

# Update On The Nation's Health Care System: 1997–1999

*Health care systems are in flux nationwide, as this in-depth look at twelve communities demonstrates.*

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**ABSTRACT:** A major component of the Community Tracking Study is biennial site visits to twelve communities randomly selected to be representative of metropolitan areas. In the second round of visits, conducted in 1998 and 1999, we found an intensification of an earlier trend toward looser forms of managed care to be causing

enormous turmoil, as health care organizations stumbled over and often abandoned strategies conceived for more tightly managed care. Communities' health care systems are not evolving as many anticipated but rather have focused increasingly on horizontal consolidation and regional scope.

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AT THE TIME OF the Center for Studying Health System Change's (HSC's) first round of site visits to twelve communities in 1996–1997 (the baseline for this Community Tracking Study analysis), pressures for looser forms of managed care had already begun. A rapid shift toward managed care enrollment had led employees to demand less restrictive forms of managed care.<sup>1</sup> Policymakers were aggressively pursuing managed care enrollment for Medicaid and Medicare beneficiaries while establishing regulations aimed at limiting some of the more restrictive practices of managed care plans.<sup>2</sup>

Health plans and providers were actively positioning themselves in response. Plans' strategies centered on consolidation and geographic expansion, aggressive pricing to expand market share, and development of less restrictive managed care products.<sup>3</sup> Providers were making efforts to consolidate and develop new organizational arrangements and partnerships for contracting with plans. Both plans and providers also experimented with ways to make care delivery more efficient and

to reap the benefits of these savings, with innovative payment arrangements and mechanisms for monitoring and reporting on practice patterns.<sup>4</sup>

This paper examines how communities' health care systems have evolved since 1996–1997. Following a brief review of our site visit methodology, we discuss the intensification of consumer backlash against managed care and its effect on product types and payment arrangements. Against this backdrop, we describe major changes in the strategies of health care organizations, including the move away from vertical integration and intermediary organizations toward a competitive dynamic that emphasizes horizontal consolidation and the pursuit of regional scope. Our discussion concentrates on the implications of these changes for consumers' access to care and the efficiency of the system.

## Methods

Twelve markets were randomly selected from a sample of metropolitan statistical areas (MSAs) with a population of 200,000 or more

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to collectively be representative of the nation as a whole.<sup>5</sup> The result is a diverse set of markets, which vary in population and health maintenance organization (HMO) penetration (Exhibit 1).

A team of researchers conducted forty to sixty interviews with key participants in each local health care market, including representatives of employers, health plans, hospital systems, physician organizations, consumer groups, and state and local policymakers. A first round of site visits conducted between June 1996 and February 1997 developed a baseline picture of each of the markets. Respondents were asked about their organization, those with which they compete or do business, and the competitive dynamic in the market overall. Respondents' reports about developments at their organizations then were compared with reports from their competitors, suppliers, or customers. Results from the first round of visits have been published elsewhere.<sup>6</sup>

In the second round of Community Tracking Study (CTS) site visits, conducted between June 1998 and February 1999, interviews focused on updating information and identifying key changes. Standard interview protocols were customized for each site to inform respondents about findings from the first visit and to probe for changes relative to that time.

### Findings

Our findings are best understood through a framework of the demand (consumers and purchasers) and supply (providers and health plans) sides of a market. During the 1997-1999 period a demand-side trend toward looser forms of managed care accelerated (unexpectedly to some respondents) and caused tremendous turmoil on the supply side, as strategies that had been conceived in anticipation of highly integrated managed care unraveled. One important exception was horizontal consolidation among plans and

### EXHIBIT 1 Characteristics Of Community Tracking Study Sites, 1998

Region and site	Population (thousands)	1998 HMO penetration
East		
Boston, MA <sup>a</sup>	4,392	49%
Northern NJ <sup>b</sup>	1,952	24
Syracuse, NY	735	20
South		
Greenville, SC	918	10
Little Rock, AR	556	27
Miami, FL	2,152	64
Midwest		
Cleveland, OH	2,223	27
Lansing, MI	450	41
Indianapolis, IN	1,519	23
West		
Phoenix, AZ	2,931	34
Orange County, CA	2,722	46
Seattle, WA	2,313	29

**SOURCES:** Population figures are from the U.S. Census Bureau, 1998. Health maintenance organization (HMO) penetration rates are from *InterStudy Competitive Edge Regional Market Analysis 8.2* (Minneapolis: InterStudy December 1998).

