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for
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STATEMENT SUMMARY

Despite the success attributed to managed care in slowing the increases in medical care costs, managed care has come under intense scrutiny. Physicians, consumer advocates, and some policymakers believe that some of managed care's success in controlling costs has been achieved by denying necessary medical services. However, employers and managed care organizations argue that managed care has eliminated much of the wasteful spending in the health care market while still maintaining the quality of the care provided. In fact, the research thus far shows that managed care plans as a whole provide quality of care equal to that provided in fee-for-service plans.

Once the discussion of health care turns to quality, a question arises concerning what quality is in the health care market. Quality is a multidimensional concept. Even though individuals may agree on its components, they may disagree on their relative importance.

Some individuals equate access with quality. Others would include in their definition of quality how respectfully their providers deal with them, to develop a consumer satisfaction definition of quality. However, an individual's satisfaction may not directly correlate with receiving the most appropriate care for a diagnosis or even a proper diagnosis. Consequently, the outcome of care is widely believed to be an indicator of quality in health care. A high quality episode of health treatment would then involve being treated under the method that restores the individual's health in the shortest amount of time at the lowest level of risk. Even under this definition, there is no clear way to measure quality because different individuals respond to treatments in very different ways. Thus, it is difficult to agree on one definition of quality that fits all circumstances, which makes measuring quality all the more complex.

Studies that attempt to measure quality can be classified into three categories: structure, process, and outcomes. Because quality has many dimensions, a complete measure of quality cannot fall into just one of these dimensions but needs to include all three. A measure of quality based on structure is not worthwhile if it cannot be shown to lead to good outcomes, while an outcome measure is not complete if the process that was used to achieve the outcome is unknown. Consequently, in order to get a clear picture of the quality of health care provided, a measure must evaluate all three dimensions.

Progress has been made toward the goal of measuring the quality of care provided in managed care plans. The Health Plan Employer Data and Information Set (HEDIS) has continued to be refined by the National Committee for Quality Assurance (NCQA) for the purpose of providing multidimensional report card on these plans' quality. HEDIS allows purchasers of health plans to compare managed care plans that are included in this report card. Currently, HEDIS focuses on structure and process measures of quality. However, as advances in outcome measures have been made, HEDIS has expanded its reliance on outcome measures. A significant drawback to HEDIS type-report card measures of quality is that they lead plans or providers to focus resources on the factors that are measured, diverting resources from those that are not measured. Consequently, any report card of this type must balance comprehensiveness against understandability, so that purchasers get an accurate depiction of the quality a certain plan provides in a manner that is easy to understand.

The quality of managed care plans relative to fee-for-service plans has not been demonstrated to be uniformly different in either a positive or a negative way. Thus, HMOs are not low or high providers of quality per se but range from good to poor, with strengths and weaknesses in the care of particular diseases. Therefore, quality measures are needed to evaluate individual health plans for various diseases and conditions rather than for broadly defined categories.

Regulations and mandates for "consumer protections" are not a guarantor of increased quality in the health care market, unless quality is defined as easier access for those with health insurance. However, if quality is defined as successful outcomes of health services provided, the effect of these regulations on quality is in need of further research. However, the regulations will have some impact on the costs of health benefits and insurance. The impact has been estimated to be relatively small to substantial, depending on the interpretation of the mandates and the assumptions derived from that interpretation. Consequently, as studies show, even a small increase in the costs of health insurance could lead to a sizable number of individuals without health insurance, especially employees of small businesses.

