Health System Change in Seattle, Wash.

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Seattle's health care market has undergone steady but significant change during the past five to six years. Seattle is a relatively self-contained and stable health market. Each of Seattle's dominant provider systems and most of its health plans are not-for-profit entities that have coexisted for at least 50 years. The past five years, however, have witnessed several important precipitating events that have shaped the financing, organization and delivery of care. These events include:

Seattle is a relatively self-contained and stable health market. Each of Seattle's dominant provider systems and most of its health plans are not-for-profit entities that have coexisted for at least 50 years.

- the introduction of Seattle's first major cost-driven, selective point-of-service (POS) product in 1992;
- the passage and demise of comprehensive health reform in 1993 and 1994;
- the drive by Boeing Company, Seattle's largest private employer, to enroll its employees in managed care during 1995 and 1996; and
- implementation of price-driven selective contracting in Washington's Medicaid managed care program in 1996.

Foremost among the changes resulting from these events was the creation of large physician groups, which occurred in anticipation of greatly expanded managed care under comprehensive health reform and the Boeing initiative. Consolidation of independent physician groups and the acquisition or development of physician networks by hospitals have resulted in the growth of large physician groups. Several hospitals have launched health plan initiatives as components of vertically integrated health systems—again, with the hope of competing for new managed care opportunities.

Other changes include increased price competition and heightened concern about costs. Public and commercial purchasers generally have regarded health care costs as stable and reasonable and have not viewed costs with much concern. However, several events indicate that Seattle may experience greater levels of price-based competition in the future:

- the 1992 introduction of a POS product that selected physicians based on claims history;

- the designation of price as the dominant criterion in Medicaid selective contracting in 1996; and
- intensification of price competition prompted in part by the entry of two national HMOs into the commercial and Medicare risk markets.

Regional expansion by Seattle's dominant insurers and health plans is another notable trend, evidenced by affiliations among several health plans to develop a statewide or multistate presence.

Three distinctive market characteristics influence provider and health plan strategies and help explain the results of change. First, it is commonly perceived that consumers in Seattle demand choice in plans, physicians, hospitals and, recently, alternative medicine. Second, respondents repeatedly maintained that success in the Seattle market hinges on a large and comprehensive market presence ("clout"), which, they say, is necessary for leverage in negotiations and to stimulate consumer demand for products. Third, there is widespread belief that some combination of healthy lifestyles and thrifty practice styles has kept hospital utilization low and overall health care costs down.

These characteristics help explain several trends observed in Seattle. For example, consumer demand for choice helps explain the breadth and overlap among Seattle's preferred provider organizations (PPOs) and the increasing popularity of POS products. Market presence is related to numeric size and geographic scope, and helps explain the rapid growth among several Seattle physician groups. Moreover, Seattle's historically low health care costs have protected the market from some national actors, including hospital chains and health plans.

A few important events have propelled change in Seattle's health care system. The first precipitating event was the introduction of the Selections POS product in 1992 by Seattle's largest indemnity plan, Regence Washington Health, formerly known as King County Medical Blue Shield.[1] For this product, Blue Shield analyzed claims data from physicians who regularly served the company's indemnity enrollees and selected for inclusion in its panel the top 40 percent of physicians with the lowest-cost practice patterns. Selections sent the message that expensive practice patterns could result in exclusion from network panels; it reportedly contributed to a rapid decline in hospital utilization.

The second precipitating event was the passage of a comprehensive health reform bill, the Health Services Act of 1993, and the subsequent demise of the Health Services Act through successive legislative actions in 1994-95. The Health Services Act would have created universal coverage through a combination of subsidized insurance mandates and employer mandates, some of which were overturned. The legislation also reformed the individual and group insurance markets, although several of those provisions also have been overturned. Health care providers altered their strategies, forming stronger physician networks and launching provider-sponsored health plans in part to take advantage of new managed care opportunities.

The third precipitating event was Boeing's effort to improve its managed care options and provide cash incentives for its work force to move from traditional insurance plans into managed care. The Boeing initiative is an important purchasing strategy change by Seattle's largest private purchaser.

The fourth precipitating event was the introduction of price as the dominant crite-

rion in the selection of Medicaid managed care contractors. This altered the array of contractors, and is credited with a 10 percent decrease in prices that has had a spillover effect on health care costs in other parts of the market.

Despite the degree of change underway in this market, informants were optimistic about quality and access to health care services, particularly for Seattle's poor and indigent populations. They believe that the long-standing coexistence and not-for-profit status of Seattle's dominant providers, plans and insurers ensure that competition will not get out of control. Access to care for the poor is provided through Medicaid managed care and the state-subsidized Basic Health Plan.

Some of Seattle's largest health care organizations (such as the University of Washington School of Medicine and Harborview Medical Center) have achieved national acclaim for their programs. Seattle serves as a multistate locus for tertiary care, trauma care and medical education in the four-state WAMI region (Washington, Alaska, Montana and Idaho). Many state policy makers and private sector health care leaders come from a "homegrown" pool based in the Pacific Northwest and affiliated with the University of Washington. Except for Seattle's historic Group Health Cooperative of Puget Sound, managed care has developed slowly in this market. Purchasing in Seattle is dominated by the state (which purchases for public employees, the medically indigent and Medicaid populations) and The Boeing Company, which purchases benefits for 86,000 local employees plus dependents (literally more than 10 times the purchasing volume of the next largest private employer, Microsoft). Brokers also have a long-standing relationship with employers and are highly influential in purchasing.

The Seattle Community

The Seattle area includes three counties (King, Snohomish and Island) on the east side of Puget Sound in the state of Washington. More than two million people live within these three counties' 4,425 square miles, but the vast majority resides between Everett (30 miles north of Seattle) and the suburbs south of Seattle. Puget Sound forms a natural geographic boundary to the west. The eastern reaches of King and Snohomish counties are rural and mountainous; rural islands in Puget Sound make up Island County. Seventy-three percent of the population lives in King County, 24 percent in Snohomish County and 3 percent in Island County.

Health status is generally better in Seattle than in the rest of the nation. Given this and other positive health indicators, it is not surprising that Seattle historically has had low hospital utilization.

The local population tends to be younger, more educated, less ethnically diverse and financially better off than the nation as a whole. The proportion of persons who are white is 13 percent higher than the national average, and the proportion who are Asian is 2.5 times higher than the national average.[2] The per capita income is 26 percent higher than the national per capita income and the percentage of families living in poverty (10 percent) is half that of the national average. Unemployment is lower than the national rate and is declining from a high point reached in 1992. Respondents report that less than 10 percent of the population has no health insurance.

Health status is generally better in Seattle than in the rest of the nation. The Seattle area has lower mortality rates among infants and the general population than the rest of the nation. Age-adjusted mortality is 20 percent lower than the national average. For example, mortality attributed to cancer and ischemic heart disease is 5 percent and 34 percent lower, respectively, than the national average.[3] Infant mortality is 21 percent lower than the national average (12 percent lower among whites and 33 percent lower among non-whites).

