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MANAGED CARE
IN THE TWIN CITIES:
WHAT CAN
WE LEARN?

by Jon Christianson, Bryan Dowd, John Kralewski, Susan Hayes, and Catherine Wisner

Prologue: Minnesota’s Twin Cities, Minneapolis and St. Paul, have long been viewed as a testing ground for how managed care can take hold in a community. Some of the nation’s first health maintenance organizations (HMOs), which many view as the basic building block for a managed competition-based health care system, flourished in the Twin Cities area during the 1970s. The long history and relatively broad acceptance of HMOs, coupled with an employer community that is active in health care purchasing for its workers, make the area ripe for comparison and study. In this paper Jon Christianson and his colleagues trace the evolution of managed care in the Twin Cities from the 1970s through more recent times. They draw on a rich literature examining the managed care market there and focus on recent developments involving mergers among some of the area’s managed care plans and hospitals. In an era when integrated health systems are growing in prevalence, these developments are of interest in communities throughout the United States. Christianson, a health economist, received his doctorate from the University of Wisconsin-Madison. He is a professor at the Institute for Health Services Research at the University of Minnesota. Bryan Dowd is a professor at the institute who has been studying the Twin Cities health care market for fifteen years. John Kralewski is the William Wallace Professor of Health Services Research and Administration at the University of Minnesota and directs the institute; he holds a doctorate in health services administration from the University of Minnesota. Susan Hayes is coordinator of external programs at the institute. Catherine Wisner, who received a doctorate in health services research and policy from the University of Minnesota, is a health services research investigator at Group Health Foundation in Minneapolis.
Managed competition was the cornerstone of the Clinton administration’s plan for health care reform and served as the basis for other legislative reform proposals as well. The essential elements of this approach include health plans competing for enrollees, with large purchasers or purchasing coalitions “managing” the competitive process. The Twin Cities market (Minneapolis/St. Paul, Minnesota), because of its history of health maintenance organization (HMO) development and active employer participation in the health care arena, is often cited as an area in which managed competition has been tested to some degree.

In this paper we review the historical development of the Twin Cities health care market and the results of past studies of this market. We describe recent developments in the Twin Cities, including the activities of large purchasers and the consolidation of providers. A final section discusses the lessons that can be drawn from the Twin Cities experience, especially those relevant to managed competition.

Impact Of HMO Growth In The Twin Cities

The health care delivery system in the Twin Cities is known nationally for its role in the development of what many believe are the building blocks of managed competition: HMOs (Exhibit 1). From 1971 to 1978 HMO enrollment in the Twin Cities grew at an annual rate of 27 percent.\(^1\) Enrollment continued to grow during the 1980s, reaching 50 percent of the population by the end of the decade. During these years HMOs in the Twin Cities encompassed a variety of organizational forms and sponsorship arrangements, and by the early 1980s most physicians were affiliated with one or more of these health plans. The 1980s saw important changes in Twin Cities HMOs and their relationships with providers, including the development of new products, such as preferred provider organizations (PPOs) and the institution of more aggressive management strategies, such as concentrating patients at lower-cost hospitals. As HMOs gained market share and introduced stronger cost control measures, their influence on the structure of the Twin Cities health care delivery system also increased.

HMOs and hospitals. One of the most contentious issues concerning HMO development during the late 1970s and early to mid-1980s was its
### Exhibit 1
**Health Maintenance Organizations (HMOs) In The Twin Cities**

