Cite this article as:
R H Miller
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Health Affairs 15, no.2 (1996):107-120
doi: 10.1377/hlthaff.15.2.107

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Competition In The Health System: Good News And Bad News
by Robert H. Miller

Abstract: Competition among health plans, hospitals, and physicians has taken place in fifteen health care markets primarily on the basis of price and secondarily on network breadth and style of care. In most markets, competition resulted in lower (or slowly growing) premium prices. Within a type of plan product, competition was leading to similar prices and networks and was reducing product differentiation among health plans. Competition was not taking place on the basis of measured and reported quality of care, which limited the capacity of employers and enrollees to make informed health plan choices. As a result, there was a substantial gap between competition as envisioned by the architects of the managed competition model and competition as it is evolving today.

Advocates of competition in health care argue that competitive health care markets lead to lower prices, premiums, out-of-pocket payments, and resource use and higher quality of care than do noncompetitive markets. From the perspective of purchasers (employers and government payers) and consumers, current competition brings both good news and bad news. The good news is that competition is taking place, even if it is primarily on the basis of price. In each of the fifteen communities that were part of The Robert Wood Johnson Foundation's Community Snapshots study, over the past two years health plan premiums either increased more slowly than in the recent past, were unchanged, or decreased. The bad news is the lack of competition based on measured and reported aspects of quality of care, especially health outcomes. Few health plan- and delivery system-specific technical quality measures that were valid, standardized, and understandable were reported to employers and consumers. For many enrollees, choice on the basis of quality of care was based on reputation or experience; for some enrollees in one community, choice of plans was based on some measures of the quality of the process of care and on enrollee satisfaction.

This paper uses information from the Community Snapshots study to describe how health plans and health care providers competed in a wide range of communities as of mid-1995. Because change is occurring so rapidly, the objective of the study was to carry out quickly an initial hypothesis-generating project that could be followed up with more deliberative, hypothesis-testing projects. Given the study's purpose and time frame, protocols for data collection and report writing were not as uniform as they might have been with different project objectives. As a result, this paper cannot provide rigorous and uniform documentation of market competition developments across the fifteen communities. Nevertheless, it is possible to obtain a preliminary picture of how competition in the health care sector took place in those communities.
Although there was no general outcry about lower quality of care in any community, so-called atrocity stories about patients' and physicians' negative experiences with managed care continue to capture media attention. Combined with widespread physician dissatisfaction with the shift to managed care, that is a politically combustible mix with ramifications for the future.

**Current Competition: An Overview**

Because current competition is relatively new in most Snapshot communities, many market participants were not well oriented to it. In particular, many physicians, hospital managers, and nonprofit hospital boards did not anticipate, and were not trained for, a competitive environment marked by capitation, utilization management, increasing large physician organizations, rapid decision making, hospital system building and diversification, organizational restructuring, substantial cost cutting, and job and income insecurity. At a minimum, competition was not a factor that attracted many physicians and managers to the medical or hospital arena.

Competition can take place on several bases: price, consumer choice of providers, access, style of care, and technical quality of care.

**Price.** Competition on the basis of price and other product attributes takes place within and among four basic health plan product lines: health maintenance organizations (HMOs), point-of-service plans, preferred provider organizations (PPOs), and indemnity insurance. A point-of-service plan can be an HMO with an out-of-plan option or a PPO with a gatekeeper. In most markets HMO, PPO, and point-of-service plans were considered to be “managed care” plans (which is how I use the term here), although PPOs were excluded from the definition in markets with high HMO penetration.

The phrase “competition on the basis of price” requires clarification. To economists, *price competition* means that firms compete on the basis of price, holding constant or adjusting for differences or changes in other product attributes. However, stakeholders and Community Snapshots researchers knew little about changes in quality of care, as health plan premiums and provider payments changed. Thus, in this analysis “competition on the basis of price” refers narrowly to the product’s price attribute, separate from its other attributes. Similarly, competition on the basis of quality of care refers narrowly to those attributes, separate from price.