Given these positive health indicators, it is not surprising that Seattle historically has had low hospital utilization. Currently, Seattle has 20 percent fewer hospital admissions and 38 percent fewer days of care per 1,000 population than the respective national averages. Despite the fact that Seattle is a regional center for medical care, it has almost 40 percent fewer short-term hospital beds per 1,000 population than the national average.[4] On the other hand, the supply of physicians per 1,000 population in Seattle exceeds the national average by 24 percent (including 28 percent more primary care and 22 percent more specialty care providers).[5]

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THE HEALTH CARE MARKET

The Seattle health service market is defined in part along geographic lines, with the central core in Seattle and suburban and rural sub-markets to the southeast (Puyallup, Renton), east (Kirkland, Bellevue) and north (Everett). Seattle's tertiary care centers and Level 1 trauma center draw from Tacoma, just to the south, and several health systems based in Seattle also operate in Tacoma.

Seattle's hospitals are generally differentiated between the downtown tertiary centers, which are referred to locally as Pill Hill, and a suburban ring of community hospitals. These downtown hospitals enjoy a reputation for high quality, and each has established specific areas of expertise. Suburban residents tend to prefer Seattle's downtown hospitals for tertiary services, particularly cardiac care and neonatal intensive care services, even when such services are available in local, community hospital settings. Generally, suburban hospitals compete in uncontested geographic niches, although some community hospitals are said to operate on relatively low margins because of excess capacity.

Physician practices are dispersed throughout the market, but many respondents feel there is an oversupply of physicians in the population centers and an undersupply in the rural and remote regions of the three counties. Many of the area's physicians and nurses are trained locally at the University of Washington, which boasts nationally regarded research and training programs.

The market for health insurance has recently expanded beyond Seattle and the eastern Puget Sound area. Several insurers and health plans have launched statewide or multistate strategies with the expectation of increasing market share from expanded statewide public purchasing (for the Basic Health Plan, Medicaid and public employees). These insurers also anticipated

that large, regional private employers would prefer to contract with a few large plans rather than with multiple plans of limited geographic scope.

LEADERSHIP AND DECISION MAKING

Many informants spoke of the reputed "healthier lifestyle" of Seattle residents, historically low health care costs and the low number of uninsured persons. They also expressed a generally low level of concern about health problems and health services in Seattle. There is relatively little consistent and organized community-wide advocacy on health issues for indigents or other consumers. Activity around health issues may have reached an all-time high during consideration of the Health Services Act, but that energy reportedly has waned since the law's demise. Other community concerns, such as the need for a cost-effective mass transit system or conflicts between environmental preservation and economic growth, appear to take precedence in the minds of local business and political leaders.

Seattle businesses—including health care institutions—have a reputation for collaboration around civic interests. For example, researchers at the University of Washington have convened meetings that include business, provider representatives, health plans, political leaders and others to discuss and develop strategies for addressing Seattle's teen pregnancy problems. Local mission-oriented providers are active in upholding community health interests. Sisters of Providence, a Catholic-owned health system active in Seattle for 140 years; Seattle's eight community health centers; the King County Health Department; Group Health Cooperative; and various University of Washington researchers and medical system leaders have met together routinely to discuss health-related concerns.

Political activity on health issues generally is played out at the state level, rather than locally. For example, the energy behind regulation of insurers and HMOs has come from the state insurance commissioner. Health reform activities for the uninsured and underinsured were directed at the state level as well. The business lobbies, such as the Association for Washington Business and the Health Care Purchasers Association, tend to focus on state legislative activities. They lobbied against the Health Services Act, for example.

Finally, brokers play a leadership role as employers' primary source of information about the quality and direction of health plans and providers. These brokers review qualitative and quantitative aspects of the delivery and insurance systems. The scope of their reviews includes not only patient care but administrative and managerial quality. Brokers' reviews weigh significantly in employers' health care decisions. For example, a broker's leadership was influential in determining the nature of Boeing's benefit options.

External Forces Affecting the Health System

PUBLIC POLICY

Public policy has broadly affected Seattle's health care system during the past three to five years. The Health Services Act of 1993 and the movement of the AFDC population into managed care have led to significant changes in the organization of health care providers. Insurance regulation has also become an important health policy issue. In general, the Health Services Act sought to expand and protect access to insurance coverage for state residents. Since 1994, however, the legislature has reversed course and

overturned several key earlier provisions. Respondents report that the impact of employers on the insurance market is felt primarily through their influence on state health policy rather than through organized or concerted purchasing efforts.

The Health Services Act of 1993 was an effort at comprehensive health reform. The Health Services Act included five major provisions:[6]

- *Employer and individual mandates.* By 1999, all employers would have been required to offer employees and dependents a choice of health plans, join a purchasing cooperative or offer coverage through a state-sponsored health plan. Individuals would have been required to subscribe to a plan by 1999.
- *The Basic Health Plan.* This subsidized insurance plan was funded through Washington's tobacco, alcohol and hospital taxes. It was designed to insure 200,000 adults and 130,000 children statewide with low incomes and limited access to health benefits and who were not eligible for Medicaid.
- *Reform of individual and small-group insurance markets.* This included guaranteed issue to all employer groups; pure community rating with adjustments only for family composition and geography; guaranteed renewal; and limits on waiting periods for pre-existing conditions.
- *Any willing provider and patient protection provisions.* These would have required insurers and HMOs to accept all licensed health providers willing to comply with terms of participation.
- *The state Health Care Policy Board.* This new entity would have replaced the powerful Washington Health Services Commission.

In addition, the Health Services Act called for certain health care task forces and studies, resulting in the creation of the Public Health Improvement Plan, a program designed to track and help improve the public health infrastructure in Washington.

The legislature elected in 1994 reversed the direction of the previous legislature. Universal coverage was rescinded, and some insurance reforms have been repealed through a series of legislative actions during the past two years. The Basic Health Plan, some insurance reforms and the task forces and commissions created by the Health Services Act remain in effect, but some informants believe that the remaining insurance reforms may be repealed as well. Although the state's medical and hospital associations and various consumer groups strongly supported the Health Services Act, powerful business lobbies (including the Association for Washington Business and the Health Care Purchasers Association) opposed it, largely because of the employer mandates.

The passage and subsequent rescission of the Health Services Act had profound effects on Seattle's health care providers and plans, which had anticipated broad expansion of managed care. For example, many physicians consolidated into large groups, and several hospitals launched insurance products to compete with health plans. Medalia, Washington's largest physician group, was created directly as a result of anticipated demand for large primary care group capacity under universal coverage. Group Health Cooperative and Virginia Mason Medical Center launched a joint POS product to compete with other plans, and the State Medical Association started a physician-owned health plan to compete for new contracts.

