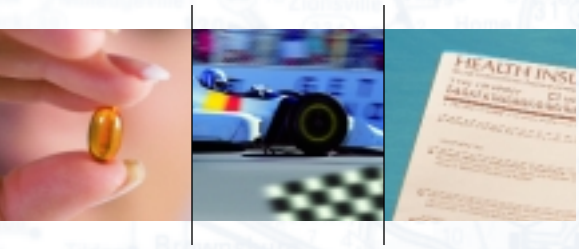

In November 1998, a team of researchers visited Indianapolis, Ind., to study that community's health system, how it is changing and the impact of those changes on consumers. More than 40 leaders in the health care market were interviewed as part of the Community Tracking Study by the Center for Studying Health System Change (HSC) and The Lewin Group. Indianapolis is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first site visit to Indianapolis, in November 1996, provided baseline information against which changes are being tracked. The Indianapolis market encompasses a nine-county region.

Local Providers Fortify Their Position

In 1996, five hospital-based systems dominated the Indianapolis market. These systems, all not-for-profit, owned the market's most successful health plans. In addition, they owned or contracted with most of the area's primary care practices. Managed care enrollment was limited. Employers and state and local policy makers were not active in the health care arena.

With the 1997 merger of two systems, providers in Indianapolis have solidified their position, and the health plans they own continue to be the most successful ones in the market. Among the developing market trends:

- Provider systems are positioning themselves relative to the 1997 merger, so they can compete for managed care contracts with the newly consolidated entity.
- Single-specialty physician groups are consolidating, and the importance of physician-hospital organizations (PHOs) as vehicles for managed care contracting is diminishing.
- Providers are increasingly resistant to assuming risk in managed care contracts.
- Public and private sector decision makers are focusing more attention on managed care plans and their performance.

Indianapolis Demographics

	Indianapolis, Ind.	Metropolitan areas above 200,000 population
Population, 1997 [1]	1,503,468	
Population Change, 1990-1997 [1]	8.5%	6.7%
Median Income [2]	$29,851	$26,646
Persons Living in Poverty [2]	10%	15%
Persons Age 65 or Older [2]	12%	12%
Persons with No Health Insurance [2]	11%	14%

Sources:
1. U.S. Census, 1997
2. Household Survey, Community Tracking Study, 1996-1997

Several hospital-based provider systems have enhanced their already strong market positions during the past two years, in part to increase their bargaining leverage with health plans and stimulate revenue growth.

Provider Systems' Influence Grows Stronger

Several hospital-based systems have enhanced their already strong market positions during the past two years, in part to increase their bargaining leverage with health plans and stimulate revenue growth. Most significant, Methodist Hospital of Indiana and the Indiana University Medical Center (with its affiliate, Riley Hospital for Children) merged in 1997 to create Clarian Health Partners. This new entity has 1,400 acute care beds—23 percent of all acute care beds in the Indianapolis market.

In the three months immediately following the creation of Clarian, the two partners combined many administrative functions. Respondents reported that the post-merger integration of medical groups has proved difficult and will take time to accomplish. In some specialties, the academic culture of the medical school faculty has apparently clashed with the more entrepreneurial culture of Methodist physicians.

The Methodist-University union ignited some controversy. Competing care systems expressed concern about the potential market power of the merged entity, while community advocacy groups raised issues about the possible impact on the poor and uninsured. Publicly owned Wishard Hospital is closely affiliated with the University's medical school faculty and is the major provider of indigent care in Indianapolis. The merger raised questions about the future of this relationship and about the continued viability of Wishard as a service provider for the poor and uninsured. In addition, other observers feared that the merger would result in restricted access to care at Riley Hospital, which was widely viewed as a unique and valuable state resource for the treatment of children.

Since the merger, other provider systems in Indianapolis have launched several strategic initiatives in response to these changing market conditions.

- St. Vincent's Hospitals and Health Services, the major provider system in north Indianapolis, reportedly expanded its subspecialty pediatric services and acquired Lifelines Children's Hospital, a 21-bed acute care hospital providing rehabilitation and outpatient services. St. Vincent's also acquired a residential facility for the developmentally disabled. These actions reportedly were in response to Clarian's decision to increase prices at Riley Hospital and use that hospital's subspecialty services as leverage in negotiating with health plans.

- St. Vincent's also has strengthened its regional ties. The Daughters of Charity, St. Vincent's parent organization, created Central Indiana Health System, a collaborative group of hospitals in Indiana. This network is attempting to grow through mergers or affiliation agreements and to contract with health plans on behalf of its members.

