COMMUNITY SNAPSHOTS PROJECT

Albuquerque, N.M.

Site Visit Report

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Overview

The Albuquerque health care market, known for its relatively high rate of managed care enrollment and vertically integrated, hospital-based provider systems, has remained largely unchanged for the past year and a half. Since the early 1990s, these provider systems have controlled the market by sponsoring or co-opting health plans to increase their market share and leverage. Neither insurers nor purchasers have been able to produce significant market change, even though both have managed to extract some discounts from providers. Recent developments, however, suggest greater changes in the near future, including the following: growing prices, product competition from insurers not aligned with hospitals, increased purchaser sophistication, and early state efforts to implement Medicaid managed care and strengthen the purchasing sector.

Considerable change occurred in the Albuquerque market in the late 1980s and early 1990s that contributed to the formation of the current provider-dominated system. As managed care plans began to increase in popularity, the two main hospital-based delivery systems developed their own health plans and began to compete with each other and with an established staff-model health maintenance organization (HMO)/group practice for a growing pool of managed care enrollees. Out-of-state health plans also entered this competitive environment. The prospect of expanded coverage through national and state health care reform spurred the provider systems toward vertical integration of health plans and physicians.

Four major vertically integrated hospital-based systems—Lovelace, Presbyterian, St. Joseph's, and the University of New Mexico—currently exist in Albuquerque and own or affiliate closely with one or two managed care plans. With two independent insurers/managed care organizations, the provider systems and their affiliated health plans attempt to maintain or attract market share from commercial and Medicare enrollees. Competition among health plans primarily revolves around existing contracts.

Provider systems and their affiliated health plans have maintained control in this market largely because of insufficient power by any other sector to successfully compete with them. Independent insurers (those without a close affiliation with one of the major providers) have not gained enough market leverage. Purchasers have not brought about a change because there is no collective purchasing, and the large public employers that dominate the local economy have sought reasonable price bargains but little else. Although some physicians are forming independent practice associations (IPAs) and merging into multi-specialty groups, most remain aligned with one system or another. And, since the 1994 state elections brought power to politicians primarily concerned with budget issues, state policy does not exert much influence over the health market.

Some recent developments may shift the balance of power, however. Preferred provider organizations (PPOs) not aligned with provider systems have become more aggressive competitors with the provider-affiliated health plans, primarily by reducing premium rates and developing less restrictive products (e.g., point-of-service) to capture enrollees from provider-affiliated health plans. Albuquerque's largest area employers are either federal, state, or local governments. Therefore, health plan contract renewals by government purchasers—increasingly pressed for funds—may become even more competitive. In addition, state purchasing initiatives show signs of gaining strength. Provider systems and health plans are gearing up to compete for Medicaid managed care enrollees in 1997 by expanding their networks of clinics in underserved communities. A new state-sponsored purchasing cooperative for small businesses with relatively little influence now could become stronger with increased enrollment.

In the next one to three years, the market is expected to experience much greater change. The following factors could lead to a major shake-up of the hospital-based delivery networks and their affiliated health plans: (1) new health plans entering the market by offering very low premium rates; (2) significant pressure from organized public purchasers and Medicaid managed care, causing large shifts in health plan membership through more exclusive contracts; and (3) cuts in Medicare and Medicaid, which could undermine the financial position of one or more providers.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

In 1990, Albuquerque's Bernalillo County had a population of 480,600, about one-third of the state's 1,600,000 people. The metropolitan area, one of the fastest growing in the nation, has 632,000 people, an increase of 14 percent since 1980. In 1990, there were about 50,500 people over age 65 in Bernalillo County—a 48 percent increase since 1980. This constituted nearly 11 percent of the county's population. Hispanics constitute about 40 percent of the state's population, and Native Americans comprise approximately 8.5 percent.

Albuquerque's residents have a higher median household income and a lower percentage of households below poverty than other southwestern cities. Still, about 15 percent of the population in Bernalillo County have incomes below poverty.

Albuquerque's local economy boomed in 1994 and 1995 as employment in construction and retail sales grew robustly. The leading employers are federal, state, and local governments, including the University of New Mexico (UNM), the city of Albuquerque, the state of New Mexico, Sandia National

Labs, Albuquerque Public Schools, and Kirtland Air Force Base. The dominant private businesses in Albuquerque are manufacturing companies (e.g., Intel, General Electric, Motorola). Health care providers are also major employers. Lovelace Medical Center, University of New Mexico Medical Center, Presbyterian Health System, St. Joseph's Healthcare System, and the VA Medical Center employ more than 12,000 people.

