Health Care Market Competition in Six States: Implications for the Poor

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This report is part of the Urban Institute's Assessing the New Federalism project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, non-partisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.
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State Case Studies on Competition and Its Effects on the Poor

Health care competition has arrived. In the late 1990s, this observation has become a truism. Market changes have important effects for all consumers of health care but may especially affect traditional access to care for the low-income population.

The stimulus for market change has been buyers’ demands for less expensive health coverage and care. In insurance markets, managed care is displacing traditional, free-choice-of-provider indemnity coverage. Indemnity plans retrospectively paid provider-set charges or costs for almost all physician-ordered services from almost any provider. Managed care plans instead use selective contracting to negotiate price and other terms of service in advance—and can also reduce utilization in various ways. Growth in managed care, prospective payment by Medicare and Medicaid programs, and increasing medical capabilities to replace inpatient with outpatient care—all have contributed to substantial excess capacity for hospital and specialist physician services in many markets. Ample supply has increased buyers’ leverage over sellers in many areas.

In provider markets, professional and nonprofit determinations of resource allocation and prices are therefore giving way to price discounting to compete for health plan business and acceptance of fee-for-service Medicare and Medicaid payment limits. This price pressure is in turn stimulating hospital budget cutting, along with downsizing, consolidation into larger provider entities, and conversions of ownership status.

Doctors and hospitals, insurers and health plans—all sellers of services are increasingly having to compete on price as well as quality and amenities, and all have reorganized themselves to do so. Insurers and health plans are growing or merging so as to serve wide-flung employer group customers, achieve economies of scale, and afford expensive information technology. The former “cottage industry” of solo physician practices and independent, unaffiliated hospitals is also giving way to larger
groupings. Corporate structures are displacing professional ones, and for-profit org-
nization is growing relative to nonprofit, both for health plans and hospitals. Nonprofit missions and professional norms remain very important, yet under vigorous price competition, nonprofit behavior necessarily comes to resemble that of for-profits. Markets serve those who can afford to purchase services, so the effect on low-income people is a concern, especially if competition erodes the cross-subsidies that have financed their access to care.

This paper describes market shifts and state market-oriented policies, focusing on how they affect health coverage and care for the poor as of the mid- to late 1990s, a period that has seen dramatic increases in the competitiveness of health financing and delivery (Ginsberg et al. 1996). This section explains the issues of importance for the poor and describes our case study methods. Six individual state case studies follow. The final section presents conclusions from the states’ experience and suggests what remains to be learned. Related reports by Urban Institute authors provide more detail on the specific issues of Medicaid managed care (Holahan et al. 1998, Hurley and Wallin 1998, Zuckerman et al. 1997), insurance regulation (Blumberg and Nichols 1995), and effects on safety net providers (Norton et al. 1998).

The Importance of Health Care Markets for the Poor

Markets for health care financing and delivery, as influenced by state policies, matter to the poor as well as the population at large: First, they may affect the extent of enrollment in public or private health coverage. Second, they may affect the access or quality of care under Medicaid or other coverage for the poor. Third, they may affect access to care for the uninsured poor, especially charity care provided by hos-
pitals. The purpose of this paper is to begin to examine these three issues through our case studies.

Extent of Health Care Coverage

Health coverage is a key concern because it is the central social mechanism by which people obtain health care and exercise consumer sovereignty. States might be more willing to expand enrollment in Medicaid and similar public programs where market developments increase use of managed care and lead to lower health care costs. Even outside managed care, states may be able to achieve savings on fee-for-service payments where managed care and excess supply have reduced market prices or helped change patterns of utilization.

In the private sector, more employment groups might also buy coverage for more people because competition and managed care have lowered prices relative to past indemnity coverage and have reduced the annual rate of growth in premiums, especially for big buyers. Effects on private coverage, including managed care plans and self-insurance, are very important for the poor and near-poor; it is easy to overlook how many have private coverage because state programs are explicitly targeted to poor people. Nationally, private plans cover 22 percent of the poor (below the federal poverty level [FPL]) and 56 percent of the near-poor (100 to 200 percent of poverty)—thus exceeding the number covered by Medicaid.1
On the other hand, slowed price inflation may make little difference to private buyers. The impact depends on the responsiveness of demand to price change (i.e., the elasticity), which seems to be relatively low, particularly as insurance offerings have shifted from patient-driven free choice of providers toward more organized systems of care. Moreover, as part of economizing, competition has also encouraged the spread of self-insurance and experience rating, even into relatively small employment groups. The resulting fragmentation of risk pools isolates higher risks, making their coverage more difficult and expensive to obtain. Lower-wage workers are disproportionately concentrated in small employment groups and retail and service industries, which have higher rates of uninsurance (Nichols et al. 1997).

Effects on Access and Quality under Competition

The operations of markets for medical and insurance services also matter for the poor if, holding prices constant, they improve access and quality. The general principle is that effective quality-price competition could increase the availability of good, cost-effective services, whereas oligopoly or monopoly may reduce it. Moving from publicly administered indemnity Medicaid to managed care plans may improve effective access to care, particularly in places where provider participation rates were low because of payment levels and other aspects of public administration.

Organized systems of prepaid care also have the potential to improve quality of care, especially compared with episodic access to emergency rooms for people who have not developed a continuing relationship with a primary care provider. Other qualitative advantages may also result from new management, from guidelines to more oversight of practice, depending on the systems applied. Moreover, where a traditional safety net hospital faces new competition for patients within a plan, it may provide better, more patient-oriented care than one whose funding is guaranteed and whose patients have few alternatives. It may also make improvements to attract referrals from community physicians.

However, there is a possibility that states may use the direct budgetary control inherent in managed care to overeconomize. After contracts are awarded, public managers are insulated from day-to-day allocative decisions, and political accountability for any cuts in care may be attenuated. Plans themselves may economize inappropriately in provider contracting, payment levels, utilization controls, and other ways—depending on the effectiveness of public oversight and quality competition for patient enrollment or provider participation.

Effects on Uninsured Access

The nature of competition affects the ability of hospitals to serve those who lack insurance and are too poor to pay for care out of pocket. In a price-competitive world, supplying a disproportionate share of uncompensated care can be a significant competitive disadvantage. When hospitals are price takers rather than price setters, they cannot so readily earn the net revenues needed to cross-subsidize care. Safety net facilities with a relatively smaller share of paying patients seem especially vulnerable to pressure. They may also find themselves excluded from managed care networks. Pressures on hospitals to economize may also limit state enforcement of the
traditional duty of nonprofit providers to provide charity care. Alternatively, to the extent that competitive pressures increase provider efficiencies, charity care could become cheaper to cross-subsidize.

Another market phenomenon is that some hospitals, as a result of consolidation or of quality reputation, may become indispensable for managed care plans to cover in order for plans to provide competitive access in an area. Such hospitals can use this market power to secure patient volume and earn net income to cross-subsidize the indigent as part of their mission. This does not mean that such institutions will necessarily be able to provide more charity care than before price competition, only that the safety net function will be better protected than it otherwise would be.

We assess these issues through case studies of six representative states.

Study Methods: Site Visits to Representative States

This report’s findings on state policy and health care competition come from general case studies of health care for low-income people undertaken for the Urban Institute’s broader Assessing the New Federalism project covering 13 states (Kondratas et al. 1998). Six states’ experience is described in the next sections. These states were selected to represent four types of markets, on the basis of the duration and extent of managed care development as well as the character of provider responses to managed care and other pressures.

Characteristics of the Site-Visit States

The 13 site-visit states—Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin—were originally selected to present a balanced view of state health and welfare activity and its impact on low-income families. Selection criteria included socioeconomic and political characteristics, availability and generosity of publicly supported health and welfare programs, and geographic diversity.

The site-visit states span the range of state demographics (table 1). Mississippi is less than one-third urbanized, for example; New Jersey is 100 percent; and the nation as a whole, 80 percent. Urbanized areas have traditionally been the first to develop price-competitive health financing and delivery markets. The states also straddle the national norms in per capita income and poverty rates.

The site-visit states also show a representative variety of provider supply (table 1), a major factor in competitive development. Mississippi and Alabama have low ratios of medical specialists per 100,000 population (at 108 and 149, respectively, versus 195 for the country as a whole), whereas New York and Massachusetts have very high ratios (at 314 and 336, respectively). Similar diversity applies for the ratio of hospital beds to population. A high supply of specialists and hospitals facilitates the formation of competitive networks of providers.

In terms of their insurance markets, the states run the gamut of penetration by health maintenance organizations (HMOs) and preferred provider organizations
Table 1  Demographics and Measures of Supply, Site Visits

<table>
<thead>
<tr>
<th>State</th>
<th>Percent Metropolitan Population, 1996&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Per Capita Income, 1996&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Poverty Rate, 1995&lt;sup&gt;c&lt;/sup&gt;</th>
<th>PCPs* per 100,000 People, 1995&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Specialists** per 100,000 People, 1995&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Percent HPSA*** Counties (whole or part), 1995&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Percent Hospital Beds, 1995&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Percent Non-profit Hospital Beds, 1995&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Percent For-Profit Hospital Beds, 1995&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Hospital Beds per 1,000 People, 1995&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Hospital Admissions per 1,000 People, 1995&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>79.7</td>
<td>$24,231</td>
<td>13.8</td>
<td>26.6</td>
<td>194.8</td>
<td>63</td>
<td>17.0</td>
<td>64.6</td>
<td>11.7</td>
<td>3.4</td>
<td>127</td>
</tr>
<tr>
<td>AL</td>
<td>67.7</td>
<td>20,055</td>
<td>20.1</td>
<td>25.5</td>
<td>149.0</td>
<td>88</td>
<td>35.2</td>
<td>38.7</td>
<td>19.7</td>
<td>4.6</td>
<td>160</td>
</tr>
<tr>
<td>CA</td>
<td>96.6</td>
<td>25,144</td>
<td>16.7</td>
<td>27.8</td>
<td>197.3</td>
<td>90</td>
<td>17.0</td>
<td>58.7</td>
<td>17.2</td>
<td>2.5</td>
<td>102</td>
</tr>
<tr>
<td>CO</td>
<td>81.2</td>
<td>25,084</td>
<td>8.8</td>
<td>34.0</td>
<td>180.1</td>
<td>83</td>
<td>19.8</td>
<td>62.0</td>
<td>11.9</td>
<td>2.5</td>
<td>102</td>
</tr>
<tr>
<td>FL</td>
<td>92.9</td>
<td>24,104</td>
<td>16.2</td>
<td>26.3</td>
<td>183.1</td>
<td>91</td>
<td>15.3</td>
<td>44.2</td>
<td>34.0</td>
<td>3.6</td>
<td>135</td>
</tr>
<tr>
<td>MA</td>
<td>98.5</td>
<td>29,439</td>
<td>11.0</td>
<td>16.5</td>
<td>335.7</td>
<td>57</td>
<td>8.8</td>
<td>82.4</td>
<td>2.2</td>
<td>2.9</td>
<td>133</td>
</tr>
<tr>
<td>MI</td>
<td>82.4</td>
<td>24,810</td>
<td>12.2</td>
<td>21.9</td>
<td>176.4</td>
<td>72</td>
<td>7.0</td>
<td>89.1</td>
<td>0.4</td>
<td>3.0</td>
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<tr>
<td>MN</td>
<td>69.7</td>
<td>25,580</td>
<td>9.2</td>
<td>45.5</td>
<td>177.6</td>
<td>40</td>
<td>42.8</td>
<td>35.6</td>
<td>13.4</td>
<td>5.3</td>
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<tr>
<td>MS</td>
<td>31.4</td>
<td>17,471</td>
<td>23.5</td>
<td>24.6</td>
<td>107.6</td>
<td>84</td>
<td>29.0</td>
<td>67.6</td>
<td>0.6</td>
<td>3.9</td>
<td>157</td>
</tr>
<tr>
<td>NJ</td>
<td>100.0</td>
<td>31,053</td>
<td>7.8</td>
<td>17.3</td>
<td>241.6</td>
<td>67</td>
<td>7.5</td>
<td>85.8</td>
<td>0.7</td>
<td>3.6</td>
<td>138</td>
</tr>
<tr>
<td>NY</td>
<td>91.8</td>
<td>28,782</td>
<td>16.5</td>
<td>18.1</td>
<td>313.5</td>
<td>76</td>
<td>13.8</td>
<td>77.4</td>
<td>2.8</td>
<td>4.1</td>
<td>138</td>
</tr>
<tr>
<td>TX</td>
<td>84.2</td>
<td>22,045</td>
<td>17.4</td>
<td>24.9</td>
<td>152.8</td>
<td>58</td>
<td>18.4</td>
<td>41.6</td>
<td>28.8</td>
<td>3.2</td>
<td>119</td>
</tr>
<tr>
<td>WA</td>
<td>82.8</td>
<td>24,838</td>
<td>12.5</td>
<td>39.4</td>
<td>170.1</td>
<td>90</td>
<td>23.3</td>
<td>63.4</td>
<td>3.6</td>
<td>2.2</td>
<td>96</td>
</tr>
<tr>
<td>WI</td>
<td>67.7</td>
<td>23,269</td>
<td>8.5</td>
<td>35.1</td>
<td>168.1</td>
<td>72</td>
<td>3.9</td>
<td>91.2</td>
<td>0.5</td>
<td>3.3</td>
<td>114</td>
</tr>
</tbody>
</table>

*PCPs are nonfederal active patient care physicians listing general practitioner or general family practitioner as their primary activity.

**Specialists include all nonfederal active patient care physicians who self-designated medical, surgical, and other specialties as their primary activity.

***Health Professional Shortage Areas.

†Hospitals are nonfederal general medical surgical hospitals, including children’s hospitals.

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d. The 1997 Area Resource File.


(PPOs) (table 2), the forms of health financing that are central to competitive developments. HMO penetration is highest in California, at 42.6 percent of the market, and lowest in Mississippi, at 1.9 percent; PPO penetration also varies widely, though the numbers are less credible because they include only state-based PPOs, not multistate ones. The states differ greatly in the extent of uninsurance as well—and on several measures of medical spending (table 2).³

**Six State Case Studies of Markets**

Across the country, states are at various evolutionary stages of price-competitive markets. This does not mean that all are on the same path, just that some have more experience with competitive developments than others. For example, advanced markets are characterized by high HMO penetration, long-standing experience with managed care, and major provider restructuring in response. Both state policymakers and coalitions of private employers may be active in seeking to influence market development and operations. State policymakers tend to address more advanced market concerns—such as whether, to what extent, and how to manage or regulate managed care, health care mergers, and nonprofit conversions.

At the other end of the spectrum lie states that have little experience with managed care, especially with HMOs and organized provider groups. Indemnity coverage and lightly managed care (with some utilization controls) predominate. The states may lack large employment groups other than the state to provide a ready market, and state policy may not facilitate development. A relative shortage of primary care physicians and a dearth of large physician groups also make it difficult for health plans to form networks. Public hospitals may have an unusually large share of the market, which also inhibits networking among private actors.

