Competition and quality among managed care plans in the USA

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Abstract

This paper examines the popular idea that competition among managed care plans will lead not only to lower prices, but also to improved quality. We explore the likelihood that competition based on quality will occur and that better quality care will result. First, we discuss key elements of competitive theory and then we attempt to apply them to markets for health care coverage and care. We identify the conditions necessary for competition to have the desired effects and assess the extent to which those conditions do or can exist. We conclude that in the USA, many consumers have no choice among plans and, therefore, cannot select one based on quality. Moreover, the evidence suggests that as long as price varies among health plans, consumers who do have a choice will tend to emphasize price, not quality, in making their selections. We conclude with suggestions to increase the likelihood that quality can improve as a result of competition.

Keywords: competition, HMOs, managed care, quality

Public policy debates in the early 1990s focused a lot of attention on the value of competition in the health care market. The Clinton administration’s Health Security Plan [1], which was the focus of much of the discussion, was a form of ‘managed competition’ [2]. This would have stimulated competition, but would have used the government to restrain some of its less salutary effects, primarily to reduce the potential for discrimination against the sick and the poor and to increase the extent to which all Americans could obtain health insurance coverage. Other proposals from that period called for purer forms of competition while still others proposed less competition and a larger role for government.

This paper examines the popular idea that competition among managed care plans will lead not only to lower prices, but also to improved quality [1,2]. The context is a USA health care system in which coverage in managed care plans has grown so dramatically that, increasingly, they dominate the health insurance picture nationally as well as in many individual markets [3]. On the other hand, although the term is a common one, managed care is a poorly understood concept because the national prominence of managed care organizations (MCOs) is relatively new and because managed care comes in a variety of forms [4–6]. Moreover, empirical evidence about the ways in which it produces its effects or the sustainability of either those effects or the plans themselves is both quite limited and inconsistent [7,8].

Given this lack of evidence, we believe that it is particularly important to articulate clearly the relevant issues regarding the relationship of competition to the goals we seek from managed care. One purpose is to guide further research, and another is to inform policy makers considering the promotion of competitive health plans. The discussion that follows draws on the limited number of, mostly small-scale, studies to date as well as on theoretical considerations and informed speculation.

In this paper, we explore the likelihood that competition based on quality will occur and that better quality care will result. First, we discuss key elements of competitive theory and then we attempt to apply them to health care. We conclude with some general comments.

General theoretical background

Like other social processes, competition has no intrinsic value. It acquires whatever worth it has only to the extent that it increases the probability that certain other things that...
we value – access, effectiveness, efficiency, innovation, quality – will occur.

Beginning with Adam Smith in 1776, the argument has been made that each individual, seeking ‘only his own security, only his gain’ is ‘led by an invisible hand to promote an end which . . . [though] no part of his intention . . . frequently promotes that of society more effectually than when he really intends to promote it’ [9]. Each individual or company, in pursuing its own profit, will produce for society better products or services, lower prices, and greater value than the society would achieve if its leaders deliberately set out to create those benefits. In the more than 200 years since Smith’s treatise, economists have elaborated on this theory and tested it with ever more sophisticated quantitative techniques. Although most continue to support it, the concept of ‘imperfect markets’, which fail to perform in the expected manner, is much discussed [10]. The question for us is: Is this argument true in health care? And, more particularly: Is one of the results improved quality of care?

Competition means, most simply, that two or more firms seek the business of the same potential customers. Assuming that all want additional business and that potential demand is finite, then, to the extent that one gains, others will lose. The theory suggests that, driven by the promise of financial gain and by the fear of financial ruin, each firm will design and present its goods and services in ways that encourage buyers to select them instead of those of its competitors. Each will be aware of the actions of its competitors and will try to gain a competitive edge on them. If the process works as expected, customers will inform themselves about the characteristics of the choices they face, and their effort will be rewarded with lower prices and/or better products and services. Successful firms will earn substantial profits, and companies with poorer products or higher prices will fail. The society benefits from a continually replenished supply of new, better, and/or less expensive products and services.

