Increased Competition and the Quality of Health Care

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PROPOSERS OF INCREASED PRICE COMPETITION wish to improve the efficiency of the health care marketplace by strengthening attention to costs among health care decision makers. The call for greater price competition arose during a period of rapidly rising expenditures, when providers and consumers, as well as employers and third-party payers, paid scant regard to the cost implications of their decisions. The intention was that decision makers would weigh costs as well as benefits in choosing among health care and other goods and services and among alternative strategies to manage health problems.

As cost consciousness has grown, however, so has public concern about threats to the quality of care that is being delivered. This situation is reminiscent of the adage that we may get what we wish for. Nothing inherent in the concept of efficiency or increased price competition predicts that the quality of care will be improved, or even maintained, at past or current levels. Besides the quality of care, consumers and others value certain amenities and styles of practice. Our national and individual values concerning equity may also temper the drive for quality and efficiency. With increased price competition, the

The Milbank Quarterly, Vol. 76, No. 4, 1998
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350 Main Street, Malden, MA 02148, USA, and 108 Cowley Road,
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quality of care and its cost could either increase or decrease in some combination. Making choices and trade-offs among costs and benefits is not new to either health care or other sectors; rationing, that is, allocating scarce resources among competing desires, has always been taking place. As price competition is growing, the challenge is to create conditions that safeguard the quality of care and reward its improvement over time in a manner that is consistent with the public's preferences.

Proposals to create more price-competitive conditions in health care focus on the individual consumer's selection of a health insurance plan (e.g., Iglehart 1988; Pauly et al. 1991; Enthoven 1993). According to these theories, consumers who are sensitive to premiums would consider the characteristics of different plans, including, but not limited to, the quality of the care they offer. Price sensitivity in the management of particular medical conditions would rest with the plans and providers, who would weigh alternative costs and benefits, including implications for enrollees' health and retention of enrollees over time. Proponents have identified certain conditions for the successful functioning of a competitive health insurance market: a defined premium contribution by a sponsor, such as an employer or the government, that does not vary by plan, so that consumers bear the cost implications of choosing plans with higher or lower premiums; a standardized benefit package covering basic services, to improve consumers' ability to compare plans and mitigate adverse selection; better information for consumers, to support their decision making; risk adjustment of premiums paid to plans, to address imperfect information about enrollees' risk and preferred risk selection by plans; monitoring of disenrollment, to assess whether or not plans are easing out high-cost enrollees; and continuing government support of insurance coverage for elderly and poor people, to address equity and distribution.

As background for assessing the quality of care under increased competition, it is useful to review how health policy and economics have used the concept of quality. Over the past decade, health policy has emphasized the importance of improving outcomes desired by consumers, as well as the challenge of distinguishing the effect of the prior medical care process from the many other factors that influence outcomes. Reflecting these complexities, health policy organizations have defined the quality of medical care as the degree to which health care increases the probability of outcomes desired by consumers, given current medical knowledge (U.S. Congress 1988; Lohr 1990). More ser-

vices or higher costs of care are not necessarily associated with better quality. Furthermore, a substantial portion of medical care is not consistent with evidence of effectiveness and safety and may be ineffective or even harmful.

In general, economics has paid scant attention to the quality of goods and services. When products do differ, economic models have typically assumed that higher quality entails higher costs of production and lower quality, lower costs. Some of the health economics literature has similarly identified quality with a greater intensity of treatment, such as the length of time spent with a physician during an office visit or the number of visits per episode of illness (Wedig, Mitchell, and Cromwell 1989). But other analyses have recognized that more care is not necessarily better, or worse (McLaughlin 1988; Rice 1993; Feldman and Dowd 1993).

This paper examines the implications of increased competition for the quality of care during a period of rapid change in the marketplace and evolving insights about its functioning. The paper first considers recent changes related to greater price sensitivity and then reviews the experience that has accumulated on how quality of care has fared under conditions of greater price competition. Based on these findings, the paper discusses strategies that the private and public sectors could take to support and supplement competition, so that the quality of care would be safeguarded.

