Informing and protecting consumers in the course of health system reform ought to be a valued end in itself, not just a means to a working health care marketplace and good health care. Managed competition will not be an easy “sell” to consumers, especially those who already have reasonably good coverage and substantial freedom in choosing providers. Consumers are wary, often justifiably based on their experiences with current managed care plans, that restrictions in provider choice and incentives for cost containment will not be just annoying but dangerous to their health. They fear queuing, rationing, poor care, and an unresponsive bureaucracy. Without a well-publicized, well-funded, and independent component of consumer information and protection, managed competition not only will fail technically—it will fail politically, even morally.

Consumers will make several decisions under managed competition. Everyone will choose an approved health plan, through an annual open enrollment period, from those offered by the health insurance purchasing cooperative (HIPC). Many consumers who enroll in managed care plans will choose a provider group and perhaps a primary care provider. Some may supplement their plan with coverage for such services as dental care or custodial long-term care. And all consumers will continue to make myriad decisions about using medical care services, following their providers’ advice, and changing personal behavior, such as smoking, that has significant health effects.

Informing consumers does not stop with support for enrollment decisions. If there is a bias here, it is that informed consumers can improve the performance not only of health care markets but of delivery systems as well. As yet, we have only scratched the surface of positive participation by consumers in maintaining and restoring their own health. The explosion of information and communication technologies can greatly enhance our ability to tap that potential; managed competition offers new structures and incentives for applying these technologies creatively.

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Choosing A Health Plan

I take the following points as given in the managed competition strategy that serves as the framework for this analysis: (1) A National Health Board will qualify approved health plans and set data requirements for the plans. (2) All plans will be community rated; no one can be denied coverage because of their health status. Capitated payments will be risk-adjusted to reduce incentives for favorable selection. (3) Each region will have a purchasing cooperative that offers consumers an array of plans, including several with different levels of managed care, plus at least one “free-choice” plan. (4) The purchasing cooperative will conduct annual open enrollment; switching plans at other times will only be permitted under special conditions. (5) All plans will offer a uniform benefit package, with the same, or close to the same, structure of coinsurance. (6) Plans can vary the amenities they offer, as well as the extent of free choice of provider. (7) As a consequence of variations in amenities, methods of paying providers, and efficiency, premiums for plans are expected to vary. Some plans will have no additional premium beyond the base rate set and paid by the HIPC.

Premiums are the core of the price competition. If service benefits are the same, consumers will be deciding on the relative quality of different plans, compared with their relative premium cost. They will be choosing among different service delivery systems, rather than selecting a level of service coverage and reimbursement.

A corollary of the policy decision to vary premiums but not service coverage is that out-of-pocket costs related to service use should not differ significantly across plans. It is difficult for consumers to compare the potential out-of-pocket costs of plans covering different health service packages. A method for comparing interplan variations in out-of-pocket costs has been developed and tested, but it is complex and requires that consumers be initiated into the arcana of insurance. In economic terms, the cost of such information is high, and its utility beyond this specific decision is limited. It is far simpler for a consumer to understand that he or she must pay no additional premium for Plans A and B but must pay $25 a month out of pocket for Plan C and $50 a month for Plan D, for the same service benefits and thus the same level of out-of-pocket cost vulnerability.

The characteristics of service delivery systems associated with different health plans will vary under managed competition. Given the ways in which systems can vary, providing consumers with adequate, accurate, and comprehensible information will probably be even more costly than providing information about the insurance characteristics of plans. But the long-term value of such information is far greater: It will be relevant to consumers whenever they use covered services to meet their health care needs.
Consumers will not be the only decisionmakers about service delivery systems. Key aspects of the quality, equity, efficiency, and economic viability of health plans should be addressed by the purchasing cooperatives and by the National Health Board, both as they select plans to offer within their region and as they monitor performance.

Information To Support Consumer Choice

Given the many potential indicators of health plan variation, criteria are needed to select indicators that are significant, salient, and useful. These indicators should be subject to change over time, especially as we develop more refined measures of quality through outcomes and effectiveness research. Initial criteria for selecting indicators include relevance (face validity); predictive validity; salience to the preferences of consumers with varying demographic, economic, and health status profiles; comprehensibility by consumers of various educational levels and cultural and ethnic backgrounds; ease of obtaining accurate and reliable information across all relevant units to be described (for example, health plan, hospital, or physician); ease of obtaining information across important subgroups of health care consumers (such as the poor, members of diverse ethnic and racial groups, and disabled persons); and capacity to be tracked over time to illuminate trends. Following are some important dimensions of health plans, along with a sample of relevant indicators that meet these criteria.