Theoretically, competition can occur in many dimensions because each available choice has not only a price but quality and other attributes as well. Consumers assess the options available to them and either select the one they believe to provide the best combination of cost and quality or choose to do without because they believe the expected benefits are not worth the price given alternative uses for their funds. In the health care field, people subscribing to managed care plans are buying both insurance and services. For several reasons, the theory of competition is not as applicable in health care markets as it may be in others: (i) insurance coverage reduces the price of most services to consumer/patients and, thus, limits their responsiveness to differences in price; and (ii) most patients know considerably less about the potential benefit of specific service options than professional clinicians and, thus, are poorly equipped to assess their caregivers’ recommendations. Moreover, since the patient’s decision about the use of services often occurs during illness, concern for his or her future health or even life may, first, impair the ability to weigh choices rationally and, second, reduce the importance of financial considerations in that decision making.

Despite these considerations, proponents of competition among managed care organizations tend to believe that: (i) managed care competitors will lower their prices in order to attract the business they need to generate the net income or profits they want; (ii) they will organize services in ways that result in care that is not only more efficient, but better; (iii) they will succeed because consumers will respond to lower prices and perhaps to higher quality; and (iv) because individual consumers will spend less as a result, the system as a whole will spend less [2].

Clearly, managed care organizations compete because they want to grow and often seek the business of the same purchasers. However, whether competitors and consumers actually behave in the way outlined in the previous paragraph, whether health care spending will decline or at least stabilize, whether care will truly be better and less expensive, and whether other less desirable results will also occur remain open questions [11,12], which are beyond the scope of this paper. Our focus here is on whether it is reasonable to expect that competition among managed care plans will lead to higher quality of care for subscribers.

Before proceeding to an examination of these issues, it is useful to recognize that the discussion is really about two different though related markets, and that the role of information, which is so important to the theory of competition, varies between them. In the market for health insurance coverage, the individual knows more about his or her own health and potential need for service than the insurer, which makes it difficult to price coverage appropriately. Insurers, therefore, use nonprice characteristics to design plans to be more attractive to those with fewer risks (e.g. offering memberships in health clubs in order to attract young, healthy people) and less attractive to those with higher risks (e.g. imposing barriers to use of services). Regardless of other plan characteristics, lowering the price would tend to attract high risk patients whose care, because the price was low, might cost the plans more than the premium. This phenomenon reduces the value of price as an attribute to attract subscribers.

In the market for particular medical services, on the other hand, the provider of service knows more about the benefits of the various choices than most patients. Since plans have incentives to limit their expenditures, they may attempt to restrain spending on services by influencing physicians to furnish fewer services than they might otherwise order. The rational subscriber/patient, therefore, wants a plan that not only offers comprehensive service at an affordable price, but also encourages clinicians to order services based on the likelihood that they will improve patient health.

**Conditions necessary for competition on quality to occur**

In order for the competition among plans to produce higher quality of care, several fundamental conditions are necessary: (i) purchasers must value quality of care enough to be willing
to make decisions based on quality; (ii) the concept of quality must be operationalized and measured; (iii) reliable data must be available on those measures to permit purchasers to differentiate among plans based on quality; and (iv) interpretation of the data must be clear to purchasers. We explore each of these conditions in turn.

Who are the purchasers and do they value quality?

In the USA the two principal groups of purchasers of health care coverage are, in a two-step process, employers and individual subscribers. Most Americans obtain coverage through their employment, and the organizations they work for make one or more coverage options available to them [13]. When their employers offer a choice, individuals select among the options. Most employers can choose from among all the plans in the local marketplace, but some national companies select multi-state plans with outlets in each of their major markets. The key issue here is the criteria companies use to choose the health plans they offer their employees.

