Health System Change in Boston, Mass.

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Boston is in a state of rapid change, with virtually every major health care organization building new capabilities and alliances. For most, this transformation involves some break from tradition and past corporate values; for some, a change in leadership and management; and for others, the painful process of downsizing. The economic importance of health care institutions to the local economy and their links to other major education technology-related institutions buffer them from a single-minded focus on health care costs by public and private employers. Despite relatively high costs and an abundance of physician and hospital resources, there is little evidence that either purchasers or health plans are bringing significant cost pressure to bear on the system.

The Boston health care community is unlike any other in the United States. It is the home of numerous world-renowned academic medical centers and clinical programs, including the Massachusetts General Hospital, Brigham and Women's Hospital, Beth Israel Hospital, New England Medical Center and Boston University Medical Center. It is the training site for many medical students, residents and nurses who are affiliated with the medical and nursing schools of Harvard, Tufts and Boston University and the many teaching hospitals. The area's institutions also sponsor prestigious clinical research programs and receive many lucrative public and private research grants and awards.

The health care industry is at the core of Boston's local economy, accounting for a sizable proportion of the local work force and revenues. Boston's health care institutions are major purchasers of goods and services produced by other local industries, such as banking, information technology and insurance.

The high-quality reputation of Boston's health care institutions, combined with local economic dependence on the health care sector, have produced a community that is proud and protective of its health care traditions and organizations—and, not surprisingly—somewhat reluctant to confront the task of containing health care expenditures.

In recent years, as rates of increase in health care premiums and expenditures for other communities have declined, pressures have mounted on the Boston health care community to keep local health care premiums reasonably in step with those of other regions. Although private and public

employers in the Boston region under the auspices of the Massachusetts HealthCare Purchaser Group have issued price challenges to insurers and health plans, they have not aggressively pursued reductions in premiums.

Both the privately insured and Medicaid populations are migrating steadily from traditional indemnity to managed care products. For the most part, these managed care products are characterized by substantially overlapping provider networks, and fee-for-service is still the dominant method of payment for providers.

Increased enrollment in managed care products has meant a decline in hospital use. In a community already characterized by excess acute care hospital capacity, further decline in demand has intensified competition among hospitals and made it increasingly difficult to use patient care revenues to cross-subsidize teaching and research functions.

Three large care delivery systems—Partners Health Care System, The Care Group and Boston Medical Center—have emerged in the last few years as a result of mergers between major hospitals located in the city proper. At the time of the site visit, one major academic medical center, New England Medical Center, had been unsuccessful in finding a partner, but subsequently announced plans to affiliate with Lifespan, a Rhode Island-based not-for-profit health system.

These large care delivery systems have focused largely on geographic expansion through acquisition of or affiliation with community hospitals and physician practices. Building geographically expansive networks serves to generate referrals for highly specialized tertiary care, but, more important, may also serve to strengthen the position of provider systems seeking to negotiate with insurers and health plans. These expansive networks are developing at the same time that some systems are negotiating with managed care plans for contracts that include nearly full capitation payment and that delegate care management responsibilities (credentialing, quality and utilization review, etc.). These actions have led some respondents to speculate that one or more of these systems eventually may try to compete directly with managed care plans.

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The Boston market is dominated by three not-for-profit plans that have local origins but now serve much of the Northeast region: Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Plan and Tufts Associated Health Plan. Growth in covered lives through geographic expansion is a key component of the long-term strategy of each of these three health plans. Health insurance products with large, geographically dispersed provider networks are viewed favorably by large employers seeking to offer the same health insurance products to their entire New England work force. Also, the level of managed care penetration in the Boston metropolitan area has reached what many believe to be a saturation point for the commercial population. Accordingly, geographic expansion is viewed as one way to keep increasing enrollment and to reap the benefits of economies of scale.

The health system changes underway pose challenges and opportunities for Boston's

safety net providers. As Medicaid recipients are moved increasingly from traditional fee-for-service arrangements to managed care options, the community health centers (CHCs), in particular, are actively working to adapt to new market dynamics. Many individual CHCs have entered into contracts with health plans and hospitals to participate in established provider networks that serve commercial and Medicaid insureds. CHCs as a group also continue to promote enrollment in the Neighborhood Health Plan (NHP), an HMO established during the 1980s under the auspices of the Massachusetts League of Community Health Centers that currently serves about 40,000 Medicaid enrollees. Because CHCs represent a diverse group with varying talents and capabilities, it is likely that some will adapt very successfully to the changing environment. However, others may not.

