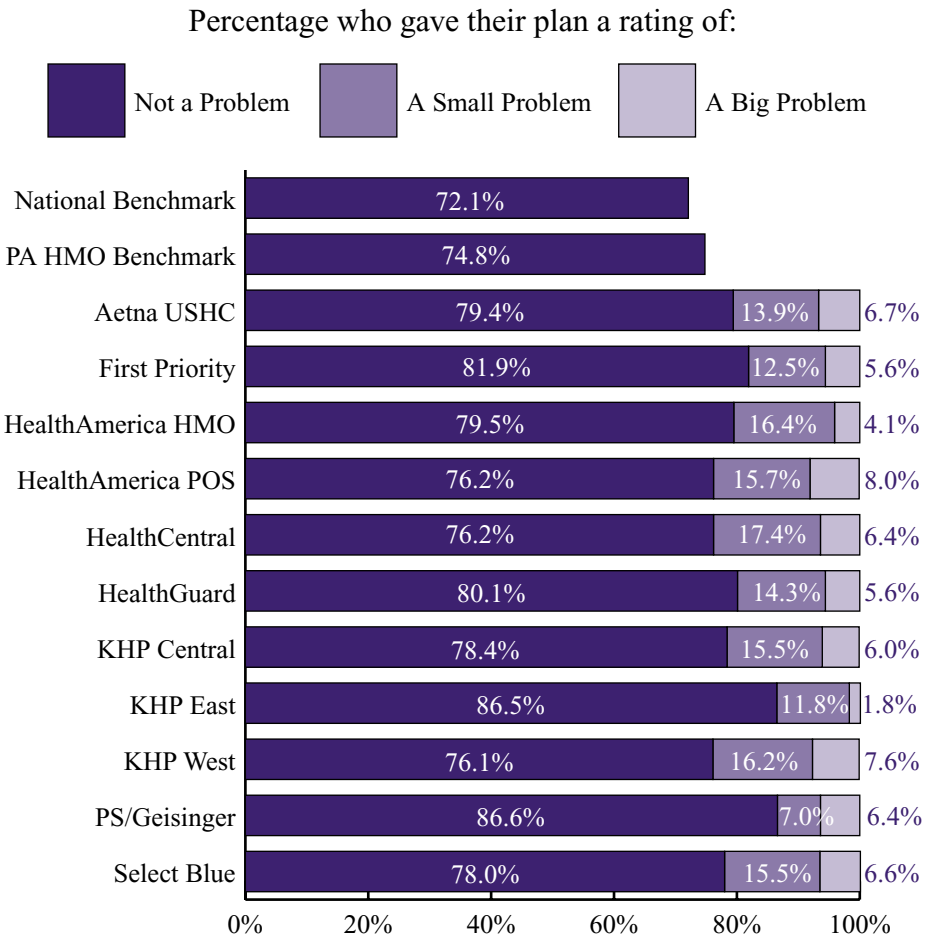
Percentage who gave their plan a rating of:



