Federal Employees Health Benefits Program
Report on Health Information Technology (HIT) and Transparency

September 2007

Executive Summary

This report is based on information collected from health plans participating in the Federal Employees Health Benefits (FEHB) Program. It is divided into two sections: 1) health information technology implementation; and, 2) availability of health care price and quality transparency information for plan members. Key results are as follow:

- 97 percent of FEHB plans report they have taken steps to educate their members on the value of HIT.

- 51 percent of health plans, representing 90 percent of FEHB enrollment, offer some type of personal health record (PHR) to their members.

- Types of personal health records vary; 18 percent of plans report their PHRs are populated by members; 14 percent report they are populated with health plan claims data; 13 percent are populated by electronic medical records, and 6 percent offer a view of personal health information with no ability for the member to up-date the information.

- However, based on the health plan reports, it appears fewer than 5 percent of plan members have accessed the PHRs available to them.

- 67 percent of plans report they have online physician or hospital cost estimators or comparison tools on their web sites.

- 75 percent of plans report they have online tools that compare physician or hospital quality.

- 23 percent of health plans state they provide financial incentives to providers for ePrescribing.

- All FEHB plans are required to comply with Federal law and policy requirements to protect the privacy of individually identifiable health information. All indicate they provide members with access to the privacy policies that describe their compliance with HIPAA.

Report on Health Information Technology (HIT) and Transparency in the FEHB Program

Background

The lack of interoperable electronic computer systems and standards inhibits the flow of critical health information among patients, providers and health plans. In addition, information about health care quality and the price/costs of services have been largely unavailable to most consumers. Without consistent health care data standards and cost and quality measures, it is difficult for consumers to have the information they need to make informed choices and seek the best quality care at the most affordable prices.

To address this need, President George W. Bush signed an Executive Order in August 2006, which committed Federal health care programs to four *cornerstone* goals for health information technology (HIT). The following spring, the U.S. Office of Personnel Management (OPM) issued an FEHB carrier letter asking health plans to commit to the following *cornerstones*:

1. Consistent standards for connecting HIT, making it possible to share patient health information securely and seamlessly;
2. Enhanced quality of care reporting, so health care providers as well as the public can learn how well each provider measures up in delivering care;
3. Enhanced provider cost reporting so when patients choose care, they can make provider service comparisons on the basis of both the quality and cost of the service or procedure; and,
4. Increasing incentives for quality care at competitive prices, as in payments to providers based on the quality of their services, or insurance options that reward consumers for choices based on quality and cost.

FEHB carriers were also asked to describe their actions to advance health information technology and transparency and to complete a quantitative questionnaire measuring their progress on the following steps:

- Actions to make consumers aware of the value of HIT;
- Actions to make personal health records available to enrollees based on their medical claims, lab test results and medication history;
- Actions to meet our health care cost and transparency standards;
- Actions to provide incentives for ePrescribing; and,
- Actions to ensure compliance with Federal law and policy outlining requirements to protect the privacy of individually identifiable health information.

Program Findings

All FEHB carriers submitted reports on the HIT and transparency information they provide to their members. There are currently 284 plan choices in the FEHB Program and about 8 million Federal enrollees, retirees, and dependents are covered under the Program. The following sections of this report summarize our findings.

Actions to Make Consumers Aware of the Value of HIT

The health plans were asked if they had taken actions to describe the value of HIT to their enrollees. 97 percent of plans indicated that they had taken steps to educate enrollees. Most used their web sites and newsletters to communicate this information. Some plans promoted their PHR and transparency tools, and the availability of health and wellness information, health risk assessments and disease management programs.

The plans reported the following:

Medium used to describe the benefits of HIT:	**Percent of plans reporting**
• Web site	86
• Newsletter	83
• Open enrollment meetings	70
• Benefits brochure	43
• Marketing literature	76
• Other	28

When was HIT information first provided to enrollees?	**Percent of plans reporting**
• Prior to 2004	33
• Mid 2004	10
• Beginning of 2005	7
• Mid 2005	8
• Beginning of 2006	10
• Mid 2006	19
• Beginning of 2007	10

Actions to Make Personal Health Records (PHRs) Available to Enrollees Based on Their Medical Claims, Lab Test Results and Medication History

Personal Health Records (PHR)

A majority of plans have developed Personal Health Records (PHR) for their enrollees. 51 percent of plans representing 90 percent of total FEHB enrollment reported PHRs are available to their enrollees. However, based on the plans' reports, we estimate fewer than five percent of enrollees have accessed PHRs.