Although discussion of health plan premiums should adjust for differences in benefits covered, Community Snapshots researchers did not have sufficient information to make such adjustments. The presumption here is that offering less generous benefits (or shifting costs to consumers) was only
a partial (at times small) cause of changes in HMO premiums, although changes in benefit packages may have played a greater role in premium changes for other types of plans.

**Other factors.** Health plans and providers also competed on several nonprice aspects of care, including consumer choice of providers, access, style of care, and technical quality of care.\(^2\) Consumer choice focuses on network breadth, whereas access includes such factors as distance to physician or hospital facilities and ability to obtain appointments when desired. Style of care includes interpersonal relating (including the nature of interactions between the enrollee and both medical and nonmedical staff) and amenities (such as ambience of facilities and quality of hospital food). Technical quality of care includes how care is delivered or aspects of the process of care (such as whether appropriate tests or procedures were performed), as well as the effects of care on enrollees' health status or outcomes of care, such as death, disease, disability, discomfort, and dissatisfaction.\(^3\)

Perceived quality, which depends heavily on the enrollee's own experience or on word of mouth or media reputation, should be distinguished from measured and reported technical quality that would involve a Consumer Reports-style comparison of various dimensions of quality of care among health plans and delivery systems.

Overall, it has been relatively easier to measure the process aspects of care (access, style of care, and technical quality) than it has been to measure outcomes of care based on technical quality.\(^4\) Widespread and uniform measurement and reporting of health outcomes has remained a mostly elusive goal, even though some argue that the latter are by far the most meaningful measures of quality of care and doubt whether other measures are good proxies for those outcomes.

Note that competition on the basis of one-stop shopping (multiple product offerings) is, in part, a way to compete on the basis of price and consumer choice of providers. By offering a point-of-service or PPO plan, an HMO can broaden its network and attract employers and new enrollees who want wider price and physician choice. Moreover, one-stop shopping can meet other employer needs: It can reduce employers' administrative costs, eliminate potential premium overpayments that are due to adverse selection, and help enrollees to make the transition into more tightly managed plans.

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**Participants In The Competitive Marketplace**

Basic shifts in purchasers', health plans', and providers' behavior underlie current competition characteristics. Instead of passively paying bills, pur-
chasers are shifting to purchasing health services (via health plans) on the competitive basis of price, making such purchases more similar to other services that they purchase. Health plans are competing vigorously for employers' business first on the basis of price and next on network breadth, while attempting to establish a presence or greater market share through acquisitions and entry into new markets. Health plans can pass some or most premium reductions (nominal or inflation-adjusted) on to providers by exploiting excess hospital and specialist capacity. Hospital and physician organizations compete mostly on the basis of price for managed care contracts, which has led to cost cutting that is made possible by the high prices and inefficiencies in the old indemnity, fee-for-service system.

Purchasers. Starting around 1990, large employers began their move to purchasing health services (via health plans) on a competitive basis. The Jackson Hole Group's September 1991 managed competition proposals reflected this shift in large employers' thinking. In many informal discussions and premium negotiations, large employers made it clear to health plans and providers that they expected real health care cost containment. The most obvious expression of this shift was the creation or strengthening of employer coalitions, including some that undertake purchasing negotiations with health plans, such as the California Public Employees Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH) in California, the Buyers' Health Care Action Group (BHCAG) in Minneapolis/St. Paul, the Gateway Purchasing Association in St. Louis, and the Community Health Purchasing Coalition in Des Moines. Other purchasing coalitions emerged but stopped short of joint purchasing. For example, in Boston the Massachusetts Health Care Purchasing Group issued annual challenges to insurers to meet a target rate of premium increase or (recently) decrease, whereas elsewhere employer coalitions have served mostly as discussion forums. Moreover, following the shift in actions by larger employers and employer coalitions, some state Medicaid programs also began emphasizing the competitive purchase of health care.

Increasingly, the actions of purchasing coalitions at regional or national levels have affected competition at the community level. For example, negotiated rates between the large California statewide purchasing coalitions and HMOs likely had an impact on employers' expectations in San Diego and Orange County about the future course of premiums and may have affected employers' expectations elsewhere.