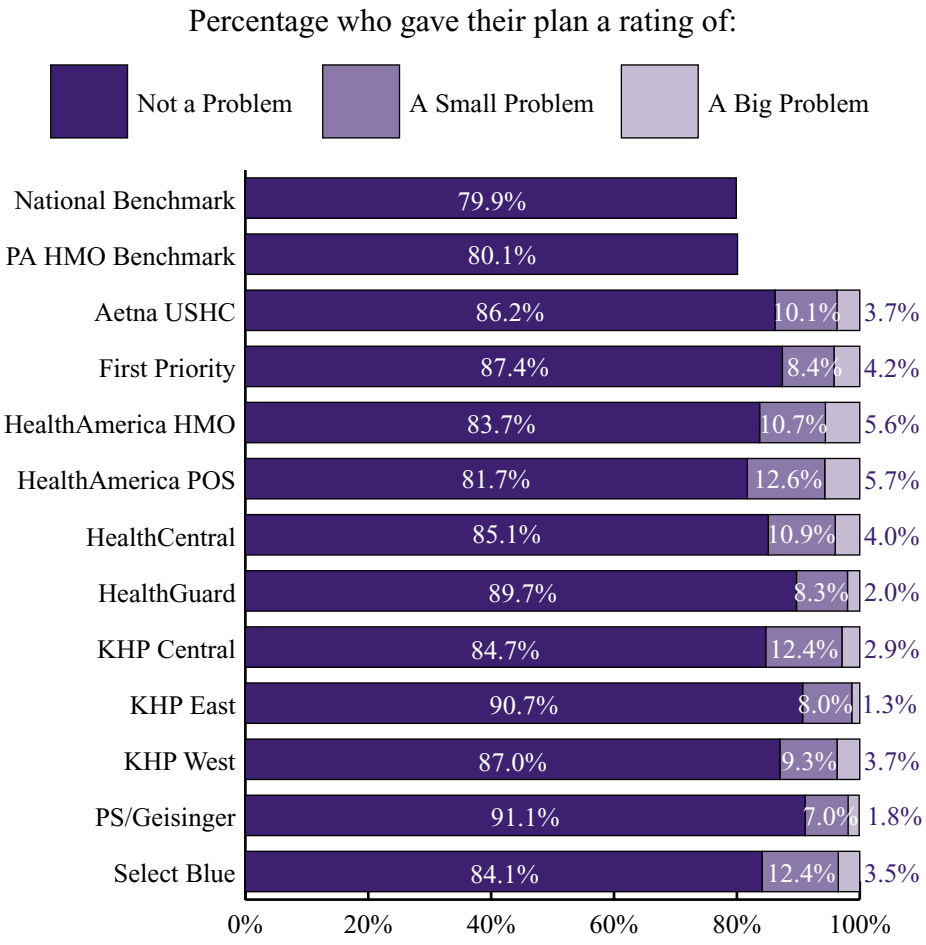
Source: NCQA, CAHPS, Calendar Year 1998
NOTE: Numbers may not add up to 100% due to rounding.

ACCESS, SERVICE AND PREVENTION

IN THE LAST 12 MONTHS, HOW MUCH OF A PROBLEM, IF ANY, WAS IT TO GET A REFERRAL TO A SPECIALIST THAT YOU NEEDED TO SEE?



IN THE LAST 12 MONTHS, HOW MUCH OF A PROBLEM, IF ANY, WERE DELAYS IN HEALTH CARE WHILE YOU WAITED FOR APPROVAL FROM YOUR HEALTH PLAN?