**NOTES:** HMO penetration includes point-of-service and open-access products. HMO penetration in metropolitan statistical areas (MSAs) nationwide is 34 percent; the U.S. total penetration rate is 33 percent.

<sup>a</sup> The Boston Community Tracking Study site varies slightly from the MSA definition. Estimates for the population enrolled in HMOs have been adjusted to reflect this variation.

<sup>b</sup> Northern New Jersey is defined by the Newark primary MSA and includes Sussex, Warren, Morris, Essex, and Union Counties.

providers, which, if anything, became increasingly emphasized.

■ **Backlash and consumer demand.**

While consumers have voiced concern about managed care for several years, the backlash against it intensified during 1997–1999 and began to have visible effects on local markets.<sup>7</sup> Backed by employers and state legislative efforts, consumers' demands for less restrictive managed care products gained force and were reflected in changes in enrollment patterns, product offerings, and health plans' policies. In contrast to widespread prior expectations about how health care markets would evolve, this period was noted for slow HMO growth and a general retreat from highly managed products.

*Employers' stance.* Strong economic growth and tight labor markets noted across all sites contributed to heightened consumer expectations and increased willingness on the part of employers to accommodate employees' preferences for more loosely managed products.<sup>8</sup> As in the first round of site visits, employers noted a continued emphasis on offering products with broad networks, out-of-network coverage, and less restrictive access to care.<sup>9</sup> This stance was particularly evident in high-technology labor markets such as Boston and Seattle, where employers expressed reluctance to promote more restrictive insurance products or limit workers' choice of providers because these actions would put them at a disadvantage in competing for skilled labor.

*State legislation.* Market demand for more loosely managed products has been bolstered by the flurry of recent state legislative activity to regulate managed care. Over the past two years new restrictions on managed care were established in states in which all twelve of our study sites are located, regardless of the levels of HMO penetration or the presence of existing legislation.<sup>10</sup> The new regulations, commonly enacted under the auspices of an omnibus "health care quality act" or "patient protection act," focused on three areas: mandated benefits, grievance procedures, and consumer protections (Exhibit 2). Some of them, such as those that require health plans

to offer certain types of products or establish requirements regarding plan operations, have had direct effects on the structure and types of the products offered in these markets. However, their most significant effect was indirect, in their contribution to the overall climate favoring less restrictive management of care.

*HMO enrollment.* Slower-than-expected growth in HMO enrollment was noted by respondents across all of our study sites, despite at least some increase since 1996–1998 in most sites (Exhibit 3).<sup>11</sup> The average large metropolitan area experienced only a seven-percentage-point increase in HMO enrollment between 1996 and 1998. Even markets that exceeded this average saw far less rapid growth than had been anticipated. For example, in Seattle, where HMO enrollment rose by ten percentage points, an even greater boost was expected. The community's largest employer, Boeing, had recently implemented an aggressive HMO-enrollment initiative, and other local employers were expected to follow suit. However, they did not, and an extensive, marketwide shift to HMOs did not take place.

Our recent site visits also reinforced the earlier finding that enrollees in preferred provider organizations (PPOs) appear unlikely to switch to HMOs as many predicted.<sup>12</sup> For example, Greenville saw virtually no increase in HMO penetration over the two-year period, despite some expectations that the community's large PPO enrollment would begin to move into more restrictive products. Indeed, in many markets PPO enrollment continued to grow rapidly; respondents now reject the notion that this is a transitional product that will lead to HMO enrollment.

