



Colorado Choice Health Plans



Accreditation – Exchange Product

Accrediting Organization: URAC – Health Plan Accreditation (Marketplace HMO)

Accreditation Status: Full

Full: Organization demonstrates full compliance of operating processes in accordance with the standards. All mandatory standards elements are met.

Conditional: Organization met most of the standards, but need some improvement before achieving full compliance. Not more than one mandatory standard not met.

Provisional: Organization has otherwise complied with all standards, but either the entity or program under review has been operating for less than six months.

CONSUMER COMPLAINTS

How Often Do Members Complain About This Company?

Why do Consumers Complain?

Consumers complain most often about things such as claims handling (i.e. delay of payment, denial of claim); cancellation of policy because of underwriting (pre Accountable Care Act); refund of premium; or coverage of a particular item or service. In a “confirmed complaint” the consumer prevailed, in whole or in part, against the company.

Consumer Complaint Index

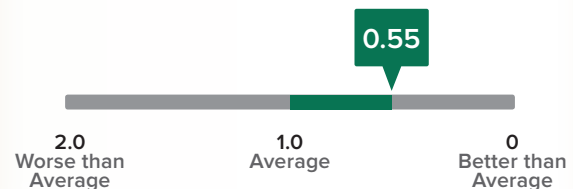
This score shows how often health plan members complain about their company, as compared to other companies adjusting for the size of the company. 1.0 is the average, so an index lower than 1.0 indicates that fewer people complained about this company than similar sized companies.

CONFIRMED COMPLAINTS

Confirmed Complaints: **3**

Total Market Share (2015): **0.58%**

CONSUMER COMPLAINT INDEX



Complaints are measured across the entire membership in that line of business for the carrier, including all group sizes.

Percentage of Total Market Share is based on all medical and dental carriers.

Source: 2014 Colorado DORA Division of Insurance

Quality Ratings* (for NCQA-Accredited Plans Only)



Star ratings provide a view of plan performance in four categories. Star ratings are determined by NCQA to provide an overall performance assessment in each area.

ACCESS AND SERVICE

★ No Data ★

NCQA evaluates how well the health plan provides its members with access to needed care and with good customer service. For example: Are there enough primary care doctors and specialists to serve the number of people in the plan? Do patients report problems getting needed care?

QUALIFIED PROVIDERS

★ No Data ★

NCQA evaluates health plan activities that ensure each doctor is licensed and trained to practice medicine and that the health plan's members are happy with their doctors. For example: Does the health plan check whether physicians have had sanctions or lawsuits against them? How do health plan members rate their personal doctors or nurses?

STAYING HEALTHY

★ No Data ★

NCQA evaluates health plan activities that help people maintain good health and avoid illness. For example: Does the health plan give its doctors guidelines about how to provide appropriate preventive health services? Are members receiving tests and screenings as appropriate?

GETTING BETTER

★ No Data ★

NCQA evaluates health plan activities that help people recover from illness. For example: How does the health plan evaluate new medical procedures, drugs and devices to ensure that patients have access to the most up-to-date care? Do doctors in the health plan advise smokers to quit?

