Making Health Care Better in 2007

Alliance of Community Health Plans

Report to Our Community

MAKING HEALTH CARE BETTER

ACHP

ALLIANCE OF COMMUNITY HEALTH PLANS

Introduction

For over 25 years the Alliance of Community Health Plans and its predecessor organization, The HMO Group, have led the way in defining high performance for health plans in the U.S. This group of non-profit community-based health plans and provider organizations continues to lead through innovation and excellence, and to grow and change with the times. 2007 was no exception.

ACHP's Board and staff leadership have set a strategic direction aimed at demonstrating the value of integrated and coordinated health care delivery. We are advantaged clinically and in the marketplace by the strong relationship between our member organizations and physician partners. Our work is anchored in sharing the knowledge and experience of innovation and excellence across our member organizations, and carrying those lessons into public policy through information and advocacy.

ACHP member organizations have long been recognized by their communities, the health care industry, and policy makers for their community-building agendas and business model that aspires to integrate care delivery, coordinate care, and put consumers first. The addition of Geisinger Health Plan (Spring 2007) and Priority Health Plan and Tufts Health Plans (January 2008) to our membership brings new perspectives and energy, and challenges ACHP to fulfill its goals of providing leadership for the success of high performing community-based plans. It is ACHP's challenge to continue to set the benchmark for clinical service performance and value and to help translate these core competencies into better health care for all.

This report is a snapshot of ACHP's work in 2007. It's a story of transition, realignment and growth, and most importantly of the extraordinary potential of community-based health plans and their provider partners across the country.

Patricia Smith
President & CEO

2007 Highlights

- ACHP hosted 9 meetings for our member plans to share information and explore issues unique to the success of community-based plans:

  - The 20th annual Symposium for the CEOs and Boards of Directors of ACHP's member plans focused on governance and strategic issues for ACHP plans.
  - Board of Directors meetings are becoming a forum for Board members to discuss topics of particular relevance to the unique strengths and challenges of community-based health plans and provider groups.
  - ACHP Medical Directors met to explore performance incentive programs and the patient-centered medical home.
  - Market-focused plan executives discussed opportunities and challenges in the small group and individual markets, and strategies for using community-based plans' unique attributes and leadership to strengthen market share.

- In a series of interviews, ACHP's Board members reexamined ACHP's strategic direction. The results of these interviews yielded strong agreement about ACHP's role as a leadership organization whose success depends upon our ability to help member organizations achieve excellence in their clinical and service performance, maximize their plan-provider relationships, offer value through affordable yet quality products, and raise our public policy voice.

- ACHP Board members convened at UPMC and UCare to hear presentations on leading strategies including:

  - UPMC: Integrated Products to Address Health and Disability Management; Growth and Development Strategies for Medicare and Medicaid Programs; Quality Improvement and Member Satisfaction
  - UCare: Implementation of Community-Based Palliative Care Programs; Successful Development of Medicare Special Needs Plans; Minnesota Community Measurement – A Partnership to Improve Health Care

- A five-part collaborative on service improvement showcased a variety of initiatives that are underway in ACHP plans and culminated in a site visit to examine benchmark strategies for excellence in customer service based on strong relationships between plans and providers.

- ACHP's signature *HealthPlan Performance Gauge* was updated to reflect the 2007 results of HEDIS® and CAHPS® surveys. In 9 general and customized presentations, ACHP helped plans anticipate their *US News & World Report*'s rankings before they were published and identify areas for future improvement initiatives.

- ACHP provided information to plans on the impact of potential Medicare Advantage payment reductions and helped plans develop their messages about the unique value of Medicare Advantage in their communities and to their customers.

- Working with leading national experts, ACHP submitted comments to the Internal Revenue Service on a proposed new Form 990. Many of the recommendations made by ACHP are reflected in the new Form 990 released by the IRS.

- ACHP has begun to build initiatives around the patient-centered medical home, medical cost benchmarking, and local/regional plan partnerships that will shape important work in 2008.