Recent Changes Related to Price Competition

There is growing evidence that changes in public and private policies regarding health insurance have in fact led to increased price competition since the early 1980s. In 1982, California enacted legislation that permitted third-party payers to restrict coverage to certain providers. Preferred provider organizations (PPOs) fostered competition among providers by negotiating discounted rates with them and offering beneficiaries incentives for using these providers. Employers that required employees to pay more if they chose a plan with a higher premium also fostered greater cost consciousness in employees' enrollment decisions. From 1982 until 1991, enrollment in HMOs and PPOs grew from under 20 percent to more than 80 percent of California's privately insured (Melnick and Zwanziger 1995; Zwanziger and Melnick 1996).

Studies concluded that, since 1983, California hospitals competed increasingly on price, which led to lower costs and slower growth in costs per admission in hospitals that operated in more competitive markets (Zwanziger and Melnick 1996). These results persisted in comparisons outside California and beyond hospital care. Compared with the overall U.S. record and with that of four states using rate regulation, California experienced much lower growth in real per capita health expenditures from 1982 through 1990, not only in hospital services but also in physician services and drugs (Melnick and Zwanziger 1995). These expenditures, however, excluded 30 percent of health care expenditures, including long-term care. Perhaps more important, the analysis did not take into account the growth in California's uninsured population during this period (Zwanziger and Melnick 1996).

Policy changes in Minnesota also established conditions proposed to increase price competition. In 1985, the state's group insurance program required employees to pay the additional premiums if they did not enroll in the lowest cost plan; in 1991, a coalition of private employers in the Twin Cities instituted the same policy. Although employees may pay their share of premiums with before-tax dollars, through 1993 the lowest-cost HMO steadily gained market share, and indemnity and high-cost managed care plans lost ground (Christianson et al. 1995; Zwanziger and Melnick 1996). These results are consistent with consumers' choosing lower premiums and managed care in preference to higher premiums and unrestricted access to more autonomous providers. On the other hand, faced with possibly biased selection of plans by enrollees, employers reduced their health plan choices, which may have fostered consolidation among plans and among hospital systems competing for plan affiliations.

Other studies have also found that employees exhibit price sensitivity in their choices among plans. Employees in a national sample of employers were sensitive to out-of-pocket premiums (Dowd, Feldman, and Maciejewski 1995). From 1988 through 1991, greater HMO market share was associated with lower HMO premiums (Wholey, Feldman, and Christianson 1995). At the University of California, which specified standard benefits and cost-sharing arrangements and limited its premium contribution to that of the lowest-cost plan, employees exhibited strong price sensitivity to expected out-of-pocket premiums (Buchmueller and Feldstein 1996).

Quality of Care under Increased Competition

How has the quality of care fared as marketplace conditions have changed, especially where price competition appears to have increased, such as in California and Minnesota and in some employment groups? Analyzing the quality of care in these circumstances poses more than the usual challenges. It is difficult to isolate the likely effect of greater competition from the myriad changes taking place in public and private policies and from other factors that may influence quality. The question is whether or not greater price competition has affected quality, not whether quality has improved or is improvable. Despite the many accomplishments of U.S. health care over the years, the quality of care offered substantial room for improvement when increased price competition began to take hold in certain parts of the country (Chassin 1997). Indemnity insurance and fee-for service (FFS) payment generally encouraged the additional use of insured services with little regard for their marginal benefit, and discouraged the use of uncovered services. Some economists in the late 1980s concluded that, given current levels of insurance and competition, declines in the quantity and intensity of physician services might even improve social welfare, because insurance had led people to overuse health care (Wedig, Mitchell, and Cromwell 1989). Studies have not found a consistent relationship between the cost and quality of medical providers. For example, studies of ambulatory practices caring for Medicaid beneficiaries in Maryland found that technical quality varied by the type of facility, but not its costliness (Starfield et al. 1994; Wagner 1994).