<table>
<thead>
<tr>
<th>HMO</th>
<th>Headquarters</th>
<th>Parent, owner, or manager</th>
<th>Year opened</th>
<th>1993 enrollment</th>
<th>History/status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus</td>
<td>Eagan</td>
<td>Blue Cross and Blue Shield of Minnesota</td>
<td>1974</td>
<td>67,411</td>
<td>Changed name from HMO Minnesota in 1988; absorbed Coordinated Health Care HMO in 1988; affiliate Minnesota Health Plans, Inc., merged into Blue Plus, effective 31 December 1990</td>
</tr>
<tr>
<td>Group Health Minneapolis</td>
<td>St. Louis Park</td>
<td>Group Health, Inc.</td>
<td>1957</td>
<td>303,573</td>
<td>Includes GroupCare, non-federally qualified HMO; merged with MedCenters Health Plan to form HealthPartners in 1992</td>
</tr>
<tr>
<td>Medica Medica Choice</td>
<td>Minnetonka</td>
<td>Aetna Health Plans</td>
<td>1973</td>
<td>214,436</td>
<td>Formed by merger of MedCenter Health Plan and Nicollet-Eitel Plan in 1983; merged with Group Health in 1992</td>
</tr>
<tr>
<td>Medica Primary</td>
<td>Minneapolis</td>
<td>United Health Care</td>
<td>1973</td>
<td>479,369</td>
<td>Formerly known as Physicians Health Plan (PHP); combined with Share Health Plan to form Medica, effective 1 January 1991</td>
</tr>
<tr>
<td>Metropolitan Health Plan</td>
<td>St Paul</td>
<td>Hennepin County Bureau of Health</td>
<td>1983</td>
<td>32,719</td>
<td>Created for Medicaid demonstration project and Voluntary AFDC Managed Care Program</td>
</tr>
<tr>
<td>NWNL Health Network</td>
<td>Minneapolis</td>
<td>Northwestern National Life WWNL Insurance Company</td>
<td>1984</td>
<td>32,875</td>
<td>Founded as Senior Health Plan; acquired and renamed by NWNL in 1987</td>
</tr>
<tr>
<td>UCare</td>
<td>Minneapolis</td>
<td>University of Minnesota, Department of Family Practice</td>
<td>1989</td>
<td>25,416</td>
<td>Created for Medicaid demonstration project</td>
</tr>
</tbody>
</table>

Sources: Citizens League Research, Minnesota Managed Care Review, 1992; and A. Baumgarten, Minnesota Managed Care Review, 1994.

Note: Group Health and MedCenters enrollment figures do not include Business Health Care Action Group employee enrollees.
impact on Twin Cities hospitals. By the end of the 1980s four major multihospital systems had been created through mergers and buyouts. Some hospital administrators believed that multihospital organizations could negotiate prices with HMOs more effectively and offer broader geographic coverage for HMO enrollees. They argued that hospital consolidation was the direct result of the growing competitiveness of the Twin Cities hospital market created largely by HMOs. However, initial studies of the effect of HMOs on Twin Cities hospitals did not find compelling evidence that competition among HMOs had contained hospital costs. By 1986, however, the pattern of HMO/hospital relationships had begun to change. Roger Feldman and colleagues found that HMOs in four large metropolitan areas (including the Twin Cities), especially staff- and network-model HMOs, were beginning to concentrate their patients at certain hospitals and that price played an important part, not so much in the HMOs’ choice to affiliate with a particular hospital, but in the volume of services demanded from the hospital. The estimated price elasticity of demand for admissions in HMO-affiliated hospitals was -3.0, indicating a considerable degree of price-sensitivity, with a 3 percent reduction in admissions associated with a 1 percent increase in price. Individual practice associations (IPAs) were not found to exhibit the same degree of price-sensitivity. The estimated price elasticity of demand for IPAs was -1.0.

During the 1980s Twin Cities hospitals faced declining discharges and lengths-of-stay across virtually all types of services. Even among the service groups that had some increase in discharges (for example, cardiology, psychiatry, obstetrics, and newborns), lengths-of-stay fell. Although part of the declining use of inpatient resources mirrored a national trend, Bryan Dowd estimated that 33-85 percent of the decline in hospital admissions in the Twin Cities from 1977 to 1982 could be attributed to HMOS. The estimate was found to depend crucially on the amount of credit that HMOs were given for reducing lengths-of-stay in the non-HMO sector.

The effect of HMOs on lengths of inpatient hospital stay provides an interesting example of the refinement of health plans’ resource management techniques. In early studies of HMOs, HMO membership was associated with a 40 percent reduction in hospital admissions but no reduction in length-of-stay. However, by the mid-1980s Dowd and colleagues found that enrollees in group-practice HMOs in the Twin Cities had significantly shorter lengths-of-stay than commercially insured patients had in five of seven diagnostic groups examined, while enrollees in IPAs had significantly shorter lengths-of-stay in three of these groups. They suggested that reductions in admissions were easier for Twin Cities health plans to achieve than were reductions in length-of-stay, since reduced admissions can occur simply if treatment is switched to an outpatient setting. Length-of-stay reduc-
tions, however, involve direct intervention in physicians’ on-site treatment decisions. Thus, it is not surprising that the initial focus of HMOs was on reducing admissions. Once HMOs reduced admissions, however, the competitive advantage to be gained by reducing length-of-stay made that task, although more difficult, worth pursuing.