- Through 60 Web-based and phone conferences throughout the year ACHP highlighted innovations, provided learning opportunities, and facilitated information exchange for ACHP member organizations.

- In partnership with the Centers for Disease Control and Prevention, ACHP used the *HealthPlan Performance Gauge* to produce and share information about health plan performance in the area of preventive services with health plans, employers and business groups.

Promoting Clinical Excellence
Through Learning, Innovation, and the Dissemination of Ideas

Medical Directors Meeting, February 2007. Plans examined the strategies, structures and results of ACHP organizations' pay-for-performance programs. Eleven ACHP member organizations and one guest plan attended the meeting in which 7 ACHP Medical Directors discussed their pay for performance experience. Some key findings:

- Most plans' pay-for-performance programs currently use HEDIS® quality measures, and some use AQA, AHRQ or CMS measures; however, these measurement sets are not complete enough to measure quality in many areas, particularly specialty care.
- Although payment is an incentive for providers to engage with health plans on performance initiatives, the main drivers of performance change appear to be creating improvement infrastructure in delivery settings and fostering competition among providers by sharing the results among program participants.
- Systems for tiering providers based on cost and effectiveness are still developing. Problems persist in linking provider information across multiple claims sources, adjusting results for disease severity or case complexity, and obtaining a large enough sample of results to have confidence in tiering assessments.
- Paying for performance when providers are affiliated through a group or staff model has its own unique challenges, including setting productivity goals and adjusting for differential practice demands. Best practices continue to be refined as new models for measuring efficiency and quality evolve.

Medical Directors Meeting, September 2007. The meeting focused on "Redesigning Primary Care" with an emphasis on the patient-centered medical home model as a vehicle to transform care delivery, eliminate perverse payment incentives and improve quality of care. Leaders from 8 plans presented on their primary care practice redesign initiatives. The meeting also featured guest presentations from the Institute for Clinical Systems Improvement (ICSI) of Minnesota and Quality Quest for Health (a partnership of OSF Health System and Caterpillar) on how they are using collaborative models to transform systems of care in their markets. At the conclusion of the meeting, ACHP's Medical Directors expressed a desire to build a distinctive medical home model that will both leverage close plan-provider relationships and provide a robust and comprehensive set of standards for patient-centered care. ACHP's Patient-Centered Medical Home collaborative was launched in December 2007.

Effectively Managing Back Pain. In this Web conference Capital Health Plan Medical Director, Chuck Tomlinson, MD, MBA, described the structure and results of Capital's medical management program, started in late 2006. The program emphasizes shared decision-making with the goals of improving patient outcomes through pain reduction and avoidance of unnecessary surgical interventions. It has reduced pain scores from 53.66/100 upon entry to 10.87/100 at discharge, and has also improved average function score from 58.9/100 at entry to 91.9/100 at discharge.

ACHP Board of Directors, June 2007. "Implementation of a Community-Based Palliative Care Program." An end of life (EOL) patient care model that blends curative interventions with palliative care delivered at home may draw more patients into hospice care. These findings of a 4-year initiative led by Eric Anderson, MD, Medical Director, Allina Palliative Care and Barry Baines, MD, Chief Medical Officer, UCare were presented by Drs. Anderson and Baines to ACHP's Board of Directors. The program has increased the percentage of EOL patients in hospice care, improved their satisfaction with care, kept people at home in their preferred setting, and reduced costs.

Promoting Clinical Excellence

EMRs: Data into Information. Health Plans, physicians, hospitals and policy makers are rapidly embracing the Electronic Medical Record (EMR) as a next step in the evolution of health care. Seven plans participated in a Web conference in which Dr. Andrew Wiesenthal, MD, Associate Executive Director of the Permanente Federation, shared the Permanente Federation's innovative use of EMRs to manage patient populations more effectively and transform health care delivery. Currently, more than 8 million Kaiser Permanente members' records are managed through the EpicCare® Ambulatory Record.

