Consumer information needs in a competitive health care environment

by Theresa Varner and Jack Christy

The role of information in facilitating choice in a competitive health care marketplace is clearly pivotal, but it is also complex and occasionally problematic. Although it is clear that information is critical to the competitive approach, less clear is the relationship between the availability of appropriate information and the exercise of informed choice, a relationship that is obscured in the tangle of influences that affect the use and delivery of medical care. Nonetheless, the centralized and standardized collection, review, and dissemination of relevant health care data remain the keys to predicting—and avoiding—adverse outcomes in the development of health care policy.

Introduction

In recent years, growing concern over rising health care costs has led to the exploration of a variety of options—both regulatory and market-oriented—to control spending for health care. Increasingly, though, in both the public and private sectors, confidence seems to be growing in the ability of the competitive approach to restrain health care costs by changing those incentives to which consumers and providers of medical care typically respond. Under the ideal competitive model, consumers, sensitive to the financial consequences of their use of medical services, seek out less-expensive health plans that have been created in response to altered consumer demand. The role of information in facilitating choice in such a system is clearly pivotal, but it is also complex and occasionally problematic.

Over the past few years, Congress and the Administration have demonstrated an interest in the competitive approach to the delivery of health care services to older Americans. This commitment is particularly reflected in the health maintenance organization (HMO) provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which encouraged the enrollment of Medicare beneficiaries in prepaid capitated health plans under at-risk contracts with the Health Care Financing Administration (HCFA). Further, the Administration has expressed interest in the concept of geographic capitation and in Medicare vouchers.

Its supporters claim that a prepaid capitated approach to health care delivery holds the potential to reduce costs to both Medicare beneficiaries and the program itself, to expand services through creative restructuring of benefit design, and even to improve quality of care. But both detractors and supporters would agree that the success or failure of any competitive model is linked in large part to the principle of informed consumer choice, a principle that is predicated on the availability of sound, comprehensive, and comparative data.

If the availability of such data represents a necessary condition for meaningful competition in the health care system, it does not constitute a sufficient one. The health care marketplace is enormously complex, responding (occasionally in paradoxical ways) to subtle, and sometimes indistinguishable, technical, economic, political, cultural, and demographic influences. Nevertheless, the systematic collection, processing, and dissemination of relevant health care data facilitate informed choice in the marketplace and protects the public directly by providing consumers with specific information on medical system costs, services, operations, and quality. It also represents an important tool that can be used by policymakers to evaluate the strengths, weaknesses, and limitations of prepaid capitation approaches. With the availability of such data, decisions governing both individual beneficiary behavior and the development of public policy can be based on information and analysis, not intuition or ideology.

Competition and a changing health care system

Over the past several years, health care costs and prices have risen at rates that have far outpaced the rate of general inflation; rates of growth in the Medicare program have historically been even higher than those in the larger health care sector. Although increases in health care spending in 1984 and 1985 fell below 10 percent, recent figures from the Consumer Price Index (CPI) for 1985 and 1986 would suggest that the battle to contain health care costs is by no means won. In 1985, when the general inflation rate was 3.7 percent, medical care prices rose by 6.2 percent. The gap is expected to be even wider in 1986. The sense of urgency that continues to pervade the cost-containment effort is heightened by a growing awareness of the inevitable increase in consumption of health resources by an aging population. Somehow the dilemma that exists between dwindling resources and growing—and sometimes conflicting—demands on those resources must be resolved.

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It is this environment of fiscal austerity and raised consciousness about health care costs that has spawned explicit and dramatic cost-containment efforts such as the Medicare hospital prospective payment system (PPS) and the physician fee freeze. But increasingly the Administration is looking to the marketplace as the most appropriate arena for controlling health care costs. This approach calls for the introduction of "proper" incentives in the delivery and purchase of medical services—incentives to the consumer to use only necessary services delivered by efficient providers and incentives to providers to deliver cost-efficient services. Such market-based reforms are intended to correct the excesses of traditional cost-based reimbursement practices. Of particular interest to the Administration is the prepaid capitation model, which involves prospective reimbursement to health maintenance organizations (HMO's) under risk-sharing contracts with HCFA at a rate equal to 95 percent of the adjusted average per capita cost (AAPCC). The AAPCC is the estimated average per capita amount that Medicare would otherwise pay for medical services provided to beneficiaries in the local fee-for-service market. The AAPCC is adjusted for age, sex, welfare status, and institutional status; it is not adjusted for health status.