The employers

Do employers value quality? When asked, they say ‘of course’. In a study of health insurance purchasing practices among large companies, employer representatives interviewed in 1996 and 1997 reported that quality was one of the factors they considered in selecting plans to offer employees [14]. Helen Darling, International Director of Compensation and Benefits at Xerox Corporation, for example, indicated that Xerox had ‘quality requirements’ in choosing health plans and that ‘the most efficient plan is the one that meets our quality requirements, such as having NCQA [the National Committee for Quality Assurance] accreditation, and has the lowest premium in that region’ [15].

Employers that make NCQA accreditation a prerequisite for inclusion among the options offered to their employees are, in effect, setting a minimum standard for quality. However, they tend to offer all plans that meet the standard at an acceptable price and not to limit the offerings further, for example, by including only the two plans with the highest quality scores at or below the acceptable price.

An exception is General Telephone and Electronics (GTE), which has occasionally decertified plans which they believe do not represent adequate value. GTE also distributes annually, to its employees, elaborate scorecards with information on each available plan, thus enabling them to compare plans before choosing one. The scorecards are based largely on the Health Plan Employer Data and Information Set (HEDIS), developed under NCQA auspices in part as a result of pressure from some employers, whose officials wanted more and better information on plan performance.

Further, some companies offer incentives in a deliberate attempt to encourage employees to select plans which company officials believe offer the best value [16]. GTE pegs its share of the premium to a benchmark plan selected on the basis of a combination of cost and quality (‘value’). As a result, the company rewards employees who choose the best plans by paying a larger amount of the premium than for those choosing plans of lower value. This is not a widely used strategy, however, because it requires considerable investment in the acquisition, analysis and preparation of user-friendly data and because ‘consumer surveys and focus groups generally have ranked information on quality low among the types of information desired by those choosing a health plan or a provider’ [17]. In addition, some argue that ‘purchasers and consumers seldom buy because of quality of care’ [17]. In interviews, senior officials of health plans complained that the companies talk about quality, but they negotiate about price [16]. Finally, in the absence of representative national data, it is impossible to know the extent to which quality and price are used by employers in selecting plans for their employees.

Individuals and families

For quality (or any other plan attribute) to be a determinant in individuals’ choice of health maintenance organization (HMO), they first must have the option to choose. However, many employers make only one insurer available. According to a recent study, 40% of firms with 200 or more workers offering health insurance offer only a single plan [18]. Moreover, because smaller firms were more likely to offer a single plan than larger firms, the number of all employers offering no choice is undoubtedly much higher [19]. For individual subscribers with no choice, competition has relevance only if the large firms that do offer choice have such a powerful effect on plans that their actions have a spillover benefit on subscribers from companies without choice. In that instance, employees of companies offering only one plan would get a ‘free ride’ on the investment of the other local companies that do offer choice.

Two other recent studies are relevant here. From one we learn that only 75% of workers were offered health insurance at all and that 20% of them declined it [13]. Although 82% of workers had access to health insurance as a result of either their own or a family member’s employment, 11% of those with such access to insurance declined it. Moreover, the family take-up rate for health insurance was higher for workers with higher incomes than for workers with lower incomes, and conversely, those with lower incomes were more likely to decline it [13,20]. The data from these studies support the conclusion that employees make health insurance choices based on price and are consistent with earlier research which showed that employees were willing to switch plans for a modest reduction in their insurance premiums [21].

Thus, consumers choose plans on the basis of price. Do they also choose plans on the basis of quality? And if they do so, how much of a price increase are they willing to accept to obtain a higher quality plan? Researchers have not answered these questions definitively. Bailit argues that purchasing...
decisions tend ‘to be devoid of quality-of-care considerations,’ and as a result, ‘health plans will continue to make business decisions to trade off quality for cost, choice of providers, and service’ [17]. Although Bailit’s comments are based on his experience as a purchaser, it is possible that he overstates the case. National surveys and other large-scale studies are needed to determine the extent to which these views accurately represent the general condition. Nonetheless, the evidence presented up to this point is consistent with the view that if employers create a competitive market for health care plans, decisions relating to choice of plan will be affected by price, assuming that all plans can demonstrate an acceptable minimum level of quality.