The areas of most interest for assessing the influence of competition are those where greater sensitivity to cost threatens to undermine quality or promises to improve it: aspects of quality that overlap with access to care, interpersonal aspects of quality, technical aspects of quality, care for vulnerable populations, and differential enrollment by plans. In the absence of much rigorous evaluation, case studies of more competitive situations may also offer instructive insights into how implementation is proceeding and where benefits or harms might be occurring.

Consumers are the best sources of information about interpersonal aspects of quality and satisfaction, and perhaps about access to care as well (U.S. Congress 1988). Consumer surveys can serve as an early warning system for assessing changes in the marketplace because they

can generate results fairly quickly and cheaply compared with other evaluation methods.

A 1995 survey queried adults in 15 communities across the country about their perceptions of access and quality over the prior three years (Knickman et al. 1996). Almost half the respondents said that access and quality had improved a little or a lot, and about one-quarter felt it had worsened. Twice as many thought the trend toward managed care was good than considered it to be bad, and more expected managed care to improve quality than to harm it. Yet more thought the system was getting worse, apparently because they were concerned about high costs and about insurance's not covering costs. The pattern of results varied across subgroups of the population. Compared with privately insured people, Medicare beneficiaries and uninsured people were less likely to report that their access had improved, whereas Medicaid beneficiaries were more likely to report improvements in access and quality. Medicare beneficiaries were least likely, and Medicaid beneficiaries were most likely, to expect that managed care would improve quality and that the health care system was changing for the better. Hispanic and African-American respondents, compared with whites, also reported improved access and quality. Most Medicaid respondents, however, were concerned about future coverage. These reactions are consistent with changes in public programs that improved access, and perhaps aspects of quality, for Medicaid more than for Medicare beneficiaries during this period. Although the responses speak to the total effect of changes experienced, the influence of competitive versus regulatory or other changes is not clear.

Uninsured people, like others, reported improved quality of care, but were the only subgroup to report deterioration in their access to care. It is reassuring that people with reported health problems did not differ from healthier people in their perceptions of access and quality changes.

Comparisons reported by extent of HMO market share should come closer to reflecting the effects of greater competition. People in areas of medium HMO penetration were significantly less likely to report improvements in access and quality than those in areas of low penetration, but respondents reporting improvement in the two areas varied only in a range of 42 to 49 percent. About 60 percent of those in all areas considered managed care growth a good thing; the highest rates of approval were found in high, and then in medium, penetration areas,

with 45 to 46 percent of these respondents expecting managed care to improve quality.

In other recent surveys, Medicaid beneficiaries in managed care have reported better access and greater satisfaction than those in the conventional program (Sisk et al. 1996). Experiences for the privately insured population may well have differed from those for Medicaid beneficiaries. A 1994 survey of insured people in employer- or union-sponsored plans in Boston, Los Angeles, and Miami found that enrollees of FFS plans were more satisfied than managed care enrollees, both with access to care and its quality of care (Davis et al. 1995). The general insured population may have experienced greater restrictions on choosing physicians and obtaining care. During the same period, Medicaid policies may have improved the conditions under which beneficiaries obtain care. Although these surveys were conducted in areas with growing diversity among plans, the influence of greater price competition, as opposed to public policy and other factors, cannot be discerned from the results.

In the 15 surveyed communities mentioned above, plans were competing for employers' business on the basis of lower premium price but did not necessarily pass price differences along to enrollees by standardizing cost-sharing arrangements (Miller 1996). Plans and providers were also competing on the breadth of provider choice offered to consumers and, in some areas, on perceived access, interpersonal quality, and amenities. In none of the areas were payments to plans or providers being adjusted for enrollees' health. There was little information or competition on measured technical quality among plans or among providers within plans. It is not surprising that plans have been giving attention to interpersonal quality, access to care, amenities, and style of practice. These dimensions of care matter to consumers, consumers have historically comprehended them, and plans may be able to intervene more quickly to improve these aspects than to improve technical quality.

