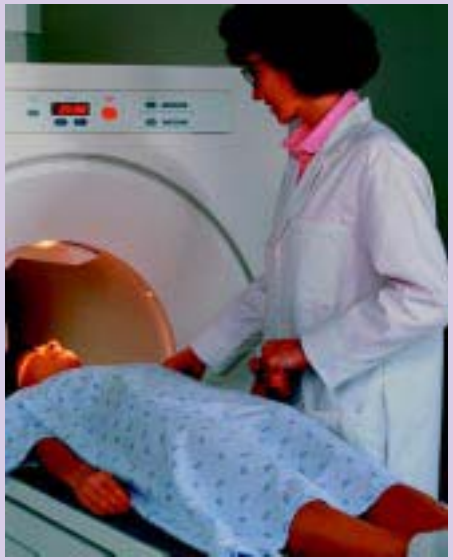

Measuring the Quality of Pennsylvania's Commercial HMOs

*A Managed Care Performance Report**

Pennsylvania Health Care Cost Containment Council (PHC4)

* Does not include Medicare or Medical Assistance HMO plans.

JUNE 2001

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About this Report - Measuring Quality

Why is reporting on HMO quality important?

Not all HMOs are the same. For this reason, using information to measure HMO quality is important. *Measuring the Quality of Pennsylvania's Commercial HMOs – A Managed Care Performance Report* is one valuable resource for this process.

Measuring the Quality of Pennsylvania's Commercial HMOs is the second in an annual series of reports produced by the Pennsylvania Health Care Cost Containment Council (PHC4) to examine the quality of care HMOs provide. Each report combines clinical results, preventive measures, member satisfaction information and financial indicators for a broad overview of HMO performance. This second edition expands on the structure introduced by the original report, but presents different clinical conditions and procedures and new measures. To allow for comparison to the previous report, the member satisfaction survey questions remained the same in this issue. In addition to the hard copy report, there is an interactive database on PHC4's web site that allows you to customize the report. With this report, Pennsylvanians have more information than ever about HMOs operating in the state.

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. 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 and other initiatives to keep their members healthy. HMO members usually are required to select a Primary Care Physician (PCP) who has 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 pre-approved referrals) with the flexibility to access services without pre-approved referrals and the option to leave the network of participating providers by paying an additional fee.

Why Focus on HMOs?

Three important functions of managed care are prevention, management of on-going illnesses and acute care. These functions result in a number of features that are attractive to those who purchase health insurance. These features include:

- Emphasis upon prevention and primary care services for HMO members
- More efficient management of the health care process
- Ability to hold down costs
- Small out-of-pocket costs for consumers for many services

This report helps to assess how well Pennsylvania's HMOs are doing in meeting some of these goals. A User's Guide found on page 5 lists a variety of ways this report can be used.

Sources of Data

Inpatient hospital data used in the analysis of treatment measures were submitted to PHC4 by Pennsylvania hospitals. Information included in the Plan Profiles was provided by the Pennsylvania Department of Health. The Pennsylvania Insurance Department provided financial information used to calculate the financial indicators for each HMO. 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). HEDIS provides the specific Prevention Measures included in this report. The member satisfaction measures were taken from the Consumer Assessment of Health Plans Survey® (CAHPS).

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 rehospitalizations are sometimes unavoidable consequences of a patient's medical condition. Hospitals, physicians and health insurance plans may do everything right and still the patient may experience other problems.

In addition, an HMO's success in helping members to manage health problems depends in part upon members' willingness and ability to comply with their providers' treatment decisions. While HMOs play an important role in the delivery of care, 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 from only 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 this report verified that they were the primary insurer for the hospitalizations analyzed in this report.

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

PHC4 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.

Additional information related to this report, such as HMO comments and the Technical Report, is posted on the PHC4 Web site at www.phc4.org. Other PHC4 publications related to HMOs include:

- *Measuring the Quality of Pennsylvania's HMOs - A Managed Care Performance Report* (first published in 2000)
- *The Role of HMOs in Managing Diabetes*

User's Guide

Measuring the Quality of Pennsylvania's Commercial HMOs – A Managed Care Performance Report provides comparative information designed for a broad audience. Users may have different needs for this information; thus, this User's Guide provides ideas about how different audiences might use this report.

Health care purchasers

Health care purchasers such as employers and union leaders design benefits packages for their employees. This report allows purchasers to:

- Compare plans based on an array of clinical, patient satisfaction and financial indicators
- Measure performance in regards to prevention/wellness and disease management, the unique elements of managed care that purportedly keep members healthy
- Negotiate health care benefits with information about the plan's performance
- Raise questions concerning variation among plans
- Share information with employees

Consumers

Ultimately, consumers are the ones most affected by health care decisions. Consumers may use this report to:

- Ask employers, HMOs and providers about the information contained in this report, especially the differences among HMOs
- Become more informed as you consider which HMO to choose
- Learn about common medical conditions, treatments and surgical procedures

Health plans

One of the primary purposes of this report is to stimulate quality improvement discussions among health plans. Health plans may use the report to:

- Compare your performance with other plans
- Evaluate your plan's performance over time
- Identify strengths and weaknesses in your company's quality improvement process
- Identify opportunities to improve the performance of providers in your network

Providers

Health care professionals and facilities provide the care that consumers receive. Providers can use the report to:

- Compare outcomes measures among health plans
- Initiate quality improvement discussions with health plans
- Evaluate current treatment strategies
- Encourage patients to use the report as a guide

Government agencies

Government agencies play many roles within the health care industry. This report is helpful to:

- Administrators who arrange, monitor and evaluate health care services for program beneficiaries, such as the Pennsylvania Employees Benefit Trust Fund; the state's Medical Assistance program, the Children's Health Insurance Program (CHIP), the Pennsylvania Department of Health and the Pennsylvania Insurance Department.

Policymakers

Policymakers formulate health care legislation and interact with constituents who have questions regarding health care in the state. This report can:

- Identify local variations in care
- Help community leaders form coalitions to improve quality at local and regional levels
- Provide a tool for more informed policy decisions
- Serve as a valuable resource for constituents.

Accounting for Differences in Illness Level, Age and Sex Across HMOs - In Brief

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 to the hospital, have longer lengths of stay, or have greater potential for complications because they are more seriously ill or at greater risk.

Age and sex adjustments are also applied. For example, a particular HMO that has a higher proportion of older patients in comparison to other HMOs will also have a higher expected hospitalization rate. PHC4's system "expects" more health problems in HMOs with older populations and makes adjustments for that expectation to allow for fair comparisons across the HMOs.

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.

Acknowledgements

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

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

Finally, thanks are also extended to PHC4's Data Systems Committee, chaired by Bernard K. Murray; its Payor Advisory Group, chaired by Leonard A. Boreski; its Education Committee, chaired by Dr. Carl A. Sirio; and its Technical Advisory Group, chaired by David B. Nash, MD, MBA, for their contributions to this report.

Prevention and wellness programs are essential parts of a good quality care effort. Promotion of good health, and early intervention when a problem is identified, encourages healthy lifestyles, prevents later complications, avoids lost productivity, and ultimately reduces the cost of health care to everyone.

There are several ways HMOs foster good health and promote healthy behavior. The first is through education. Most HMOs provide newsletters, information packets and recorded telephone messages for the use of their members. Members with serious health problems or on-going illnesses may have access to special programs. HMOs also provide direct services to members, usually at a modest cost, for the prevention or early detection of health problems. These include childhood immunizations, periodic breast and cervical cancer screenings, and prenatal care. Other efforts, such as advising smokers to quit, address the health care provider's role in helping HMO members maintain a healthy lifestyle. This section focuses upon two important prevention measures:

- Advising Smokers to Quit
- Reducing Hospitalizations through Primary Care

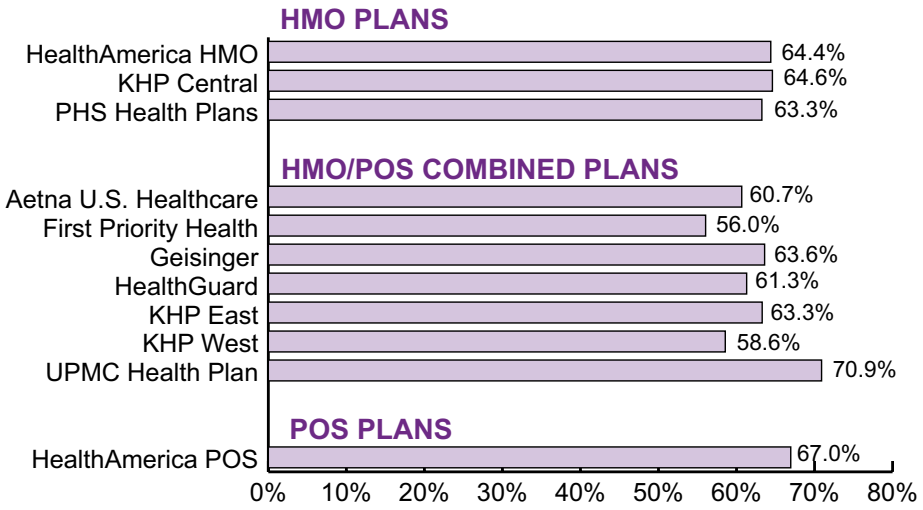
Advising Smokers to Quit

A particularly important prevention measure is advising smokers and other tobacco users to quit. The graph to the right reports the percent of adult smokers (or recent quitters) advised by their PCP during an office visit over the past twelve months to quit smoking. As a risk factor for heart disease and many of the conditions included in this report, smoking is a major contributor to premature death in the United States. Smoking also aggravates many of the conditions included in this report, including hypertension, COPD, diabetes and recovery from neck and back surgery.

Secondhand smoke affects others, but especially children because of their lung development. Children exposed to secondhand smoke are more likely to develop asthma, and children with asthma experience more severe and frequent episodes.

NCQA recommends that HMOs encourage doctors in their networks to talk openly with patients about smoking and to provide opportunities and programs that encourage and support members to quit. Other assistance, such as nicotine patches and other pharmaceutical aids, may also be offered through an HMO.

Percent of Adult Members Advised to Quit Smoking During a Doctor's Visit Last Year



* These scores are for calendar year 1998 in accordance with NCQA's rotation strategy. Please see the Technical Report for a full explanation.

Reducing Hospitalizations through Primary Care

When the HMO provider network is functioning properly, an enrollee's primary care physician, all specialists and all facilities involved in providing care should work together to insure that the patient receives the care necessary to treat or prevent illness. The HMO coordinates these efforts.

A good way of measuring the effectiveness of a plan's coordination of care can be seen by analyzing "unnecessary" or "preventable" hospitalizations. When the plan's network functions as it should, care for these conditions can generally be provided on an "outpatient" basis, often in the PCP's office, and should not necessitate inpatient hospitalization.

This report includes a sample of medical conditions for which timely and effective primary care will reduce hospitalizations by preventing or managing a condition. Each HMO's rate of "preventable" hospitalizations is included for the following conditions:

Ear, Nose and Throat Infections – Ear, nose and throat infections include medical conditions that cause an inflammation of the various parts of the head and throat. Outcomes are reported separately for pediatric (under 18 years) and adult members (18 years to 64 years). Foremost among pediatric conditions is otitis media, or inflammation of the middle ear, the most frequent diagnosis recorded for children who visit physicians for illness. Otitis media is the most common cause of hearing loss in children.

The most common conditions for adults include infection of the tonsils, sinuses, trachea, and the collective group of infections commonly known as "sore throat."

Gastrointestinal Infections – This term is used to describe a variety of viral, bacterial or parasitic infections of the digestive tract. Outcomes for this measure are provided for all HMO members under age 65. Symptoms of adult gastroenteritis include severe nausea, vomiting, abdominal pain, diarrhea and fever.

Kidney/Urinary Tract Infections – The term "kidney/urinary tract infection" covers a wide variety of medical conditions. These infections are common, second only to respiratory infections, and are usually treated with antibacterial medications. Women are especially prone to these infections. These measures include all HMO members under the age of 65 years.

Hypertension – Hypertension, or high blood pressure, is an example of an adult chronic condition that can benefit from primary care. Left untreated, hypertension can lead to serious cardiac and other circulatory problems. Measures for hypertension include HMO members from 18 to 64 years old.

Chronic Obstructive Pulmonary Disease (COPD) – COPD is an incurable disease of the lungs. It includes a number of chronic lung disorders that obstruct the airways or damage the air sacs deep in the lungs. The disease results from damage to the lungs over a period of years from such factors as smoking, occupational exposure (breathing chemical fumes, cotton, wood or mining dusts) or from bacterial or viral infections. Measures for COPD include HMO members from 18 to 64 years old.

Understanding the Tables

What we measured…

Hospital Admissions – This is the number of HMO members who were hospitalized during calendar year 1999 where the condition reported was the principal reason for being hospitalized as an inpatient.

Hospitalization Rate – This is the number of hospital admissions per 10,000 HMO members. This rate is age and sex adjusted. A *lower* hospitalization rate suggests that the plan's network was effective in fostering disease prevention and wellness.

Statistical Rating – Symbols representing statistical significance or importance are displayed for hospitalization rates. These symbols will tell you if the difference between the actual and expected rates was statistically:

- ○ Less than expected,
- ⊙ Same as expected, or
- ● Greater than expected.

Why are these measures important?