Further, we believe that competition would be much more likely to be about quality if price were taken out of play. European countries, like Germany [22,23] use administered prices to allocate resources among providers. A public–private body created under law is charged with determining how much is to be spent on health care for the year, and then, other publicly-designated private bodies determine the rates of pay for physicians, hospitals, and other providers. If expenditure trends exceed projections as the year progresses then service prices are reduced to compensate. A similar approach could be taken in the USA under a national health insurance plan: if premiums were set in advance and were identical for all subscribers [24] (or preferably adjusted by a subscriber’s health status [25]) then not only would national health care spending be predetermined, but competition among plans would be based on other dimensions, including quality. In the absence of a national health insurance plan, individual employers could decide what premiums they were willing to pay and agree to contract with all plans that both met a minimum quality threshold and were willing to accept that premium.

**Conceptualizing and measuring quality**

If purchasers (whether employers or employees) do value quality enough to include it in their decision making, they need evidence about the relative quality of plans. First, in order for that evidence to be available to them, quality needs to be conceptualized and defined. Second, in order to know that good care has been provided, we need measures of the concepts and their elements. Finally, we need data from which these measures can be constructed so that plans and practitioners can actually be compared.

Patients receive good quality care when they obtain services that are appropriate for their needs and when those services are delivered competently and at the optimal time, given their condition. In other words, good quality is doing the right thing well and at the right time. Donabedian conceptualized the elements of quality in three categories: structure, process, and outcome [26]. Structure relates to the availability of resources, both human (e.g. board-certified physicians) and capital (e.g. medical technology) that are thought to make provision of quality of care possible. Structural measures, however, give no information about whether these resources are, in fact, used effectively to provide quality care. Process relates to the provision of care itself, for example, whether a service appropriate for a patient’s illness was provided. Such measures can be difficult to obtain, particularly measures that attempt to assess, not only if, but also how well a service was provided. Moreover, those assessments need to capture both the technical elements of care (e.g. was the correct medication prescribed in the correct dosage and at the appropriate time?) and the interpersonal components (e.g. was the patient instructed about how to take the medication properly, and about what benefits and risks to expect from it?). Outcome measures relate to changes in patient health status following the receipt of services. Thus, plans can be compared on measures such as mortality rates, morbidity rates, functional status, and the elapsed time for patients to return to work following treatment. Lack of information systems that capture an entire episode of illness often makes outcomes data difficult to compare; even when it is possible to make comparisons, it is usually difficult to adjust for the effect of patient health status prior to treatment on health outcomes.

At its most basic level, health care is intended to produce better health for people who use it than they would have without it. Since ‘cure’ is not the only purpose of care however, even determining quality by the outcome of measured improvements in health status may be inadequate. With chronic illness, in particular, the goal is not cure, but effective management of an on-going condition so that people can lead productive, contented lives.

Finally, in addition to traditional measures, new indicators are needed to capture the distinctive contribution of managed care to service delivery. Since MCOs are responsible for the entire scope of covered services, it is expected that they will deliver care more efficiently and with less waste and more integration than care provided under indemnity coverage. But they can also profit by providing fewer and/or less expensive services than are indicated by the patient’s condition [6]. Therefore, quality measures need to include structural, process, and outcome indicators associated with reducing the risk of under-service and promoting integration of care.

