Competition on quality in managed care

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Abstract

There is intense competition between managed care organizations (MCOs) in the USA based on cost and benefit coverage, but scant attention to differences in quality. Consumer preference for ‘choice’ has stimulated the growth of overlapping networks of providers across competing MCOs. These networks have tended to perform less well on the quality indicators in report cards than staff model MCOs. Ideally one would measure individual provider performance; but the overlapping networks, and the fact that each MCO represents a small fraction of each provider’s practice, make that difficult to do. MCOs could potentially collaborate to measure individual provider performance. Financial incentives and risk-adjusted premiums might stimulate competition on quality within MCOs. It seems more likely that true competition on quality will occur between groups of providers, organized or integrated delivery systems, than between MCOs. Nevertheless, MCOs are likely to offer some quality-improving programs directly to their members, and can stimulate the competition between providers by collaborating to obtain provider-specific measurements.

Keywords: choice, competition, managed care, quality

There is an extraordinary degree of competition in managed care in the USA; however, the competition is primarily about insurance premium cost and benefit coverage. Much of the competition has been stimulated by employers, who are the major purchasers of health insurance for employed persons and their dependents. Some employers want an array of insurance products to offer to their employees, e.g. closed network health maintenance organizations (HMOs), point-of-service and preferred provider organization plans, with a variety of copayment or coinsurance structures. Others simply want to minimize cost, and competition among managed care companies has been credited with moderating local and national health care costs in the USA over the past several years. Furthermore, at any point in time, some managed care company in a competitive market may be interested in ‘buying business’ and will offer an exceptionally low price to an employer-purchaser. Other competitors may follow suit in an attempt to retain the employer as a customer. This leads to a price war; and local price wars have been common, as might be expected in a highly competitive market.

Unfortunately, while many employers say that assuring quality is very important in health plan selection [1], relatively few employers act as if they believe there are differences in quality between managed care plans. Fewer still appear willing to pay a premium for higher quality. To a great extent, the employers who are driving the competition on cost and coverage, appear to reflect the views of their employees about quality. Population surveys indicate that the American public feels that quality is an extremely important attribute of their health care; indeed that it is the most important attribute. The public, however, appears to define quality in a different way from medical and health care professionals. Most consumers act as if they believe that the health care they receive, especially if they are unfettered in the choice of health care professional, will be assuredly excellent. Consumers define quality directly in relation to attributes such as their ability to choose their health care providers, their ease in getting an appointment to see the provider of their choice, and whether the relationships they establish with those providers are satisfactory or not.

Health Plan Employer Data and Information Set

Despite the general trend, some employers have demonstrated an interest in technical aspects of quality of care. These have tended to be large employers; and several years ago a few of them joined together with an organization called the HMO Group to develop the collection of measures of managed care organization (MCO) performance called HEDIS (Health Plan Employer Data and Information Set). The HEDIS measures were designed to encompass several domains of MCO performance, including quality, access and satisfaction, membership and utilization, and finance [2]. The initial instrument, HEDIS 1.0, was never used for cross-MCO...
to attract the attention of the physician to a particular MCO's practice by an MCO are potentially related to the ability of MCOs to manage technical aspects of quality of care. In this regard, the relationships between network characteristics and quality are crucial.

In most urban managed care markets, the importance of choice to the consumer has led to the proliferation of network model managed care organizations. These organizations contract with large numbers of physicians, so that there is a high probability that each consumer's physician is included in the network. Obviously, when there is more than one network model MCO in the market area, each MCO is going to try to sign up the same physicians. The physicians, who are usually not bound exclusively to any one MCO, are going to have contracts with several MCOs. Thus, the larger the number of MCOs in an area and the more competitive the marketplace, the smaller the proportion of any single physician's practice that is likely to consist of members of a specific MCO. We shall discuss the implications of this organizational structure of overlapping delivery systems below.

Staff model HMOs (in which the physicians are employed directly by an MCO) or group model HMOs (in which the physicians are in an independently incorporated group which has an exclusive contractual arrangement with an MCO) account for a small proportion of the MCOs in the USA. In each of these, the number of physicians is relatively small compared with that in a network and the penetration of the physicians' practices by the MCO's members is close to 100%.

