Health System Change In 1997

Consumer activism and renewed legislative activity shaped many of the year’s changes in the health care system.

By Paul B. Ginsburg

The year 1997 was a particularly important one in the evolution of the financing and delivery of health care. Two broad developments were especially key: one is the rise of the consumer. Consumers have demanded a broader choice of providers, and the market has responded. In addition, consumers’ concerns about managed care have led to extensive legislative activity. The second related development is the reemergence of public policy activity. In 1993, after the demise of the Clinton health care reform proposal, the prevailing view was that public policy would play a much more limited role in health care. But in 1997 legislators took important steps to expand health insurance coverage and to regulate health care markets.

This paper addresses the ways in which these two broad changes have influenced other dynamics in the health care system. It is based on my observations, on the intensive tracking efforts undertaken during the past three years by staff at Health System Change (HSC), and on interviews with prominent experts.

Consumer Choice

As consumers have exchanged traditional insurance coverage for managed care—often at the behest of their employers—they have demanded that managed care provide a broader choice of providers. During site visits conducted in twelve communities nationwide in mid-1995 by HSC, managed care execs described out-of-network options such as preferred provider organizations and point-of-service plans as a mechanism for helping way consumers make the transition to “real managed care.” But in site visits conducted in late 1996 and early 1997, such options were seen as a permanent part of the health care landscape. Indeed, both employers and health plan executives told of efforts to broaden networks of providers. In some communities all of the hospitals and a large proportion of the physicians are now included in the networks of many health plans. Exclusive relationships between plans and providers are giving way to a tremendous overlap of networks.

This demand for choice has profound implications for the organization of health care delivery. It reverses health plans’ drive to develop closer relationships with a limited network of providers. When, for economic survival, providers must deal with all of the health plans in a given community, plans are less likely to provide them all with clinical information systems and other cutting-edge care management tools. As a result, broad and overlapping networks tend to push health plans and providers further apart.

Broad and overlapping networks also change the dynamics between plans and physicians. The importance of any single plan to a physician’s practice is diminished. Global capitation becomes more attractive to some health plans in situations where provider organizations have the ability to assume risk; this will shift the focus of care management from the health plans to provider organizations. However, such a shift will require mechanisms through which a captivated organization can reimburse other network

Paul Ginsburg is president of the Center for Studying Health System Change, a health policy research center in Washington, D.C., which is funded by the Robert Wood Johnson Foundation.
providers that consumers are entitled to use. Broader choice also has implications for market dynamics. Health plans will be less differentiated for employers, and since changing plans will be less disruptive to enrollees’ relationships with physicians, employers will find it easier to do so. This, in turn, will increase employees’ bargaining power. Similarly, hospitals and organizations with a large proportion of physicians in a specialty will have more bargaining power with health plans when consumers are demanding choice.

**MANAGED CARE BACKLASH**

Consumers and physicians have been pressuring their elected representatives at the state and federal levels to restrict some managed care practices. Physicians probably have stronger feelings about these issues than consumers have, and are better organized, so they are playing a more prominent role. However, the interests of consumers and physicians are not always alike, especially on issues with significant economic dimensions.

For consumers, the pressure to make the rapid shift to managed care is one of the factors behind the backlash. In the 1990s most consumers chose managed care over traditional plans, but many recent managed care enrollees had no such choice.

Among providers, loss of clinical autonomy and the practice of clinical economies have fueled a strong backlash. In private practices, providers have sought to consolidate to increase their bargaining power with managed care plans and to form organizations capable of assuming the care management functions typically performed by health plans. Through public policy, providers are seeking to limit managed care plans’ scope of authority over care delivery and to regulate their contractual relationships with providers.

At the federal level, the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry has developed a “consumer bill of rights.” Adoption of the Reciprocity of Improvements by the federal government in this role as a purchaser and as well as by a number of leading employers is likely to lead to their rapid implementation, whether or not the protections are mandated through legislation. Congress will now deal with the more contentious issues, such as whether patients may sue Employee Retirement Income Security Act (ERISA)-protected health plans for forgoing care and whether to require outside experts to review appeals. Concerns about the cost implications of specific provisions have been more prominent than the objections to government’s more active role. States have jumped into consumer protection even faster, seventeen states enacted legislation in 1997. According to Geraldine Dallek, an expert on consumer protection issues, “Never have so many states addressed a single legislative issue at the same time.”