Although the demise of universal coverage undermined the viability of these strategies, many of these entities became contractors under the Basic Health Plan. The changes they made to participate in this program left them well positioned for Boeing's managed care announcements.

Following passage of the Health Services Act, several area HMOs and individual health insurance carriers, particularly the popular Group Health Cooperative of Puget Sound and Blue Cross, reportedly experienced problems with adverse selection. This adverse selection may have resulted from insurance reforms that remained in effect even after universal coverage was repealed—leaving sicker patients in plans without a large increase in healthy patients to counter their effect. Informants suggested that the Basic Health Plan has attracted its own adverse selection. As a result, they said, costs of care are higher than expected and resources are running out earlier than expected.

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The mandate to enroll the entire AFDC population in Medicaid's Healthy Options managed care program, which took effect on a statewide basis in 1993, created a new market opportunity for Seattle's health plans. Washington also passed a law to move the SSI population into Healthy Options, although the time frame for this transition has been pushed back several times. Healthy Options' initial purchasing approach included only limited qualifying requirements for plans. In July 1996, it switched to a selective strategy in which price counts for 60 percent of the selection decision. Respondents generally credited the Healthy Options program with improvements in access to primary care. But new price competition in the program may result in lower revenues for participating providers or, as in the case of Providence Health Plans, discontinuation as a contracted plan.

Regulation and legislative advocacy by the state Department of Insurance has also influenced the Seattle landscape. The department regulates insurers and licenses HMOs and Health Care Service Contractors (HCSCs, which include provider-sponsored or provider-operated health plans, as well as more traditional HMOs, such as PacifiCare). Like HMO licenses, HCSC licenses have been available in Washington for more than 10 years. However, they require fewer assets and are easier to obtain than HMO licenses. Traditional insurers and PPOs are not licensed in Washington.

The Department of Insurance also responds to consumer concerns about health benefits, a role highlighted by the department's commissioner. Informants credit the department with supporting insurance reforms and other recently enacted mandates, including:

- minimum length of stay for deliveries,
- expanding the definition of primary care providers to include non-traditional therapists, such as naturopaths and chiropractors (this mandate was subsequently struck down in a federal court for violating ERISA laws); and
- provisions allowing access to obstetricians and gynecologists without gatekeeper control.

PURCHASING

Seattle's two largest health care purchasers have altered their purchasing strategy in the past two years. The Boeing Company, which purchases benefits for 86,000 local employees plus dependents, has undertaken a plan to move beneficiaries into managed care. The state of Washington, which purchases coverage for public employees, recipients of subsidized insurance and Medicaid enrollees, has increased its level of contracting with managed care and instituted price-driven selective contracting in Medicaid. Brokers also have a long-standing relationship with public and private purchasers and are highly influential in purchasing.

• Private Purchasing

Private sector employers reportedly are satisfied with the health care costs, quality and benefit designs available in Seattle. They have not insisted on deep cuts in premiums or changes in benefit designs, as long as prices remain "reasonable." After price, their primary concern is provider choice, which has worked against plans' efforts to establish more exclusivity in their physician and/or hospital networks. Contracting generally has been with traditional insurance plans, or with Group Health Cooperative of Puget Sound. Prior to 1996, Seattle's major employers (including Boeing, Microsoft, Nordstrom, SeaFirst Bank and The Bon Marché) reportedly had devoted little energy to health benefits purchasing. Instead of trying to make major changes in their health benefit options, these employers reportedly have sought to influence state policies related to health benefits. For example, employers opposed small-group insurance reforms that established mandated benefits or provided guaranteed issue.

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In 1994, Boeing took the first major step by a large private employer in decades by launching plans to convert its employees, dependents and retirees to managed care in the July 1995 open enrollment period. Prior to this initiative, 85 percent of Boeing's work force plus retirees and dependents were enrolled in traditional insurance; the remainder were enrolled in HMOs. The Machinists' Union (Boeing's largest union) went on strike in 1995 over pay and health benefits. The machinists were generally concerned about converting to managed care, and they were particularly disturbed by Boeing's proposal to make employees who chose other than the cheapest health plan option available pay more out of pocket. That proposal was dropped, and Boeing proceeded with the initiative for the 1996 open enrollment.

Boeing revised its menu of plans and sought to standardize its benefit packages by requesting proposals from specific plans. After awarding contracts to five plans, Boeing began offering financial incentives to employees who converted to—and remained with—those plans: $600 for the first year, $400 for the second year and $200 for the third year. Although these changes were met with some concern initially, many of Boeing's beneficiaries are now enrolled in managed care. As of July 1996, 60 percent of salaried workers, 50 percent of hourly workers and 25 percent of retirees had converted to managed care. Informants believe that Boeing's plan faces its real test during the next open enrollment period—July 1997.

Brokers play a prominent role in Seattle; one estimate suggests that more than 1,100 individuals act as brokers. Employers hire brokers to evaluate, recommend and help negotiate with plans. While many brokers work solo or in small firms, brokers for Seattle's larger employers work in large consulting firms, where they have research staff available to gather and analyze data on the health plans, including information about the providers within the networks and the care management provided by the plan. One broker expressed concern that brokers increasingly will need to demonstrate the added value they bring to purchasers to retain their positions. Health plans reportedly are not happy with the influence that brokers wield, but accept them as a fact of life.

Three purchasing cooperatives were launched recently in Seattle under the direction of three major business groups:

- the Employers Health Purchasing Cooperative, created by the Health Care Purchasers Association;
- a cooperative founded by the Seattle Chamber of Commerce; and
- the Purchasers Alliance, which was launched by the Association for Washington Business.

These cooperatives were created largely by Seattle's small and medium-size employers to increase their purchasing power and ensure stable health care costs. Their impact on the local market reportedly has been minimal. The Employers Health Purchasing Cooperative (EHPC) illustrates how a purchasing cooperative works in this market. Established two years ago with funding from the Hartford Foundation, the EHPC has more than 200 members but represents only 10,000 covered lives. It caters to small employers and does not view itself as a viable vehicle for larger employers who want benefits more tailored to their needs. Instead, the EHPC secures a rate cap from plans in exchange for three-year contracts from employers.

More changes are predicted in purchasing and health plan strategies. Several health care providers and purchasers predict more movement toward direct, capitated contracting with provider systems. Meanwhile, respondents said that purchasers would prefer direct contracting as a way to circumvent plans and pick the provider systems that they believe offer the best value.

Health plans, on the other hand, are developing regional and multistate strategies with the hope that large purchasers will prefer to contract centrally with a few plans. However, there is no evidence of success with such regional strategies.

• Public Purchasing

State actors dominate public purchasing in Seattle, although different entities are responsible for Medicaid, public employees and Basic Health Plan enrollees. The Washington State Health Care Authority purchases for the Public Employee Benefits Board (state employees and teachers) and the subsidized Basic Health Plan. The Medicaid Authority purchases for Medicaid's Healthy Options managed care program.