Health plans. Health plans have responded to the purchaser shift to competition by competing primarily on the basis of price, and secondarily on consumer choice. In some areas plans competed on the basis of access and style of care. Very little competition took place on the basis of technical quality of care. As many HMOs increased the breadth of their networks and
could not demonstrate differences in technical quality of care, health plan offerings became commodity products in some communities, with little to differentiate one product from another.

The purchaser shift helped to fuel HMOs' current drive to establish a presence in many markets and to gain size in any one market, which has implications for competition. HMOs seek increased market share to gain greater bargaining leverage with providers, to obtain savings from economies of scale, and to offer the convenience of one-stop shopping to statewide and nationwide employers, private and public employee purchasing coalitions, and Medicaid purchasing agencies.

Other factors have fueled HMOs' drive for market presence and size. The debate sparked by the Clinton administration's health care reform proposal also led some larger insurers to conclude that only a few large HMOs would survive in each market area, even without the Clinton plan. Obviously, to be a survivor, an HMO must first have a presence. Health plan expansion can be quite profitable, as HMOs can benefit by exporting proven cost containment techniques into areas with less rigorous managed care.

Moreover, all communities but those with high HMO penetration appeared to be contestable markets for health plans. In communities with moderate to low HMO penetration, even high HMO market concentration did not create insuperable barriers to entry, as indemnity and PPO enrollees and their employers appeared more willing to try a new or a small HMO than were existing HMO enrollees and their employers in a community with high HMO penetration, who were accustomed to name-brand HMOs. In Houston, with its relatively small HMO market, the two insurers that had accounted for more than 80 percent of the HMO market for years could not stop the recent explosion of new entrants.

The quest for market presence and size has in turn led to stepped-up competition on the basis of price. In some communities with lower HMO penetration, such as Houston, north central Florida, and Fargo/west central Minnesota, new HMOs have entered the markets, or existing health plans or delivery systems have started new HMOs, which again increases competition. For example, in Houston twenty HMOs operated or had filed applications to operate as of mid-1995, compared with five HMOs in 1992, and some new HMOs appeared to be willing to incur losses by offering low premiums to gain a market foothold. In Columbia even the threat of new health plan entry from outside appeared to heighten competition among existing participants.

Mergers and acquisitions were reported across a wide spectrum of communities. In south Florida out-of-state companies were engaged in a "frenzy" of activity acquiring HMOs (there were twenty-six HMOs as of mid-1995), in part to gain entry and in part to strengthen their existing
The drive for market presence and size that has contributed to price competition is leading to consolidation that could hamper such competition. In several communities with high HMO penetration, HMO market concentration had already become substantial by the time of the Community Snapshots study. In Minneapolis/St. Paul three HMOs controlled more than 90 percent of the HMO market, and in Oregon (the Portland/Vancouver market) five HMOs also controlled about 90 percent of the HMO market.

The shift by states to Medicaid HMO enrollment created competition on the basis of price in that market. Competition has been facilitated by the ability of health plans or provider consortia not in the group health market to enter the Medicaid market in such communities as south and north central Florida and Orange County. Even in areas with high HMO penetration, such as Orange County, new plans or provider consortia that might not be able to enter the group health market could enter the Medicaid market by recruiting existing Medicaid providers, some of whom were outside the networks that other health plans already controlled.

Providers. Providers in various markets' delivery systems engaged in fierce competition on the basis of price, which led to cost cutting in virtually all communities, without an obvious decrease in quality of care. With few measurable differences in product characteristics, increasingly hospital and physician services were becoming undifferentiated commodity products.

Providers in most Snapshot sites could list the ways in which they cut costs without raising substantial concerns about quality of care. This capacity to cut costs is critical to facilitating premium competition among HMOs. Without the possibility of delivery system cost cutting, insurers would be less able to pass to providers most or all of the premium cuts, and thus insurers would be more resistant to employers' premium demands.