Lack of effective preventive care can result in more hospitalizations, especially for certain clinical circumstances and for groups of at-risk individuals. For this reason, analyzing potentially avoidable hospitalizations provides a way to monitor access to, and quality of, health care services by HMOs.

Comparing hospitalization rates (and future patterns observed over time) should begin a discussion of how the HMO's provider network is functioning. It may also help identify specific groups or conditions where care is effective or in need of improvement. Though some of these conditions are chronic, the entire membership of an HMO is affected by these outcomes. All will benefit from improved delivery of primary care and lower costs due to fewer hospitalizations.

EAR, NOSE AND THROAT INFECTIONS

	PEDIATRIC MEMBERS			ADULT MEMBERS		
	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating
HMO Plans						
HealthAmerica HMO	45	8.0	⊙	24	1.7	⊙
KHP Central	27	4.4	○	17	1.3	⊙
PHS Health Plans	8	14.7	●	3	1.9	⊙
HMO/POS Combined Plans						
Aetna U.S Healthcare	211	8.4	●	148	2.5	●
CIGNA	5	2.7	○	2	0.5	○
First Priority Health	23	4.2	○	29	2.3	⊙
Geisinger	30	4.5	○	27	1.5	⊙
HealthGuard	28	10.2	●	10	1.5	⊙
KHP East	110	5.5	⊙	87	1.9	⊙
KHP West	203	6.3	⊙	136	1.6	⊙
NewAlliance	4	2.7	⊙	4	1.1	⊙
UPMC Health Plan	15	3.9	○	11	2.6	⊙
POS Plans						
HealthAmerica POS	26	10.1	●	12	1.9	⊙
Total/Average:	735	6.4		510	1.9	

Source: PHC4

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

GASTROINTESTINAL INFECTIONS

	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating
HMO Plans			
HealthAmerica HMO	64	3.3	⊙
KHP Central	71	3.7	●
PHS Health Plans	6	2.8	⊙
HMO/POS Combined Plans			
Aetna U.S Healthcare	252	3.0	⊙
CIGNA	12	2.1	⊙
First Priority Health	47	2.6	⊙
Geisinger	29	1.2	○
HealthGuard	19	2.0	⊙
KHP East	154	2.3	⊙
KHP West	338	2.9	⊙
NewAlliance	11	2.2	⊙
UPMC Health Plan	28	3.3	⊙
POS Plans			
HealthAmerica POS	22	2.5	⊙
Total/Average:	1,053	2.7	

Source: PHC4

KIDNEY/URINARY TRACT INFECTIONS

	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating
HMO Plans			
HealthAmerica HMO	56	2.9	⊙
KHP Central	58	3.1	⊙
PHS Health Plans	10	4.8	⊙
HMO/POS Combined Plans			
Aetna U.S Healthcare	366	4.4	●
CIGNA	9	1.7	○
First Priority Health	48	2.7	⊙
Geisinger	54	2.2	○
HealthGuard	27	2.8	⊙
KHP East	206	3.2	⊙
KHP West	411	3.5	⊙
NewAlliance	15	3.0	⊙
UPMC Health Plan	27	3.2	⊙
POS Plans			
HealthAmerica POS	26	2.9	⊙
Total/Average:	1,313	3.4	

○ Less than Expected
⊙ Same as Expected
● Greater than Expected

HYPERTENSION

ADULT MEMBERS ONLY			
	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating
HMO Plans			
HealthAmerica HMO	19	1.4	⊙
KHP Central	9	0.7	○
PHS Health Plans	3	1.9	⊙
HMO/POS Combined Plans			
Aetna U.S Healthcare	109	1.9	⊙
CIGNA	6	1.8	⊙
First Priority Health	13	1.1	⊙
Geisinger	13	0.7	○
HealthGuard	13	1.8	⊙
KHP East	127	2.9	●
KHP West	114	1.3	○
NewAlliance	4	1.1	⊙
UPMC Health Plan	12	2.4	⊙
POS Plans			
HealthAmerica POS	5	0.8	⊙
Total/Average:	447	1.6	

Source: PHC4

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

ADULT MEMBERS ONLY			
	Hospital Admissions	Hospitalization Rate per 10,000 Members	Statistical Rating
HMO Plans			
HealthAmerica HMO	64	4.5	⊙
KHP Central	34	2.7	○
PHS Health Plans	16	10.2	●
HMO/POS Combined Plans			
Aetna U.S Healthcare	324	5.6	●
CIGNA	10	3.3	⊙
First Priority Health	59	5.0	⊙
Geisinger	47	2.7	○
HealthGuard	18	2.4	○
KHP East	184	4.4	⊙
KHP West	455	5.1	⊙
NewAlliance	17	4.9	⊙
UPMC Health Plan	23	4.1	⊙
POS Plans			
HealthAmerica POS	26	4.1	⊙
Total/Average:	1,277	4.7	

○ Less than Expected
⊙ Same as Expected
● Greater than Expected

THE MANAGEMENT OF ON-GOING ILLNESSES

This section looks at two areas in which HMOs have invested a large amount of resources to help their members manage on-going illnesses: diabetes and mental health.

HMOs manage on-going conditions through the design and implementation of proactive programs. These programs are often called "disease management." There are several functions involved in managing on-going illnesses, all designed to work together to improve the health of the HMO member and to reduce or avoid future medical costs. These functions include:

- Correctly identifying members that will benefit from a disease management program and matching them with an appropriate program (examples include specific programs for members with diabetes or asthma).
- Working with physicians and the HMO members to gain their cooperation and participation in education and treatment programs.
- Providing programs and treatment interventions that measurably improve the health and quality of life for participants.

These programs often follow recommendations and treatment standards provided by appropriate organizations (such as the American Diabetes Association) or by the physicians within the HMO. Sometimes specific services are subcontracted to companies or facilities that provide specialized programs. For instance, HMOs may send their members to diabetes education and monitoring programs provided by local hospitals.

Perhaps the most important part of managing on-going illnesses is the partnership between the HMO and its physicians. They collectively have the responsibility to assure that HMO members are receiving appropriate and optimal medical treatment and to help HMO members change personal behaviors to help control their disease.

HMOs often share information about chronic diseases, offer continuing education from the PCP and other sources, monitor the results of the medical intervention, and track the degree of compliance of HMO members with programs and medical advice.

Outcome measures are reported for two on-going illnesses: Diabetes and Mental Health. Diabetes measures were derived from hospital data submitted to PHC4. Also included are the HEDIS Diabetes Comprehensive Care measures. In addition, information regarding the specific programs offered to members with diabetes was reported by each HMO. A second set of measures summarizes participation and outcomes for Mental Health services. These outcomes were reported to NCQA by participating HMOs.

Diabetes

Diabetes is an on-going disease in which the body does not produce enough or properly use insulin – a hormone needed to convert blood sugar into energy. There are two main types of diabetes:

- Type 1 diabetes usually appears in children or young adults and accounts for 5 percent to 10 percent of all diagnosed cases of diabetes. With Type 1 diabetes, the body does not produce enough insulin, so people with Type 1 diabetes receive daily insulin injections.
- Type 2 diabetes is the most common form of diabetes, estimated to account for about 90 percent to 95 percent of all diagnosed cases of diabetes. Cases of Type 2 diabetes have historically developed in people over age 45, but are now being diagnosed in younger people as well. With Type 2 diabetes, the body is resistant to insulin and cannot use it properly. While most people with Type 2 diabetes control their disease through oral medications, diet and exercise, approximately 40 percent of people with Type 2 diabetes require insulin injections.

More than 500,000 Pennsylvania residents have been diagnosed with diabetes, and several hundred thousand more may also be suffering from the disease, but have yet to be diagnosed. Diabetes is a serious health concern that can be associated with severe complications. It can lead to work loss, disability and premature death. In addition, diabetes exacts a hefty toll on the resources of the health care delivery system. The American Diabetes Association estimates the direct medical cost of diabetes to be 44 billion dollars nationally, with an additional 54 billion dollars attributable to disability, work loss, and premature mortality. For people with diabetes, the key to a healthy life is to follow prescribed treatment plans involving nutrition, exercise and medication.

Diabetes management plays an important role in helping members with diabetes avoid or minimize complications by focusing on education, prevention, wellness, and compliance with accepted treatment protocols. The results may be fewer hospitalizations and an improved quality of life for people with diabetes.

Understanding the Tables

What we measured. . .

Hospitalization Information:

Members with Diabetes - This figure was provided by each health plan and corresponded to the definition used for HEDIS reporting, i.e. people between 18 and 75 years of age who met a standard definition for diabetes and continuous enrollment criteria. This definition does not distinguish between Type 1 and Type 2 diabetes.

Hospital Admissions - This is the number of members with diabetes who were hospitalized during calendar year 1999 where diabetes was the principal reason for being hospitalized.

Hospitalization Rate - This is the number of hospital admissions per 10,000 members with diabetes. This rate is age and sex adjusted. Note that the lower the hospitalization rate of an HMO, the more effective that plan's network was in fostering prevention and wellness for its members with diabetes.

Statistical Rating - Symbols representing statistical significance or importance are displayed for hospitalization rates. These symbols will tell you if the difference between the actual and expected rates was statistically:

- ○ Less than expected,
- ⊙ Same as expected, or
- ● Greater than expected.

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

Percent of Admissions for Short-Term Complications of Diabetes - These hospitalizations may be an immediate reflection of how well members are managing their diabetes. Short-term complications of diabetes are acute, life-threatening events related to blood sugar control (such as diabetic ketoacidosis or diabetic coma.)

Rehospitalization Rate (risk adjusted) - This rate represents the percent of members with diabetes who were rehospitalized within six months of the initial hospital stay.

Preventive Care Measures (HEDIS):

Percentage of members . . .

- who had a Hemoglobin A1c (HbA1c) blood test, which is recommended on a regular basis to monitor diabetes (the higher the rate, the more members had a HbA1c test).
- with poorly controlled HbA1c levels (the lower the rate, the more members that had good control over their HbA1c levels).
- who had a retinal eye exam performed, which is recommended on a regular basis (generally annually) for members with diabetes (the higher the rate, the more members underwent an eye exam).
- who had an LDL-C (low-density lipoprotein cholesterol) screening performed, which is recommended on a regular basis for members with diabetes to determine cholesterol levels (the higher the rate, the more members had this screening performed).
- with controlled LDL-C, reflecting members' low LDL cholesterol levels (the higher the rate, the more members have good cholesterol levels).
- who were monitored for kidney disease (the higher the rate, the more members were being screened or treated for kidney disease).

Also presented is the HEDIS national benchmark. This benchmark includes scores from all commercial HMOs, combined HMO/POS plans and POS plans nationally that participate in NCQA's *Quality Compass* program.

Diabetes Management Initiatives:

Plans were asked to respond to a series of questions that provide information about some of their current diabetes management initiatives. They also provided information regarding access to benefits.

Why are these measures important?

In many ways, a hospitalization for diabetes or a complication of diabetes may represent a breakdown in diabetes care. While some hospitalizations for diabetes are expected, appropriate preventive care can minimize these admissions. In 1998, the Pennsylvania General Assembly passed Act 98, which was subsequently signed into law by Governor Tom Ridge. Act 98 mandated insurance coverage for appropriate medical supplies, educational resources and medical tests related to the treatment of diabetes. It was expected that the mandate would help people with diabetes and their physicians monitor the disease more effectively, and among other things, reduce the overall number of hospitalizations

Diabetes Hospitalizations
(Members 18 to 75 Years Old)

	Members with Diabetes	Hospital Admissions	Hospitalization Rate per 10,000 Members with Diabetes	Statistical Rating	Length of Stay (Days) Risk Adjusted	Percent of Admissions for Short-term Complications of Diabetes	Rehospitalization Rate (Percent) Risk Adjusted
HMO Plans							
HealthAmerica HMO	5,609	90	164.3	⊙	4.6	54.4	18.0
KHP Central	4,900	47	99.1	○	5.0	36.2	21.0
PHS Health Plans	554	34	579.8	●	3.9	35.3	4.1
HMO/POS Combined Plans							
Aetna U.S Healthcare	19,885	635	318.5	●	4.5	40.0	18.1
CIGNA	945	14	135.3	⊙	3.2	28.6	23.7
First Priority Health	4,503	59	132.7	○	5.0	50.8	8.1
Geisinger	5,148	36	69.3	○	4.4	52.8	13.7
HealthGuard	2,263	48	210.1	⊙	3.7	25.0	14.5
KHP East	14,307	175	121.0	○	4.0	45.7	10.5
KHP West	27,995	340	123.3	○	4.3	44.4	15.5
NewAlliance	1,476	22	143.3	⊙	3.9	50.0	15.7
UPMC Health Plan	2,063	42	180.6	⊙	4.5	31.0	12.2
POS Plans							
HealthAmerica POS	1,602	28	170.1	⊙	3.4	42.9	17.4
Total/Average	91,250	1570	172.1		4.4	42.3	15.8