The Health Care Authority issues a single request for proposals to solicit separate bids from plans for the Public Employee Benefits Board and the Basic Health Plan. The process and criteria used to review bids for these separate contracts are the same. The Health Care Authority reviews proposals against minimum threshold requirements for quality and access, price and financial solvency. The Health Care Authority offers at least eight plans in the Seattle area to

Basic Health Plan members and at least 11 plans in the Seattle area to Public Employee Benefits Board enrollees, who must pay higher premiums if they subscribe to one of the more expensive plans offered. The Uniform Medical Plan has been the Health Care Authority's self-funded plan (and among the state's most expensive options) for decades. In 1996, the authority required employees enrolled in the Uniform Medical Plan to pay a higher premium for the first time. To encourage state employees to select other offerings, the authority has been beefing up benefits in its HMO options for the last decade.

Before 1996, the Medicaid Authority contracted with health plans that met certain minimum thresholds for quality and access. In 1996, Medicaid introduced a selective contracting process in which price considerations counted for 60 percent of the purchasing decision. The designation of price as the dominant criterion sparked what some informants referred to as a competitive bidding "price frenzy." Other selection criteria include access to emergency services; availability of prenatal, family planning and medical interpreter services; and the use of quality improvement measures. The Medicaid Authority strongly encourages plans to obtain and analyze encounter-level data from physicians and hospitals. Plans receive additional consideration if they include traditional safety net providers in their networks.

Medicare managed care enrollment has grown over the past few years, driven especially by the recent entry of California-based PacifiCare into the Seattle market. Medicare managed care penetration is currently about 26 percent.[7] PacifiCare eliminated the premium for its Medicare product, and Group Health quickly matched that strategy. Informants now wonder whether this competition will actually increase enrollment in Medicare HMOs or the plans essentially will battle each other for the same pool of enrollees. They also expressed mixed views on the attractiveness of the Medicare risk business, because of the large senior population in Seattle and low AAPCC rates.

The broad expansion of the Basic Health Plan and the introduction of price-based selective contracting in Medicaid managed care may amount to the most significant changes in public purchasing. The Basic Health Plan has expanded the market to include the previously uninsured. However, some respondents believe that some individuals who were privately insured previously have discontinued their coverage in order to be picked up under the state-subsidized plan. In addition, by introducing price into the Medicaid contracting equation, the state for the first time has placed plans on alert to keep their costs down. This new cost-consciousness may affect the composition and management of provider networks in the future.

The broad expansion of the Basic Health Plan and the introduction of price-based selective contracting in Medicaid managed care may amount to the most significant changes in public purchasing.

Organization of the Health Care System

As noted, the health system is composed almost entirely of locally owned and operated not-for-profit organizations. Two national HMOs are active in the market

(PacifiCare and QualMed), but the remaining plans and providers were founded in Seattle and have operated there for more than 50 years. Most area hospitals are independent; two local health care systems each own and operate two hospitals. In addition, provider-sponsored health plans and vertically integrated delivery systems have emerged.

INSURERS AND HEALTH PLANS

• Organization

The two Blue Cross/Blue Shield carriers, Regence Washington Health (formerly King County Medical Blue Shield) and Blue Cross of Washington and Alaska, have been the dominant insurers in Seattle for decades. Their roots date back to the county medical bureaus of the 1930s, when Blue Shield was essentially a prepaid health plan largely serving the timber industry. Each of these two Blues carriers has more covered lives across different products than any other insurer or plan in the market, and together account for more covered lives than all other plans in the market.

Regence Washington Health is now a division of The Regence Group, a holding company for Blue Shield plans in Washington, Oregon and Idaho. It is the largest carrier in the Seattle market, with 767,000 enrollees in King and Snohomish counties.[8] Its subsidiaries include HMO Washington, a troubled HMO product that is undergoing redesign, and Washington Physician Services, a management services organization (MSO). In 1992, Regence Washington Health purchased a proprietary software program designed to profile physician practice patterns, with an emphasis on cost, and used this information to design its Selections product. The introduction of this POS product has had a particularly strong impact because nearly all physicians in Seattle serve Regence Washington Health enrollees, and Regence has amassed extensive claims data to use for profiling.

Blue Cross of Washington and Alaska is now owned by a holding company called Premera. Blue Cross traditionally has been the second-largest indemnity carrier behind Regence Washington Health. Blue Cross lost access to the Boeing population this year when Boeing selected another set of plans. Blue Cross also has a PPO product that offers a 15 percent discounted fee schedule. HealthPlus, the HMO subsidiary of Premera/Blue Cross, includes commercial and individual products, Basic Health Plan and Medicaid products.

Seattle is also the home of the historic and nationally recognized Group Health Cooperative of Puget Sound, which was founded in 1948. Selected recently as one of the three highest-quality HMOs[9] in the United States, Group Health Cooperative of Puget Sound is the largest HMO in the Puget Sound region, with more than 500,000 enrollees. Sagging enrollment forced Group Health to cut its premiums in 1995.

Group Health also jointly sponsored a POS product with Virginia Mason Medical Center called Alliant anticipating that the two entities together could improve their market share beyond what their individual HMOs could accomplish. This venture expanded the hospital and physician panel available to HMO enrollees in Group Health and the Virginia Mason Medical Center; enhanced the perceived quality associated with Group Health; and expanded the Virginia Mason Medical Center's primary care base. Alliant is now very popular and was selected by Boeing for its employees.

Related to this joint venture was the closure of Group Health's downtown hospital as a

cost-saving strategy, and the transfer of patient volume to Virginia Mason Medical Center. In addition, Group Health and Kaiser Permanente Northwest have announced plans to merge their operations throughout the Pacific Northwest, making the resulting entity the largest HMO in the region.

Seattle has eight HMOs, which spend about $.87 of each premium dollar on health care services, although that figure ranges from 74 percent (HMO Washington) to 91 percent (Group Health Cooperative of Puget Sound).[10] Overall, HMO penetration in Seattle is estimated to be about 22 percent.[11] Respondents reported that commercial HMO penetration grew only 1 percent between 1990 and 1995, and PPO products offer little more than discounted fee schedules. Several factors help explain the slow growth of managed care enrollment in this market:

- historically low health care prices and low hospital utilization;
- the process for obtaining HMO/HCSC licenses;
- consumer demand for provider choice; and
- the low price differential between HMO and non-HMO options (Group Health's premiums, for example, are not substantially lower than those of indemnity insurers).

Informants believe that Seattle physicians historically have been thrifty, treating patients cost-effectively without making unnecessary use of hospital services. In addition, already low prices and a relatively sparse population outside Seattle serve as barriers to outside entrants that may not be able to price products sufficiently below market to generate enough profit. However, informants said that the Seattle market is starting to lean more heavily toward managed care; the Boeing initiative is a clear example of this.