There is no direct information on the relation between increased price competition and technical quality. Through the early 1990s, the literature on privately insured and Medicare beneficiaries reported that managed care plans delivered care of at least comparable quality to indemnity plans (Miller and Luft 1994). Although there were no systematic differences between group- and staff-model HMOs versus independent provider associations (IPAs) and network models, these findings have

questionable relevance to newly evolving organizational and financial arrangements and to situations with increased price competition.

A study of open-heart surgery procedures in California is relevant to an indicator of technical quality in a region of increased price competition. The relation between a higher volume of cardiac surgery performed in a hospital and better health outcomes has been well established (Luft, Hunt, and Maerki 1987). From 1986 to 1991, Kaiser-Permanente, a large group-model HMO, directed all its enrollees to high-volume hospitals, defined as those performing more than 200 coronary artery bypass grafts (CABGs) annually (Chernew, Hayward, and Scanlon 1996). All but one of the group- and staff-model HMOs contracted only with high- or medium-volume hospitals, with the latter defined as having 151 to 200 CABG procedures annually. The exception was a county-owned HMO that covered only Medicaid beneficiaries and used county hospitals for open-heart surgery. Even without Kaiser enrollees, multivariate analysis controlling for patient characteristics and diagnoses, county, source of admission, and availability of other providers found that HMO enrollees were significantly more likely than commercial plan enrollees to receive treatment at high-volume hospitals.

Despite health implications, about 25 percent of CABGs for Medicare patients and 44 percent for Medicaid patients took place outside high-volume facilities. These patterns suggest that HMOs with more integrated delivery systems were providing care of better technical quality to their CABG patients, and that federal and state programs were not sufficiently using their purchasing power to obtain achievable quality for their beneficiaries. If California exemplifies an area with increased price competition, these findings raise the question of where enrollees of HMOs and other plans in areas with less competition have been obtaining CABG surgery.

Similar results on health-related outcomes are available for Minnesota, another area that is presumed to have greater price competition. During the mid-1980s, elderly and chronically mentally ill Medicaid beneficiaries randomly assigned to HMOs versus the conventional program had the same or better health status over the short term (Christianson et al. 1995). The employer coalition in the Twin Cities, described earlier, has assumed responsibility for using its purchasing power to foster cost-effective provider systems and has undertaken a quality improvement program to implement clinical guidelines.

In sum, the information available does not indicate either that quality has deteriorated with greater price competition, or that it has improved. Effects on access, satisfaction, and interpersonal quality appear to have varied among subgroups of the population. The changes that have taken place may have ameliorated these aspects of care under Medicaid, but they have reduced access for the uninsured at the same time that their numbers have increased. These differences and changes, however, cannot be clearly attributed to increased competition. Similarly, studies of care provided in different kinds of plans and in areas such as California, where there is more price competition, do not indicate that technical quality has been undermined, and they may suggest some improvement. Even less information exists on technical aspects of care than on interpersonal quality and access, however. The meager information, coupled with the great flux in marketplace conditions and organizational and financial arrangements for delivering care, argues for more intensive monitoring and evaluation in the future.

Strategies for Safeguarding the Quality of Care under Increased Price Competition

Both government and private organizations have crucial roles in creating the conditions for competition to reward plans and providers that deliver the levels of quality, access, and cost that people want. It is not reasonable to expect the choices of individual consumers alone to bear the responsibility for maintaining or improving the quality. We do not expect that of individuals in other sectors, especially those involving technical acumen, such as air travel and automobiles. Instead of relying on one mechanism, combining supportive policies of public and private purchasers and government regulation with individuals' choices is more likely to achieve quality of care consistent with people's preferences.