STATEMENT

Introduction

In the last decade, substantial changes have occurred in the health care market. Many of these changes were prompted by employers who were no longer able or willing to accept the relatively large annual increases in medical care costs that occurred during the late 1980s and early 1990s. The fee-for-service system of reimbursing health care providers was one of the causes attributed to these substantial increases.¹ Under this system, providers were reimbursed retrospectively for the services they performed. Thus, providers did not have economic incentives to control costs or to perform only services for which the benefits outweighed the costs or risks. In addition, the fee-for-service system tended to focus on the treatment of illnesses as opposed to their prevention. As employers searched for methods to reduce annual health care cost increases to a manageable level, they turned to managed care as their vehicle for providing health benefits to their employees. They embraced managed care because this system provides financial incentives to control costs, e.g., payments to providers are structured to reward an efficient level of care such as a capitated payment (a fixed fee to cover all services provided), salaries, and bonuses. Furthermore, managed care organizations (MCOs) have developed guidelines for the treatment of various illnesses to promote more efficient care. These incentives and guidelines, designed to reduce expenditures for unnecessary utilization, have been the primary factors in the success attributed to managed care. This system in turn has led to significantly smaller increases in medical care costs in recent years. Today, managed care plans have become the overwhelmingly dominant type of health care coverage for the nonelderly population because of their success in controlling costs.

Despite its success in slowing increases in medical care costs, managed care has come under intense scrutiny. Physicians, consumer advocates, and some policymakers believe that part of managed care's success in controlling costs has been achieved by denying necessary medical services. In addition, many consumer advocates contend that employers and health plans are more concerned with reducing costs than with increasing the quality of care provided. Consequently, policymakers have responded by introducing numerous legislative proposals at both the state and federal level to regulate the operation of managed care plans. However, employers and MCOs argue that managed care has maintained health care quality while eliminating much of the wasteful spending in the health care market. In fact, the research thus far shows that managed care plans, as a whole, provide quality of care equal to that provided in fee-for-service plans.² Furthermore, employers contend that managed care's success in reducing costs has allowed them to continue to provide health benefits for their employees. Yet, due to managed care opponents' doubts about the quality the system provides, many employers require that managed care plans prove they provide high quality health care. These demands have focused a great deal of attention in the marketplace on the development of quality measures that both employers and consumers will find easy to understand.

This statement looks at quality in the health care market as well as the potential effects of regulations ("consumer protections") on health plans in terms of costs and the number of uninsured. In addition, it discusses the impact of these various regulations on quality in the health care market.

Quality³

The perception that health care costs are under control and/or the belief that MCOs reduce costs by denying necessary care has led many health care market observers to question the quality these organizations provide. However, once the discussion of health care turns to quality, a question arises about what defines superior quality in the health care market. Quality is a multidimensional concept. Thus, even though individuals may agree on the components, they may not agree on their relative importance. Therefore, analysts disagree not only on how to measure quality but also on how it is defined. Consequently, policy decisions on health care quality should be based on an evaluation of a particular law's actual effect as opposed to its stated goal or intent. This distinction is important because a law that addresses access or consumer rights does not necessarily address the quality of care a consumer receives. Ultimately, whether a law truly addresses quality will depend in large part on an individual's subjective opinion of what quality entails.

Defining Quality

Some individuals equate access with quality. If they can choose freely among providers, they believe they are receiving quality health care. However, these consumers may not choose the providers who can treat them most effectively, whereas a managed care plan may provide an incentive for the consumer to use providers who are most qualified to treat them. However, the reverse situation could also occur. Other individuals would include in their definition of quality how respectfully their providers deal with them. Here again, an individual's satisfaction may not directly correlate with receiving the most appropriate care

for a diagnosis or even a proper diagnosis. Consequently, the outcome of people's care is widely believed to be the best indicator of quality. A high-quality episode of health treatment would then involve being treated according to a method that restores the individual's health in the shortest amount of time at the lowest level of risk. Even under this definition, there is no clear way to measure quality because different individuals respond to treatments in very different ways. Thus, it is difficult to agree on one definition of quality that fits all circumstances. This in turn makes measuring quality even more complex.

