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

September 2008

Executive Summary

This program-wide report is based on individual reports collected from health plans participating in the Federal Employees Health Benefits (FEHB) Program. Many plans have made significant progress on their health information technology (HIT), personal health records (PHR), and transparency initiatives since the last report in 2007.

Program Findings For 2008

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

- 75 percent of plans, representing 96 percent of total FEHB enrollment, will have PHRs available for their members in 2009. In 2007, only 51 percent of plans reported offering PHRs.

- Although the majority of FEHB plans continue to report that less the 5 percent of their members have actually used their PHRs to conduct one or more sessions, 16 percent of plans reported over 75% of their members used PHRs.

- Types of personal health records vary; 22 percent of plans report their PHRs are populated by members; 30 percent report they are populated with health plan claims data with the option for members to add personal information; 8 percent are populated by electronic medical records, with the ability to add information, and 15 percent allow members to view their personal health information with no ability for the member to up-date the information.

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

- 77 percent of plans report they have online tools which compare physician or hospital quality.

- 26 percent of health plans state they provide financial incentives to providers for e-Prescribing.

- 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 privacy policies describing their compliance with the Health Insurance Portability and Accountability Act (HIPAA).

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

Background

The lack of interoperable electronic 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 price/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 soliciting commitment 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.

For the past few years, FEHB carriers have been asked to describe their actions to advance health information technology and transparency on the following:

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

Program Findings For 2008

In August 2008, all FEHB health plan carriers submitted reports to the U.S. Office of Personnel Management (OPM) on their Health Information Technology (HIT) and Transparency initiatives and the electronic tools they provide to their members to support their healthcare decisions. There are currently 283 health plan choices in the FEHB Program and about 8 million Federal employees, retirees, and family members are covered under the Program. The following sections of this report summarize the program-wide findings on carrier initiatives.

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. 95 percent of plans indicated they had taken steps to educate enrollees. Most used their web sites, newsletters, and educational materials to communicate this information.

More advanced plans have developed marketing and educational materials to specifically highlight their PHRs, health and wellness information, disease management programs, health education classes, health risk assessments (HRAs), price/cost estimators, and quality transparency tools and resources. This information is direct mailed to members and included on plan web sites in the public domain throughout the year. Some plans advertised their HIT tools and information in radio and television advertising. The plans reported the following:

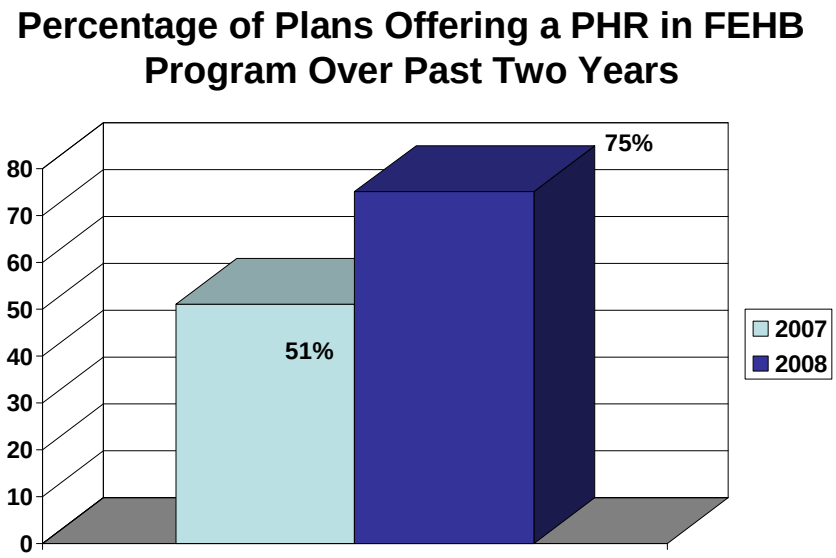
Medium used to describe the benefits of HIT?	**Percent of Plans Reporting**
• Web site	92
• Newsletter	89
• Open enrollment meetings	84
• Benefits brochure	65
• Member education materials	86
• Other	47

When HIT information was first provided to enrollees?	**Percent of Plans Reporting**
• Prior to 2004	45
• 2004	11
• 2005	14
• 2006	19
• 2007	12
• Beginning of 2008	6

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 offer Personal Health Records (PHR) to their members. In 2007, only 51 percent of plans reported offering PHRs. This year, 75 percent of plans representing 96 percent of total FEHB enrollment reported PHRs will be available to their members in 2009.