Most states lie in the middle of the spectrum, either just embarking on serious competition or at a somewhat more advanced stage with a longer tradition of price competition and provider reaction to it. One can argue whether a state is at the lower or higher end of the middle, but the middle range is generally distinct between the extremes of high and low. Table 3 groups the site-visit states by these market characterizations.

The following sections discuss the six states asterisked in table 3, in that order. The states were selected to illustrate the constraints and opportunities created by market developments at different stages. They also reflect the range of policies pursued by states with different circumstances and political-programmatic preferences.

Alabama is at an early stage of development. Blue Cross/Blue Shield dominates insurance, with rather traditional coverage instead of heavily managed care. Competition from HMOs is just getting under way. The state has a very large poverty population and a relatively small Medicaid program, and it relies heavily on public provision of care by hospitals and public health nurses.

New York is a large state with a long tradition of extensive regulation in health care. State action has been particularly important to developments there, notably hospital deregulation implemented in 1997 and the state’s desire to move rapidly to Medicaid managed care, given its high levels of spending on acute care in that program (table 2). New York illustrates how rapidly markets can shift. There, thor-
Thoughgoing market change is just beginning, as hospital rates were deregulated only beginning in 1997, but hospital consolidation began quickly after deregulation. Also, the extreme concentration of its poor populations poses special problems for the safety net.

Texas still has relatively low HMO penetration (table 2), owing to strong resistance from patients who value choice and physicians who value independence. As a result, Texas has very strong regulation of managed care organizations, testing the limits of what federal Employee Retirement Income Security Act (ERISA) preemp-
tion allows states to regulate. The state has a very high rate of poverty and an even higher rate of uninsurance, and it relies heavily on public hospitals. For-profit competition with nonprofits is extremely vigorous.

For-profit hospital competition and hospital consolidation are notable features of Florida’s markets. Within the HMO market are many plans that compete for Medicare beneficiaries, drawn by the state’s very high indemnity Medicare spending (table 2), which sets the HMO capitation allowance. Florida has unusual local programs of third-party payment for safety net care.

<table>
<thead>
<tr>
<th>Table 3 States by Stages of Market Development</th>
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<tbody>
<tr>
<td>Stage</td>
</tr>
<tr>
<td>Very early</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Early</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td>Intermediate</td>
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<tr>
<td></td>
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<tr>
<td>Advanced</td>
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<td></td>
</tr>
</tbody>
</table>

*Note: Within stages, states are in alphabetical order; six marked states (*) are presented as case studies in this paper.*
Massachusetts is a latecomer to fully competitive markets, having regulated hospital rates and promised to regulate all health insurance under a comprehensive state scheme until repeal at the end of 1991. It has a long tradition of high-quality HMOs and hospitals, but price competition is relatively new to the state. Since deregulation, hospital mergers led by prestigious medical centers in Boston have created two megasystems expanding regionally that may challenge HMOs. The state has actively increased public coverage, and it operates an unusual pool to share the burden of hospital charity care. Medical costs remain high (table 2).

Minnesota has had HMOs since the mid-1950s and pioneered PPO development in the early 1980s. The state has a long tradition of physician group practice, hospitals and clinics have formed organized delivery systems, and organized buyers have actively pressed for better prices and other changes. Both state and private opinion leaders strongly support competitive mechanisms but also help for the needy. Consolidation of hospitals and health plans is very far advanced, especially in the Twin Cities, but the organized buyers are attempting to reestablish competition among smaller groups of providers by contracting directly with them rather than through managed care organizations (MCOs). The state lags in Medicare HMOs, as a result of very low past Medicare spending and hence low Medicare HMO capitation rates (table 2).

Site Visits and Reporting

To study market development and state policy, Urban Institute researchers made a site visit to each state between July 1996 and May 1997. We conducted about 40 interviews in each, meeting with public officials as well as stakeholders outside government. In each state, we also studied safety net providers in one metropolitan area, focusing on hospitals and community health centers (Norton et al. forthcoming). Those local interviews helped us understand how markets and public policy have shaped delivery of care at the grass roots; other than these safety net interviews, we did not gather local-level information on health care and insurance markets. Our unit of observation was the entire state, because we focused on state policy. Information was updated as needed for a series of statewide case studies published in 1997–98. This paper also draws upon a set of unpublished, internal supplements prepared in May and June 1998.

The key interviewees for market developments and policy were state attorneys general; HMO regulators; insurance commissioners; Medicaid managed care staff; representatives of state HMO associations, hospital associations, and medical societies; and local safety net providers.

These six states illustrate a variety of experience with market change and state policies. Implications for the poor depend on the interaction of competitive developments and state policies designed both to encourage competition and to protect the vulnerable.
Alabama: Dominated by Blue Cross/Blue Shield

Alabama’s health care insurance and delivery markets are shaped by Blue Cross/Blue Shield of Alabama (BCBSAL), which insures or administers benefits for almost three-quarters of the state’s residents. Some complain that this near-monopoly power has kept premiums higher than need be, but HMOs to date have had difficulty entering the market because BCBSAL can undercut their prices, and per capita costs are below national averages. The Blues’ dominance has helped limit insurance reform efforts and created special regulatory status for the plan.

The modest presence of HMOs in Alabama has left hospital and physician markets untouched by much of the competitive pressure faced by health systems elsewhere around the country. As a result, there is no immediate shortage of uncompensated care. Yet some early signs of market evolution are present: HMO membership continues to grow, some providers are creating physician-hospital organizations (PHOs), and hospitals are merging to some extent. Perhaps most important, BCBSAL itself has taken initial steps to enter the managed care arena.

The Insurance Market and Managed Care

BCBSAL

Referred to by some as a “benevolent dictator” and even a “benevolent monster,” BCBSAL insures or is the third-party administrator for fully 70 percent of the state’s privately insured population. The insurer has fostered its market power by maintaining good relationships with providers (hospitals are paid on a discounted charge basis, and physician payments are considered generous); maintaining broad choice of providers and rich benefits (low copayments) for consumers; and offering acceptable, if not necessarily low, rates to employers. BCBSAL apparently has not
leveraged its substantial market power to obtain large discounts from providers, however, and has been accused of keeping prices unnecessarily high. Critics say BCBSAL has little incentive to lower health care utilization because 75 percent of its business is third-party administration and it is paid a fee for each claim processed (AHL 9/25/96; AHL 3/21/97). Nevertheless, as HMOs have grown in number, BCBSAL has become more price-conscious to discourage further entry of new plans.

BCBSAL has taken steps toward managing care. The insurer runs a small HMO with approximately 1,000 enrollees, but most of its “management” of health care is embodied in its PPO and the policies it sets. Its PPO is largely responsible for Alabama’s high PPO penetration rate, 34.5 percent in 1994 (HIAA 1995). The BCBSAL PPO includes all but 5 percent of the state’s physicians. At first, all physicians were eligible to join; now that the panel is closed, some physicians who originally chose not to sign up are suing BCBSAL to be included. While the PPO may not reap significant enhanced efficiencies because of the broad physician participation, it does encourage referrals to selected specialists.

In perhaps its most controversial (in the eyes of providers) cost-cutting measure, BCBSAL placed a moratorium on payments to new outpatient facilities such as ambulatory surgi-centers and radiology centers in 1996 (AHL 11/13/96). BCBSAL decided to refuse reimbursement to any newly constructed facilities because it pays them on a cost basis; thus, any new construction increases reimbursements. The new policy was predicted to result in lawsuits, as some proposed facilities already had received a state certificate of need (CON).

Some observers noted that BCBSAL can selectively lower its rates to ward off new entry into the market. One example is the way it won the business of the Alabama Healthcare Council, a purchasing coalition of more than 20 large employ-
ers with 100,000 employees, by offering a 20 percent premium discount. Observers said that BCBSAL’s sizable assets and reserves and low overhead allow it to risk a loss to protect its market share (AHL 9/25/96, 3/21/97).

HMOs

According to some observers, HMO penetration is slowed not only by the efforts of BCBSAL but also by anti-HMO sentiment among the public and the press and the relatively rural nature of much of the state, which inhibits HMO development. Despite these obstacles, HMOs have steadily gained members and currently enroll about 16 percent of the privately insured population (AHL 2/3/98). The number of HMOs is increasing as well, despite some plan exit (e.g., Foundation and PCA). As of October 1996, 13 companies (mostly out-of-state) held 15 HMO licenses, and another 6 organizations were seeking HMO licensure.

HMOs in the state are struggling financially for several reasons. First, to compete with BCBSAL, they have to maintain low premiums, which is difficult because they have not been able to secure hospital discounts in the face of BCBSAL’s dominance. Physicians often are not willing to accept rates lower than BCBSAL’s because the BCBSAL contract requires physicians to offer the Blues the lowest rates negotiated with any party, or BCBSAL can drop them from its panel. In addition, because BCBSAL sells a rich benefit package, HMOs have offered a similarly generous package. Further, because of the priority Alabamians place on “choice,” HMOs have had trouble attracting new enrollees in large numbers. To address this problem, at least one HMO has expanded its choice of hospitals.

Despite the HMOs’ unsuccessful bid for the Alabama Healthcare Council’s business, many viewed the process as an indication that employers are interested in HMOs and that competition is slowly mounting. Some predict that employers will begin to seek savings more vigorously by limiting provider choice via managed care. In addition, a recent state survey of HMO customers found higher levels of satisfaction than the National Committee for Quality Assurance’s nationwide survey found (AHL 2/3/98). Others in the state noted that the future of capitated managed care depends on whether BCBSAL itself moves in that direction. BCBSAL did, in fact, introduce a health plan that features a limited network of primary care gatekeepers in 1997. Some believe BCBSAL’s initial steps to reinvent itself as a managed care plan foreshadow heated managed care competition in the state (AHL 9/25/96).

Medicaid Managed Care

In spite of the limited HMO infrastructure, Alabama’s Medicaid program has moved toward managed care. The state has incrementally introduced managed care programs for targeted populations, without relying on commercial HMOs. Instead, it relies largely on primary care case management, such as its Section 1915(b) waiver program for pregnant women operated in two-thirds of all counties. The program has been successful in attracting physicians to participate and is credited with increasing prenatal care utilization and lowering the infant mortality rate. Under another 1915(b) waiver, Alabama will implement primary care case management in 26 counties for all Medicaid recipients except the dually eligible.
State officials intend to move toward full-risk capitation over time. Under a Section 1115 waiver, the state piloted a fully capitated Medicaid HMO in the Mobile County area in 1997. The demonstration is unique in that one HMO will be the sole contractor, enrolling all 41,000 county Medicaid clients (including the disabled population) (AHL 2/4/98b).

### Provider Markets

The health care delivery market in Alabama has not yet come under the intense competitive pressures associated with higher levels of managed care penetration. Hospitals and physicians alike consider themselves well paid by BCBSAL and are on good terms with the insurer. One benefit of the generous payment rates is that providers appear to be in a better position to provide uncompensated care. BCBSAL’s relationship with providers may come under some strain, however, as it makes tentative steps into the managed care arena.

#### Hospitals

At present, the hospital market in Alabama is in good financial health, despite pockets of excess capacity. In Birmingham, for example, some hospitals are operating at only 30 to 50 percent capacity. (Some hospitals can survive for a time while losing money on operations because they are well endowed.) Though the state has maintained its CON regulations to curtail hospital expansion, there is speculation that market-driven downsizing will occur eventually, making CON obsolete. One hospital administrator predicts consolidations and mergers that would result in only a few systems operating in the state. Integration is also occurring to some degree. Nearly every hospital has formed a PHO with the objective of contracting with HMOs.

Although there is some for-profit takeover activity, state officials do not appear concerned. In fact, no one in the state attorney general’s office specifically oversees conversions of nonprofit hospitals. Columbia/HCA is the largest for-profit entity, with eight hospitals in the state.

#### Physicians

Physicians, like hospitals in Alabama, have been insulated from competitive change. Many physicians, especially those in rural areas, still practice solo; the average group size is said to be three to four. One meaningful change for Alabama physicians, however, is that hospitals are assuming a more controlling role in the health care system. In the past, physicians dominated health care delivery, serving on the staff of every hospital in town. Today physicians are aligning themselves with a single hospital, and some are even selling their practices to hospitals to ensure a stable income for the future. In addition, in some areas physicians are increasingly participating in HMOs. In 1996, it was estimated that 40 percent of physicians in Mobile County and 65 percent of physicians in Jefferson County had some HMO patients.
Alabama suffers a physician shortage in rural areas, and specialists are particularly rare. Fully 88 percent of Alabama’s counties are federally designated as whole or partial Health Professional Shortage Areas (HPSAs). One response has been to encourage the practice of mid-level practitioners. For example, in 1996, nurse practitioners and certified nurse-midwives were authorized to write prescriptions under a physician “sponsor” (AHL 2/23/96). In addition, new training programs for nurse practitioners and physician assistants have emerged in Alabama.

State Regulation of Health Care Markets

The Department of Insurance regulates the insurance industry through fairly standard measures. Although insurance companies have to file premiums with the state, the Department cannot disallow increases, only require justification. The Department has no authority over BCBSAL because it is granted special status as a nonprofit “health care service plan” (AHL 3/21/97). Of course, the Department also has no authority over self-funded ERISA plans, which abound in the state.

Managed Care Regulation

HMOs are regulated by both the Department of Insurance (on issues of solvency) and the Department of Health (on issues of quality). Policymakers have become concerned about the state’s limited regulatory authority over the increasing number of PHOs. To monitor quality of HMOs, the Department of Health requires tracking of 20 HEDIS (the Health Plan Employer Data and Information Set, from the National Committee for Quality Assurance) indicators, with additional indicators for Medicaid and Medicare clients. The state also has begun an annual HMO customer satisfaction survey. HMOs are required to pay $8,500 each to participate and are induced to comply under an existing law that requires HMOs to provide accurate and consistent information (AHL 2/3/98). The Department of Insurance noted that it monitors HMO solvency carefully, because many HMOs are financially marginal. HMOs charge that the regulatory environment places them at a competitive disadvantage with BCBSAL, which is not subject to the same requirements.

In addition, Alabama has enacted legislation to counter potential limits on patient care imposed by managed care. Recent laws require insurance companies to provide direct access to obstetricians/gynecologists (ob-gyns), 48-hour hospital stays for maternity care, and mammography screenings. Also, Alabama has an “any willing provider law” for pharmacies. BCBSAL challenged the law in court and the Blues are now exempt from the law, though other insurers must abide by it.

Access, Cost, and Quality for the Low-Income

Low-income Alabamians may have some difficulty obtaining insurance, but probably no more than in other parts of the country. Alabama’s rate of uninsurance is only slightly above the national average, at about 17 percent, and down from
1990–92, when it was almost 20 percent (Liska et al. 1998). Improved coverage tends to lessen the potential impacts of market change on the poor, because fewer people will require uncompensated care. Few reforms have been undertaken to further improve the insurance coverage rate, however, and two legislators noted little public or provider pressure to tackle the issue.