The New England HEDIS Coalition, a regional coalition of purchasers and MCOs, has issued three annual comparative reports on HEDIS quality indicators. In each instance, the staff and group model MCOs have, on average, had higher scores than the network model MCOs. Furthermore, within a mixed model MCO, such as Harvard Pilgrim Health Care, the staff model components of the organization have consistently had higher scores than the network.

One factor which probably contributes to these results is that staff/group model MCOs were the original HMOs, or health maintenance organizations. They took the notion of prevention seriously. Their benefits included coverage for preventive services long before most insurance plans were accepted by individual physicians. Several of the HEDIS quality indicators measure preventive services, e.g. childhood immunization, screening for breast and cervical cancer, and diabetic retinal examination, and so it is not surprising that the staff/group model MCOs have, on average, performed better on these indicators. In addition, staff/group model MCOs are more cohesive organizations than network model MCOs. They truly are an organized delivery system. It is relatively easy to implement quality management programs within these group practices; and this probably explains why their better performance is not entirely limited to improving the quality indicators have not necessarily been measured, or measured widely, the latest versions of HEDIS include some test measures – measures which are being refined for possible widespread use.

Despite the fact that report cards have made available important measurements of MCO performance, these measurements usually do not reach the level of the individual provider. Many employers are now adopting the position of consumers in that they see the individual provider or medical group as the locus for quality. They would like to see more provider-based measures of performance and to be assured that plan networks include a broad representation of high quality providers. This would put in the hands of the consumers the responsibility to act on provider-based performance measures in choosing their physician, hospital, etc. and would be a desirable response to the public's wants and needs. Unfortunately, the paucity of publicly available, reliable measures of provider performance, makes it an as yet unattained objective.

Relationships between network characteristics and quality

In most urban managed care markets, the importance of choice to the consumer has led to the proliferation of network model managed care organizations. These organizations contract with large numbers of physicians, so that there is a high probability that each consumer's physician is included in the network. Obviously, when there is more than one network model MCO in the market area, each MCO is going to try to sign up the same physicians. The physicians, who are usually not bound exclusively to any one MCO, are going to have contracts with several MCOs. Thus, the larger the number of MCOs in an area and the more competitive the marketplace, the smaller the proportion of any single physician's practice that is likely to consist of members of a specific MCO. We shall discuss the implications of this organizational structure of overlapping delivery systems below.
of children who are 18 months of age, distribute them to
the medical assistants in its pediatric or family practices,
instruct them on how to review the medical record to ascertain
whether the child has been fully immunized, and provide
them with explicit instructions on how to do outreach to the
families of children who are missing one or more rec-
ommended immunizations. In some instances it can go
further, by linking automated reminders to its clinical in-
formation systems; e.g. appointment systems, or even com-
puterized medical records systems. The staff model MCO
has enormous control of the processes and the personnel,
who are its employees. In contrast, in a network, an MCO
could generate lists of 18 month old children and distribute
them to the physicians; but they would represent only a
fraction of the physicians' practices. The MCO could offer
training sessions to the physicians' office staff; but as neither
the physician nor the staff members are employees, they are
not likely to come to the training without some incentive
(possibly financial). The MCO could also give advice to the
physicians and their office staff on how to set up better
reminder and outreach systems in their offices; but once
again the MCO has little control over implementation or
maintenance of these systems.

Although quality indicator measurements such as the
HEDIS results usually favor staff/group model MCOs, sur-
veys of members and employers usually show that they rate
network model MCOs higher on 'quality of care'. As stated
above, it is likely that these higher ratings for network model
MCOs reflect their greater choice of physician and a different
interpretation of quality of care by the general public vs.
health care professionals.

Implications of overlapping physician
networks

Another issue which arises when there are several competing
MCOs in a market area with essentially the same network of
physicians, is whether they truly can differ in quality? Most
medical care is determined or delivered by a clinician working
with the patient behind a closed office door, and it is likely
that the same decisions will be made by the physician for
members of competing MCOs. Accordingly, to the extent
that the networks of competing MCOs overlap, one would
expect similar processes, outcomes and scores for the MCOs
in the area. National HEDIS data demonstrate regional differences in average scores on quality indicators, and within
some regions (such as New England and the Pacific) where
there is a lot of overlap of the networks, there is clustering
of the scores around the regional average.