- Community Hospitals and Health Services, which has three facilities in east and south Indianapolis, has extended its service area outside metropolitan Indianapolis by acquiring Community Hospital of Anderson and Madison. In addition, Community Hospitals continues to search for a merger or affiliation partner in the Indianapolis area.

- After a collaborative arrangement with St. Vincent's dissolved, Community Hospitals entered into merger and affiliation discussions with St. Francis Hospitals and Health Centers. St. Francis operates two hospitals in southeast Indianapolis, where the two provider systems have overlapping service areas. If Community Hospitals and St. Francis can reach an agreement, they may convert one acute care facility in this area to other uses. The combined systems would enjoy a strong negotiating

position with health plans seeking to offer inpatient services in south and east Indianapolis.

Physicians Realign

A recent spate of consolidations among specialty practices has strengthened the position of some specialists in bargaining with health plans and provider systems. Although specialists in Indianapolis are realigning much more actively than they were in 1996, it is not possible to detect clear trends at this time or to identify common catalysts for change.

In 1996, the Indianapolis metropolitan statistical area (MSA) had 32 percent more specialists per capita than the national average. Today, small, single-specialty practices remain the norm. Typically, specialists still access patients through direct contracts with managed care plans, under fee schedules that have eroded over time or through subcontracts with PHOs. Fees typically are set as a percentage of Medicare reimbursement; few multispecialty groups are available to accept capitated contracts.

In a merger that has drawn considerable local attention, the market's two largest cardiology groups combined in January 1999. The new organization, Care Group, includes 87 cardiologists, six related subspecialists and 52 primary care physicians. It is the largest cardiology group in the state and, reportedly, one of the largest in the country. Similarly, Community Hospitals' radiology group has merged with the radiology group at St. Vincent's and is considering another merger with St. Francis's group to form a single organization that can serve all three systems. Other recent single-specialty mergers in the market were noted in sports medicine, neurology, urology and orthopedics.

In contrast to the single-specialty approach, SpecPrime is a 350-physician, multispecialty network affiliated with Community Hospitals. SpecPrime contracts with a number of health maintenance organizations (HMOs), including Maxicare, HealthSource and HealthPoint, on a capitated, full-risk basis. It is currently adding specialists and expanding into adjacent geographic areas. Most market observers view SpecPrime's approach as an exception in the current market for specialty care and do not see it as indicating a trend.

Changes in the organization of physicians have had little impact on Indianapolis's primary care physician practices, most of which continue to be owned by provider systems or health plans, or remain closely affiliated with provider systems. However, many of the systems and plans that made aggressive efforts to acquire primary care physician practices in the early 1990s are now questioning the wisdom of this strategy. For example, Anthem Blue Cross and Blue Shield, the Blue Cross-Blue Shield plan in Indianapolis, recently sold its 250-member primary care physician arm, the American Health Network, back to member physicians. The network remains in place under physician ownership to represent its physician members in contracting with health plans.

Provider-Sponsored Health Plans Maintain Strong Market Position

Health plans owned by local provider systems, which dominated the market in 1996, have gained even more strength in Indianapolis. This stands in contrast to other parts of the country, where many provider-owned plans have struggled. In general, Indianapolis's provider-owned plans offering HMO and preferred provider organization (PPO) products have fared well financially during the past two years, while other plans, such as those owned by Anthem and Maxicare, have experienced financial losses. PPO products continue to dominate the

Health System Characteristics

Indianapolis compared with the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

STAFFED HOSPITAL BEDS† PER 1,000 POPULATION, 1996

Indianapolis, Ind.	*3.6*
Little Rock, Ark.	*5.3*
Seattle, Wash.	*1.9*
Metropolitan Areas	*3.2*

Source: American Hospital Association
†At nonfederal institutions designated as community hospitals

PHYSICIANS†† PER 1,000 POPULATION, 1997

Indianapolis, Ind.	*1.9*
Boston, Mass.	*2.6*
Greenville, S.C.	*1.5*
Metropolitan Areas	*1.9*

Source: American Medical Association and American Osteopathic Association
††Nonfederal, patient care physicians, excluding certain specialties—e.g., radiology, anesthesiology, pathology

HMO PENETRATION, 1997

Indianapolis, Ind.	*23%*
Miami, Fla.	*64%*
Greenville, S.C.	*8.4%*
Metropolitan Areas	*32%*

Source: InterStudy Competitive Edge 8.1

Providers in the Indianapolis market are increasingly resistant to assuming financial risk from contracting health plans, and, as a result, they are lessening their reliance on PHOs as contracting vehicles.

market, although commercial HMO enrollment has grown from 19 percent at the time of the first site visit to 23 percent in 1997. Between 1996 and 1998, Medicaid managed care penetration grew from 35 to 41 percent in the Indianapolis MSA, while Medicare risk plan enrollment remained small, increasing from 4 to just 6 percent.