**HMOs and consumer choice.** During the 1980s some policy analysts argued that high-risk, fee-for-service enrollees were more likely to have a long-standing relationship with their fee-for-service physicians and, therefore, were less likely to join a staff- or group-model HMO. Employers in the Twin Cities who offered their employees a choice of HMOs and a fee-for-service plan sometimes saw their total health insurance costs increase as the relatively healthy employees left the experience-rated, fee-for-service plan to join HMOs. However, when employers offered a choice among managed care plans, employees were quite sensitive to out-of-pocket premium differentials. Feldman and colleagues studied choice of health plans by employees in seventeen large Twin Cities firms in 1984. The elasticities they reported were considerably higher than those found in previous studies, as large as -8.6 for choice among single-coverage plans. This means that a 1 percent increase in the out-of-pocket premium differential between two plans reduces the enrollment share of the higher-cost plan by 8.6 percent.

Although the HMOs’ incentive to cut prices to consumers was limited by prevailing employer premium contribution methods under which employers typically contributed more toward the premiums of higher-price plans, cost-cutting incentives for HMOs were not similarly impaired. Health plans’ cost-cutting efforts precipitated a shift from relatively close collaborative relationships between plans and providers to a distinct division between financing and service delivery functions. The change was sometimes slow and subtle, but at times it was abrupt and contentious and played out on the front pages of the local press. For example, Physicians Health Plan, started by physicians for physicians, experienced a bitter dispute between physicians and the health plan’s management over fees and administrative practices. The same fate befell MedCenters Health Plan and its founding group, the Park-Nicollet Clinic.

Changes in the relations between health plans and providers in the latter part of the 1980s appear to have been driven in part by consumer preferences, as revealed in their choice of health plans. Factors such as coverage, clinic locations, and out-of-pocket premiums often outweighed consumers’ loyalty to specific providers. Since premiums were an important determinant of plan choice, even small out-of-pocket differences among plans produced consumer pressure on plans to restrain premium increases. That pressure eventually was transmitted to providers in contract negotiations.

**HMOs, access, and health outcomes.** Some analysts have expressed
concern that competition among capitated health plans for enrollees, and the pressure on premiums that it creates, could have a negative effect on access to services and patient outcomes. Three studies using data from the mid-1980s compared the health outcomes of subgroups of Medicare or Medicaid beneficiaries in Twin Cities HMOs with those of beneficiaries receiving care from providers under normal arrangements. One study examined the difference in physical functioning and perceived general health status between Medicare beneficiaries enrolled in HMOs and those in traditional Medicare. This study found no significant difference in predicted health status, as measured by physical functioning, between the two groups. However, there was a difference in perceived general health status: Those enrolled in HMOs reported a significantly higher status. For a subgroup of lower-income enrollees, no significant differences were found.

A second study, by Nicole Lurie and colleagues, compared health and functional status measures of noninstitutionalized elderly Medicaid recipients randomly assigned to prepaid plans and traditional fee-for-service Medicaid. The analysis found no significant difference between the two groups in number of deaths or in any of the listed outcome measures, thus providing no evidence, in the short term, of harmful effects of enrolling elderly Medicaid patients in Twin Cities HMOs. In a third study, Lurie and colleagues examined the effect of HMO enrollment on chronically mentally ill Medicaid recipients, using a similar research design. Here, too, no significant differences were found in general health or mental health status between beneficiaries in traditional Medicaid and those in HMOs. Access to services and use of services by the same group of chronically mentally ill Medicaid recipients also were analyzed. There were no statistically significant differences between HMO enrollees and fee-for-service Medicaid beneficiaries’ access to either physical or mental health care, nor were there significant differences in use of inpatient or outpatient services for HMO enrollees. In particular, there was no statistically significant evidence that Medicaid HMO enrollees with severe mental illness used community-based treatment programs differently than did beneficiaries in fee-for-service Medicaid. However, there was evidence that the HMOs reimbursed programs at a lower percentage of charges than did fee-for-service Medicaid.