Generally, PHRs have tools that allow for creation of personal health profiles, enrollee demographic data, and insurance information. Most PHRs in the FEHB Program are populated with member entered data or health plan claims data. When the FEHB plans populate the PHRs, they mainly use member claims data. This means the claims information is automatically loaded in the PHR by the plan's claims system.

A few health plans have PHRs which are populated with clinical data from electronic health records (EHR) or electronic medical records (EMR), and a few PHRs are available on a "view only" basis. However, most plans do not have the capability to populate PHRs from provider EHR/EMRs. In fact, only a limited number of medical providers currently use EHR/EMRs. A 2006 study published in *Health Affairs* found that provider EHR adoption rates varied from 9.3 percent to 23.9 percent depending on the functionalities that a fully-defined EHRs is expected to have. The inability of health plans to draw clinical information from medical provider EHR/EMRs limits the clinical data their PHRs contain and the decision support functions they can provide to patients and providers. An exception is in a few HMOs where providers' EHR/EMRs are fully integrated with patient PHRs so that clinical decision support and ePrescribing are the norm – not the exception.

Some plans do have electronic systems that query claims and pharmacy records and/or patient PHRs to determine eligibility for case management, disease management, health information, and other types of clinical decision support. The more advanced PHRs use health risk assessment tools (HRA) to help populate the PHR and the plan's system queries the information to determine the patient's health needs. Once health needs are identified, the system automatically sends clinical decision support guidance to the enrollee.

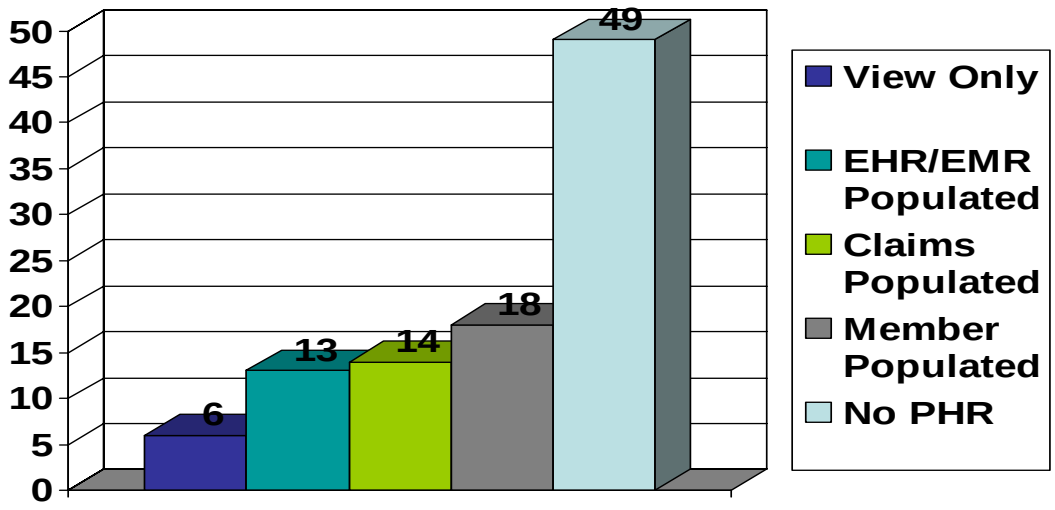
Some plans indicate they have been closely watching the market as numerous PHR definitions emerge and vendors compete with different operating models for PHR systems. As HIT is an emerging technology, there is a degree of market confusion. There remains a lack of market acceptance of a common PHR definition and associated data content or portability standards. With such a young technology, the PHR market is still sorting itself out. Potential lack of vendor stability and longevity make commitment to a given solution very risky for a health plan. For these reasons, some plans have taken a conservative approach to offering/sponsoring a PHR solution for their enrollees.

Plans were asked if they offer a personal health record to their enrollees and given the following four options:

- Do you offer members a freestanding PHR (information only provided and populated by the member)?
- Do you offer a PHR tethered to your claims data base (PHR pre-populated by your claims system and supplemented by member entered information)?
- Do you or your providers offer a PHR tethered to provider electronic health records (EHR) or electronic medical records (EMR) and supplemented by member entered information?
- Does the plan offer a view-only PHR (member can view their personal health information over the internet but cannot update the information)?