The prepaid capitation model appears to represent a useful tool in the public effort to restrain medical cost increases. But it is not without its problems. Health economists who have commented recently on the capitated approach suggest that the claims about its putative success in reducing costs, particularly through reduction in hospital admissions, are possibly exaggerated or premature (Merrill and McLaughlin, 1986; Luft, Maerki, and Trauner, 1986; Johnson and Aquilina, 1986; Feldman et al., 1986). Concerns about adverse selection, enrollment/disenrollment practices, marketing and advertising abuses, government overpayments, the provision of care to the frail elderly and to the indigent, premium and capitated payment calculations, and underutilization of services are widespread.

In theory, the availability of information—the enabler of informed consumer choice—could act to correct some of the problems or potential problems that have been identified under a capitated approach. In any event, the primary function of consumer information is to protect consumers and to guide them in effective use of the health care system. But even those who recognize the pivotal role of information in a competitive medical environment believe that the standard competitive model ignores the uniqueness of the health care industry; i.e., it ignores the unique nature of the medical "product" and the relationship between the provider of medical services and consumers of those services.

Moreover, it is naive to expect uniformly judicious decisions by consumers of medical care, even though they may share similar medical conditions and access to the same information about treatment options. The complexity of medical data alone invites a variety of responses to an identical set of relevant facts. And that inherent complexity is confounded by the intensely personal and usually collaborative nature of the medical decision itself, a decision frequently made under stress and carrying possibly profound implications for the patient. The selection of one course of action over another, springing as it does from a variety of considerations, may not always be predictable or even apparent; nevertheless, this cannot be used to rationalize the withholding of critical information from consumers.

Burton Weisbrod (1983) contends that the health industry is *not* unique, but that "it has characteristics that make inappropriate certain assumptions—such as that of well-informed consumers—and that therefore raise doubts about the economic consequences of increased competition." Weisbrod points out that in negotiating the health care delivery system: (1) "the consumer is not purchasing a standardized commodity consumed under standardized conditions; so learning from experience is more complex"; (2) the consumer is often unable to judge "the 'counterfactual'—what would happen if the consumer did not obtain the care compared with what would happen if he or she did obtain it. . ."; (3) consumers are likely to turn to "agents" for guidance in making health care decisions, in a sense relinquishing their decisionmaking authority to "sellers" of medical services who may be better informed than "buyers" of those services (a phenomenon that Weisbrod characterizes as "informational asymmetry"); and (4) physician-agents may be placed in a "position of dual and conflicting responsibility. . . ." Weisbrod concludes that despite the presence of "mechanisms for coping with informational asymmetries in health care, even quite sophisticated consumers are often poorly informed about options that are important to them."

Weisbrod's observations are troubling, for they call into question the fundamental premise on which the competitive approach is based, i.e., that informed consumer choice is not only necessary but achievable. His caveats should not deter us, however, from the goal of designing an appropriate information system, but rather should alert us to the special requirements of that system. For if we can expect any positive economic consequences from increased competition in the health care marketplace, they must be rooted in informed consumer choice. Without adequate information to guide consumers in their assessment of medical plan options, they are participating in a game that deprives them of access to its rules. Thus, consumer participation may be random or irrational. And without adequate information, the public policymaker may pursue a policy course whose implications for the delivery of adequate, appropriate, and cost-effective medical care are unforeseeable, especially for the long term.

Information system characteristics

At least in theory, one of the exciting features of a health care system in transition, especially one headed in the direction of market-based reform and increased competition, is that it tends to encourage experimentation and innovation. Presumably, in a competitive environment, traditional providers of health care, health insurers, and alternative delivery entities vie with one another for the enrollment of consumers in their medical plans. The process by which providers and insurers attempt to attract potential enrollees supposedly spawns the development of new and enhanced benefit packages carrying lower out-of-pocket costs. Thus is the health care landscape dotted with the confusing acronymic byproducts of competition—HMO's, CMP's (competitive medical plans), IPA's (independent practice associations), PPO's (preferred provider organizations), SHMO's (social health maintenance organizations), etc.

