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# *In the Literature*

## HEALTH PLAN QUALITY DATA: THE IMPORTANCE OF PUBLIC REPORTING

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Managed care plans that publicly release data about their performance on standard quality measures are more likely to provide better care than plans that do not. The correlation between quality of care and public access to performance data is so strong, according to a recent study, that purchasers choosing among health plans should avoid those that fail to make their data public.

In **"Health Plan Quality-of-Care Information Is Undermined by Voluntary Reporting,"** a study funded by The Commonwealth Fund, Joseph W. Thompson, M.D., and colleagues present evidence that health plan performance is highly associated with whether a plan publicly releases its performance information. The finding makes a compelling argument for the support of policies that mandate reporting of quality-of-care measures. Currently, there are no universal reporting requirements imposed on managed care plans.

Many health plans voluntarily report quality-of-care information through the national database known as the Health Plan Employer Data and Information Set (HEDIS). Dr. Thompson and his coauthors selected women's health indicators as a basis to compare performance among plans. These indicators are significant because women have more frequent interactions with the health care system than men, and often are responsible for the health care decisions in a household.

The study examined eight indicators unique to women's health, such as breast cancer screening using mammography and cervical cancer screening using Pap tests.

The study examined 1997 HEDIS data reported in 1998 to the National Committee for Quality Assurance (NCQA). At that time, health plans could report their HEDIS data to NCQA for accreditation purposes, but could either restrict public availability or allow NCQA to release the performance data publicly. (As of 1999, NCQA requires public reporting of data for accreditation.)

Of the 630 insurance companies that operated managed care companies in 1998, only 333, or 53 percent, submitted HEDIS data to NCQA for one or more of their health plans. These 333 companies submitted quality data on the eight women's health indicators chosen by the researchers from 493 different health plans.

The managed care plans were evaluated for how well they met the national public health goals outlined in Healthy People 2010. The authors found wide variation in how the plans performed. Several plans met or exceeded specific goals. But when the authors examined the average performance of *all* reporting health plans for each of the eight indicators, the average plan exceeded the national goals for only two indicators: mammography rates and vaginal births after prior Caesarean section.

Armed with data on the wide variation in performance among health plans, the authors then compared plans that chose to reveal their performance data with those that did not. Some 40 percent of plans restricted public access to one or more of their quality results. These same plans consistently reported data that was inferior to plans with unrestricted data, under-

performing them by three to six percentage points (see table). Restricted plans, for example, had mammography rates of 68 percent, compared with 73 percent for health plans with unrestricted data. When applied across the 50 million enrollees covered by these plans, these results have potential clinical significance. The study also pinpointed important regional differences in quality of care, depending on the region, state, and community in which health plans operated.

The authors conclude that public reporting is the single largest determinant of variation in performance on quality indicators. Many health plans that restricted access to their performance data, in fact, were unable to demonstrate that they delivered primary preventive and pregnancy care services for as many as 50 percent of their enrolled women. The authors caution purchasers to avoid health plans that choose to restrict access to their performance data, given this inconsistency in the quality of care delivered by commercial plans.

This study has several policy implications. Its findings support current efforts at a national level to mandate reporting of HEDIS quality-of-care measures. For now, selective reporting of data continues. For example, while NCQA requires plans undergoing accreditation and those already accredited to submit and publicly report HEDIS information, managed care plans in general do not have to publicly disclose the data.

Increasing public accountability through performance measurements would have the potential to systematically improve the care that patients receive. "Consumers of health care deserve tools that will assess the quality of care delivered by health plans and monitor longitudinal improvements in plans," the authors conclude. "Unfortunately, the voluntary aspect of the current reporting process allows poorer-performing plans to escape public scrutiny and may serve to undermine efforts to safeguard patients and better inform health care purchasers in their plan selection decisions."

**Health Plans That Restrict Public Access to Quality-of-Care Data Perform More Poorly Than Plans That Do Not**

| | PLANS PUBLICLY REPORTING HEDIS PERFORMANCE DATA | | | PLANS RESTRICTING PUBLIC ACCESS TO HEDIS PERFORMANCE DATA | | |
|---|---|---|---|---|---|---|
| **HEDIS Indicator** | **Number of Plans** | **Number of Women** | **Average Percentage of Eligible Patients Receiving Service (range)** | **Number of Plans** | **Number of Women** | **Average Percentage of Eligible Patients Receiving Service (range)** |
| Breast cancer screening (mammography) | 282 | 1,964,077 | 73% (47%–100%) | 187 | 549,721 | 68% (47%–83%) |
| Cervical cancer screening (Pap test) | 286 | 11,891,766 | 73% (41%–100%) | 193 | 3,069,292 | 68% (13%–85%) |
| Prenatal care in first trimester | 267 | 535,917 | 85% (30%–100%) | 180 | 82,410 | 80% (5%–99%) |
| Postpartum checkup | 256 | 494,163 | 69% (19%–97%) | 176 | 163,481 | 63% (2%–95%) |
| Access to preventive or ambulatory health services (ages 20–44) | 271 | 8,151,846 | 85% (9%–98%) | 141 | 1,331,043 | 82% (48%–97%) |
| Access to preventive or ambulatory health services (ages 45–64) | 271 | 6,548,220 | 88% (9%–100%) | 141 | 845,262 | 85% (48%–100%) |
| Caesarean section | 275 | 646,851 | 20% (6%–35%) | 155 | 516,028 | 22% (10%–36%) |
| Vaginal birth after prior Caesarean section | 240 | 65,164 | 41% (2%–100%) | 146 | 41,240 | 38% (0.7%–100%) |

Note: The 3% to 6% difference in reported results for these indicators represents a clinically significant deficiency when applied across the 50 million enrollees covered by these plans. HEDIS stands for the Health Plan Employer Data and Information Set.

Source: Joseph W. Thompson et al., "Health Plan Quality-of-Care Information Is Undermined by Voluntary Reporting," *American Journal of Preventive Medicine* 24 (January 2003): 62–70.