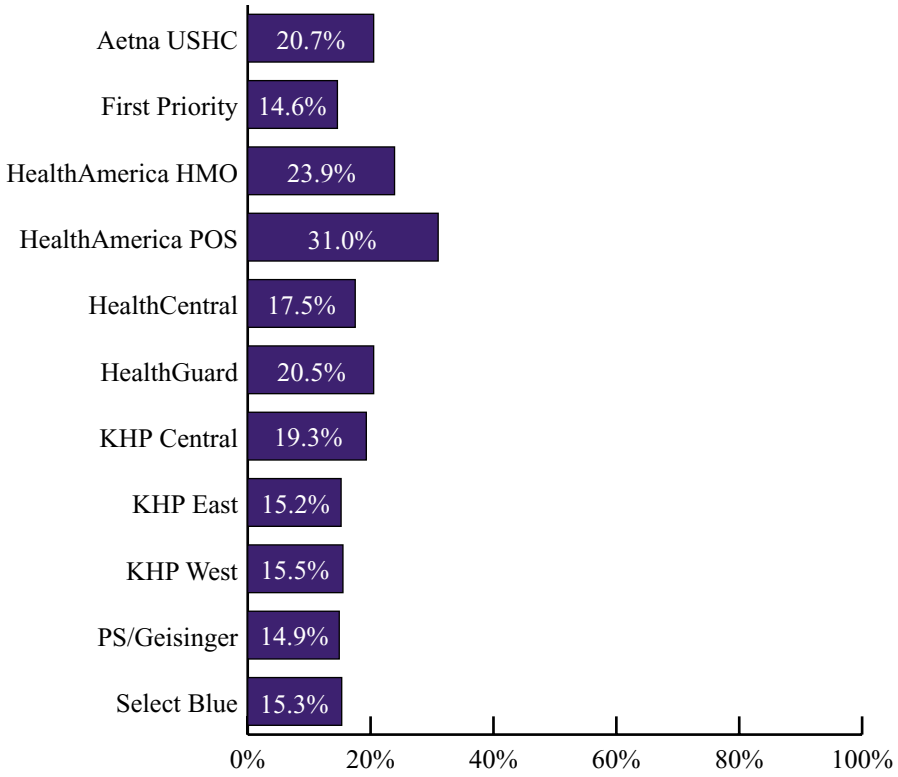


Source: NCQA, CAHPS, Calendar Year 1998
NOTE: Numbers may not add up to 100% due to rounding.

ACCESS, SERVICE AND PREVENTION

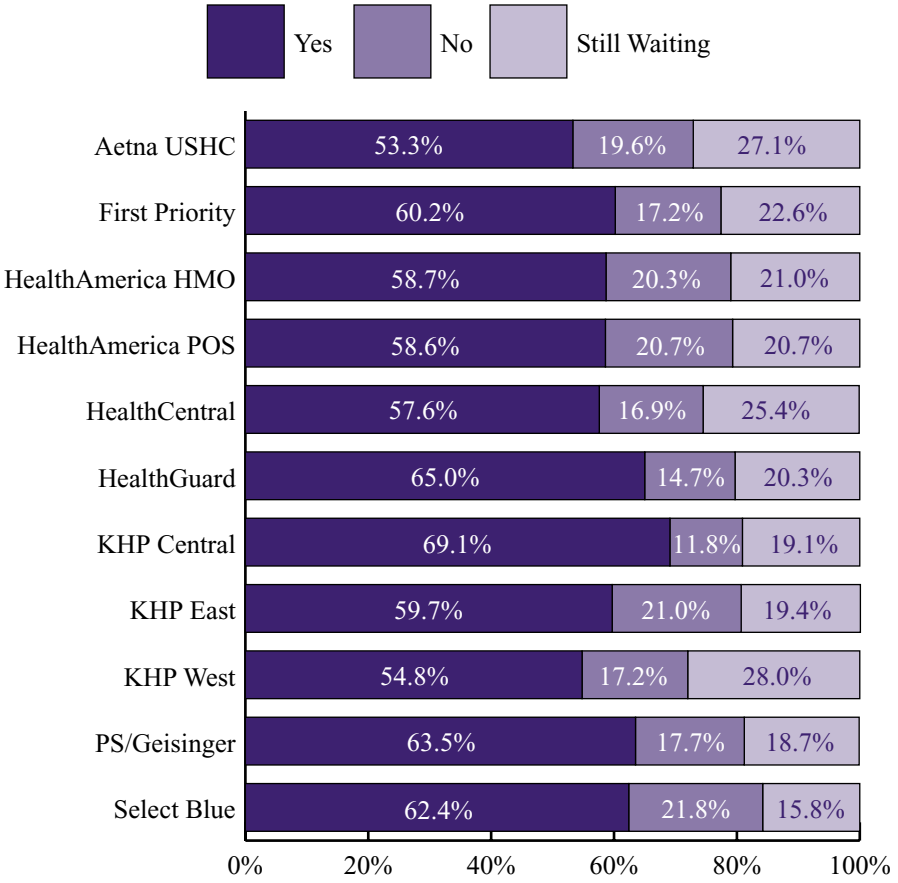
THE PERCENTAGE OF COMPLAINTS RECEIVED IN THE LAST 12 MONTHS

Percentage of members who filed a complaint:



WAS YOUR COMPLAINT OR PROBLEM SETTLED TO YOUR SATISFACTION?