Access to care seems a more pressing concern, given the state’s large number of physician shortage areas. Many residents, low-income and high-income alike, face physical access problems because of physician scarcity and long distances to facilities. However, the low-income population may have more trouble obtaining transportation and may be less likely to receive care (or care of equal quality) where they must compete for physicians’ time with better-paying patients. Furthermore, in rural areas, there may be cause for concern about quality if health care professionals must deliver care beyond their scopes of practice.

As mentioned above, state officials do not appear concerned about any potential negative ramifications of for-profit takeover activity in the state. If a large percentage of hospitals were to convert to for-profit status, however, the norm for uncompensated care provision among hospitals could decline. Furthermore, without oversight, community assets accumulated over years of tax exemption could fall into private hands.

Marketplace changes do not appear to be reducing uncompensated care provision at this time. The generosity of BCBSAL’s rates has limited cost- and utilization-control pressures on hospitals, so facilities have maintained enough cushion in their operating margins to preserve some level of charity care. However, it is not clear how adequate traditional levels of uncompensated care have been, relative to need.
New York: Managed Care Growth and Deregulation

The New York health care marketplace is changing dramatically, primarily as a result of growth in managed care and hospital rate deregulation. The regulatory environment, especially the rate-setting system and the CON requirements, slowed the entrance of managed care into New York. New York deregulated hospital rates beginning in January 1997, and as a result, competition and consolidation in the hospital marketplace have accelerated. Market changes brought about by hospital deregulation pose both hazards and opportunities for managed care plans in New York. So far, the poor have been protected by the continuing breadth of Medicaid eligibility and the state’s unusual charity care pool.

The Insurance Market and Managed Care

HMOs

HMOs have grown rapidly in New York at the expense of traditional indemnity plans. As of 1996, about one-third of New York residents were enrolled in HMOs or PPOs, up from 24.3 percent in 1994. There are currently 36 licensed HMOs, mostly for-profits.

There were perhaps 10 HMOs in New York in the 1980s, when regulations were adopted acknowledging the legal authority to license for-profit HMOs, and the number of HMOs exploded. In addition, HMO growth was fueled by the state’s authorization in 1984 of prepaid health service plans (PHSPs) to serve Medicaid clients exclusively. Their number is capped statutorily at 20 statewide.

While the hospital rate-setting system applied to HMOs, they were also granted the authority to negotiate alternative payments (subject to state approval). Few HMOs exercised the option to negotiate rates before 1988, when the rate-setting
system converted to diagnosis-related groups (DRGs). Through the early 1990s, the level of HMO-negotiated deals increased significantly as they sought to recapture the advantage of per diem payments and excess hospital capacity. Interviewees said HMOs believed that states without hospital rate setting offered better cost-cutting opportunities, in part because rate-setting states initially controlled costs relative to unregulated fee-for-service markets. But as advances in managed care reduced costs in unregulated markets, rate-setting states began to appear to have high costs and excess capacity. Thus, HMOs now are poised to take advantage of New York’s substantial excess hospital capacity, which improves plan leverage in bargaining for discounts. Furthermore, shaky 1997 financial performances by two of the state’s leading insurers, Oxford Health Plan and Empire Blue Cross/Blue Shield, may offer other HMOs an opportunity to expand enrollment (BNA 4/27/98).

On the other hand, certain factors act against the growth of HMOs in New York. First, because HMOs were the only insurers with authority to deviate from state-set hospital rates, deregulation could be seen as removing an advantage for HMOs, now that HMO enrollment is large enough to entice hospitals to accept below-market rates. Second, the state strictly regulates HMOs, some believe disproportionately compared with regulation of other health-insuring entities. Indeed, one response to the level of regulation of HMOs, and a third threat to their growth, is the spread of other insurance products that are not regulated, such as PPOs. Such loose forms of managed care may yield lower overall system cost reductions than traditional HMO enrollment would.

A final threat to the growth of HMOs is hospital consolidation and integration, which may increase the market power of hospitals vis-à-vis health plans. Hospitals are consolidating rapidly in the state, as discussed further below. In addition, some hos-

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Sources: See tables 1 and 2.
hospitals and physicians may compete directly with HMOs through integrated delivery systems (IDSs), authorized by the New York Health Care Reform Act of 1996 (NYHCRA). These plans are favored by hospitals primarily as a way to protect their Medicare market share as seniors move into risk HMOs. IDSs will be regulated like HMOs, but they may have more lenient solvency provisions. It remains to be seen how provider-sponsored insurance plans will affect the HMO market.

**Medicaid Managed Care**

The commercial HMOs have traditionally participated in Medicaid because they faced a 9 percent penalty applied to hospital charges if they did not. In the 1996 Medicaid procurement process, commercial HMOs accepted what they believed to be relatively low Medicaid rates in order not to be precluded from the Medicaid business and face the 9 percent penalty. When the penalty was lifted under rate deregulation in 1996, some commercial HMOs, including PruCare, MVP, Travelers, and IH, exited the Medicaid market or left specific counties. Other HMOs limited enrollment in some counties and refused to expand into new ones. A legislatively commissioned study of Medicaid HMO rates concluded that rates were too low, and the state raised them by 2 percent in New York City and 7 percent upstate. However, some HMOs argue that Medicaid rates and increased quality-monitoring requirements are still unreasonable. Plans are also said to be frustrated by the cumbersome New York system of contracting with individual counties.

Some observers fear that commercial HMOs will abandon the Medicaid market. The state approved two additional rate increases in August 1997, one just implemented in April 1998. These increases provide bonuses to plans that expand enrollment into new regions. Whether these incentives will improve plan participation, however, remains to be seen. Recently, a number of PHSPs appear to be expanding and will perhaps provide an alternative to commercial plans. There is still concern over the exit of commercial plans or access to primary care in areas of the city where there are no PHSPs.

**Provider Markets**

**Hospitals**

How the managed care market evolves, and whether HMOs are able to reduce health care costs in the state, depend to a great extent on the changes in the hospital market under deregulation. While the New York state hospital rate-setting system appeared to control costs relative to fee-for-service systems, it is widely believed that the state’s system now has high costs relative to more price-competitive markets. In addition, some believe the state has substantial excess hospital capacity, funded by loans from the Federal Housing Authority under the Hospital Mortgage Insurance Program (AHL 11/22/96). This increase in inpatient capacity runs counter to developments in other states, where more outpatient clinics and surgical centers are being built.
The perception that New York has high costs and capacity relative to other markets led to the enactment of NYHCRA in 1996 to end the hospital rate-setting system. Another contributing factor was that, as HMO market share grew, about 25 percent of hospital services were paid for outside of the rate-setting system. It was believed that competition among insurers and HMOs would drive down hospital costs, admissions, lengths of stay, and number of beds. Officials expected that a number of hospitals would close and that most hospitals would reduce capacity.

Indeed, hospital deregulation and the large amount of hospital debt probably intensified hospitals’ interest in consolidation to develop bargaining power with HMOs. Two patterns emerge from the many postderegulation mergers and affiliations: the development of hospitals with considerable market power in some parts of the state, and the increasing power of academic medical centers. State officials and other interviewees suggested that merger activity outside of New York City could begin to present serious problems for competition in the health care market. Interviewees believed that in small cities, such as Newburgh and Poughkeepsie, mergers could result in a large number of monopolies, which could be a serious problem. In such cities, managed care plans would have to contract with the sole local hospital, with little ability to negotiate prices and services. In addition, managed care efforts to move care out of hospitals could be limited by hospitals with a local-area monopoly. In other markets, oligopolies could diminish access for low-income people if competition between hospitals reduces their provision of charity care. In Buffalo, CGF Health System has only one serious rival: a multiprovider affiliation of Catholic health care entities (AHL 2/4/98a). Another possibility is that there would remain many hospitals but only one large academic medical center (e.g., the Albany Medical Center), which would be a critical piece of any managed care network operating in that region.

New York City is a more complicated case. Many interviewees believed excess capacity was so great that mergers have not threatened competition. Others believed that because the mergers and affiliations were led by the largest and most prestigious teaching hospitals, Mt. Sinai and New York Hospital, they could eventually threaten competition. They argued that even in New York City, a large HMO could not compete successfully for a middle-class clientele without access to either the Mt. Sinai or New York Hospital networks. The prestige of these hospitals’ networks gives them tremendous bargaining power, and they are expected to broker the process of downsizing the New York City hospital industry. In 1997, they were actively affiliating with community hospitals throughout Queens, Brooklyn, and the Bronx to feed the larger academic medical centers. Most have preserved community hospitals as part of their systems, but referral patterns are changing.

Other hospitals in New York City are struggling. Average hospital margins were around 1 percent in 1996, compared with a national average of 5 percent. A United Hospital Fund study concluded that New York City hospitals may soon experience a competitive shakeout. Between 1995 and 1997, hospitals there saw changes in admissions ranging from a 13 percent decline to a 6 percent increase. Two-thirds of the hospitals with the largest inpatient gains were located near hospitals with the largest inpatient losses, prime candidates for consolidation. Municipal hospitals, large facilities, and financially distressed hospitals fared worst. Furthermore, one-third of
the city’s hospitals in 1996 depended on Medicaid for more than 50 percent of discharges, a potential vulnerability if Medicaid HMO enrollees are moved to other hospitals.

**Physicians**

Physicians are also in oversupply in New York, compared with most of the rest of the country. This is particularly true of medical and surgical specialists. In 1997, New York had about 313 specialists per 100,000 population, versus 195 for the nation. Physician oversupply generally acts to the advantage of HMOs, allowing them increased bargaining power.

### State Regulation of Health Care Markets

#### Managed Care Regulation

The state strictly regulates HMOs. All HMOs must have open enrollment; they must participate in the individual market; and they are subject to limits on preexisting condition exclusions. Plans also must detail for the state their bylaws, management and staffing plans, quality review procedures, grievance processes, and the adequacy of their provider networks.

A large state staff monitors HMO quality, and some observers consider its regulations excessive. New York requires collection of HEDIS and other quality monitoring data for both commercial and Medicaid enrollees and additional encounter data for the Medicaid population. The state conducts annual surveys to review plan structures, processes, and medical records, and it has recently expanded its complaint investigation activities, including a new hotline.

The state also enacted a comprehensive “Patient’s Bill of Rights” in 1996 as the result in part of efforts by consumer advocates and the Medical Society of the State of New York (MSSNY) to limit many managed care practices. The law applies to managed care plans and insurers, protects commercial and Medicaid enrollees equally, and includes some provider protections as well.

The law prohibits “gag clauses,” which seek to bar providers from discussing more expensive treatment alternatives with patients. It also requires continuity of care for people with chronic conditions and pregnant women whose providers leave the plan. It defines procedures for standing referrals to specialists and permits specialists to act as care coordinators for patients with chronic conditions. In addition, it grants out-of-network access to specialty care not available through the plan and sets a “prudent layperson” definition for payment for emergency services.

The law also requires disclosure of plan benefits, cost-sharing, provider rosters, referral and preauthorization procedures, access to specialty services, and, on request, guidelines for utilization review of specific conditions and compensation arrangements with physicians. Furthermore, it standardizes procedures for consumer appeals and grievances. The state also mandated due process protections for physician ter-
mination. Finally, the access provisions of this law are extensive: Consumers must have a choice of at least three primary care providers, subject to travel time and distance restrictions, and plans must offer a sufficient number of specialists in all classes of licensed health professionals.

Despite its many provisions, some consumer advocates in New York did not endorse the law because it designated HMOs, rather than independent panels, as the ultimate decisionmakers, and it did not mandate an out-of-network option or coverage of experimental treatments. Legislation introduced and passed in the 1998 session addresses some of these perceived shortcomings, including independent review, a statewide managed care consumer assistance program, and an HMO malpractice liability measure to allow enrollees to sue their health plans (BNA 2/2/98). A Business Council of New York report argued that the 1998 managed care bills would raise health care costs by billions of dollars and force thousands to go without insurance (AHL 5/6/98).

**Antitrust Policy**

The state’s review of hospital mergers is typical, not particularly activist. Plans for mergers are announced and the state reacts to them. The State Department of Health will review only mergers that actually involve one entity taking over another, where the acquiring entity’s board members exercise day-to-day control over the hospital. More of the mergers in New York state have been of a passive nature, where the entities come together to bargain with HMOs and to increase efficiency in purchasing but control of operations does not change. In the past, the state has tended to accept mergers and joint ventures because it could control hospital rates through the rate-setting system and excess capacity through certificates of need. Now with deregulation, some fear the state may be left with too few competitors because of its past decisions. Interviewees also felt that recent court rulings against the U.S. Department of Justice in antitrust suits constrain the state’s ability to credibly challenge merger activity.

State antitrust officials were clearly frustrated with existing case law. While the state’s position is deferential to the federal Department of Justice and the Federal Trade Commission, it was clear that the state Attorney General’s Office was monitoring the merger activity taking place and assessing its possible consequences. State officials said they would not “go along” if they thought there was significant anticompetitive activity among state hospitals.

**Access, Cost, and Quality for the Low-Income**

In 1995–96, 16.8 percent of New Yorkers lacked health insurance coverage, slightly more than the national average (Liska et al. 1998). Although employer-sponsored insurance is slightly below the national average (at 63.3 percent, compared with 66.1 percent), broader-than-average Medicaid coverage and the presence of a state bad-debt and charity care pool seem to have protected low-income New Yorkers to some degree from the potential negative effects of marketplace change. But there are concerns about whether this situation will persist.
Some fear that past antitrust decisions may have left insufficient competition in the hospital market, especially in small cities. Monopoly power of combined entities could drive up costs and reduce access for those with low incomes. Where there are oligopolies, heated competition between hospitals could reduce the ability of each to provide charity care.

In New York City, deregulation and consolidation may increase the market power of the more prestigious hospitals and enhance their ability to bargain with managed care plans, possibly achieving high enough rates to support current levels of graduate education if they are so inclined and to continue their current levels of charity care. But other hospitals, especially public ones, will likely have less ability to provide uncompensated care. Observers fear that a few small, highly competitive hospital networks will evolve that will provide only limited care for the poor and will exclude many of the nonprofit and public safety net hospitals, several of which are already financially distressed. These latter facilities will not be able to compete for private patients. Without some intervention beyond the uncompensated care pools, they are likely to fail, given the amount of uncompensated care they will be forced to bear. Some interviewees even say the large hospital chains will also be unable to compete if they absorb this burden.