Generally, PHRs have tools whch allow for creation of personal health profiles (including health conditions, medications, procedures and laboratory results), patient and attending provider demographic data, and insurance information. Most PHRs in the FEHB Program are populated with member-entered data (22 percent) or health plan claims data (30 percent). When FEHB plans populate PHRs, they mainly use claims data. This means claims information is automatically loaded in the PHR template by the plan's information technology systems. Fifteen percent of health plans report they offer a view-only PHR, with limited functionally, where a member can view their claims or EHR/EMR data over the internet but cannot update the information.

A few health plans (8 percent) have PHRs which are populated with clinical data from provider electronic health records (EHR) or electronic medical records (EMR). 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. As of early 2008, a survey commissioned by Massachusetts General

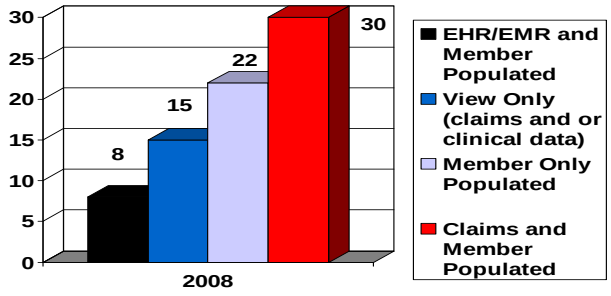
Hospital and the Office of Management and Budget showed only four percent of physicians have extensive fully functional EHRs, and only 13 percent have a basic EHR system. The inability of health plans to draw clinical data from medical provider EHR/EMRs limits the clinical information their PHRs contain, 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 and clinical decision support and e-Prescribing are the norm – not the exception.

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. There remains a lack of market acceptance of a common PHR definition and associated data content or portability standards. The potential lack of vendor stability and longevity make commitment to a given solution risky for health plans. For these reasons, some plans have taken a conservative approach to offering PHR solutions to their members.

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

- Does the plan 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 claims or EHR/EMR data over the internet but cannot update the information)?
- Does the plan offer a member populated PHR (information only provided and populated by the member)?
- Does the plan offer a PHR tethered to your claims data base (PHR pre-populated by your claims system and supplemented by member entered information.

Percentage of Plans Reporting PHRs By Type



Beginning with the 2008 contract year, all plans in the FEHB program are contractually required to use interoperability standards recognized by the Secretary of the Department of Health and Human Services (DHHS) as they update their information technology records systems. As physicians and hospitals increase their adoption of electronic medical records using recognized interoperability standards, FEHB plans will be positioned to securely receive personal health information from providers to populate and update member PHRs. This year, the plans reported the following progress on interoperability, portability and participation in the Nationwide Health Information Network (NHIN).

Plan Progress on Interoperability, Portability and Participation in the Nationwide Health Information Network (NHIN) Initiative:	**Percent of Plans Reporting**
Has your plan implemented, acquired, or updated its health IT systems to use products that meet interoperability standards recognized by the Secretary of the Department of Health and Human Services?	54
Does your plan's PHR contain America's Health Insurance Plans (AHIP) endorsed data fields and transaction standards that allow members to transfer their PHR data to a different health plan's PHR that uses the same AHIP endorsed data fields and transaction standards (is it portable)?	20
Is your health plan participating in a trial implementation of a nationwide health information network (NHIN) cooperative?	24

PHR Best Practices

The more technologically advanced FEHB plans have internet based PHRs which allow members to:

- Review medical, facility, pharmacy, and laboratory claims or clinical information all in one location.
- Record allergies and immunizations, family health history, advanced directives, and personal contacts.
- Print or download historical claims summaries which can be taken to appointments to be reviewed by physicians or accessed over the internet.
- Manage health and wellness by accessing web links to the plan's provider directory, completing a health risk assessment and reviewing online health and wellness information targeted to the member's specific health condition.
- Access health trackers to monitor blood pressure, cholesterol, and weight.
- Access calendars or provide reminders or prompts for preventive services and screenings.
- Be alerted to adverse drug interactions.
- Have decision support engines which query the entire PHR to determine appropriate decision support alerts and generate health and wellness information targeted to the member's specific health condition.

Some plans have electronic systems which query claims and pharmacy records and/or patient PHRs to determine eligibility for case management, disease management, targeted health information, and other types of clinical decision support. The more advanced PHRs use online health risk assessment (HRA) tools 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 member.