Mandate Minimal Requirements

Certain structural requirements help to ensure minimal protection for plan enrollees and fulfillment of a plan's obligation to provide covered benefits. Such requirements include consumer grievance and appeals

processes, licensing and certification of providers, and conditions for a plan's continued financial solvency. Regulation of the insurance industry has traditionally been left to the states, although the 1996 federal Health Insurance Portability and Accountability Act limited the ability of plans to restrict coverage for preexisting conditions. The "Consumer Bill of Rights" adopted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry addresses many of these points (U.S. Advisory Commission 1997). The private sector, through employers, purchasing coalitions, or organizations that were established to accredit plans or providers, such as the National Committee for Quality Assurance (NCQA), can also enforce these conditions.

All plans should be subject to the same tax and regulatory requirements (Pauly et al. 1991), so that enrollees in all plans enjoy the same protections. Putting plans sponsored by self-insured employers on the same footing as other insurers requires amendment of the federal Employee Retirement Income Security Act (ERISA) (Mariner 1996). Government is also in a better position to respond to practices that the body politic considers egregious and wishes to prohibit, such as "gag" clauses or limitations on information in a plan that clinicians may convey to their patients. Clinicians whose services are paid by capitation or bundled payment face a dilemma. They have financial incentives to use services judiciously, but they also have professional responsibilities as agents of patients, who deserve to have information that might influence their decisions. By forbidding plans to impose such restrictions on clinicians, legislation has bounded, but not resolved, that dilemma.

Consumers may now face an often bewildering array of health insurance options that differ in benefits covered, provider networks, and cost-sharing implications. Instituting a fixed premium contribution from employer or government makes the consumer more responsible for the financial implications of plan choice. A standardized benefit package covering basic services would go the next step in improving consumers' ability to compare the costs and benefits of different plans. Standardized benefits would reduce differentiation among plan options and channel comparisons toward the quality of care and other dimensions that consumers value. A standardized package also mitigates adverse selection of people with certain health problems into plans that offer related benefits, such as mental health, and broadens the effective choices open to each consumer.

Basic benefits could be set by the government for the population or by an employer or other sponsor for a group (Pauly et al. 1991; Enthoven 1993). That entity would have to determine the scope of benefits for both basic and supplemental coverage. Presumably, the basic package would cover comprehensive benefits, but decisions would have to be made about categories such as long-term care and pharmaceuticals that have been restricted by Medicare and other insurers, and opinions may well vary about what should be deemed basic benefits.

Since August, 1992, federal legislation has required that all policies to supplement Medicare coverage conform to one of ten uniform benefit packages, or to those approved by individual states, instead of the hundreds previously available (McCormack et al. 1996). By 1995, state and federal officials, insurance representatives, and public interest groups reported that standardized packages made the market more understandable to beneficiaries, although beneficiaries were not contacted directly. Consumer complaints generally decreased, and at least ten carriers continued to operate in nine states studied. Premium increases during the first two years were modest, with one exception. Perhaps reflecting biased selection, the plan with the most comprehensive benefits, including high drug coverage, raised its premium 17 percent, compared with the 1 to 6 percent increases for the others.

Research to Improve Knowledge and Methods

Efficacy, Safety, and Effectiveness. Evaluating and improving the quality of care requires knowledge about the efficacy, safety, and effectiveness of health care interventions. The dearth of such information undercuts efforts to establish criteria by which to assess quality and guidelines to promote improvement. Support for government responsibility to develop this fundamental knowledge is widespread, but government funding for clinical research has not grown accordingly. The need for results from well-designed studies promises to grow if increased sensitivity to costs pressures providers to justify and improve their medical management.

Synthesis of available information is being supported in the public and private sectors, for example, by the federal Agency for Health Care Policy and Research (AHCPR) and the Cochrane Collaboration. Here

too, however, efforts have been insufficient. Some large plans sponsor their own evaluations, but the results are usually kept proprietary. The absence of systematic and open procedures has led to anxiety among consumers about the soundness of coverage decisions and to attempts, often successful, to have legislatures mandate coverage of certain benefits. One danger is that when legislatures respond to consumers' concerns, they may mandate requirements that run counter to evidence on effectiveness and safety, such as minimum lengths of stay for delivery (Gazmararian and Koplan 1996).