**The availability and reliability of data related to quality**

If quality is to be operationalized, then data that are sufficiently reliable to construct valid quality measures must be available. Several efforts have been made in recent years to construct such measures and to use them to compare plans. The best known of these efforts is the previously mentioned HEDIS, currently in Version 3.0. In the fall of 1997, a summary report on the state of managed care quality [27] presented data on eight quality measures (out of more than 50) collected from 330 health plans, covering three quarters of all HMO enrollees. Among the clinical measures were: the breast cancer screening rate; Cesarean section rate; eye examination rate for patients with diabetes; and the percentage of pregnant women who began prenatal care during the first trimester of pregnancy. In addition, from NCQA’s annual member health care survey, the report also presented several measures related to member
satisfaction, which can be a good indicator of the quality of interpersonal care if satisfaction surveys are carefully designed, administered, and analyzed. Survey instruments and methodologies must be similar, if not identical, in order to justify comparisons, and response rates must be high enough to warrant confidence in the results.

Although the clinical measures can be useful, their limitations also need to be acknowledged. They represent the extent to which certain appropriate services were provided to people for whom they were indicated, but do not reflect the skill with which they were provided. Further, several report the extent to which various tests were performed, but neither the rate of positive results nor the extent to which appropriate treatments were provided to patients with positive results. In addition, the reliability of these measures is in question, especially between plans that use administrative data instead of primary data to construct the quality measures, because specific ratings can be a function of the data source. Finally, because the data are self-reported by plans, it is important that they be audited independently. Although NCQA has made progress in this area, there is still considerable room for improvement. Some employers, such as Digital Equipment Corporation, collect comparative data, but have not made it available to employees because of doubts about the reliability and validity of some of the measures [19].

Another organization collecting and publishing data related to quality is the Foundation for Accountability incorporated in November 1995 [28]. Its measures tend to be substantively comprehensive about particular health conditions. For example, the data for adult asthma include measures related to a patient's education, use of peak flow meters, use of inhalers, satisfaction, functional status, self-reported symptoms, self-management knowledge and behavior, and ability to maintain daily activities. All data for these measures are obtained from annual surveys of patients and, thus, are subject to patient knowledge and recall, as well as other limitations of such surveys.

The meaning of quality-related data

Finally, assuming data are available on a comprehensive set of measures, how should the corporate purchaser or individual consumer interpret them? The difficulty of determining the meaning of these data and measures is illustrated by the 1996 report published by the Massachusetts Healthcare Purchasers Group (MHPG) for its member companies [29]. The report compared 17 plans serving Massachusetts residents on seven quality indicators and five patient satisfaction measures, assigning each plan from one to five stars based on their relative standing on each measure. The MHPG awarded four stars (‘very good’ quality) to the highest rated plan because 94.7% of its members answered ‘good,’ ‘very good,’ or ‘excellent’ when asked to rate ‘overall quality’ of care and service. The lowest rated of the plans had similar responses from 87.3% of its members, and was awarded two stars (‘fair’ quality). Thus, a difference of only 7.4% in members’ response about overall quality was interpreted to mean that one plan provided very good care while another provided only fair care. Partly over this issue, Massachusetts Blue Cross Blue Shield refused to continue to participate in the MHPG effort following the release of these data.

The MHPG report also showed inconsistencies between quality and satisfaction rankings and among the quality rankings. For example, the top three plans by quality measures were ranked eight (two plans tied) and fourteenth on satisfaction. Similarly, scoring high on one measure did not appear to have much predictive value related to scores on other measures. All but four of the 17 plans in Massachusetts had one or two stars on some measures at the same time that they had four or five stars on others. These inconsistencies contribute to employees’ difficulty in determining which plan is best for them or their families.

It is fair to say that measurement of quality is evolving. Today’s measures are much more comprehensive and reliable than those of just a few years ago. Although they still have major flaws, they show variation in performance among plans that is so great as to indicate a great deal of room for quality improvement. Based on its 1996 data, NCQA concluded that HMOs vary greatly in terms of preventive care, treatment of acutely ill and chronically ill patients, and member satisfaction [27]. Further, only 56.2% of managed care plan members indicated they were ‘completely’ or ‘very’ satisfied with their current health plan. Clearly, continued progress on both quality measurement and quality improvement is needed regardless of the nature or amount of competition among plans.