Payers (insurers/health plans) could force delivery systems in these communities to compete on price because they exploited excess hospital and specialist capacity and disorganization among physician groups. Moreover, where statewide or nationwide insurers confronted local or regional provider organizations, insurers gained additional price leverage because they had less at stake financially in negotiations than providers did and tended to be financially stronger than delivery systems. The balance of economic power further tilted in favor of insurers where for-profit health plans confronted nonprofit delivery systems, because the former tended to act more quickly and decisively than the latter. For example, in San Diego and Orange County for-profit statewide and multistate insurers confronted smaller, local, not-for-profit delivery systems.
In all communities, provider organizations competed by attempting to become large enough to become a must-have network for health plans and therefore to gain more enrollees and attempt to gain better payment rates. In many markets, hospital systems acquired primary care physician organizations to gain HMO enrollees, in part to achieve better negotiating leverage with HMO plans. For example, because Sharp HealthCare served more than 30 percent of San Diego’s HMO enrollees, it became a must-have network for HMO plans and thereby gained competitive advantage over hospitals without associated primary care physician organizations and over physicians in less powerful physician organizations. Alliances and mergers also could help provider organizations to gain a competitive advantage by facilitating lower costs, one-stop-shopping convenience for health plans, and enhanced access to capital.

As delivery systems have grown in size, they have added to health plan competition by either starting their own health plans or threatening to do so. Clearly, many health plans want to contain this new actual or potential source of competition. In some markets interviewees from health plans and provider organizations indicated that HMOs would punish a delivery system that contracted directly with an employer or that offered its own plan (which essentially is the same thing) by directing its enrollees to other delivery systems that were not health plan competitors. As a result, the St. Joseph Health System in Orange County sold its HMO several years ago to avoid competing with its HMO customers. San Diego’s Sharp HealthCare developed an HMO but offered it only to its own employees, again out of concern about health plan retaliation. In Houston a leading HMO warned the Memorial/Sisters of Charity delivery system alliance that if its new HMO plan appeared likely to succeed, the other HMOs would direct enrollees elsewhere. Some California health plans even discouraged paying global (full-risk) capitation (that is, one capitation payment for all health care services) to delivery systems, in part out of fear that employers would see the plans as irrelevant.

As a result, although there was much talk among providers about contracting directly with purchasers or offering HMO plans, there was less action. On the other hand, health plans appeared to be more tolerant of delivery system sponsorship of PPOs. Note that when a delivery system had an exclusive relationship with a health plan (the Southern California Permanente Medical Group in San Diego and Orange County), the problem of HMOs’ taking their enrollees to other delivery systems disappeared.

Despite obstacles, some delivery systems competed with existing HMOs. In larger markets with higher HMO penetration, such as Portland/Vancouver and Albuquerque, delivery systems offered their own health plans. In some markets with moderate or lower HMO penetration (St.
Louis and Indianapolis), delivery systems feared HMO plan retaliation less because they depended less on revenues from the often small HMOs. In some smaller markets, such as Des Moines and Fargo/west central Minnesota, because it is difficult for a plan not to contract with all local delivery systems, hospitals or hospital systems could offer their own HMO product or contract directly with purchasers. Delivery systems in Wilmington and north central Florida were contemplating similar actions.

Some state and local governments created openings for providers to contract directly with purchasers in the future; this heightened health plan competition. For example, the city of Fargo contracted directly with provider systems, and the Minnesota state government joined the Twin Cities' BHCAG that intends to contract directly in 1997. In California and Minnesota the state Medicaid programs intended to contract directly with delivery systems as well as with health plans. Nevertheless, until purchasers demand that health plans not retaliate against delivery systems that contract directly with purchasers, health plans in some markets will be able to limit delivery system-sponsored health plan competition.

### Health Plan Competition

In the Snapshot communities, health plan competition took place on the basis of several product attributes.

**Price to employers.** Competition on the basis of price was the most important type of health plan competition for employer business. Within a product line (such as HMO plans), many employers clearly shopped for better prices. One informant in San Diego claimed that the market appeared to be similar to “an auction,” whereas an HMO representative in north central Florida said that “people will walk for [a premium difference of] as low as $10 a month.”