If New York hospitals continue to consolidate, managed care may have difficulty containing costs. Health plans maintain that state regulation constrains their ability to reduce the costs of health care. Health plans have already had to request substantial rate increases because of adverse selection in the individual market under community rating. Some are concerned that HMOs will not in the end serve Medicaid patients because of the low capitation rates and the high degree of managed care regulation. Others believe that there is such a large amount of capacity in the system that low capitation rates will simply force HMOs to be even tougher bargainers with physicians and hospitals. In this scenario, at least Medicaid HMOs will remain viable and could expand operations. Medicaid beneficiaries would be served, but by essentially the same traditional providers.
Texas: Uneasy Acceptance of Market Change

The Texas HMO market is experiencing great upheaval: The number of health plans is growing rapidly as new HMOs enter, even as others leave. A simultaneous consolidation trend is under way because overall profits have been low. Plans are squeezing provider payments to compete better. Providers are attempting to protect themselves from managed care by consolidating, contracting directly with employers, and attacking managed care politically. Physicians and consumer groups have won what may be the strongest managed care regulation in any state.

The Texas safety net is very important, as almost a quarter of Texans are uninsured. For-profit acquisitions have stimulated market change and made nonprofit conversion a major topic of public debate. The state now has twice the national percentage of for-profit hospitals. There are fears that hospital conversions and payment cuts under managed care will reduce the supply of uncompensated care and injure safety net providers, but as yet there is no evidence of major negative impacts on poor Texans.

The Insurance Market and Managed Care

Some 800 to 900 insurers compete in Texas, including a large Blue Cross/Blue Shield plan (BCBST). Well over half of the market is estimated to be in self-insured plans, including almost all large employment groups (IHPP 10/13/97).

HMOs

The number of HMOs has grown rapidly throughout the 1990s, most recently because of expansions in Medicaid and Medicare managed care. Most HMOs are for-profit, and 41 percent are affiliated with an insurance company, often a national one.
Another 26 percent of HMOs are aligned with a hospital. The state HMO association says that eight nonprofit HMOs operate in Texas, three of which are run by BCBST, which is estimated to have 12 percent of the state’s managed care business. Interviewees considered competition among plans to be fierce.

HMO enrollment has also grown rapidly, to about 3.5 million at the end of 1995, most under self-insured arrangements. In 1996, penetration was around 13 percent of the total state population. Texas Department of Insurance (TDI) interviewees reported that hospital rates paid by managed care organizations are declining substantially. Many hospitals were said to be accepting capitated rates, not just discounted fees. Nevertheless, HMO net income per member per month after taxes declined by about 60 percent between 1993 and 1995 (TDI undated), and losses mounted in 1997 (BNA 10/20/97). The industry blames competitive pressures, overregulation, and high pharmacy costs, and expects premiums to rise in the near future (IHPP 5/11/98). A long-predicted series of closures and mergers appears to be under way, notably in north Texas (AHL 3/12/98, AHL 3/24/98).

**Medicaid Managed Care**

The state relies on conventional HMOs to serve its Medicaid managed care program. Competition among commercial HMOs is vigorous enough to ensure their participation in Medicaid, according to state officials. Medicaid-only organizations exist but are not relied upon by the state. Interviewees from an HMO and the HMO Association viewed mandatory Medicaid managed care positively but said they would favor starting with pilot programs for disabled individuals and the dually eligible.

### Summary Statistics Texas and U.S. Total

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Sources: See tables 1 and 2.
Preferred Provider Organizations

PPOs have grown to serve about half of the non-HMO insured market, according to TDI staff. There were thought to be some 80 PPOs in 1995 and 120 by July 1996. PPOs are not independently licensed by the state. They typically operate as part of a licensed insurer or contract directly with a self-insured employer. HMOs complain that their PPO competitors face less state regulation.

Provider Organizations

Organized provider groups may seek to assume risk by forming nonprofit medical corporations under Section 501(a) of the state code. These 501(a) entities have cropped up in response to Texas’s ban on the corporate practice of medicine. Under the ban, nonphysicians (e.g., corporate entities) may not own physician groups except as 501(a) entities. These 501(a) corporations must be nonprofit under Texas statute and must have a board of directors composed exclusively of Texas physicians (Hilgers and Cunningham 1996). Consequently, hospitals, physician management companies, and other medical groups have formed 501(a) corporations as a means of integrating without violating the ban on corporate practice of medicine. A 501(a) is currently the only organization that can contract on a capitated basis for both physician and hospital services (Hilgers and Cunningham 1996). Providers are seeking legislation to allow them more flexibility in taking on risk, according to the hospital association.

Provider Markets

Hospitals

Texas has roughly equal shares of nonprofit, public, and for-profit hospitals. Many rural hospitals are public, run by hospital districts created by counties under state law. The districts are independent authorities permitted to assess property taxes up to a constitutionally set limit. These hospitals typically have high Medicaid caseloads and play a large role in indigent care. The largest for-profit entity is Columbia/HCA, with about 75 hospitals and a dominant presence in Dallas and Houston.

The financial health of hospitals in Texas is generally good, according to the hospital association, despite widespread discounting and some capitation under managed care. There are some recent signs of resistance to HMO rate reductions, however, notably against Aetna in north Texas (AHL 1/14/98a). Some hospitals are heavily dependent on Medicaid, which is currently viewed as a relatively good payer, especially compared with HMOs. Medicaid-dependent hospitals have fared well. For example, children’s hospitals have benefited from special reimbursement status and disproportionate share hospital (DSH) payments, eligibility expansions for children, and broadened early and periodic screening, diagnosis, and treatment (EPSDT) requirements. However, Medicare fee-for-service is still the largest single hospital payment source, and some think hospitals will be hurt by growth in Medicare man-
aged care; one Houston hospital respondent said Medicare HMOs paid the lowest rates of all.

Texas has seen many hospital conversions to for-profit status, led by Columbia/HCA’s aggressive expansion as it acquired many hospitals and threatened to build new ones near existing facilities. Its stance softened after its federal legal problems surfaced in mid-1997; for example, in Houston, Columbia dropped its plans to build a new children’s hospital in favor of a collaborative agreement with an existing facility (AHL 10/16/97). Public hospitals are also converting; four localities put public hospitals under private management or sold them outright.

Hospital consolidation has been under way for a number of years. The state shed 120 hospitals in the 1980s, but further closures are not expected because the weakest facilities have already closed. Nevertheless, merger activity continues at a brisk pace. For example, 24 large Texas and New Mexico nonprofits formed a corporation to lease, acquire, or manage troubled nonprofits, specifically to forestall conversions (AHL 11/25/97). Also, the two largest nonprofit hospital systems in north Texas planned to create an alliance by June 1998, joining 22 hospitals and an HMO, subject to antitrust approval (AHL 4/8/98).

Despite mergers, excess capacity remains in some areas. Hospitals are responding by cutting costs and staff. According to the hospital association, layoffs are easier to implement in Texas than elsewhere because there are no health care employee unions and Texas law allows termination without cause. To date, however, few hospitals appear to have closed beds.

Many hospitals are also playing an aggressive role in managed care by developing integrated networks and PHOs, buying physicians’ practices, shifting care to outpatient settings, creating partnerships with HMOs, or even pursuing HMO licensure (TMA and MTI 1996). Urban hospital networks have expanded into rural areas in order to protect their referral bases. One Lubbock hospital network, for example, includes almost every rural hospital within 100 miles (TMA 1996).

Physicians

Physicians have also consolidated. Solo practice has dropped to 40 percent (TMA and MTI 1996).11 In addition, many physicians participate in integrated provider networks, through PHOs, IPAs, 501(a) provider networks, and physician practice management organizations. Network formation is uneven across the state, however, with most developing in the big cities, where managed care penetration is highest (TMA 1996).

Managed care participation by physicians has increased rapidly. According to the 1996 Survey of Texas Physicians, HMO and PPO patients accounted for 31 percent of physicians’ patients, twice the rate in 1992, and 18 percent of physicians had some capitated patients.12 Approximately 20 percent of physicians reported being denied inclusion in a plan network.

Many Texas physicians dislike HMOs, and the Texas Medical Association has actively lobbied both to restrain managed care through regulation and to circumvent HMOs by accepting capitation risk directly from buyers. Physicians have won
requirements that Medicaid managed care programs in some areas include primary care case management options, viewed as less threatening to physician autonomy than HMO-only programs.

Texas has vast underserved areas. Geographic maldistribution of physicians is worst for specialty services. The medical association has worked with the state and medical schools to develop loan repayment programs, rural health clinics, registries of provider needs, continuing education, and recruiting programs for rural students. Although these efforts were initially successful, rural physician supply has plateaued in the past three years. While some communities can recruit doctors, they often cannot retain them. Urban HMOs pay higher salaries and lure primary care physicians, nurse practitioners, and physician assistants away from rural areas.

**The Role of Large Buyers**

Employer coalitions are active in Houston and Dallas but do not yet play a large role in influencing Texas health care markets. The Houston Healthcare Purchasing Organization contracts with 55 hospitals and more than 4,000 physicians to serve more than 130,000 “covered lives.” The Dallas coalition focuses on quality issues. In 1993, the state created a statewide Texas Purchasing Alliance (TPA) to buy coverage for employment groups with 3 to 50 workers.

**State Regulation of Health Care Markets**

**Managed Care Regulation**

Texas has extensive HMO regulation. HMOs’ public image has suffered from bad publicity and medical association lobbying. State requirements have been imposed in stages. First, administrators promulgated some limited rules, and then in 1996 the legislature passed a bill modeled on the American Medical Association’s “Patient Protection Act.” Governor George Bush vetoed the bill because he felt it did more to protect providers than patients, but he ordered health and insurance regulators to adopt some of its provisions. In 1997, a comprehensive consumer protection bill was enacted that codified many of these administrative rules (Laudicina et al. 1998). The regulatory movement continues both within government agencies and in the political arena (BNA 5/11/98). In 1998, both Bush and Democratic candidates for governor have promised new efforts to ensure patient choice of providers by mandating a point-of-service option for all HMOs (AHL 3/4/98).

Texas law sets HMO quality and access standards, including a ban on gag clauses, coverage of out-of-network referrals and emergency room services, continuity of care when a provider leaves a plan, direct access to ob-gyns, and disclosure requirements (Laudicina et al. 1998). A 1997 statute also permits HMO enrollees to request binding, independent review of treatment denials by the Insurance Department, at a cost to health plans of $500 each (AHL 3/19/98, IHPP
HEALTH CARE MARKET COMPETITION IN SIX STATES: IMPLICATIONS FOR THE POOR

5/11/98). The same statute allows enrollees to bring medical malpractice lawsuits against health plans, making Texas the first state to enact such a law (Laudicina et al. 1998). One plan sued to overturn the law under ERISA (AHL 4/24/98). This case promises to be an important test of state authority, with implications for many states considering similar regulation.

Another important and unusual Texas law prohibits MCOs from using financial incentives that directly or indirectly induce physicians to limit medically necessary services. TDI has found one plan in violation for using payment withholds and bonuses for pooled groups of physicians—and was supported in court (BNA 5/18/98b). Depending on the further interpretation of “medically necessary,” this provision could be a major blow not only to MCOs’ management of care but also to the general use of capitation and other incentive approaches in Texas.

PPOs

The state regulates insurers that run PPOs rather than the PPOs themselves. However, most of the HMO patient protection rules also apply to PPOs, including the provisions regarding out-of-network referrals. Furthermore, no gatekeeper arrangements are permitted in PPOs. TDI wants to update PPO regulations to require PPOs to register with TDI and address new risk-sharing arrangements.

Antitrust Policy

Market concentration is of concern to the attorney general’s (AG’s) staff, who think that current regulation and case law lag behind changes in the marketplace. This lag is notable with respect to the formation of large integrated systems, which may facilitate one-stop shopping for purchasers but which also may inhibit competition. Texas has an antitrust immunity process under the Health Care Cooperative Act, but it applies to such ventures as the joint purchase of a magnetic resonance imager (MRI) rather than to mergers. The immunity process has never been used.

Nonprofit Requirements and Conversion Policy

Texas enacted a law in 1993 to ensure that nonprofits earn their tax-exempt status (THT 1996). Charity care plus government-sponsored indigent health care must equal at least 4 percent of net patient revenue or 100 percent of the value of state and local tax exemption. Alternatively, a hospital may show that its charity care level is reasonable in relation to community needs (to accommodate areas with few uninsured patients). Providing other community benefits may also help qualify a hospital for nonprofit status, but only where charity constitutes an acceptable amount as well. Hospitals must file a community benefits plan with the Texas Department of Health and document their compliance. Hospitals that receive Medicaid DSH payments are automatically deemed in compliance, and public hospitals, nonprofits that receive no payment, and hospitals in Health Professional Shortage Area counties with populations under 50,000 are exempt.

Nonprofit conversions to for-profit status have occurred among hospitals, HMOs, and, more recently, insurers, but the state’s involvement historically has not been great. In 1996, the state sued to block a proposed merger of the Texas and
Illinois Blues. BCBST proposed to dissolve and move operations to Illinois, and the AG sued, arguing that nonprofit assets accrued in Texas would go to enrich Illinois policyholders rather than being dedicated to Texas communities. A district court ruled against the state, holding that BCBST is not a charity and “operates only for the benefit of its policyholders, not the public at large” (AHL 2/13/98). Legislators encouraged the AG to appeal the decision (BNA 4/6/98).

Perhaps in reaction, in 1997 the state enacted a law governing future nonprofit conversions (AHL 8/15/97). The AG’s office will apply three major standards in nonprofit conversions: (1) Does the organization have the authority in its bylaws to sell or merge? (2) Is the converting organization getting proper value for its assets? (3) Are the funds received being used for the originally charted purposes? However, there is currently no requirement to provide notice of conversion, and officials report they typically get “paperboy” notification by reading a newspaper. The state is contemplating changes to the conversion statute.

Access, Cost, and Quality for the Low-Income

In Texas, 23.9 percent of the population lacks health insurance, 8.4 percentage points more than the national average and the second-highest rate among the states, after New Mexico (Liska et al. 1998). Although the state’s Medicaid coverage rate is similar to the national rate, among people with incomes below 200 percent of FPL, the uninsurance rate is still 12.5 percentage points above the national average. Thus, Texas has more poor people who are vulnerable to the potential effects of market change than most other states.

The low coverage rate accentuates the importance of safety net hospitals, including the state’s large number of public facilities. Public hospitals typically have high Medicaid caseloads and play a large role in indigent care, but the hospital district system may be an unstable way to finance care for the poor. The willingness and ability of the local tax base to support charity care may prove unreliable, especially given the strong antitax sentiment in Texas. In addition, public hospitals are at a disadvantage in the competitive environment, because they are constrained by enabling legislation that narrowly defines their mission and prevents them from networking with privately held providers (CRHI 1995).

Unlike many other states, Texas has set standards for charity provision for nonprofits to earn their tax breaks. But 4 percent of revenues is not a particularly high level of required charity, given the state’s high uninsured rate; further, nonprofit hospitals are only a third of the hospitals in Texas. Aggressive competition in the HMO market has brought significant hospital discounting and capitation from health plans. As competition increases, even low levels of charity care may become unsupportable. More safety net hospitals may be forced into conversion or closure. But so far, officials say there have been no complaints about access to charity care.