Conditions needed for quality in managed care plans to improve

A statement that ‘the quality of care in Plan A is good’ implies that the leadership in Plan A has done something to increase the probability that subscribers selecting that plan will receive good quality care when they need it. To say that ‘the quality of care in Plan A is better than that in Plan B’ implies that Plan A’s leadership has taken additional or more effective actions than the leadership of Plan B. The data presented in the last section showing inconsistencies among the measures raises doubts about this assumption. To what extent do the measures — even those which are audited and reliable — reflect deliberate actions of the health plans?

Because most HMOs are independent practice association (IPA) model plans, and in a given market most physicians tend to be in most of the plans, in what sense can it be said that Plan A is better than Plan B? If the physicians, hospitals, and other providers overlap to a considerable degree, Plan A is better than Plan B only if the plan itself does something to add value to what the individual caregivers do. The critical question is therefore, What do the leaders of Plan A do to produce better results? At the structural level, they can ensure that only board-certified physicians and accredited facilities
provide services under their auspices. In addition, at the process level, plan leaders can ensure high rates of appropriate tests (e.g., eye examinations for patients with diabetes) and can introduce processes to ensure appropriate follow-up for patients with positive test results. They can go further and not only install an automated clinical information system (a structural action) that allows clinicians to access data about the patient’s medical history, including services provided by others, but also effectively induces them to use it in caring for patients (a process action). They can also introduce processes to improve the integration of services provided during an episode of illness. In these and other ways, the organization can add value to the work of individual clinicians.

To justify judgments about quality at the plan level based on data of the types discussed in this paper, the most fundamental criterion is that they show consistency. This is important because under managed care arrangements, when individuals choose a plan, they get access only to that plan’s clinicians. In most instances, and without paying a higher fee, they cannot select more highly rated specialists from another plan even if they are satisfied with their primary care physician. If Plan A scores high on one measure, but not on other measures, observers can assume that quality measures at the plan level are either random artifacts or result from other factors (for example, the distribution of particular illnesses among plan members). The inconsistencies in the data reported earlier suggest that this is a real possibility.

The essential point is that unless plan-level differences on measured quality can be related to actions that the HMOs have taken, particular measures could reflect the actions of particularly good doctors (e.g., a cardiology group) or of a particularly good chief of service. Unless we also see high scores on treatment of patients with other illnesses or conditions, we should not ascribe judgments about quality to the plan as a whole.

Finally, to be able to draw appropriate conclusions about plan-level quality, information is needed about the nature of the managerial interventions taken to increase the probability of consistently high quality treatment for patients in particular clinical categories. Gold et al. surveyed plan managers and reported considerable plan-level activity in this regard [30]. A recent survey of physicians demonstrated the importance of having data on the clinicians’ experience also. Florida physicians reported very little effort from HMOs as a whole on activities such as the use of diagnosis-specific practice guidelines or feedback on their own utilization and expenditure rates. On the other hand, almost 70% reported that they needed to obtain authorization before providing certain services [31].

The literature reviews by Miller and Luft [7,8] the inconsistencies in HEDIS data [27] and the experience reported by Florida physicians [31] provide reason to doubt that many HMOs have taken comprehensive actions to influence physician practice patterns in ways that promote quality. This absence may not be surprising given that purchasers’ decisions tend to be motivated largely by price and that the predominant form of HMO is the IPA, which has little leverage over its physicians. This picture may change as time passes, especially if physician groups grow and health plans consolidate, if clinical information systems continue to develop, and if better measures of quality become available.