Further, as Ginsburg and Hackbarth (1986) have pointed out, with the shift of financial risk from the Federal Government to private health plans under prepaid capitated contracts comes a parallel shift in the locus of responsibility for making decisions about the spending of health care dollars and the allocation of medical resources. "The essence of the ADS (alternative delivery system) approach," they say, "is to decentralize those complicated and often subjective decisions." Ginsburg and Hackbarth favor this decentralization from the Federal Government to private health plans because, in their view, it offers greater flexibility and protection to physicians and patients.

In a competitive system, however, the proliferation of health delivery plans and the decentralization of responsibility for decisionmaking about medical practice and provider payment create special problems for an emerging but still inchoate data collection system. For example, it is the availability of standardized health care use and expenditure data that has enabled Medicare to develop risk contracts with HMO's and thus participate in the current competitive environment. For the population under 65 years of age, however, uniform health care use, expenditure, and quality data do not exist. Thus, the ability of consumers to manipulate a competitive marketplace to their advantage is critically impaired.

What is required—now more than ever before—is the collection of uniform and comprehensive health service delivery data, using standardized instruments covering a broad spectrum of relevant health care information. It makes little sense to collect information if it does not permit us to compare and contrast health care providers and plans. Further, the data collected must be systematically processed and analyzed and presented in a form that is intelligible and meaningful to consumers and policymakers.

Responsibility for such data collection, processing, and dissemination appropriately resides with the Federal Government. Working with providers and consumers, the Federal Government must exercise its authority to define the necessary elements of such an information system and require its use throughout the country. In addition, the Federal Government must coordinate data collection and must monitor the methodology used in the data collection process to ensure uniform reporting.

In the past, HCFA has funded various beneficiary-awareness projects. One such project is HealthChoice in Portland, Oregon, a health brokerage program designed to inform Medicare beneficiaries about their health care options and to enroll them in alternative health care plans. Similarly, the American Association of Retired Persons publishes a consumer's guide to HMO's and has operated a HCFA-funded beneficiary-awareness project, The HMO Informed Buyer. The latter made use of older volunteers to educate the public about HMO's and to influence the way in which HMO's deliver medical services. Because the health care brokerage and beneficiary education projects are of undeniable benefit to consumers, it is imperative that funding for such programs be stable and reliable.

It is sometimes suggested that consumers may be overwhelmed by the sheer volume of health care information available to them. Deregulation of the telephone industry was expected to yield cost savings as corporate competitors lowered prices to attract customers. A byproduct of this competitive environment has been the proliferation of confusing and noncomparative data that has frustrated even the most ardent of prudent consumers. But the problems associated with information overload in the telephone industry should not be used to justify restrictions on consumer information in the medical marketplace. Rather, they should be seen as clear evidence of the need for centralized and standardized data collection, processing, and dissemination.

The design of such an information system lies beyond the scope of this article. At a minimum, however, the system must address: (1) coverage issues; (2) cost and financing issues; (3) administrative and operational issues; and (4) quality of care issues. The types of information that might be subsumed under each one of these issue areas are discussed below.

Coverage

HMO's have the discretion to add services beyond those covered by Medicare and to price their benefits package accordingly. HMO's also have an obligation to return to the beneficiary—either through additional benefits, reduced premiums, or a combination of the two—the difference between Medicare's prospective payment and the actual cost to the HMO of providing services under the capitation contract. Consequently, there is great diversity among HMO's in terms of plan benefits. Complete information regarding the range of additional services should be collected.

To facilitate comparison, data on plan benefits should be reported on a uniform grid. The grid should include the broad range of services needed by older consumers, and HMO's should be required to indicate those services covered and those excluded under their plans. It is recommended that the uniform data collection instrument include at least the following categories:

- Hospital care.
- Physician services.
- Home health care.
- Homemaker and personal care services.
- Dentures, crowns, bridges.
- Mental health services.
- Medical and psychiatric care for patients with Alzheimer's disease.
- Routine physical, vision, and hearing examinations.
- Routine dental services.
- Health promotion/wellness programs.
- Prescription drugs.
- Eyeglasses.
- Hearing aids.
- Skilled or intermediate level nursing care.
- Routine and nonroutine foot care.
- Chiropractic services.
- Nutrition services.
- Transportation services.
- Hospice services.