LIVING WITH ILLNESS

★ No Data ★

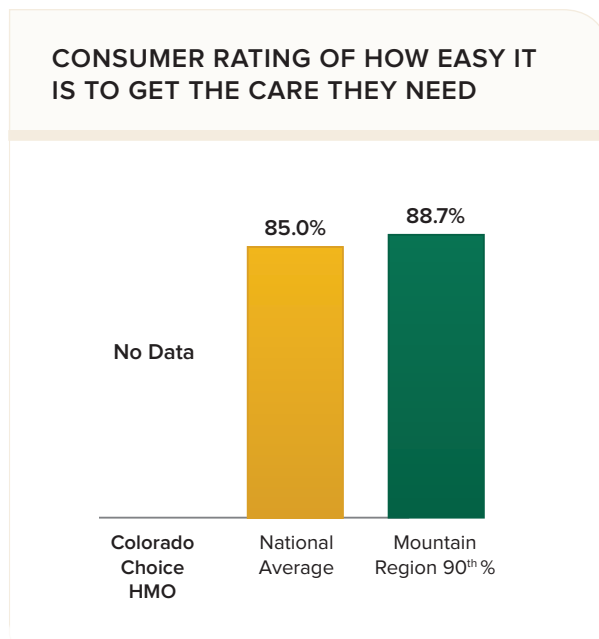
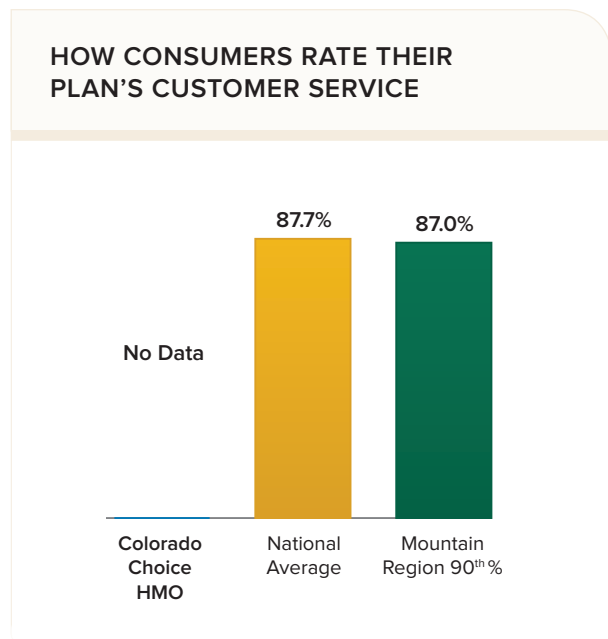
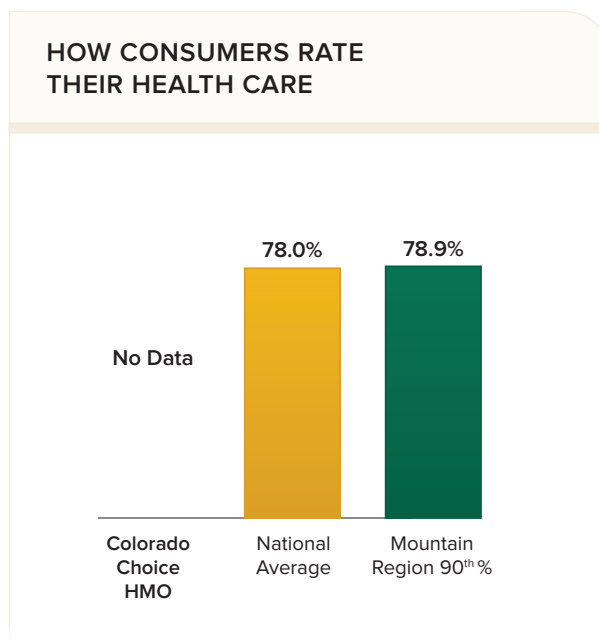
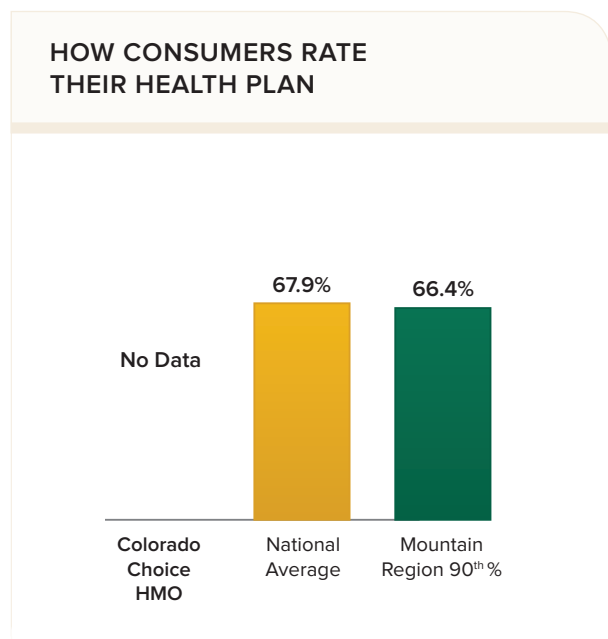
NCQA evaluates health plan activities that help people manage chronic illness. For example: Does the plan have programs in place to assist patients in managing chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

