Ominous Signs And Portents: A Purchaser’s View Of Health Care Market Trends

A decline in competition and few rewards for higher-quality care threaten the health of the managed care marketplace.

by Michael H. Bailit

Private employers and public purchasers such as Medicare and Medicaid turned to managed care and the health care marketplace in the late 1980s and early 1990s to solve the seemingly intractable problem of health care inflation. Their efforts appear to have paid off. Competition among health maintenance organizations (HMOs), coupled with the decline of inflation in the U.S. economy, has driven dramatic reductions in health insurance premium growth. Purchasers have sought documentation of quality, and health plans have begun to report more and better performance information. This is largely the result of the creation of the Health Plan Employer Data and Information Set (HEDIS).

In the mid-1990s we have witnessed some adverse reactions to managed care. These have taken form in provider-initiated legislation to curb certain offending HMO practices (for example, “gag rules” and “drive-through deliveries”) and critical stories in the popular media. Still, it is clear that managed care has become the norm for the delivery and financing of health care for privately insured persons and will soon be the same for Medicaid recipients. In 1995, 73 percent of employed persons received their health insurance through a managed care plan, and in 1996, 40 percent of Medicaid recipients were enrolled in managed care.1

Dark Clouds Gathering

Although this should be a time of exultation for purchasers, two dangerous trends have emerged that threaten the health of the managed care marketplace, just as that market appears to be succeeding: consolidation of suppliers of health care services, and less concern for quality.

Supplier consolidation. Virtually every supplier in the health care services marketplace (health plans, home care agencies, physicians, physical therapists, and hospitals) is engaging in frenetic merger and acquisition activity. Almost 40 percent of U.S. nonfederal hospitals have been involved in such activity in the past three years.2

Consolidation is driven by two factors: the potential to create efficiencies by eliminating oversupply of selected services, and the desire of health plans and health care providers to eliminate competitors and increase prices. This second factor is the most prevalent motivation for consolidation. By eliminating competitors, organizations can more easily dictate cost and performance terms to their customers—a long-established pattern in the managed care and health services market-

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places until the recent buyers' market for managed care redirected market control to purchasers.

HMOs. HMOs are merging and acquiring feverishly. For example, in the Twin Cities and in Boston there are only three dominant HMO competitors in each market area. This is a fraction of the number present in each market in 1990. The level of managed care consolidation in the Twin Cities, often a bellwether for managed care trends, became so great that the Business Healthcare Action Group, a group purchasing consortium of major employers (now known as the Buyer’s Health Care Action Group), chose in 1997 to contract directly with providers because of their dissatisfaction with the remaining choices. Here, and in many other maturing markets, purchasers are finding themselves with fewer and increasingly similar product options. The available products all have extremely broad network composition, reflecting minimal health plan selectivity in contracting and catering to consumers’ desire for choice. All of this potentially threatens the value that purchasers can obtain. Without meaningful competition among plans and providers, there is little incentive to provide increased value for consumers and purchasers.

Providers. As ominous as the trend is with health plans, it is more so with providers. An example is the planned merger of two of the three acute care hospitals in Worcester, Massachusetts. Each hospital has an occupancy rate in excess of 85 percent. Minimal consolidation and few layoffs are anticipated as a result of the merger, according to the future chief executive officer of the new organization. Instead, the incentive for the two hospitals to merge is the increased leverage they will gain in negotiations with health plans—leverage that will diminish health plans’ ability to be accountable to purchasers and the consumers for whom they buy health insurance. This incentive for provider organizations to merge is further strengthened by HMO mergers and acquisitions. The larger and stronger the HMOs, the greater the desire for providers to consolidate.

Provider consolidation is a greater threat to marketplace competition than is health plan consolidation because the barriers to providers’ entry into the market are much greater than they are for health plans. A group of purchasers can respond to health plan consolidation by directly contracting with providers, as was done in the Twin Cities, or by enticing new managed care organizations into the marketplace. Once provider consolidation has reduced marketplace competition, it is extremely difficult for purchasers or health plans to reintroduce it.

Lack of concern for quality. Despite the great strides made in quality measurement and reporting, purchasers and consumers seldom buy because of quality of care. Instead, purchasing decisions are based on cost, network size, and administrative convenience. Few purchasers have ever terminated an HMO contract because the quality of the plan’s care management or the care itself was poor compared with that of an HMO’s competitors. Yet purchasers and consumers alike shift from one plan to another on the basis of cost, the presence of consumers’ providers in the network, or the way that consumers and purchasers have been treated by health plan and provider staff. Although the last two criteria might be defined as elements of quality, they are at most indirectly related to the effectiveness of care delivered by a provider or health plan.