*Changes in health plans.* Instead, this period was marked by stepped-up efforts by health plans to make their HMO products less restrictive. Two years earlier, health plans across our study sites were already responding to purchasers' demands for provider choice and improved access to specialists by expanding networks, easing gatekeeping restrictions, and offering "open access" and point-of-service (POS) options in their HMO

**EXHIBIT 2****Summary Of Selected Managed Care Regulations Enacted Since First-Round Site Visits, As Of 31 May 1999**

<b>Community Tracking Study site</b>	<b>Grievance procedures or review processes</b>	<b>Consumer protection</b>	<b>Mandated benefits</b>
Boston	Yes <sup>a</sup>	No	No
Cleveland	Yes	Yes	Yes
Greenville	No	Yes	Yes
Indianapolis	Yes	Yes	Yes
Lansing	Yes	Yes	Yes
Little Rock <sup>b</sup>	Yes	Yes	Yes
Miami	Yes	Yes	Yes
Northern New Jersey	Yes	Yes	Yes
Orange County	Yes	Yes	Yes
Phoenix	Yes	No	Yes
Seattle	No	Yes	No
Syracuse	Yes	Yes	Yes

**SOURCE:** Data for this chart are drawn from the National Conference of State Legislatures, Health Policy Tracking Service, and were confirmed during our site visits and follow-up phone interviews.

**NOTES:** The categories are defined to include the following: (1) Grievance procedures or review processes: Requirements pertaining to external review and grievance processes, mandated time frame for internal reviews of appeals, and other requirements concerning health maintenance organization (HMO) internal review procedures and arbitration decisions. (2) Consumer protection: Requirements pertaining to plan product offerings and product design (such as mandatory point-of-service option, restrictions on "gag clauses," adequate choice of providers, access to nonformulary prescription drugs, and ability to seek out-of-network care for limited price differential), disclosure of information regarding provider network and plan performance, liability requirements regarding risk-based capital or other financial solvency standards, and any-willing-provider provisions. (3) Mandated benefits: Requirements to cover certain services according to a set standard, such as prudent layperson standard for emergency room services or forty-eight-hour hospital stay for deliveries, and requirements to allow direct access to certain providers, such as obstetrician/gynecologists.

<sup>a</sup> Passed via a governor's executive order.

<sup>b</sup> The state assembly was not in session at the time of the second visit. Developments represent what happened during and immediately after the first-round site visit in 1996.

product lines.<sup>13</sup> Between 1996–97 and 1998–99, however, these efforts to loosen up HMOs had become even more pronounced.

Across sites, respondents reported that broad and inclusive provider networks have become the norm. Gatekeeping restrictions that require patients to obtain approval from a primary care physician for access to certain services or referrals have become less popular. Gains in market share were often attributed to strong POS products that provide for out-of-network coverage as well as to "open-access" products that allow enrollees to have direct access to certain specialists within a closed panel of providers. UnitedHealth-Care's "open-access" plan was noted in several sites as a popular product and important in helping United to build market share.

Health plans in several sites also appear to

have been making more behind-the-scenes changes in how they manage care, revamping their approaches to claims appeals, the services they cover, and how they monitor utilization. Some of these changes are directly related to new state regulations. In other cases, however, the changes appear to be in response to environmental pressure for less-restrictive products or in anticipation of new regulations. For example, market respondents in several communities noted that plans have become more willing to reverse coverage denials when challenged through an appeals process. Respondents viewed these developments as health plans' efforts to demonstrate their responsiveness to consumers, while moving away from care management techniques that have not proved cost-effective.

■ **Slow growth of capitation.** Growth in

**EXHIBIT 3****Health Maintenance Organization (HMO) Penetration In Study Sites, 1996–1998**

<b>Community Tracking Study site</b>	<b>January 1996</b>	<b>January 1998</b>
Boston <sup>a</sup>	35%	49%
Cleveland	18	27
Greenville	10	10
Indianapolis	17	23
Lansing	32	41
Little Rock	33	27
Miami	46	64
Northern New Jersey	21	24
Orange County	41 <sup>b</sup>	46
Phoenix	27	34
Seattle	19	29
Syracuse	14	20
Metropolitan areas with more than 200,000 population	27	34
Total U.S. (metro and nonmetro)	18	33

**SOURCES:** January 1996 data are from *InterStudy Competitive Edge Regional Market Analysis 8.2* (Minneapolis: InterStudy December 1998). January 1998 data are from *InterStudy Competitive Edge Regional Market Analysis 6.2* (September 1998).