The more advanced PHRs are populated by health plan claims data and are updated without effort on the member's part, giving the member the option of filling gaps by entering information not provided by claims data. Physician, hospital, laboratory results, diagnostic tests, and screening claims data are automatically integrated into the appropriate sections of the PHR template. Some systems are configured to remind and encourage members to input personal health data to maintain the timeliness and accuracy of the information in the PHR. More advanced systems allow members to access a variety of information on the medications they take, including date, medication, dosage, usage and other members comments directly from the PHR.

One plan offers a new clinical decision support tool where members can enter a condition or symptom and the tool uses the member's health and demographic profile; where they live, their plan design, and other information to provide the member with:

- Doctors in the local area which specialize in treating their condition and who participate in their health plan.
- Commonly prescribed medications and treatment options associated with their condition.
- Estimated health care costs.
- Programs and discounts to help members manage their health needs.
- Easy to understand health articles and tips.

This decision support tool can also show search results in a visual diagram to provide a picture of the member's condition, treatment options, and potential costs.

Plan Reported PHRs

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
• Hospital admissions	69
• Physician services	78
• Laboratory	69
• X-ray	59
• Prescriptions	79
• Emergency room	68
• Allergies	73
• Mental health	70
• Preventive care/screenings	78
• Immunizations	74
• Pre-cert/pre-authorization requirements	36
• Health education	72
• Personal health history	74
• Family health history	63
• Family planning	40
• Advanced directives	43
• Registration and insurance information	65
• Other	49

Plans were asked what estimated percentages of their FEHB members have actually used their PHRs to conduct one or more sessions?	Percent of Plans Reporting
• Did not respond or not applicable	39
• 0% to 5%	26
• 6% to 10%	5
• 11% to 25%	3
• 26% to 50%	9
• 51% to 75%	2
• 76% to100%	16

Plan Reported Electronic Tools

Plans were asked how they identify potential case management and disease management candidates. They responded they obtain this information mainly by querying their claims and pharmacy data bases and health risk assessments (HRAs). 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**
• Health plan claims database?	90
• Member PHRs?	24
• Provider EHRs or EMRs?	25
• Member prescription information?	90
• Member health risk assessment questionnaires?	76

Health Plan Members

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

Members are able to:	**Percent of Plans Reporting**
• Schedule appointments online	26
• Access their claims information online	81
• Access evidence-of-benefits forms (EOBs) online	79
• Complete their physician's office registration summary (clipboard) and medication history online prior to their office visit	8
• Access the results of their laboratory tests online	34
• Communicate with physicians online to discuss clinical issues	30
• Track their preventive care, screenings online	71
• Track immunizations online	66

Do members receive through online web portal or email?	**Percent of Plans Reporting**
• Appointment reminders	24
• Reminders to refill prescriptions	55
• Reminders of preventive screening tests and exams	56
• Immunization reminders	49
• Information to support their clinical decision making	69

Health Plan Providers

Plans were asked if they had the following capabilities:	Percent of Plans Reporting
• Does your plan offer pay for performance or pay for use as an incentive to providers to use HIT?	34
• Does your plan participate in the Bridges to Excellence pay for performance program?	11
• Does your plan provide incentives for physicians and hospitals to use certified electronic health records (EHR) or electronic medical records (EMR)?	37
• Do you send online information to your providers to support their clinical decision making?	47
• Do you reimburse your providers for online patient consultations?	10
• Does your plan participate in the annual Leapfrog Hospital Survey?	37

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

Fee-for-Service PPOs, CDHP, HDHP

Price/cost comparison tools are generally more useful to members in fee-for-service preferred provider (PPO) plans, consumer driven health plans (CDHP), and high-deductible health plans (HDHP) where members pay coinsurance and deductibles. These plans require members to pay a deductible out-of-pocket before the plan begins to provide benefits toward provider costs. After members pay the deductible, plans generally pay providers on a fee-for-service basis and the member's financial obligation is typically a percentage of the plan's allowance paid to the provider.

If the provider has a contract with the health plan, the provider will normally accept the plan's payment as payment in full after the member pays a coinsurance percentage (e.g., 20% of the plan's allowance). If the member uses a provider outside the plan's network, the member is subject to higher out-of-pocket costs because a non-network provider does not have a contract with the member's health plan to accept the plan's allowance as payment in full and can charge the member for the difference between the plan's allowance and the provider's retail charge (balance billing).