Methods to Assess the Quality of Care and Implement Findings. The federal government, primarily through AHCPR and its precursor agencies, has pioneered the development of methods required for valid assessments of the quality of care. AHCPR is continuing this role by funding research on methods to assess the quality of care provided for specific conditions, to risk-adjust health-related outcomes, and to use outcomes to assess health plans. Work is also required, and is underway, to clarify the sort of information consumers want and use to choose health plans and to explore timely and effective ways of making this information available. Research on methods to implement evidence-based recommendations is being supported because, even when good evidence is available about health care interventions, there is often a substantial lag before it is incorporated into medical practice.

Given the current state of quality-assessment methods, process measures validated for their relation to improved health outcomes are likely to provide the best information on the quality of care when case mix may influence outcomes (Siu et al. 1991). Evidence-based criteria drawn from rigorous studies, such as ACE inhibitors for heart failure patients, could form the basis for quality evaluations. Developing knowledge that would link health care interventions with improved outcomes typically requires large numbers of patients and well-designed trials. In data drawn from a particular plan's enrollees, the myriad other influences on health outcomes, often with greater effects, may mask those associations.

The timeliness and cost of record review pose obstacles to reliance on process measures. Over time, the adoption of computerized medical records could improve the timeliness and lower the cost of the record review. The Health Care Financing Administration (HCFA), in concert with accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and NCQA, could require its plans and providers to convert to computerized patient records as a

condition of participation or accreditation. By facilitating data collection from diverse locations, providers, and plans, such a policy has the potential to improve the validity and lower the cost of quality-of-care evaluations, and other indicators could be used as well. In the nearer term, reports from consumer surveys could provide data that experts could evaluate for quality-of-care implications.

Although it is reasonable to continue to rely on the federal government to be the primary funder of methods research, state governments and private organizations, including some health plans, have also initiated projects in these areas. In the absence of available information and methods to undergird their comparisons of health plans, employers fostered the development of the Health Employer Data and Information Set (HEDIS). This effort draws on existing methods and pioneers new ones to generate information that employer-purchasers want to compare health plans. Similarly, the Foundation for Accountability (FAACT), a coalition of purchasers and consumer organizations based in Portland, Oregon, is identifying evidence-based measures of health care quality for consumers (Skolnick 1997).

Methods to Survey Consumers. Consumer surveys can provide a wealth of valuable information to assess the quality of care. Surveys of patients' ratings of their care can provide valid information about its interpersonal aspects and about their satisfaction with ambulatory and inpatient care (U.S. Congress 1988). The validity of patients' ratings of technical aspects of care is more questionable, however. A promising strategy might be to collect patients' reports of what did and did not occur and then rely on clinicians and other experts for assessments of the quality of the technical process (Sisk et al. 1990). Consumer surveys have become more central to the timely evaluation of aspects of access that overlap quality. Their use for monitoring disenrollment, in order to ensure that plans are not pushing out high-cost enrollees, is promising and merits closer evaluation. Surveys could also provide data on enrollees' health status, to permit more valid risk adjustment of premiums.

Consistent with the importance of sound methods in this area, AHCPH is funding the Consumer Assessment of Health Plans Study (CAHPS) to develop and test a standard instrument to survey consumers about their ambulatory care (Edgman-Levitan and Cleary 1996). Researchers are reporting, however, that consumers in focus groups have difficulty interpreting indicators related to the quality of care (Hibbard and Jewett 1996). These difficulties extend to the general concept of holding plans

accountable for care and to individual indicators of quality on prevention or undesirable events.