Examples among HMOs. The HMO industry knows this. It knows that high quality-of-care scores win few if any contracts. For ex-
ample, Fallon Community Health Plan and Harvard Community Health Plan—recently ranked as the two highest-quality HMOs in the United States by U.S. News and World Report—have watched their competitors experience dramatic enrollment growth while they have lagged behind. These two HMOs, both closed-model plans, must restructure themselves to compete. Fallon now contracts with physicians outside of the group practice and offers members easy access to Boston teaching hospitals. Harvard (now known as Harvard Pilgrim Health Care), originally founded as a staff-model HMO, merged with an independent practice association (IPA)–model HMO and is spinning off its health centers. Although these fundamental structural changes may help each health plan to regain market share, they threaten each plan’s preeminent position as quality leaders, since it was their structures and resulting cultures that contributed heavily to their successes in quality of care.

Reasons for lack of interest. Some may argue that quality considerations have been marginal in purchasing decisions because existing information is rudimentary and does not address the primary concerns of consumers. Yet large employers have been assessing health plan performance with the aid of consultants, or have had the capacity to do so, for some time. Few have rewarded higher-quality plans with more business, and few have demanded accountability of plans when performance is deemed mediocre or poor.

This lack of interest on the part of purchasers emanates from consumers. A study conducted in Pennsylvania indicated that consumers seldom consulted publicly available information on comparative cardiac bypass mortality rates before undergoing bypass surgery. Similar results were found after the public release of hospital mortality data by the Health Care Financing Administration (HCFA). Consumer surveys and focus groups generally have ranked information on quality low among the types of information desired by those choosing a health plan or a provider.

Possible consequences. If purchasing decisions continue to be devoid of quality-of-care considerations, health plans will continue to make business decisions to trade off quality for cost, choice of providers, and service. For the health plan, sound marketing practice will dictate that it is better to retain a personable, well-liked doctor whose clinical skills are marginal than to remove that physician. Who can blame the health plan or the provider? They are responding to the desires of their customers.

Unfortunately, under these circumstances, quality will decline, and the interests of the public will suffer. Government, appropriately, will surely enter the market with consumer-protection regulations that are far more stringent than any of those now being contemplated in Congress or in state-houses.

Making The Market Work

How can these threats to markets be addressed? There are two potential solutions. To deal with the issue of excessive industry consolidation, the answer must come from government. Only government can regulate markets. Unfortunately, there has been minimal activity at either the state or federal level to guard against the decline of competition in managed care and health care markets. In fact, the courts have ruled against the U.S. Department of Justice and the Federal Trade Commission (FTC) on more than one occasion in the past two years on this very issue. Federal and state governments must turn their focus from for-profit medicine and any-willing-provider legislation to ensuring continued market competition among providers and among health plans through regulatory oversight, using existing laws. In addition, em-
Employers must question whether mergers in their communities will create actual efficiencies and must be willing to speak out in a court of law if they perceive that a merger is likely to be anticompetitive. Too often the FTC and the Justice Department are constrained by employers’ support of unfounded efficiency claims made by merging entities.

To address quality, large purchasers—including employers, purchasing coalitions, states, and the federal government—must make quality of care a real criterion in purchasing decisions. Purchasers must work closely with contracting health plans to target measurable improvements in health care delivery and population health status. For example, purchasers should set forth annual quality-improvement goals with their contractors (for example, decrease hospital admissions for asthma by 10 percent) and then regularly measure goal attainment. Health plans that deliver better-quality health care at a competitive premium should be rewarded with higher enrollment volume. Plans that perform less well should initially have enrollment limited by the purchaser and ultimately lose their contracts.

Simultaneously, purchasers and government will need to step up efforts to give consumers more and better information in formats, at times, and on topics that are relevant to them. This might include comparative information on individual physician or hospital performance relative to treatment of specific conditions (for example, for women with breast cancer, which hospitals and physicians show the best outcomes for patients with characteristics similar to those of the consumer).

A marketplace approach to purchasing can work, but it requires a healthy marketplace and sophisticated purchasers. As is often the case, only combined efforts on the parts of government (as both regulator and purchaser) and industry can right the market so that it more effectively serves purchasers’ and consumers’ interests.

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NOTES

9. F.T.C. v Freeman Hospital, 69 F.3d 250 (8th Cir. 1995); U.S. v Mercy Health Services et al., 902 F. Supp. 968 (N.D. Iowa 1995), vacated and remanded (8th Cir. Iowa, 26 February 1997); and F.T.C. v Butterworth Health Corporation, Dkt. no. 1:96 CV49 (W.D. Mich.).