For these reasons, it is important for members to have access to information on quality, cost, and the contractual relationship of the health plan with the provider they intend to use. Equipped with this information; the member can select a physician or hospital with the best overall value. To aid members in these decisions, FEHB health

plans have implemented a number of price/cost and quality initiatives and decision support tools.

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

Hospital cost and quality comparison tools appear to be more prevalent than physician comparison tools. Hospital tools often compare various hospitals by the cost of specific procedures. Most hospital comparison tools offer quality measures on patients treated for a particular condition, including patient volume, percentage of complications by hospital, average length-of-stay, and mortality rate. Some plans include tools which report *Hospital Compare* data and *Leapfrog Hospital Patient Safety Survey* results.

HMOs

Most HMOs use a variety of reimbursement methods for their network providers, such as discounted fee-for-service with utilization and quality incentives, capitation, or salaried physicians or physician groups. Some HMO benefit designs charge member copayments where the member's financial obligation is a flat dollar amount (e.g. $15 per visit) that does not vary based on the plan's provider reimbursement methods.

HMOs control costs and quality by negotiating provider network discounts, offering providers incentives based on quality and efficiency, and managing member treatment to ensure patients receive evidence-based care in the most cost-effective care setting. Use of member copayments and contracted provider networks limits member out-of-pocket costs by eliminating the balance billing which occurs when members use out-of-network providers. Some HMOs, however, do charge deductibles and coinsurance on certain services.

Many of these plans offer members price/cost and quality transparency tools. Some use tools to display their own hospital and facility cost and quality measures and some use publicly available, evidence-based hospital outcomes data such as the *Hospital Compare*. These online interactive tools provide members with information to help them compare hospital treatment outcomes for certain procedures, conditions and diagnoses and decide at which hospital they should have a service performed.

Quality and Price/Cost Transparency Best Practices

Some health plans offer hospital and physician quality information on their web site including: National Committee for Quality Assurance (NCQA) accreditation status, clinical effectiveness of care measures of performance from the Health Plan Employer Data and Information Set (HEDIS), health plan member satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, hospital accreditation status and national quality improvement goals from The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and hospital patient safety information from The Leapfrog Group.

The more technologically advanced plans help members gauge their out-of-pocket health care expenses by providing online access to cost estimators to show actual discounted provider costs for the most common office-based services offered by their primary or specialty care physicians. A few plans display and update on a "real-time" basis the reimbursement rates negotiated between the health plan and a specific network provider for office visits, diagnostic tests, and other minor and major procedures.

A few plans offer a suite of transparency tools to provide members with one place to access information on doctors, hospitals and ambulatory facilities. For example, one plan offers the following suite of tools:

- Compare Doctor: Displays unique physician cost information for common office visit procedures. This guidance tool also provides questions to ask the doctor, a link to the American Academy of Family Medicine's information on the member's condition, and the types of laboratory tests, imaging studies and drugs expected for a visit for the selected condition.
- Compare Hospital: Side-by-side comparisons of cost and performance for hospitals and facilities, by condition or procedure.
- Compare Outpatient Facility: Cost results for outpatient surgery and diagnostic procedures which highlight differences between hospital and freestanding ambulatory settings.

Some plans offer online treatment cost estimators to calculate estimated member out-of-pocket health care costs (both in-network and out-of-network) for selected diseases and conditions, surgeries and procedures, office visits and tests, and drugs so members can gain a better understanding of the true cost of their health care and can plan accordingly. These estimated costs are based on average costs of health care within the ZIP code where the services are received.

Quality and Efficiency Designation Transparency Tools

Some plans have enhanced their transparency initiatives to provide members with online access to clinical quality and efficiency data. Members can view clinical quality and efficiency information for network provider specialty categories. A few

plans have created performance networks of specialists and help members easily identify those physicians who have met nationally recognized standards for clinical quality and efficiency. The physician-specific clinical performance and efficiency information is updated annually, and is taken from the plan's or a nationally recognized organization's (e.g., NCQA) evaluation process to identify specialists in certain specialty categories for quality and efficiency designations. This information is based on volume of members treated, cost-effectiveness, and clinical performance. Some also include health information technology capabilities.

Some plans have web site capabilities which allow members to search their provider data base or provider directories for specialty physicians and facilities which have met the plan's or a nationally recognized organization's (e.g., NCQA) quality and efficiency designations. Physicians and hospitals must pass an absolute quality threshold based on national standards to receive these designations. Some plans link these designations to pay-for-performance programs.