How can one encourage improved levels of performance,
either by an MCO or across a region with multiple MCOs?
One way might be to encourage collaboration rather than
competition among the MCOs. Purchasers or regulators, who
deal with multiple MCOs, might convene the MCOs and
inspire them to work together to improve quality. Since
measurement is a critical component and driver of quality
improvement, it is not surprising that in order to stimulate
competition among MCOs on quality, it was a necessary first
step to get collaboration between them to provide information
about quality indicators, e.g. the development and im-
plementation of HEDIS. But, purchasers or regulators might
consider fostering further and more extensive collaboration.
For instance, despite the fact that measurement of individual
physician performance is highly desirable, it is difficult and
expensive. Furthermore, if an MCO has as its members only
a small percentage of a physician's practice, then there are
likely to be very small numbers of persons meeting the
requirement for inclusion in the denominator of the measure.
The MCO has no legal basis for obtaining information on
the persons in the practice who are not its members. Thus,
to bring measurement down to the individual practice level,
it is important to consider collaboration.

It is likely that in the future third partyurers will
evaluate quality indicators in individual practices, either by
going to those practices directly on behalf of several MCOs
and reviewing records or by analyzing pooled administrative
data from several MCOs. The overall results could be returned
to each MCO, which then would have several options for
working to improve quality — individually or collectively.
Currently there are attempts to do this in Minnesota and
California, and the effort is beginning to be organized in
Iowa and Massachusetts. One potential problem with this
approach is legislation in Minnesota which requires that the
individual person give explicit informed consent to providing
each item of information to the third-party measurer when
the measurement can be considered to be research [4]. Thus
far, consent has been obtained from only a small percentage
of Minnesota residents from whom it has been requested.
Should this continue to be the case and should such legislation
become commonplace, it would severely hamper efforts
to develop new or better measures of individual provider
performance. The public, in its fear of breaches in con-
fidentiality of the data, would deny itself the information on
individual providers necessary for making informed choices.

A variation of the approach of pooling information is
occurring currently in Massachusetts. Through the Mas-
sachusetts Health Quality Partnership, four major MCOs,
the agency which provides medical benefits to the State's
welfare population, and other key stakeholders, have joined
forces to encourage acute care hospitals to participate in
measuring patient experiences. They are using standardized
tools developed by the Picker Institute and the Maryland
Quality Indicator Project. Their ultimate objective is to en-
courage each hospital to focus improvement efforts on its
top priority areas. The same collaborators are now considering
involving nursing homes in a similar initiative.

Interestingly, in many states, there has been legislation
requiring MCOs to accept into its network any willing provider
who meets a set of criteria that the MCO must predetermine.
Arguments that such a practice would make it more difficult
for the MCO to manage quality of care have had little
acceptance among legislators. One can wonder whether many
colleges or medical schools would be able to function, or
function at their current level of quality, if they had to accept
any applicant who met a predetermined criteria set. It is well known that many excellent institutions have many more qualified applicants than they can accept if the character of the institution is to be maintained.

So, one can wonder what strategies are available to an MCO or group of MCOs who have a competitive drive to improve quality but have also chosen to have, or must include, any willing provider? One possibility is for the MCO to work directly with its members. This has two effects: First, although the MCO is likely to inform the physician of its plans and actions, the MCO will not need each individual physician to cooperate actively in reaching the member. Secondly, to the extent that one MCO has a program to outreach to its members and others do not, it may be able to establish a competitive advantage.

Some examples of this approach are in order. A simple one is to stimulate mammography screening an MCO can identify women in the recommended age bracket from its enrollment files. Then, from its claims database, it can determine which women have not had a test within the recommended screening period and generate a direct invitation to the member to be screened. It can even direct the location of the screening, which may improve its cost competitiveness. Using this approach, Harvard Pilgrim Health Care has achieved a mammography screening rate in its network which is slightly higher than that of its staff/group models. Another, more complex example, is that of trying to get each network physician to develop standardized treatment plans for asthmatic members, the MCO can set up a centralized asthma management program. Using its claims database, the MCO can identify asthmatics. It can have a nurse clinician contact the member and offer one-on-one counseling. It can advise the member on when it is appropriate to see the physician for further evaluation or treatment; it can offer the member an opportunity to attend group teaching sessions; and, it can provide information back to the individual physician on what the MCO is doing with the member. If devised carefully, ideally with input from practicing physician’s, such programs can be seen as an aid to the physician rather than meddling by the MCO. Thus, in the absence of collaboration among MCOs, an individual MCO can develop programs which are designed to improve quality of care for the member and carry the brand of the MCO.