Measuring Quality

Studies that attempt to measure quality can be classified into three categories: (1) structure, (2) process, and (3) outcomes.⁴ Structure studies examine the characteristics of the providers or institutions of care such as providers' credentials or hospitals' teaching status. In process studies, the methods that providers use to make treatment decisions are evaluated through, for instance, the investigation of the use of specific protocols or a treatment's appropriateness. Outcome analysis measures the patient's resulting health status or patient satisfaction. However, a complete measure of quality must evaluate all three of these dimensions. A measure of quality based on structure is not worthwhile if it cannot be shown to lead to superior outcomes, while an outcome measure is not complete if the process that was used to achieve the outcome is unknown.

Progress is being made in measuring the quality of care provided in managed care plans. The Health Plan Employer Data and Information Set (HEDIS) has continued to be refined by the National Committee for Quality Assurance (NCQA) to furnish a more multidimensional report card on the quality of care provided by managed care plans. HEDIS allows purchasers of health plans to compare managed care plans that are included in this report card of quality. Currently, HEDIS focuses on structure and process measures of quality. However, as advances in outcome measures have been made, HEDIS has expanded its reliance on outcome measures. These advances are difficult because a large number of factors can affect the outcome of a health care treatment, and there is a need to control for all of the factors that could affect a measure when it is compared across plans or providers. A significant drawback to HEDIS-type report card measures of quality is that they lead plans or providers to focus resources on the factors that are measured, diverting resources from factors that are not measured. Consequently, any report card of this type must balance comprehensiveness against understandability, so that purchasers get an accurate depiction of the quality a certain plan provides in a manner that is easy to understand.

Quality of Managed Care Plans

To date, a comparison of the quality of managed care plans relative to fee-for-service plans has not produced evidence that these two plan types are uniformly different in either a positive or a negative way. A review by Miller and Luft⁵ of various studies comparing the quality of HMOs versus fee-for-service plans points out, "HMOs produce better, the same, and worse quality of care, depending on the particular organization and particular disease." Thus, HMOs are not providers of high or low quality per se but range from good to poor, with strengths and weaknesses in the care of particular diseases.⁶ Therefore, measures of quality are needed to evaluate individual health plans in terms of various diseases and conditions rather than more broadly defined categories.

It is important to note that the current debate on the quality of care in the health care market is not new to the present managed care era. As Millenson⁷ points out, *The New York Times* ran features on the failings of doctors and hospitals in the United States in 1976, and a 1982 President's Commission report concluded that as much as 35 percent of some high-tech hospital care was unnecessary. Thus, Millenson concludes that "deep public dissatisfaction with unfettered doctor and hospital autonomy led to the explosive growth in managed care in the first place."

Quality and Regulations of Health Plans

Proponents of the various regulations of health plans argue that these regulations will increase the quality of health care. However, if these regulations are to be truly considered quality of care measures, they should guarantee that health care consumers will receive a higher quality of health care. The regulations might lower obstacles to access to certain types of care that insured individuals may or may not need. They might also increase insured individuals' satisfaction. In addition, providers of health care would gain protections from various techniques that some MCOs use to limit the way providers practice medicine. Yet, the regulations would do very little to ensure improvement in the outcomes of health care treatments administered by medical providers. Therefore, policymakers need to thoroughly understand the effects of these regulations on the health care market.

Access, consumer satisfaction, and provider protections are important components of the health care market, but improvements in these components would not necessarily improve the overall quality of health care. However, they would increase costs, which could have serious consequences in terms of the number of uninsured individuals. Although estimates of the impact of the cost increases on the number of uninsured

have not been developed for most of these consumer “rights” issues, the Congressional Budget Office (CBO) estimated that for a mental health parity amendment in H.R. 3103 (introduced in 1996) a 4 percent increase in health insurance premiums would lead to 800,000 fewer people having health insurance.⁸ In a general analysis of increases in health insurance premiums for employers, The Lewin Group estimates that a one percent increase in employer premiums would lead to an additional 400,000 individuals being uninsured. Thus, if the regulation of health plans has even a relatively small impact on costs, a significant number of people could potentially lose health insurance coverage. Access could be reduced for some in order to increase the satisfaction of those who still have insurance. In addition, health plans and their sponsors contend that these regulations would reduce quality, because plans and sponsors would have limited ability to steer patients to higher quality providers and to enforce protocols for treating various diseases that have proven to be the most effective methods for treating these diseases.