Methods to Risk Adjust Premiums. Wherever people can choose among insurance plans and plans can market to potential enrollees, plans have a financial incentive to enroll people at low risk of incurring medical expenses and to avoid high-risk people, unless their premiums reflect risk (Luft 1995). Studies have generally found that plans that restrict enrollees' choice of providers, such as HMOs, often experience favorable selection (Hellinger 1995). These findings pertain mainly to selections when an HMO or PPO was first offered and may not hold for all enrollees or for enrollees over time.

Methods to adjust plans' premiums for enrollees' risk of incurring high costs represents another area in which the federal government has a responsibility to develop information that is required by many decision makers and whose use will safeguard health care quality. Ideally, factors used to assess risk of incurring medical costs and adjust plan premiums should be easy to measure and difficult to game (Luft and Miller 1988). Both AHCPR and HCFA have been funding research on risk-adjustment methods. HCFA's stake in having valid and feasible methods has grown with the increasing enrollment of Medicare and Medicaid beneficiaries in managed care plans. Reflecting the importance of equitable premium rates to plans, Kaiser-Permanente, for example, is also supporting such research.

Plans have a financial incentive to encourage high-cost members to disenroll if premiums do not compensate for the plans' costs of care. Even if premiums are prospectively adjusted for risk, plans will have this incentive unless there is also some retrospective adjustment based on what actually occurred during the time period of the premium. It is clearly undesirable, on grounds of equity, quality, and efficiency, for high-cost enrollees to be pushed, or even eased, out of plans. Studies of disenrollment have not been able to distinguish those situations from voluntary departure by enrollees who wished to obtain care through other plans or return to previous providers (Luft and Miller 1988).

A reasonable option in the short term would be for public and private purchasers to conduct surveys of people who switch plans in order to learn their underlying motivations and provide a firmer basis for developing policies. One ongoing study funded by the Robert Wood Johnson Foundation, for example, is analyzing survey data from University of California employees (Alpha Center 1997).

Publication of Information on the Quality of Care

Easily accessible and valid information on the quality of care is vital to safeguard quality under increased price competition. Although information on health plan options has become more available, surveys continue to find that consumers want more information about their plan and provider choices (Edgman-Levitan and Cleary 1996; Isaacs 1996). Consumers have overwhelmingly (95 percent) ranked the quality of physicians in a plan as the most important factor in their choices, out-ranking the next most important—the ability to choose one's own physician, the courtesy of the physician and staff, and the ability to choose specialists (all 82 percent) (Isaacs 1996).

A consensus, if not unanimity, has supported a role for government in ensuring that such information is publicly available. Information is often used to exemplify a good that is in everyone's interest to have but in no one's interest to finance individually. The establishment of HEDIS and FAACT indicated that at least some private employer-purchasers have concluded that there is inadequate information to compare plans' quality of care and that such information is sufficiently important to justify their developing it.

Largely because it is difficult to evaluate technical quality, some have advocated that sponsors, consumer advocacy groups, purchasing coalitions, or regional purchasers with technical experts assume this evaluative function (Enthoven and Singer 1995; Iglehart 1988). These institutions could play a larger role by comparing plans on prices and benefit coverage, as well as on quality, and making the information available to individuals during enrollment periods. It is expected that such comparative information would highlight differences and lead to choices that were more sensitive to trade-offs between price and quality.

A reasonable division of responsibility would recognize different roles within government and between government and private purchasers. As protector of the public's health, government should continue to support the development of methods to provide valid assessments and their implementation, as outlined above. Government agencies that serve as public insurers or purchasers of care have a particular responsibility for ensuring the availability of such information to beneficiaries and program managers. HCFA's requirement that Medicare managed care plans use HEDIS measures and CAHPS, and its support for sections oriented

to Medicaid, represent efforts to facilitate plan comparisons (Iglehart 1997). At the same time, private purchasers have the responsibility for making comparative information available to their insured. It is noteworthy that public and private organizations, like AHCPR, HCFA, NCQA, and FAACT, have successfully collaborated in recent years to develop methods and information.

Government and private purchasers share an interest and a responsibility in ensuring the quality of information that is reported about the quality of care. They could address this issue by requiring that data provided by plans (e.g., for HEDIS reports) be audited, or that an external organization audit records and conduct consumer surveys.