<sup>a</sup> The Boston Community Tracking Study site varies slightly from the metropolitan statistical area (MSA) definition. Estimates for the population enrolled in HMOs have been adjusted to reflect this variation.

<sup>b</sup> January 1996 InterStudy data on Orange County are not available; instead we have used the *InterStudy Competitive Edge Regional Market Analysis 7.1* (June 1997).

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the use of capitation to pay providers stagnated in most markets, and a number of communities saw major disruption from failures of organizations that had accepted extensive capitated risk. At the time of the first site visit, CTS data indicated that capitation accounted for 16 percent of physicians' total practice revenue, with much variation across sites. The most common type of capitation involved providers' accepting risk for the services they deliver themselves, such as primary care physicians' accepting capitated payment for primary care services. Global capitation arrangements, in which providers or provider contracting intermediaries accept risk for a wide array of services—including physician, hospital, and ancillary services—were infrequent, with the exception of Orange County and Indianapolis.<sup>14</sup> Regardless of this low baseline, however, there was widespread anticipation that capitation—and global capitation in particular—would flourish quite rapidly. Providers were actively positioning themselves for this growth in the

hopes of capturing savings from the more efficient delivery of care.<sup>15</sup>

By 1998–1999, however, capitation arrangements did not proliferate as anticipated, and health plans and providers in several communities experienced serious setbacks as a result of experiments with global capitation in particular. In markets such as Indianapolis, Phoenix, Miami, and northern New Jersey, physicians and hospitals collaborated to establish new vehicles to secure contracts with health plans that would pay for a broad range of services on the basis of capitation, but these contracts failed to materialize.

*Management concerns.* Provider respondents contended that health plans were reluctant to delegate financial risk and associated responsibility for care management to a coordinated physician/hospital organization (PHO) that could exert significant market power. Health plan respondents contended that their reluctance to enter into broad-scale capitation arrangements stemmed from concerns about the adequacy of provider organizations' infra-

structure to manage financial risk and utilization. Also, the increased emphasis on more loosely managed products made the delegation of substantial levels of risk more difficult and appears to have hindered its growth.

Meanwhile, in markets having extensive capitation arrangements, physician organizations encountered serious difficulties, leading providers to back away from these arrangements as well. In Orange County many providers had begun to participate in global capitation, thanks in part to the rapid growth of national physician practice management (PPM) firms, which aggressively pursued these contracts in southern California. However, these organizations struggled with higher-than-expected cost increases from factors that they believed to be outside of their control, such as increased pharmaceutical costs and (in California) expansions of mandated benefits.

In addition, providers in Orange County reported difficulty managing more loosely managed products. For example, under POS products, plans typically reduced providers' capitation rates to account for enrollees' use of out-of-network providers. However, providers contended that out-of-network use was in addition to, rather than substituting for, in-network use. As a result, providers reported that capitation rates under POS products were particularly inadequate.

*Further developments.* Although both health plans and providers are now approaching capitation with greater caution, neither has abandoned this payment model altogether. Rather, in many markets providers and plans continue to experiment with ways to fine-tune these arrangements to control costs and offer opportunity for both parties to benefit from the potential savings from increased efficiency. For example, in Orange County and Indianapolis many providers are insisting that plans retain some level of financial responsibility for difficult-to-control components, such as pharmacy costs. There also were some isolated instances of providers and plans experimenting with "contact capitation," which attempts to adapt arrangements in which

providers accept risk to the demands for direct access to specialists and out-of-network use.

Moreover, providers and plans in some sites remained committed to pursuing global capitation and maintained expectations for its growth. In Boston, systems led by academic medical centers (AMCs) have focused greater attention on their global risk contracts, even though these arrangements remain a relatively small share of their business and reportedly have not been profitable. Nevertheless, with the expectation that these contracts will grow, AMCs have invested heavily in infrastructure and continue to push health plans to entrust them with more responsibility for care management. Even in Orange County there is no indication that the market is moving away from this model. Instead, there has been increased attention to regulatory reforms and independent industry initiatives to improve ways to structure and oversee these arrangements, signaling their expected staying power in the market.