The Boston Community

This case study focuses on the Boston metropolitan area, as defined by six counties: Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk.[1] The population of the Boston metropolitan area is similar to that of the nation as a whole in terms of age distribution, but there is less ethnic diversity. Nearly 90 percent of the Boston metropolitan area is Caucasian, compared with 75 percent for the United States as a whole. The median income is $25,874, compared with $20,789 for the United States.[2]

The Boston metropolitan area compares favorably with the nation as a whole along many health status indicators. Overall age-adjusted mortality rates are comparable to national averages. The age-adjusted mortality rate for cancer is 5 percent above the national average, and the rate for ischemic heart disease is 12 percent below the national average.[3] Infant mortality rates are well below national average for both the non-white and white populations (42 percent and 19 percent below U.S. averages, respectively).[4]

THE HEALTH CARE MARKET

Compared with other geographic areas, the Boston metropolitan area has an abundance of health care resources. While the number of hospital beds per 1,000 population is slightly higher than the U.S. average, the Boston area has 45 percent more physicians per 1,000 people than the national norm (29 percent more primary care physicians and 58 percent more specialists).[5]

In recent years, the markets for health insurance products and health services have undergone significant geographic expansion, with a consequent blurring of geographic lines that have traditionally demarcated various sub-markets. Historically, the market for health insurance products has been defined by state boundaries, but most leading health plans now serve multiple New England states and are pursuing a strategy of steady regional expansion.

Similarly, the market for health services traditionally has consisted of two segments:

- a core of highly specialized providers in the urban center (i.e., academic medical centers and physician specialists organized in faculty practice plans) that concentrate on providing tertiary-level and some secondary-level services to local, national and even international markets, as well as some primary and secondary services for city residents; and
- various sub-markets in suburban areas that typically consist of community hospitals and affiliated primary care

providers (either from private small-group practice settings or, in a few submarkets, multispecialty group practices).

During the last few years, at least two systems in the city of Boston launched by academic medical centers have aggressively pursued a strategy of building broad-based physician and hospital networks capable of providing comprehensive services to most or all of the Boston metropolitan area. In addition, a multispecialty group practice, Lahey Hitchcock, is developing a regional provider network that extends into the Boston metropolitan area.

LEADERSHIP AND DECISION MAKING

Many respondents expressed the view that factions of providers and health plans orchestrate health system change, while private purchasers, consumer advocacy groups and the public sector influence but do not drive the overall course of change. Many noted the strong leadership of the major academic medical centers (AMCs) and the significant influence they wield over government and business. Health plans also were viewed as influential in leading the transition from indemnity to managed care insurance products, and, in doing so, assuming a great deal of control over the allocation of the community's pool of health care dollars.

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Virtually all respondents viewed the Boston health care system as very high-quality. Many expressed a strong commitment to protecting the market's local institutions and preserving its not-for-profit character.

The Boston community also has a history of providing health care access to the poor and the uninsured. There are a number of well-defined, politically organized neighborhoods (e.g., Jamaica Plain, Codman Square and Roxbury) that serve as catchment areas for community health centers and exert some degree of influence over public and private health care decisions. Although attempts to provide universal insurance coverage have been unsuccessful, there have been continued incremental expansions in Medicaid eligibility. In addition, the state's uncompensated care pool has represented a major source of revenue for the many community health centers, and Boston City Hospital and Cambridge Hospital, which serve a disproportionate share of the uninsured and underinsured.

The respected leaders in the business community, organized consumer advocacy groups and the public sector are not viewed as potent change forces at this time. Because of the inherent conflicts of trying to contain health care expenditures in a community whose local economy and labor force depend heavily on the health care sector, purchasers have adopted a cautious approach. Consumer advocacy groups, such as Health Care For All, have been effective in their past efforts to expand health care coverage to the uninsured, but some of these more expansive public sector initiatives have been rolled back. In addition, the current Republican governor is less receptive to broadening the public sector's role.

External Forces Affecting the Health System

These values and economic realities have shaped public policy and decision making of private and public purchasers. Support for preserving the community's state-of-the-art health care system and maintaining broad access to that system is strong, in both the public and private sectors. But there is also recognition that significant changes in health care financing and delivery are necessary to ensure that local health care costs begin to align with those of other regions.

PUBLIC POLICY

Many respondents observed that the government's role has changed from the regulatory approach of the Dukakis administration in shaping the health care market to a more collaborative model based on complementary public and private sector initiatives that encourage free market dynamics on a level playing field. But although its approach may have changed, the government remains very influential, they emphasized.

State policy has focused on two major areas:

- ensuring access to health care for the poor and uninsured and
- providing safeguards to protect consumers.

Massachusetts has a long history of providing health care for the poor and the uninsured. Currently, care for the poor is financed through two mechanisms: the Medicaid program and the state's Uncompensated Care Pool. The state's Medicaid program provides coverage to approximately 500,000 people. The Uncompensated Care Pool, funded at a level of about $315 million annually, compensates hospitals and ambulatory care providers for providing services to the uninsured.[6]

State health reform legislation passed during the late 1980s included a mandate that employers directly provide health insurance coverage as a part of their employee benefit package or contribute to a state-sponsored insurance pool. This provision was never implemented, however, because of strong opposition from the business community and the current governor's lack of support. As the number of Massachusetts residents without insurance coverage has increased steadily, pressures have mounted to implement the pay-or-play provision or provide for expanded coverage through other means.