Affordability. Besides information on monthly plan premiums, consumers should get data on trends in premium rates to help them choose plans with demonstrated, long-term histories of controlling costs and avoid plans (and thus providers) that may not be affordable for long.

Convenience. To assess the relative convenience associated with each plan, consumers need information on the geographic region each plan is designed to serve and on the locations where care is delivered, including proximity to public transportation, access to and cost of parking, hours and days of service, and availability of child care.

Structural aspects of quality. To judge the relative quality of different plans, consumers need information on the “structural” dimension of quality, that is, the quality of the organizations (hospitals, ambulatory surgery centers, labs, pharmacies, medical groups, home health agencies, nursing homes, and so on) and professionals (physicians, psychologists, mid-level practitioners) associated with each plan. In approving a health plan, the National Health Board or HIPC must assure consumers that the plan’s providers meet minimum standards of licensing and certification. In addition, the HIPC should define a target enrollment range each year, for each plan, and assure that the plan has an adequate number of geographically
and linguistically accessible providers to serve the target area. Lack of real capacity can be a major source of the queuing and rationing that consumers fear as a consequence of managed care. Consumers also need information to select a provider group or primary provider within the plan. Standardized information about participating professionals might include provider names; licenses; where and when professionals received their degrees and performed residencies and fellowships; specialties they practice; specialties in which they are board eligible or board certified; facilities where they have staff privileges; locations and accessibility of practice; whether they are accepting new patients; and languages they and their office staff speak.

Similar information on facilities and agencies should also be provided, including name and location; ownership; certification status; academic affiliations and teaching programs; number of licensed and staffed beds; and nurse-patient staffing ratios in general medical/surgical wards. Consumers should have easy access to additional information on specialized inpatient, emergency, and outpatient services at each facility, including data on the annual number of highly specialized procedures performed where the National Health Board or other standard-setting groups have identified a minimum necessary to ensure quality.

**Provider continuity.** Especially in the early stages of managed competition, providers will move among health plans. Provider switching can be disruptive, especially to patients who are currently under treatment and to consumers who have joined a plan because their physician was affiliated with it. Consumers therefore should get information on the rate of provider switching in each plan. This indicator has considerable relevance, or face validity, for consumers; however, additional research is needed to determine its predictive validity with respect to health plan outcomes.

**Consumer satisfaction.** Consumers need data about quality that go beyond the structural aspects of health plans. The best approach in the short term is to provide plan- and provider-specific information on consumer satisfaction and dissatisfaction rates. HIPC should require health plans to collect, aggregate, and report such information using standard formats and procedures. The National Health Board should also specify standard formats and procedures for collecting consumer satisfaction information on the HIPC.

To date, many health care facilities have begun regular patient satisfaction surveys either as a potential source of data for marketing (if the news is good) or to predict disenrollment levels (if the news is bad). The items used in such surveys, however, may be less comprehensive than what is needed to provide comparative data to a wide audience of current and potential enrollees. For example, one item that is not frequently included in such surveys is the extent and nature of consumers’ out-of-plan service use. Such
data might be an important indicator of the experienced accessibility and quality of services for different plans. It is also a good indicator of whether a particular health plan is containing costs or simply, through use of excessive rationing or queuing, shifting costs to their enrollees.

**Process and outcome measures.** The least developed area of information for consumers is the process and outcome dimensions of quality. To date, data on procedure-specific mortality and malpractice rates are among the only outcome indicators widely publicized to consumers. The development of outcome measures that are “accessible” to consumers is still in its infancy. Many found that initial presentations of mortality data, for example, led to both unnecessary anxiety and inappropriate conclusions.

Providing information on process and outcomes aspects of plans’ quality is the point at which consumer information and quality assurance intersect. This is also a point at which consumer information and HIPC governance intersect. Quality assurance systems are unlikely to generate information for consumers (as opposed to administrators, professionals, and perhaps researchers) unless HIPCs involve consumers or their representatives directly in design and monitoring. Further, health plan performance indicators needed by consumers should also be useful to those overseeing the HIPC.

**Health maintenance orientation.** Much of the data on quality have emphasized what happens to patients who become quite sick. Other performance measures should focus on the effectiveness of preventive services provided by health plans. The recent development of age- and risk-specific guidelines in this area provides the basis for several appropriate indicators.