Physician Pay-for-Performance Through Quality and Efficiency Designations

A few plans have physician practice reward programs to recognize and reward physicians who meet defined quality, efficiency and administrative criteria by providing them with an enhanced fee schedule. Some plans develop their own criteria for designating their physician or physician groups and others use a nationally recognized designation such as NCQA's Physician Practice Connections.

These are not bonus programs; rather they are the financial recognition of physician performance using an enhanced fee schedule. Physicians who do not meet the criteria continue to be reimbursed according to the terms of their existing contracts and fee schedules. Eligibility for these programs begins with physicians who have received the plan's quality and efficiency designation through their designation program.

Physician groups are also eligible as long as one or more of the group's physicians has received the quality and efficiency designation. Some of these programs also consider a practice's use of health information technology. Eligibility for the fee schedule adjustments usually occurs annually for contracting physicians. Notification is sent to physicians and medical groups advising them of the effective date and the percentage increase for the covered services provided to members.

Some plans use these provider quality and efficiency designations in cost-sharing "Tiering Programs" for their non-FEHB lines of business. In these programs, a member's copayment or coinsurance can be lowered or waived if they use a provider who meets the designation criteria. This provides an incentive for members to use the highest quality and most cost efficient providers in the plan's network.

Plan Reported Quality Tools

Plans reported the following on their quality transparency initiatives:

Quality Transparency	**Percent of Plans Reporting**
Does your plan have online tools that compare physician or hospital quality?	77
Does your plan provide members with online tools that compare ***physician*** quality indicators (e.g. board certification, credentialing, Ambulatory Quality Alliance (AQA) data, or physician recognition programs such as NCQA's Physician Practice Connections)?	49
Does your plan provide members with online tools that compare ***hospital*** quality indicators (e.g. accreditation, average-length-of-stay, complication rates, Hospital Quality Alliance (HQA) data etc)?	72

If your plan offers member tools to compare physician or hospital quality, what estimated percentage of your FEHB members have actually used the tools to conduct one or more sessions?	**Percent of Plans Reporting**
• Did not respond or not applicable	63
• 0% to 5%	26
• 6% to 10%	5
• 11% to 25%	2
• 26% to 50%	1
• 51% to 75%	3
• 76% to100%	

Quality Transparency	Percent of Plans Reporting
Do your quality metrics clearly describe the sources, currency, and geographic limitations of the data?	76
Does your plan participate in state or regional health information network exchange programs?	64
Does your plan participate in collaborative efforts with other public/private sector partners for data aggregation and quality analytics?	73
Does your plan contribute to all-payor claims sets?	36
Does your plan intend to support and participate in the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs?	28

Does your plan publicly report, on its web site, provider quality performance measurement information from any of the following organizations:	Percent of Plans Reporting
• Hospital Quality Alliance (HQA)	11
• Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	37
• Leapfrog Group	59
• Ambulatory Quality Alliance (AQA)	10
• National Committee for Quality Assurance (NCQA)	51
• NCQA's Physicians Practice Connections	23

Plan Reported 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
Does your plan have a standard set of procedure codes and their costs posted on your web site for FEHB members to view?	30
Does your plan post on its web site published average reimbursement rates related to procedures and services (e.g. Medicare reimbursement rates)?	38
Does your plan post actual reimbursement rates for specific procedures and services?	15
Does your plan have online physician or hospital cost estimators or comparison tools on its web site?	69

Does the plan have online cost estimator tools that:	Percent of Plans Reporting
• Show physician costs?	54
• Show hospital costs?	62
• Compare physician costs?	26
• Compare hospital costs?	53
• Compare costs by diagnosis?	48
• Compare costs by procedure?	53
• Compare costs by episodes of care?	42
• Reflect plan provider costs by geographic area?	51
• Reflect average industry costs by geographic area?	47
• Clearly describe the sources, currency, and geographic limitations of the data?	66

If your plan offers members physician or hospital cost estimator tools, what estimated percentage of your FEHB members have actually used the tools to conduct one or more sessions?	Percent of Plans Reporting
• Did not respond or not applicable	66
• 0% to 5%	24
• 6% to 10%	5
• 11% to 25%	2
• 26% to 50%	
• 51% to 75%	3
• 76% to100%	