**PROVIDER CONSOLIDATION**

The pace of hospital consolidation declined in 1997 after years of increases. Recent data show an 18 percent decline in the number of hospitals involved in mergers and acquisitions in 1997. The investigation of Columbia/HCA as a key factor behind this trend. Columbia/HCA sharply curtailed its acquisitions in the latter half of 1997, and this probably affected acquisition activity among other companies as well. Researchers at HSC were frequently told that acquisitions of hospitals thought to be Columbia/HCA targets were being pursued by other local hospitals primarily to keep the for-profit giant out of the market and that hospitals were merging to prepare to compete with Columbia/HCA in the future.

By contrast, physician consolidation is continuing. A survey of 12,000 physicians conducted by IHS showed that in 1997 only 41 percent of physicians were practicing in one- or two-physician practices. Group practices continue to form, and physicians continue to sell practices to hospital systems or to physician practice management (PPM) firms. In contrast to a few years ago, when health plans focused on organizing the delivery of primary care, great attention is now being paid to specialty care. This shift may reflect managed care’s efforts to address the portion of the care spectrum that has the highest costs and requires the greatest sophistication to manage effectively. Some new PPM firms work with one or a select group, and some health plans are deemphasizing capitation of primary care physicians and instead paying specialists on a capitated or per episode basis. Hospitals and physicians pushed very hard for legislation that favored provider service organizations (PSOs) and had some success in 1997. Their greatest accomplishments were in public purchasing. Risk-contracting opportunities in both Medicare and Medicaid have expanded. Now, the period of implementing business strategies is at hand, and many observers are skeptical about PSOs’ ability to assume and manage risk. Consumer advocates are concerned about the effects of potential PSO insolvencies on patients. Joseph Davis, president of Medi- metrix, noted, "Many medical groups are forming PSOs out of knee-jerk machismo because they are sick and tired of being told what to do by insurers. Unfortunately, many such organizations will fail because they don't understand how to manage risk and don't have adequate capital."

**THE UNINSURED**

In 1997 Congress enacted the State Children's Health Insurance Program (CHIP), the largest expansion of health insurance for children since the enactment of Medicaid in 1965. CHIP provides states with matching funds to offer health insurance to uninsured children with low income. The Congressional Budget Office estimates that 2.3 million uninsured children will be covered. Many states developed program proposals in 1997 for legislative action in early 1998. These proposals addressed setting income criteria for eligibility and whether to serve these children through Medicaid programs or through contracting with private insurers. In either case, managed care is the standard vehicle used to deliver CHIP benefits. The higher the income limit that states are contemplating, the more state officials must grapple with issues of equity and crowding out (the replacement of private with public coverage).

President Clinton has proposed that the next incremental step in expanding coverage be an opportunity for the near-elderly to buy into Medicare. This proposal, if enacted, may have greater importance for future policy than for reducing uninsured among the near-elderly because so few eligible uninsured persons can afford the Medicare premium.

Regarding the uninsured, research from HSC and others shows that although more employers are offering insurance, fewer workers are taking that insurance. A rise in the portion of premiums that employers must pay is undoubtedly a factor, as is the long-term trend of premiums increasing more rapidly than earnings, especially for low-wage workers.

Policies to reduce the number of uninsured persons seem to be moving away from an employment-based insurance solution. New initiatives to insure low-income persons involve government purchase or provision of insurance rather than employer subsidies or mandates. Increasingly, children are covered through a government program, while their parents, if covered at all, obtain coverage through employment. Recent proposals for the middle class have emphasized bending the link between tax subsidies for the purchase of health insurance and obtaining it through employment.