* Note: Ratings on this page and the following pages reflect quality results from the carrier's commercial products. Results from the Marketplace product(s) are not available in 2016.

Consumer Ratings (CAHPS Results)



CAHPS: A set of standardized surveys that measure patient satisfaction with the experience of care. CAHPS® is sponsored by the Agency for Health Care Research and Quality (AHRQ). The graphs below represent consumers who are satisfied or very satisfied (8, 9 or 10 on a 10 point scale).



Mountain Region includes Colorado, Montana, Idaho, Wyoming, Nevada, Utah, Arizona, and New Mexico.
 Disclaimer: Consumer ratings are from 2014 and represent performance of similar pre-ACA plans.
 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
 CAHPS® ratings are based on health exchange data.

Quality Measures (HEDIS Results)

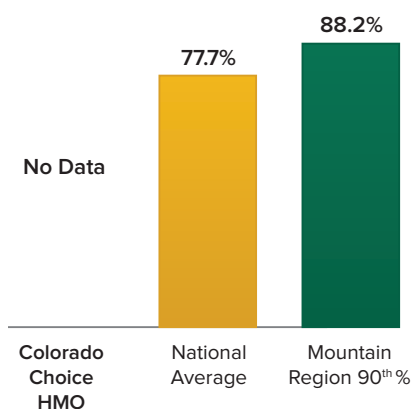


HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by many health plans working with NCQA to measure performance on important dimensions of care and service.

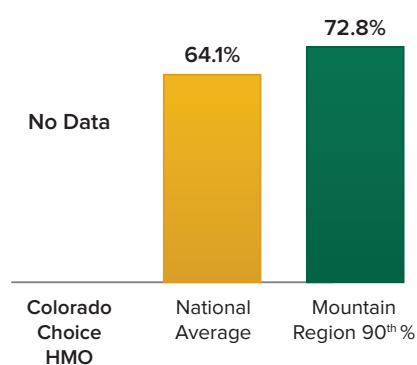
PREVENTIVE CARE

Mountain Region includes CO, MT, ID, WY, NV, UT, AZ, and NM.

Percent of Children Receiving Recommended Immunizations

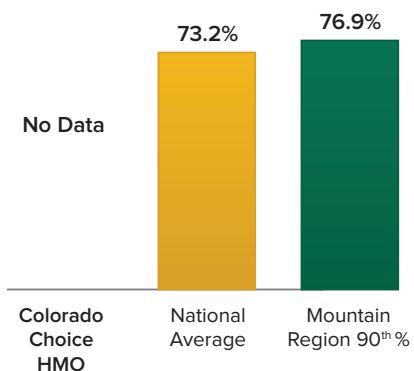


Percent of Adults Screened for Colorectal Cancer

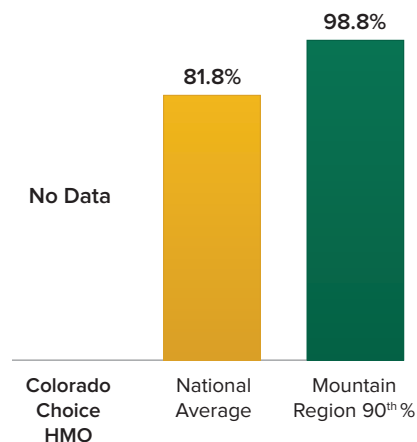


WOMEN'S HEALTH

Percent of Women Screened for Cervical Cancer



Percent of Women Receiving Timely Prenatal Care



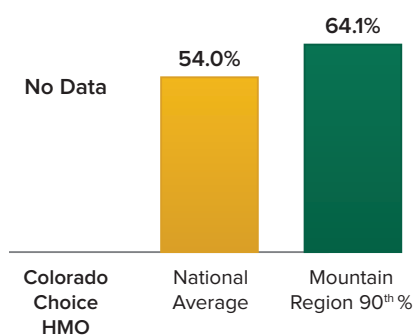
Disclaimer: Quality measures are based on 2014 data and represent performance of similar commercial health plans.