Percentage who gave their plan a rating of:

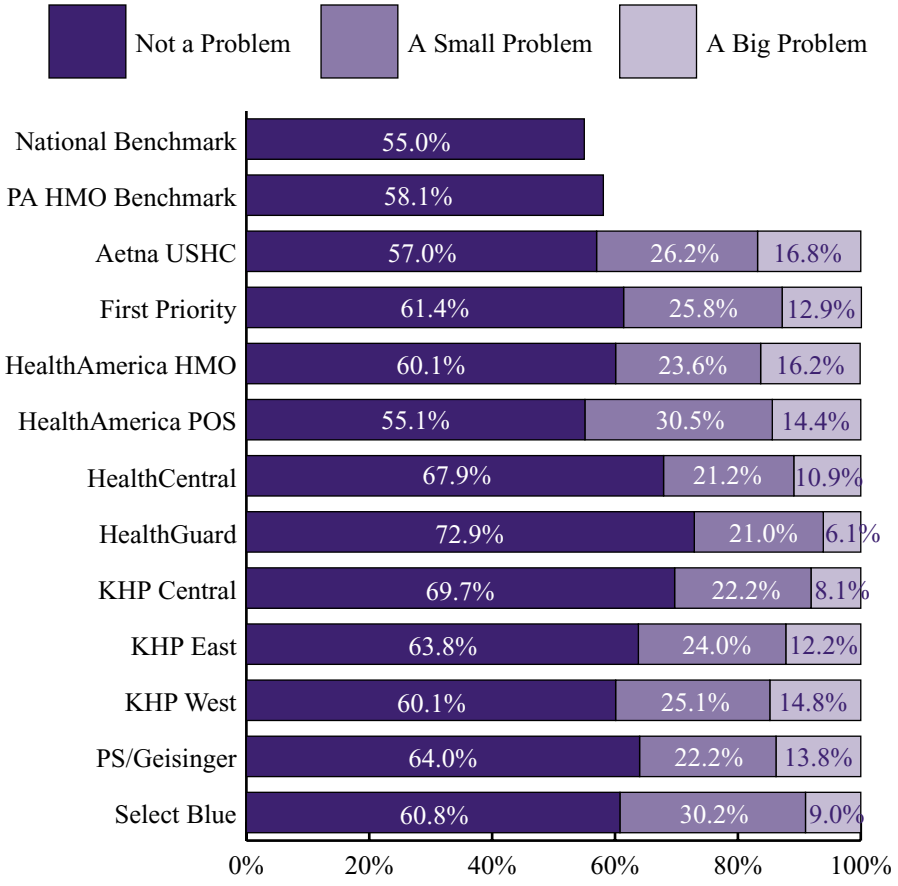


Source: NCQA, CAHPS, Calendar Year 1998
NOTE: Numbers may not add up to 100% due to rounding.