**QUALITY OF CARE**

Evidence of uneven quality of care has been mounting in both fee-for-service and managed care plans, and health care leaders have developed an increasing sense of urgency about addressing this problem. A small number of large employers have led activities to hold health plans and provider organizations more accountable for quality, but future progress is likely to come from Medicare and Medicaid, which have begun to
HEALTH TRACKING: FROM THE FIELD

use their clout as purchasers to promote quality. Given their size, they have the wherewithal to force plans and providers to collect and report data in a standardized format. These activities, in turn, will benefit private purchasers, many of whom care about these issues but have been limited in their ability to get data. Thus, when Medicare and Medicaid require plans to report Health Plan Employer Data and Information Set (HEDIS) measures, employers can get these measures reported to them as well. Janet Corrigan, who served as executive director of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, noted, "Barriers to moving the quality agenda forward are significant, but by no means insurmountable. There is an inadequately scientific evidence base; low level investment in information systems; absence of risk adjustment, payment, and quality measurement strategies; and many unresolved issues about malpractice liability."*

MEDICAID MANAGED CARE

States have proceeded very rapidly to enroll Medicaid beneficiaries in risk-based managed care plans; at midyear, almost half of beneficiaries were enrolled. The Balanced Budget Act (BBA) of 1997 is expected to accelerate the process by making it easier for states to mandate enrollment in managed care plans. The new regulations are designed to ensure that plans deliver quality care at an affordable cost. The goal is to increase the number of beneficiaries enrolled in managed care plans each year, reaching 90% of the Medicaid population by 2002. However, the implementation of managed care has been met with resistance from providers, consumers, and state officials.

Experts are again predicting sharp increases in premiums, which are likely to result from (1) health plan difficulties in gaining further provider discounts; (2) limitations of broad networks and out-of-network options in managing care; (3) increased administrative costs; and (4) a reluctance of purchasers to pursue cost controls that might anger employers.

HEALTH CARE COSTS

In 1997, health care costs increased for the third consecutive year, with total costs rising by 7.3%. The increase in health care costs continues to be driven by the rising costs of prescription drugs and hospital stays. Medicare payments per beneficiary increased by 5.5% in 1997. The KPMG Peat Marwick study of employers shows that premiums for a private insurance policy increased by 10.1% in 1997, compared to a 5.6% increase in 1996.

Some experts have predicted that premiums for health care will continue to increase. These experts cite the rising costs of prescription drugs, hospital stays, and other medical services as factors contributing to the increase in health care costs. The KPMG Peat Marwick survey of employers shows that premiums for a private insurance policy increased by 10.1% in 1997, compared to a 5.6% increase in 1996.

LOOKING AHEAD

Although it is difficult to forecast developments in health care, one enduring trend is the incorporation of evidence on effectiveness into medical practice. Health care delivery is increasingly influenced by research on outcomes. However, the mechanisms through which further strides will be made are uncertain. Close partnerships between provider organizations and health plans are not surviving consumers' demands for broader choice of providers. Risk and responsibility for the delivery of care may shift to provider organizations, which in turn will be looking to hospital systems, PPO systems, and information technology vendors as well as health plans for infrastructure support.

Whether these developments will depend on how consumers react to the changes. We saw clearly in 1997 that consumers feel strongly about developments in health care financing and delivery and are prepared to act both in the marketplace and through public policy. Will consumers be more comfortable signing on with a delivery system than they are with a health plan?

Technological change produces even greater uncertainty about the future. Advances in science and information technology are likely to dramatically change the nature of care and how that care is delivered. Not only will there be additional care and preventive strategies, but opportunities for life enhancement will become an increasingly important part of medical care. Increasingly, consumers will accelerate the pace at which medical innovation is incorporated into medical practice.

The author thanks Janet Corrigan, Helen Darling, Joe Davis, Gerri Dallal, Robert Glaser, Jeff Goldsmith, Uwe Reinhardt, Trish Riley, Bill Roger, and Steve Sonens for valuable discussion. Ann Gutser provided valuable comments. None of these individuals is responsible for opinions stated in this paper (except those directly attributed to them). A version of this paper is slated to appear in HSC's 1997 Annual Report.

NOTES

6. Author's calculations based on unpublished data from the Health Care Financing Administration, May 1998.
8. For example, the Wall Street Journal coverage (12 January 1997) of the release of the Forbes-Higgins 1996 survey of employers sponsored health plans, which predicted rising premiums in 1997.
9. These views were expressed by a group of Wall Street analysts at "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change," a conference sponsored by Health System Change, Washington, D.C., 3 June 1998.

HEALTH AFFAIRS - Volume 17, Number 4