Finally, the main state assistance to safety net hospitals is Medicaid payment and DSH funding, but DSH funding is decreasing under federal reform, and Medicaid managed care will likely cut hospital utilization and payment rates. State officials
acknowledged that Medicaid managed care and other market changes would place safety net institutions under pressure and that some would not fare well. Some have already begun to privatize. Although the Medicaid managed care program currently requires MCOs to contract with all willing “significant traditional providers,” the requirement applies for only three years (Sec. 533.006, Texas Government Code). Moreover, policymakers see their primary obligation as being to Medicaid beneficiaries, not safety net providers.
Florida: Consolidation and Conversion

Enrollment in managed care has increased rapidly in Florida, in turn putting pressure on hospitals and physicians to provide services at discounted rates. The current market can be characterized as volatile: Florida HMOs are merging and acquiring one another at a fast pace. The hospital market also has seen rapid consolidation into three major systems, as well as a high rate of ownership conversions, leaving one-third of Florida hospital beds in for-profit hands.

Florida recently enacted comprehensive managed care regulation, but most respondents indicated that the state maintains a positive attitude toward managed care. Both HMOs and hospitals have so far enjoyed relative financial security, and the poor have been well served. But as HMO enrollment grows and consolidations in the two markets continue, that may change.

The Insurance Market and Managed Care

Managed care has been growing rapidly in Florida. Commercial HMO enrollment grew 17 percent a year between 1990 and 1995, according to respondents. As of 1996, 26.3 percent of the state’s population was enrolled in HMOs. HMO market penetration, however, varies by area, with highs of 42.1 percent in Tallahassee and 40.8 percent in Dade County (Miami) in 1995. Rural areas of the state have much lower rates.

Competition among managed care organizations is considered greatest in Jacksonville, Miami, Orlando, and Tampa. Statewide, however, enrollment in commercial managed care is largely concentrated in a few HMOs. As of 1996, 10 HMOs accounted for approximately 81 percent of commercial enrollment and 5 HMOs accounted for almost 60 percent of the market. As in other parts of the country, HMOs in Florida are consolidating through acquisitions and mergers; 18 occurred between 1993 and 1995 (FAMCP 1994–95, FHA 1988–1995).
HMOs, particularly Medicaid HMOs, reaped enormous profits in the early 1990s, but state rate reductions and increasing competition have cut margins over time. In October 1997, the state announced that 26 of its 39 HMOs had not met its minimum financial reserve requirements. Sixteen of them were placed on a “watch list” because they had missed the reserve threshold in four consecutive quarters. One observer remarked that HMO premiums had been level since 1994, and the observers expected a 10 to 15 percent increase across the board in 1997–98 (F&G 1997). While the HMO market is still profitable overall, HMOs that are unable to meet the state’s financial solvency requirements are considered ripe pickings for larger HMOs.

Despite high HMO enrollment, Miami and Ft. Lauderdale also had the highest rates of hospitalization in the state among nonelderly enrollees in 1996, at 421 patient days per 1,000 enrollees in Miami and 344 per 1,000 in Ft. Lauderdale. One explanation for this anomaly is that south Florida HMO business is divided among 20 plans, diluting their ability to force significant change in practice patterns. Most HMOs there pay hospitals on a per diem basis (AHL 10/30/97).

### Medicaid Managed Care

Medicaid enrollment in HMOs has grown along with commercial HMO rolls. Florida Hospital Association (FHA) documents indicate that, as of 1996, 24 percent of the state’s Medicaid enrollees were enrolled in HMOs, up from 12 percent in 1991. Most Medicaid HMO enrollment is concentrated in Jacksonville, Miami, Orlando, and Tampa.
Like the commercial market, Medicaid HMO enrollment is very concentrated. Five HMOs account for 82 percent of the Medicaid market, and the statewide PCA Family Health Plan alone accounts for almost 40 percent. HMOs with a significant share of Medicaid HMO enrollment are not faring as well financially as their commercial counterparts, however. Three of the ten leading Medicaid HMOs—including PCA—experienced net losses in 1995. Six of the ten largest Medicaid HMOs experienced losses in the third quarter of 1996.

Preferred Provider Organizations

PPOs experienced significant growth in the early and late 1980s as indemnity insurance companies moved into managed care. Of the 108 PPOs operating in the state, only 30 are based in Florida. In 1994, 22 percent of the population was enrolled in Florida-based PPOs (HIAA 1995). Managed Care of America has almost half of the PPO market, according to the Association of Managed Health Care Organizations.

Provider Markets

The competitive pressures exerted on hospitals by HMOs have forced hospitals to consolidate rapidly. By 1996, 76 percent of the beds and hospitals in Florida were in a hospital system. The resultant market is dominated by three multistate systems—Columbia/HCA, Tenet Healthcare, and Adventist Health System/Sunbelt—which together account for 45 percent of the hospitals and beds in the state.

According to the FHA, 77 acquisitions or mergers of a hospital or group of hospitals have occurred since 1990. Consolidations peaked in 1994, when 19 hospitals (10 nonprofit and public and 9 investor-owned) were involved in mergers. Since 1993, 23 Florida facilities have closed or been subsumed into hospital systems, 9 of which were community hospitals (FHA 1996).

Two for-profit chains, Columbia/HCA and Tenet Healthcare, have been the leading forces in the consolidation movement. Columbia currently owns 57 acute care hospitals, controlling 24 percent of Florida’s acute care hospitals and beds. In 1995, Columbia acquired three hospitals from Community Health System in Tampa and quickly closed two of them, reflecting its strategy to reduce excess capacity and duplication in markets in which it invests. Tenet Healthcare controls 13 hospitals in the state, with 3,091 total beds. Nonprofit systems including Adventist Health, Baptist/St.Vincent’s Health, and Orlando Regional Health Care have also moved actively to acquire other hospitals.

Despite consolidations, the Florida hospital market remains overbedded. Hospitals currently average a 51 percent occupancy rate. Between 1990 and 1995, only 213 net acute care hospital beds closed. Hospitals do appear to have reduced the administrative labor force: According to state reports, hospitals increased the ratio of patient care full-time equivalents (FTEs) to total FTEs from approximately 2.8 in 1990 to 4.1 in 1994. According to the FHA, acquired hospitals typically act as satellites, allowing the central hospital to reduce or eliminate duplication in pur-
chasing and administration. Also, some acute care beds have been converted to nursing beds.

Florida hospitals are also purchasing physician practices, developing PHOs, and creating or purchasing HMOs as strategies for maintaining control of local markets. According to FHA data, as of 1994, 70 of the state’s 180 hospitals had developed PHOs. A group of hospitals in Miami, each with its own PHO, formed the Dimension system, a “super-PHO” composed of both for-profits and nonprofits. The group controls 26 percent of the hospital beds in the county and owns an HMO that spreads risk among its members.

According to respondents, many hospitals in Florida have been forced to rethink their ownership status because of (1) increasing competition, (2) reductions in public funds (both tax support and funds for capital investment), and (3) stringent laws that reduce the operational flexibility of nonprofits and publics. These constraints have resulted in a significant number of conversions. Chollet et al. (1996) found that while Florida had only 3 percent of U.S. hospitals, the Florida market accounted for approximately 6.5 percent of all U.S. hospital ownership conversions between 1990 and 1993. Many conversions from public status were among rural hospitals, which were particularly hard hit by increases in competition and reductions in public funds (Chollet et al. 1996, FHA 1996).

The Role of Large Buyers

In its 1993 health reform legislation, Florida created 11 regional Community Health Purchasing Alliances (CHPAs) to help employers with up to 50 workers pool their purchasing power. As of 1998, CHPAs purchased insurance for nearly 80,000 Floridians, half of whom were uninsured before they enrolled in the CHPA (AHCA 1998). CHPAs must now face the challenge of surviving without state financing, which was provided only through 1997. CHPAs are cutting costs, marketing heavily, and trying new ideas, such as acting as third-party administrator for self-insured businesses. A 1998 law continued CHPA eligibility for groups that expand beyond 50 employees (F&G 1997).

State Regulation of Health Care Markets

Managed Care Regulation

In 1996, the state enacted S.B. 886, which included a number of changes to state regulation of managed care organizations. First, the bill required the Department of Insurance to publish the medical loss ratios of all plans, though there continues to be debate around categorizing medical expenses versus administration and profit. S.B. 886 also required HMOs to pay for emergency room screening tests that are consistent with symptoms. The state also enacted other HMO-related laws, includ-
ing provisions covering diabetes and osteoporosis education, civil remedies, and minimum length of maternity stay.

In 1997, Florida added comprehensive consumer protection regulation to its existing statutes. The 1997 law created HMO “report cards,” prohibited gag clauses, required disclosure of referral policies for unique medical needs, and created internal and external review processes for enrollee grievances. Amendments to the law in 1998 added time limits for dispute resolution, including 24 hours for life-threatening issues (HPTS 4/13/98).

Although the state is generally considered HMO-friendly, some portion of the population still has significant problems with HMOs. The Florida Supreme Court invalidated a proposed state constitutional amendment that would have provided citizens with an inalienable right to see any provider they desired. The amendment, periodically submitted by Floridians for Health Care Choice for a statewide referendum, would have made HMOs and other selective provider networks illegal (AHL 1/23/98).

Antitrust Policy

In 1993, the Florida legislature passed a law designed to foster the development of rural health networks by providing safe harbors for hospitals involved in cooperative agreements or joint ventures designed to consolidate services or technologies among providers. Hospitals interested in such activity must receive approval from the state Agency for Health Care Administration (AHCA). The state AG has an advisory role in the process, but it is not clear that the AG must be involved. After receiving approval, AHCA is required to review the agreement at least once every two years. The legislation, however, does not detail evaluation criteria.

Nonprofit Requirements and Conversion Policy

Nonprofit and for-profit hospitals have engaged in a heated debate in Florida about the merits of each type of ownership status. Columbia/HCA and the for-profit hospital association (Florida League of Hospitals) challenged the rights to tax exemption of several Florida nonprofits and secured sponsorship of a 1994 bill to require that nonprofit hospitals either allocate more than 3.7 percent of their revenues to charity care and bad debt (the average amount provided by for-profit hospitals in 1993) or pay the state’s 6 percent sales tax. Although the bill died, the for-profit/nonprofit debate still rages.

Consumer advocates are primarily concerned about losing community assets in light of dealings between some nonprofit board members or managers and for-profit buyers. For example, Tampa General’s former head, now employed by Columbia/HCA, is accused of purposely reducing the net value of the hospital in preparation for purchase by Columbia. Tampa General is a primary safety net hospital for the city. In another case, directors of the nonprofit Anclote Psychiatric Center in Tarpon Springs reconstituted themselves as a new board, sold themselves the facility for $6.3 million, and then resold it two years later for a $30 million profit.

The state AG’s office has taken some interest in ownership conversions, notably in 1996 when the financially troubled University Medical Center (UMC) in
Jacksonville refused to provide documents regarding a proposed relationship with Columbia/HCA. In late 1997, UMC abandoned plans to join Columbia because of political opposition and concerns about UMC’s ability to retain tax-exempt status as part of Columbia (AHL 12/11/97).

### Access, Cost, and Quality for the Low-Income

Florida’s 19.2 percent uninsured rate is high compared with the national average of 15.5 percent (Liska et al. 1998). This is partly because employer-sponsored coverage is lower in Florida than the national average, especially among dependents. Florida has slightly more small businesses than other states, and more small-firm workers are uninsured in Florida (31.7 percent) than nationally (25.2 percent) (Liska et al. 1998). The demand for uncompensated care in Florida is therefore high. The large number of conversions of hospitals, especially public hospitals in rural areas, and the pressures of competition as a result of the growth of managed care have many in the state worried about possible declines in charity care.

Safety net institutions currently remain in relatively good financial health, however, in part because of the unique non-Medicaid financing arrangements that exist in some metropolitan areas with large low-income populations. An example is Hillsborough County, which has used local tax dollars to fund the Hillsborough County Health Care Plan since 1992 to insure nearly two-thirds of its uninsured low-income residents. Providers in the county faced a double-digit growth rate in uncompensated care before the plan’s inception. However, it should be noted that local government financing of charity care depends on the ability and willingness of a small population to support an expensive program with local tax dollars. This source of funding is probably not as stable as a state program, which draws from a larger tax base, might be.

The unstable condition of several of the Medicaid HMOs may also pose future difficulties for the poor. HMOs may fail or leave the market, with implications for the state’s efforts to maintain cost reductions in its Medicaid program. Florida has the fourth-largest total Medicaid enrollment in the nation, but its per capita spending for Medicaid is ranked 46th.

Another insurance access issue for the low-income is the uncertain future of the Community Health Purchasing Alliances, which are currently facing the challenge of surviving without state financing. Low-income workers in small businesses could face increasing insurance costs (or even the loss of coverage) in the absence of CHPAs.
Massachusetts: A Slow Starter Catches Up

Massachusetts has come late to aggressive market competition, given its many HMOs, in part because of its long-standing regulation of hospital rates. Also, Massachusetts planned to phase in fully state-run health insurance under its 1988 employer mandate. Since the repeal of these policies in 1992, markets have been in a state of “tumultuous” change.

Managed care has come to dominate insurance coverage, and plans are negotiating more aggressively with hospitals and other providers. The state ranks above all national norms for medical costs and utilization, so observers predict reductions in inpatient days, hospital budget cuts, and closures. Accordingly, hospitals (and to a lesser extent, HMOs) are trying to position themselves to survive, notably through a series of mergers, alliances, and consolidations.

The state is both proactive and reactive toward market change, using Medicaid policy in particular to promote managed care and competition. Massachusetts also has expanded insurance coverage for the needy, largely in the public sector. Thus far, thanks to strong hospitals and thorough public support for charity care and public hospitals, the Massachusetts safety net is in very good shape despite the new competitive pressures.

The Insurance Market and Managed Care

Blue Cross/Blue Shield

The biggest story in the insurance market has been the decline of Blue Cross/Blue Shield of Massachusetts (BCBSM) in the face of competition from HMOs. Traditionally the state’s main indemnity insurer, BCBSM served as the insur-
er of last resort and subsidized individual and small-group coverage. By law, it had to contract with all providers.

Even before deregulation, BCBSM was losing ground to HMOs, which were exempt from the hospital rate-setting system. After deregulation, it acquired a bankrupt independent practice association (IPA) that quickly lost enrollment and suffered severe adverse selection in its Medigap product, that is, attracted disproportionate high-risk enrollees. When the state enacted insurance reforms in 1996, the statutory requirement to provide open enrollment for individuals was lifted, but the plan still faced the selection problems. BCBSM suffered losses in 1996, and even though profits returned in 1997, the margin was small (Pham 3/4/97, 2/10/98).

BCBSM has sought to reorganize and focus on profitable business. It ended its contract to administer Medicare in New England and exited the state Medicaid program to halt continuing losses (AHL 1/21/97). Its proposal to move its Medex business and other indemnity plans into a separate insurer was rejected by the state (Pham 6/9/98). Rumors have circulated that BCBSM is in talks with a for-profit management firm (AHL 2/10/98). Despite all its problems, however, the plan has improved its fiscal status and is no longer subject to Insurance Department solvency oversight. For now, it has most of what indemnity coverage remains in the state (AHL 6/12/98).