Financial Tools --- *Does your plan provide web based tools that…*	Percent of Plans Reporting
Model the members projected annual health care spending, estimating out-of-pocket costs and tax implications?	52
Provide the current balances for personal health accounts (e.g. health savings accounts, health reimbursement accounts, medical funds) and check spending against plan deductibles and out-of-pocket maximums?	58

Prescription Drug Price/Cost Tools

Plans have a variety of ways in which they provide members with information on prescription drug prices/costs. Most plans have tools to compare a member's current drug costs to lower priced therapeutic equivalents or retail drug costs. More

advanced plans have tools to calculate the total cost of what the plan pays for a drug which enables members to view their out-of-pocket costs. The calculation is based on each member's pharmacy plan provisions, such as plan type, maximum day supply, copayment, deductible, etc.; and provides the estimated cost of the prescription if obtained at a participating retail pharmacy or through mail-order.

Plan Reported Pharmacy Tools

Plans were asked to report on their price/cost transparency tools:

Pharmacy Tools --- *Does your plan have online tools that…*	**Percent of Plans Reporting**
Compare prescription drug costs or quality?	79
Show prescription drug retail costs compared to network copayments?	62
Show the generic equivalent or brand name formulary drug costs compared to retail costs?	72
Compare a member's current drug costs to lower priced therapeutic equivalents?	72
Can members view the plan's formulary online?	95
Are members notified when the formulary changes?	50

Actions to Provide Incentives for e-Prescribing

Overall provider adoption rates for the industry are at six percent according to a report entitled *Electronic Prescribing: Becoming Mainstream Practice* developed collaboratively by the eHealth Initiative and the Center for Improving Medication Management.

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. Some plans pay for the cost of the device, technology, license fee and transaction fee. E-Prescribing can enable physician access to plan formularies, drug reference guides, drug-to-drug adverse events, drug-to-allergy screening information, information regarding patients' drug claim histories, and member coverage eligibility.

HMOs were more likely to report they used e-Prescribing as a part of the EHR or EMR.

Plan Reported e-Prescribing Tools

Plans were asked to report on their progress in e-Prescribing; results are as follows:

Actions to provide incentives for e-Prescribing	**Percent of Plans Reporting**
Do you provide any financial incentives to providers for e-Prescribing?	26
Can physicians order prescriptions online?	65
Do you provide any equipment to your providers for e-Prescribing?	36
Can members request a prescription refill over the internet?	69
Can providers access the plan's formulary online?	89

What estimated percentage of *hospital* providers in your plan network use e-Prescribing?	**Percent of Plans Reporting**
• Did not respond	19
• 0% to 5%	47
• 6% to 25%	10
• 26% to 50%	13
• 51% to 75%	2
• 76% to100%	9

What estimated percentage of *physician* providers in your plan network use e-Prescribing?	**Percent of Plans Reporting**
• Did not respond	17
• 0% to 5%	43
• 6% to 25%	13
• 26% to 50%	16
• 51% to 75%	2
• 76% to100%	9

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

All plans reported they comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). This includes the posting of a privacy notice on each plan's web site disclosing plan compliance with HIPAA and how it uses a member's protected health information (PHI); who has access to PHI; how members can obtain a copy of their PHI; and, how members can request to amend or annotate their PHI. Plans also indicate they train their employees on the HIPAA Privacy and Security regulations.

HIPAA coverage and protection extends to covered entities, including vendors defined as "business associates". Some carriers contract with vendors which do not meet that definition. Therefore, OPM is adopting a new carrier contract clause designed to hold non-HIPAA covered PHR and price/cost and quality transparency vendors accountable for privacy and security protections equivalent to those of HIPAA covered entities.

Recommendations

FEHB carriers should continue to:

- Upgrade their health information technology systems using recognized interoperability standards so plan PHRs can accept more granular clinical data as provider adoption of electronic health records (EHR) increases. See recognized interoperability standards at http://hitsp.org/ . See EHR vendor certification criteria at http://www.cchit.org/.

- Increase the amount of personal health information (PHI) which is automatically populated in PHRs to make them easier to use and less labor intensive to create and update.

- Move away from view-only PHRs by allowing members to add supplemental information and increase functionally.

- Configure PHRs to allow members to access their information in one organized location on plan websites.

- Increase the interactivity and functionally of PHRs and transparency tools.

- Promote PHR and transparency tools on the plan's home website.

- Display HIPAA compliant privacy notices prominently along with PHRs and transparency tools.