Regulations of Health Care Plans

Managed care’s new dominance in the health care market has changed the organization, financing, and delivery of health care. These changes have prompted discussion of the potential need for additional consumer protections or rights within this new structure. Health care consumers are worried about any restrictions on their access to physicians and to various forms of care (e.g., emergency room care, experimental treatments) and about their ability to dispute denied claims or services. In addition, potential limitations on providers, such as so-called “gag rules” and network participation rules, have also come under scrutiny, because they have the potential to undermine the physician/patient relationship.

In response to real or perceived negative reactions to managed care, state lawmakers have proposed and passed many laws or imposed regulations that claim to provide protections for managed care plan participants and to increase the quality of care. These measures are commonly referred to as anti-managed-care legislation by the managed care industry, because they would limit or forbid certain activities that are thought to be used by managed care plans while forcing the plans to perform other new or additional activities. State lawmakers introduced over 1,000 bills relating to health plans by mid-year 1997, of which 20 percent were enacted.⁹ Federal lawmakers have also introduced legislation in this area, using either single-issue proposals or comprehensive packages such as the Patient Access to Responsible Care Act (PARCA) (S. 644/H.R. 1415) introduced by Rep. Charles Norwood (R-GA) and Sen. Alfonse D’Amato (R-NY).

Discussion of Regulations of Health Plans

Consumer advocates and some policymakers believe that more regulation and increased liability exposure would increase the quality of care health plans provide. In addition, these groups contend that mandating patients’ right to have coverage for the services of any physician they choose would also enhance quality of care. They maintain this opinion because legislation in these areas would greatly reduce any existing barriers to the physician/patient relationship. However, plan sponsors and health plans contend that these measures would increase costs and thus reduce the ability of employers and unions to provide health benefits as well as individuals’ ability to afford employer-sponsored health coverage. Consequently, more individuals would become uninsured. Furthermore, health plans argue that an increase in mandates would reduce individuals’ choices among plan types. Under the proposed mandates, individuals who may not want a certain benefit would be forced to pay for it if they choose to have any coverage. The same idea would hold true for plan sponsors in their decisions to offer health benefits.

Regulations and mandates for “consumer protections” are not a guarantor of increased quality in the health care market, unless quality is defined as easier access for those with health insurance. However, if quality is defined as successful outcomes resulting from health services provided, these regulations’ effect on quality is in need of further research. The regulations would have some impact on the costs of health benefits and insurance. This impact has been estimated to be relatively small to substantial, depending on the interpretation of the mandates and the assumptions based on that interpretation.¹⁰ Despite the wide range of estimates, any increases in the cost of health benefits could have serious implications for the likelihood of small businesses offering health benefits. Feldman et al.¹¹ estimated that in the state of Minnesota, a \$1 increase in monthly premiums would lead to an approximate decrease of 0.017 in the proportion of small establishments (with fewer than 50 employees) offering health insurance. Consequently, if these regulations raise the costs of health insurance significantly, a potentially sizable number of individuals could be without health insurance, especially employees of small businesses.

Conclusion

The health care market has undergone significant change in the last decade. One of the most significant changes has been the huge shift from fee-for-service to managed care for health care coverage. This change was precipitated by the tremendous increases in health care costs. During the shift to managed care, health cost increases have abated. As costs appeared to be under control, many observers began questioning the

quality that was being provided under this new system of managed care. Some have suggested that managed care has brought costs under control by denying necessary care. This belief has led to a tremendous push by consumer advocates for the regulation of MCOs to ensure quality.