**HMOs**

HMOs remained small players in Massachusetts until rapid growth during the 1980s. Helped considerably by their exemption from state-set hospital rates, they grew to cover nearly one-third of the population by the early 1990s. Today, more

### Summary Statistics Massachusetts and U.S. Total

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<th>Percent HPSA Counties (whole or part), 1995</th>
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**Sources:** See tables 1 and 2.
than 60 percent of the state’s population is enrolled in HMOs, according to the state HMO association. Until recently, HMO competition was mainly based on quality: The large Harvard and Tufts plans were started by well-respected medical schools, and Massachusetts HMOs still top the comparative lists (USNWR 1996a). Observers noted that HMOs have not cut costs aggressively—seldom capitating providers, for example—but as payers have demanded lower premiums, expectations appear to be changing.

Consolidation among HMOs has reduced their number from 21 to 14. Most notably, New England’s largest nonprofit managed care plan, Harvard-Pilgrim Health Care, was created in 1995 by the merger of Harvard Community Health Plan and Pilgrim Health Care, themselves products of prior mergers. Harvard-Pilgrim serves more than a million members in Massachusetts, Rhode Island, New Hampshire, and Maine. The Tufts plan has surpassed BCBSM’s HMO Blue to become the state’s second-largest HMO. Observers suggest that Tufts is most active in motivating providers to manage care, through fiscal incentives and otherwise, but Harvard-Pilgrim is known for its bold decision not to renew contracts with the prestigious New England Medical Center.

Many observers commented on the lack of entry in the managed care market, particularly noteworthy in light of the state’s high costs. Most think that existing HMOs are simply too well established for new entrants to gain a foothold. Moreover, Massachusetts HMOs reported lean profits for 1997 after several years of relatively flat premiums (AHL 3/3/98). Low profits tend to discourage entry, unless a failure makes room for new competitors. Thus most interviewees expected the current HMO leaders to continue to dominate Massachusetts insurance markets.

**PPOs and Other Coverage**

Interviewees all said that HMOs were the main form of managed care, along with point-of-service (POS) options added to basic HMO coverage. Preferred provider organizations have a low profile in Massachusetts. A big national firm, Private Healthcare Systems (PHCS), offers PPOs, EPOs (exclusive provider organizations), and other management services through insurers and directly to employer, union, and association benefits plans, but its market share is not known. The number of ERISA plans and enrollees is also unknown.

**Provider Markets**

**Hospitals**

Massachusetts has long had an ample supply of high-quality, richly endowed, and expensive hospitals, a mainstay of the state economy. The Boston area boasts four leading medical schools—Harvard, Tufts, Boston University, and the University of Massachusetts; five major tertiary hospitals; and many affiliated teaching hospitals. Boston hospitals rank high in quality ratings (USNWR 1996b) and generate per
capita research funding from the National Institutes of Health that is at least twice what any other state receives.

Starting in the mid-1970s, hospitals faced state rate regulation, which evolved into an all-payer regulatory system in the 1980s. Hospitals made significant capital improvements and expansions in the late 1980s because of easy access to low-interest loans and guaranteed payment rates, even as many other institutions closed or merged and the total number of beds dropped. The state’s hospitals have always been very high priced relative to national norms, despite the considerable HMO penetration. Expenses are high because of high utilization as well; Massachusetts patients receive more inpatient care per 1,000 people than their neighbors in Connecticut or Maine and much more than people on the west coast.

Since deregulation, however, hospitals’ operating budgets have come under great fiscal pressure. In Worcester, for example, indemnity payments fell from roughly 25 percent of hospital revenues to about 5 percent in only a few years. Today, almost all payers demand and receive discounts relative to the old regulated rates. Medicaid has become a relatively good payer because of the drop in private rates. Most hospitals expect even greater pressure in the future, and this expectation is driving substantial change in institutional structures.

The hospital market has downsized, but not as fast as hospital utilization has declined. Average occupancy rates are still falling. Between 1986 and 1995, some 35 Massachusetts hospitals closed. Sixteen were converted to other health care uses; another 16 were involved in mergers. Worcester, where the Fallon Community Health Plan HMO dominates insurance, provides the most extreme example. The city went from having 14 independent hospitals in the 1980s to only 2 systems by February 1997.

Probably the most important mergers, however, occurred in Boston, where Massachusetts General Hospital and Brigham and Women’s Hospital formed a strategic alliance. This alliance led to the creation in 1994 of Partners Healthcare System, a holding company for the two institutions, which subsequently added North Shore Health Systems, the Dana-Farber Cancer Institute, Newton-Wellesley Hospital, and others.

In reaction, the other tertiary institutions in Boston sought their own partners. Beth Israel and Deaconess Hospitals joined in July 1997 and formed CareGroup, an integrated system including themselves, the Pathway network, and Mt. Auburn Hospital (in Cambridge). The last tertiary giant, Tufts New England Medical Center (NEMC), remained the odd hospital out. Courted by Columbia/HCA through 1996, it held discussions with many institutions before it merged into the nonprofit Lifespan system from Providence. That merger was restructured to avoid the application of Rhode Island’s new nonprofit conversion statute, and it allowed NEMC to be added to Lifespan’s contract with Harvard-Pilgrim (AHL 10/20/97).

The two hospital leaders, Partners and CareGroup, have both continued to expand, even outside the state. Expansions involve hospital acquisitions, new relationships with doctors, and setting up clinics (Rodriguez 2/15/98). In an unusual move, the two competitors have agreed not to acquire facilities in Cambridge,
located between them, as both collaborate with the Cambridge public hospital in clinical and public health efforts (Knox 8/3/97).

Much change in the hospital market so far seems to be “positioning” for the future. Teaching hospitals’ main motivation is to create a high-quality network that is an indispensable tertiary component of any health plan. For now, Partners and CareGroup seem to be essential providers for HMOs and insurers. NEMC can be omitted, at least by the HMO market leader, Harvard-Pilgrim. A longer-term objective for hospitals is to create attractive integrated systems to compete for larger shares of capitated dollars, either from HMOs or directly from employment groups. Some observers suggested that CareGroup is ahead of the older Partners plan in consolidating services and administration across its two sites.

**Physicians**

Boston is a leading educator of physicians, and many stay in Massachusetts. The state has a high physician-to-population ratio and a large supply of specialists. Membership in physician groups is growing, and hospital-based physician practice plans or IPAs are common. Salaried practice is not uncommon. Almost all doctors participate in HMO networks.

Many physician practices have been bought by hospitals, especially by Partners and Deaconess Hospital’s Pathway Health Network. Medical Society sources say the most recent trend is for hospitals and others to contract with doctors rather than acquiring their practices (AHL 9/24/97). Even the Harvard Community Health Plan (HCHP), a staff-model HMO, is moving from salaried employment to contractual arrangements (AHL 8/5/97).

A number of physician clinics and practice groups are forming integrated networks as well. Perhaps the best known is the Lahey Hitchcock Clinic, a nonprofit, multispecialty group practice of more than 900 salaried physicians at 60 sites, formed in 1995 (LHC 1997). Other Boston-area physician networks include Allied Community Health System and Primary Care (Morrissey 1996). How well these consolidations perform in the marketplace remains to be seen.

**The Role of Large Buyers**

Until the early 1990s, Massachusetts lacked activism among large private employers. This situation may relate to employers’ political focus on the planned employer coverage mandate in the 1980s. Also, the state has relatively few large purchasers but more medium-sized employers. Notably, some of the largest employers are hospitals and insurers, with an interest in health care other than as purchasers. A 1980s coalition focused on universal coverage and rate-setting issues but disappeared with these issues. In the 1990s, a new employer coalition has arisen called the Massachusetts Healthcare Purchaser Group, which includes the state’s Group Insurance Commission and the Medicaid program, along with 60 large private employers. Members of the group negotiated a 2 percent average rate increase in 1998, while the overall average premium increase was 4.9 percent (BNA 5/18/98a).
Such large buyers may play an important role in shaping future markets for care and coverage.

State Regulation of Health Care Markets

Managed Care Regulation

Managed care is somewhat regulated in Massachusetts. The Insurance Department oversees HMO finances and applies some PPO rules to plans sold by insurers. The AG created additional, voluntary HMO standards in early 1996, mainly disclosure by HMOs of their community benefits. The state has enacted some coverage mandates (e.g., length of maternity stays) and any-willing-provider (AWP) legislation limited to pharmacies. The AWP law was not effectively enforced, according to interviewees. Harvard-Pilgrim just implemented its response in 1998 (BNA 3/30/98). Broader regulation of managed care has been proposed but tends not to be supported by the administration. Instead, most state efforts to increase coverage, control spending, and promote managed care occur through public coverage or state purchasing rather than through insurance regulation. The biggest continuing issues are whether to expand coverage and whether to impose consumer protection legislation.

Under consideration in April 1998 were bills to limit HMO spending on administration, advertising, and profits and a comprehensive consumer protection bill. The consumer protection bill would set standards for emergency care, direct access to specialists, disclosure of provider lists, and payment methods, and would establish internal and external consumer grievance procedures. It also would create an office to regulate managed care plans and publish quality data (IHPP 4/13/98, AHL 4/2/98b).

Antitrust Policy

All closures and mergers require state regulatory approval, but as yet there has been little occasion to intervene. Great excess hospital capacity and consumer choice still exist in hospital markets. The AG did set conditions on the 1995 HCHP-Pilgrim merger. The plans agreed to freeze nongroup and small-group rates for a year and limit other raises to 2 percent; to provide $4 million in public benefits (e.g., violence prevention programs); and to enroll 40,000 new elderly subscribers over three years. More recently, Harvard-Pilgrim was investigated for excluding NEMC from its contracts; the plan was cleared of wrongdoing and reached agreement with NEMC after the investigation closed (Blanton 9/9/97, AHL 11/4/97).

Conversion Policy

Traditionally, the state has had only nonprofit hospitals, evidently more by custom than by rule. Rate setting and CON did discourage national chains, without explicitly barring entry. The first for-profit entry into the state occurred in 1995, when Columbia/HCA bought MetroWest Medical Center in Natick and
Framingham (central Massachusetts). A second for-profit entered in 1996 when OrNda acquired St. Vincent’s Hospital in Worcester (since transferred to Tenet). Now Columbia is pulling out of the state as it restructures itself in the wake of its federal legal problems and has sold its holdings to Tenet (AHL 6/23/98).

Legislative leaders and the AG say they do not oppose for-profit enterprises, although many health care professionals in Massachusetts do (M&H 12/8/97). State officials do think that any new for-profits should act much like nonprofits. The AG’s voluntary guidelines on community benefits, for example, apply regardless of profit status. The AG’s office took some criticism for approving the two for-profit acquisitions, however, and even rumors of for-profit entry draw significant press coverage and provoke political reaction.

In January 1997, an emergency bill was filed to place a moratorium on for-profit conversions until a bill regulating such conversion could be considered, but the moratorium was ultimately rejected (AHL 8/27/97). The issue seems to have a lower profile after the decline of Columbia/HCA’s fortunes, but Massachusetts remains hostile territory to for-profit conversion.

The Charity Pool

Massachusetts is unusual in its support of charitable hospital care. It runs a statewide pool begun under rate setting that is now funded by assessments on hospitals and, beginning in 1998, on all private payers (including individuals and third-party administrators paying on behalf of self-insured plans). BCBSM sought to offset its assessment by lowering hospital rates by the same amount, but it retreated in the face of political pressure and the threat of legal action (AHL 12/22/97). The pool has been built into the Medicaid program as a uniform hospital tax that supports federal DSH matching.

Federal Medicaid funds under a Section 1115 waiver have also been used to pay for services at the two biggest safety net hospitals, Boston Medical Center and the Cambridge Hospital (Bovbjerg, Evans, and Holahan 1998). Under that waiver, the two hospitals are to experiment with prepayment for charity care.

Access, Cost, and Quality for the Low-Income

Massachusetts has lower-than-average uninsurance, precipitated by high rates of employer-sponsored coverage (Liska et al. 1998). Where there is broad coverage, the potential negative effects of market change on the poor may be diminished.

Until recently, both insurance and hospital competition seem to have been almost genteel. Buyers seem to have wanted cost control, but they did not seek to promote cutthroat price competition or premium cuts. Emphasis was on quality and utilization control more than on price. If only because prices are so high, new entry seems plausible, particularly from out of state. More vigorous competition might result from entry or from more assertive self-insured buyers or health plans. If price competition accelerates, services and insurance might become more affordable for the poor.
Through Medicaid, the charity pool, and other programs, the state has created a market for providing care to the poor. Hospitals, HMOs, and clinics all actively seek to participate and appear to welcome indigent patients. All interviewees, within and outside government, agree that indigent access to hospital care in Massachusetts is quite good.

However, especially in Boston, major hospitals are restructuring to cope with expected increases in competitive pressure and to compete for capitated payments. Which hospitals survive, where, and in what networks will affect the accessibility of charity care. The leading tertiary hospitals, which now supply a lot of charity care, currently have an irresistible “brand” that compels health plans to include them in networks, but if brand loyalty diminishes, their ability to provide uncompensated care could suffer. One hospital executive said that the premium commanded by prestige would surely decline over time. Under any scenario, internal cross-subsidy seems unlikely to remain a viable source of support for the safety net population.
Minnesota: Market Reliance, with Checks and Balances

The health care market in Minnesota is characterized by high insurance coverage, high HMO penetration, and very high market concentration among both health plans and providers. Despite the concentration, activist buyers, including the state, have successfully encouraged price competition among health plans and limited past premium growth. Premiums are again on the rise, however, and there is considerable disagreement about whether market concentration and HMO penetration have positive or negative effects on Minnesota’s health care markets.

For more than a decade, the state’s market strategy has balanced competition and regulation, with varied focus over time. It enacted, then retreated from, comprehensive health reform that some would call market engineering; it has both a moratorium on some mergers to protect competition and an antitrust immunity process to allow other suspect mergers; and it balances the power of the highly consolidated health plans by encouraging pooled purchasing among buyers. The state also relies on HMOs to meet public health and coverage goals, but it closely regulates HMO quality and requires nonprofit status.

The state also influences the health care market as a purchaser. In the 1980s, it stimulated HMO growth and insurance price competition by starting a Medicaid managed care program and encouraging state employees to enroll in the lowest-cost health plan. Recently, expansions of managed care for public programs have introduced HMOs to many new service areas. The state also joined the largest and most influential business purchasing coalition in Minnesota.
Managed care is strong in Minnesota, with 31.5 percent of the total population in HMOs in 1996. In 1993, the state estimated that 25 percent of the privately insured market was in HMOs and 38 percent was in PPOs (Minnesota Market Report 1995). Managed care penetration remained roughly constant in the early 1990s, according to Minnesota Department of Health (MDH) officials, but now appears to be growing again.