**Investments in quality improvement and quality assurance**

Although this appears to be a rather bleak picture, it is also apparent that some HMOs are making substantial investments in activities intended to influence the delivery of services. What is not clear at this juncture, however, is how much of this investment focuses on efforts to reduce costs and how much focuses on attempts to improve quality, and in either event what methods are used. For example, we know that HMOs use financial incentives to either reward restraint or punish ‘excessive’ utilization rates and that these efforts occur even under fee-for-service payment through the use of ‘withholds’. We also know that HMOs use prior approval methods that substitute the clinical judgment of the plan for that of the clinician, and that some plans have invested in information systems and implemented clinical protocols and performance feedback systems in efforts to improve quality of care. However, we do not know the extent to which these and other efforts are being used inside individual plans or throughout the managed care sector as a whole, nor the outcomes they produce.

Research is needed urgently to determine the nature and extent of HMO activity aimed at enhancing quality as well as other efforts (e.g., the use of financial incentives to compensate professionals) that may affect the delivery of services. Articles have begun to appear that may shed some light on these questions, and the Agency for Health Care Policy and Research has a managed care research funding initiative. Among others, the United HealthCare Corporation [32], US HealthCare [33], the Prudential Health Care System [34], Kaiser Permanente [35], Harvard Pilgrim Health Care, and Group Health of Puget Sound are investing in a variety of health services research projects related to such efforts. Reports of these studies may provide evidence about management attempts to influence the delivery of services. But, perhaps even more important, are comparative studies across plans about the nature and effects of a variety of investments in quality-enhancing activities. Among other things, it is important to learn about the following types of investments:

- **clinical information systems** — to reduce duplication of tests and other services; to enhance communication among clinicians during an episode of care; and to provide feedback about quality measures and guidelines;
- **protocols and guidelines** — to increase the extent to which evidence-based medicine is practiced; and to reduce variation among physicians in treatment of patients with particular conditions;
- **processes to enhance the connections between segments of an episode of care** — to increase the integration of care among providers treating the same patient [36].
Determ inants of investments in quality improvement

Assuming that HMOs know what investments might improve quality, whether they actually invest in quality enhancement — and, therefore, whether quality measures that differentiate among HMOs have meaning — will depend on several factors, including the following:

(i) Market conditions. How many plans operate in the market? How large a share of the market does each have? Do physicians have relationships with many plans? Do hospitals serve patients of multiple plans? Is the strategic focus on building market share by including a broad range of providers and lowering prices, or is it on improving quality, efficiency, and productivity?

(ii) Free rider problem. If Plan A has arrangements with many physicians most of whom have arrangements with other plans as well, and if it has a relatively small share of the market, it faces two problems: despite limited leverage, it must gain the attention of physicians and attempt to influence their clinical decisions. But then, if it succeeds in that effort, plan A's investment in influencing physicians will also benefit plan B unless physicians treat plan A's patients differently than plan B's patients. In other words, plan B will have a free ride on plan A's investment.

(iii) Access to capital. All of these efforts — whether it is developing and implementing protocols, buying (or developing) clinical information systems, purchasing hardware — require capital, which can be difficult to obtain. The conventional wisdom is that investor-owned plans have an easier time than not-for-profits obtaining funds because of the promise of substantial returns. In fact, however, it may be less the promise of profit than the risk of loss that makes such plans better able to obtain capital. A health plan that can promise a profit should be a good candidate for low-interest loans because it is likely to repay them. In a volatile market, however, surplus or profit are no longer as certain as they were. Therefore, lenders will require higher interest rates, thereby increasing the cost of the plan's investment. For-profit plans that acquire capital from investors who are willing to accept the risk because of the possibility of profit pay the investors only if they earn a profit.

Conclusions

The primary questions addressed in this paper were: What is the relationship between competition and health care quality in a managed care environment? Will managed care organizations compete on the basis of quality? Will subscribers be able to choose plans based on quality? Will competition improve the level of quality in the system as a whole?