Selective Contracting and Regionalization of Services

Some public and private purchasers are using their leverage to promote better quality of care by contracting with plans and providers that have superior evaluations. Such a policy should be restricted to indicators with a strong evidentiary basis. For some services, like the performance of CABG surgery in hospitals and the delivery of high-risk babies at level III hospitals, there is good evidence that the volume or level of care is associated with better health outcomes. Quality of care is improved, and costs are probably lowered, by regionalizing such services.

A successful example is regionalization of CABG surgery and reduction of complications in New York (Chassin, Hannan, and DeBuono 1997). State regulation limited the number of hospitals performing cardiac surgery and worked with hospitals and clinicians to improve mortality rates (Chassin 1997). New York succeeded in channeling patients to higher-volume hospitals and reducing risk-adjusted mortality rates. By comparison, in California a substantially greater percentage of patients have received surgery in lower-volume hospitals

The California experience with CABG for HMO enrollees illustrates the potential for quality improvement and health benefit that results from directing patients to certain providers (Chernew, Hayward, and Scanlon 1996). There is a theoretical possibility that, over time, this policy might lead to a monopoly by a certain provider in an area. Despite regionalization, this has not occurred for open-heart surgery facilities or level III neonatal care units. If it did, bilateral negotiation between the sole supplier and a dominant buyer, like HCFA, or gov-

ernment regulation could be undertaken to maintain the health benefits and mitigate cost implications.

Payment for Physician Services

Alternative payment methods for physician services have positive and negative implications for the quality of care that must be addressed and managed (Sisk et al. 1987). Most favorable for the quality of care would be a blend of different payment methods, so that the advantage of one might offset the disadvantage of another and reward desired behavior. Salary might be linked with bonuses for achieving certain immunization levels among enrollees, like the policy of the British National Health Service. Or capitation payment could be linked with a bonus for implementing clinical guidelines. Some plans are already taking such steps. Of the managed care plans responding to a 1994 national survey, 46 percent reported adjusting payment to primary-care physicians for quality measures, 36 percent for consumer surveys, and 21 percent for enrollee turnover rates (Gold et al. 1995).

An advantage of purchasers' contracting with insurance plans is that they can hold the plans accountable for the quality of care. This approach also recognizes that an entire system, not just physicians, influences the quality of the care that is delivered and can be enlisted to improve it. The problem causing the shortfall in quality may originate outside the physician's immediate purview, or it may be more effective to address there. For example, systemwide strategies to improve immunization rates have proved to be more effective than outreach to consumers or approaches in physicians' offices. Plans could be given bonuses or penalties based on their quality-of-care performance. Such an adjustment, however, would cloud consumers' comparisons of benefits and costs among plans and the trade-offs among them.

Conclusion

Increased sensitivity by consumers to the cost of their health insurance plans does not have clear implications for the quality of care. Even the working of Adam Smith's invisible hand required that government create a favorable environment for competition and remedy any major

problems that arise. Although the conditions required to safeguard quality under increasing price competition are gaining ground, they are notable in only a handful of states. Based on the very limited information available, circumstances may have deteriorated for the growing number of uninsured people, but the quality of care appears not to have declined for others, and it may even have improved.

Increased price competition is not the only change that is occurring. Evidence about health care interventions continues to expand and challenge the ability of the health care community to incorporate the findings into medical practice. It remains to be seen what degree of trade-off between cost versus quality and other benefits proves to be acceptable to consumers and the body politic. We should not expect this to be a one-time event, but, rather, we should view it as an iterative process, where what is learned informs future policies to safeguard and improve the quality of care.

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Acknowledgment: This paper was originally prepared for the Conference on Integrated Strategies for Quality Improvement, sponsored by the Institute of Medicine's National Roundtable on Health Care Quality, and held in Airlie, Virginia, on October 30, 1997.

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