What Do We Know about Quality of Care in For-Profit and Nonprofit Managed Care Plans?

As described on pp. 167–69 of the book, the U.S. health care system underwent a fundamental shift in the period of approximately 1985–2000. That shift was from a system organized principally on a nonprofit basis, to one dominated by for-profit corporations. While for-profit ownership has made only moderate inroads in the hospital industry, for-profit has become the dominant model in the market for health insurance. Most HMOs and nearly all PPOs are operated as for-profit entities.

In May 2006 the American Medical Association reported that the process of consolidation in the health insurance market had continued to the point where a few major plans dominated most regional markets. The report stated that “in just about every metropolitan area, one or two firms control at least half the HMO/PPO market . . . local market domination is a fact of life in just about every metropolitan area in the country.”


James Robinson, of the University of California, Berkeley, published an in-depth discussion of the changes that are taking place in the private health insurance market in light of the steady erosion of employer-sponsored health insurance discussed in Chapter 4 above.

Physicians and the Profit Motive

On pp. 179–83 of the book, I describe some of the recent changes in physician practice patterns that appear to create new or increased economic incentives for physicians. When issues of what type of care and how much care to provide also subsume opportunities for physicians to increase their incomes, the separation between appropriate and inappropriate care sometimes gets murky.

The *New York Times* reported on just such an issue. It turns out that 12,000 physicians have purchased an automated electronic instrument that is able to check for nerve damage. Formerly a tool only for the neurologist, a wide range of physicians, including primary care physicians, are now acquiring the instrument. The instrument costs about $5,000; regular use of it in one’s practice is estimated to net physicians upwards of $50,000 per year. The news report interviews primary care doctors who are in favor of more general use of the instrument, specialists who question its widened use, and the doctor who founded the company that sells the device. Stories such as these raise added concerns about the question of physicians’ motives when clinical decisions carry with them economic consequences.


While the inappropriate use of a nerve-tester seems to present a straightforward case of mixed motives, the frequency with which a physician or a group of physicians recommend a clinical procedure that does not involve the use of a new device can be less clear. The frequency with which doctors recommend a procedure such as angioplasty presents just such an issue. Described on p. 244 of the book, angioplasty has become the most common procedure to reopen
clogged arteries feeding the heart. The *New York Times* reported data on the North Ohio Heart Center, a group of more than thirty cardiologists in Elyria, Ohio. Using a small, local, nonprofit hospital as the site of treatment, the doctors at the Heart Center were found to have performed about 3,400 angioplasties in 2004. In 2003, the latest year for which Medicare data was available, the doctors at the Heart Center had performed 42 angioplasties per 1,000 Medicare patients. The average rate for the rest of Ohio was 13.5 angioplasties per 1,000 Medicare patients; for the country as a whole the rate was 11.3 angioplasties per 1,000 Medicare patients.

No one interviewed in the news story suggested that the doctors at the Heart Center were acting for pecuniary gain. However a number of commentators suggested that, when the rate is three times higher than the rest of the country, not all of the procedures were equally appropriate. As one doctor from San Francisco is quoted as saying, “It’s sort of like you go to a barber and ask if you need a haircut. He’s likely to say you do.” (For a discussion of how different rates of angioplasty and other revascularization procedures are associated with death rates from cardiac disease, see pp. 50–51 in the book.)


**Physicians and Specialty Hospitals**

The issue of physicians having an ownership interest in a specialty hospital to which they refer their patients continues to be a contentious one. Until issues of possible conflict of interest were sorted out, beginning in 2003 the federal Centers for Medicare and Medicaid Services (CMS) had placed a moratorium on certifying any new specialty hospital. (This issue is discussed on pp. 181–83 of the book.) After thorough review, CMS lifted the moratorium in the
summer of 2006. However, new specialty hospitals will be required to provide more publicly available information about their ownership structure.

The health policy journal *Health Affairs* published a series of articles addressing the issue of physician-owned specialty hospitals. Understandably, the authors, representing a variety of backgrounds, came to a variety of conclusions: “Specialty hospitals provide generally high-quality care to satisfied patients” (Greenwald et al., p. 106). “Research findings thus far confirm that physicians’ ownership and referral present conflicts of interest through medical and economic patient selection and potentially excessive utilization” (Kahn, p. 130). Articles in this issue of *Health Affairs* (2006; 25[1]) include:

- Guterman S. Specialty hospitals: A problem or a symptom? (pp. 95–105).
- Kahn CN. Intolerable risk, irreparable harm: The legacy of physician-owned specialty hospitals. (pp. 130–33).
- Stensland J, and Winter A. Do physician-owned cardiac hospitals increase utilization? (pp. 119–29).

An important article also appeared in March 2007 in *JAMA*. The authors studied the rates of cardiac revascularization procedures among Medicare beneficiaries for the years 1995–2003. Using the “hospital referral region” (HRR) as the unit of comparison, the authors found that, “The opening of a cardiac hospital within an HRR is associated with increasing population-based rates of coronary revascularization in Medicare beneficiaries.”

Nallamothu BK, et al. 2007. Opening of specialty cardiac hospitals and use of coronary
revascularization in Medicare beneficiaries. *JAMA* 297:962–68.

In an editorial that accompanied the article by Nallamothu et al, Cram and Rosenthal stated, “the current findings suggest that physician ownership of specialty hospitals may be problematic if such ownership increases the use of services for patients with marginal indications. As specialty hospitals evolve, vigilance will be needed to determine if benefits are being delivered as promised and if untoward effects on the delivery system are emerging.”