Network arrangements in Seattle reflect the preference of individuals and employers for broad choice and minimal restrictions on access to care. PPO panels are overlapping and inclusive. A typical PPO product offers a slight discount off traditional fee-for-service rates with a broad network. Although HMO physician panels are fairly exclusive, Seattle has experienced success with POS products, which allow enrollees the option to pay for greater choice of physicians. In addition, plans have responded to consumer demand for choice by not insisting that physicians direct patients to particular hospitals. For example, Providence Health Plans (a subsidiary of the Sisters of Providence, which offers HMO and PPO products) has more patients in Swedish Health System hospitals than in Providence's own hospitals.

Several hospitals and physician entities have discussed or launched health plan initiatives, partly as a strategy to improve their clout and to enhance their visibility in the marketplace. These initiatives have achieved success in the health plan market.

First Choice Health Network offers a PPO product with a very broad network and discounted fee-for-service payments for 265,000 enrollees in the Seattle and Tacoma markets. It has been awarded an HCSC license and is enrolling in a new HMO product. First Choice Health Network is owned by nine hospitals, including eight community hospitals in Seattle and Tacoma, and Swedish Health System. First Choice has contracted to be part of Columbia/HCA's national PPO network. In addition to being part owner of First Choice Health Network, Swedish Health System owns the former Cigna

HMO license and markets an HMO product called Health First Partners.

The Sisters of Providence Health System owns the Sisters of Providence Health Plans, which offers three products:

- Sound Health, one of the four largest PPOs in the market, with 166,000 members in Seattle;
- Good Health, an HMO with 53,000 commercial enrollees in Seattle; and
- Providence's POS product, Providence Healthcare, which has 36,000 enrollees in Seattle, two-thirds of whom are enrolled through Boeing.

Providence Health Plans recently consolidated operations in the Washington and Oregon markets. Providence Health Plans had a sizable Medicaid population in its HMO, but was dropped from the Healthy Options program in King County after the first round of selective contracting.

In 1995, the Washington State Medical Association launched the Unified Physicians of Washington, a physician-owned health plan designed to bolster physician influence on the market. Unified Physicians has developed a statewide PPO network and is now working on an HMO product.

All AFDC beneficiaries are in the Medicaid Healthy Options managed care program. Plans call for folding in the SSI population, but the timetable for this transition is uncertain. Of close to 135,000 Medicaid eligibles in the Seattle area, NYL Care had the most enrollees (fewer than 31,000 members), followed by the Community Health Plan, the plan sponsored by Seattle's Community Health Centers (close to 20,000 members). These are followed by:

- Unified Physicians of Washington (17,000 members);
- Group Health Cooperative (12,000 members);
- CareNet, a Blue Cross-led consortium that includes the University of Washington hospitals and the King County Health Department (11,000 members);
- Providence Health Plans (10,000 members);
- Blue Cross (apart from CareNet, with 6,000 members); and
- QualMed (5,000 members).

About 19,000 Medicaid-eligible children are enrolled in Basic Health Plus, a component of the state's Basic Health Plan.[12]

PacifiCare and Group Health are the top two HMOs in the Medicare market. While PacifiCare's entry caused trepidation among local health care leaders, it has not had much impact outside the Medicare risk market. PacifiCare is consolidating its administrative functions with its Oregon operation, where PacifiCare also has a strong Medicare risk product. If the federal government raises its low AAPCC rates, national plans likely will view the Seattle market with greater interest. Respondents reported that the current low rates make it difficult for plans to compete for Medicare business, because they cannot afford to entice enrollees with additional benefits.

• Changes

Seattle's health insurance market has seen several recent horizontal mergers by entities pursuing regional or multistate market strategies. Market analysts estimate that 25 to 35 percent of the small- and large-group markets are with statewide or multistate purchasers. For example, public purchasing for the Basic Health Plan, Medicaid and public employees has led several plans to develop statewide strategies. Most of

Seattle's dominant plans participate in a regional or multistate strategy. For example, Blue Shield plans in King and Pierce counties have formally merged, and (together with all of Washington's Blue Shield entities) have adopted the name Regence Washington Health. Regence Washington Health is also part of a larger holding company (The Regence Group) that owns Blues plans in Idaho and Oregon. As mentioned earlier, Blue Cross of Washington and Alaska (already a multistate actor) is now owned by Premera, a holding company with regional aspirations. Providence Health Plans and PacifiCare are consolidating administrative functions among their Portland, Oregon, and Seattle offices. Group Health has a Group Health Northwest division and, according to respondents, its planned merger with Kaiser is part of an effort to establish a strong regional strategy. However, these plans reportedly have not yet succeeded in securing regional or multistate contracts.

Under the planned merger between Group Health and Kaiser Permanente Northwest, Kaiser will provide cash to help Group Health improve its marketing and management information system development. Kaiser is not currently in the Seattle market, but is strong in Portland, Oregon, where Group Health has not yet entered. The affiliation with Kaiser would strengthen its competitive edge in a regional market. According to one respondent, Group Health's lack of a regional presence proved instrumental in Safeway Inc.'s decision to pass on it as a contractor. Observers viewed Group Health's merger plans with Kaiser, in part, as a way to keep up with other plans, like Regence Washington Health, that already have strong regional networks. They were uncertain, however, whether the Kaiser-Group Health affiliation would affect the Alliant HMO product jointly sponsored by Group Health and Virginia Mason Medical Center.

Plans are considering new product options as well. Informants indicated that Regence Washington Health and Premera may introduce Medicare risk products. Despite low AAPCC rates, Medicare risk contracting could be attractive to some insurers because:

- it virtually guarantees rate increases into the future, whereas non-Medicare group insurance premiums are flat or declining; and
- these carriers historically have been the largest indemnity carriers in Seattle, and they believe that their insured populations will prefer to stay with them as they retire and move on to Medicare.

PROVIDERS

• Organization

All of Seattle's strong health care provider systems are locally owned and have been active in Seattle for more than 50 years. Residents reportedly have come to trust these providers. Competition among providers is moderate, and is as focused on quality and reputation as it is on price. For example, respondents differentiated among providers of certain high-end services—like Providence and Swedish Health hospitals in downtown Seattle, which have highly respected cardiac care capabilities—solely on the basis of quality and reputation rather than price.

Seattle's hospitals have had to contend with decreasing utilization for well over a decade, but few hospitals have been forced to close or consolidate. Group Health found it could no longer support two hospitals in the metropolitan area, but its efforts to close the suburban Eastlake hospital sparked strong

staff protests and a nurses' strike. Instead, Group Health has closed its downtown hospital and transferred patient volume—and many physicians, nurses and other staff—to Virginia Mason Medical Center. Sisters of Providence acquired a second hospital in Everett, and is converting one campus into ambulatory surgery and long-term care facilities. Respondents believe that all hospitals in the market are operating on very low margins (1 percent, for example), and wonder whether capacity will be further reduced.