Rural areas of Minnesota are very different from the Twin Cities. While 43 percent of the Twin Cities population was in HMOs in 1995, in other regions penetration was as low as 3.4 percent and no higher than 14 percent (Baumgarten 1996). Blue Cross/Blue Shield of Minnesota (BCBSM) dominates rural areas, with 64.7 percent of the market outside the Twin Cities, whereas Allina Health Systems and HealthPartners dominate the seven-county Minneapolis–St. Paul area (Baumgarten 1996).

Market concentration among managed care plans is high. In 1993, Allina, BCBSM, and HealthPartners accounted for more than 90 percent of the HMO enrollment statewide, according to state estimates (Minnesota Market Report 1995). The three plans also accounted for 72 percent of all fully insured premium revenue collected that year (Minnesota Market Report 1995). A 1995 estimate suggests that these three plans had roughly 80 percent of the statewide managed care population (including PPO plans) (Baumgarten 1996). Although the late 1980s and early 1990s saw rapid consolidation among already large HMOs, merger activity among
health plans fell, perhaps in part because of the state moratorium on mergers among the three largest plans.

Despite the domination of the market by a small number of plans, large buyers were successful for several years in obtaining some level of price control and product innovation from health plans. HMO commercial premiums decreased by 0.6 percent in 1995 (Baumgarten 1996), compared with increases of 4.2, 5.8, 7.5, and 14.5 percent in the four prior years (Minnesota Market Report 1995). Small groups also saw moderation in premium growth. For example, BCBSM small-group premiums stayed level between 1993 and 1995 and decreased in 1995. Allina also lowered its small-group premiums an average of 10 percent in July 1994 (Minnesota Market Report 1995).

Low premiums have begun to take a toll on the financial health of many HMOs, however, and now premiums are rising again. The Minnesota Council of Health Plans reported that seven of the state’s nine HMOs (which are required by law to be nonprofit) lost money in 1997, the worst industry performance in 10 years. Losses were $54 million on premium revenue of $3.81 billion, despite enrollment increases of 12.5 percent in 1996 and 5.9 percent in 1997. The Council blamed an aging population, rising medical use (of expensive drugs and technologies and physician visits), and state-mandated benefits. HMO medical expenses rose 11.2 percent in 1997, compared with average premium revenue increases of 9.8 percent. Health plans expect to make money in 1998, so buyers hope premium growth will decelerate in 1999 (AHL 4/2/98a).

Even as plans increase premiums, however, they are struggling to revive the lost luster of their public image. Only 65 to 79 percent of enrollees in the State Employees Insurance Plan (SEIP) were satisfied or very satisfied with their health plan in 1997 (AHL 10/15/97), a decline from past years. In response, the Minnesota Council of Health Plans launched an effort to better educate consumers about how managed care works (AHL 11/7/97).

As for Medicaid managed care, the Prepaid Medical Assistance Program (PMAP) is in the process of moving enrollees outside the Twin Cities into HMO plans. MinnesotaCare, the state’s subsidized insurance program for low-income people not eligible for Medicaid, completed its transition to managed care in 1996. Thus, commercial managed care may also expand into rural areas where it has not existed before. This expansion could increase insurer competition in those areas, which may benefit private purchasers of insurance.

While the public populations are not an obvious driver of competition among the plans, one source reported that PMAP accounted for “half the surpluses earned by HMOs” in 1995. The state was said to have cut payment rates because of these surpluses, however (Baumgarten 1996). Furthermore, some plans suffered substantial 1997 losses because of low capitation rates for prepaid MinnesotaCare. There are no concerns that plans will exit public markets, however, because they are required to serve public programs as a condition of licensure.
Provider Markets

In both the hospital and physician markets across the state, independent providers have largely disappeared, particularly among hospitals in the Twin Cities.

Hospitals

Hospital consolidations and closures began in the 1980s in response to the increasing bargaining power of HMOs (Christianson et al. 1995). In the Twin Cities, the hospital market consolidated into three large systems—HealthSpan (owned by Allina), HealthEast, and Fairview—which account for 64.5 percent of inpatient days (Baumgarten 1996). Statewide, hospital systems own 58 percent of staffed beds in urban areas and 17 percent of staffed beds in nonurban areas. Outside the urban areas, most counties have only one hospital.

Mergers among hospitals continued through the time of our site visit in July 1996, when the University of Minnesota Hospital (UMH) was merging with Fairview Health Systems. The AG’s office reported that UMH has experienced a trend of declining admissions over recent years. Several interviewees noted that managed care plans do not use UMH because its prices are too high. The state did not oppose the merger. One source estimated that Fairview-University will account for 28 percent of hospital admissions in the Twin Cities (Scott 1996).

Physicians

Physicians are also highly consolidated in Minnesota compared with other regions of the country. In 1993, 95 percent of Minnesota physicians were in group practice, a 37 percent increase over 1979 (Minnesota Market Report 1995). Some practices are being bought by HMOs and hospitals, and some are merging with other practices. A state survey showed that 94 percent of physician practices were owned by corporations, 5 percent by partnerships, and only 1 percent by a single physician. “Clinics without walls,” affiliations among practices that do not involve a merger of assets, are also on the rise. The state listed six such organizations in 1995 (Minnesota Market Report 1995).

Minnesota has a high ratio of general physicians per capita and an average ratio of specialists. Provider supply is good in most parts of Minnesota, although there are a few shortage pockets. The state has asked the University of Minnesota Medical School to increase its ratio of primary-care-to-specialist graduates by 20 percent over eight years.

The Role of Large Buyers

Large buyers wield considerable power in the state. The two most influential large purchasers have been the State Employees Insurance Program and the Buyers’ Health Care Action Group (BHCAG). In the early 1990s, SEIP and BHCAG won slower growth in premiums and product innovation from health plans. The two
joined in 1997 and began to contract directly with provider “care systems,” potentially a first step in eliminating the health plan middleman.

The state employees’ benefits program, SEIP, began to influence the market in the 1980s through a change in its purchasing practices. After enduring an average premium increase of 42 percent in 1989, SEIP moved to a strategy of funding the entire premium cost for only the lowest-cost plan offered to employees. As employees moved to the low-cost plan, plan incentives were to lower prices in order to gain enrollees. In 1990, the rate of growth in premiums took a huge drop to 13.7 percent. The growth rate continued to decline steadily, and by 1995 SEIP saw average premiums actually decrease by 1.7 percent.

According to officials at the Department of Employee Relations (DOER), SEIP is now exploring ways to include the state public assistance populations in a group purchasing arrangement. Combining the 150,000 employees covered by DOER programs, the 600,000 covered through Department of Human Services programs (Medicaid, General Assistance Medical Care, and MinnesotaCare), and perhaps as many as 200,000 covered under BHCAG, the proposed alliance would represent about a quarter of the market in the state, according to a DOER official.

BHCAG issued its first request for bids in 1992 and began offering health plans in 1993. It represents 400,000 employees, retirees, and dependents from 24 self-insured employers. This purchasing group shaped the health care market by issuing a request for proposals (RFP) that led to the development of one of the largest health plans in the market, HealthPartners, to meet the RFP’s geographic requirements. The BHCAG RFP included the development of practice parameters and outcomes measurement, in addition to fueling price competition among the plans.

Now BHCAG is again leading marketplace change by entering into direct contracts with provider networks. Care systems bid on a total claims target and are arranged into a three-tiered system by relative cost (Baumgarten 1996). Employee premium contributions vary according to the tier of the care system chosen. Actual claims for care are compared periodically with the claims target, and the care system’s fees are adjusted upward or downward to meet the target (Baumgarten 1996; Buyers 1995).

BHCAG hoped to encourage enrollees to choose less expensive providers themselves. It appears to have been successful: Low-cost care systems experienced 15 to 57 percent growth in enrollment after cost and quality reports were provided to enrollees. The care systems won high approval ratings from the majority of BHCAG enrollees (AHL 10/15/97).

Other purchasing groups active in the state are the Minnesota Employees Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP), which are state-run purchasing groups for small businesses and for municipal and school district employers, respectively. Another private purchasing group is the Employers’ Association Buyers Coalition (EABC), a Minneapolis–St. Paul consortium of firms with anywhere from 2 to 340 workers (50 on average). The state estimated that more than 253,000 people were covered by these five smaller purchasing groups in 1993 (Minnesota Market Report 1995). MinnesotaCare law also permits private purchasing pools to form among groups linked by location, occupation, or
other common characteristics. As of July 1996, however, no pools had formed under this provision.

State Regulation of Health Care Markets

Managed Care Regulation

Minnesota has been a leader in HMO quality assurance, and the state contributed to the development of the National Committee for Quality Assurance standards. The Minnesota Department of Health, which regulates HMOs for commercial and public assistance populations, has been accused of micromanaging. MDH requires focused studies of specific conditions and reviews basic operational and process issues, utilization review, and provider contracts (to establish the incentives used). It also makes site visits to HMO clinics.

In addition to these quality functions, MDH conducts annual financial audits and biannual market conduct studies. Finally, MDH investigates some 650 complaints against HMOs each year. The state can impose financial penalties of up to $25,000 per violation; each year, about 10 of the state’s 13 plans are required to pay penalties. Despite the penalties, MDH concludes that there is little evidence of poor performance. The focused studies suggest that there is only small variation across HMOs, according to respondents, and little value in trying to distinguish among them on a quality basis.

Minnesota is one of only two states that have forbidden networks to require providers to sign exclusive contracts as a condition of participation in the network (Massachusetts is the other). The law also applies within the same company, so that Allina hospitals cannot be forced to serve Allina enrollees exclusively. Providers may choose to participate in only one plan, however.

In 1993, Minnesota passed a law requiring health plans to include any willing nonphysician provider (e.g., chiropractors and nurse practitioners) in an “expanded network” to be offered to all enrollees. Plans have the option of opening all existing products to any willing nonphysician provider or creating a separate option available for an additional premium. Referrals to these providers are governed by the same rules that apply to in-plan use. The law was proposed by alternative providers who feared being left out of managed care plans.

In response to consumer backlash against HMOs, a coalition of state regulatory agencies, health plans, indemnity insurers, consumer advocates, business groups, and health care professionals introduced a 1998 bill to create a state Office of Health Care Consumer Advocacy and Information to answer questions and help resolve problems for Minnesota consumers. The measure was enacted in the 1998 session. Platforms for some of the 1998 candidates for AG endorse increased funding for the office or moving it into the AG’s office (AHL 8/25/98).
Insurers, PPOs, and Provider Networks

BCBSM and commercial carriers are regulated by the Department of Commerce. It regulates “market conduct”—how claims are processed and how coverage mandates are adhered to—and requires insurers to justify rate increases. It also ensures that medical necessity rules are applied appropriately. Commerce oversees this market primarily in response to complaints (as opposed to the preemptive audits that MDH uses). PPOs are not directly regulated, but they are indirectly regulated through the insurers that hire their networks. Commerce also monitors the adequacy of provider access in insurers’ service areas.

The BHCAG strategy of contracting directly with selected providers has raised issues about regulation of provider networks. Minnesota providers are not permitted to bear risk (i.e., accept capitation from self-insured plans) without licensure as an HMO. Within most HMOs in the state, providers are paid on a fee-for-service basis rather than under capitation.

Antitrust Policy

Mergers and consolidations are assessed for antitrust violations by the AG but proceed unchallenged unless the AG feels the merger poses an anticompetitive threat. The threat ultimately may be judged permissible depending on the defenses for the action. MDH officials reported some criticism of the AG for not being active enough in pursuit of antitrust violations.

Minnesota also has an antitrust immunity option that is extended with the approval of the Commissioner of Health. Immunity requires that the state regulate and monitor the activities of the merged entity as the price of being allowed to merge despite detrimental competitive effects. The immunity process was enacted by the legislature in 1992 in response to a disagreement between the state and federal attorneys general regarding the 1992 LifeSpan/HealthOne hospital systems merger, which created HealthSpan, one of the three largest hospital systems in the Twin Cities. This was the only time the state’s antitrust immunity process has been used, however, probably because the state monitoring requirements are considered too burdensome.

Out of concern over the degree of consolidation in the health plan market, the AG sought a moratorium on mergers among the three largest health plans in the state, HealthPartners, Allina, and BCBSM. The moratorium expired in July 1996.

Conversion Policy

HMOs in Minnesota are required by law to be nonprofit enterprises. In addition, very few hospitals in the state are for-profits, although there is no law prohibiting them. MDH officials attribute the absence of serious quality problems in the state in part to the nonprofit status of the HMO and hospital industries, and they are not concerned that the nonprofit HMO requirement keeps companies like Humana out of the state. Although some legislators feel that repealing the nonprofit requirement could infuse additional competition into the plan market, little has come of the idea. State officials felt there was no interest in conversion among health plans or hospi-
tals; state hospital association representatives supported this view, explaining that for-profit hospitals often fail in Minnesota because of the value placed on nonprofit health care in the state. More recently, however, one source reported that for-profit chains have considered buying some rural Minnesota hospitals (BNA 4/20/98).

In the 1998 session, the legislature passed a bill to require review of nonprofit hospital conversions by the attorney general. Governor Arne Carlson vetoed the legislation (S.F. 695), stating that it would lock for-profit companies out of the hospital market and diminish the authority of community hospital boards. The bill would have given the AG broad leeway in deciding how to review hospital sales to for-profit companies. Legislators will likely reintroduce the bill next year under a new governor (the current AG is a political rival of Carlson’s).

Access, Cost, and Quality for the Low-Income

Minnesota enjoys high insurance coverage compared with the national average because of generous public programs and high rates of employer-sponsored coverage, especially for dependents of employees. Only 9.2 percent of the population was uninsured in 1994–95, compared with 15.5 percent nationally. Higher coverage rates generally diffuse some of the potentially negative effects competitive pressures may have on low-income populations.

Thus far, there is no indication that mergers, consolidation, or managed care have decreased the provision of uncompensated care in hospitals or increased the uninsurance rate in Minnesota. Nevertheless, some experts are concerned that the level of consolidation in Minnesota markets will ultimately lead to price-fixing by hospitals and health plans. In addition, Commerce officials asserted that managed care has squeezed hospital and physician margins as the principal means of controlling costs thus far, and “the next squeeze” will likely affect quality and charity care. Cuts in the state’s generous Medicaid rates under managed care could also affect charity care levels and the stability of safety net providers. For example, cost-based reimbursement for Federally Qualified Health Centers is being phased out under the Medicaid managed care demonstration waiver.

Access to private insurance may also decline in Minnesota for some low-income individuals. Through 1996, market competition was strong and premium rate increases slowed, potentially expanding the availability of health insurance. By 1998, however, there were signs that premiums are again on the rise.