Source: PHC4

○ Less than Expected
⊙ Same as Expected
● Greater than Expected

Diabetes Preventive Care Measures

	Hemoglobin A1c (HbA1c) Tested (Percent)	HbA1c Poorly Controlled (Percent)	Eye Exam Performed (Percent)	LDL-C Screening Performed (Percent)	LDL-C Controlled (Percent)	Kidney Disease Monitored (Percent)
National Benchmark - All Lines of Business	75.1	44.8	45.3	69.1	36.7	36.1
Pennsylvania Plan Average	81.3	34.7	51.9	76.8	42.9	43.5
HMO Plans						
HealthAmerica HMO	86.9	33.3	59.4	75.9	47.5	43.8
KHP Central	83.7	14.6	54.3	81.5	23.6	37.2
PHS Health Plans	NR	NR	20.8	NR	NR	NR
HMO Average	*85.3*	*24.1*	*55.0*	*78.7*	*35.7*	*40.6*
HMO/POS Combined Plans						
Aetna U.S Healthcare	78.2	44.9	55.0	76.4	43.5	45.8
CIGNA	83.5	34.6	38.0	80.5	47.5	44.3
First Priority Health	75.4	38.9	45.0	75.8	44.8	27.0
Geisinger	84.9	24.1	64.0	80.1	49.4	62.3
HealthGuard	90.0	28.7	58.9	81.8	48.9	36.3
KHP East	75.2	41.9	42.4	72.2	46.5	44.4
KHP West	85.2	28.7	53.8	78.8	41.9	41.4
NewAlliance	NR	NR	NR	NR	NR	NR
UPMC Health Plan	70.1	40.9	22.6	66.4	26.5	46.7
HMO/POS Average	*80.6*	*36.0*	*51.2*	*76.7*	*43.8*	*43.9*
POS Plans						
HealthAmerica POS	86.4	33.3	61.1	74.0	41.4	42.8

Sources: NCQA, HEDIS, Calendar Year 1999

NR = Not Reported (Measure not calculated by plan or, if calculated, plan chose not to report it)

Diabetes Management Initiatives

HMO	Has your plan adopted standards and protocols for members with diabetes...		Which of the following diabetes disease management initiatives are provided by your plan?				
	Based on those of the American Diabetes Association?	Through internal development procedures?	Assessing diabetes health risk through member surveys	Monitoring primary care provider encounters for members with diabetes	Sharing profiles of care for members with diabetes with providers	Assessing member satisfaction with diabetes management program	Monitoring inpatient hospital admission rate for members with diabetes
HMO Plans							
HealthAmerica HMO	✓		✓	✓	✓	✓	✓
KHP Central	✓	✓	✓		✓	✓	✓
PHS Health Plans	✓		✓		✓	✓	
HMO/POS Combined Plans							
Aetna U.S Healthcare	✓	✓	✓	✓	✓	✓	✓
CIGNA	✓	✓	✓	✓	✓	✓	✓
First Priority Health	✓	✓	✓	✓	✓	✓	✓
Geisinger	✓	✓	✓	✓	✓	✓	
HealthGuard	✓	✓	✓		✓	✓	
KHP East	✓		✓	✓	✓	✓	✓
KHP West	✓	✓	✓		✓	✓	✓
NewAlliance	✓	✓	✓	✓		✓	✓
UPMC Health Plan	✓	✓	✓	✓	✓	✓	✓
POS Plans							
HealthAmerica POS	✓		✓	✓	✓	✓	✓

NOTE: The information on this page was self-reported by the health insurance plans and is intended to reflect current program activities. It was not audited or verified by the Pennsylvania Health Care Cost Containment Council. Contact your plan's Member Services Department with specific benefit coverage questions.

Diabetes Management Initiatives

	Does your plan place members diagnosed with diabetes in diabetes management initiatives as part of the basic benefit package?	Does your plan provide case managers assigned solely to members with diabetes?	Are diabetes supplies available to your members...			Does an annual diabetic retinal eye exam require a referral from a primary care provider in order to be a covered benefit?
HMO			Through the basic benefit plan?	If Yes, is there a copay for these diabetic supplies?	Through a pharmacy benefit?	
HMO Plans						
HealthAmerica HMO	✓	✓	✓	✓	✓	
KHP Central	✓	✓			✓	
PHS Health Plans	✓		✓	✓	✓	
HMO/POS Combined Plans						
Aetna U.S Healthcare	✓	✓	✓	✓	✓	✓
CIGNA	✓		✓		✓	
First Priority Health	✓	✓	✓		✓	✓
Geisinger	✓		✓		✓	
HealthGuard	✓				✓	✓
KHP East	✓	✓	✓		✓	✓
KHP West	✓	✓	✓		✓	✓
NewAlliance	✓	✓	✓	✓	✓	
UPMC Health Plan	✓				✓	
POS Plans						
HealthAmerica POS	✓	✓	✓	✓	✓	

NOTE: The information on this page was self-reported by the health insurance plans and is intended to reflect current program activities. It was not audited or verified by the Pennsylvania Health Care Cost Containment Council. Contact your plan's Member Services Department with specific benefit coverage questions.

Mental Health

According to the U.S. Department of Health and Human Services, about 20 percent of the adult population in the United States suffers from some form of mental illness.

Left unaddressed, mental illness can contribute to substantial business and social costs: lost work time, lower work productivity, and higher medical costs. Almost all suicides are associated with depression. Suicide is the ninth most common cause of death in the general population and the third most common cause of death among adolescents in the United States.

Mental illness cannot be separated from physical health care. More than 50 percent of PCP visits involve some kind of significant mental health component. Many serious physical illnesses, such as multiple sclerosis, diabetes or breast cancer, increase the individual's risk for depression. Conversely, depression can complicate the effective management of other illnesses.

Understanding the Tables

What we measured…

National Benchmark - This is the average value for all plans in the United States that participated in NCQA's Quality Compass Program. The figure shown includes all lines of business (HMOs, combined HMO/POS plans and POS plans).

Pennsylvania Plan Average - This is the average value for the 13 Pennsylvania plans included in this report. The average is weighted by the number of members in each plan.

Percent of Members Receiving Any Mental Health Service - This is the percent of all HMO members accessing mental health services in calendar year 1999.

Hospitalization Rate - This is the actual number of HMO members who were hospitalized for a mental health condition, adjusted per 1,000 members.

Average Length of Stay - This is the average number of days hospitalized.

Follow-up after Hospitalization for Mental Illness - This is the percent of HMO members hospitalized for a mental condition who followed up with a doctor's visit within 7 days or within 30 days after being discharged from the hospital.

Antidepressant Medication Management:

- Percent of Members with at least 3 Follow-up Visits - This the percent of members who were hospitalized that had at least three follow-up office visits within three months.
- Percent of Members with Adequate Phase Trial of Medication - This is the percent of patients initiated on an antidepressant drug who received an adequate, acute phase trial of medications over the next three months.
- Percent of Members Who Complete Six Months of Treatment - This is the percent of patients who completed a period on continuous treatment from major depression over six months.

Why are these measures important?

Depending upon the severity of the symptoms, depression and other mental illnesses can be extremely difficult to diagnose. Most studies estimate that ten to fifteen percent of all depressed adults remain undiagnosed. Therefore, it is important to measure and report the number of HMO members receiving treatment for mental illness. These measures include the percent of all HMO members accessing mental health services and total admissions to the hospital per 1,000 members for mental health treatment.

Post-hospitalization care is important for several reasons. First, there is evidence that failure to coordinate post-hospitalization care can have serious consequences for the patient, including the need to be readmitted to the hospital. Additionally, a lack of adequate post-hospitalization care may indicate more pervasive problems with an HMO, such as the lack of adequate oversight by mental health professionals or lack of HMO provided case management for hospitalized members.

THE MANAGEMENT OF ON-GOING ILLNESSES

Mental Health

	Percent of Members Receiving any Mental Health Service	Mental Health Inpatient Admissions per 1,000 Members	Mental Health Inpatient Hospitalizations: Average Length of Stay (Days)	Follow-up after Hospitalization for Mental Illness		Antidepressant Medication Management			Plan's Mental Health Subcontractor
				7 Days (Percent)	30 Days (Percent)	Percent of Members with at least 3 Follow-up Visits	Adequate Phase Trial of Medications (Percent)	Percent Who Completed 6 Months of Treatment	
National Benchmark - All Lines of Business	4.3	2.55	5.7	47.6	70.1	21.3	58.9	42.2	
PennsylvaniaPlan Average	4.2	3.61	6.9	49.6	73.2	15.1	63.9	46.7	
HMO Plans									
HealthAmerica HMO	6.1	3.93	6.2	70.6	87.0	38.2	59.9	44.9	Magellan
KHP Central	6.8	3.65	6.1	45.0	70.2	23.5	62.8	48.0	Magellan
PHS Health Plans	NR	NR	NR	13.1	31.2	NR	NR	NR	Not Subcontracted
HMO Average	*6.5*	*3.79*	*6.2*	*55.7*	*76.3*	*31.0*	*61.3*	*46.5*	
HMO/POS Combined Plans									
Aetna U.S Healthcare	2.4	3.03	6.4	56.1	75.1	7.8	68.9	54.0	Magellan
CIGNA	4.7	1.90	6.8	52.6	65.8	NA	NA	NA	Not Subcontracted
First Priority Health	4.9	4.11	8.0	39.4	69.2	16.6	60.4	40.4	Community Behavioral Healthcare Network of NEPA
Geisinger	3.2	3.60	7.4	54.0	84.7	5.5	59.8	40.7	Not Subcontracted
HealthGuard	NR	NR	NR	NR	NR	NR	NR	NR	Magellan
KHP East	3.6	4.24	6.5	47.5	64.2	EXC	58.0	37.3	Magellan
KHP West	4.6	3.68	7.5	45.7	77.1	14.3	65.4	48.8	Magellan
New Alliance	NR	NR	NR	NR	NR	NR	NR	NR	NR
UPMC Health Plan	5.5	1.11	6.4	6.6	15.8	25.2	71.4	54.7	Community Care Behavioral Health
HMO/POS Average	*3.8*	*3.54*	*7.0*	*48.2*	*72.4*	*11.8*	*64.3*	*46.9*	
POS Plans									
HealthAmerica POS	8.0	5.33	6.5	75.5	90.9	38.7	61.3	43.2	Magellan

Sources: NCQA, HEDIS, Calendar Year 1999

NR = Not Reported (measure not calculated by plan, or if calculated, plan chose not to report it)

NA = Not Applicable

EXC = Excluded (submitted measure not calculated correctly according to HEDIS standards)

Acute care is usually provided at the level of an inpatient hospitalization or an outpatient service (also called ambulatory) beyond the care provided by the PCP. The outcome of acute care is dependent upon a coordinated system that includes the hospital, the doctors, the HMO and the patient. Outcome measures for two acute care treatments – breast cancer procedures and neck and back procedures – are included in this section.

One concept of managed care is the establishment of "practice guidelines." These guidelines, prepared by the HMO in conjunction with its contracted physicians, provide standards of care for a given diagnosis. Standards are developed through outcomes research conducted by doctors and health care organizations to determine the most effective medical treatments. HMOs try to assure that all members receive these most effective treatments. Guidelines help physicians deliver quality care and avoid unnecessary procedures, tests and hospitalizations.

The development of outcomes research and use of treatment standards affects acute care utilization by HMO members. These standards prescribe which procedures are appropriate when a patient is hospitalized, but also address other health care issues such as how long a patient should remain in the hospital for a given procedure. Acute care utilization is also affected when HMOs encourage use of primary care and other ambulatory services for most patients, reserving hospitalizations for only its sickest members.

The measures included in this section address the outcomes of care for HMO members with complex or acute illnesses. To be sure, outcomes are affected by how sick the patient is, and the outcome measures that follow statistically take this into account. But outcomes are also dependent upon how well the continuity of care for patients is managed by the HMO and its provider network, and by how well the network coordinates care for patients from doctor to doctor and between primary care, specialist care and hospital care.

Breast Cancer Procedures

Significant progress in the diagnosis and treatment of breast cancer has occurred in recent years. Medical science has evolved from simply finding tumors to predicting the likelihood of the disease, providing earlier diagnosis and developing new technology for treatment. Educational programs have increased public awareness of the disease, leading to increased use of self-examination, clinical examination and mammography as tools to detect breast cancer in its earliest stages. New technologies and therapies have allowed more women with breast cancer to survive longer than before. When the disease is identified (often by mammogram) and treated early, patients have a five-year survival rate of approximately 96 percent. In addition, less invasive procedures have been developed and other therapies have provided women with more treatment options.

Contrary to common belief, most breast cancer cases are not hereditary; only 5 to 10 percent of cases are considered hereditary breast cancer. All women are at risk of contracting breast cancer, but those at higher risk include those:

- With a personal history of breast or ovarian cancer
- Who began menstruating before the age of 12
- Who reach menopause late (after age 55)
- Who give birth to their first child after the age of 30 or who do not have children.

The most important risk factor for contracting breast cancer is age. For this reason, as women age, more frequent physical examinations and tests are encouraged to discover the cancer while it is in an early stage of development. The earlier the disease is detected, the higher the chance of curing the illness. Act 148 of 1992 addresses breast cancer screening and requires that health insurance policies cover annual mammograms for women 40 years and older or for mammograms based on a physician's recommendation for women under 40.

Lumpectomy, sometimes called breast sparing surgery, and mastectomy are the two most commonly used surgical options, and the two procedures included in this report. Lumpectomy is the removal of the lump in the breast and some of the surrounding tissue. Mastectomy is removal of the whole breast and some lymph nodes under the arm. Clinical trials have shown that both options provide similar long-term survival rates for most types of early breast cancer.