Competition on the basis of price among HMO plans appeared to have a spillover effect on containing PPO and indemnity premiums. Even in a community with low HMO penetration, such as Fargo/west central Minnesota, the fear of new HMO entry may have helped to curb PPO and indemnity premium increases. Nevertheless, in at least some communities with higher HMO penetration, such as San Diego and Orange County, HMO premiums to employers were substantially less than premiums for PPO, point-of-service, and indemnity coverage, and the differential was growing, which led some employers to cease offering indemnity insurance.

**Price to enrollees.** The limited available evidence suggested that many employers appeared reluctant to risk the workforce disruptions that might ensue if large front-end incentives were put in place to make employees pay most or all differences in premiums among plans and thus drive enrollees
into managed care plans. This reduced health plan competition based on price to enrollees. In some markets with higher HMO penetration, such as San Diego and Orange County, where premium differences among product lines were greater, employers appeared to be more willing to create incentives for enrollees to choose lower-cost plans. Whenever there were such incentives, enrollees' choice of health plans appeared to be price-sensitive. Employers appeared to be willing to create back-end, out-of-pocket incentives for employees to choose lower-cost plans. By reducing coverage in higher-cost plans, employers could lower the premium that they paid for that plan while increasing subscribers' out-of-pocket payments, thereby creating incentives for subscribers to choose lower-cost plans.

**Consumer choice.** Across most Snapshot communities, health plans competed on the basis of consumer choice: that is, on network breadth. This was the second most important basis of competition. As a legacy of the old indemnity insurance/fee-for-service system, many consumers want generous physician choice, to keep their own physician, see providers with better perceived reputations, or see a nearby physician. Generally, employers appeared reluctant to greatly restrict choice, to avoid angering employees as well as to maintain their own choice.

Competition on the basis of consumer choice/network breadth led to little difference in the provider panels of important large plans in such disparate communities as Columbia and San Diego. In San Diego, Orange County, Portland/Vancouver, Houston, and Albuquerque, staff- or group-model HMOs experienced the least growth, and some broadened their networks or offered point-of-service plans to increase network breadth and membership.

Nevertheless, in some markets with high HMO penetration several plans had integrated or were in the process of integrating more closely with delivery systems, possibly setting the stage for future competition on network exclusivity. In Portland, where Kaiser and Providence had integrated delivery system/health plan combinations, the Legacy system had combined with three medical clinics and Blue Cross/Blue Shield of Oregon. In Albuquerque, Lovelace was an integrated health plan/delivery system, Presbyterian Health System offered its own plan, and St. Joseph's Health System contracted with FHP. In Minneapolis/St. Paul, the two major HMOs, Allina and HealthPartners, controlled significant hospital and physician organizations and were seeking more restrictive relationships with other physicians. Even in San Diego and Orange County, where health plan/delivery system integration is low (with the exception of Kaiser), PacifiCare was engaging in longer-term partnerships with some providers. However, even in some of these cases, plans had multiple arrangements with other providers, to permit broad consumer choice of
physicians.

**Access and style of care.** In some Snapshot communities, health plans competed on the basis of perceived (as opposed to measured) access, interpersonal relations, and amenities. It can be attractive for health plans to compete on this basis because enrollees understand these aspects of services, and it appears that style of care can be improved more quickly and less expensively than is the case for technical quality of care.

Some competition on measurable access to and style of care (interpersonal relations and amenities) had occurred in a couple of communities, because such measures are more developed and standardized than is the case for outcomes measures of technical quality. In Boston large purchasers required health plans to collect and report Health Plan Employer Data and Information Set (HEDIS) measures, which contain access and style-of-care measures. Some informants were concerned that health plans and delivery systems might substitute improving satisfaction with “warm and fuzzy” aspects of services for improving technical quality of care, which is harder to measure and harder for enrollees to understand. Although Community Snapshots researchers collected little hard data on advertising and promotional activities, some health plans clearly were using media purchases heavily to present their consumer choice, access, style of care, and quality of care in a favorable light.