If specific services are available through the HMO but not provided for Medicare beneficiaries, it is important to know whether, and under what circumstances, Medicare beneficiaries may use those services on a fee-for-service basis.

The lock-in provisions of the HMO should be clearly delineated, as should regulations governing the use of out-of-plan services. The data collection instrument should also be capable of determining the portability of the HMO benefit. Information on benefit portability should specify the financial consequences to the enrollee who uses out-of-plan services or emergency services outside the service area of the HMO.

Administration and operation

Disclosure statements and HMO comparative information should identify whether the HMO is a publicly held corporation, a private investor-owned corporation, or a nonprofit corporation. Because the issue of portability of HMO coverage is important to older consumers, information about the relationship of the HMO to a larger network (e.g., HMO-U.S.A., Kaiser-Permanente Health Plan, etc.) would be helpful. Data covering the composition of the Board of Directors should also be gathered.

HMO data collection materials should include information about the structure of the HMO (e.g., staff, group, network, or IPA) and the nature of HMO subcontracts for specialty care, home health services, hospice care, and other support services. Information on the nature of subcontracts should indicate which department in the HMO is responsible for controlling payment for subcontracted services. (For example, an HMO structure requiring that the primary care physicians pay the bills for specialty referrals or home health services from their capitated monthly allowance invites underuse of services).

Data collection instruments should be able to assess the degree to which the HMO promotes member participation in decisions about policies and procedures. Information gathered should include member participation in the election of the HMO Board of Directors, the existence of a Medicare advisory council or senior caucus, and/or the presence of a Medicare beneficiary ombudsman within the member services department.

Consumers are entitled to know the provisions the HMO has for member protection should the HMO face insolvency. Because Federal regulations allow a federally qualified HMO to demonstrate insolvency protections through a variety of means, it would be useful to know whether the HMO protects members against insolvency damages through hold-harmless provisions in agreements with hospitals and physicians, bonds or guarantees, or restricted reserves. Such information needs to be presented in language understandable to a lay reader.

There must be prompt public disclosure of any corrective actions ordered by the Federal Office of Prepaid Health Care or State Insurance Department, if financial reviews reveal a negative net worth or the inability of an HMO to maintain its financial projections.

Data collected from HMO's should provide complete information on enrollment and disenrollment practices. Further, data gathered should indicate whether the HMO is newly organized or well established. Disclosure data should include information about membership size, the number/percent of Medicare members, and the number/percent of Medicare members the HMO aims to enroll. Data collected should also include demographic breakdowns of the member population.

Disenrollment data can be useful as an indication of member satisfaction; results from formal member satisfaction surveys should also be available to members and potential members.

Costs and financing

HMO data collection should include the monthly premium for membership in the HMO (or premiums, if the entity offers both low- and high-option plans); that portion of the premium used to finance additional benefits should be so indicated.

HMO comparative material should also provide the current county per capita cost set by HCFA for the counties making up the HMO service areas, as well as historical increases or decreases since the HMO's entered into prepaid at-risk contracts with HCFA. Beneficiaries are entitled to know what the Federal Government has decided is an appropriate per capita payment for their care.

Information gathered on the financing of the basic Medicare benefit and any supplemental benefits should indicate deductible and coinsurance requirements.

Since, by law, savings accruing from differences between the AAPCC and the premium charged by the

HMO must be returned to Medicare beneficiaries, it is important that the form in which such savings are recast be explicitly stated. Has the HMO historically used the savings differential to: (1) reduce the HMO premium or reduce or eliminate deductibles and coinsurance; (2) offer supplemental services; (3) accept lower payments from HCFA; or (4) offer a combination of these approaches? What HMO policies govern the disposition of savings?

HMO comparative data should reflect the relationship between the total revenues of an HMO and its total expenditures; that is, they should provide a uniform indication of the existence of plan surpluses and deficits, both currently and over time.