While lumpectomy and mastectomy are the primary surgical options, they are often supplemented by other treatments. These include radiation therapy (the use of high-dose x-rays to kill cancer cells), chemotherapy (using drugs to kill the cancer cells), and hormone therapy (changing the way the body hormones work, or stopping the production of hormones).

Each surgery has risks and benefits, and each may be performed in the hospital or in an ambulatory care setting. The National Cancer Institute recommends women discuss with their doctor each surgery option in detail when planning treatment for breast cancer. A recent study found that although lumpectomy combined with radiotherapy has produced

successful results, fewer women in 1995 than in 1990 received this treatment combination. This finding has raised concerns that women treated by lumpectomy are either not choosing or not being prescribed radiotherapy, thereby limiting the effectiveness of the lumpectomy.

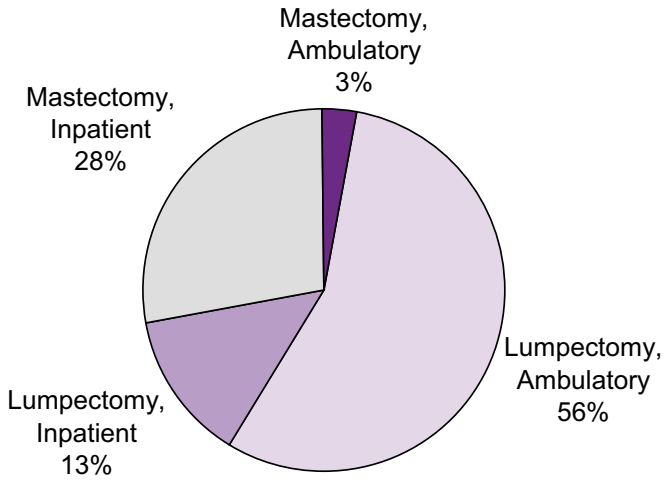
In addition to insurance coverage for mammography, Pennsylvania law (through Act 51 of 1997) prohibits health insurers from requiring outpatient care following a mastectomy and requires that insurers cover inpatient care for the length of time the treating physician determines is necessary for safe discharge. This law also provides coverage for home health care and prosthetic devices, and covers reconstructive surgery after a mastectomy for up to six years after the surgery.

Statewide, a total of 8,277 breast cancer procedures were performed for women under the age of 65 in calendar year 1999. Of these, 69 percent were lumpectomies and 31 percent were mastectomies. Overall, 41 percent of these procedures were performed during an inpatient hospitalization, but the setting differs by type of procedure. Most lumpectomies (about 81 percent) were performed in an ambulatory surgery setting, leaving 19 percent performed in an inpatient hospital setting. Conversely, 90 percent of mastectomies were performed in an inpatient hospital setting. The high number of mastectomies performed in the hospital is, in part, due to breast reconstruction that is performed at the time of the mastectomy.

Reconstruction of the breast may be performed at the time of the mastectomy, or may be performed months or even years later.

Breast Cancer Procedures

Statewide, by Procedure Type and Hospital Setting



Understanding the Tables

What we measured…

Total Breast Cancer Treatment Procedures – This is the actual number of lumpectomy and mastectomy procedures performed during calendar year 1999. Note that this number represents the total number of breast cancer procedures, not the number of patients receiving a breast cancer procedure.

Breast Cancer Screening Rate – This is the percent of the HMO's female members from the age of 52 to 69 who had at least one mammogram during the past two years. This measure covers a different age group of HMO members than the other breast cancer measures in this report.

Procedure Rate – This is the rate per 10,000 female HMO members who had a lumpectomy or mastectomy procedure in calendar year 1999.

Statistical Rating – Symbols representing statistical significance or importance are displayed for hospitalization rates. These symbols will tell you if the difference between the actual and expected rates was statistically:

- ○ Less than expected,
- ⊙ Same as expected, or
- ● Greater than expected.

Percent of Procedures that were Lumpectomies – The percent of total breast cancer procedures that were lumpectomies is reported in this column.

Lumpectomy Procedures:

Number of Lumpectomy Procedures – This is the actual number of lumpectomy procedures, performed in an inpatient or ambulatory care setting, for calendar year 1999.

Percent of Lumpectomies Performed "Inpatient" – This is the number of lumpectomies performed as an inpatient procedure divided by the total number of lumpectomy procedures.

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

Actual and Expected Complication Rate – The actual complication rate is the number of complications divided by the total number of inpatient breast cancer procedures. The expected complication rate is calculated by PHC4 and takes into account the patient's age and severity of illness.

Statistical Rating – A statistical test is used to determine if the actual and expected complication rates differ significantly.

Mastectomy Procedures:

Number of Mastectomy Procedures – This is the actual number of mastectomy procedures, performed in an inpatient or ambulatory care setting, for calendar year 1999.

Percent of Mastectomies Performed "Inpatient" – This is the number of mastectomies performed in an inpatient setting divided by the total number of mastectomies performed.

Length of Stay (risk-adjusted) Actual and Expected Complication Rate and Statistical Rating – These measures are inpatient only and similar to those described for lumpectomies.

Percent Reconstruction During the Same Admission – This is the percent of total mastectomies performed in an inpatient setting where reconstruction of the breast was performed during the same hospitalization.

Why are these measures important?

Advances in breast cancer diagnosis and treatment have had an impact on treatment options and survival, and the measures included in this report reflect the importance of these issues.

The breast cancer screening (mammography) rate relates to the importance of early diagnosis. When the disease is detected and treated early, patients have a much improved survival rate. The U.S. Preventive Services Task Force, the American Academy of Family Physicians and the American College of Preventive Medicine recommend mammograms as an effective method for detecting breast cancer at a time when it is most treatable.

The information provided on hospitalizations for lumpectomies and mastectomies (including the information on the percent of these procedures being performed in the inpatient setting) might help in understanding treatment options. While there are important quality of care issues that this report cannot address (such as the variation in quality of mammograms and the way they are interpreted, the adequacy of patient counseling about treatment options, and the appropriate use of radiation therapy and chemotherapy after surgery), the information on length of hospital stay and complication rates may help to offer insights into differing treatment standards among HMOs or identify differing treatment patterns by physicians or hospitals in particular HMO provider networks.

Ultimately, this information can assist HMO members or potential members make more informed decisions about their care and treatment options for breast cancer.

Breast Cancer Procedures

	Total Breast Cancer Procedures	Breast Cancer Screening Rate* (Percent)	Procedure Rate per 10,000 Female Members	Statistical Rating	Lumpectomy Procedures (Percent)	LUMPECTOMY					
						Lumpectomy Procedures	Percent Performed "Inpatient"	Inpatient Only			
								Length of Stay (Days) Risk-Adjusted	Complications		Statistical Rating
									Actual (Percent)	Expected (Percent)	
HMO Plans											
HealthAmerica HMO	132	78.1**	18.0	⊙	66.7	88	9.1	NR	NR	NR	NR
KHP Central	133	78.2**	20.2	⊙	65.4	87	11.5	1.8	0.0	4.0	⊙
PHS Health Plans	34	69.1	41.1	●	64.7	22	27.3	NR	NR	NR	NR
HMO/POS Combined Plans											
Aetna U.S Healthcare	824	73.7	26.9	●	68.8	567	22.4	1.9	4.0	4.5	⊙
CIGNA	28	66.7	16.6	⊙	71.4	20	15.0	NR	NR	NR	NR
First Priority Health	125	69.7	19.9	⊙	72.0	90	15.6	2.3	0.0	5.0	⊙
Geisinger	146	78.3	15.8	○	71.9	105	6.7	NR	NR	NR	NR
HealthGuard	60	79.8	16.0	⊙	63.3	38	23.7	NR	NR	NR	NR
KHP East	459	73.6**	19.9	⊙	71.0	326	26.4	2.0	3.6	4.5	⊙
KHP West	697	74.5	15.2	○	73.7	514	18.7	2.1	4.3	4.8	⊙
New Alliance	27	NA	14.5	⊙	48.1	13	15.4	NR	NR	NR	NR
UPMC Health Plan	48	72.5	18.2	⊙	87.5	42	23.8	1.5	10.0	4.3	⊙
POS Plans											
HealthAmerica POS	44	70.9**	13.2	○	70.5	31	19.4	NR	NR	NR	NR
Total/Average	2,757		19.3		70.5	1,943	19.8	2.0	4.3	4.6	
Fee-for-Service Sample	2,022		NA		70.1	1,417	18.6	2.1	2.3	4.6	

* Mammography rate only; includes women ages 52 to 69. (Source: NCQA, HEDIS Calendar Year 1999)

** These scores are for calendar year 1998 in accordance with NCQA's rotation strategy. Please see the Technical Report for a full explanation.

Source: PHC4

○ Less than Expected
⊙ Same as Expected
● Greater than Expected
NR Not Rated - Small Inpatient #s
NA Not Available

	MASTECTOMY						
			Inpatient Only				
	Mastectomy Procedures	Percent Performed "Inpatient"	Length of Stay (Days) Risk-Adjusted	Complications		Statistical Rating	Percent with Reconstruction During Same Admission
				Actual (Percent)	Expected (Percent)		
HMO Plans							
HealthAmerica HMO	44	77.3	2.0	5.9	5.5	⊙	17.6
KHP Central	46	76.1	1.8	2.9	7.2	⊙	34.3
PHS Health Plans	12	100.0	2.2	0.0	7.6	⊙	41.7
HMO/POS Combined Plans							
Aetna U.S Healthcare	257	94.9	1.9	9.0	6.7	⊙	30.7
CIGNA	8	100.0	NR	NR	NR	NR	NR
First Priority Health	35	97.1	2.4	3.1	5.6	⊙	23.5
Geisinger	41	75.6	2.1	3.2	5.6	⊙	22.6
HealthGuard	22	90.9	1.5	0.0	6.4	⊙	15.0
KHP East	133	96.2	2.1	5.7	7.4	⊙	36.7
KHP West	183	88.0	2.0	7.0	6.2	⊙	23.6
New Alliance	14	85.7	1.5	8.3	5.7	⊙	8.3
UPMC Health Plan	6	83.3	NR	NR	NR	NR	NR
POS Plans							
HealthAmerica POS	13	92.3	1.6	8.3	7.2	⊙	33.3
Total/Average	814	90.4	2.0	6.7	6.6		28.7
Fee-for-Service Sample	605	89.4	2.1	5.0	6.3		27.2

Source: PHC4

○ Less than Expected
⊙ Same as Expected
● Greater than Expected
NR Not Rated - Small Inpatient #s
NA Not Available

Neck and Back Procedures

Neck and back pain affects about 80 percent of adults at some time in their lives. It is the most common cause of work loss for people under age 45, the reason for about 15% of all sick leaves, and estimated to cost society at least $50 billion each year.

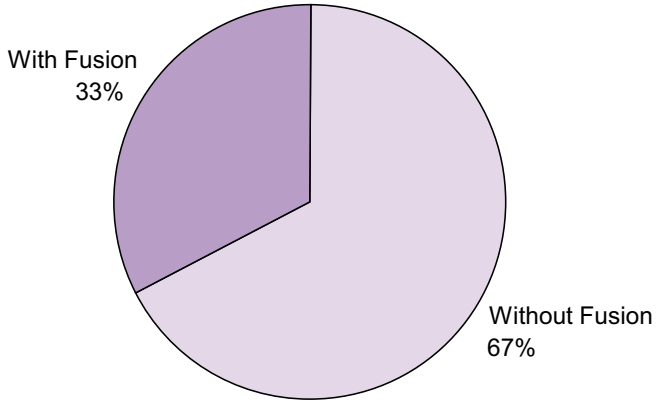
Treatment for neck and back pain typically begins with conservative methods such as rest, anti-inflammatory medications, physical therapy or professional spinal manipulation. Many patients respond positively to these therapies and avoid the need for surgery.

When surgery is required, one common procedure known as "decompression" is often performed. Decompression is performed to reduce pressure on the nerves in the spine. Decompression procedures (discectomy or laminectomy) involve removing a small portion of bone and/or disc material because of a slipped or damaged disc. Decompression procedures are the primary focus of this report and include both the neck (cervical area of the spine) and the back (dorsal and lumbar areas of the spine).

When patients have a decompression procedure, they may also undergo spinal fusion. Spinal fusion is a surgical procedure that adds bone graft to an area of the spine to stop pain that occurs from motion in an unstable portion of the neck or back. Although there are indications for when fusion of the spine might be done, agreement about its efficacy is unclear. Information about the decompression procedures reported here is broken down by whether the patient also had spinal fusion. Approximately 33 percent of the neck and back procedures in calendar year 1999 also included spinal fusion. Of these spinal fusions, 36 percent were performed on the back and 64 percent were performed on the neck.

Neck and Back Procedures

Statewide



Understanding the Tables

What we measured…

Total Neck and Back Procedures – This is the actual number of adult HMO members under age 65 who underwent an elective neck or back procedure during calendar year 1999.

Procedure Rate – This is the rate per 10,000 HMO members who had a neck or back procedure in calendar year 1999.

Statistical Rating – Symbols representing statistical significance or importance are displayed for hospitalization rates. These symbols will tell you if the difference between the actual and expected rates was statistically:

- ○ Less than expected,
- ⊙ Same as expected, or
- ● Greater than expected.

Percent of Procedures with Fusion – The percent of total procedures that included a spinal fusion is reported in this column.