**Amenities.** Current proposals assume that competing plans can and will vary in amenities. Since such features are not normally thought to affect the technical quality of care, they should not be a focus of consumer information provided or mandated by the HIPCs. However, it is important to ensure that a higher level of “amenity” does not come to mean (or is not presented in marketing material as meaning) differential access to services, facilities, or equipment. This would undermine the notion of a standardized benefit and thus the fundamental equity as well as efficiency of the system.

**Choice of provider or service.** Consumers need data on the extent of choice of providers, and sometimes services, in different plans. The ground rules each plan sets for how care is delivered are of enormous importance to consumers. Suspicion of managed care often arises from these ground rules.

Given the proliferation of techniques for “managing” care over the last decades, provider choice is multidimensional, not a simple dichotomy between free choice and no choice. Furthermore, consumers can mean different things when they say that they want provider choice. Some consumers mean they want access to a particular doctor as their primary provider. If he or she is on the “list” for a particular plan, and if their
appointments will almost always be with that doctor, that is enough choice.

Other consumers may define freedom of choice as the absence of pre-
authorization barriers to the use of expensive medications, diagnostic pro-
cedures, or hospitalizations. Perhaps most frequently, freedom of choice
means freedom to visit their favorite dermatologist or cardiologist without
having to go through a primary care “gatekeeper.” This may be an immedi-
ate concern of a consumer with a preexisting chronic condition for which
he or she receives care from a specialist. But even the healthiest consumers
are concerned about whether they will have access not just to good care but
to the very best care available when faced with a life-threatening illness.

The issue of provider choice is further complicated because for many
consumers, choice serves as a proxy for quality. They assume that the
physicians and hospitals that participate in managed care plans do so
because, as a consequence of their mediocre quality, not enough patients
come to them “voluntarily.” Such consumers assume that these providers
are willing to give fee discounts, or agree to money-saving practice “short-
cuts,” to gain access to a “captive audience.” Consumers often impute
higher value to higher-priced items. When health plans with more choice
also have higher premiums, this can reinforce the use of choice as a proxy
for quality, with perverse effects for the system. This is all the more reason
for providing salient, valid, and comprehensible information on quality.

To assess provider choice in a multidimensional manner, consumers
need to know, at a minimum and before enrollment: (1) whether and how
enrollees are assigned to a provider group; (2) whether and how enrollees
are assigned to a single, regular primary care provider or team of providers
or whether even their routine care will be delivered by any available
provider; (3) whether and how enrollees can change provider groups and
primary providers; (4) the extent to which the primary care provider is a
gatekeeper with respect to specialty care; (5) how different kinds of ap-
pointments are made and how quickly-in particular, how urgent and
emergency situations are handled; (6) whether and how enrollees can
request and get exceptions to the “standard” rules of practice in the plan;
and (7) the procedures for complaints and grievances.

Consumers should have easy access to additional information regarding
(1) the incentives faced by primary care providers for and against referral to
specialists and admission to inpatient care; (2) guidelines, if any, for referral
to complex and expensive diagnostic and treatment services; (3) whether
there is a formulary for pharmaceutical products and how restrictive it is;
(4) whether and when second opinions or preauthorization are required or
encouraged prior to scheduling surgical procedures; (5) definitions of
“medical necessity” for services such as rehabilitation, skilled nursing, or
home health; and (6) the extent to which certain highly specialized serv-
ices are located far from the core facilities of the plan.8 Ultimately, HIPCs will not generate consumer confidence unless they provide information in plain English, ahead of time, about standard ground rules for all plans and interplan variations in ground rules. Information can also be provided about enrollee satisfaction with plan rules. Well-validated patient satisfaction surveys address many of these issues.

Choosing Whether To Buy A Supplement

Another decision consumers will make under managed competition is whether to purchase supplementary coverage. Some employers may purchase such coverage on behalf of their employees. The nature and size of the supplementary coverage market can be viewed, as is out-of-plan use of health services, as an indicator of overall satisfaction with the performance of managed competition in general and individual HIPCs in particular. HIPCs should monitor the extent to which enrollees in their region understand their coverage, the number and profile of consumers who have purchased supplements, and the reasons for such purchases. The National Health Board should monitor supplementary coverage across HIPCs.