In July 1996, the state legislature enacted, over the governor's veto, the Act Providing for Improved Access to Health Care, which removed the pay-or-play provision and authorized an expanded version of Medicaid.[7] Under these expansions, it is estimated that an additional 160,000 children will be entitled to some Medicaid benefits, as well as some adults and adolescents in families experiencing prolonged periods of unemployment. The law also provides prescription drug coverage for some 65,000 elderly low-income residents.

Taken together, these Medicaid expansions in effect have replaced categorical eligibility requirements with a basic income standard that provides coverage for eligible residents with household incomes under 133 percent of the federal poverty level and who are not covered by employer-sponsored insurance. These expansions in Medicaid coverage are being financed through three sources:

- a 25-cents-a-pack cigarette tax;
- federal matching funds, to which the state is entitled under its 1115 waiver; and
- moneys redirected from other state assistance programs being absorbed into the Medicaid expansion.

The state also hopes to contain growth in Medicaid expenditures per eligible through expanded use of managed care.

Although these Medicaid expansions are expected to reduce demands on providers for uncompensated care, the state legislature is also considering options for shoring up the Uncompensated Care Pool. Currently, the pool is financed through contributions by hospitals proportionate to their revenue from private payers. As private insurers and health plans have reportedly become more effective in negotiating fees and volume discounts, the hospitals have found it increasingly difficult to contribute their share to the Uncompensated Care Pool. This situation reached a critical level for many hospitals in 1996, when Blue Cross and Blue Shield unexpectedly lowered payment rates to hospitals in response to the Blues' own worsening financial situation.

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The state is also imposing certain requirements on health plans and hospitals to provide free care and other services to the community. The Massachusetts attorney general's office has been actively enforcing the community benefits standards that apply to not-for-profit organizations, which are expected to provide benefits to the community in return for their tax-exempt status. More recently, the attorney general has raised the issue of ongoing community benefits in negotiations with parties seeking state approval for proposed mergers or acquisitions that would convert the tax status of a not-for-profit hospital or health plan. The state legislature is considering a bill that would add teeth to these negotiations by requiring organizations that convert to for-profit status to maintain their current levels of free care.

Most state policy has focused on improving health care access for the poor and the uninsured, but as the pace of health care change has accelerated in recent years, various consumer protection issues have surfaced on the state's policy agenda. These consumer protection issues fall into two categories: restrictions on the actions of managed care organizations and quality oversight and reporting mechanisms for health care providers.

Many respondents referred to growing antimanaged care sentiments, as reflected in bills introduced in the state legislature to restrict various managed care practices, including financial incentives to providers, same-day hospital stays for normal deliveries and so-called gag rules in provider contracts. Some respondents viewed these proposals as a manifestation of consumer dissatisfaction with managed care, while others saw them resulting from the influence and lobbying efforts of physician-sponsored organizations. In hopes of averting an ad hoc legislative process, the Joint Committee on Health Care (a committee created by the House and Senate of the state legislature) has been asked to develop a new regulatory framework for insurers and health plans

that will respond to the many concerns raised by various constituencies and interest groups.

The state also passed legislation in 1996 giving consumers access to physician profile information maintained by the state licensing board. These data include biographical information (e.g., board certification, residency training, medical school), malpractice experience, disciplinary actions and criminal convictions. Responding further to demands for physician performance data, the Massachusetts Medical Society recently agreed to serve as the first pilot site for a national physician accreditation program being implemented by the American Medical Association.

Federal policy also has had an impact on Boston's health care organizations, and many leaders of Boston's AMCs and community health centers appear to have been quite active in federal policy deliberations. In particular, Boston teaching hospitals derive considerable support from Medicare payment policy pertaining to direct and indirect teaching expenses.

PURCHASING

Both public and private sector employers have influenced the direction and pace of health system change to some extent through their purchasing decisions. But for the most part, purchasers are not viewed as a potent force. Many respondents noted the conflicting incentives that face both public and private purchasers in a community where the health care system is integral to the local economy.

Public purchasers are large and well-organized and include the Commonwealth of Massachusetts (which purchases health insurance for its employees through the Group Insurance Commission) and the state Medicaid program. Private employers are predominantly mid-size companies that operate in multiple New England states. A limited number of national companies have a sizable presence in Massachusetts, including Digital Equipment Corporation and Raytheon Company. Leading industries include high technology and financial services.

There is a good deal of cooperation between public and private purchasers. The Group Insurance Commission and the state Medicaid program, along with many private employers, participate in the Massachusetts Healthcare Purchaser Group, a coalition that represents about one million covered lives, of which 50 percent are Medicaid enrollees, 15 percent public employees and 35 percent commercially insured lives. So far, the Massachusetts Healthcare Purchaser Group, which is chaired by the director of the state Medicaid program, has focused primarily on the collection and dissemination of information on cost, satisfaction and quality, but consideration is being given to launching a joint purchasing initiative in 1998.