Activating and Engaging Members around Health and Wellness. Group Health Cooperative-Seattle showcased their *Health Profile* and *Lifestyle Coaching*. In this Web conference, GHC-Seattle experts discussed how members' Health Risk Assessments (HRAs) are integrated into Group Health's Electronic Medical Record to produce customized recommendations for medical screening, chronic disease management, and health promotion activities to improve the members' health status and their readiness to engage in healthier behaviors.

Geisinger ProvenCare: Surgery with a Warranty. Within 2 weeks after this Geisinger initiative was highlighted in the *New York Times*, Geisinger senior leadership described the ProvenCare program in an ACHP Web conference. ProvenCare is seen as a new way to encourage hospitals and doctors to provide high-quality care that can avoid costly mistakes. Dr. Duane Davis, Chief Medical Officer and Vice President of Geisinger Health Plan, Dr. Ron Paulus, Chief Technology and Innovation Officer at Geisinger Health System, and Dr. Al Casale, Director of Cardiothoracic Surgery at Geisinger Health System explained their innovative approach to elective heart bypass surgery—charging a flat fee that includes 90 days of follow-up treatment.

Retail Clinics. The health plan marketplace is demanding increased access to care. Retail clinics have entered this space providing fast, efficient urgent care through streamlined processes and less costly providers. However, some hypothesize this increased access may come at the expense of coordination and quality. In a Web conference, UPMC discussed their contracting strategy to provide high quality, convenient care to their members. UPMC showcased early results of their experience including increased satisfaction without significant changes in utilization patterns. Participants also discussed potential regulatory barriers for retail clinics, and possible next steps for plans interested in learning more about this delivery model.

ACHP Medical Directors Queries. In a continuing effort to help ACHP Medical Directors identify and implement best practices in their organizations, ACHP facilitates queries across the ACHP Medical Directors Council. Summaries of these queries are posted on the ACHP members-only web site. Some of the topics explored in 2007 included nurse call lines, member engagement programs for Medicaid enrollees, contractual pay-for-performance practices for hospitals and specialty groups, a colon cancer screening pay-for-performance measure, and predictive modeling in care management.

Promoting Marketplace Success

Marketplace Focus Meeting, May 2007. "Opportunities and challenges in the Small Group and Individual Markets." Twenty-six representatives from 13 ACHP member organizations and 3 guest organizations convened for a series of case study discussions, each led by staff from an ACHP member organization. Participants discussed:

- optimizing product innovation in the small group and individual markets,
- strategies to build loyalty and increase enrollee retention,
- developing a tailored marketing strategy for small employers, and
- the impact and opportunities of state health reform and federal reform proposals.

Results and findings from the meeting include:

- A market segmentation strategy effectively orients a health plan's sales and marketing activities toward its purchasers. However, to reach its full potential, this process requires updating, refinement and maintenance with accurate market intelligence and analysis.
- The small group and individual markets both demand some product options that are affordable and provide necessary coverage. These products may also require tailored marketing strategies depending on the target segment.
- Brand recognition and identification are critical in the individual market and may even trump network and price in an individual's purchasing decision.
- State and federal policies such as proposals to emulate Massachusetts or California health care reform initiatives, and Federal proposals allowing for the creation of small group purchasing associations can drastically impact the small group and individual markets.
- Regional health plans have unique advantages in the small group and individual markets through closer relationships with their purchasers, providers and communities. However, to leverage these advantages effectively, a regional health plan must be adaptable in administration and proficient in customer service differently than is required for their larger accounts.
- HIT will have increasing and dramatic impact on how health care is purchased and delivered. Competencies required in this new arena, including transparency, customization and connectivity should reinforce efforts to expand small group and individual market business.

Marketplace Focus Meeting, October 2007. "Leadership to Market Share." Representatives from 7 ACHP member organizations and 1 guest organization convened to discuss how ACHP plans have translated leadership in health, wellness, technology and clinical management solutions into increased market share and expanded revenue opportunities. Topics included:

- developing a community brand,
- selling health, wellness and technical expertise outside core delivery networks, and
- opportunities for plans to expand into the senior market.