HMOs and health care spending. Although it is widely believed that overall health care costs in the Twin Cities are relatively low, data are not available to test this hypothesis in a rigorous manner. This would require comparable data over time on insurance premiums and out-of-pocket expenses for residents of the Twin Cities and other U.S. metropolitan areas, adjusted for differences in level of benefits and demographic characteristics. Lacking these data, comparisons of the Twin Cities with other metro areas tend to focus on different components of costs, expenditures, and prices.
Surveys by health benefits consulting firms report that Twin Cities costs and premiums are below national averages, but the samples on which these studies were based are not random, nor are the measures of costs comprehensive.” The medical Consumer Price Index (CPI) for the Twin Cities consistently tracks below other communities, while the overall CPI is about the same as the national average. With respect to inpatient care, Minnesota as a whole has fewer admissions and emergency room visits than the national average, as well as shorter lengths-of-stay.\textsuperscript{20}

Consistent with the results on private-sector employees, data from the Health Care Financing Administration (HCFA) suggest that spending for fee-for-service Medicare beneficiaries in the Twin Cities is low, relative to the national average and expenditures in other major metropolitan areas.\textsuperscript{21} Medicare costs in the Twin Cities have not always been low, however. In 1974 age- and sex-adjusted reimbursements were 28 percent higher in the Twin Cities than the national average.\textsuperscript{22} Most of the higher cost was due to Medicare Part A (hospital) costs, which were 35 percent higher, as opposed to Medicare Part B (physician) costs, which were only 8 percent higher. By 1982, however, these costs were only 3 percent higher in the Twin Cities than the national average, with Part A costs 10 percent higher and Part B costs 14 percent lower. In contrast to these results, the Physician Payment Review Commission (PPRC) reported that Minnesota as a whole had adjusted per capita health care expenditures only 1 percent below the national average in 1991.\textsuperscript{23}

While the weight of available evidence suggests that health care costs probably are lower for Twin Cities residents than for residents of most other large metropolitan areas, it is not clear to what extent this can be attributed to the growth of HMOs and managed competition in the Twin Cities. Unfortunately, the data simply do not exist to construct comprehensive, comparable measures of health care costs and expenditures over time in different communities. Even were such data available, obtaining accurate estimates of the incremental effect of variation in managed competition across different communities on expenditure levels would be problematic.

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**Recent Reconfiguration Of Twin Cities Providers**

Three recent mergers involving Twin Cities HMOs have captured national attention. The first merger involved two large HMOs; the second, an HMO and a hospital; and the third, an HMO and a hospital system. To understand the importance of these mergers, one should view them in the context of consolidation activities that began in the early 1980s and occurred in three phases. The 1980s’ consolidation occurred primarily through formation of multihospital systems, as noted previously. Some
absorption of relatively small HMOs by larger ones occurred during this time as well, but it had little effect on the overall HMO market. The beginning of the 1990s saw a substantial shift in the scale of mergers for both hospitals and HMOs. The merger of Health One and Lifespan, two large multihospital systems, raised serious concerns about aggregation of market power relating to the provision of inpatient services. The merger of SHARE and Physician Health Plan (PHP), which created Medica, was the first merger of large HMOs in the Twin Cities and the first HMO merger that resulted in a substantial consolidation of HMO enrollment. As it turned out, these mergers represented only the leading edge of a rapid series of consolidations and organizational reconfigurations in the Twin Cities that have occurred in the past three years.

