

PROFESSION**Gap on guideline use between HMOs and PPOs narrows**

For example, patients with diabetes receive eye exams at virtually the same rate in both plan types.

By KEVIN B. O'REILLY, amednews staff. Posted Oct. 24, 2011.

Patients insured by HMOs are likelier to receive guideline-based wellness, preventive and chronic disease care from their physicians than patients covered by preferred-provider organizations, but the gap between the two types of health plans is shrinking.

For the first time, the National Committee for Quality Assurance publicly reported in October how PPOs compared with HMOs on all of its performance metrics.

The committee's dozens of process and outcome performance measures, largely based on the Healthcare Effectiveness Data and Information Set, cover areas such as antibiotic use, childhood immunizations, cholesterol management, medication management, mental illness and hypertension. The publicly reported data are intended to give patients and employers a way to choose among plans on the basis of how well they encourage quality care.

In 2005, for example, 65% of HMO patients with diabetes received eye exams, compared with 55% of patients in PPOs. By 2010, the gap virtually disappeared. HMO and PPO patients with asthma receive the right medications to treat the condition nearly 92% of the time.

On a majority of metrics, HMOs still fare better. For example, 45% of HMO patients who smoke get advice on quitting from their doctors, compared with 39% of PPO patients.

Fifty-five percent of American workers are covered by a PPO, said a Sept. 27 Kaiser Family Foundation report. Seventeen percent are insured by HMOs, 17% are in high-deductible plans and 10% are in point-of-service plans.

Yet the NCQA report found that commercial HMO patients are more highly satisfied with their plans. In 2010, 40% of HMO patients gave their health plan a rating of nine or 10 on a zero-to-10 scale. Only 34% of PPO patients were similarly satisfied with their insurance packages, which typically feature broader coverage networks than HMOs but also have higher deductibles.

The report was based on quality data from more than 1,000 health plans that cover 118 million Americans. Among HMOs, which the committee has graded for the longest, there have been clear improvements over time, the report said. For example, the rate of HMO patients with diabetes receiving blood-glucose screening has increased by 15 percentage points to 90% since 1999.

"What we see today is a much clearer recognition of the value of public reporting to spur improvement and that these kinds of achievements can be accomplished with different kinds of models," said Susan Pisano, vice president of communications for the insurer trade group America's Health Insurance Plans, which did not take part in the report. "That's important information to have as we move on with health reform."

Improving quality of care

Health plans that are designed to reward coordinated care, patient engagement and evidence-based care can improve quality, said Margaret E. O'Kane, president of NCQA. Insurers increasingly are looking to work with physician groups on quality initiatives and analyze data to help identify high-risk patients, she said.

"Partnering with practices means this doesn't have to be hand-to-hand combat," O'Kane said. "This can be a win-win."

Yet there are points of friction. A recent analysis of 2.4 million claims processed by seven commercial insurers found that they often fumble the basic task of administering claims, paying the wrong amount 19% of the time. The research, conducted by the American Medical Association and released in June, said eliminating the mistakes would save \$17 billion annually.

The AMA has policy supporting performance measures that are created with physician involvement, evidence-based, relevant and clinically meaningful. The Association-convened Physician Consortium for Performance Improvement has developed 271 metrics in 42 clinical areas.

One of the insurers highlighted in this year's NCQA rankings is Capital District Physicians' Health Plan, a doctor-founded and directed nonprofit that covers 350,000 patients in New York with HMO, PPO and self-insured plans. The company's Medicaid, Medicare and commercial HMO plans landed fifth, 16th and 27th, respectively, on the NCQA's

list of top performers.

"We offer what we call an enhanced primary-care model -- an advanced patient-centered medical home," said John D. Bennett, MD, president and CEO of the plan. "Aligning the incentives of physicians is crucial. I think fee-for-service is broken. I lived there for 25 years -- it's a mess. We need to bring quality into the payment equation."

ADDITIONAL INFORMATION:**WEBLINK**

"Continuous Improvement and the Expansion of Quality Measurement: The State of Health Care Quality 2011," National Committee for Quality Assurance, October (www.ncqa.org/LinkClick.aspx?fileticket=FpMqqADPo8%3d)

"Employer Health Benefits 2011 Annual Survey," Kaiser Family Foundation, Sept. 27 (ehbs.kff.org)

"2011 National Health Insurer Report Card," American Medical Association, June (www.ama-assn.org/resources/doc/psa/2011-nhirc-results.pdf)

Physician Consortium for Performance Improvement (www.ama-assn.org/go/pcpi)

Copyright 2011 American Medical Association. All rights reserved.

RELATED CONTENT

- » **Insurers mishandle 1 in 5 claims, AMA finds** July 4
- » **U.S. quality improvement steady, but progress on disparities elusive** March 14
- » **Quality initiative claims it saved 22,000 lives** Dec. 13, 2010
- » **Physician background doesn't tell the whole quality story** Sept. 27, 2010
- » **Quality ratings on coronary artery bypasses made public with surgeons' help** Sept. 20, 2010