Results and findings from the meeting include:

- Advertising products and community benefit can be complimentary components of developing a plan's community brand. Opportunities for secondary advertising such as television/radio segments or other visibility around community-focused sponsorships and partnerships are important to brand definition.

Promoting Marketplace Success

- Employers are becoming more sensitive and sophisticated in making health care purchases. Reporting tools that help employers connect utilization to premiums can work both to strengthen the partnership with a plan and to showcase a plan's value equation more explicitly. Plans must work with brokers to assure that the best possible information is made available to employers. Many brokers prefer to manage the information an employer receives from a plan themselves and may see more sophisticated reporting as a threat to their value to employers.
- ACHP plans have strong competence in delivering extra value health and wellness solutions and may be well-situated to bring these higher value products into broader markets. However, plans aiming to market health and wellness solutions as stand-alone products outside their delivery network must confront the key challenges of service disintegration, selling in regions where a plan has little or no brand identity, scalability, vendor affiliations, and cannibalization of one product segment by another.
- *Bona fide* wellness products offer an opportunity to integrate a plan's health and wellness capabilities into a clear product design. Such products can help employers promote a healthier workforce and offer a lower-priced product to small groups. Conversely, the actuarial foundations of these plan designs are especially susceptible to moral hazard and adverse selection.
- Plans that have expertise in managing clinically complex and elderly populations may find substantial revenue opportunities in Programs for All-inclusive Care for the Elderly (PACE) programs. Additionally, plans may wish to consider if opportunities exist in other senior service areas such as assisted living facilities.

Service Improvement Collaborative. Key organization leaders from 11 member organizations joined this collaborative Web conference series to share operational best practices on improving enrollees' health care experiences. The collaborative:

- discussed goals and challenges around service improvement, including the importance of provider partnerships to foster strong customer service;
- heard from UPMC, regarding its strategies and experience, as the greatest service improver among ACHP plans in 2006;
- examined current initiatives by several plans and their evaluation approaches, including the Kaiser Permanente Service Quality Strategy and their Labor Management Partnership Service Quality Action Team; and
- culminated their work with a well-attended one-day site visit to Independent Health in Buffalo, NY to explore key elements of a service quality strategy for network plans.

Web conference series on Tiered Networks. In separate Web conferences, Fallon Community Health Plan and HealthPartners presented their experiences in designing tiered network products.

Reciprocal Networks. Many regional and national employers are looking to consolidate and streamline health benefits. ACHP facilitated a discussion among a subgroup of plans – including Independent Health, Geisinger Health Plan, UPMC Health Plan, and Fallon Community Health Plan – to discuss the requirements necessary to create a reciprocal network agreement among similar community-based health plans. Based on their experience in building a partnership with Capital District Physicians Health Plan (CDPHP) in Albany, Independent Health led these discussions.

Benchmarking and Analytics to Support Strong Performance

Understanding the 2007 U.S. News Rankings. Many new tools are available for health insurance purchasers to compare the quality of available plans. One of the most high-profile is *U.S. News & World Report*'s "Best Health Plans" rankings. The 2007 rankings, released on October 26, ranked over 400 commercial, Medicare and Medicaid health plans. ACHP provided analytic support and analysis of the *U.S. News* rankings in two ways:

- On October 1, ACHP presented predictions for ACHP plan performance drawing on the ACHP *HealthPlan Performance Gauge* to compile the results. An overview of the rankings methodology and changes for 2007 were also presented. Over 42 participants representing 14 plans participated in the Web conference.

- To help ACHP member plans prepare for the release of the 2007 health plan rankings and formulate strategic improvement efforts into their 2008 budgets, ACHP hosts a series of customized plan-specific Web conferences on quality benchmarking and improvement. ACHP's analytic team used the ACHP *HealthPlan Performance Gauge* to tease apart the data behind the *U.S. News & World Report* rankings and assisted members in pinpointing drivers of their plan's performance. As an adjunct to these customized analytic presentations, ACHP also offers prioritization reports and training for plan staff to use the *HealthPlan Performance Gauge.*