■ **Vertical dis-integration.** Markets experienced a continued trend away from the vertically integrated organizational models that only a few years ago were envisioned as the future of health care delivery. At the time of the first round of site visits in 1996–1997, and even in the preceding pilot study site visits in 1995, there was clear evidence that organizations were moving away from combining insurer and provider functions under owned and exclusive arrangements.<sup>16</sup> At the time of our first visits, long-standing staff- and group-model HMOs had recently spun off their provider capacity, while a number of providers had opted to sell off their health plan subsidiaries.<sup>17</sup> Two years later few vertically integrated models remained in these communities.

Plans' efforts to unwind owned and exclusive arrangements appear to have occurred primarily in earlier years, as they attempted to respond to purchasers' demands for broad networks and redress the productivity losses associated with salaried physicians.<sup>18</sup> Over the past two years, however, providers' divesti-

tures of health plans accelerated. In Seattle three provider organizations sold off their health plans, including the prestigious multispecialty group, Virginia Mason Medical Center, which sold its plan to Aetna U.S. HealthCare. Similarly, in Phoenix the area's largest hospital system, Samaritan Health System, sold its sizable commercial and Medicaid plans to UnitedHealthCare. In Greenville a health plan established jointly by three of the leading local hospitals was disbanded.

Providers abandoned their vertical integration strategies for the same reasons noted among plans in the previous round of site visits.<sup>19</sup> Respondents contended that the efforts required significant investment of energy and capital and distracted them from their core activities. Cultural differences between staffs of health plan and provider lines of business also were more of an obstacle than anticipated. Soft premium rates dampened health plan profitability and may have hastened providers' decision to exit. Some of the plans sold had been reasonably successful, but the capital that could be raised by selling them often was needed in the core hospital operation.

There was little new activity on the part of providers to establish their own health plans. Two years earlier it was expected that these arrangements would flourish under the new option for provider-sponsored organizations (PSOs) to contract directly with the federal government for Medicare risk business.

Providers have continued to operate their own plans in markets with highly concentrated provider systems and among traditional safety-net providers, which have established health plans to serve the Medicaid managed care population. Provider-sponsored health plans that serve the commercially insured persist and appear quite stable in Lansing, Syracuse, and Indianapolis.

■ **Provider intermediary organizations stumble.** In 1996–1997 new organizations seeking to serve as contracting intermediaries between providers and plans grew rapidly in local markets; two years later many of these experimental models appear to have failed. Across all of the study sites, providers were

actively forming PHOs, independent practice associations (IPAs), and management services organizations (MSOs) to enable them to accept capitated contracts from health plans or to blunt downward pressure on payment rates.<sup>20</sup> At the same time, national PPM firms were just beginning to emerge, purchasing physician practices in key markets with the promise of providing management services, gleaning efficiencies from economies of scope and scale, and bargaining with health plans from a stronger position. By the time of our second round of site visits, many of these new organizations had stumbled badly.

Unrealized expectations concerning risk contracting was commonly cited as a factor in the demise of these organizations. However, as noted previously, this story cut two ways. In some communities, such as Miami and northern New Jersey, PHOs and IPAs struggled in the absence of the risk contracts that they had been created to manage. In communities such as Orange County, where risk contracting was well established, several organizations—most prominently PPMs—suffered from their inability to keep costs below the capitation rates they had negotiated.

These new organizations also had internal management problems. PHOs, commonly led by hospital administrators, often could not garner the trust of physicians; respondents noted that physicians often feel that PHOs negotiate contracts with plans that are good deals for the hospital but not for physicians. This tension contributed to the demise of several PHOs and has led to more arm's-length relationships between hospitals and physicians elsewhere.