The regulations that have been introduced can just as easily be categorized as access measures or provider protections as they can be categorized as quality measures. The determination of whether the regulations discussed in this report actually improve the quality of health care provided depends on one's definition of quality. If a definition only addresses access and consumer satisfaction, these regulations might provide some improvement in quality.¹² However, if the definition of quality refers to the outcome of a health care treatment, these regulations are of questionable value. While they do address consumer rights, it is debatable whether these rights are necessary considering the expense they add to the provision of health care coverage.¹³

While these regulations' effect on quality depends on one's definition of quality, the effect on costs is clear regardless of the definition of quality—an increase. As stated before, any increases in costs will almost certainly increase the number of uninsured. Consequently, these regulations would come at price. Thus, the choice is between regulation that would increase access and consumer “rights” but would be of questionable value in relation to the quality of outcomes versus allowing market forces to improve quality through experimentation. Recent experimentation has led to some competition on quality through the use of such quality indicators as HEDIS, but the level of the quality of care provided still remains a hotly debated topic.

Endnotes

¹ The tremendous growth in technological innovations in health care is another important cause attributed to the increases in medical care costs.

² Robert H. Miller, and Harold S. Luft, “Does Managed Care Lead to Better or Worse Quality of Care,” *Health Affairs* (September/October, 1997): 7-25; and Robert H. Miller and Harold S. Luft, “Managed Care Plan Performance Since 1980: A Literature Analysis,” *Journal of the American Medical Association* (May 18, 1994): 1512-1519.

³ For a more thorough discussion of quality in the health care market, see William Custer, “Measuring the Quality of Health Care,” *EBRI Issue Brief* no. 159 (Employee Benefit Research Institute, March 1995). This section draws from that report.

⁴ Avedis Donabedian, “The Quality of Care: How Can It be Assessed?,” *Journal of the American Medical Association* (September 23-30, 1988): 1743-1748.

⁵ Miller and Luft, *Health Affairs*, 1997.

⁶ There appears to be some limited evidence that HMOs provide lower quality of care for chronic physical conditions. However, this has not been universally demonstrated (Miller and Luft, *Health Affairs*, 1997).

⁷ Michael L. Millenson, “Beyond the Managed Care Backlash: Medicine in the Information Age,” Health Priorities Project Policy Report No. 1 (Washington, DC: Progressive Policy Institute, July 1997).

⁸ The CBO has subsequently cautioned that this estimate cannot be generalized to all mandates on health insurance, because people may place different values on other mandates, which would affect the number of employers continuing to offer health insurance and the number of people taking it up.

⁹ “1998 Industry Outlook: Quality,” *Healthcare Trends Report* (January 1998).

¹⁰ Millman & Robertson conducted an analysis of PARCA, which contains many of these regulations, for Wal-Mart and determined that health insurance premiums would increase between 7 percent and 39 percent. However, they did not examine the health plan liability issue. Muse & Associates also examined PARCA in a study funded by members of the Patient Access to Responsible Care Alliance and determined that health insurance premiums would increase between 0.7 percent and 2.6 percent.

¹¹ Roger Feldman, Bryan Dowd, Scott Leitz, and Lynn A. Blewett. “The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance,” *Journal of Human Resources* (Fall 1997): 635-658.

¹² In Miller and Luft's (*JAMA*, 1994) review of managed care quality studies, they found that HMO enrollees were generally satisfied with their care. However, HMO enrollees appear to be less satisfied with the quality of their care relative to fee-for-service plan enrollees. Yet, in terms of satisfaction with financial aspects of the plan, HMO enrollees were more satisfied than fee-for-service plan enrollees. Thus, some patients appear to be willing to trade some quality satisfaction for lower costs.

¹³ A survey by the Kaiser Family Foundation and Harvard University found overwhelming support (72 percent in favor) for the consumer bill of rights endorsed by President Clinton. However, if the bill of rights were to increase monthly premiums by \$15 to \$20, the support erodes tremendously (only 28 percent would favor) See Kaiser Family Foundation/Harvard University. *National Survey of Americans' Views on Consumer Protections in Managed Care* (The Henry J. Kaiser Family Foundation: January 21, 1998).