M-Plan, which is owned by Clarian, has the largest share of HMO enrollment; its membership grew from 122,000 in 1996 to 175,000 in 1998. During the same period, Anthem lost approximately the same level of enrollment from both its PPO and HMO products. Many respondents attribute this erosion to Anthem's lack of attention to the local market as it pursued regional and national expansion strategies.

M-Plan is now attempting to strengthen its statewide presence through a merger with HealthPoint, another provider-owned managed care plan. If completed, this merger would create a 600,000-member plan and a statewide network, with two-thirds of plan members located outside Indianapolis and enrolled in a PPO product.

With the exception of Maxicare, which has 81,000 commercial and Medicaid enrollees, national, for-profit plans continue to play a relatively small role in the Indianapolis market. However, CIGNA recently entered the market through its purchase of HealthSource Indiana, an HMO that serves enrollees statewide. Its ability to grow market share locally remains to be seen.

PHOs Become Less Important in Contracting Strategies

Providers in the Indianapolis market are increasingly resistant to assuming financial risk from contracting health plans, and, as a result, they are lessening their reliance on PHOs as contracting vehicles. In 1996, provider systems often used their affiliated PHOs to secure full-risk, globally capitated contracts with health plans. At that time, hospitals and physicians believed that they could control their costs and realize profits under global capitation.

Providers are now reassessing that assumption. Many are insisting that high-cost, difficult-to-control components such as pharmaceuticals be carved out of capitation payments, and that health plans retain some level of financial risk. Furthermore, many physicians are bypassing the PHOs and contracting independently with health plans to get some of the contract dollars previously allotted for PHOs' administrative costs.

Hospitals also see advantages in contracting directly with health plans. They believe they can negotiate better reimbursement for inpatient care than they can obtain under global capitation, where they need to satisfy the reimbursement demands of the medical staff, often to the detriment of the hospital.

Employer Roundtable Takes a Closer Look at Health Plans

Employers are beginning to take a more active role in the Indianapolis health care market, not through joint purchasing but through a collaborative group called the Roundtable, whose objective is to gather comparative information on health plans. Formed in 1997 by Eli Lilly and several other major Indianapolis employers, the Roundtable has issued a common request for information (RFI) to health plans. All but one HMO has agreed to participate. One health plan respondent suggested that by consolidating employers' information requests, the Roundtable's RFI has already reduced plans' administrative costs.

Roundtable employers also have contracted with a vendor to conduct a health status assessment of selected managed care and fee-for-service employees. In addition, they have made clear their belief that Indianapolis HMOs should achieve accreditation

from the National Committee for Quality Assurance (NCQA).

These initiatives represent a significant increase in activity by employers, which in 1996 were a relatively unorganized part of the Indianapolis health care market. Since then, health plan premiums, which had been stable for several years, have started to rise. In 1999, premiums are expected to increase by 6 to 8 percent for large employers and by 10 to 15 percent for small employers. In addition, employers have become increasingly concerned about the ability of health plans to manage care in a way that enhances quality and minimizes consumer complaints.

The Roundtable has brought together Indianapolis's major employers to address joint concerns regarding their relationships with a relatively diffuse health plan market. The initial focus has been on quality of care, care management and administrative issues. In the future, the Roundtable may serve as a vehicle for supporting care management initiatives such as disease management programs and reporting performance data. And although there are no plans to develop joint purchasing agreements, the Roundtable clearly could serve as a platform for addressing this in the future.

Legislature Pursues More Aggressive Managed Care Policy Agenda

State policy makers have been much more active in the health care arena during the past two years, particularly with respect to managed care. Like many other states, the Indiana legislature has taken a relatively aggressive position in enacting new controls over managed care plans, including requirements concerning grievance resolution, provider access, the use and distribution of formularies, coverage of new technologies and the annual submission of standardized information to the state. In addition, the State Department of Insurance has been instructed to review data from HMOs annually for NCQA's Health Plan Employer Data and Information Set (HEDIS) and release them to the public in a report card format.