As a general rule, purchasers have not been bold in their demands. Respondents cited several reasons for this:

- The financial interests of local employers and the public sector are intertwined with those of the health care sector.
- Relatively low unemployment rates in recent years have resulted in a good deal of labor market competition and reluctance on the part of many employers to impose restrictions on health benefits.
- The public sector is constrained by the potential effects of rapid downsizing on public sector revenues and financial

obligations. During the 1980s, state-backed bonds represented a major source of capital for hospital expansion and renovation. Reductions in payment rates and service volume may place some hospitals in serious financial peril, jeopardizing their ability to make bond payments. Short-term labor displacement resulting from hospital downsizing is likely to cause a drop in state income and sales tax revenues, as well as increases in unemployment and Medicaid expenditures.

Although most purchasers have not engaged in aggressive negotiations with insurers and health plans, they have sent consistent signals in recent years that premium increases must be moderated. For example, the Massachusetts Healthcare Purchaser Group has issued an annual price challenge requesting insurers to keep premium increases at or below target levels. Some large private purchasers have tied premium contributions to the lowest or average plan premium in the market, thus encouraging employees to consider cost and other differences in various plan offerings when choosing a health insurance product.

Unlike many other geographic areas, HMO products rather than PPO products account for the greatest share of the managed care market in Boston. In 1995, approximately 35 percent of the total population in Boston and the surrounding metropolitan area was enrolled in HMO products, with HMO penetration at about 45 percent in Boston itself.[8] HMO products in Boston are characterized by large provider networks that afford people a great deal of choice, thus minimizing demand for products that provide some coverage for use of out-of-network providers. The popularity of HMO products also stems in part from the provisions of the state's hospital rate-setting system that until its repeal a few years ago provided HMOs with distinct advantages over other insurers in negotiating discounted hospital rates.

Widespread perception holds that to be successful in the market, managed care products must offer broad choice of both primary care and hospital providers. Like consumers elsewhere, Bostonians place a premium on maintaining established primary care relationships. They are also accustomed to having access to the most prestigious clinical specialists for more serious ailments.

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Numerous respondents characterized the Boston HMO market as having only limited product differentiation. Although there are several large competing health plans in Boston, all have substantially overlapping provider networks, and all are perceived as price-competitive and high-quality. Variations in benefits and copayments were described as nominal.

The efforts of public and private purchasers to compare health plans and hospitals were characterized as having promoted dialogue between purchasers and plans around quality issues, but falling short of providing the requisite market incentives and information to providers to improve performance. Respondents cited two reasons for the limited impact of comparative performance data to date.

- First, products characterized by broad overlapping networks tend to appear

quite similar across many measures of patient satisfaction, access and technical quality.

- Second, methodological limitations (e.g., lack of risk adjustment, limited emphasis on quality measures for acute and chronic illness and the absence of measures of statistical significance of reported differences) make it difficult to interpret comparative performance data.

Organization of the Health Care System

The Boston health care sector has undergone many organizational changes during the last few years. Five of the area's major AMCs have been involved in mergers. Two of the three major insurers and health plans have merged with or been acquired by other health plans and all three have grown rapidly to become regional players. The physician community has also been affected by organizational change, with numerous primary care practices being purchased by AMCs and many others entering into new contractual arrangements with hospitals, AMCs, insurers and health plans.

AMC-BASED DELIVERY SYSTEMS

At the heart of many of these changes is the formation since 1994 of three large care delivery systems: Partners Health Care System, The Care Group and Boston Medical Center.

Partners Health Care System represents the union of the two largest and most prestigious Harvard-affiliated academic medical centers in the region, Brigham and Women's Hospital and Massachusetts General Hospital, both recognized for their successful and financially lucrative clinical research programs.

The Care Group consists of Beth Israel Hospital and the five-hospital Pathway System (which includes Deaconess Hospital in Boston and four community hospitals), also highly regarded for their clinical expertise and viewed by many interviewees as a more efficient and patient-oriented system than Partners.

Boston Medical Center is a new corporate structure that brings together two financially weaker institutions with different capabilities and serving very different populations: Boston University Medical Center, which provides a full spectrum of primary, secondary and tertiary services to a predominantly suburban population, and the Boston City Hospital, a newly renovated facility, which, through its relationships with community health centers, plays an integral role in the community's safety net. This last union has produced a system whose financial well-being is still uncertain and heavily dependent on continued public funding for care of the uninsured. Since the mid-1996 merger, there have been significant reductions in staff.

At the time of the site visit, one major academic medical center had been unsuccessful in finding a partner. New England Medical Center (NEMC), a teaching hospital affiliated with the Tufts Medical School, had held discussions with Partners Health Care System and Boston Medical Center, but neither had borne fruit. There was much speculation that NEMC might be acquired by Columbia/HCA, which recently became the first for-profit hospital system in the state through its purchase of MetroWest, a small suburban community hospital. This acquisition was a source of great anxiety among those who seek to preserve the community's not-for-profit, local orientation. Subsequent to the site visit, NEMC announced it would affiliate with Lifespan, a Rhode Island-based not-for-profit health system.