Deterrents to competition for quality among MCOs

There are a number of deterrents to competition for improvement of quality of care among MCOs.

Kerr et al. [5] have shown that capitated physician groups are most likely to work on quality improvement projects/processes that also decrease cost. This is hardly surprising in a cost-driven industry and is likely to apply to MCOs and not only to capitated physician groups. In the current environment, if a quality improvement project is likely to increase costs, it is not likely to be undertaken voluntarily. What may be less obvious is that there is also reluctance on the part of MCOs to undertake quality improvement efforts which do have long-term, but not short-term, returns on investment. For-profit MCOs have to keep an eye on the quarterly financial statements, and even not-for-profit MCOs have to keep an eye on the annual financial statements. In the highly cost-competitive environment that currently exists in the USA, it is difficult for any MCO to budget a substantial expenditure for a quality enhancing program that will not begin to yield returns until the second or third year.

Another deterrent to competition for improvement of quality of care is the fear of adverse selection. Health insurance premiums are, at best, crudely adjusted for health risk. Thus, the MCO that develops an outstanding program for the management of HIV disease is likely to attract a high risk population for which it will receive average premiums. Not surprisingly, when capitated Medicare programs began to proliferate in MCOs, stories began to circulate through the industry about how various MCOs were attempting to attract low risk populations, i.e. the healthy elderly. Recently, the United States Health Care Financing Administration (HCFA), which runs the Medicare program, has been examining ways to risk-adjust premium payments to MCOs. This would, if well done, take away the disincentive that currently exists for MCOs to attract the frail elderly and should lead MCOs to develop programs for providing more effective care for these chronically ill persons.

A less obvious, but real, deterrent to improvement of quality by MCOs is that the standard financial arrangements between physicians and MCOs do not support a significant volume of quality improvement activities. Physicians are used to one of two basic compensation schemes from MCOs — either capitation or discounted fee-for-service, the latter of which is much more common. An MCO which is both trying to control/compete on costs and give a physician an incentive to improve quality would have to reserve some portion of a physicians expected level of compensation and pay it out on the basis of quality-related performance. The physician is unlikely to favor such an arrangement, and the MCOs which did not hold back any of the expected compensation would have a competitive advantage with the physician. Conversely, the MCO which offers the physician a bonus above expected compensation on the basis of quality-related performance would be likely to have a higher cost structure than those MCOs which did not offer the bonus. Its premiums would be higher than its competitors, and it would have a disadvantage in a competitive marketplace primarily driven by premium cost.

Although it may be a bit easier to build in financial incentives related to quality in capitation arrangements than in discounted fee-for-service payments, all of these schemes suffer from two problems: first, the amount of money involved usually is small, especially if only a small percentage of the physician’s overall practice consists of members of a single MCO; secondly, financial incentives usually have to be tied to specific performance indicators. The greater the number of indicators one wants to improve, the more money that has to be allocated; or if the total amount of money is
kept constant, the less the incentive for improving any single indicator.

**Current state of quality in managed care and outlook for the future**

There have been a number of studies over the years comparing the performance of MCOs with indemnity insurance/fee-for-service care. These have been compiled and summarized in two time periods by Miller and Luft [6,7]. The results are mixed. In their analysis of literature published between 1980 and 1994, the results for MCOs were better than or equal to the results for fee-for-service plans on 14 out of 17 quality of care measures [6]. In their review of studies published between late 1993 and early 1997 [7], Miller and Luft found approximately equal numbers showing better and poorer results for MCOs. They also found several studies in which elderly MCO members with chronic conditions appeared to fare less well. They attributed the lack of improved overall quality among MCO members to ‘slow clinical practice change, lack of risk-adjusted capitation rates, and inadequate quality measurement and reporting’.