Respondents suggested several possible explanations for this new legislative posture toward managed care, including a new governor who is more interested in health care issues, the concerns of a small number of influential legislators, the activities of other states and antimanaged care publicity in the national media. It is too early at this time to assess the impact of these new requirements on plans. However, it seems safe to say that health plans in the Indianapolis market will be subject to increasing scrutiny from the public as well as the private sector.

Substantial changes have also been made in Indiana's Medicaid program, mainly to accommodate the incorporation of the federal Children's Health Insurance Program (CHIP). Respondents reported that initial enrollment in CHIP, which began in June 1998, has been disappointing. Consequently, the state plans to expand its outreach and enrollment efforts.

New Programs for the Uninsured

The Health and Hospital Corporation (HHC) of Marion County remains the dominant provider of health services for the indigent in Indianapolis. Its flagship facility, Wishard Hospital, enjoys strong community support and receives $50 million annually from real estate tax levies; it also benefits from disproportionate share funding. During the past few years, Wishard has expanded its capacity to provide indigent services, launched an innovative managed care program for the uninsured and renovated and modernized its physical plant.

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During the past few years, Wishard has expanded its capacity to provide indigent services, launched an innovative managed care program for the uninsured and renovated and modernized its physical plant.

In response to growing demands for outpatient care, Wishard has opened three new community health centers since 1996. The number of visits to these centers has increased significantly during the past two years, even though the number of uninsured in Indianapolis has remained relatively constant. The Indiana University Medical Group-Primary Care, a physician group sponsored by HHC and the University's medical school, runs the centers. In 1997, Wishard launched the Wishard Advantage managed care program for the uninsured, with a benefit package similar to that offered by Indiana's managed care Medicaid program. Physician services are provided by the University's primary and specialty care medical groups, and Wishard provides ancillary and inpatient services. Uninsured Marion County residents and their families who are at or below 200 percent of the federal poverty level are eligible. Enrollees with incomes of less than 150 percent of poverty receive free care; others pay a monthly fee on a sliding-scale basis. In the program's first 18 months, inpatient use reportedly dropped from 800 to 400 days per thousand annually, and emergency room use fell by 30 percent. As of October 1998, Wishard Advantage had 18,800 enrollees.

Because of Wishard's close ties with the University's medical school and faculty, officials at Wishard were concerned that the creation of Clarian Health Partners would have a negative impact on their operations and on their relations with medical school faculty. To date, this has not happened. Instead, the merger between Methodist and the University Medical Center has forced Wishard to re-evaluate its relationships with physician groups and the medical school and to consider other options for aligning with physicians. It also has led Wishard to explore alternative relationships with other organizations and to develop new strategies and programs.

Issues to Track

During the past two years, large provider systems in Indianapolis have remained strong, and some have even expanded their influence outside the city. The physician market is consolidating, as physicians try to enhance their negotiating power with health plans, but at a measured pace. Since 1996, policy makers have become more active in the health care arena, particularly concerning managed care. Meanwhile, large private purchasers have begun to work collaboratively to influence health plan performance.

As market developments continue to unfold, several issues will be important to track, including the following:

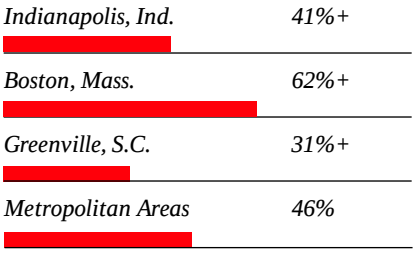
- Will there be additional provider mergers? If so, how will they affect physicians and their relationships with health plans?
- Will increasing pressure from employers and policy makers spur health plans to turn more attention to care management and to compete more aggressively on quality?
- Will locally owned, provider-sponsored plans continue to dominate the market, or, as in other communities, will provider systems move to exit the plan business and sell their assets to national companies seeking market entry?
- Will Wishard Hospital's new program for the uninsured prove to be a financially attractive and clinically appropriate managed care model for indigent care?