The plans responded as follows:

Percentage of Plans Reporting PHRs by Type



Plans were asked about the information included in their PHRs. (Some plans without PHRs also responded to these questions because they had a number of electronic features, but not organized into a consolidated PHR.) The responses were as follows:

What information is included in your PHR?	**Percent of plans reporting feature**
• Hospital admissions	49
• Physician services	57
• Lab	53
• X-rays	45
• Rx	57
• Emergency room	47
• Allergies	53
• Mental health	48
• Preventive care/screenings	60
• Immunizations	57
• Pre-cert/pre-authorization requirements	21
• Health education	52
• Personal health history	54
• Family health history	50
• Family planning	26
• Advanced directives	27
• Registration and insurance information	45
• Other	26

Plans were asked how they identify potential case management and disease management candidates. They responded that they obtain this information mainly by querying their claims and pharmacy data bases. Plans with more advanced HIT also queried enrollee PHRs and provider EHRs/EMRs:

Does your plan identify potential case management and disease management candidates by querying:	**Percent of plans reporting feature**
• Health plan claims database?	90
• Member PHRs?	25
• Provider EHRs or EMRs?	22
• Member prescription information?	89

Health Plan Members

Plans reported that members are able to perform the following tasks on their electronic systems, some through their PHRs:

Members ---- *Are members able to...*	**Percent of plans reporting feature**
• Schedule appointments online?	17
• Access their claims information online?	78
• Access EOBs online?	65
• Complete their physician's office registration summary (clipboard) and medication history online prior to their office visit?	9
• Access the results of their lab tests online?	25
• Communicate with their physicians online to discuss clinical issues?	20
• Track their preventive care, screenings online?	52
• Track immunizations online?	52
Plan members can receive the following through online web portals or email:	**Percent of plans reporting feature**
• Appointment reminders	20
• Reminders to refill prescriptions	31
• Reminders of preventive screening tests and exams	37
• Immunization reminders	29
• Information to support their clinical decision making.	67

Health Plan Providers

Plans were asked if they had the following capabilities:	**Percent of plans reporting feature**
• Does your plan offer pay for performance or pay for use as an incentive to providers to use HIT?	31
• Does your plan provide incentives for physicians and hospitals to use certified electronic health records (EHR) or electronic medical records (EMR)?	22
• Do you send online information to your providers to support their clinical decision making?	36
• Do you reimburse your providers for online patient consultations?	11

Actions to Meet FEHB Health Care Transparency Standards
(Price/Cost and Quality Tools)

Fee-for-Service PPOs, CDHP, HDHP

Price/cost comparison tools are generally most useful to members in fee-for-service plans, consumer driven health plans (CDHP), and high deductible health plans (HDHP) where there is member cost sharing. These plans generally pay providers on a fee-for-service basis and an enrollee's financial obligation is typically a percentage of the plan's allowance.

Most plans show physician costs based on what they pay on average for in-network and out-of-network services for specific procedures. Some plans report actual in-network costs along with out-of-network average costs. Few plans compared one physician's costs to another.

Most physician quality indicators focused on accreditation (e.g., NCQA) and physician credentialing and medical board certification.

Hospital cost and quality comparison tools appear to be more prevalent than physician comparison tools. Hospital tools often compared various hospitals by the quality and cost of the hospital by procedure. Most hospital comparison tools offer quality measures on patients treated for a particular condition, including percentage of complications by hospital, number of patients, average length-of-stay, and mortality rate.

HMOs

Some HMOs are capitated and enrollee financial obligations are flat dollar amounts (copayments or copays) which do not vary based on the plan's payment to providers. HMOs control costs by negotiating provider discounts or paying providers on a salaried basis and performing utilization review.

Some HMOs stated that consumer information on quality and price/cost indicators for particular providers are not relevant in an HMO delivery system. This is because the plan has already done the price/cost and quality shopping for the enrollee by only offering providers that accept efficient capitation arrangements and meet the plan's licensing and credentialing requirements.

Quality Tools

Plans reported the following on quality transparency:

Quality Transparency	**Percent of plans reporting feature**
• Does your plan have online tools that compare physician or hospital quality?	75
• Does your plan provide members with online tools that compare ***physician*** quality indicators (e.g. board certification, credentialing)?	50
• Does your plan provide members with online tools that compare ***hospital*** quality indicators (e.g. accreditation, ALOS, complication rates)?	71
• Do your quality metrics clearly describe the sources, currency, and geographic limitations of the data?	74
• Does your plan participate in state or regional health information network exchange programs?	47
• Does your plan participate in collaborative efforts with other public/private sector partners for data aggregation and quality analytics?	71
• Does your plan contribute to all-payor claims sets?	26

Price/Cost Tools

Plans have a variety of ways in which they provide their members with information on provider and prescription drug prices/costs. They were asked to report on their price/cost transparency tools:

Price/Cost Comparison	**Percent of plans reporting feature**
• Does your plan have a standard set of procedure codes and costs posted on your web site for FEHB members to view?	37
• Does your plan post on its web site published average reimbursement rates related to procedures and services (e.g. Medicare reimbursement rates)?	47
• Does your plan post actual reimbursement rates for specific procedures and services?	18
• Does your plan focus on products where patient contribution is a function of price (e.g. percentage cost sharing)?	50