**Technical quality of care.** In general, there was almost no competition on the basis of measured and reported technical quality process or outcomes measures. Some enrollees in Boston could refer to HEDIS measures, which included several technical quality process measures but only one outcomes measure (rates of low birthweight) and one outcomes proxy measure (asthma admissions), both of which are limited in scope. Otherwise, in no community could employers and enrollees choose plans on the basis of quality-of-care health outcomes indicators that are valid, measured, reported, and comparable across plans.

**Delivery System Competition**

Competition among providers took place on several bases in the Snapshot communities.

**Price.** Price was the predominant basis of competition. In some communities (such as Houston, San Diego, and Orange County) hospitals' per diem rates were unchanged or falling, and specialists' fees were falling. Where HMOs capitated primary care physicians, the limited available evidence suggested unchanged or dropping capitation rates.

**Consumer choice, access, and style of care.** In many communities, delivery systems competed on the basis of broad networks and, in some
communities, perceived access to and style of care. In no community did they compete on the basis of measured and reported indicators of these performance aspects, reported at the delivery system level.

Technical quality of care. Without measured technical quality of care, some hospitals and physician groups used their reputations of technical quality, bolstered by use of mass media, to obtain more patients and higher prices. In larger markets (such as Boston, St. Louis, Houston, San Diego, and Orange County) many large hospital systems included at least one prestigious teaching hospital in their system or alliance.

Although providers competed on the basis of perceived technical quality of care, again there was little competition on the basis of a measured and reported technical quality process and outcomes indicators that are comparable across delivery systems. Delivery systems in several markets, including Houston and Orange County, were incurring substantial marketing costs to tout access, style of care, and technical quality.

Competition Based On Quality Of Care

Competition based on quality-of-care outcomes is an important part of the managed competition model, and the lack of it is but one way in which the marketplace has diverged from that model. There are several major reasons why such competition has not occurred, and why it is developing only slowly.

Lack of purchaser demand. In the past, purchasers did not insist on sophisticated quality measurement and reporting because their attention was riveted on containing health care costs. However, as the pressure of premium increases has abated (at least for now), purchasers have begun to pay greater attention to quality of care, including through the development of new HEDIS measures. Efforts to develop new quality measures are under way in several Snapshot communities, including Boston, Minneapolis/St. Paul, and Portland/Vancouver, and on the national level.

Lack of useful, standardized quality-of-care indicators. Few quality-of-care outcomes indicators exist, and few methods that adjust for differences in patients' health characteristics have been validated and accepted as standards. Also absent is the implementation of information technology that could produce such measures in a timely and routine manner.

Two features of present market competition may slow down the provision of information needed by consumers and employers to make informed choices, and therefore fail to reward delivery systems with higher quality of care. These features are (1) conflict between health plans and providers; and (2) lack of risk-adjusted premiums and provider payments.

Health plan/provider conflict. Conflict between health plans and
provider organizations that are potential insurers gives health plans the incentive to report quality-of-care measures at the health plan level but not at the provider level. Health plans want the loyalty of employers and enrollees to rest with the plan, not with the delivery system. For example, one provider organization in Orange County reported that although it scored well in an HMO's internal quality-of-care review, the HMO refused to make its ranking public. Note that when health plans are integrated with provider organizations, this problem is eliminated.

Reporting and measuring technical quality of care at the provider level is important because it can be argued that competition based on quality should take place at that level, not at the health plan level. In cases in which several health plans contract with the same provider organizations, health plan outcomes performance measures would tend to be similar if quality outcomes could be measured. Only quality-of-care reporting at the provider level would enable employers and consumers to determine actual quality differences, at the place where services are actually delivered, and thereby reward delivery systems that demonstrate higher quality of care. Among the fifteen communities, the BHCAG purchasing coalition in Minneapolis/St. Paul was furthest along in facilitating competition based on quality of services and quality of care at the delivery system level.