If consumers purchase supplements for services that were never intended to be covered by the HIPC, such as dental or vision care, this is not a sign of system failure. However, if many consumers or employers purchase supplements to enhance their access to services that are intended to be substantially or completely covered by the HIPC, such as mental health, prescription medications, or skilled nursing care, a red flag should go up.

Beyond quality and access problems, extensive purchase of supplements for services that indeed are covered by the standard benefit package can also indicate questionable marketing practices by companies offering such supplements. As we have learned from our experience with the market for Medicare supplements, it is quite easy to frighten certain consumers into purchasing coverage they do not need. While HIPCs may play no regulatory or consumer information role with respect to supplements, they must ensure that consumers have a clear understanding of their basic coverage.

Providing Information To Consumers

HIPCs must play the central role in providing health plan information to consumers. The National Health Board should be legislatively mandated to set overall policy regarding the kinds of information provided, when, how, and by whom. The HIPC should be mandated as the sole agent responsible for providing standardized, comparative information on all health plans to all current and potential enrollees in their region. To achieve this legisla-
tive mandate, the HIPC budget must include a line item for consumer information activities, perhaps calculated on a per capita basis for each covered individual in the region. Given our limited experience with consumer information (as opposed to marketing), special efforts will be needed to analyze existing activities to estimate initial budget levels. One expected source of cost savings in managed competition is reduced expenditures for marketing, but the “information” (as opposed to the “sales”) component of marketing costs should not be eliminated and may need to be increased.9

Some HIPCs might choose to carry out their consumer information responsibility directly. Others might contract all or part of this responsibility to organizations, either for profit or not, which are demonstrably independent of health plans and health care providers. The latter approach would encourage the development of specialized expertise and sorely needed innovation. Furthermore, while the HIPC may become competent at informing most consumers, special populations may require customized efforts because of differences in language or dissemination channels.

The role of health plans and associated providers in informing consumers is debatable. HIPCs might decide that standardized comparative information should be provided by each health plan directly, rather than by the HIPC. In this case the HIPC should develop information specifications and preview them, leaving development, production, and dissemination of materials to the health plans. Alternatively, the HIPC might develop and produce materials that compare all plans but permit health plans and providers to produce and disseminate additional marketing materials, using their own funds. Such materials would need to be reviewed by the HIPC to ensure they were not misleading and to guard against the use of marketing as a method for biasing enrollment.10 In particular, marketing materials might be used to describe the amenities available under various plans.

Methods. There is enormous potential for innovation in methods for providing health information to consumers. Innovation is essential if consumers are to be genuinely informed rather than overwhelmed with a barrage of disconnected “facts.” We yet know little about what informational techniques are most effective with respect to providing information on health plans and providers. Previous studies indicate that well-planned educational efforts can make a difference but also indicate that different approaches are effective with different subgroups of consumers.11 Consumers’ information needs and preferences will vary widely, as will the media through which they can most effectively be informed. Information strategies used by the HIPC should be user-friendly, allowing consumers to select the level of detail they want on different aspects of plans. Given the cultural and educational diversity of our nation, HIPCs should use as wide a range of information dissemination strategies as possible. Additional
research on effective consumer education is needed; the work of HIPCs will provide ample opportunities for experimentation and assessment.

While expanding the variety of the HIPCs' consumer information efforts, the marketing efforts of individual health plans and providers will need to be constrained. In particular, it is critical to severely limit person-to-person marketing by plans and to ban “house-to-house” marketing entirely. The potential for abuse in such “invisible” settings is enormous.

### The HIPC's Role in Consumer Protection

An important way to protect consumers in managed competition is to mandate, through a combination of legislation, regulation, or specific delegation of authority, an effective system for consumer information. In addition, however, the National Health Board and the HIPCs must provide protection for individual consumers who have complaints about accessibility or quality of care, inappropriate implementation of ground rules for receiving care, or inappropriate marketing methods.

Each level of the system should have an independent but related mechanism in place for hearing and resolving complaints: the health plan, the HIPC, and the National Health Board. Consumers should be able to appeal from one system level to another if they do not get satisfaction. To ensure that an appeal to the HIPC is consequential, contracts between the HIPC and the health plans must specify when the HIPC is empowered to overrule health plan decisions that deny or limit access to a particular procedure, service, provider, medication, or other benefit. The HIPC should also be empowered to determine whether access or quality of care is so low that the patient should be free to change to another plan outside the normal enrollment period. Where neglect or poor care was especially egregious, the HIPC might be further empowered to require that the original plan be liable for part or all of the cost of services that patient receives for that condition from his or her new plan and provider. This would be a powerful, and we hope rarely used, “last resort.”