As this initial phase of care delivery system consolidation draws to a close, two of the major systems, Partners and The Care Group, have shifted much of their focus toward geographic expansion through acquisition of or affiliation with community hospitals and physician practices. Partners, through its Partners Community Health Inc. (PCHI) division, reportedly has established relationships with at least 600 primary care physicians in surrounding areas, either by purchasing their practices directly or through contractual agreements that give PCHI the exclusive right to contract with managed care organizations on their behalf. The Care Group is pursuing a different strategy, extending its geographic reach to suburban areas and townships by entering into more loosely structured arrangements with community hospitals.

Building geographically expansive networks serves both short-term and long-term objectives for AMCs. One short-term rationale is to generate referrals for highly specialized and tertiary-level care. Despite wide recognition that reducing the community's acute care bed capacity is necessary and inevitable, all AMCs are seeking to minimize downsizing at their own institutions by strengthening and maintaining existing referral sources and by expanding their service areas. The extent to which community-wide overcapacity will be reduced through hospital closures or conversion of inpatient capacity to ambulatory and sub-acute inpatient care remains unclear.

Between 1986 and 1995, 18 hospitals in Massachusetts were converted to rehabilitation, post-acute care and substance abuse facilities[9] and speculation holds that others will follow. Some respondents contended that the closure or conversion of entire facilities would be preferable to partial reductions in capacity across many facilities. In this case, they said, less would be more: a leaner but stronger provider community capable of maintaining a full complement of clinical specialty and subspecialty programs with the breadth and depth to achieve economies of scale and superior clinical outcomes.

Building an expansive geographic network is also viewed by many as an essential first step for provider systems seeking to negotiate with insurers and health plans from a position of considerable strength. Specifically, respondents reported that a provider system's bargaining position with health plans is greatly enhanced by a network with a broad geographic reach (i.e., the ability to provide access to large numbers of insureds) and the inclusion of key AMCs and hospitals with strong reputations (i.e., brand-name recognition in the marketplace). It was perceived that insurers and health plans would be unable to exclude such indispensable provider networks from their product offerings in a market such as Boston, where consumers place a high value on having broad choice of providers and are accustomed to having access to the world's leading medical institutions.

In their quest for greater geographic presence and expansive networks, the AMC systems are walking a tightrope between short-term objectives and long-term strategic positioning. Although AMCs generally described their efforts to work with hospitals and providers outside the city's core as collaborative, many outlying providers described the AMCs as heavy-handed. Immediate efforts to attract patients from outlying areas through the purchase of or affiliation with community-based hospitals and primary care physician practices must be balanced against the desire to build lasting network relationships. In many communities, local hospitals provide needed

geographic access to services, and may also serve as a vehicle for AMCs to develop formal or informal ties to medical staff in individual or small-group practice.

Respondents also pointed out that as some AMC-based systems assume greater responsibility for managing populations under capitated arrangements, they begin to view community hospitals less as competing inpatient facilities and more as efficient, low-cost providers offering geographically accessible services. Consistent with this perspective of community hospitals as long-term strategic partners, some respondents described a new ethic of returning patients to the referring provider with a handshake and a thank you note.

The AMC systems also must tread lightly to avoid raising concerns among insurers and managed care plans that these organized care delivery systems eventually might pursue direct contracting with employers or offer competing managed care products. For example, some eyebrows were raised by the actions of Partners, which is attempting to secure exclusive contracts with many primary care physician practices in its network. Both Partners and The Care Group are investing in the development of quality and utilization management functions and information systems that are necessary to manage financial risk and ensure quality.

The ultimate success of the AMCs' strategies of network-building and geographic expansion is still uncertain. These systems face a good deal of resistance and competition in parts of the state outside the inner core—a situation that is likely to intensify. A sizable number of strong community hospitals have chosen not to align closely with an AMC system, and some consideration reportedly is being given to forming an integrated system of leading community hospitals.

The Boston-based systems also face considerable competition from provider-sponsored systems headquartered further northeast and on the South Shore, including the Lahey Hitchcock Clinic, which was formed by the 1994 merger of Lahey Clinic in Burlington, Mass., and the Hitchcock Clinic in Nashua, N.H. This system consists of two large multispecialty clinics, 25 group practices ranging in size from 4 to 20 physicians, a 400-bed hospital, five smaller clinics and a newly formed network of primary care physicians who work in independent or small-group practices. On a smaller scale but with growth potential is the Goddard Medical Group, consisting of 85 physicians based in Brockton, Mass., and serving the South Shore.

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It is also unclear how successful the Boston-based provider systems will be in their efforts to assume greater degrees of financial risk and establish care management systems to manage this risk effectively. Capitation payments to these systems are limited at this time, and in spite of the significant network-building activities to date, it is questionable whether any one major provider system has established the internal care management systems needed to monitor and control costs and quality for a defined population.