Administrative Cost Benchmarking Series. Responding to strong interest by some plans to benchmark administrative expenses and contain costs, ACHP is leading a collaborative series to facilitate the exchange of benchmarks and operational best practices to achieve administrative efficiency and improve medical resource management among ACHP plans. In 4 sessions to date, this ongoing Web conference series has engaged 23 participants from 10 plans. Geisinger Health Plan, Fallon Community Health Plan, Security Health Plan, HealthPartners, Group Health Cooperative of South Central Wisconsin, CareOregon, Capital Health Plan, UCare, and Independent Health led discussions that focused on the exchange of reporting and benchmarking methods, identification of key operational areas as well as common structures and functions that would permit benchmarking across the member organizations, and an exchange of meaningful and comparable performance data on quality and productivity.

- ACHP has developed a claims processing benchmarking tool with cross-plan performance data on key efficiency and productivity measures.
- We are working with financial and operational leaders across our plans to facilitate exchange of strategies, operational drivers, and best practices for financial performance.
- This series will continue in 2008 with other sessions including:

    - *Eliminating the Paper: UPMC Health Plan's OnLine Claims Submission Tool* featuring innovative strategies to increase electronic claims submissions, contain costs, and increase productivity, efficiency and accuracy; and
    - *Benchmarking ACHP plan performance and identifying operational best practices in the marketing and sales arenas.*

Medicare Payment Analysis. In preparation for the Medicare Advantage (MA) payment debate in the Congress, ACHP modeled MA payment nationally, mirroring key data sources used by the Congress. With this analysis, plans could examine how their Medicare payment compared to other plans across the country, and were better positioned to understand Congressional proposals and their impact and to build their own messages about the added value of MA plans. A major driver of MA and fee-for-service (FFS) payment differentials is the underlying FFS costs in a community; the highest differentials between fee-for-service and MA rates occur in localities where FFS costs are the lowest.

Public Policy and Advocacy

Medicare Policy

ACHP's work on MA policy and payment has focused on helping member organizations craft their best individualized lobbying efforts by providing information and counsel. We have also provided technical assistance to policy makers on the differences among Medicare products, technical requirements for Special Needs Plans, quality reporting, marketing requirements, Medicare operational issues, and the added value provided by plans.

In 2007 health plans have aggressively lobbied to educate congressional leaders on the added value MA plans provide to beneficiaries through coordination of care, additional benefits, and lower out-of-pocket costs. This strategy has helped explain the complexity of the Medicare payment structure, the value of health plan coverage to consumers, the risk of creating uncertainty in the public's mind about the continued participation of MA plans, and the risks of deep, across-the-board cuts.

Equal measurement and reporting. Within the Medicare program, ACHP has long been concerned that accurate and comparable quality data are not available to compare MA and traditional fee-for-service Medicare. In addition, not all MA plan types are required to submit the same quality data. The Board of Directors reaffirmed ACHP's policy on equal measurement and reporting:

> *ACHP supports equity in performance measurement and reporting across all of Medicare as a means of supporting performance excellence and improvement and creating a foundation for value-based purchasing.*

Pay-for-Performance. A key part of ACHP's mission is to promote quality, performance excellence, and incentives for improvement. We support the notion of using higher payments to reward high quality providers and plans. In previous years, ACHP has worked with congressional staff to help shape several legislative proposals that have been introduced and discussed in the House and the Senate.

- ACHP has promoted pay-for-performance in Medicare, including helping to shape several legislative proposals that have been introduced and discussed in the House and the Senate.
- ACHP has strongly supported equity of measurement and reporting in regulation and legislation to require that all types of health plans (e.g., Medicare HMOs, PPOs, and Private fee-for-service) report performance data.
- ACHP helped to craft and pass a Congressional directive for an IOM study on pay-for-performance measurement in Medicare; that study was completed and published by the IOM in 2006.

In 2007 the ACHP Policy Committee proposed, and the Board of Directors approved revised policy regarding Medicare pay-for-performance, including the following components.