"With Fusion" Procedures:

Number of Procedures with Fusion – This is the actual number of neck and back procedures that included a spinal fusion during calendar year 1999.

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

Actual and Expected Complication Rate – The actual complication rate is the number of complications divided by the total number of neck and back procedures. The expected complication rate is calculated by PHC4 and takes into account the patient's age and severity of illness.

Statistical Rating – A statistical test is used to determine if the actual and expected complication rates differ significantly.

"Without Fusion" Procedures:

Number of Procedures without Fusion – This is the actual number of neck and back procedures that did *not* include a spinal fusion during calendar year 1999.

Length of Stay (risk adjusted), Actual and Expected Complication Rate and Statistical Rating – These measures are similar to those described for procedures with fusion.

Why are these measures important?

Studies have shown that practice patterns for neck and back surgery vary across providers and geographic locations. The guidelines for when to perform back surgery and more particularly fusion are unclear. Most health care professional organizations recommend conservative treatment before performing surgery, but recommendations for the duration of conservative treatment vary widely.

Neck and back procedures are high volume, high cost surgeries with important implications for quality of care. One area of consideration might be whether performing the surgery was the appropriate course of action. While this report cannot fully answer that question, it does provide insight into that issue by looking at the hospitalization rates for these procedures and the percent of procedures with fusion. The information provided on length of hospital stay and complication rates may help to offer insights into differing treatment standards among HMOs or identify differing treatment patterns by physicians or hospitals in particular HMO provider networks.

NECK AND BACK PROCEDURES

HMO	Neck and Back Procedures	Procedure Rate per 10,000 Members	Statistical Rating	Percent of Procedures w/ Fusion	WITH FUSION					WITHOUT FUSION				
					Number of Procedures with Fusion	Length of Stay (Days) Risk-adjusted	Complications			Number of Procedures without Fusion	Length of Stay (Days) Risk-adjusted	Complications		
							Actual (Percent)	Expected (Percent)	Statistical Rating			Actual (Percent)	Expected (Percent)	Statistical Rating
HMO Plans														
HealthAmerica HMO	340	24.3	●	33.8	115	1.8	4.3	6.5	⊙	225	2.1	4.4	4.4	⊙
KHP Central	182	14.4	○	31.3	57	1.8	5.3	8.8	⊙	125	2.3	3.2	4.4	⊙
PHS Health Plans	28	17.5	⊙	39.3	11	2.4	0.0	4.2	⊙	17	1.6	0.0	4.6	⊙
HMO/POS Combined Plans														
Aetna U.S Healthcare	1,195	20.2	●	30.9	369	1.9	7.0	6.7	⊙	826	1.8	4.8	4.2	⊙
CIGNA	24	6.5	○	20.8	5	NR	NR	NR	NR	19	1.6	10.5	3.5	⊙
First Priority Health	280	22.8	●	36.8	103	1.5	1.9	6.4	⊙	177	1.6	1.7	3.8	⊙
Geisinger *	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HealthGuard	241	34.2	●	23.2	56	2.0	5.4	8.7	⊙	185	1.4	0.5	4.4	○
KHP East	499	11.2	○	27.3	136	1.8	2.2	5.9	⊙	363	1.8	4.7	4.1	⊙
KHP West	1,287	15.0	○	33.3	428	2.0	8.2	6.6	⊙	859	2.1	5.5	4.2	⊙
New Alliance	84	23.8	●	45.2	38	1.8	7.9	6.9	⊙	46	2.2	4.3	4.1	⊙
UPMC Health Plan	116	24.5	●	24.1	28	2.4	14.3	9.0	⊙	88	2.0	9.1	4.1	⊙
POS Plans														
HealthAmerica POS	125	19.6	⊙	28.8	36	1.9	11.1	8.4	⊙	89	1.6	3.4	3.7	⊙
Total/Average	4,581	16.8		30.2	1,385	1.9	6.5	6.8		3,196	1.9	4.5	4.1	
Fee-for-Service Sample	2,920	NA		29.8	871	2.0	6.8	7.3		2,049	2.0	3.6	4.2	

Source: PHC4

* Suppressed due to data inconsistencies

○ Less than Expected
⊙ Same as Expected
● Greater than Expected
NR Not Rated - Small #s
NA Not Available

The Plan Profile presents general information about the HMO. A listing of the plan's enrollment, a description of its provider network (Primary Care Physicians, specialists and acute care hospitals available to plan members), the ratio of PCPs and specialists per 1,000 members, and the HMO's NCQA accreditation status are provided.

Enrollment

The commercial HMO enrollments shown in the following table are current as of December 31, 1999. Enrollments were taken from the *Annual Report,* submitted by law to the Pennsylvania Department of Health each year by each HMO licensed to operate in Pennsylvania. Additionally, the percentage change in enrollment from December 31, 1998 to December 31, 1999 is provided. Knowing plan enrollment indicates the size of the HMO and the comparison with the prior year's enrollment shows if membership is growing or declining. These figures do not include members enrolled in a plan's Medicare or Medical Assistance managed care program.

Provider Network

Each HMO in Pennsylvania builds a provider network to deliver health care services to their members. The provider network is comprised of the doctors, hospitals, and other health care professionals under contract with the HMO. The minimum number of doctors and facilities needed for licensure is set by Pennsylvania law. HMOs may differ by the number and types of providers placed in the network and by how each monitors the performance of doctors and hospitals to influence the quality and cost of care.

In an HMO, the Primary Care Physician assumes major responsibility for an individual member. All care is funneled through the PCP: the PCP usually provides a first diagnosis, makes referrals to specialists and plays an active role in the on-going management of the patient's health care. It is important that individuals have an appropriate choice of PCPs. Availability of PCPs is measured by the total number of PCPs from which to choose and the ratio of PCPs to the plan's total enrollment. This ratio compares the relative number of choices offered by each HMO.

The availability of acute care hospitals is also presented. The first column shows the number of hospitals located in the plan's licensed service area (those counties where the Department of Health has authorized the HMO to operate). The second column is the percentage of all acute care hospitals in those counties that belong to the HMO network. The third column shows the number of additional hospitals included in the network that are outside the HMO's service area. These hospitals are also accessible to members.

Accreditation Status

Accreditation of commercial HMOs in Pennsylvania is voluntary and provided by the National Committee for Quality Assurance (NCQA). Accreditation is achieved by passing a detailed, independent assessment of quality and performance measures. The accreditation status provided in this report reflects the most recent NCQA listing at the time of publication. The possible NCQA ratings are (beginning with the highest rating): excellent, commendable, accredited, provisional, denied, and suspended or under review. Additional information regarding HMO accreditation ratings, including the most current ratings, can be found on NCQA's Web site: www.NCQA.org.

PLAN PROFILE

	Number of Commercial Members as of 12/31/99**	Percent Change in Commercial Enrollment Between 12/31/98 and 12/31/99	Number of Primary Care Physicians (PCPs) ***	Number of PCPs per 1,000 Commercial Members	Number of Specialists in the Network ***	Number of Specialists per 1,000 Commercial Members
HMO Plans*						
HealthAmerica HMO	198,656	-10.11	2,349	11.8	6,684	33.6
KHP Central	192,057	-9.91	1,641	8.5	4,106	21.4
PHS Health Plans	21,470	-2.65	2,397	111.6	5,709	265.9
HMO/POS Combined Plans*						
Aetna U.S Healthcare	849,633	-1.90	5,520	6.5	19,108	22.5
CIGNA	56,053	10.92	1,648	29.4	4,065	72.5
First Priority Health	184,077	6.66	584	3.2	1,724	9.4
Geisinger	247,650	10.44	1,225	4.9	2,098	8.5
HealthGuard	98,700	7.60	816	8.3	1,599	16.2
KHP East	657,579	8.92	2,533	3.9	7,380	11.2
KHP West	1,185,007	1.82	2,593	2.2	6,185	5.2
NewAlliance	50,625	-0.18	328	6.5	586	11.6
UPMC Health Plan	84,237	36.31	1,474	17.5	2,244	26.6
POS Plans*						
HealthAmerica POS	90,524	4.72	2,349	25.9	6,684	73.8

* All information for the listed plans covers the portion of the company's business licensed by the State of Pennsylvania.

** Does not include Medicare or Medical Assistance members.

*** Number of Primary Care Physicians and Specialists may include physicians serving Medicare/Medical Assistance Managed Care members.

SOURCE: Pennsylvania Department of Health

	Number of Acute Care Hospitals in the Plan's Service Area	Percent of All Acute Care Hospitals in the Service Area	Additional Acute Care Hospitals in Plan's Network*	NCQA Accreditation Status as of June 2001
HMO Plans				
HealthAmerica HMO	76	75	2	Commendable
KHP Central	35	95	1	Excellent
PHS Health Plans	52	81	22	Provisional
HMO/POS Combined Plans				
Aetna U.S Healthcare	133	79	82	Excellent
CIGNA	49	91	11	Provisional
First Priority Health	24	92	6	Excellent
Geisinger	37	56	4	Excellent
HealthGuard	13	54	1	Excellent
KHP East	53	98	64	Excellent
KHP West	77	100	1	Excellent
NewAlliance	9	100	3	Commendable
UPMC Health Plan	26	46	2	Scheduled
POS Plans				
HealthAmerica POS	76	75	2	Excellent

* This column reports the number of acute care hospitals in the HMO's network that are located outside the plan's licensed service area.

SOURCE: Pennsylvania Department of Health and NCQA for Accreditation Status.

Member Satisfaction

It is important to know if the HMO's members are satisfied with the plan in general, and what specific services were rated as satisfactory or unsatisfactory. The graphs in this section provide information about HMO performance as reported by each HMO's members.

Satisfaction surveys offer a view of HMO quality and service from a member's perspective. These member satisfaction measures were taken from the annual Consumer Assessment of Health Plans Survey® (CAHPS). CAHPS is a voluntary assessment. The survey is conducted by an independent research company and the resulting member satisfaction measures become part of the HMO's accreditation review. Results are based on a randomly selected sample of adult members from the HMO.

The survey asks plan members about their experience with their HMO and their satisfaction with the care they received. Ten managed care plans in Pennsylvania participated in the CAHPS survey.

What we measured…

Ten specific questions have been selected from the CAHPS survey to report:

- A general rating of the HMO
- Ability to get needed care
- Ability to get care quickly
- An evaluation of customer service.

In addition to member responses from each HMO, a "national benchmark" is included when available from NCQA. This national benchmark is the average score for all managed care plans in the United States that participated in this survey.

The specific survey questions included in this section were selected with the assistance of the HMOs. The questions provide measures for those issues deemed most important to HMO members. These include:

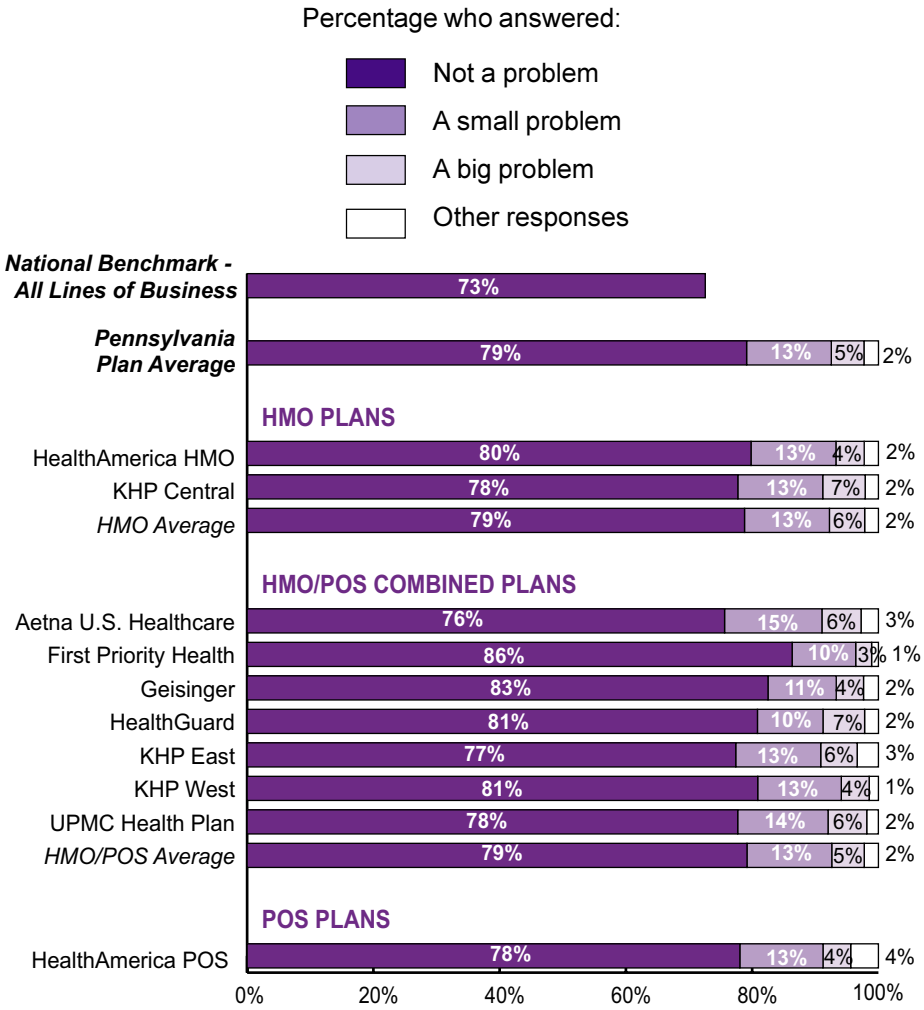
- Access to care or a doctor believed necessary
- Problems (if any) getting referrals to specialists
- Problems (if any) with delays while waiting for approval from the HMO
- Occurrence of problems or complaints and their satisfactory resolution
- Satisfaction with customer service
- Timely access to doctors for routine care or illness/injury

Why are these measures important?