ACCESS, SERVICE AND PREVENTION

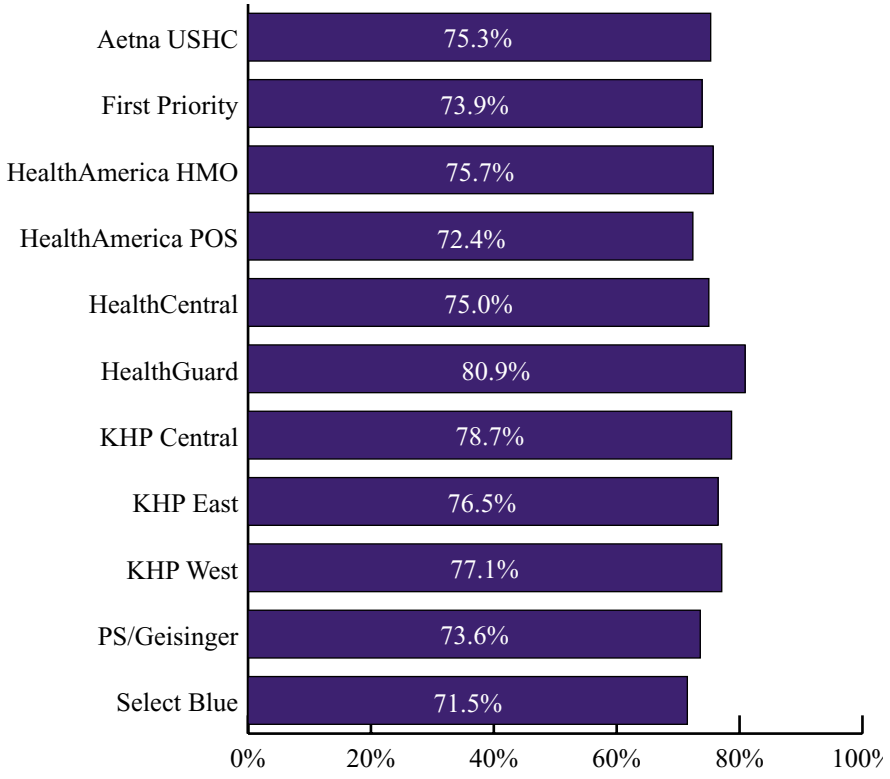
IN THE LAST 12 MONTHS, HOW MUCH OF A PROBLEM, IF ANY, WAS IT TO GET THE HELP YOU NEEDED WHEN YOU CALLED YOUR HEALTH PLAN'S CUSTOMER SERVICE?

Percentage who gave their plan a rating of:



IN THE LAST 12 MONTHS, DID YOU MAKE ANY APPOINTMENTS WITH A DOCTOR OR OTHER HEALTH PROVIDER FOR REGULAR OR ROUTINE HEALTH CARE?

Percent of total adult membership accessing the network

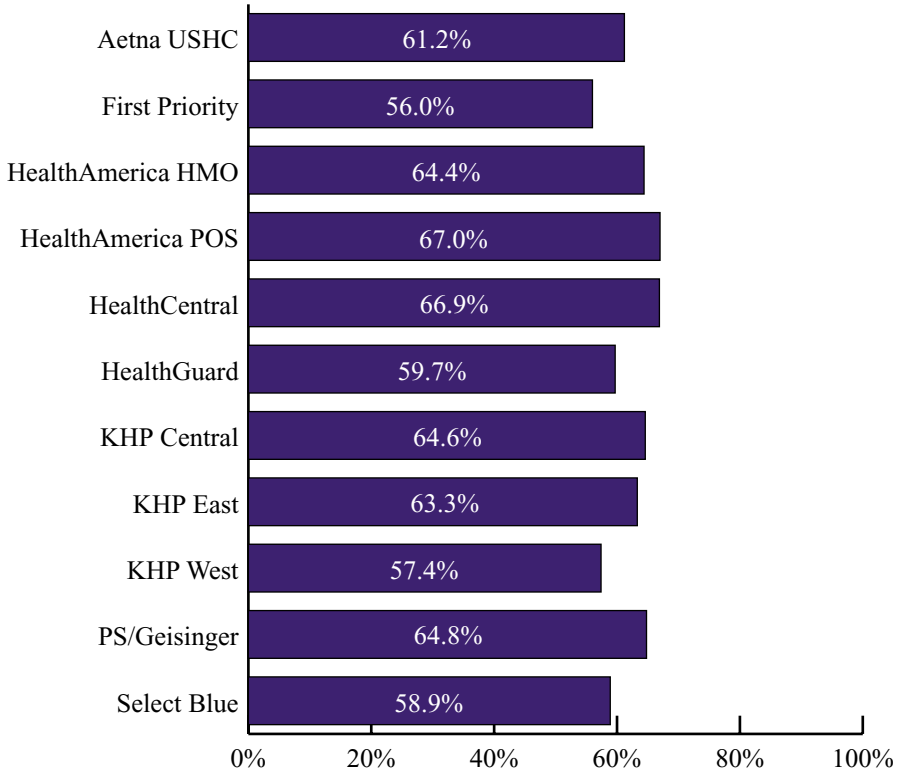


Source: NCQA, CAHPS, Calendar Year 1998
NOTE: Numbers may not add up to 100% due to rounding.