Some in the state criticize its reliance on managed care, and there is evidence of a consumer backlash against HMOs. A few state advocacy organizations maintain that managed care has removed adequate choice for Minnesotans. One group argues further that managed care rations services to the elderly and disabled and could thereby threaten their lives. Minnesota county governments and a coalition of health care advocacy groups successfully delayed the expansion of the state’s Medicaid managed care demonstration and pilot programs for managed care for the disabled in the 1996 legislative session. This recent opposition to managed care could limit the savings the state might obtain through reliance on HMOs.
Conclusion: Market Change, State Policy, and Access for the Poor to Health Coverage and Care

States are generally supportive of allowing markets to allocate resources through price competition. State policymakers and others we interviewed credit managed care with reducing inflation in health prices, to the benefit of all purchasers, particularly the Medicaid programs that claim such large shares of state budgets. Almost all states have therefore abandoned broad economic regulation—most recently New York, which ended hospital rate-setting as of 1997. The market has appeared to make reductions in hospital bed capacity, for example, that state health planners had previously sought in vain to achieve.

In their role as general overseers of health markets, however, policymakers are more ambivalent. From an antitrust perspective, some policymakers are concerned about concentration of market power in very large health plans or provider delivery systems. Mergers and acquisitions have reduced the number of competitors in many markets, but typically not enough to warrant intervention, according to our interviewees. Minnesota did take strong action, putting a moratorium on mergers while creating a new review process for further approvals. Moreover, many states have moved toward greater protections for individual providers and consumers; Texas has been particularly active. Finally, states differ substantially in their policies on for-profit health plans and hospitals; some have very few of either (Massachusetts, Minnesota), others have many (Florida, Texas).

Did the poor benefit from market change along with states and other big buyers of coverage? We conclude, first, that price competition seems to have offered buyers of coverage better value for money, thus probably increasing public and perhaps also private insurance coverage relative to what it would have been without market change, to the likely benefit of the poor. Second, effects on access and quality under public plans or charity care appear mixed and uncertain. Third, hospitals’ ability to cross-subsidize charity care is threatened by new competition, thus potentially cut-
HEALTH CARE MARKET COMPETITION IN SIX STATES: IMPLICATIONS FOR THE POOR

Increased access to care among the poor, though most states report no major impacts as yet. An emerging issue is whether and how to craft a competition-era safety net for the substantial share of poor Americans who lack coverage. Because this paper examines states and their policies, its conclusions summarize state views of problems and opportunities created by market change, and concrete actions taken in response.

Increased Insurance Coverage from Decreased Prices

Market developments have probably increased coverage for the poor, compared with what it would otherwise have been, most notably for public beneficiaries. Many states in the 1990s are explicitly increasing coverage through Medicaid and other programs, although the decline in the welfare rolls has also reduced Medicaid eligibility. Expansions include MinnesotaCare, BadgerCare (Wisconsin), and MassCare (Massachusetts). Very recently, almost all states have begun major expansions for children, through Medicaid and other coverages, encouraged by the new State Children’s Health Insurance Program enacted under the federal Balanced Budget Act of 1997 (Bruen and Ullman 1998). Such extensive efforts were seldom seen under traditional fee-for-service Medicaid. States are also turning rapidly to Medicaid managed care to achieve budgetary economies they might otherwise have sought by reducing eligibility. Private market growth of managed care has facilitated its use by states, and federal strictures have also been eased. Most states’ managed care programs rely on commercial HMOs or other health plans in addition to their Medicaid-only plans.

Large public program expansions seem able to greatly increase a state’s coverage. The most striking example may be Minnesota, which has reduced its uninsurance rate through Medicaid expansions and MinnesotaCare, a public insurance program for the working poor. Another is Tennessee, which greatly expanded public coverage through its TennCare program.

Increases in private coverage are harder to document, but market-driven price cuts can hardly have hurt, especially for low-income workers. Many factors influence private coverage other than increased price competition, however—California can thus be a leader in both market evolution and rates of uninsurance (table 2), and Houston, a hotbed of competition, can have the highest uninsurance rate of any metropolitan area (Employee Benefit Research Institute data in AHL 7/8/98). Nationwide, private coverage has been falling for some years (EBRI 1997) despite competitive success in controlling price inflation.

States are not trusting private markets alone to improve access to coverage: Most states have regulated enrollment and rating for small-group and individual insurers (Blumberg and Nichols 1995), and half have for some time run high-risk pools (Bovbjerg 1991). Some states have created purchasing pools to get good rates for small groups (as in Florida), and a few states have subsidized private purchase (as proposed in Massachusetts). State interviewees were typically pleased with these reforms, though they could cite little evidence of increases in coverage. Other research suggests that guaranteeing issue and renewal has beneficial effects for small groups, but rating restrictions do not (Marsteller et al. 1998).
Access and Quality under Price Competition

The picture on access and quality appears mixed and is certainly incomplete. New provider networks under managed care may get new providers to serve the poor, especially where traditional Medicaid physician participation was low and the concentration of Medicaid hospital care was high. Some state officials urge this rationale for reform. The trade-off may be reduced access to traditional safety net providers.

Whether the old or the new providers better serve the poor has no a priori answer, and evidence on plan performance is only beginning to accumulate. The case for improved service appears strongest where public programs rely on private plans serving substantial numbers of paying patients as well and enforce multiple choice of plans for enrollees. A positive portent is that states often survey enrollees about their satisfaction; other useful information for state oversight can come from complaint or grievance procedures being implemented. A negative one is the strong complaints heard about inadequate payment, for instance under MinnesotaCare and New York Medicaid; there are some signs that commercial HMOs are withdrawing from Medicaid managed care, increasing reliance on Medicaid-only plans (AHL 4/7/98, Hurley 1998).

At the provider level, interviewees spoke mainly about the fiscal response to price pressures from buyers, less about qualitative changes. In state after state, hospital sources described wrenching changes in hospital practice: Under price competition, hospitals must either increase revenues—by improving collections, joining alliances, buying or wooing referral physicians, and in other ways—or they must reduce costs, with economics ranging from cutting layers of management, to cross-training nurses, to bulk purchasing. Community health centers made similar points.

Alliances and market consolidation may improve efficiency and even quality where they achieve economies of scale, eliminate duplication of services or facilities, and improve services by specialization or investment in new quality systems. Hospital mergers can lead to closure or redecoration of a weaker facility to a different purpose (for example, in Florida and New York). In Florida, however, despite substantial consolidation, during 1990–95 there was a net reduction statewide of only 213 acute care beds, though the average occupancy rate was only 51 percent.

Competition sometimes encourages hospitals to improve their attractiveness to poor patients and referring physicians, at least where poor patients come with funding, from Medicaid or other sources. Hospital executives speak of such effects. One Boston hospital executive noted that poor people, like other patients, had no problem driving right by a hospital to go across town. Another Massachusetts public hospital executive was proud of attracting low-income patients from halfway across the state by virtue of the hospital’s culturally sensitive settings for care. Massachusetts, of course, provides funding not only from Medicaid but also from a charity care pool, essentially creating a market for charity patients. Elsewhere hospitals are wooing fee-for-service Medicaid patients with amenities, as state payment rates seem more generous now that private payments have fallen (Harden 1998).
Declines in Access to Charity Care

Competition, cuts in public subsidies, and growth in the for-profit sector are widely expected to reduce hospitals’ traditional mission and ability to cross-subsidize care for patients who lack insurance coverage or personal resources. Markets generally serve buyers, not charity cases, except to the extent that public regulation or social or professional norms require charity or outside subsidies are made available. There is no legal duty to serve all patients, although federal law requires hospitals to examine patients and at least stabilize their condition for transfer (Bovbjerg and Kopit 1986). Nonprofits are required to provide charity, but enforcement is unusual. All hospitals provide some charity, and the evidence on the effect of for-profit status is controversial. Conversions to for-profit status have drawn much attention, mainly to preserve accumulated assets rather than to ensure ongoing provision of charity (Marsteller et al. forthcoming).

In most of the 13 focus states, however, qualitative interviews suggested that the safety net continues to function adequately, even according to interviewees outside of government. The study team heard of only a few major safety net hospitals that closed (e.g., in Milwaukee and Newark), though it heard of more that changed ownership status (as in Florida) or that fear the impacts of Medicaid managed care (as in Houston). Texas legislation acted to protect significant traditional providers of Medicaid and charity care by requiring Medicaid managed care plans to seek their participation for at least the first three years. Minnesota has similarly protected essential community providers (mostly clinics).

Many interviewees nonetheless expressed concern over the longer-run effects of the price pressures of managed care, the excess of hospital beds in many areas, and cutbacks in disproportionate share hospital (DSH) and graduate medical education (GME) funding (Norton et al. forthcoming). It is important to track empirically the extent to which the poor retain access to care of different types, either from traditional safety net hospitals or from other sources.

Economic theory suggests that competitive markets reduce sellers’ prices to their cost of producing the service that buyers want, plus normal profit. Profit-maximizing buyers are expected not to subsidize patients outside their own groups. If this happens, charity and below-cost care will suffer over time. Alternatively, real-world buyers might want to include some charity as part of what they buy from hospitals. And state requirements for provision of charity by nonprofit hospitals and medical professional norms might dictate a certain level of charity (Marsteller et al. forthcoming). However, the unaided market has no way to move cross-subsidies from hospitals with low demand for charity to those with high demand, institutions whose location or missions attract a disproportionate share of uncompensated care. In contrast, managed care can move paying patients across hospitals in search of better value, so that high-charity hospitals are severely disadvantaged in price competition.

The interviews for this study suggested one partial exception to this market expectation: Some high-prestige nonprofit teaching hospitals can attract paying patients while commanding a premium price, as described by interviewees especially in Boston and New York City. These higher prices are potentially enough above the
cost of an efficiently produced service to allow these hospitals to continue to earn high net revenues with which to cross-subsidize charity cases—if that is what they choose to do. There is some concern that an increasingly business-oriented climate of hospital management may erode traditional missions to serve the poor. Higher earnings could also be used to maintain prestige, build up endowments, or benefit other stakeholders (whether shareholders, host universities, or others).

Any redistribution across hospitals typically must come from government action, like federal and state funding of Medicare and Medicaid payments for medical education and extra funds for disproportionate share hospitals. However, GME and DSH payments are scheduled to decline. Massachusetts and New York have legislated charity care pools that help reduce the unevenness of the charity care burden across hospitals.

Competitive developments tend to highlight previously hidden cross-subsidies (Nichols 1998). Making the need apparent and providing more assurance of cost-effective provider operations could generate more public support for explicit subsidies. Pools or other methods that provide funds to numerous hospitals while bolstering poor people’s ability to choose a provider may be the most attractive approaches.

For now, the study team has only qualitative information about market effects and has observed chiefly states’ initial policy efforts. The next few years should help answer the main questions raised to date about the effects of competition on access to coverage and care for the poor.
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Notes

1. Among those below the poverty level, 22 percent have private insurance, 49 percent Medicaid; among the near-poor, 56 percent have private coverage, 5 percent Medicaid. Calculated from two-year average of March 1995 and March 1996 Current Population Surveys, nationwide.


5. This section draws heavily from an internal memorandum (Wallin 1996).

6. There is some concern that the data on costs and quality used to create the BCBSAL panel are flawed.

7. This section draws heavily from an internal memorandum (Holahan 1997).

8. This section draws heavily from an internal memorandum (Evans 1996).

9. HMO Association data and Insurance Department data (1996) disagree on the number of HMOs, perhaps partly for definitional reasons, because corporate parents may have one license but operate more than one local plan.

10. According to Texas HMO Association staff, approximately 3.6 million Texans were enrolled in HMOs, including 2.4 million enrollees through self-insured plans. The Insurance Department at the end of 1995 estimated there were about 3.3 million enrollees in the state, of whom almost 60 percent were under Administrative Services Only arrangements.

11. The other survey response options were partnerships, salaried, and teaching/administrative/resident. (Residents were not included in these analyses.)

12. The survey question reads, “What percentage of your current patients are in the following categories?” Possible answers are: uninsured, covered by Medicare, covered by Medicaid, covered by HMOs, covered by PPOs, covered by fee-for-service indemnity plans, covered by workers compensation plans, and included in capitated contracts.

13. This section draws heavily from an internal memorandum (Norton 1998).


15. The Florida table shows the percentage of Medicaid enrollees who are in HMOs (either federally qualified or state-defined), health insuring organizations, prepaid health plans, primary care case management programs, and other forms of managed care.

16. The Dimension system includes Baptist Hospital, Hialeah Hospital, Mercy Hospital, Miami Children’s Hospital, Mount Sinai Medical Center, and North Shore Medical Center.

17. We did not speak with the AG’s office.

18. This section draws heavily from an internal memorandum (Bovbjerg 1997).

19. This section draws heavily from an internal memorandum (Marsteller 1997).

20. The MinnesotaCare Acts of 1992–1995 included global health care spending limits, a subsidized insurance program funded by provider and health plan taxes, phased-in community rating for the small-group market, new comprehensive health plans called integrated service networks, and an all-payer rate-setting system for providers who did not join ISNs.

21. Baumgarten (1996) reports market share for the three largest plans, all other HMOs, and the largest PPOs. These represent 3.4 million enrollees. Note that he includes BCBSM’s indemnity enrollees and its Medicare supplement enrollees. These estimates represent approximately 83 percent of the total insured population of 4,095,000 (based on MDH estimates of total Minnesota population at 4.5 million, 9 percent of whom are uninsured). By this estimation, the three plans have 2,707,000 members, or 66 percent of the total insured population. PPO data were self-reported. PPOs do not consistently count dependents and may also include self-insured plan enrollees, rather than reporting this group separately. For these reasons, these data should be considered estimates (Baumgarten 1994).

22. Health plans continue to put pressure on hospital prices in the Twin Cities area. In a recent altercation between BCBSM and Allina Health Systems over Allina’s hospital prices, BCBSM has threat-
ened to terminate its contracts with Allina hospitals. It says Allina’s prices are 8 to 9 percent over the market average. Blue Cross accounted for 12 percent of Allina’s hospital revenues in 1995.

23. Baumgarten (1996) reports that 26.8 percent of Twin Cities inpatient days in 1995 were provided by Fairview Hospitals and the University of Minnesota combined.

24. Firms in BHCAG are encouraged to offer other plans in addition to the BHCAG plan. About 40 percent of eligibles were enrolled in the BHCAG plan as of November 1994 (Minnesota Market Report 1995).

25. HealthPartners was formed from the union of Group Health (a staff-model HMO) and MedCenters (an IPA), which each felt unable to meet the geographic coverage area BHCAG required. The addition of Ramsey Health Care (a hospital, clinic, and research unit) to HealthPartners prompted the merger of HealthSpan Hospital System with Medica health plan to form Allina.

26. States are quite aware of ERISA limitations on state authority over employee benefit plans, and “patient rights” have become a federal issue as well. By federal executive action, many such provisions are to be applied in Medicaid managed care as well as other federal programs (AHL 11/11/97).


28. A recent survey by a traditional safety net hospital in Chicago, however, found that it enjoys significant loyalty from its safety net patients (Ansell et al. 1998).
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