Indianapolis Compared to Other Communities HSC Tracks

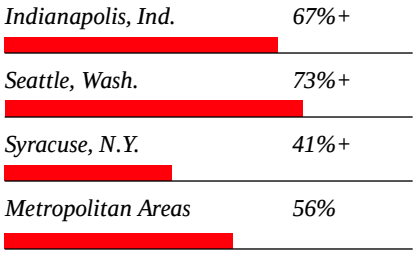
Indianapolis, the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

Gatekeeping and Compensation Arrangements

Insured Persons Covered under Gatekeeping Arrangements

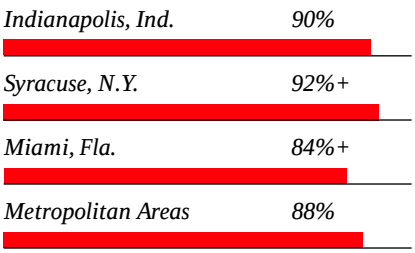


Physicians Receiving Capitation for at Least Some of Their Patients

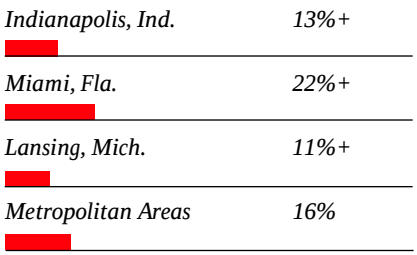


Consumer Perceptions of Access to Care

Families Satisfied with the Health Care Received in the Last 12 Months

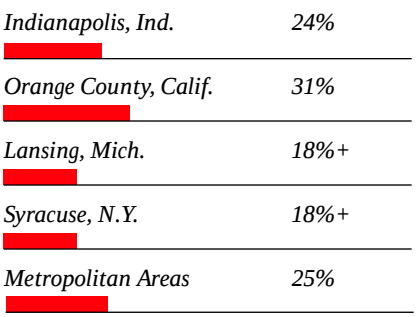


Patients Agreeing That Their Doctor Might Not Refer Them to a Specialist When Needed

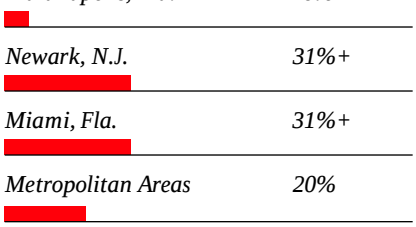


Physician Perceptions of Access to Care

Physicians Not Agreeing That It Is Possible to Provide High-Quality Care to All of Their Patients



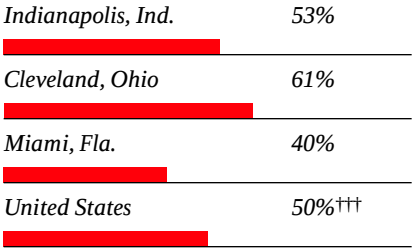
Primary Care Physicians Reporting That They Cannot Always or Almost Always Obtain Referrals to High-Quality Specialists When Medically Necessary



* *Lowest study site*

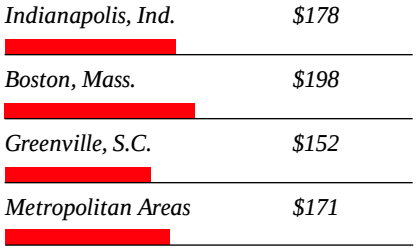
Employers and Health Insurance‡

Employers Offering Health Insurance



††† *Metropolitan area data not available*

Average Monthly Premium for Employer-Sponsored Insurance



‡ *Based on preliminary data*

There are no significance tests for results reported.

The Community Tracking Study, the major effort of HSC, tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in the following 12 communities:

- *Boston, Mass.*
- *Cleveland, Ohio*
- *Greenville, S.C.*
- *Indianapolis, Ind.*
- *Lansing, Mich.*
- *Little Rock, Ark.*
- *Miami, Fla.*
- *Newark, N.J.*
- *Orange County, Calif.*
- *Phoenix, Ariz.*
- *Seattle, Wash.*
- *Syracuse, N.Y.*

\+ *Site value is significantly different from the mean for metropolitan areas over 200,000 population.*

The information in these graphs comes from the Household, Physician and Employer Surveys conducted in 1996 and 1997 as part of HSC's Community Tracking Study. The margins of error depend on the community and survey question and include +/- 2 percent to +/- 5 percent for the Household Survey, +/-3 percent to +/-9 percent for the Physician Survey and +/-4 percent to +/-8 percent for the Employer Survey.

Health System Change (HSC), a nonpartisan research organization, seeks to provide objective, incisive analyses about health system change that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

Findings from the first round of the Community Tracking Study site visits are documented in *Health System Change in 12 Communities*. The Community Report series documents the findings from the second round. HSC conducts site visits in 12 communities in collaboration with The Lewin Group.

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Survey data from the Community Tracking Study are published by HSC in Issue Briefs, Data Bulletins and peer-reviewed journals. These publications are available at www.hschange.com.

Community Reports are published by Health System Change (HSC).

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