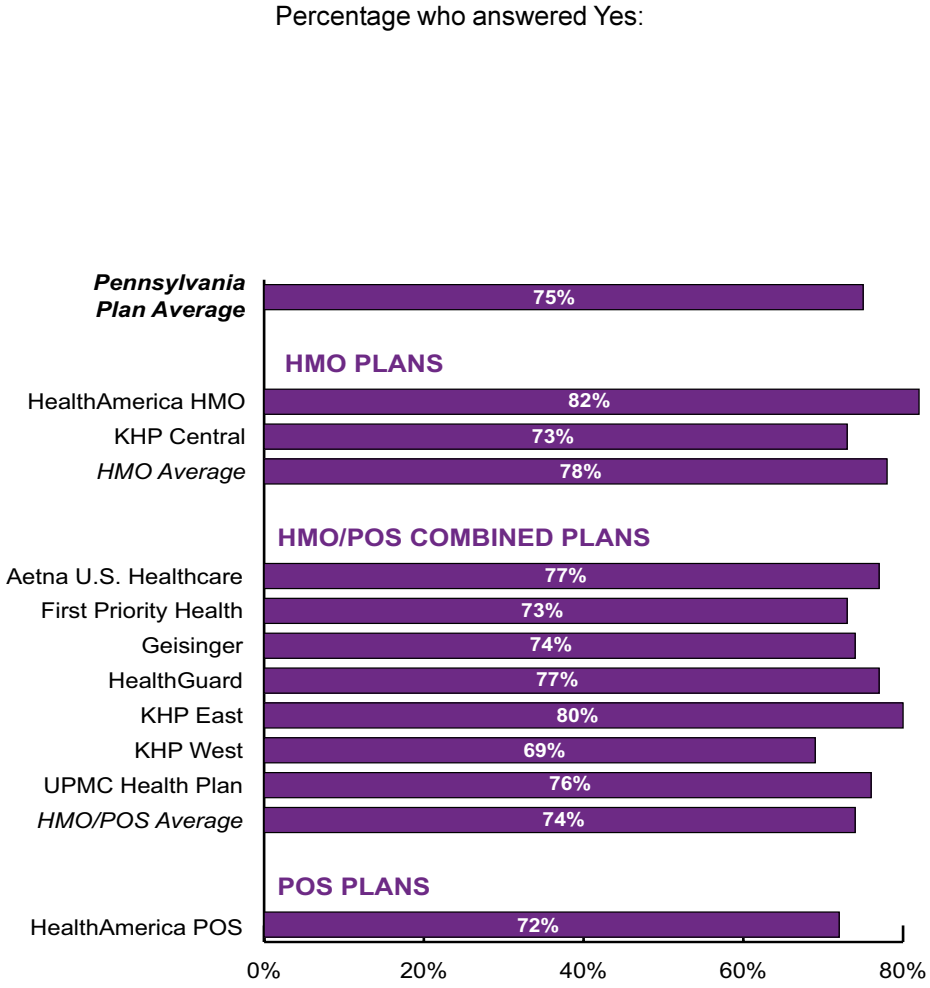
CAHPS Surveys provide a standardized measure of HMO member satisfaction—this means that comparisons for items are directly comparable for the HMOs included in this report. The items effectively summarize HMO member satisfaction with their experience of care through ratings and other scores.

Research shows that consumers and potential HMO members value the opinions and ratings of their peers. The survey provides specific information that is not available from any other source—the person receiving care.

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?



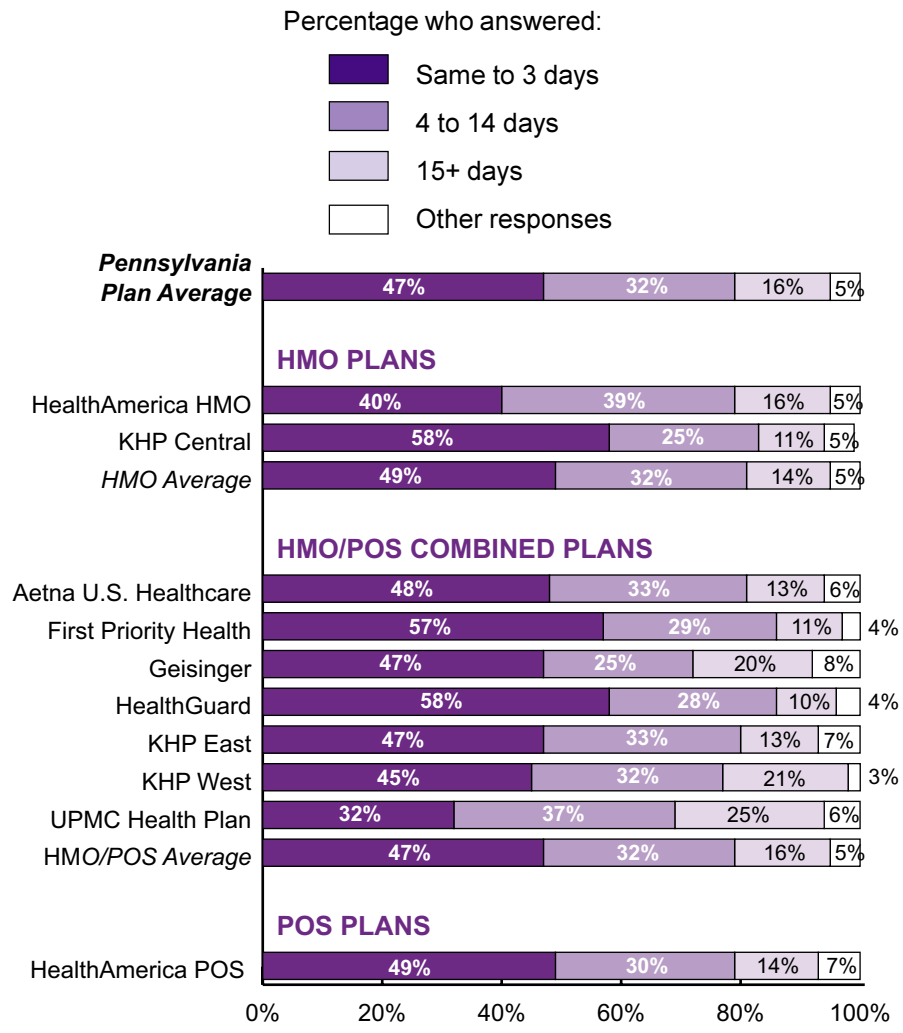
In the last 12 months, did you make any appointments with a doctor or other health care provider for regular or routine health care?



Source: CAHPS, Calendar Year 1999
Note: Numbers may not add up to 100% due to rounding.

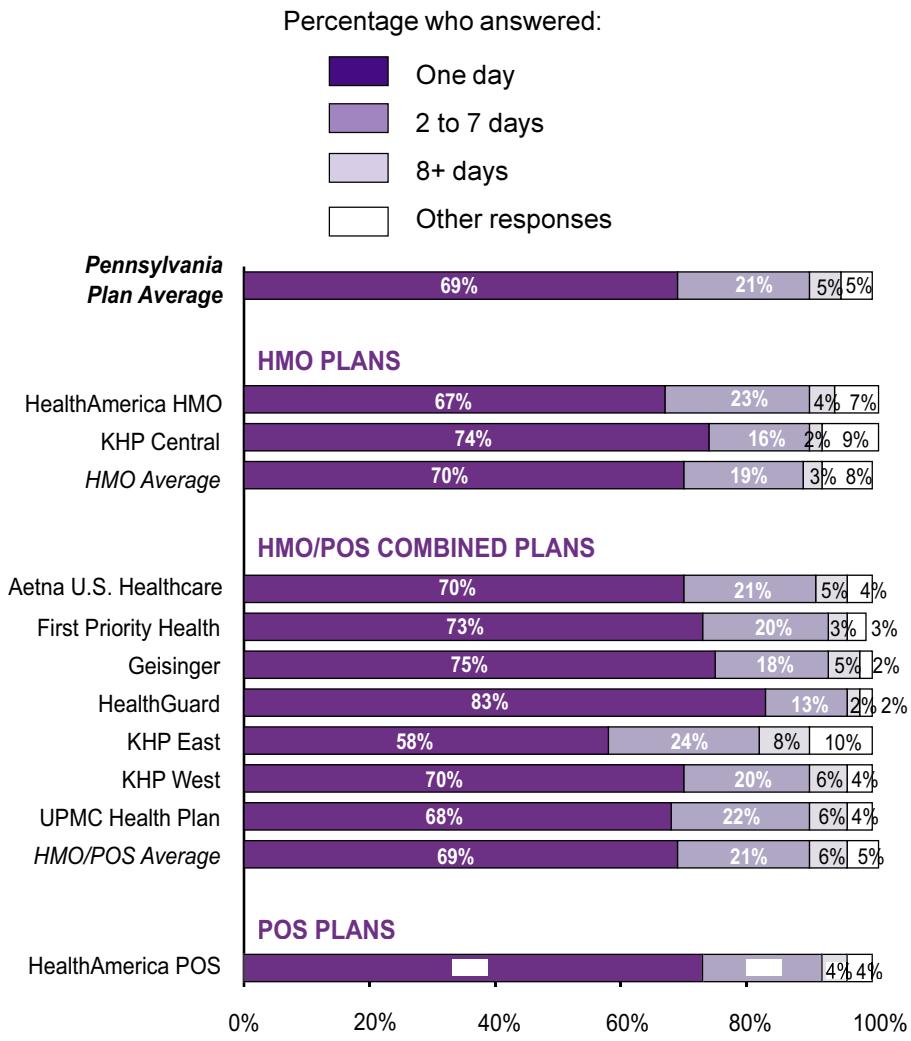
MEMBER SATISFACTION

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?

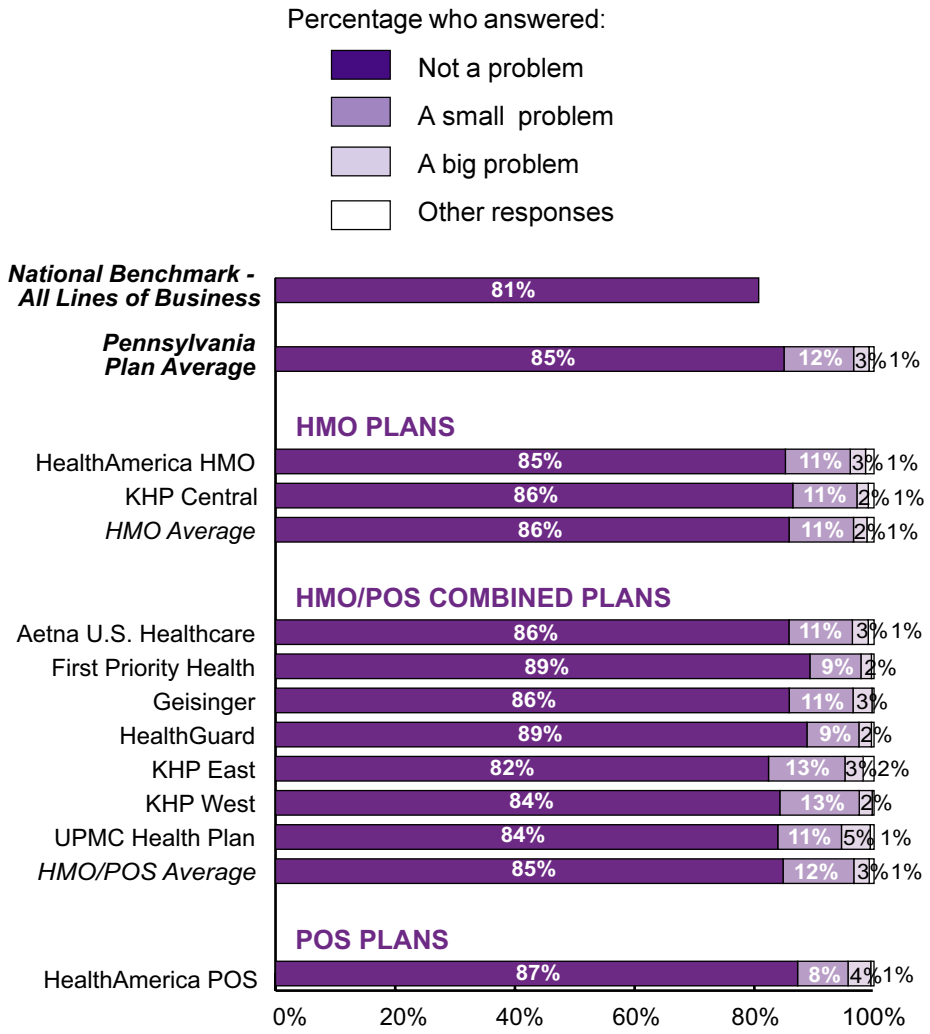


Source: CAHPS, Calendar Year 1999
Note: Numbers may not add up to 100% due to rounding.