**Merger of Group Health and MedCenters.** Merger discussions first began between MedCenters and Group Health in 1991 in the wake of the SHARE/PHP merger. Both organizations were concerned that they would not be able to compete effectively with Medica and Blue Cross/Blue Shield for employer contracts when employers demanded a “total replacement” product with provider networks that offered comprehensive geographic coverage. What precipitated the merger was the development of the Business Health Care Action Group (BHCAG), a large private employer purchasing coalition in the Twin Cities. The company resulting from the merger, HealthPartners, continued to offer both HMOs as separate products but developed a new joint product (Choice Plus) in response to BHCAG requirements. At the time of the merger HealthPartners had 580,000 enrollees, forty medical clinics (twenty-four owned and eighteen under long-term contracts), four hospital contracts, and approximately $860 million in annual revenues. Together, Medica and HealthPartners accounted for about 90 percent of HMO enrollees in the Twin Cities.24

**Merger of HealthPartners and Ramsey HealthCare.** The creation of HealthPartners set the stage for its merger with Ramsey HealthCare. When HealthPartners was awarded the BHCAG contract, it attempted to renegotiate its hospital relationships to be able to deliver services for the premium offered to the BHCAG. HealthPartners issued to all Twin Cities hospitals a request for proposals for new, long-term relationships with the health plan. This stimulated initial discussions between HealthPartners and Ramsey HealthCare in August 1993, which hastened the merger of the two organizations. A formal merger was completed 2 December 1993, with HealthPartners assuming management control of the three different components of Ramsey HealthCare: a hospital with 325 staffed (435 licensed) beds, a 200-member multispecialty physician group (the Ramsey Clinic), and an educational and research unit (the Ramsey Foundation). HealthPartners viewed the merger as an opportunity to achieve better integration
of inpatient and outpatient services, greater cost control, and better geographic coverage for inpatient care in the eastern metropolitan area.

**Merger of HealthSpan and Medica.** The first merger in the Twin Cities between a hospital system and a health plan was announced 8 December 1993: the merger of HealthSpan and Medica. The assets of the existing organizations were merged under a new entity, Allina. At the time of the merger, there were approximately 750,000 members in the existing health plans (550,000 in Medica products and 200,000 in SelectCare, a PPO sponsored by HealthSpan). HealthSpan owned or managed seventeen hospitals in Minnesota and Wisconsin and forty-five clinics and had 3,200 affiliated physicians. Medica was managed by United Health Care Corporation under a long-term management contract and had contracted with 5,000 physicians. Together, as Allina, they became the largest nonprofit firm and the eighth-largest firm in Minnesota. Allina will eventually form the basis for an integrated service network (ISN) that will meet the requirements of an integrated health care delivery system under the new MinnesotaCare legislation. Some reduction in the number of hospital beds and consolidation of other services are expected under Allina.

**Other developments.** During the early 1980s, as HMOs gained market share, Blue Cross/Blue Shield of Minnesota (BCBSM) experienced substantial operating losses. In response, it restructured its health product lines, forming a PPO that by 1990 had more than one million enrollees statewide. It also sponsored a network-model HMO that grew slowly during the early 1980s but had 70,000 enrollees by 1990. Now, with the enactment of MinnesotaCare legislation and recent mergers in the Twin Cities market, BCBSM has begun to pursue the development of ISNs. In June 1993 it announced participation in a partnership with a provider group to form an ISN in the west metropolitan area. In July 1993 it acquired a large, multispecialty physician group practice system, laying the groundwork for an ISN to serve residents throughout the Twin Cities. That ISN will be developed in cooperation with Fairview Health Systems (a multihospital corporation) and the University of Minnesota Hospital and Clinics (UMHC).

UMHC is also reassessing its traditional role in the Twin Cities health care market. In 1993 UMHC formed a corporate structure that brought the clinical faculty and hospital together to contract with ISNs and to negotiate with health insurance plans. One result was the BCBSM/Fairview Health System joint venture. The danger for the university is that providers affiliated with competing organizations could restrict referrals to university physicians and thus restrict their participation in its teaching programs. However, according to the president of the University of Minnesota Health System, “Not to join [an ISN] could mean being left without a patient base in the competitive Minnesota health care environment. At the same time,
we won’t be an exclusive partner. Our mission makes it imperative that we be available to any Minnesotan who needs us.”

Development Of MinnesotaCare

Over the past three years the reconfiguration of the Twin Cities health care delivery system has taken place simultaneously with the implementation of health care reform legislation at the state level. MinnesotaCare was enacted in 1992 through a bipartisan agreement among legislators and the governor. Its general objectives were to enhance the availability of insurance for uninsured persons in the state while reducing increases in health care costs. The legislation created the Minnesota Health Care Commission (MHCC), which was charged with developing a cost containment strategy. The goal was to slow the rate of growth in total private and public health care spending in Minnesota by at least 10 percent per year over five years.