Smoking Cessation

A particularly important HEDIS measure is smoking cessation which indicates the percent of smokers who reported that their doctor advised them to quit. As a risk factor for acute myocardial infarction, heart failure, and asthma, smoking is a major contributor to preventable premature mortality in the United States. Secondhand smoke affects others, but especially affects children because of their lung development. Children exposed to secondhand smoke are more likely to develop asthma and those with asthma experience more severe and frequent episodes. Smoking cessation decreases these risks and may prevent the onset of cardiac diseases, cancer, and other related illnesses. Individuals who quit smoking after coronary bypass surgery reduce the frequency of angina and the number of hospital admissions while improving function and survival. Drugs, such as nicotine nasal spray, nicotine gum, and transdermal nicotine patches are available by prescription and over-the-counter to help smokers break the habit.

PERCENT OF MEMBERS ADVISED TO QUIT SMOKING DURING A DOCTOR'S OFFICE VISIT OVER THE LAST YEAR

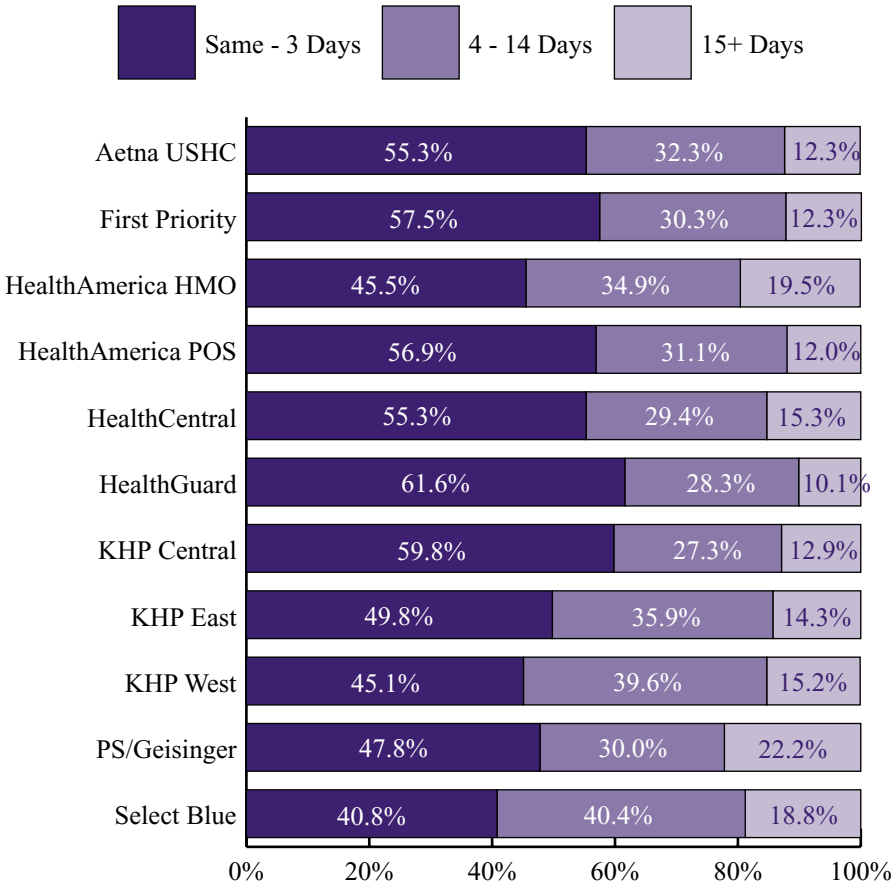


Source: NCQA, HEDIS, Calendar Year 1998

ACCESS, SERVICE AND PREVENTION

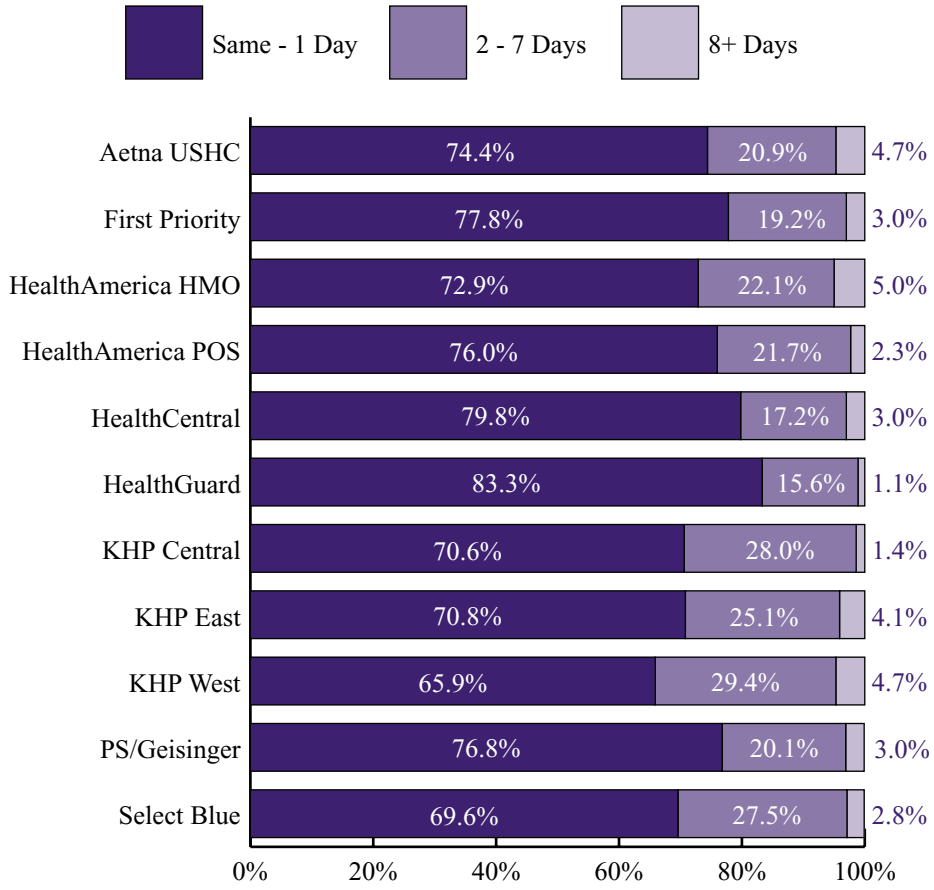
IN THE LAST 12 MONTHS, HOW MANY DAYS DID YOU USUALLY HAVE TO WAIT BETWEEN MAKING AN APPOINTMENT FOR REGULAR OR ROUTINE CARE AND ACTUALLY SEEING A PROVIDER?

Percentage who gave their plan a rating of:



IN THE LAST 12 MONTHS, HOW LONG DID YOU USUALLY HAVE TO WAIT BETWEEN TRYING TO GET CARE AND ACTUALLY SEEING A PROVIDER FOR AN ILLNESS OR INJURY?

Percentage who gave their plan a rating of:



Source: NCQA, CAHPS, Calendar Year 1998
NOTE: Numbers may not add up to 100% due to rounding.