Most primary care physicians are organized into large groups, as are many specialists, and generally are only informally tied to hospitals. Respondents reported that 75 to 80 percent of primary care physicians and 40 to 50 percent of specialists are employed by large groups in Seattle. The Washington State Medical Association reports that two-thirds of its Seattle members are employed by one of six large physician groups. There are eight physician groups with more than 100 physicians in the Seattle market.[13] Although many physicians (including those whose practices are owned by large groups) still provide care through small-group or solo practices, it is increasingly common to find large, multispecialty clinics. Although physicians generally do not have formal relationships with hospitals, they nevertheless may have strong hospital ties. For example, some physicians prefer to refer cardiac care patients to Providence, while others prefer Swedish Health or the University of Washington.

There are 28 hospitals in the Seattle area, including eight that are either owned or operated by one of Seattle's dominant provider systems:

- Swedish Health System;
- Sisters of Providence Health System;
- Virginia Mason Medical Center; or
- the University of Washington.

Each system includes a tertiary care center and affiliated physician groups and (with the exception of the University of Washington) sponsors a health plan. For the most part, hospitals in the market are independent: Only Swedish Health and Providence have two hospitals each (the University of Washington owns one hospital but staffs and operates two additional hospitals). Group Health Cooperative of Puget Sound owns one hospital (after closing one in downtown Seattle) and has numerous primary and specialty care sites throughout the market.

The Swedish Health System includes Seattle's largest hospital (558 beds) as well as a hospital in Ballard (149 beds), representing 14 percent of beds in the market. For many years, Swedish Health has enjoyed an excellent reputation for quality among local residents, as well as a large endowment that enhances its financial stability. Unlike Seattle's other major provider systems, Swedish Health does not have a strong and geographically diverse primary care physician network; in fact, Swedish Health divested itself of Swedish Medical Partners in 1996. Instead, Swedish Health aligned with three local hospitals to provide continuing education, health promotion support and certain administrative services in exchange for increased tertiary care volume. Swedish Health is also affiliated with Multi-Care, a Tacoma-based hospital system.

The University of Washington plays a significant role in Seattle as a teaching institution, research center and significant provider of hospital and physician services. The University of Washington is the only medical school in Washington, Idaho, Montana and Alaska. It owns and operates the nationally recognized, 377-bed University of Washington Medical Center,

and operates (under contract) Harborview Medical Center (the area's public hospital and only Level 1 trauma center) and Seattle Children's Hospital. Each university-operated hospital is staffed by the University of Washington Physicians. The university recently created a primary care network that will provide care through 10 clinic sites in the area.

Among Seattle's remaining hospital systems, the Sisters of Providence is the largest. The Sisters of Providence joined forces with Tacoma-based Franciscan Health System in 1994 to form a regional Catholic-owned system. The Providence system includes two hospitals (661 beds in Seattle and Everett), the Medalia physician group (the largest physician group in the state with 41 primary care clinics and more than 400 primary care physicians), two home health agencies, the Providence Health Plans and other health services.

Virginia Mason Medical Center was formed in the 1920s as a physician group, and 10 years later built a hospital in downtown Seattle. Virginia Mason Medical Center is physician-led, and its staff compares it with the Mayo Clinic.

• Changes

The purchase of physician groups by Medalia, Virginia Mason Medical Center and other hospital and physician groups is among the most significant ownership and control changes in Seattle in recent years. The large physician groups (either multispecialty or primary care) have been purchasing many of the small and independent physician practices in or close to Seattle. Medalia and Virginia Mason Medical Center are also acquiring practices in outlying communities as well as outside the metropolitan Seattle area with the hope of establishing comprehensive care networks and strengthening the referral base for tertiary care to their downtown facilities. However, informants indicated that in the rush to buy physician practices, buyers overpaid for assets that are depreciating in value.

Two factors have driven the expansion of physician networks.

- First, physicians and hospitals alike anticipated that managed care would increase under the Health Services Act and, subsequently, with Boeing's new purchasing initiative. Large physician networks—particularly primary care networks—were expected to be more successful under the Health Services Act, and Boeing made physician networks an important criterion for plan selection. For example, Medalia was created as a direct result of the Health Services Act and was well positioned for Boeing's 1996 solicitations.
- Second, Seattle's hospitals have pursued stronger ties with physicians to bolster occupancy. Virginia Mason Medical Center has been actively purchasing physician groups, in part to secure its referral base from outlying areas. About 42 percent of Virginia Mason's inpatient admissions come from outside the Seattle metro area. The University of Washington needed a community-based primary care capacity to support the University of Washington Medical Center.

Physicians are attracted to large groups for their ability to manage care under capitated payments. The size and scope of these groups improve their financial solvency; help supply the assets needed to capitate physician services; enhance their negotiating clout with managed care plans; and attract the interest of payers seeking broad area networks. Some physi-

cian groups are becoming experienced with managing care under capitation, and are beginning to pursue fully capitated contracts with plans and fully capitated direct contracts with employers.

Some informants expressed doubts that extensive physician capitation will emerge any time soon. They argued, for example, that the original Medicaid managed care capitation rates were high, making it relatively easy for physicians to provide care, earn a living and become interested in other capitated contracts. Some plan respondents are concerned that physicians still lack the ability to manage full capitation; they believe that commercial capitation may not be as generous as Medicaid. Two health plans indicated they will only share risk with physician groups that have managed at least 1,000 lives.

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There are several examples of organizations that own and control hospital and physician services and insurance. However, there is little evidence of economies, exclusivity or common strategies across entities owned by the same system, and the nature and degree of integration achieved varies by entity. Informants generally said that clout and visibility were essential to success in the Seattle market. Control over several functions may be viewed as one indicator of clout. An example is the Sisters of Providence Health System. While Sisters of Providence owns the Providence Health Plans and Providence Health Systems, which in turn owns two hospitals and is majority owner of the Medalia physician group, Medalia has no exclusive referral relationships with Providence hospitals. Typically, there are more Providence Health Plan patients in Swedish Health hospitals than in Providence hospitals.

Historically, physicians have been informally aligned with hospitals and not aligned with health plans (except for Group Health). However, physicians have developed strong working relationships with some hospitals. For example, some physicians prefer to refer cardiac care patients to Providence, while others prefer Swedish Health or the University of Washington. Physicians who are employed by Group Health, Virginia Mason Medical Center and the University of Washington, however, are tied exclusively to those hospitals. It is common for primary care and specialty care providers to belong to several PPO and HMO panels, according to several respondents, who said that choice of physicians within a health plan (particularly a PPO) is very important to consumers. As a result, networks tend to be broad and overlapping. The reported success of POS options is cited as evidence that consumers want choice.