**Lack of risk-adjusted premiums and provider payments.** There were no reports of premium and provider payments that had been adjusted for enrollees' health characteristics. Usually premiums were adjusted only on the basis of age, sex, and location. Without health risk-adjusted payments, health plans and providers have a strong disincentive to compete on quality because they do not want to be known as having the best quality of care for higher-cost illnesses if that would lead to unfavorable selection of enrollees. Without risk-adjusted payments, successful competition based on quality of care could mean substantial financial losses.

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**Managed Competition: Model And Reality**

The Community Snapshots study indicated that there was strong price competition in health care markets—even in smaller communities with only two remaining health care systems. However, current competition is substantially different from what was envisioned by the managed competition model. The most important differences include the following.

**Purchasing coalitions.** Few small employers are part of the type of small-business purchasing coalitions envisioned in the managed competition model.

**Financial incentives for enrollees.** Employers are only slowly creating financial incentives for enrollees to choose lower-cost plans and stan-
standardized benefit packages, to allow informed enrollee choice. Ironically, purchasers' success in obtaining premiums that are lower or growing more slowly have reduced pressure on employers both to create purchasing coalitions and to craft incentives for enrollees to choose lower-cost plans.

**Risk-adjusted payments.** Employers are not paying health risk-adjusted premiums to health plans, and plans are not paying health risk-adjusted capitation rates to providers. This key pillar of managed competition is designed to reduce incentives for health plans and providers to select healthier enrollees and leave enrollees with higher costs in other plans.

**Access, style of care, and technical quality of care.** As explained above, enrollees are not choosing health plans and providers on the basis of valid, understandable, measured, and reported indicators of important aspects of care, although efforts are under way to change this situation.

**Integrated systems.** Accountable Health Partnerships (integrated health plan/delivery system organizations with exclusive relationships with each other), one component of the original managed competition model, continue to be the exception rather than the rule, although their constituent elements (large insurers and organized delivery systems) are emerging.

**Transformed practice of medicine and prevention.** The practice of medicine and care of populations is changing only slowly. Many of the activities that require clinical integration and prevention-potential pillars of the future health care system— are only beginning in many areas, as are the sophisticated information systems that those activities require.

**Self-regulation.** The self-regulatory bodies envisioned in the managed competition model that would oversee market competition are not in place, although some organizations (such as the National Committee for Quality Assurance) fulfill some aspects of the roles foreseen for those bodies.

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**Concluding Comments**

Evidence from the Snapshot communities that indicates that competition is not progressing quickly along the lines of a “pure” managed competition model is not surprising. It is impossible to forecast the pace of progress toward that system or some other competitive system, given the number of changes that are taking place. In particular, we do not know how demanding purchasers will be in obtaining valid, understandable, and reported measures of health outcomes that reflect important dimensions of quality of care. In the current political environment, it is doubtful that the Health Care Financing Administration will take the lead in pushing the boundaries of quality-of-care measurement and reporting. Moreover, it is unclear what will force employers to demand sufficient competition on the basis of
quality so that informed employer and employee choice could be made on that basis. As Robert Evans observed several years ago, there is no direct competition among health plan sponsors that drives their activities, unlike the competition in all other aspects of the managed care system.\(^\text{11}\) As a result, in an era of less government, the social responsibility of employers and purchasing coalitions (public and private) becomes great, because the cooperative action of purchasers will be vital in determining the nature of competition, and the quality of health care, in whatever health care system emerges.

NOTES

1. P.B. Ginsburg and N.J. Fasciano, eds., *The Community Snapshots Project: Capturing Health System Change* (Princeton, N.J.: The Robert Wood Johnson Foundation, 1996); and P.B. Ginsburg, “The RWJF Community Snapshots Study: Introduction and Overview,” *Health Affairs* (Summer 1996): 7-20. The fifteen Snapshot communities were Albuquerque, New Mexico; Boston, Massachusetts; Columbia, South Carolina; Des Moines, Iowa; Fargo, North Dakota/west central Minnesota; Houston, Texas; Indianapolis, Indiana; Minneapolis/St. Paul, Minnesota; north central Florida; Orange County, California; Portland, Oregon/Vancouver, Washington; St. Louis, Missouri; San Diego, California; south Florida; and Wilmington, Delaware.