Legislation based on the work of the commission established a comprehensive cost containment plan in 1993. This plan encourages the development of ISNs by providers or purchasers of medical care to provide a comprehensive set of health services to a designated population for a prospectively set budget. The state health commissioner was given the power to approve ISN arrangements and issue state exemptions from antitrust liability that might arise. Each ISN will be subject to an overall limit on the rate of growth in its annual expenditures.

By 1 July 1997 the intention is that large purchasing pools will be available to all purchasers, regardless of employment status or group membership. Recommendations will be submitted by the MHCC to the 1995 legislative session regarding whether all or some purchasers should be required to obtain coverage through purchasing pools. Recommendations also will be made regarding the creation of a state-administered purchasing pool, which would serve all Minnesotans who do not have access to other purchasing pools, and for permanent market reform strategies based on evaluations of existing reforms and the evolution of national reform initiatives. The immediate impact of MinnesotaCare on the Twin Cities market clearly has been to stimulate collaborative arrangements among providers with the intention of laying the groundwork for ISN formation.

Development And Role Of Purchasing Coalitions

During the 1980s many analysts familiar with the development of the Twin Cities market expressed disappointment with the actions of employers purchasing care from HMOs. For instance, in 1984 Paul Ellwood said that the “biggest disappointment about health care developments in the
Twin Cities is the failure of corporations to take advantage of their purchasing power in the market. Major national corporations based here . . . have been unwilling to go out and buy care on the basis of price.”

Beginning in the late 1980s some major employers in the Twin Cities took steps to change the way in which they purchased health care. Among these employer initiatives, two efforts—the BHCAG and the managed competition approach used by the State of Minnesota Group Insurance Program (SIP)—have achieved the highest visibility in the Twin Cities.

**Business Health Care Action Group.** In 1988 several large private-sector firms headquartered in Minneapolis/St. Paul formed a coalition called the BHCAG to lobby for health care reform. In 1991 coalition members decided to create a health plan for their employees and dependents; after a bid process, the MedCenters/Group Health coalition (HealthPartners) was chosen. At the firm level, the HealthPartners product (Choice Plus) is being offered by BHCAG employers as their basic self-insured plan. Employees typically can enroll in this plan or select one of the other plans offered by their employer. In most cases, the employer’s contribution to an employee’s health plan is limited to the amount contributed to the BHCAG plan. In 1993, the first year of the HealthPartners contract, 55,000 employees enrolled. Seventy percent of those were previous MedCenters or Group Health members. In 1994, 100,000 employees, 40 percent of all eligible employees, joined the Choice Plus plan.

Although Choice Plus is modeled on the HMO concept, HealthPartners is not paid on a capitated basis. Instead, providers are paid on a discounted fee-for-service basis, and each employer has a contract with the participating providers. HealthPartners receives a set fee, currently 8 percent of total expenditures, to administer the program. BHCAG employers estimate that the plan reduced their expected health care costs for enrolled employees by about 10 percent in 1993, as compared with similar coverage available through competing managed care products.

An important part of the BHCAG effort is a quality improvement program, consisting of clinical guidelines focused on cost-effective treatment modalities and clinical outcomes assessment programs. Eight HealthPartners medical groups have volunteered to serve as pilot sites to test and implement the sixteen guidelines. Eventually, eighteen medical groups (which provide about 88 percent of the care delivered to BHCAG enrollees) will participate in development and implementation of guidelines.

The charter organizations that formed the BHCAG believe that knowledgeable purchasing groups are the key to restructuring the health care system. To that end, they believe that the BHCAG has the responsibility to develop quality assurance programs and use its purchasing power to create competing, cost-effective provider systems. While the BHCAG has
expressed strong support for competitive health services markets, its actions helped precipitate the merger of two large HMOs-MedCenters and Group Health. However, the BHCAG remains committed to broadening consumers’ choice of health care systems by creating competition among these systems around cost and quality. Its intention is that by 1997 employees will have more health care systems to choose from.