Does your plan have online physician or hospital cost estimators or comparison tools on its web site?	**Percent of plans reporting "Yes"**
	67
If yes, does the plan have online cost estimators that:	**Percent of plans reporting feature**
• Show physician costs?	44
• Show hospital costs?	51
• Compare physician costs?	20
• Compare hospital costs?	49
• Compare costs by diagnosis?	51
• Compare costs by procedure?	57
• Compare costs by episodes of care?	38
• Reflect plan provider costs by geographic area?	34
• Reflect average industry costs by geographic area?	45
• Clearly describe the sources, currency, and geographic limitations of the data?	60
Pharmacy Tools --- *Does your plan have online tools that…*	**Percent of plans reporting feature**
• Compare prescription drug costs or quality?	69
• Show prescription drug retail costs compared to network copayments?	52
• Show the generic equivalent or brand name formulary drug costs compared to retail costs?	62
• Compare a member's current drug costs to lower priced therapeutic equivalents?	62
• Allow members to view the plan's formulary online?	92
• Notify members by email when the formulary changes?	14
Financial Tools --- *Does your plan provide web based tools that…*	**Percent of plans reporting feature**
• Model the member's projected annual health care spending, estimating out-of-pocket costs and tax implications?	52
• Provide the current balances for personal health accounts (e.g., HSAs, HRAs, Medical Funds) and check spending against plan deductibles and out-of-pocket maximums?	51

Actions to Provide Incentives for ePrescribing

Some plans in the FEHB Program have e-Prescribing capabilities, but not for all providers. A number of plans have been conducting e-Prescribing pilots or participating in collaborative efforts. Some plans provide e-Prescribing equipment to their providers and others offer incentives. HMOs were more likely to report that they used e-Prescribing as a part of the EHR or EMR. Many PPO plans did not respond to this question.

Plans were asked to report on their progress in ePrescribing; results are as follows:

Actions to provide incentives for ePrescribing	**Percent of plans reporting feature**
• Do you provide any financial incentives to providers for ePrescribing?	23
• Can physicians order prescriptions online?	59
• Do you provide any equipment to your providers for ePrescribing?	40
• Can members request a prescription refill over the internet?	80
• Can providers access the plan's formulary online?	90

Actions to Ensure Compliance with Federal Requirements for the Protection of and Privacy of Individually Identifiable Personal Health Information (PHI)

All plans reported that they comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA) and/or that the vendors they use for their PHRs are business associates under HIPAA regulations and therefore subject to HIPAA requirements. Some plans reported that they had internet security protections in place but they do not routinely disclose them to enrollees. Some plans reported their enrollees can control who sees their PHR information because they are the only ones who can access the information.

The plans were asked the following questions on the privacy and security of their enrollees' individually identifiable personal health information:	**Percent of plans reporting feature**
Does the plan provide members with an easily accessible and understandable privacy and security policy that describes:	
• The plan's compliance with HIPAA or that the member's PHI is maintained by an entity not protected by HIPAA?	100
• How the plan uses a member's PHI?	98

The plans were asked the following questions on the privacy and security of their enrollees' individually identifiable personal health information (Continued):	Percent of plans reporting feature
• Who has access to the member's PHI?	98
• How and when members can limit access to their PHI?	97
• When the plan can disclose their PHI without further consent (e.g., law enforcement, court orders)?	97
• When the plan will ask for a member's consent prior to disclosure?	97
• Any secondary uses (e.g., marketing, research, quality reporting) of the member's PHI?	93
• How the member can obtain a copy of their PHI?	98
• How the member can request to amend or annotate their PHI?	97
• How the member will be notified of a breach of privacy?	74
• Any remedies for misuse of PHI or breach of privacy (enforcement and dispute resolution mechanisms)?	77
• How PHI will be handled if the plan or its vendor goes out of business?	55
• The plan's computer system security features (e.g., identification, authorization, access control, auditable) that protect against unauthorized disclosure of PHI?	77

Conclusion

The information in this report represents a baseline from which FEHB carriers can move forward in their implementation of HIT and transparency initiatives. We believe significant progress has been made by many of the health plans over the past several years. Some plans now offer state-of-the-art personal health records (PHRs) and excellent price and quality transparency information on their web sites, while others are just getting started. We are continuing to encourage FEHB plans to expand on their HIT and transparency initiatives and to make more of this information available to consumers. We are closely monitoring the progress of all plans and will highlight those that represent best practices on OPM's web site so FEHB employees, retirees and dependents have this information available when selecting their health plans during the annual Open Season.