- *Payment-for-performance should eventually apply to all Medicare providers, including fee-for-service and Medicare Advantage. Given health plans' long record of reporting on standardized measures of quality, Congress should begin to align a portion of the payment to Medicare Advantage plans based on standardized measures of quality.*
- *Payment-for-performance incentives should be based upon standards of excellence and improvement and favor excellence.*
- *Measures to evaluate both fee-for-service Medicare and Medicare Advantage plans should be developed. In the interim, incentives should be based on existing measures, strongly favor clinical effectiveness, and recognize patient experience.*

More…

Public Policy and Advocacy

In the course of discussions with Congress in 2007, and in consultation with Policy Committee members, ACHP declined to endorse a House proposal for pay-for-performance in a trade-off against base payment rates that would have meant significant payment cuts for most of our member plans—even those with the highest performance scores.

Additional ACHP pay-for-performance initiatives included:

- Monthly ACHP Legislative Committee calls, focusing on MA strategy, grassroots outreach and activity, Congressional proposals and their impact on plans, and potential for pay-for-performance provisions.

- Compilation and distribution of information showing the additional value of MA plans relative to fee-for-service and to other types of Medicare products.

Summaries of Congressional activity, including the House-passed Children's Health and Medicare Protection (CHAMP) Act. Analysis of MA payment county-by-county, allowing ACHP plans to understand more clearly the impact of proposed payment reductions, by county and enrollment. Our analyses showed that the impact of proposed payment reductions varies considerably across plans, since the differential between MA payments and fee-for-service varies considerably by geography. As part of this information strategy, ACHP hosted two widely attended Web conferences explaining the details of MA payment for our member plans.

Medicare Operations

Preparing for CMS audits of MA plans. This Web conference, led by a compliance and audit expert, responded to plans' request for assistance in preparing for Centers for Medicare and Medicaid (CMS) audits.

Long-term care pharmacy rebate data reporting. ACHP worked closely with member plans and CMS staff to avert a potential problem associated with difficulties some plans were having in obtaining rebate data from long-term care (LTC) pharmacies. CMS required that plans begin to report rebate/price concession data from their LTC pharmacy providers, with the first reporting to CMS due September 30.

ACHP led a meeting with CMS to express our plans' concerns at which representatives from Kaiser Permanente, Independent Health, and Fallon Community Health Plan, discussed their experiences in obtaining the rebate data from a large pharmacy vendor with CMS. At that meeting, CMS noted that plans would be held in non-compliance if they did not submit the data. However, they also stated their concern about the subcontractor's performance and suggested that plans indicate to the subcontractor that CMS was aware of the potential non-compliance.

In the weeks after the meeting, ACHP plans reported that the subcontractor returned signed contract amendments, and sent the data to the plans, enabling plans to submit the required data to CMS on time.

Public Policy and Advocacy

Advocating for Non-profit Health Plans

In June the IRS released a discussion draft of a redesigned Form 990, *Return of Organization Exempt from Income Tax*, filed annually by tax exempt organizations. The discussion draft constituted a significant redesign of the form, which has been revised only on a piecemeal basis since 1979. According to the IRS, the redesign of Form 990 was based on three guiding principles: enhancing transparency, promoting tax compliance, and minimizing the burden on the filing organization.

ACHP worked with T.J. Sullivan, a nationally recognized non-profit organization tax expert and former IRS official, and tax experts from Kaiser Permanente and other ACHP plans to develop comments on the form that were submitted in September. The majority of these comments were reflected in the final revised Form 990 document released by the IRS in December 2007. In particular, ACHP requested that the Form allow more opportunity for plans to describe their community benefit; that the IRS remove proposed questions on ratio calculations for compensation; and that only licensed hospitals be required to complete Schedule H. The new Form 990 reflects these changes.

Leaders on Health Care Reform

Health Care Reform Now! A Prescription for Change. George Halvorson, CEO of Kaiser Foundation Health Plans and Hospitals, led via Web conference a pre-publication discussion with other plan leaders of his new book, *Health Care Reform Now! A Prescription for Change.* The book is a roadmap for reform action, particularly noting the importance of payment and delivery system reforms, and the infrastructure changes that make these reforms possible.