Quality Measures (HEDIS Results)

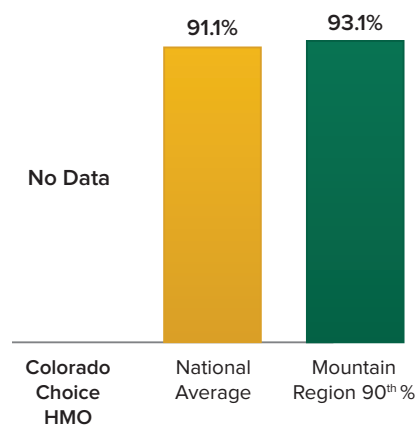


DIABETES CARE

Percent of Enrollees with Diabetes with in Control (HbA1c < 8.0)

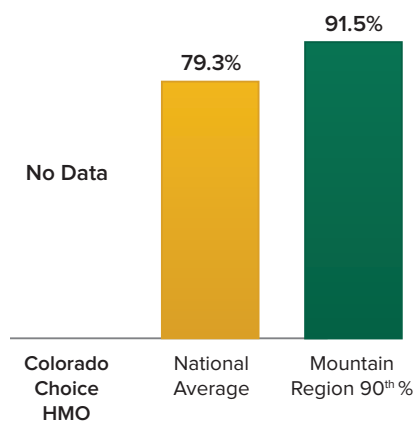


Percent of Enrollees with Diabetes Screened for Kidney Disease

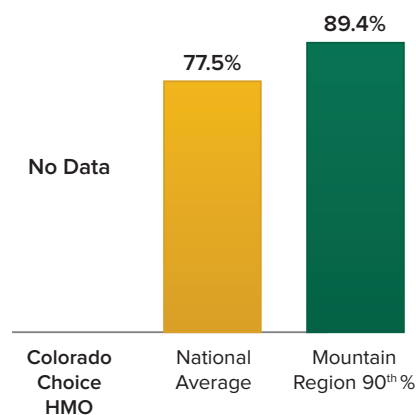


MANAGING CONDITIONS

Percent of Adults Who Have Their Weight Assessed



Percent of Adults with Low Back Pain Who Do Not Get Inappropriate Imaging Studies



Mountain Region includes Colorado, Montana, Idaho, Wyoming, Nevada, Utah, Arizona, and New Mexico.

Disclaimer: Quality measures are based on 2014 data and represent performance of similar commercial plans.