It is certainly true that many markets boast multiple health plans and that they compete with one another to be among those plans offered by employers (especially large ones) to their employees. However, we believe the evidence to date offers little support for the view that competition among health plans improves quality to a substantial degree. It appears that a growing number of employers use available data to identify plans that meet some minimum level of quality — often NCQA accreditation; to the extent that they reject plans that fail to meet that standard, it is fair to say that quality is improving. However, we could find no published evidence that employers reject managed care plans because, although they meet the threshold criterion, they have lower scores on quality measures than other plans.

On the other hand, some employers do provide information to their employees which permits them to differentiate among managed care plans on a variety of factors, including quality. Some even adjust their contribution to the premium to encourage employees to select plans that they believe offer the best ‘value’; however, this practice appears to be uncommon. Furthermore, officials of managed care plans have been quoted as saying that employers talk about quality, but negotiate about price. In the absence of evidence to the contrary, we take that to reflect the dominant experience.

In addition, many employers in the USA, perhaps the majority, offer no choice of plan to their employees. Thus, although the employer may be selecting among plans — on price, quality, or other factors — their workers can subscribe to only one plan. That practice alone limits any impact that competition can have.

It is also important to recognize that quality is a complex construct, hard to define and still harder to measure. Moreover, most if not all measures in use to date could have been used equally well under indemnity plans because they do not incorporate the distinctive contribution expected from the managed care process. Further, the available measures are hard to interpret, often leading both employers and employees to resort to price as the key criterion because it is so easy to understand. This situation may change as efforts to conceptualize and measure quality develop further.

Finally, quality is an even more important issue today than in earlier times because the market discipline represented by consumers’ ability to go to another provider when dissatisfied is much more constrained under managed care arrangements. Therefore, it is important to induce plans to devote considerable effort to improving the delivery of services — making it more efficient, less wasteful, more integrated, more evidence based, and with less variation in clinical practice patterns than has been typical.

In that connection, we recommend a number of steps to increase the likelihood that competition can result in health care quality improvement:

(i) Individual purchasers of health care coverage must have a choice among plans. Organizational purchasers — whether corporations, unions, or government — have a role here in ensuring that at least two plans are offered to their employees. Government has a role in protecting competition and, thus ensuring choice, by enforcing antitrust laws.
(ii) Competition on the basis of quality would be more likely if there were no competition on price. In countries with national health insurance, if premiums are set in advance to be identical for all subscribers, except for health status adjustments and local cost differentials, national health care spending would be predetermined and competition among plans would occur on other dimensions, including quality. In the absence of national health insurance, employers or health care purchaser consortia could set the premium and contract with plans that were willing to accept it and that met a minimum quality threshold.

(iii) The state of the art of quality measurement needs to be advanced. Government has a clear role in funding research efforts in this area. Of particular importance is additional work to develop measures of quality applicable to those with chronic conditions and relatively poor health, such as the frail elderly, who may be most at risk of poor health outcomes as a result of cost-conscious, managed care practice styles. The purchaser also has an essential role: to demand from health plans the data and analysis needed for reliable, valid, comprehensive, and comprehensible quality measures.

(iv) Comparative quality reports of health plans must be available so that individuals can choose a health plan based on information about quality as well as on price and accessibility. In addition to the usual documents and educational sessions, reports can be made available through employer's internal computer networks as well as on the Internet to facilitate access to updated information.

(v) Individuals should be provided with an effective appeals and grievance mechanism for those instances when they feel they have not received sufficient quality of care. Even if the previously discussed ‘conditions necessary for competition on quality’ are in place, quality shortfalls will nevertheless occur. In such instances, knowledge of an effective mechanism to assist individuals to deal with them should contribute greatly to public confidence in and acceptance of a competitive health care market place.

The quest for quality in health care is complex and difficult, but on the basis of our analysis, we believe that taking these steps will substantially increase the probability that quality of care will improve in a competitive health care system.

References


28. For information, consult the internet at http://www.facct.org