State Health Reform. In a Web conference led by Fallon Community Health Plan, UPMC, and Kaiser Permanente, ACHP executives outlined leadership strategies for successfully engaging in state health reform. In states where reforms are already underway, ACHP CEOs and their teams have found that the best way to encourage changes that will make health care better and position us to influence the outcome is to be at the state leadership table early and work in partnerships toward common ground.

Participants discussed:

- health plan leaders' role as catalyst and collaborator on reform
- how plan executives have engaged public policy makers and other stakeholders; and
- how such leadership has offered opportunities for improving health and health care, and simultaneously expanded plans' ability to shape emerging state strategies.

Equal Measurement and Reporting of Quality Data. Equal reporting on quality measures, including HEDIS® and CAHPS® by all types of health plans supports higher performance and better value across the health care system. Early in 2007 NCQA proposed changing its accreditation standards to require this equal quality reporting from PPOs. As NCQA explained in its press release, "Under the new program, NCQA will evaluate preferred provider organizations (PPOs) on the same set of standards, clinical measures and patient experience ratings on which NCQA has evaluated health maintenance organizations (HMOs) and point-of-service (POS) plans." ACHP commented to NCQA supporting these proposed changes and urging NCQA to implement the changes quickly. NCQA will implement these new accreditation standards in 2008. In September, 14 PPOs covering 10 million lives committed to meeting these new standards.

Communications

ACHP provides information to our members and other stakeholders through several regular publications.

- The **ACHP Bulletin**, our monthly newsletter, offers readers an in-depth look at our members, programs and public policy priorities. Currently, the ACHP Bulletin reaches approximately 2,000 contacts, including policymakers, academics, industry leaders, and ACHP members.

- The **Member Minute** serves as ACHP's primary communications tool for monthly updates on ACHP programming, including Web conferences, conference calls, and in-person meetings. Located in the Newsroom section of ACHP's Web site, this Web-based resource also links to presentations, recorded Web casts and other materials from past events.

- Distributed daily, ACHP's **Media Monitoring Report** provides a focused look at timely business and policy issues, and offers links and a concise summary of articles appearing in the national and trade press. Media outlets frequently cited include: *The Wall Street Journal*, *The New York Times*, *USA Today*, *BNA's Health Care Daily Report*, and *CQ HealthBeat*.

In addition, the ACHP Web site, www.achp.org, provides a catalog of most ACHP learning and innovation-focused activities, including Web conferences and meetings, putting at the fingertips of ACHP member organizations a wide range of information on best practices and strategies for success.

ACHP, the Organization

Staff Leadership

In 2007 ACHP hired new Directors for Learning and Innovation and for Public Policy. Hitting the ground running, these new leaders helped ACHP exceed goals for programming events by 50 percent and for member participation by 100 percent across our member plans. We are a lean but strong team, with energy to bring superior programming, analysis, advocacy and support to ACHP member organizations.

Financial Position

ACHP contributed to its reserves in 2007 and has now built those reserves to over 25 percent of annual operating expenses. A clean audit for 2006 is a statement of ongoing discipline and fiscal management. Membership growth and a dues increase that went into effect on January 1, 2008 will help ACHP increase capacity to meet the growing demands for expanded activity.

ACHP Member Organizations 2007

Capital Health Plan
Tallahassee, FL

CareOregon
Portland, OR

Fallon Community Health Plan
Worcester, MA

Geisinger Health Plan
Danville, PA

Group Health Cooperative
Seattle, WA

Group Health Cooperative of South Central Wisconsin
Madison, WI

HIP Health Plan of New York
New York, NY

HealthPartners
Bloomington, MN

Independent Health
Buffalo, NY

Kaiser Foundation Health Plans and Hospitals
Oakland, CA

OSF HealthPlans
Peoria, IL

The Permanente Federation
Oakland, CA

Security Health Plan
Marshfield, WI

UCare
Minneapolis, MN

UPMC Health Plan
Pittsburgh, PA