Managed Care Organizations

Each of the three major insurers and health plans intends to expand the geographic breadth of the employers it serves and of its provider networks as a key component of its long-term competitive strategy. As noted earlier, large and mid-size employers view favorably those health insurance products with large, geographically dispersed provider networks. These products are more likely to ensure their goals of minimizing benefits administration costs and maximizing their purchasing power by contracting with one insurer or health plan to serve their entire New England work force. Also, as the level of HMO penetration has reached what may be the saturation point among the commercial population in the Boston area, geographic expansion into new markets, along with new Medicare business, is viewed as a means to continue increasing enrollment.

So far, the Boston market is dominated by three not-for-profit firms that have local origins but now serve much of the Northeast region: Harvard Pilgrim Health Plan, Tufts Associated Health Plan and Blue Cross and Blue Shield of Massachusetts.

Harvard Pilgrim Health Plan (HPHP) is a predominantly IPA model that serves people in seven Northeastern states. It was formed in 1995 as a result of the merger of a Boston-based plan, Harvard Community Health Plan, one of the oldest and most highly regarded group/staff-model health plans in the country, and Pilgrim Health Plan, an IPA-model plan serving northern Massachusetts. In its decision to merge with Pilgrim Health Plan, Harvard Community Health Plan was forced to choose between remaining competitive within the insurance market by pursuing flexible, nonexclusive provider contracting arrangements (i.e., offering employers and consumers managed care products with broad geographic coverage and maximum choice of providers in any given local market) and its historical commitment to a vertically integrated financing and delivery system.

Subsequent to the site visit, HPHP physicians sought a spinoff of the staff-model component, which had experienced productivity problems and was viewed as having limited growth capabilities. As of January 1997, HPHP reorganized its 14 staff-model health centers, which employ 600 physicians and 3,500 other employees, into an independent, not-for-profit multispecialty group practice.[10] The new group's contract with HPHP provides for:

- a degree of financial risk-sharing between HPHP and the group practice;
- a commitment on the part of the plan to increase membership at the centers; and
- a requirement that the group's internal medicine physicians and pediatricians exclusively serve HPHP for two years (other specialists are free to contract with competing health plans).

If HPHP enrollment at the centers fails to achieve targeted increases by 1999, the new group practice is free to provide both primary care and specialty services to other health plans.

Tufts Associated Health Plan, an IPA model, also has expanded rapidly in recent years through steady growth in its provider network; it now serves enrollees in Massachusetts, New Hampshire and Maine. With a strong reputation as provider-friendly and well-managed, Tufts is positioned to increase its market share, especially in the Medicare population. Under a franchise arrangement with

PacifiCare in California, Tufts has introduced to the New England area a highly successful Medicare product from the West Coast known as Secure Horizons.

Unlike HPHP and Tufts, which appear to have adapted quite successfully to new market dynamics, the third major player in the Massachusetts insurance market, *Blue Cross and Blue Shield of Massachusetts* (BCBSM), is in a difficult position. Although BCBSM still accounts for about 12 percent of the Massachusetts insured market, it faces serious managerial and financial problems. As the largest indemnity insurer in the state, BCBSM had the greatest transition to make as the market shifted toward managed care products. BCBSM currently offers HMO products in Massachusetts, Rhode Island and New Hampshire through two health plans, HMO Blue and Bay State Health Care.

BCBSM has experienced a great deal of senior management turnover and has suffered serious financial losses. In its weak position, BCBSM is viewed by many as the most likely takeover target for an outside company. As a result of 1995 and 1996 financial losses, BCBSM was forced to make sudden, mid-year downward adjustments in hospital payment rates, and most recently, to lay off hundreds of employees and decrease employee benefits. Some of the insurer's financial difficulties stem from losses on individual and small-group policies, which BCBSM must provide as the states designated insurer of last resort. But recent legislative changes requiring all insurers and HMOs to serve this high-risk segment of the market will help to level the playing field. BCBSM also was forced to pay penalties and to freeze enrollment in its successful Medicare risk product, when it was found to have submitted fraudulent documents to the Health Care Financing Administration.

Attempts by national, for-profit firms, including United Healthcare and U.S. Healthcare, to enter the market have had limited success. These companies have confronted difficulty in securing contracts with physicians due to strong preferences in the local medical community to work with local plans, which purportedly treat physicians more as partners. Consequently, outside companies also have faced an uphill battle in selling their products to employers and consumers, who place a very high value on broad choice of providers.

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Although outside firms have been unsuccessful in capturing local market share to any significant degree, the fact that they have knocked on the door has played an important role in shaping the strategies of the indigenous plans. Local plans recognize that their long-term survival depends on their ability to offer products that are competitive with those of national companies in terms of price, benefits, quality and service. They fear that if employers and consumers perceive too great a difference between their products and those offered by potential market entrants for any of these characteristics, they will be more receptive to the overtures of national firms.

Clinical Practice and Delivery of Care

Numerous efforts underway in the Boston community are intended to influence clinical practice and health care delivery. The major insurers and health plans in the market are all involved, to varying degrees, in quality and utilization management. The systems and approaches developed by health plans were generally described as comprehensive and systematic, and highly collaborative in how they have engaged providers in a positive way as active participants in quality improvement processes.