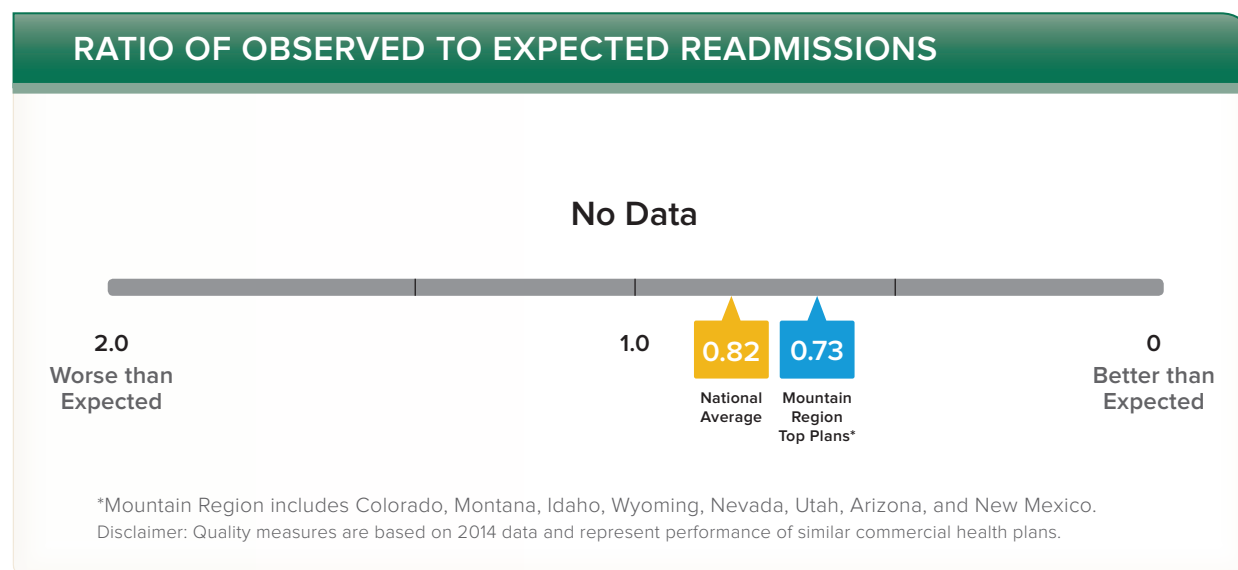
The HEDIS® measures and specifications were developed by and are owned by the National Committee for Quality Assurance ("NCQA"). The HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures or any data or rates calculated using the HEDIS measures and specifications and NCQA has no liability to anyone who relies on such measures or specifications. ©2014 National Committee for Quality Assurance, all rights reserved.

For more information, please visit www.NCQA.org

Plan All Cause Readmissions



Measures readmissions for any reason within 30 days after discharge from a hospital, adjusted for how sick the patient is, and compared to other companies. More than “1.0” means the plan had more readmissions (did worse) than expected, less than “1.0” means the plan had fewer readmissions (did better) than expected.



How is this plan different or unique from other plans?

Answers to the following questions were supplied by the company.



HOW THE HEALTH PLAN WORKS TO MAKE ITS MEMBERS HEALTHIER:

Colorado Choice offers members a variety of voluntary Medical Management Programs to help them better manage their own care:

- The Health Resources Program promotes health awareness, education and prevention through a menu of activities.
- When identified for our Care Management Program, a CO Choice nurse will contact the member and offer assistance with patient advocacy, navigation of the health care system, and optimal utilization of benefits and resources. Nurses can assist members with special needs and coordination of community resources to mitigate barriers to care.
- The Disease Management Program provides proactive and supportive management for members with certain chronic diseases (Diabetes, Asthma, Heart Disease, High Blood Pressure, and more) or a newly diagnosed disease. The program is designed to provide nurse support to members to reduce risk and increase compliance with physician treatment plans.
- A Health Risk Assessment designed in partnership with Duke Medicine provides individuals with an easy to understand, simplified report with lifestyle recommendations that not only promote healthy behaviors but reduce health risks as well.
- Targeted Outreach Materials are sent to members through specific condition analysis. For example, diabetics receive tools such as: My diabetes care record, Getting control of diabetes, and Know your diabetes numbers.
- A regionally-based incentive program utilizing a Health Risk Assessment, biometric screening, and health coaching allows members to earn a financial incentive for meeting program requirements.



HOW THE HEALTH PLAN WORKS WITH PROVIDERS IN INNOVATIVE WAYS:

Colorado Choice Health Plan is working with providers in several communities around the State in the following innovative pilots:

- Comprehensive Primary Care Initiative – a program to support provider practice changes in care delivery by providing additional funding and transparent data to primary care providers focused on improving quality of care and outcomes.
- Implementation of an Innovative Benefit Design that combines shared decision-making between patients and their physicians while removing financial barriers such as copays and coinsurance for basic services related to chronic conditions.
- Prometheus Pilot – Colorado Choice uses a robust application to place transparent data into the hands of physicians enabling them to improve patient access to care with a goal of improving outcomes and quality of life for members with chronic illnesses.