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?

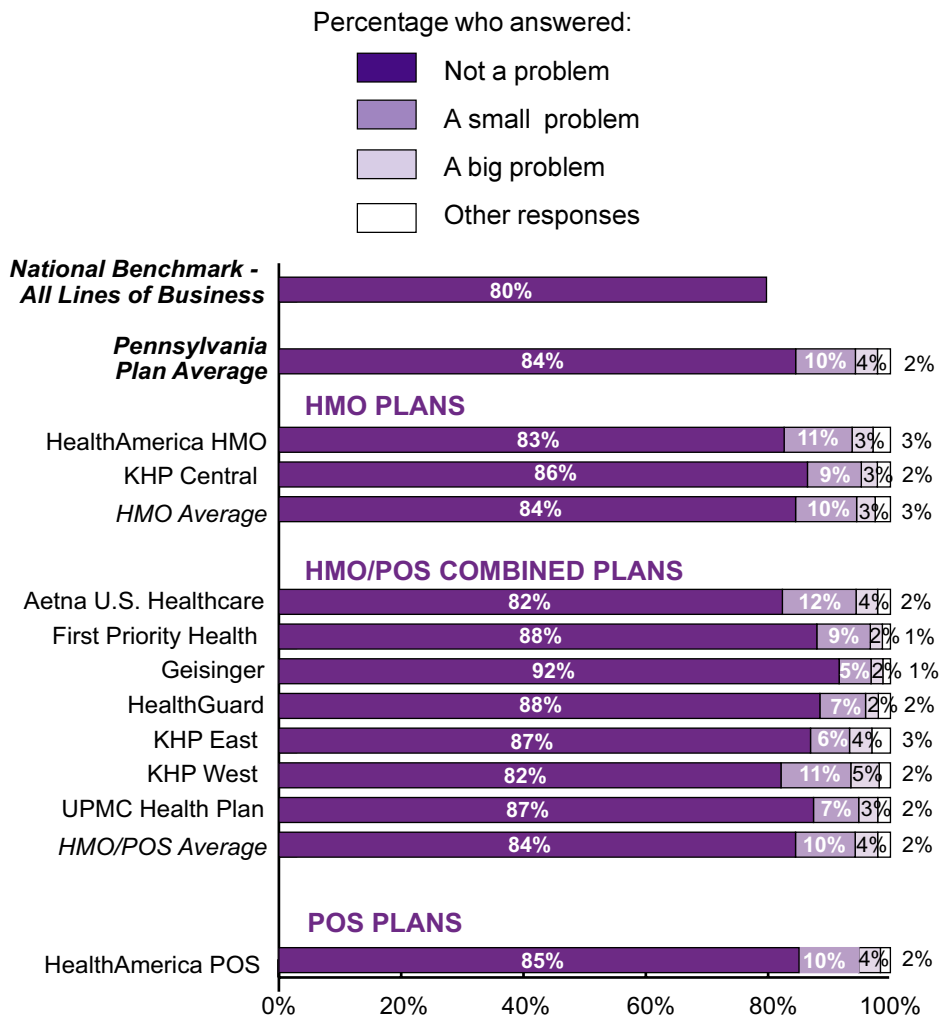


In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor believed necessary?



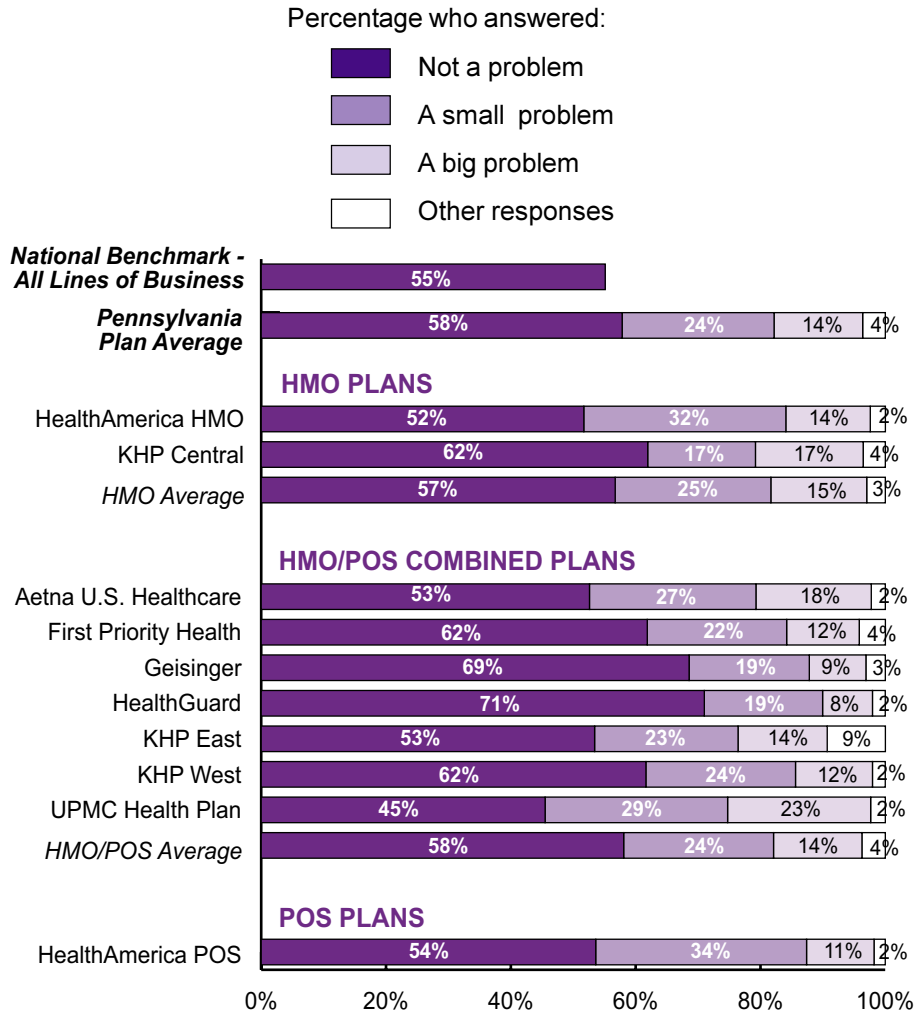
Source: CAHPS, Calendar Year 1999
Note: Numbers may not add up to 100% due to rounding.

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?

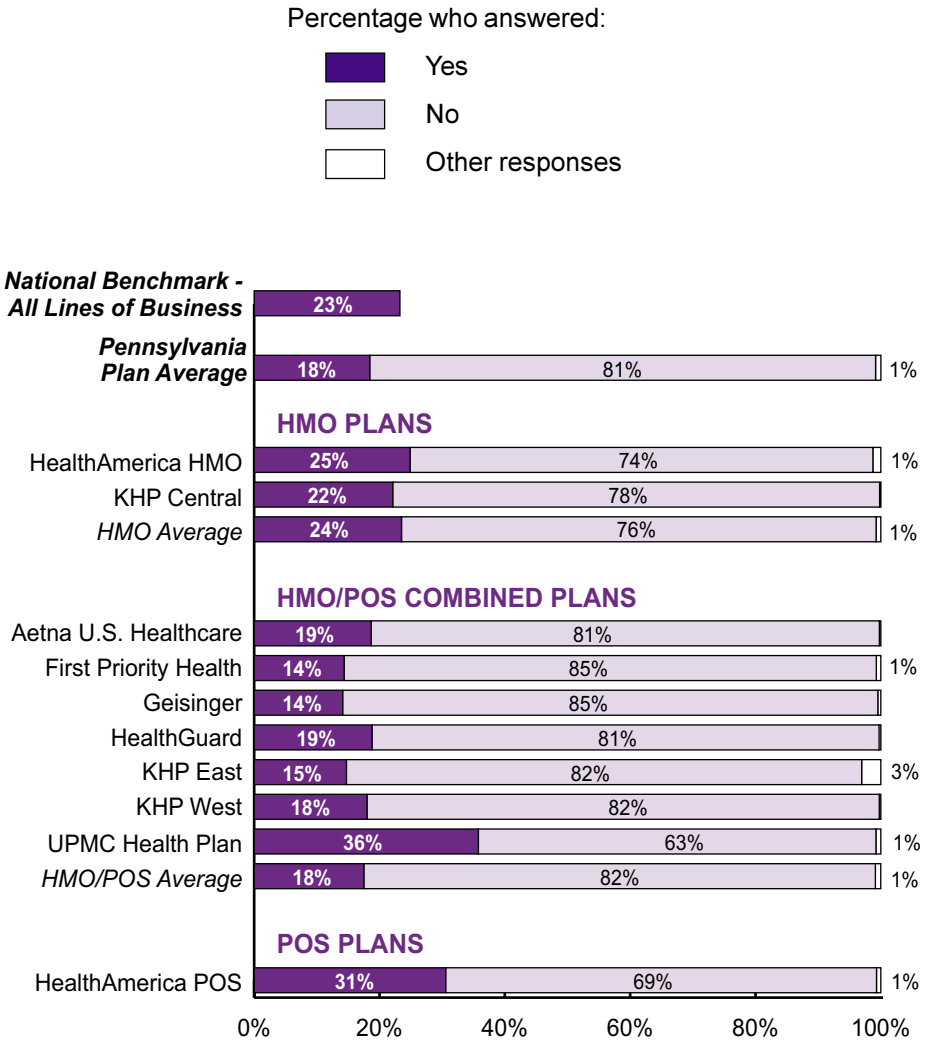


MEMBER SATISFACTION

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?

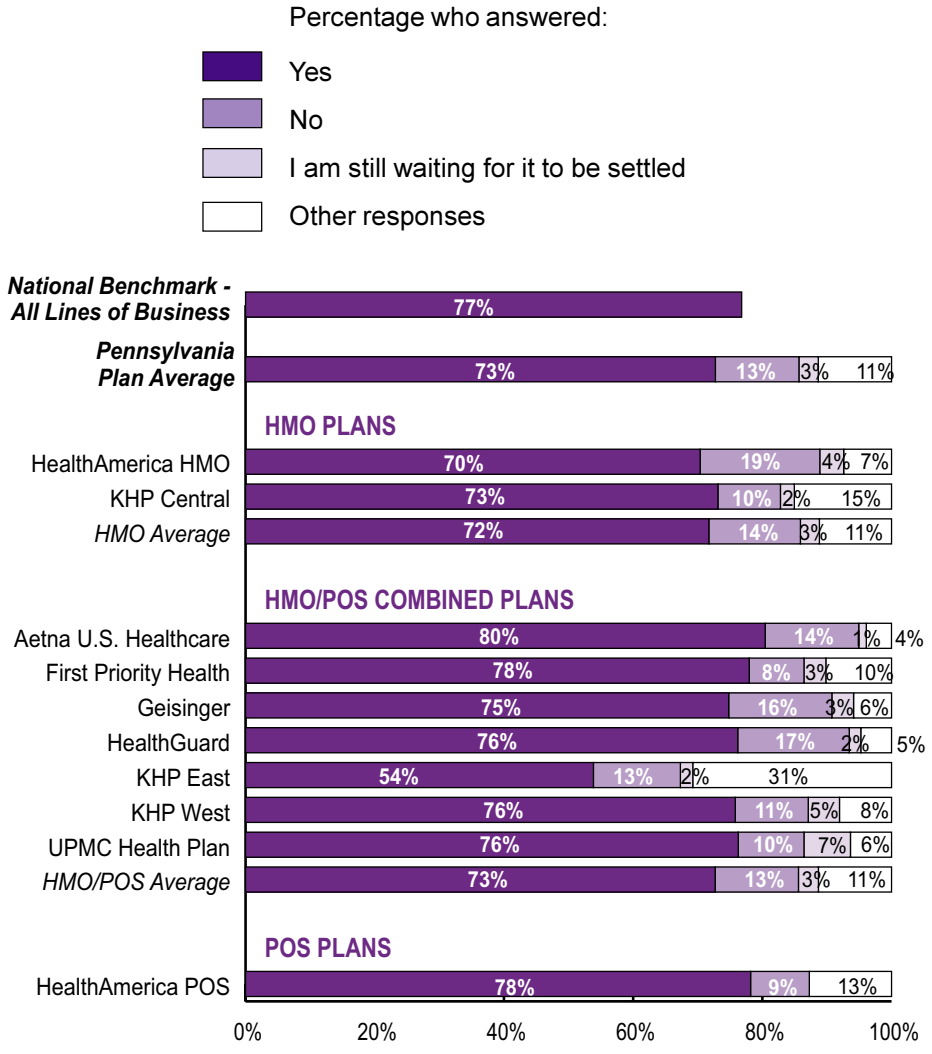


In the last 12 months, have you called or written your health plan with a complaint or problem?