**State of Minnesota Group Insurance Program.** SIP covers 144,000 persons (employees, dependents, and retirees). Until 1985 this program tied its contribution to the premium for the fee-for-service option. In 1985 the program consolidated its HMO offerings and instituted a new contribution formula that required employees to pay the premium difference out of pocket if they did not enroll in the low-cost plan. From 1986 through 1988 the fee-for-service plan continued to have the lowest rate and remained the basis for the employer contribution. Over time, however, the HMOs were able to offer lower rates in addition to their better coverage. In 1989 seven HMOs were low-cost carriers in at least some part of the state. (Plans submit one statewide premium, but not all plans are offered in all counties, so different plans are low-cost carriers in different counties.)

Introduction of the low-cost carrier formula led to striking changes in the pattern of health plan premiums. Exhibit 2 shows the trend in the growth of average total premiums for single and family contracts for all state

<table>
<thead>
<tr>
<th>Years</th>
<th>Percent change in average premium for single coverage</th>
<th>Percent change in average premium for family coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-81</td>
<td>20.26%</td>
<td>14.28%</td>
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<td>18.83</td>
<td>18.66</td>
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<tr>
<td>1993-94</td>
<td>2.66</td>
<td>2.99</td>
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</table>


*a Average over four years.*
employees, not just Twin Cities employees, from 1980 to 1994. These changes in average premiums reflect not only changes in premium levels for individual plans from year to year but also changes in enrollment shares of the different health plans. The transition period to the “flat-dollar” contribution approach (1985-1988) was chaotic, characterized by wild swings in premium costs. However, since 1989 the annual percentage increase in total expenditures on health insurance by the state and its employees has fallen steadily to less than 3 percent in 1993-1994. It is interesting to note the experience of the two largest plans in the program, the BCBSM and Group Health, during the period 1988-1994. The BCBSM plan typically was either the most expensive or the second most expensive plan during that period, while Group Health was consistently the lowest-cost plan. In the Twin Cities metropolitan area, Group Health’s share of enrollment rose from 24.7 percent for employee contracts (28.3 percent for family contracts) to 47.5 percent (54.4 percent for family contracts), while BCBSM’s market share fell from 42.5 percent for single contracts (47.9 percent for family contracts) to 13.7 percent (17.1 percent for family contracts). Feldman and Dowd found that health plan switching by employees saved the state $3.8 million in 1993 alone, and they contend that these savings would have been larger if state employees were not permitted to pay their out-of-pocket premiums with before-tax dollars.\(^{31}\) The premium increases announced for 1995 suggest that competition for Minnesota employees continues to be vigorous. Medica Premier, a gatekeeper IPA that was the second-highest-cost plan in 1994, dropped its premium 25 percent to become the lowest-cost plan in 1995.

The success of SIP can be attributed to several factors. The most important of these, based on the historical trend of premiums, appears to be limitation of the employer’s premium contribution to the premium of the lowest-cost plan. Another important factor is the size of SIP and its goals. At 144,000 covered lives, the program is large enough to elicit swift response from health plans to demands for better products and lower prices. However, the program is not so large that its decisions have become politicized and subject to regulatory capture.\(^{32}\) SIP has been successful without risk-adjusting its premiums or imposing a standard benefit package, two common elements of managed competition proposals at the national level. Instead, program administrators have focused their efforts on the aggressive management of relationships with health plans.

### Drawing Lessons From The Twin Cities Experience

The well-known dangers of drawing national lessons from state/city case studies suggest caution in assessing the public policy implications of the
Lower premiums versus unrestricted access. When Twin Cities consumers have faced the choice of paying higher premiums for unrestricted access to relatively autonomous health care providers versus lower premiums and more restricted, “managed” access to providers and services, a majority have chosen lower premiums and managed care. The steady growth over time in Group Health’s share of participants in SIP provides a clear illustration of this. Studies of consumer behavior in choice of health plans in the Twin Cities have found remarkable sensitivity among employees to differences in relative out-of-pocket premiums. In an attempt to accommodate these consumer preferences, fee-for-service plans have evolved into managed fee-for-service plans, and PPOs have been formed. This supports the assumption of managed competition advocates that consumers will place substantial importance on costs in their choice of health plans. There is mixed evidence about the importance of health plan switching to secure lower prices for the distribution of health risks among plans. Early studies suggest that biased selection occurred, and employers responded by reducing their health plan choices. This contributed to the consolidation of health plans in the Twin Cities.