How is this plan different or unique from other plans?

→ EXAMPLES OF INNOVATIVE APPROACHES TO HEALTH IN THIS HEALTH PLAN:

Through utilization of wireless technologies Colorado Choice has deployed health monitoring devices to members with diabetes, high blood pressure and heart disease to facilitate the following:

- Ease of managing their health status between physician visits
- Sharing of health related information with caregivers and designated family members
- Remote monitoring that triggers necessary intervention when health status thresholds are breached and in emergency situations
- Sharing of real-time data with physicians which enables more timely clinical intervention



Definitions

ACA – The Patient Protection and Affordable Care Act (PPACA), commonly called Obamacare or the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Accreditation – Accreditation is a process by which an impartial organization (for health plans, NCQA or URAC) will review a company's operations to ensure that the company is conducting business in a manner consistent with national standards.

Aggregate Family Deductible – No individual deductible. Expenses will only be covered if the entire amount of the deductible is met.

BMI - Body Mass Index – Body mass index is a commonly used weight-for-height screening tool that identifies potential weight problems in adults, as well as their risk for developing other serious health complications associated with being overweight or obese.

CAHPS – The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey that asks health plan members to rate their experiences with their health plan and the health care they receive.

Complaint Index – A standardized measure to compare number of complaints by different size companies. It is calculated by dividing a company's confirmed complaints by its total premium income by specific product (e.g. HMO vs. PPO).

Confirmed Complaints – A complaint in which the state Department of Insurance determines that the insurer or other regulated entity committed a violation of: 1) an applicable state insurance law or regulation; 2) a federal requirement that the state department of insurance has the authority to enforce; or 3) the term/condition of an insurance policy or certificate.

Coverage Area – A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services.

Disease Management – An integrated care approach to managing illness, which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve quality of life while reducing health care costs in those with chronic disease by preventing or minimizing the effects of a disease.

Embedded Family Deductible – Deductible includes an individual deductible and a family deductible. Individual expenses will be covered if an individual has met their deductible even if the entire family deductible has not been met.

HEDIS – The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the health care quality.

HMO – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

MLR - Medical Loss Ratio – A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, health plan salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Definitions (continued)

Mountain Region Top Plans – The average performance of plans that scored in the top 10% on that particular measure from the Census Mountain Region, which includes Colorado, Montana, Idaho, Wyoming, Nevada, Utah, Arizona and New Mexico.

National Average – The average performance of all plans across the country that submitted results to NCQA for a particular performance measure.

NCQA – The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

Network – The facilities, providers and suppliers the health insurer or plan has contracted with to provide health care services.

Performance Standards – A basis for comparison or a reference point against which organizations can be evaluated.

Performance Measurement – The regular collection of data to assess whether the correct processes are being performed and desired results are being achieved.

PPO – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Readmissions – A situation where the patient was discharged from the hospital and wound up going back in for the same or related care within 30 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that the follow-up care wasn't properly organized, or that the patient wasn't fully treated before discharge.

Star Ratings – Star ratings provide a view of plan performance in five categories. To calculate the star ratings, accreditation standards scores and HEDIS measure scores are allocated by category. The plan's actual scores are divided by the total possible score. The resulting percentage determines the number of stars rewarded.

URAC – An independent, nonprofit organization, well-known as a leader in promoting health care quality through its accreditation, education and measurement programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

Value Based Purchasing – Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Wellness Programs – A program intended to improve and promote health and fitness that may be offered through the work place, or through an insurance plan. The program allows an employer or plan to offer premium discounts, cash rewards, gym memberships, and/or other incentives to participate. Some examples of wellness programs include programs to help with stopping smoking, diabetes management programs, weight loss programs, and preventive health screenings.

For more information please visit
ConnectforHealthCO.com