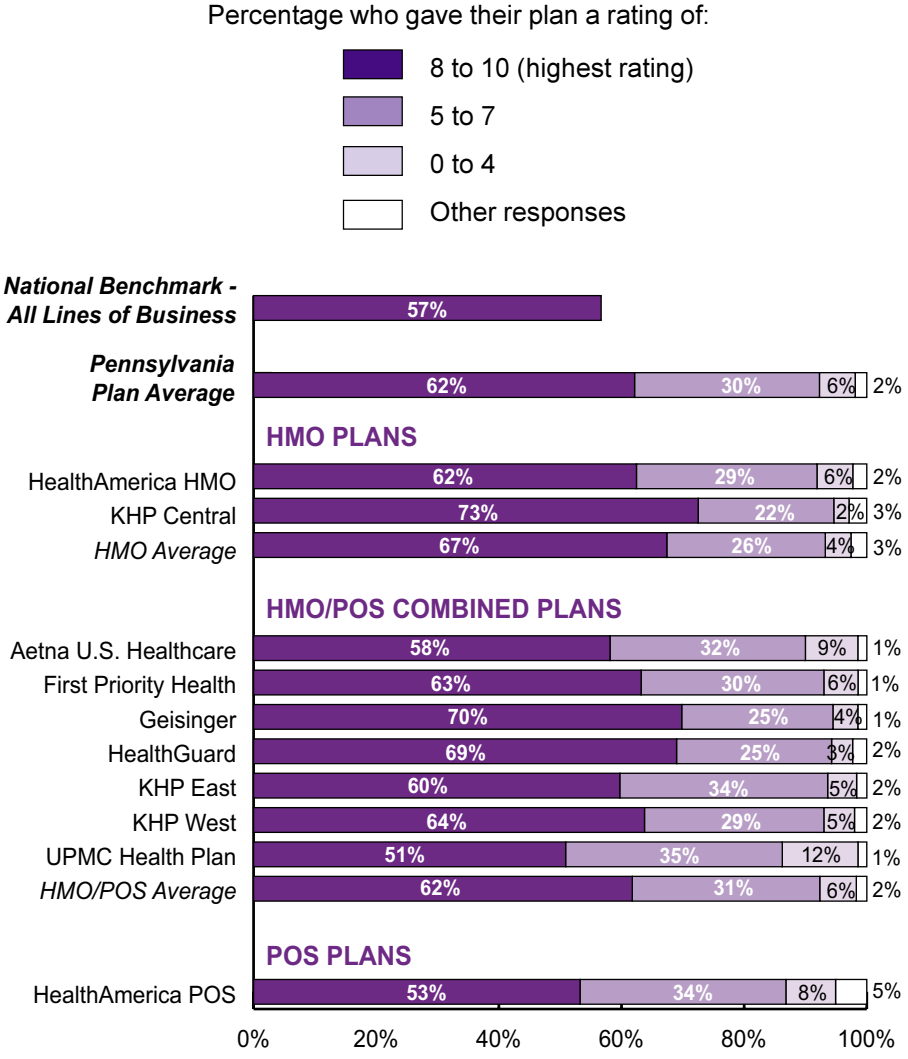


Source: CAHPS, Calendar Year 1999
Note: Numbers may not add up to 100% due to rounding.

Was your complaint or problem settled to your satisfaction?



How would you rate your health plan now?



Source: CAHPS, Calendar Year 1999
Note: Numbers may not add up to 100% due to rounding.

3. Financial Indicators

Most HMOs in Pennsylvania (and across the United States) are for-profit corporations. As such, there is concern that improving the quality of health care may conflict with the need to increase profits, or that needed health care may be denied to decrease costs.

Comparing financial indicators across HMOs enables decision makers (purchasers, consumers and policy makers) to select or monitor plans on the basis of financial stability.

What we measured…

- Total HMO Revenue
- Three-Year Change in Total Revenue
- Total Premium Revenue as a Percent of Total Revenue
- Commercial Premium Revenue as a Percent of Total Premium Revenue
- Commercial Premium Revenue Per Member Per Month
- Medical Loss and Administrative Expense Ratios
- Federal Tax Rate
- Commercial Net (after-tax) Margin
- Total HMO Net (after-tax) Margin
- Three-Year Average Net Margin
- Current Ratio
- Net Worth to Total Liabilities

Why are these measures important?

HMOs need a positive income to stay in business. They need sufficient revenue over expenses to maintain staff, provide good service, and to meet the changing health care needs of their members. Adequate profits are necessary to enable the HMO to fund appropriate levels of reserves. These reserves ensure that the HMO has adequate funds to pay for all future medical expenses incurred by its members. HMOs become insolvent when they underestimate the premium revenue needed to cover medical expenses and they do not have sufficient reserves to cover the shortfall.

It is important to monitor HMO finances because relatively small changes in revenues or expenses can make a significant difference in the total financial health of the HMO. Monitoring key financial indicators may reveal positive or negative changes in the financial stability of an HMO.

Calendar Year 1999 Financial Indicators

	Total HMO Revenue	3-Year Change in Total Revenue 1996-1999	Total Premium Revenue as a Percent of Total Revenue	Commercial Premium Revenue as a Percent of Total Premium Revenue	Commercial Premium Revenue PMPM (Per Member, Per Month)
HMO Plans					
KHP Central	$332,601,155	69.28%	98.84%	63.43%	$141.18
PHS Health Plans	$125,771,332	-41.48%	98.20%	27.59%	$135.15
HMO/POS Combined Plans					
Aetna U.S Healthcare	$1,945,816,994	25.94%	99.17%	57.60%	$132.60
CIGNA	$4,385,095	-62.96%	94.32%	98.93%	$159.90
First Priority Health	$415,649,483	122.61%	99.91%	60.73%	$124.69
Geisinger	$504,101,128	98.61%	99.30%	56.59%	$119.35
Health America (combined HMO/POS)	$420,084,416	-0.63%	97.56%	68.94%	$115.48
HealthGuard	$104,708,777	122.79%	97.32%	77.62%	$127.94
KHP East	$2,298,842,781	77.28%	98.93% [4]	38.16% [4]	$135.30 [4]
KHP West	$1,366,646,908	98.95%	98.65%	34.25%	$137.47
NewAlliance [2]	$78,758,913	132.92%	99.84%	100.00%	$128.17
UPMC Health Plan	$186,731,407	4186.75% [3]	93.65% [4]	24.30% [4]	$136.12 [4]

See footnotes on the following page.
Source: Annual Statements to the Pennsylvania Insurance Department for the calendar years ending December 31, 1996 through December 31, 1999.

Calendar Year 1999 Financial Indicators

	Commercial				Total HMO Net (After-Tax) Margin[1]	3-Year Average Net Margin 1996-1999	Current Ratio	Net Worth to Total Liabilities
	Medical Loss Ratio	Adminstrative Expense Ratio	Federal Tax Rate	Net (After-Tax) Margin[1]				
HMO Plans								
KHP Central	87.40%	11.11%	0.51%	2.76%	0.37%	-1.87%	0.81	0.25
PHS Health Plans	109.68%	17.55%	-10.34%	-14.63%	-7.32%	-2.84%	0.82	0.18
HMO/POS Combined Plans								
Aetna U.S Healthcare	87.84%	11.81%	0.10%	1.07%	0.31%	0.51%	0.46	0.30
CIGNA	75.67%	19.77%	5.50%	4.54%	10.17%	-1.28%	1.64	0.62
First Priority Health	97.64%	14.03%	-4.21%	-7.36%	-6.62%	-6.79%	0.52	0.41
Geisinger	90.14%	9.78%	NP	0.86%	-0.56%	0.06%	0.96	0.46
Health America (combined HMO/POS)	88.85%	10.47%	0.65%	2.94%	1.51%	1.44%	0.59	0.25
HealthGuard	90.94%	12.67%	-0.02%	-0.04%	0.66%	-2.16%	0.24	0.44
KHP East	79.94%	17.32% [4]	2.25%[4]	2.71% [4]	2.26%	2.77%	0.41	0.57
KHP West	89.42%	13.30%	0.03%	1.20%	0.02%	-0.61%	0.66	0.26
NewAlliance [2]	100.70%	13.26%	0.00%	-13.78%	-13.78%	-7.84%	0.16	-0.82
UPMC Health Plan	86.41%	18.48% [4]	NP	-4.33% [4]	-9.56%	-15.56%	1.21	0.27

NP Non-profit corporation.

1 Since non-profit (NP) corporations do not incur income taxes, there is no tax expense deducted from the income levels used to compute the Net Margin for non-profit corporations.

2 Beginning January 1, 2000, the Alliance Health Network was replaced by a new corporation, the NewAlliance Health Network. As of September 30, 2000, the NewAlliance Health Network had a current ratio of .90 and a ratio of Net Worth to Total Liabilities of 0.41.

3 The UPMC Health Plan experienced a relatively large growth in revenue over the three-year period because calendar year 1996 was its first year of operatlon. UPMC began with a Medical Assistance product and started to enroll commercial members in July 1998.

4 These plans include revenue garnered from administrative contracts in their data reported to Pennsylvania Insurance Department. To keep consistency across all plans, this revenue has been removed from this table.

Source: Annual Statements to the Pennsylvania Insurance Department for the calendar years ending December 31, 1996 through December 31, 1999.

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 handbook
- Lists of doctors and facilities included in the HMO's provider network
- Services available to members
- Newsletters
- Brochures and pamphlets on a variety of topics.

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

As you do that, consider the following issues:

- Does the HMO cover the services and include the 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?

Using the Worksheet

On the next pages you will find a table with the names of each HMO licensed in Pennsylvania. With that name you can find the counties where they are licensed to do business. Availability of an HMO may depend more upon the location of your place of work than the place of your residence.

Also included is a list of HMOs with telephone numbers and Web site addresses. This will help you contact the HMO and receive additional information.

The actual worksheet is found on page 51 of this report. Use it to help organize your questions and the information provided by this report.

Counties Where HMOs are Licensed to Do Business by the Pennsylvania Department of Health

	Adams	Allegheny	Armstrong	Beaver	Bedford	Berks	Blair	Bradford	Bucks	Butler	Cambria	Cameron	Carbon	Centre	Chester	Clarion	Clearfield	Clinton	Columbia	Crawford	Cumberland	Dauphin	Delaware	Elk	Erie	Fayette	Forest	Franklin	Fulton	Greene	Huntingdon	Indiana	Jefferson	Juniata
Aetna U.S. Healthcare	x	x	x	x		x	x	x	x	x	x		x		x	x		x	x		x	x	x		x	x			x	x			x	
CIGNA									x						x								x											
First Priority Health								x					x					x																
Geisinger					x	x	x	x			x		x	x			x	x	x		x	x									x			x
HealthAmerica	x	x	x	x		x	x			x	x			x			x	x	x		x	x				x				x	x	x	x	x
HealthGuard						x															x	x												
KHP Central	x					x								x					x		x	x												x
KHP East									x						x								x											
KHP West		x	x	x	x		x			x	x	x				x	x			x				x	x	x	x			x	x	x	x	
NewAlliance																				x					x									
PHS Health Plans									x						x								x											
UPMC		x	x	x	x		x			x	x									x					x	x				x		x		

	Lackawanna	Lancaster	Lawrence	Lebanon	Lehigh	Luzerne	Lycoming	McKean	Mercer	Mifflin	Monroe	Montgomery	Montour	Northampton	Northumberland	Perry	Philadelphia	Pike	Potter	Schuylkill	Snyder	Somerset	Sullivan	Susquehanna	Tioga	Union	Venango	Warren	Washington	Wayne	Westmoreland	Wyoming	York
Aetna U.S. Healthcare	x	x	x	x	x	x	x		x		x	x		x	x	x	x	x		x	x	x	x	x					x	x	x	x	x
CIGNA												x					x																	
First Priority Health	x					x	x				x							x					x	x	x					x		x	
Geisinger	x	x		x		x	x			x	x		x		x	x			x	x	x		x	x	x	x				x		x	x
HealthAmerica		x	x	x		x	x		x	x					x	x				x	x	x				x			x		x		x
HealthGuard		x		x																													x
KHP Central		x		x	x					x			x	x	x	x				x	x						x						x
KHP East												x					x																	
KHP West			x					x	x										x			x					x	x	x		x		
NewAlliance																											x						
PHS Health Plans	x					x						x					x																
UPMC			x						x													x					x		x		x		

List of HMO Telephone Numbers and Web Site Addresses

Full Name	Abbreviated Name	Contact Number	Web Site Address
Aetna U.S. Healthcare	Aetna U.S. Healthcare	1-800-991-9222	www.aetnaushc.com
CIGNA Healthcare of PA	CIGNA	1-800-345-9458	www.cigna.com/healthcare
First Priority Health	First Priority Health	1-800-822-8753	www.bcnepa.com
HealthAmerica Central	HealthAmerica	1-800-788-8445 (Central Pennsylvania)	www.healthamerica.covty.com
HealthAmerica Pittsburgh	HealthAmerica	1-800-735-0708 (Pittsburgh Area)	www.healthamerica.covty.com
HealthGuard of Lancaster	HealthGuard	1-800-822-0350	www.hguard.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	KHP West	1-800-386-4944 1-800-350-4130 (PEBTF Only)	www.highmark.com
NewAlliance Health Network	NewAlliance	1-800-255-4281	n/a
Geisinger Health Plan	Geisinger	1-800-631-1656	www.thehealthplan.com
PHS Health Plans	PHS Health Plans	1-800-988-2840	www.phshealthplans.com/home.html
UPMC Health Plan, Inc.	UPMC	1-800-644-1046	www.upmc.edu/upmchealthplan/

Your Personal Worksheet

PLAN NAME	LOCATION Which plans service your area? Pages 48, 49	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 7-34	Access and Service Pages 35-46

PHC4

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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.

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