There must be easy access to each level of the complaint and grievance system; a twenty-four-hour toll-free number would be an ideal mechanism for immediate access. It should be well publicized through multiple media and in multiple languages as appropriate. The complaint and grievance system will also be a rich source of data on the performance of health plans (rate and source of complaints) as well as the HIPCs themselves (speed of resolution and trends in the overall complaint rate across plans). The most fundamental consumer protection role of the National Health Board and the HIPC is in offering consumers choices among plans that each meet a minimum, but not minimal, standard of quality, convenience, efficiency,
and reliability. The overall rate of disenrollment across plans will be an indicator of both HIPC and plan performance.

The HIPC’s role in consumer protection also intersects with its roles in quality assurance. Ultimately, the core issue will be improving health system performance. Performance in each HIPC will be linked to the competence and motivation of health care providers within the region. As Albert Hirschmann articulates so eloquently, for individual consumers and for the HIPC itself, there will always be a tension between the use of exit, voice, and loyalty in improving the quality of products and services. Given the relatively high cost, especially for institutional providers, to enter or leave a health care market, there will be a limit to the effective use of what we might call “total exit”—that is, the elimination of a particular provider from participation in any health plan within a region.

For this reason, the HIPC should have a staff of advocates who would be available to work with individual consumers and their health plans or providers to resolve misunderstandings, problems, and grievances. Some health plans may also hire patient advocates whose role should be to address issues to keep consumers from leaving a plan. The emphasis should be on the effective use of voice through negotiation.

Finally, given increasing ethnic diversity and the presence of vulnerable populations, the HIPC has a role not only in assessing and assuring the aggregate performance of plans, but in assessing how different subgroups fare in and across plans. The National Health Board may identify vulnerable populations for whom separate consumer satisfaction data would be examined. Each HIPC, depending on its regional characteristics, may identify additional special populations they will track, to ensure that they are receiving care comparable to that of the “typical” consumer.

**Looking Ahead**

As we embark on the road to national health care reform, we would be wise to look back to our most recent experience with a major change in health care coverage legislation: the passage and repeal of the Medicare Catastrophic Coverage Act of 1988. While multiple factors influenced the demise of this legislation, public misunderstanding of its intent and consequences certainly contributed. We cannot afford such a scenario with national health system reform. Our first “consumer information” challenge will be to take a complex proposal, articulate it in simple, clear, and forthright language, and disseminate it widely. Having done that, we must offer citizens clear opportunities to respond. Proposals for managed competition will have to pass the gauntlet, not only of the many special interests in the health care industry but of American consumers as well.
NOTES


2. Consumers will still need to understand their financial vulnerability with respect to services that are not covered. And some consumers may believe that if “managed care” attenuates their access to covered services, this will in fact make them financially vulnerable in any case by forcing them to go out of plan for care.

3. The HIPC will have to develop and apply guidelines regarding minimum levels of service capacity. Given the power of supply-induced demand and its attendant costs, as well as extensive small area variations in both supply and service use, it is clear that guidelines that freeze unnecessary supply in place can prevent effective cost containment. But given the excess capacity in many systems, a HIPC will be under pressure from both providers and consumers to set fairly high ratios. They will need support from outcomes and effectiveness research to bolster their decisions about capacity.

4. We normally expect such listings solely for managed care plans. However, “free-choice” plans may eventually find that some providers choose not to see their members, either because they have exclusive linkages with a particular managed care plan, or because they already have enough business. If this is the case, these plans may also need to identify the facilities and providers that do not “accept” their coverage.


7. A given HIPC might decide that grievance and complaint procedures should be standard across all plans.


9. In addition, health plans will continue to incur at least some of the costs of “selling,” although this should not be included in the HIPC budget for consumer information.

10. Proposed risk-rating techniques should limit incentives for favorable selection. But plans and providers may bias their marketing for or against individuals on the basis of income, education, age, race, ethnicity, or occupation. It is important to remember that managed competition may result, in some regions, in a massive “privatization” of the care of patients who are currently served primarily in public hospitals and clinics and in nonprofit community-based agencies. It remains to be seen whether “mainstream” health care providers can serve such patients effectively and respectfully.