Two concrete examples of exclusive relationships and formal integration across functions within one organization are Group Health and Virginia Mason. Group Health has the only vertically integrated system for health insurance and health services provision. Group Health enrollees use only the Group Health (and now the affiliated Virginia Mason Medical Center) health service facilities, and Group Health's staff-model physicians provide

care management exclusively to Group Health enrollees. Each enrollee has a consolidated medical record, and Group Health sees its population-based clinical initiatives as long-term investments in the health of its many long-tenure enrollees. Finally, there is a high degree of economic and clinical integration between Virginia Mason Medical Center's physicians and the medical center they own.

The joint venture between Group Health and Virginia Mason Medical Center has strong potential for clinical and other integration. To date, however, there has been little clinical integration between the two entities, aside from the transfer of some Group Health staff to Virginia Mason Medical Center. Informants attribute this lack of clinical integration to culture clashes between staff in the two institutions. For example, Group Health staff previously did not have to contend with the emphasis on patient volume that is more common at Virginia Mason Medical Center. In addition, Group Health physicians place more emphasis on prevention and wellness, while Virginia Mason's physicians are quicker to pursue state-of-the-art care and high-end technology.

Clinical Practice and Delivery of Care

Clinical decision making still appears to be very much in the hands of physicians, although strong influences from insurers have altered—to a degree—how care is delivered. Local HMO products reportedly rely heavily on primary care providers, some of whom are capitated, for care management decisions. As physician groups become better equipped to accept full risk, it appears likely that physicians will retain control over clinical decision making. While informants generally felt positive about this scenario, they also expressed fear that new managed care companies might enter the market and exert greater control. Some health plans expressed doubts that physicians in this market are sufficiently experienced to manage care under capitation, while other plans were developing strategies to pass risk along to physicians.

As noted, the introduction of Regence Washington Health's Selections product in 1992 had a significant influence on clinical practice. Selections sent the message to physicians that they may not be included in networks if their practice patterns are deemed too expensive. Several informants attributed a rapid decline in hospital utilization to Selections.

Informants from all sectors believe that Seattle-area physicians historically have practiced in a thrifty manner. Accordingly, attempts to influence medical practice have been few. "Physicians historically have preferred keeping patients out of the hospital" was a common observation. No examples were found of health plans that penalized or dropped physicians from networks for overuse of specialists or inpatient services (Selections was a new product that created a network by including selected physicians). Instead, informants indicated that Seattle hospitals and physician groups are beginning to use rewards to influence care. For example, Medalia, Everett Clinic and Virginia Mason Medical Center are offering bonuses and merit-based salary increases to reward high patient satisfaction. Several providers also consider patient volume as a measure of productivity in establishing bonuses, salaries or both.

The predominance of the University of Washington Medical School and School of Nursing in local clinical education and research is another important influence on care delivery. Many local physicians and nurses were trained there. In addition, respondents cited a consistent emphasis on primary care associated with the medical school.

Certain improvements in information technology and development of clinical protocols are held out as examples of clinical improvement. Virginia Mason Medical Center, for example, has an electronic medical record that allows real-time information sharing with physicians at the hospital as well as with all of the Virginia Mason Medical Center practice sites.

Several area organizations have formulated practice guidelines and are beginning to see them implemented. Group Health has developed clinical pathways for 10 to 15 conditions; two of the pathways were cited and praised by competing health plans. In addition, Medalia (the Sisters of Providence primary care physician group), Harborview and Virginia Mason Medical Center are implementing clinical pathways. The University of Washington Medical Center and University of Washington Physicians have established common clinical pathways, which now apply to 80 percent of their patients. Blue Cross has developed protocols for diabetes, asthma, congestive heart failure and AIDS for use in its HMO product.

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Several area organizations have formulated practice guidelines and are beginning to see them implemented. Overall, informants were pleased with early evidence on the impact of these guidelines.

For example, the University of Washington reports that length of stay was shortened 15 percent, and $10 million was saved in operating expenses. Moreover, Group Health found that the application of clinical pathways is an important part of a comprehensive approach that can result in better clinical management and improved quality.

Examples of organized disease management or outcome analyses in Seattle are limited. Providence Seattle Medical Center has developed a series of protocols around cardiac care and total joint replacement procedures that involve the collection of background information from patients that may affect care decisions, and (in the case of cardiac care) two-year patient follow-up. Virginia Mason Medical Center and at least one community health center have implemented clinical reminder systems to apprise physicians of their patients' specific chronic diseases, and to prompt them to obtain specific information or schedule follow-up visits.

Despite interest in outcomes data, the consensus is that consumers have no more information today than they did 20 years ago, in part because reportedly there has been little private sector support for information sharing. In addition, the electronic infrastructure needed to facilitate collection and dissemination was not in place, respondents said. Outcome data have been gathered from hospitals as part of statewide studies on obstetrics and coronary artery bypass graft procedures. Data from these studies have been shared with the participating hospitals, but have not

been analyzed for or broadly distributed to the public.

However, a new Seattle-based organization called the Health Information Institute plans to use Internet technology to disseminate community health information. New data strategies are also taking shape, including plans by public health agencies and private providers to establish a statewide immunization tracking system.

Informants were more enthusiastic about data collected from—and reported at—the provider level than about data reported at the plan level. For example, they almost universally believe that HEDIS data are not useful in Seattle, where provider networks are frequently broad and overlapping.

Finally, respondents generally credit managed care with certain care delivery improvements. For example, managed care reportedly is improving the quality of clinical documentation. In addition, as physicians accept risk, they reportedly are becoming more interested in prevention and health promotion and have increased their control over the utilization review processes. There is, however, little systematic documentation that these or other efforts have improved access to or quality of care.

Care of the Poor

Informants perceive Seattle's safety net as strong, and they believe that responsibility for providing indigent care is shared among several providers. Nearly all of Seattle's providers serve some segment of the medically indigent population, a fact that informants attribute to Seattle's rich array of not-for-profit, mission-oriented health care providers. Most informants believe that as long as not-for-profits continue to dominate the market, the safety net will remain viable. Most of the care for indigent and Medicaid populations is provided by the community health centers, three publicly funded hospitals (University of Washington Medical Center, Harborview and Children's Hospital) and the Catholic, mission-oriented Providence hospitals. Virginia Mason Medical Center and Group Health historically have served the Medicaid population. Group Health is involved in local health promotion and advocating for care for the underserved, but typically does not provide direct care for the indigent population as do Providence, Virginia Mason Medical Center and the University of Washington-operated hospitals. The King County Health Department provides some clinical services, but sees its primary role as providing population-oriented services (e.g., immunizations) with integrated delivery systems that work with publicly funded health plans (e.g., Healthy Options, the Basic Health Plan).

Nearly all of Seattle's providers serve some segment of the medically indigent population, a fact that informants attribute to Seattle's rich array of not-for-profit, mission-oriented health care providers. As long as not-for-profits continue to dominate the market, the safety net will remain.