Recognizing that the health care marketplace in the USA, rightly or not, has been shaped by concerns about cost not quality, it is less important what MCOs have done in the past about quality than what they might do in the future. Several possibilities are open. As we have previously noted, HCFA, a major purchaser of care, is working on risk-adjusted capitation methodologies, which addresses one of Miller and Luft’s concerns. Collaboration among MCOs, probably promoted by purchasers or regulators, could lead to progressive improvement of quality measurement and reporting.

Some observers of managed care in the USA believe that local markets will move towards the emergence of a few highly integrated delivery systems which will compete against each other on quality. Though a few markets, e.g. Albuquerque, New Mexico, have developed along these lines, we doubt that most markets that currently consist of broad, overlapping networks will become so differentiated. What seems more plausible is that MCOs having extensive overlapping networks will, if cost and coverage become relatively standardized, try to avoid being perceived as commodities by competing primarily on service to members and purchasers. There is also an opportunity for MCOs to compete in the future on the basis of a few branded quality programs. Theoretically, these programs could be directed by the MCO towards network providers and could be designed to win the loyalty of these providers. It is debatable, however, whether an MCO could win sufficient loyalty because of its service or quality programs for providers to overcome a differential in payment to providers. Thus, the MCO which tries to win provider loyalty with programs must also be extremely cost efficient. Branded quality programs, such as the asthma example above, are more likely to be targeted by the MCO directly to the member.

It is possible that MCOs, in an attempt to differentiate themselves from others with similar networks, might try to distinguish certain parts of their networks in the minds of their customers. Up to now MCOs have not made significant efforts to enhance the public’s knowledge of differences between component delivery systems within their networks. Indeed, they usually try to present themselves as a homogeneous entity or single delivery system, rather than the heterogeneous entities they actually are. In contrast, in the Minneapolis marketplace, one MCO has been trying to portray itself as an agent which offers a portfolio of delivery systems with different price and quality attributes. In short, the MCO is stimulating internal competition on price and quality among its component delivery systems. It is not yet certain that this effort will succeed or become a model for other MCOs.

Will MCOs in the future compete voluntarily on quality in a serious way? MCOs certainly could be a significant force for improvement of quality of care either directly, or by stimulating improved quality from the delivery systems with which they contract. Whether MCOs will actually do so depends on whether the general public becomes engaged with the following ideas: (i) quality of care is not just about choice of provider; (ii) quality of care can be improved over its present state; and (iii) MCOs can play a significant role in improving quality of care. Right now, the public appears to be uninterested in aspects of quality other than choice, and the public has definitely not been impressed by quality indicators such as HEDIS. The public may think that quality needs to be improved because it seems to believe, erroneously, that quality of care used to be better than it is today [8]. There is little evidence, however, that the public believes that MCOs are likely to improve care or are even capable of doing so. Indeed, for those interested in technical aspects of quality of care, the marketplace seems perverse, because the public has driven it towards the overlapping networks which are the most difficult environment in which to improve quality.

Finally, there is the possibility, as always, that the market is not perverse, but right. Cost has been a major problem for health care in the USA, and the trend in health care delivery there over the past several years has been towards a more cost-efficient system which still preserves what the public appears to value most — choice. Perhaps it is too much to expect that competition among MCOs, in addition to managing cost, will be the principal mechanism for managing and improving quality of care. The public does not perceive the MCO as the principal locus for managing quality. Rather it sees the provider as the locus. That idea is correct. Individual providers and organized groups of providers have more direct control over quality of care than do MCOs.

As noted before, provider level quality measures would be an important response to the public’s perceptions and needs. These measures can either be developed through collaboration of network MCOs or by the organized/integrated delivery systems that are likely to make up the overlapping networks of the future. If these delivery systems continue to have an excess supply of providers, the providers will be stimulated to compete with each other, not by the MCOs per se, but by their own need to attract patients within the MCOs. As the
health care system becomes more organized and as better information systems become available, it may be possible to build on this infrastructure and develop robust competition on quality. This competition, organized by delivery system, not by MCO, should bring the public the improved health care it deserves, while the MCO brings the public the cost and coverage options it also needs. For now, the MCO can play the role of “prudent purchaser” by stimulating competition on quality among network providers, because only the MCOs have access to comparative performance data across the delivery systems within their networks.

References