Respondents cited many examples of quality improvement initiatives, including:

- development of practice guidelines, physician profiling, clinical targets and monitoring systems for high-cost and prevalent diseases and conditions; and
- collaborative work with plans in other geographic regions to benchmark performance in selected clinical areas and to identify and share best practices.

Health plans emphasize the importance of positive incentives to providers, as opposed to punitive measures. Some viewed this choice as evidence of plans' convictions that physicians are more likely to respond favorably to quality improvement processes that rely on information feedback, guidance from respected clinical leadership and positive reinforcement.

In the case of two plans, Lahey Hitchcock and HPHP, it was also noted that some or all clinical management systems were developed as integral components of a multispecialty group practice environment, and probably reflect the emphasis on group process and peer review that is characteristic of this organizational culture. But others were quick to note that in a market characterized by health insurance products with broad overlapping networks and minimal risk-sharing with providers, health plans may lack the requisite leverage and incentives to influence clinical decision-making processes through mechanisms other than information feedback and education.

As discussed earlier, the AMC-based systems have made considerable progress in acquiring and piecing together the components of a comprehensive care delivery system, and some early signs indicate that they may be positioning themselves to assume more discretion over capitated dollars and care management functions. Partners, in particular, has communicated its intention to negotiate with insurers and health plans for nearly full capitation payment and delegation of credentialing, quality and utilization review functions.

But both Partners and The Care Group face major challenges in integrating and transforming the various internal management and operational processes of the system components to achieve economies of scale, efficiencies and improved care outcomes. There is evidence that this internal restructuring and infrastructure building phase is well underway at The Care Group. The Care Group is devoting considerable resources to the integration of academic programs, clinical services and financial operations of its two major area hospitals, Beth Israel and Deaconess, and to the centralization of key functions (e.g., contracting with health plans, physician billing, administration of management information systems and purchasing and materials management) for the entire six-hospital system.

There is less evidence of reengineering and internal system development among other major provider systems, and it is too early to assess the likely impact of these efforts on patient care.

Care of the Poor

Massachusetts has a long history of promoting broad access to health care through cultivation of a strong, well-supported network of safety net providers. The Boston area has 26 community health centers (CHCs) and two major hospitals that provide a disproportionate share of care to the uninsured and to Medicaid recipients: Boston City Hospital (now a part of Boston Medical Center) and Cambridge Hospital, a public hospital owned by the city of Cambridge.

Safety net providers derive the bulk of their revenues from two public funding sources: the Uncompensated Care Pool and Medicaid. As discussed earlier, the funds in the Uncompensated Care Pool have been seriously depleted in recent months, and emphasis is being placed on expanding the Medicaid program to provide coverage for many of the uninsured.

Although recent state legislative changes provide for increased funding to the Medicaid program to care for an expanded pool of eligibles, safety net providers face competition from managed care plans to capture these revenues. About one in seven Medicaid eligibles in the Boston area is currently enrolled in an HMO. Although current numbers of enrollees in managed care options are small, Medicaid is expected to account for a sizable share of the HMO market by the year 2000. Each of the three large health plans, BCBSM, HPHP and Tufts Associated Health Plan, has a contract to serve the Medicaid population.

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The migration of Medicaid recipients from traditional fee-for-service arrangements to managed care options poses significant challenges and opens up new opportunities for CHCs. In response, CHCs collectively and individually have pursued various alternatives for protecting existing and attracting new revenue sources, or, as one respondent explained, hedging their bets. Under the auspices of the Massachusetts League of Community Health Centers, an HMO known as the Neighborhood Health Plan (NHP) was established during the 1980s. Somewhat constrained by its small size (about 40,000 enrollees), lack of capital and dependence on public funding sources (most enrollees are Medicaid), NHP is now trying to develop strategic partnerships with commercial plans. Many individual CHCs are also pursuing contracts with health plans and hospitals to participate in established provider networks that serve commercial and Medicaid insureds.

CHCs face serious competitive challenges as they adapt to the changes in public financing programs and new market dynamics. For a variety of reasons (e.g., provision of social and enabling services, productivity), their costs appear to be higher than those of many other ambulatory care providers. But they also have important strengths, including networks of geographically accessible and culturally sensitive providers with loyal patient bases that many AMCs are eager to tap. CHCs, it was also noted, represent a diverse group. Some will probably be very successful in adapting to change; others may not.

Boston City Hospital and Cambridge Hospital, which rely heavily on public funding sources, are taking steps to ensure

their continued financial viability. As discussed earlier, Boston City Hospital recently merged with Boston University Medical Center to form Boston Medical Center, a hospital system with a more diversified revenue base and comprehensive array of services and capabilities.