Community health centers are an important part of the delivery system for Medicaid and uninsured populations. Respondents report that the eight community health centers in Seattle are competing with each other for patient

volume. To help ensure their viability, community health centers statewide created a Community Health Plan to receive Medicaid Healthy Options and Basic Health Plan contracts. In doing so, the centers had to forgo retroactive federally qualified health center fee-for-service payments to which they were entitled, but instead received what they viewed to be generous Medicaid capitation rates. Community Health Plan operates statewide; in Seattle, it refers patients to the hospitals that historically have worked with indigent and Medicaid populations.

Native Americans access care through county-level Indian health boards that provide care funded by the federal government's Indian Health Service. Commercial insurers and Medicaid typically do not include Seattle's Indian Health Board in their contracts, although some insurers outside King County do.

Washington's prepaid Medicaid program, Healthy Options, has streamlined access and created continuity for Medicaid recipients, many of whom did not have a dedicated primary care provider. Informants reported fewer unnecessary emergency room visits. The state has also undertaken measures to protect and strengthen providers that have traditionally served the uninsured and Medicaid populations. For example, the state awards additional consideration in selective contracting to plans that include traditional providers in their networks.

However, some respondents expressed concern about the impact of policy changes on the Medicaid and uninsured populations. They predicted that welfare reform will decrease the number of Medicaid eligibles in the area, particularly among the large immigrant population, and that price competition for Healthy Options contracts will drive prices down and hurt providers that traditionally have cared for the uninsured and Medicaid populations.

The state's subsidized Basic Health Plan has reduced the number of uninsured in Seattle. Passed in 1993 as part of the Health Services Act, the Basic Health Plan is the state's primary vehicle to provide access to insurance—and medical care—for the uninsured. It is funded through tobacco, alcohol and hospital taxes. Purchasing is centralized at the state level, and most of the major carriers in Seattle participate. Networks, services and benefits are all reportedly comparable with commercial health plan products. Although the Basic Health Plan is considered a success, one informant noted that, with the demise of the Health Services Act, strategies for dealing with the uninsured are now incremental rather than comprehensive, because no one entity is responsible for addressing this problem.

Issues to Track

Given the relatively stable array of health plans and health care providers and the apparent satisfaction of purchasers with price and quality, this market does not seem headed for substantial changes in prices, quality or access. The Basic Health Plan expanded access to health insurance among the poor, and Medicaid managed care has streamlined access to care (and reportedly improved the quality of care) among Seattle's Medicaid-eligible population. Although purchasers are generally satisfied with costs, the introduction of the Selections product by

Regence Washington Health and price-driven selective contracting in Medicaid managed care suggest that more emphasis will be placed on controlling costs. Informants are almost unanimously convinced, however, that the stable array of not-for-profit hospitals and physician groups ensures that quality will not be sacrificed as a result.

Informants remain concerned about the possible entry of for-profit national managed care companies or hospital chains, despite little evidence that such changes are on the horizon. They are concerned that intensive price competition from national HMOs with substantial cash reserves could make local plans less viable, and that they would reward greater exclusivity from physicians and hospitals in order to bolster their position in the market. Recent experiences with PacifiCare in the Medicare market and QualMed in the commercial HMO market were cited as evidence that the entrance of for-profit entities could further challenge existing providers and plans. PacifiCare eliminated premiums for its Medicare risk product, which drove an already strapped Group Health to do the same. While informants mentioned several specific HMOs that have been interested in the Seattle market, they also cited others that were not able to price products low enough to be competitive.

The dominance of Group Health Cooperative in the HMO market may continue to be challenged by existing plans and new entrants. The merger of Group Health and Kaiser Permanente appears, however, to strengthen Group Health Cooperative's position by providing the assets needed to bolster its marketing and management infrastructures. Respondents suggested that this merger may drive other plans to pursue similar, strong affiliations on a local or regional basis.

Prices could play a much more important role in the future. First, respondents anticipate that federal policy may result in increases to AAPCC, which would make Seattle's Medicare risk market more attractive. For example, Regence Washington Health and Premera (Seattle's two Blues plans) have indicated a desire to introduce Medicare products. Outside entrants (in addition to PacifiCare and QualMed) may find the market more viable as well. These entrants could leverage their new position into commercial lines and accelerate price-driven competition. Moreover, continuation of the Regence Selections product and adoption by other plans of similar practice profiling techniques could continue to make costs a primary concern of physicians and hospitals. Respondents also suggested that adoption of price-based criteria for Medicaid selective contracting has already had spillover effects on health care costs for commercial products. Continuation of selective contracting in the Healthy Options program could reduce prices for physician and hospital services further. Declining prices in the Healthy Options program could hurt providers that cross-subsidize care for the uninsured with Medicaid and other revenue sources.

In one possible future scenario, physicians will seek an increased role and prominence as the market corrects for an oversupply of physicians, and the remaining physician groups become more competitive. Physicians likely will continue to pursue risk-based contracting, and they could become powerful enough that they do not need to align with hospitals.

A key trend underlying physician strategies—and borne out by some purchasers—is the increased use of direct contracting. Direct contracting is being spurred by physician consolidation, eagerness to share risk and employers' desire to bypass third-party plans and brokers. As a result, plans in this market may evolve into "administrative service" entities, focused chiefly on providing marketing, enrollment and claims processing services. Ultimately, this may lead physicians, hospitals and plans to concentrate on their core business and rely on contractual relationships, rather than ownership. For example, physicians will become more responsible for primary care and access to specialty care, hospitals will provide acute and ambulatory surgical care and health plans will become administrative entities rather than risk-bearing entities.

Seattle has seen steady but not disruptive change, largely propelled by a few important precipitating events. Although some re-evaluation is inevitable, respondents generally are upbeat about the future. They are satisfied with the prices and quality offered by Seattle's health system, and they believe that the long-standing and cooperative relationships among Seattle's dominant health system actors will continue to ensure quality health care.

NOTES

1 King County Medical Blue Shield was renamed Regence Washington Health in April 1997, after merging with Pierce County Medical Blue Shield.

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.

3 *Ibid.*

4 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term care units in hospitals.

5 Estimates are based on the 1996 American Medical Association Master File and 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

6 State Legislative Health Care and Insurance Issues: 1995 Survey of Plans, Blue Cross and Blue Shield Association, 1996.

7 Health Care Financing Administration, 1997. Medicare HMO enrollment by county.

8 Regence Washington Health (formerly King County Medical Blue Shield) enrollment as of August 1996.

9 Rubin, R., and Beddingfield, K. Rating the HMOs. *U.S. News and World Report,* September 2, 1996, p. 121.

10 Washington State Office of the Insurance Commissioner, 1994.

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

12 Department of Social and Health Services, Medical Assistance Administration. Healthy Options Enrollees, June 1997.

13 Enbysk, M. Medalia's Primary Mission: Name Brand Quality Health Care. *The Washington CEO,* April 1996.