The willingness of consumers to switch providers also has given health plans greater leverage in negotiations for services, creating price competition both among hospitals and physicians for managed care plan enrollees. Hospitals responded by consolidating their operations into a relatively small number of systems, to negotiate more effectively with HMOs and to facilitate the closure or conversion of individual facilities to reduce acute care capacity. From a strategic standpoint, survival in the Twin Cities market has increasingly been viewed by hospital administrators as dependent on the establishment of strong linkages with managed care organizations and/or the purchase of physician practices.

Aggregation of purchasing power. One of the major structural elements of most managed competition reform proposals is the aggregation of purchasing power through large employers or health care alliances to solicit bids and oversee competition among plans. The BHCAG and SIP function in a manner similar to that envisioned for such purchasers. These purchasers have influenced the structure of the health care delivery system for their employees, while maintaining premium increases at relatively moderate levels. The BHCAG has structured a health care delivery system designed to meet the needs of its employees and has stimulated collaboration among several provider groups in the development of practice guidelines; SIP has successfully managed a multiple health plan benefit offering with a fixed-dollar contribution tied to the lowest-price health plan and has greatly
reduced increases in health plan premiums.

The number of enrollees in these programs is much lower than the 500,000 persons suggested in some early health care reform proposals as the minimum number necessary for the operation of a successful health alliance. Also, these purchasing programs have existed simultaneously in a single market, to the apparent advantage of each program. If one of the purchasing programs drops a managed care organization from its offerings, that organization can remain a viable competitor in the market and a contender in the next round of contracting.

Providers’ responses. The Twin Cities experience suggests that providers will respond to greater organization on the demand side with greater aggregation and organization of supply. Whether this is a favorable or unfavorable development from a public policy perspective is not yet clear. Consolidation of providers could benefit consumers by reducing excess capacity and promoting efficiencies in service delivery. If purchasers are able to use their bargaining power to achieve improvements in the quality of care and to effect changes in the way that care is delivered, payers and consumers may benefit through lower premiums. To date, the reorganization of provider systems in the Twin Cities has facilitated a realignment of physician incentive systems (with a shift toward salaried positions), the development of extensive information technologies, and improvements in patient care that have the potential to go beyond the formation and implementation of practice guidelines. The long-run effects of these efforts on the cost and quality of care delivered through health plans will be difficult to measure but will be important to any future assessment of the impact of managed competition in the Twin Cities. Ultimately, while consumers may have fewer choices among health plans and more limited options in their benefit coverage, they may experience improved quality and lower prices. However, large purchasers in the Twin Cities are aware that the consolidation of providers also poses risks in the longer run. Because it means fewer plan options, purchasers may become “locked in” to their existing plan offerings. As a consequence, their negotiating leverage could diminish, and any potential efficiency gains resulting from either consolidation or the improvement of the cost-effectiveness of services may not be passed on to consumers.
NOTES


13. Feldman et al., “HMOs: The Beginning or the End?”


15. This contrasts with the finding of John Ware and colleagues that low-income persons in Seattle had worse outcomes in an HMO, compared with fee-for-service care. J. Ware


21. For the years 1993, 1994, and 1995, fee-for-service costs in the Twin Cities were 7.0, 11.3, and 11.7 percent below national fee-for-service costs, respectively, and 15.3, 17.5, and 17.8 percent below fee-for-service costs for other urban areas (defined as metropolitan statistical areas, or MSAs). The comparisons are between member-weighted adjusted area per capita costs (AAPCC) for the eleven-county Twin Cities metropolitan area and the national average and the MSA-average AAPCC for aged Medicare enrollees. These data were provided by Bob Power of HealthPartners, Inc., a Twin Cities HMO. However, if Twin Cities HMOs enrolled relatively healthy Medicaid beneficiaries (as Randall Brown and colleagues found to be the case for Medicare HMOs nationally), then the 1993-1995 figures could understate the true risk-adjusted difference. See Brown et al., “Does Managed Care Work for Medicare.”


