

# Findings Brief

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– Jinnet Fowles,  
Park Nicollet Institute for  
Research and Education,  
HealthSystem Minnesota.

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## Health Plan Report Cards May Influence Insurers More Than Consumers: Their Effect on Insurer Behavior in Minnesota

Whether because of reality or perception, consumers are increasingly concerned that managed care strategies for cutting costs have a negative effect on quality of care. In response to these concerns — which are often voiced by public and private purchasers on behalf of consumers — many purchasers and independent accreditation organizations periodically issue report cards allowing current and potential enrollees to see how plans are rated on a number of different performance measures. While particular report card features differ, the goal of report cards is to equip group and individual purchasers with information so they can base their purchasing decisions on a plan's value — defined as a combination of plan cost and quality — rather than on cost alone. While there is not much research on the effectiveness of these comparative reports, the research that has been done has found that *health plans* may be more responsive readers of the report cards than purchasers or consumers, at least when the reports are based on surveys of enrollee satisfaction with health plan quality.

In a *Changes in Health Care Financing and Organization* (HCFO) study, Jinnet Fowles, Ph.D., vice president of the Park Nicollet Institute for Research and Education at HealthSystem Minnesota, David Knutson, also of HealthSystem Minnesota, and Jon Christianson, Ph.D., professor at the University of Minnesota, examined a Minnesota-mandated report card initiative that began in 1991 and required all health plans selling policies to state employees to participate in a consumer survey-based report card. They found that within four years, some of the five<sup>1</sup> plans involved had undergone a significant degree of internal restructuring to improve their quality ratings, including restructuring key front-line positions, garnering additional support for quality improvement initiatives, and reorienting clinics toward service quality initiatives. Through a series of interviews and case studies, the researchers found that the implementation of the report card initiative was generally cited as an incentive for the increased attention given to quality improvement and service initiatives.

### Apparent Lack of Consumer Use Raised Questions of Card Impact

According to Fowles, the principal investigator for this study, the apparent lack of direct effect of report cards on consumers seemed to

warrant an examination of the possible effect of report cards on health plans. Fowles and colleagues believed that “there was an untold story at the market level that needed to be examined. Getting the full picture of the effects of report cards requires looking at all parties involved, including the plans being rated.” Health plans may be concerned about the potential impact that negative survey results could have on future enrollment. Thus, the researchers hypothesized that plans might respond to the surveys by making adjustments to internal systems, resulting in changes in the way consumers receive care.

### Background

Beginning in 1992, and every two years thereafter, the Minnesota Department of Employee Relations (DOER) released a report card that included detailed information on health plan choices for state employees. This information included both administrative information from the plans on such measures as out-of-pocket and premium costs, and data from a DOER-sponsored survey of enrollees that asked questions about plan quality, access, and other areas of performance central to the consumer-provider relationship. The plans were surveyed every two years between 1991 and 1996. Starting in 1993, they were required to design and implement “action plans” for improving quality and to submit quarterly progress reports.

In conducting their research, Fowles and colleagues interviewed both DOER representatives and a range of senior-level representatives at the five plans, including CEOs, senior medical directors, medical and administrative heads of quality assurance and improvement, marketing directors, and information systems directors. The goal was to glean factual information as well as subjective opinions and insights into the effects of health plan report cards on the various levels of operation within health plans. The researchers also collected data from other contemporaneous sources when possible. The study's primary research objective was to determine the magnitude and direction of health plan response to the report card and to identify plan factors that were associated with their response.

The researchers found that changes by the health plans in response to the report card were most evident in both magnitude and direction

<sup>1</sup> At the start of the initiative, eight plans were involved. By the time the study ended, however, mergers reduced the number of plans to five.

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according to the following: 1) the nature of the relationship between the plan and its provider network; 2) the relative importance of the state's employee enrollment to the plan; 3) the size of the plan; 4) the degree of market competition faced by the plan; and 5) the plan's articulation of a strategic business vision.

## Minnesota Market Stability May Explain Plans' Responsiveness

According to the researchers, Minnesota's health plans responded to the report card initiative to a much greater extent than did consumers. In fact, the effects of the report card on the market were considered out-of-proportion with their effects on consumers. One reason for this, according to Fowles, is that "managed care did not have the same negative reputation in 1991 that it does now. The magnitude of the response is an indication of how innovative these plans were in their reaction." The researchers report that what plans valued most — and reacted to most significantly in the face of a quality and value-based report card — was their reputation. "Concern about reputation was the largest driver of health plans' response, even when they saw that consumers were not likely to react to the report card information," says Fowles. "It is a phenomenon that is explained less by economic theory and more by human nature."

All five plans studied were affected by the report card initiative, albeit to differing degrees and with different specific changes. Concrete changes that occurred concurrent with report cards include the development and implementation of internal quality improvement initiatives, an increase in internal measurement and monitoring, and the reorientation of clinics and clinical professionals within the separate health plans toward quality improvement and service initiatives. Of particular significance was the fact that some plans experienced a significant increase in the number of and, in some cases, the salary for staff dedicated to working on issues of health care quality. Fowles says, "Plans took the challenge to meet consumer complaints very seriously." For example, to improve responsiveness, plans enhanced the ability of front-line staff to resolve some problems without referral. These responses added up to measurable internal improvements that could be associated with the report card initiative.

The researchers caution against attributing these positive outcomes to the report cards alone, noting that market characteristics, demographics, and insurance regulations also play a role in any measurable health plan struc-

ture. In terms of market characteristics, Fowles says that Minnesota has had a relatively stable health care market due to state regulation against the operation of for-profit plans. Thus there is no opportunity for plans to "come in for the kill" — entering the market with an under-priced product, making a profit, and then leaving. In addition, while the key staff at a specific health plan may leave their positions, they often move to a different plan within the same market, making accountability easier to track. Market stability may play a large role in why a plan would be concerned enough about its reputation to take constructive action in response to a report card that was compiled primarily for purchaser use. From a policy perspective, it would appear that the state wisely linked the report card initiative with an action plan and progress report requirement.

However, it is the health plans' perspective on the purpose a report card serves that helps determine their response to survey results. If the card is considered a marketing tool that directly affects enrollment or a symbol of quality similar to accreditation, then there is a market-based motivation to improve quality in ways that enrollees can identify. Policymakers might ask whether regulations or market forces have a stronger impact on quality improvements — particularly in areas where market competition among managed care organizations is high.

## Questions Remain About the Value of Producing Costly Plan Comparisons

Extensive costs are associated with designing and disseminating information on health plans, and many wonder, given the seeming lack of interest on the part of consumers, whether these expenditures are justified. Fowles states "there is definitely benefit in using public information, but currently it appears that the benefit is being realized at the institutional level and not the consumer level." She and her colleagues are currently working on a study evaluating consumer response to report cards that compare care systems rather than health plans. As with most health services research, the results of this completed study trigger other questions. Would the results have been the same in different markets at different times? Would newer managed care organizations react the same way as more established ones? Because many players have an interest in producing report cards, evidence of their effect, or lack thereof, will continue to be a source of debate and research. ■

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