*PPMs' demise.* Perhaps most disconcerting from the perspective of most stakeholders was the lack of progress in developing the infrastructure necessary to manage financial risk and to streamline and improve clinical care delivery. PPM firms, in particular, touted the promise of these advances. However, respondents contended that PPMs placed too much attention on the acquisition of practices at the expense of investing in these activities. Some suggest that organizations lost the lead-

ership resources essential to making these advances when key physicians defected because of management disputes or the sudden wealth obtained from the sale of their practices. Others noted that the transition to compensation via salary diminished physicians' incentives to push for such advances. Finally, some argued that PPMs simply did not have the time needed to achieve these far-reaching goals in an environment of deteriorating physician bargaining power with health plans and pressure from Wall Street investors for quick success. Ultimately, there was the sense that these organizations got too big, too fast, adding costly and often redundant layers of overhead and providing little value in return.

PPM firms' downfall caused considerable upheaval in communities where they had made significant inroads and had begun to reshape provider/plan relationships. The greatest effect was observed in Orange County, where two PPMs—MedPartners and FPA Medical Management—and their affiliated contracting entities included a significant portion of the market's physicians and acted as a critical component of health plans' contracting arrangements. Their unanticipated bankruptcies not only rendered worthless the stock that these physicians received in exchange for the assets of their practices, but also left numerous physicians practices without a vehicle for contracting with health plans. FPA also had been in Phoenix, and although it did not involve as many physicians, its bankruptcy had a strong psychological impact on the market, as it resulted in the dissolution of a long-respected local multispecialty group. Indeed, many respondents viewed the PPM failure as a setback to physician organization activity in general, even in markets where they had not secured an important role.

*Hospital-led organizations.* Hospitals, meanwhile, have begun to reassess their physician integration strategies. Several are shutting down their PHOs and, in some instances, reconstituting them as IPAs and MSOs that have lower overhead and provide more targeted services to physicians. Some physicians are rejecting hospital-led organizations alto-

gether in favor of physician-led ones. Physician-led IPAs have gained membership rapidly in Syracuse, Miami, and Phoenix.

In other communities, however, especially where the hospital market is highly concentrated, hospitals continue to play a leading role as intermediaries. In Boston, for example, the two major AMC-based systems, Partners HealthCare and CareGroup, have established provider networks with more than 3,500 and 3,000 physicians, respectively, and continue to act as the major unifying force for managed care contracting.

■ **Horizontal consolidation and regional scope.** While provider intermediaries stumbled and health care organizations continued to move away from vertical integration, the emphasis on horizontal consolidation strategies and the pursuit of broad geographic scope continued. As in previous years, most of this activity involved hospitals and health plans, with physician consolidation lagging behind considerably.<sup>21</sup>

At the time of our first round of site visits, local health plans across our study sites were involved in mergers, acquisitions, and joint ventures to build enrollment, expand networks or product lines, and fend off competitors and potential outside entrants to the market. Much of this activity revolved around geographic expansion to respond to employers' demands for broad geographic coverage and to pursue scale economies to compete with national health plans.<sup>22</sup> Similarly, hospitals were consolidating rapidly, with mergers recently announced or under way in ten of the twelve sites. This activity focused largely on regional expansion as well, with the goal of enhancing their indispensability to health plans' networks and gaining economies of scale in response to the competitive threats posed by aggressive expansion of national hospital chains, especially Columbia/HCA.<sup>23</sup>

*Hospital mergers.* Two years later merger activity among hospitals appears to have slowed and is no longer driven by the threat of outside entry. The reversal of Columbia/HCA's aggressive acquisition strategy removed a key competitive pressure for hospitals in all sites.

However, its related decision to exit certain markets produced further concentration of ownership as local systems acquired these holdings. This occurred in Cleveland, where Columbia/HCA's decision to sell off its 50 percent share of the Sisters of Charity system created an acquisition opportunity for University Hospital and Health Systems (UHHS). As a result of this and other recent consolidation, UHHS and the Cleveland Clinic Health System now control all but a handful of independent community hospitals in the market.

The extensive consolidation that had already occurred in communities also appears to have contributed to a slowdown of hospital merger activity. Indeed, by our 1998–1999 visit most sites' hospital sectors had become or were in the process of becoming largely concentrated in just two to four systems. While some markets historically have been concentrated, major change occurred in many of our study sites over the past few years. Increased concentration was observed in markets of varying sizes, such as Boston and Lansing.