Both public hospitals have also created managed care for the uninsured programs by enrolling uninsured patients in shadow managed care plans. Under these programs, uninsured individuals are treated as if they were enrolled in a managed care plan (e.g., individuals are assigned a unique individual identifier and a primary care physician and resource use is tracked). These programs are intended to serve several purposes:

- They provide uninsured patients with a medical home and coordinated health care services.
- They build patient loyalty to the hospital system in the event that these individuals are folded into Medicaid under future insurance expansions.
- The shadow plans generate utilization statistics and data on care-seeking patterns for the uninsured population that will be useful to the hospital system in negotiating capitation payments in the event that these individuals are enrolled in Medicaid managed care.

Issues to Track

Because the Boston area is in a state of rapid flux, it is not possible to predict with any certainty its future course or the implications of change for the population. But this first round of site visit observations provides baseline data and insights into those areas that are most important to track.

THE SHAPE OF COMPETITION

Many respondents believe that the nature of competition will change dramatically during the next few years. One issue to track is the acceptance of narrower networks. It is possible that one or more large employers will choose to accept a managed care product with a narrower network of providers in return for lower costs or, possibly, perceived higher quality. This would increase the likelihood that AMC-based systems, which have narrower networks than fee-for-service insurers and health plans, will enter into direct contracting arrangements with self-insured employers or offer insurance products directly. It may also open the market to entry by national firms.

Another issue to track is competition at the sub-network level. If the AMC-based systems succeed in assuming greater amounts of capitation risk, and if employer and consumer preferences for insurance products that afford broad choice are sustained, competition may intensify at the sub-network level. Insurance products might continue to consist of broad networks of thousands of physicians and many hospitals, but providers might be organized into sub-networks that individual enrollees might select at time of enrollment. Employee premium costs and copayments might vary, depending on the sub-network selected. Although the emergence of sub-networks is well underway in Boston under the direction of the AMC-based systems, there are few signs so far that the emerging sub-networks, such as the Partners PCHI system, are seeking brand-name identification in the market through advertising.

THE ROLES OF HEALTH PLANS AND PROVIDER SYSTEMS

The intensity and level of competition within the market undoubtedly will have a

profound effect on the roles and functions performed by health plans and provider systems, and the relationships between them. Current dynamics within the insurance industry are pushing local insurers and health plans to rapidly acquire regional stature by focusing resources on network development, marketing and customer relations. At the same time, local market conditions have given way to the development of provider-sponsored systems seeking to assume greater degrees of financial risk and responsibility for care management (e.g., quality and utilization management functions).

It will be important to track the roles, responsibilities and financial investments of various types of organizations in the development of care management systems. Less exclusive relationships between health plans and providers will reduce plans' incentives to make the required investment and develop the expertise necessary to build more sophisticated care management systems. In a market characterized by large overlapping networks, individual health plans often lack the control and leverage necessary to restructure care delivery systems. Their financial incentive to invest in sophisticated clinical information systems and disease management programs is also attenuated, because the benefits that derive from changing practice patterns accrue to all the competing plans in the area.

Under this scenario, some health plan responsibilities for provider credentialing, quality and utilization management may shift to provider-based care delivery systems. However, if competition were to develop at the sub-network level, health plans might assume new responsibilities for producing descriptive information and comparative quality and cost reports on the various sub-networks to assist consumers in selecting a sub-network.

EFFECTS ON PEOPLE

It is unclear the extent to which health system changes in Boston will affect the accessibility, quality or cost of care. Most respondents felt that there has been little impact to date on consumers, but many were quick to point out that it is much too early to assess the long-term impact of the many organizational changes that have occurred.

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The health system changes in Boston have the potential to produce both positive and negative effects. For example, the formation of more organized systems of care may result in more coordinated, effective and efficient care management programs, but this will only happen if these systems invest in the management and information system infrastructures needed to improve patient care. Similarly, Medicaid recipients enrolled in managed care options may benefit from more coordinated and comprehensive care, but depending on the contractual arrangements that develop between safety net providers and health plans, they may experience disruptions in established provider relationships and encounter a less culturally sensitive delivery system. It will be important to monitor the impact of health system changes in these and other areas.

NOTES

1 In New England, where metropolitan statistical areas (MSAs) do not conform to county lines, we have used New England County Metropolitan Areas, a conventionally accepted set of county approximations to MSAs.

2 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Population data are for 1995; income data are for 1993.

3 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997. Data are for 1994.

4 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Data are based on a five-year average for 1988-1992.

5 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term care units in hospitals. Physician estimates are based on the 1996 American Medical Association Master File and 1996 Master File of the American Osteopathic Association, excluding some specialists (radiology, anesthesiology, pathology), residents and fellows.

6 McDonough, John E., Christie L. Hager and Brian Rosman. Health Care Reform Stages a Comeback in Massachusetts. 336(2) *NEJM* 148-151. January 9, 1997.

7 *Ibid.*

8 InterStudy Competitive Edge Regional Market Analysis 6.2, February 1997.

9 Massachusetts Hospital Association, Caring for People into the 21st Century. September 1995, p. 4.

10 Harvard Pilgrim Nixes Staff-Model HMO; MD Group Will Contract with Others. Atlantic Information Services. *Managed Care Week*. Washington, DC, November 25, 1996.