Quality

The need for consumer information on quality of care in a capitated system is a major issue for consumers because of the negative incentives inherent in such a system to skimp on care. Clearly linked to issues of quality care in a capitated system are issues of quality service. If consumers find it difficult to reach a doctor by telephone, to secure an appointment to see a doctor, or to have elective surgery, then quality-of-service issues quickly merge with quality-of-care concerns.

The availability of comparative medical outcome data for capitated entities is critical to an evaluation of the ability of an HMO to provide quality care to its members. Such outcome data should include mortality and morbidity rates adjusted for age, sex, and case mix.

Data should be gathered on hospitals affiliated with the HMO. Is the affiliated hospital accredited? What is its range of services? What is its age/sex/case-mix-adjusted mortality rate? What is its nosocomial infection rate? Full explanatory material and interpretive aids must accompany such data to ensure their proper use.

Information gathered on the service delivery plan of an HMO should address the qualifications of the medical staff. Are physicians board-certified or board-eligible in their specialities? Is there a program of continuing medical education? What is the ratio of staff to patients by professional category? What use is made of the services of nonphysicians, e.g., registered nurses, physician assistants, nurse practitioners, etc., and under what circumstances?

An HMO comparative data base should incorporate various medical care use rates. These should include hospital admission rates (physician- and HMO-specific), referral rates, total days of hospital care, procedural volume, and average length of stay. Group-specific as well as aggregate data would be helpful, and disaggregation by diagnostic group is desirable.

Data should be collected on the process by which quality care is ensured within the HMO and by which beneficiaries can appeal decisions affecting their medical treatment. The design of the in-house quality assurance program, including the peer review process and provisions for external review of medical records, should be described. So should the formal grievance system by means of which beneficiaries can appeal health care decisions with which they take issue. Complaint rates and general disposition data should also be collected.

A range of access issues should be covered in the data collection process. What provisions are made for emergency and after-hour care? What is the mechanism for referrals to plan and out-of-plan specialists? What is the mechanism for obtaining second opinions? What is the standard waiting time to secure a routine appointment? What is the average lag between the appointment time and the actual appointment? What is the typical length of encounter with physicians and other medical professionals? What provisions are made for ensuring continuity of care within the system?

HMO's should be required to disclose annual information about the number of physicians affiliated with the HMO and the number who left the HMO during the previous year for reasons other than retirement. Other useful information, in addition to requirements of the HMO for board certification of its physicians, would include the results of reviews of Board of Medicine records for disciplinary actions or complaints, and reviews for medical malpractice judgments.

Conclusion

It is appealing to believe that if we can create the proper climate for competition, market forces will control health care costs with little or no regulatory "interference." Certainly, the Administration's confidence in market reforms is reflected in its commitment to a capitated approach in meeting the health care needs of older Americans. But in attempting to alter the incentives to which consumers and providers respond, we should remember that the health care marketplace has proven to be resistant to the normal forces of supply and demand. A host of confusing and interdependent factors may intervene between the perception of need for a medical service and the delivery of that service.

Too, while it is clear that information is critical to the competitive approach, less clear is the relationship between the availability of appropriate information and the exercise of informed choice in the tangle of influences that affect the use and delivery of medical care. The relationship is further clouded by the simultaneous development of an array of new alternative delivery systems and the incorporation of those delivery systems into giant monolithic units through the mechanisms of vertical and horizontal integration, merger, and consolidation.

Finally, we must remember that the commitment to the capitated approach has its impetus in the need to control costs. But actions to control costs may not always be compatible with the delivery of quality medical care. We must ensure that quality of care is more than a subsidiary concern.

The centralized and standardized collection, review, and dissemination of data from existing capitated models remain the key to predicting—and avoiding—adverse outcomes in the development of health care policy. Before we proceed, then, down that Panglossian road to the world of capitation, we would be well advised to consider carefully the implications of our actions for the contract between society and its aging members.

Acknowledgment

The authors wish to thank Helen Savage, Alan Kaplan, and Stephanie Kennan for their valuable contributions to this article. They also wish to thank Marilyn Moon and John Rother for their helpful comments on drafts of this article.

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