*Limited consolidation of services.* Despite increased concentration of ownership, however, there has been limited consolidation of services or capacity. There is still little evidence that hospitals are making the "hard decisions" to close facilities, reduce beds, or eliminate duplicative services.<sup>24</sup> Rather, the desire to maintain a full spectrum of services across a broad geographic area to attract managed care contracts and draw in referrals has worked against closing duplicative services in neighboring markets. Moreover, in some instances it appears to be creating incentives to expand existing services and excess capacity. For example, in Cleveland the two major provider systems have been adding services in suburban areas outside of their core markets. Similar expansions of services and capacity—largely outpatient, although some inpatient as well—were observed in Little Rock, Indianapolis, and Phoenix.

*Health plan mergers.* Hospitals' continuing emphasis on achieving broad regional scope has emanated in part from a parallel emphasis

on consolidation and geographic expansion on the part of health plans. Unlike in the hospital sector, national firms continue to play a leading role in health plans' merger activity, with mergers and acquisitions among national plans producing greater market concentration and/or new entry in a number of study sites. The most striking example was seen in northern New Jersey, where the Aetna U.S. Healthcare merger, first with NYLCare and more recently with Prudential, consolidated more than 40 percent of local HMO market share with the plan. Although HMO enrollment still represents only 24 percent of the market, Aetna's dominance in this market segment raised concern for many local respondents. In other communities national plans' acquisition of local entities facilitated entry in the local market or expansion of market share. For example, Aetna's acquisition of the Virginia Mason Medical Center plan brought it back into the Seattle market, while in Phoenix United's purchase of Samaritan Health System's two plans caused it to become the second largest plan locally, with respect to overall market share.

*Local health plans.* At the same time, the perceived and real threat of national firms' growing presence has led local plans to continue to pursue horizontal consolidation and geographic expansion as well. For example, in Syracuse the area's largest plan, Blue Cross and Blue Shield of Central New York, gained much broader geographic reach as a result of its merger with Blues plans in neighboring Rochester and Utica. Another merger involving Syracuse- and Buffalo-based plans also created a new regional plan to compete in this area.

Local health plans also have pursued regional scope by expanding into new geographic markets on their own. Extensive activity in this regard was observed in northern New Jersey, where Blue Cross and Blue Shield of New Jersey has begun to expand into markets in neighboring states, while Blues plans in New York, Pennsylvania, and Delaware have made forays into New Jersey.

However, geographic expansion has led to serious difficulty for some plans. The most sa-

lient example is seen in Boston, where Tufts Health Plan and, more recently, Harvard Pilgrim Health Plan incurred large losses from operations in neighboring markets. These experiences may suggest the possibility of diseconomies associated with horizontal consolidation and geographic expansion, as has been noted among vertical integration strategies in recent research.<sup>25</sup>

Despite continued consolidation among health plans, when one looks across all insurance products—ranging from indemnity plans to HMOs—those markets defined as fragmented at the time of the first site visit (Miami, northern New Jersey, and Phoenix) remained so two years later.<sup>26</sup> Although consolidation has produced fewer competitors in these markets, multiple plans remain, and market share is widely distributed among them. In addition, although national mergers have led to entry and consolidation across several markets, local plans continue to maintain a leading position in most. Nonetheless, respondents viewed the growing presence and market share of national for-profit firms as a continuing, and in some cases, intensifying, threat to local plans in several study sites.

### Implications For Consumers

The period between 1997 and 1999 marked a continuing movement away from tightly managed products and the vertically integrated model that many associate with managed care and expected local health systems would evolve into over time. Rather, health care markets have been reverting to a more traditional organizational model, although with a much higher degree of horizontal consolidation and much greater emphasis on geographic breadth and unfettered access. Indeed, if a theory of market evolution were developed today, it likely would focus on the march toward increasing consolidation rather than the drive toward integration emphasized in earlier research.<sup>27</sup>

This shift has important implications for consumers. On the one hand, the changes have been responsive to consumers' demands for unrestricted access to care and choice of

providers. However, the way in which local markets are evolving threatens to jeopardize the cost control that has been achieved in recent years and to stunt the drive to produce further efficiencies necessary to maintain an affordable, accessible health system.