- Continue to collaborate with industry organizations recognized for their quality

and cost transparency initiatives, such as the National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Leapfrog Group, Joint Commission on The Accreditation of Healthcare Organizations (JCAHO), National Quality Forum, Hospital Quality Alliance (HQA), the Ambulatory Quality Alliance (AQA) and other like organizations.

Conclusion

Significant progress has been made by many health plans over the past several years. Some plans now offer state-of-the-art personal health records (PHRs) and excellent price/cost and quality transparency information on their web sites. We continue to encourage FEHB plans to expand their HIT and transparency initiatives and to make decision support tools and information available to consumers. We will closely monitor the progress of all plans and continue to highlight those with best practices on OPM's web site so FEHB employees, retirees, and their families have this information available when selecting their health plans during the annual Open Season.

Attachment

Guide to Federal Benefits

Federal Employees Health Benefits (FEHB) Program Health Information Technology and Price/Cost Transparency Leaders

Over the past few years, OPM has encouraged FEHB health benefits plans to increase their use of health information technology (HIT). HIT can help your health plan and healthcare providers deliver safer more efficient care. Using HIT, your health plan can offer you tools to help you organize your health information, access information targeted to your health needs, and determine the quality and price/cost of the doctors, hospitals and other providers that you and your family use for day-to-day healthcare needs.

HIT based on broadly accepted standards, allows patients, healthcare providers and health plans to share information securely, driving down costs by avoiding duplicate procedures and manual transactions. More importantly, HIT reduces medical errors; for instance, from misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate health information. HIT can also help you find appropriate health information to aid you and your doctor in making appropriate clinical decisions regarding your care. Since privacy and security considerations are vitally important, safeguards have been established to keep your records safe from inappropriate disclosure.

Personal Health Records

The health plans listed below have made a commitment to offer you and your family access to internet based personal health records (PHR). PHRs come in a variety of forms but what they all have in common is that they give you a convenient way to track, view, and manage your personal health information. PHRs also allow you to share your health information with your healthcare providers so they have a better picture of your health history. When providers know your health history they can make more accurate diagnoses and provide you with safer more efficient care.

Quality and Price/Cost Transparency On-line Tools

The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The web site information available includes online decision tools with cost estimators and quality indicators for physician and hospital services and prescription drugs used to treat common or chronic illnesses and conditions. These health plans describe the sources of this health information and any limitations so you can understand what the information means. Some examples of the types of surgical procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract repair, cesarean delivery, colonoscopy, corneal surgery, gall bladder removal, heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information helps you understand the true price/cost and quality of your healthcare and enhances your ability to

compare hospital, physician, prescription and other provider value as you make healthcare choices. FEHB health plans are working to expand the price/cost and quality information they provide to you.

The health plans listed on this page met OPM's HIT, quality and price/cost transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our web site. So, please check the updated information at www.opm.gov/insure before you make your healthcare decisions.

The following health plans have demonstrated their commitment to efficiency, safety and quality through computer system enhancements that offer PHRs, quality information, and price/cost transparency decision support tools:

Aetna Health Plans	HealthPlus of Michigan
Altius Health Plans	HIP Health Plan of New York
Anthem Blue Cross HMO	HMO Health Ohio
APWU Health Plans	Humana Health Plans
AvMed Health Plans	Independent Health Association
BlueCross BlueShield Government Wide Service Benefit Plan	Kaiser Foundation Health Plans
Blue Cross & Blue Shield of RI	KPS Health Plans
CareFirst BlueChoice, Inc	Mail Handlers Benefit Plan
ConnectiCare, Inc	M.D. IPA
Coventry Health Care Plans	Medica Health Plans
Blue Care Network of Michigan	MVP Health Care, Inc.
Blue Preferred HMO	NALC Health Benefit Plan
Geisinger Health Plan	Optima Health
GHI Health Plan	PacifiCare Health Plans
Government Employees Health Association, Inc. (GEHA)	PersonalCare of Illinois
Group Health Plan	Physicians Health Plan of Northern Indiana, Inc.
Health Alliance Plan (HAP)	Preferred Care
Health America Pennsylvania	SAMBA
Health Net of Arizona, Inc.	UniCare Health Plans of the Midwest
Health Net of California	Unitedhealthcare (except the River Valley, Inc. in Iowa and Illinois)
HealthPartners, Inc.	UPMC Health Plan