FINANCIAL INDICATORS

HMO	Total Revenue	Profit After Taxes[3]	Percent of Premium Revenue Spent on Health Care
Aetna USHC	$1,003,291,606	$11,628,675	87.4%
Alliance	$61,659,147	($1,702,335)	88.7%
CIGNA	$13,284,171	$7,279,202	121.1%
First Priority	$182,175,845	($13,047,060)	93.5%
HealthAmerica HMO/POS	$286,082,813	$11,477,445	87.3%
HealthCentral	$51,290,501	($1,586,060)	84.7%
HealthGuard	$71,826,538	($1,260,962)	93.9%
Horizon	$6,660,921	($9,871,594)	143.0%
KHP Central	$194,128,708	($1,523,600)	91.0%
KHP East	$744,080,551	($3,295,984)	78.1%
KHP West	$402,509,634	($11,155,325)	89.6%
PS/Geisinger	$215,324,767	$9,019,005	89.6%
PruCare	NA	NA	NA
QualMed East	$43,881,190	($56,345)	84.8%
QualMed West	$23,100,347	($897,336)	85.8%
Select Blue	$1,391,020,002	($17,994,501)	90.8%
UPMC	$10,381,132	($3,113,575)	96.0%

Source: Pennsylvania Insurance Department
NA - Not Available
[3] Brackets indicate a negative number.

GETTING MORE INFORMATION

The following table includes the HMOs and POS options included in this report. For each, the telephone number and Web site addresses are provided to help you contact the plans of most interest to you. Not every HMO may be available in your area; check with your employer or the plans for additional information regarding availability.

Full Name	Abbreviated Name	Contact Number	Web Site Address
Aetna U.S. Healthcare	Aetna USHC	1-800-991-9222	www.aetnaushc.com
Alliance Health Network	Alliance	1-800-255-4281	NA
CIGNA Healthcare of Pennsylvania	CIGNA	1-800-345-9458	www.cigna.com/healthcare
First Priority Health	First Priority	1-800-822-8753	www.bcnepa.com
HealthAmerica[4]	HealthAmerica HMO	1-800-788-8445 (Central PA)	www.healthamerica.covty.com
	HealthAmerica POS	1-800-735-0708 (Pittsburgh PA)	www.healthamerica.covty.com
HealthCentral	HealthCentral	1-888-672-9652	NA
HealthGuard of Lancaster	HealthGuard	1-800-822-0350	www.hguard.com
Highmark Blue Cross/Blue Shield (Select Blue)	Select Blue	1-800-350-4130	www.highmark.com
Horizon Healthcare	Horizon	1-800-404-4661	www.horizon-healthcare.com
Keystone Health Plan Central	KHP Central	1-800-547-2583	www.khpc.com
Keystone Health Plan East	KHP East	1-800-555-1514	www.ibx.com/1
Keystone Health Plan West (Keystone Blue)	KHP West	1-800-350-4130	www.highmark.com
Penn State Geisinger Health Plan	PS/Geisinger	1-800-631-1656	www.thehealthplan.com
Prudential Health Care Plan	PruCare	1-800-991-9222	www.aetnaushc.com/pruhealthcare
QualMed Plans for Health	QualMed East	1-800-988-2840	www.qualmedpa.com
QualMed Plans for Health of Western PA	QualMed West	1-800-922-3323	www.qualmedpa.com
UPMC Health Plan, Inc.	UPMC	1-800-644-1046	www.upmc.edu/upmchealthplan/

NA - Not Available

[4] HealthAmerica is licensed in Pennsylvania as HealthAmerica of Pittsburgh and HealthAmerica of Central PA. Both branches offer POS and HMO health insurance.

PERSONAL WORKSHEET

The worksheet below can help you consider the points that are important to you when choosing an HMO. Use the worksheet to organize the information that is in the booklet and in other materials you may have obtained from your employer or the HMOs.

Plan Name	*Location* Which plans service your area? Page 18	*Benefits* Which plans offer the benefits you want?	*Doctors/Hospitals* Which plans include your preferred doctor and hospital?	*Cost* Which plan can you best afford?	*Quality* Which plans scored well on the quality ratings in this booklet?	
					Treatment Measures Pages 8-17	Access, Service and Prevention Pages 18-25

Cut Along Dotted Line

Reporting Number: 2000-08/14-01