It appears that consolidation and geographic expansion continue to be focused primarily on enhancing organizations' market power, often at the expense of opportunities to reduce costs. This dynamic is seen most clearly during this period in providers' efforts to expand regionally, where the quest for bargaining power is clearly more compelling than opportunities to rationalize duplicative services and excess capacity.

Both plans and providers continue to feel financial pressure from the demands of employers and shareholders and cuts in Medicare reimbursement. This pressure on providers is contributing to greater conflict between hospitals and physicians over a shrinking pie. However, growing provider bargaining power appears to have slowed or stopped the trend toward greater price discounts, suggesting that cost control gains may now plateau or begin to reverse. While many organizations continue to develop initiatives aimed at improving quality and reducing costs, there is much greater skepticism about their ability to produce significant efficiencies in the delivery of care, at least in the near term.

Developments in information technology (IT) and Internet-based solutions in particular present one potential exception. However, expectations that IT will transform the delivery of care have met with disappointment for years. The decentralized nature of the Internet and (at least until recently) the ready availability of capital to finance Internet companies working in health care have lowered barriers to feasibility, but the success of these ventures remains to be seen.

Another development that could alter the current trajectory of change is a return to higher rates of increase in health insurance premiums. Although tight labor markets are delaying employers' bold responses to such increases, these responses are probably only

two years off. Once employers do respond, we expect more of an emphasis on patient cost sharing and financial incentives for employees to choose options involving more restrictive forms of managed care. In an environment in which managed care has become stigmatized, consumers must either assume a greater financial burden for unfettered access to care or push the industry and/or policymakers toward alternative solutions to contain costs and preserve access.

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7. R. Blendon et al., "Understanding the Managed Care Backlash," *Health Affairs* (July/Aug 1998): 80-94; and Christianson, "Role of Employers."
8. J. Gabel, "Ten Ways HMOs Have Changed during the 1990s," *Health Affairs* (May/June 1997): 134-145; Grossman, "Health Plan Competition"; G. Jensen et al., "The New Dominance of Managed Care: Insurance Trends in the 1990s," *Health Affairs* (Jan/Feb 1997): 125-136; and J. Robinson, "The Future of Managed Care Organization," *Health Affairs* (Mar/Apr 1999): 7-24.
9. Christianson, "Role of Employers"; and Grossman, "Health Plan Competition."
10. Boston was the only site where new legislation was not passed, although new regulations concerning grievance procedures and provider reimbursement were implemented through the governor's executive order in May 1998.
11. We define HMO products to include those in which health services are provided by a network of affiliated providers, where services delivered by out-of-network providers are generally not covered, other than for some specialized services or in emergencies. To be consistent with the InterStudy data referred to in this paper and often cited by local respondents, we include enrollment in point-of-service (POS) products as a form of HMO enrollment. POS products allow persons to select in-network or out-of-network providers at the "point of service," usually with differences in coinsurance or deductibles. These products are sometimes referred to as "open-ended" HMOs or "triple-option" plans.
12. Grossman, "Health Plan Competition"; and Christianson, "Role of Employers."
13. Grossman, "Health Plan Competition."
14. Kohn, "Organizing and Managing Care."
15. *Ibid.*
16. Grossman, "Health Plan Competition."
17. *Ibid.*
18. *Ibid.*; and Robinson, "The Future of Managed Care Organization."
19. Grossman, "Health Plan Competition."
20. Kohn, "Organizing and Managing Care."
21. *Ibid.*
22. Grossman, "Health Plan Competition."
23. Kohn, "Organizing and Managing Care."
24. *Ibid.*
25. Grossman, "Health Plan Competition"; and Robinson, "The Future of Managed Care Organization."
26. Grossman, "Health Plan Competition."
27. APM/University Health System Consortium, "How Markets Evolve," *Hospitals and Health Networks* (5 March 1995): 60.