About 80 percent of the workforce is, however, employed by small firms (fewer than 500 employees) or is self-employed. The 39 firms in metropolitan Albuquerque with 500 or more employees employ approximately 15 percent of the working-age population. An estimated 55 percent of the small businesses do not offer health insurance to their employees, a factor that contributes to the 20 percent rate of noninsured employees.

Health System History

The Albuquerque health care market has two distinct characteristics that have evolved over the past two decades. The first is a relatively high rate of managed care penetration (37 percent HMO and 17 percent PPO), which has given the community a reputation as one of the more advanced and competitive managed care markets in the country. The second is a core of hospital-based provider systems that sponsor or affiliate with the area's leading health plans. As a result, these hospital-based systems have assumed a dominant role in the market.

Several factors have contributed to a climate favorable to managed care in Albuquerque and have helped to accelerate its growth. Unlike most other southwestern cities, Albuquerque has had an HMO presence in the market since 1973, when Lovelace Health System, a multi-specialty clinic, developed an HMO insurance product. Lovelace's historic presence in the community engendered cultural acceptance of managed care, and its popularity among young families inspired other health plans. Additionally, the government-dominated employment sector has promoted managed care arrangements for its employees and retirees as a strategy to contain costs. Furthermore, Medicare beneficiaries have been very receptive to managed care. Approximately one-third of all Medicare beneficiaries are enrolled in a Medicare risk product, a figure nearly three times higher than the national average.[1] Between 1990 and 1993, HMO enrollment increased 33 percent, from 195,000 enrollees to nearly

[1]Although Medicare's average adjusted per capita cost (AAPCC) in Albuquerque is 15 to 20 percent lower than in comparable southwestern cities, FHP Inc.'s entrance into the Medicare risk market and the product's success with low-income seniors prompted other health plans to offer competing products. The 1995 AAPCC for Bernalillo County was $204.86 for Medicare aged Part A and $147.52 for Part B. By comparison, Maricopa County (Phoenix) rates are $264.02 for Medicare aged Part A and $176.62 for Part B.

260,000 enrollees, spurring an influx of new managed care plans to the market, including Prudential and Blue Cross and Blue Shield.

The most substantial gains in provider capacity and integration with health plans occurred in the 1970s and 1980s. The leading hospitals began to develop their own health plans, initially in reaction to Lovelace's early success in gaining managed care enrollees and eventually in response to new market entrants. Two of the major hospital systems (Presbyterian and St. Joseph's) created a health plan together in the 1970s to expand and secure their patient base. Although that health plan dissolved in 1981, the two systems jointly developed another health plan in the mid-1980s. Presbyterian eventually gained sole ownership of the health plan. Now, three of the four major hospital-based systems have their own health plans or are closely aligned with one through a principal contractual arrangement. This has created a vertically integrated market.

Despite a high concentration of managed care, the provider system remains oversupplied with hospital beds, high-tech services, and specialty physicians. In the early 1980s, hospitals divided the market by carving out separate "centers of excellence" for specialty services. Hospitals tried to develop capacity in all areas to compete for health plan contracts and generate more physician referrals, which led the hospitals to make large capital investments in new facilities and high-tech equipment. The building boom was also spurred by the repeal of the state's certificate-of-need (CON) law in 1983. In the late 1980s, several general hospitals, specialty hospitals, and urgent care centers were built in areas expected to have the highest growth in population. Horizontal integration has not occurred to any significant degree across hospital systems, and the four systems continue to compete vigorously. Therefore, the market continues to have an excess of resources. This excess also reflects the limited influence of managed care plans to act independent of the four systems.

▼ ▲ ▼ Health System Changes

Public Policymakers

The recent influence of state policy on the market has been minimal since the decline of recent national and state health care reform efforts. However, between 1991 and 1994, state actions to expand insurance coverage and control costs were much more influential. Of the state policies adopted during that time, Medicaid managed care is expected to have the greatest effect on the market in the future because it offers health plans a chance to expand into a new market. A recently established state-sponsored purchasing alliance for small businesses may also be a force in strengthening the purchasing sector.

In 1991, the legislature passed a law allowing insurers to offer a minimum benefit package to individuals and small groups. However, these "bare bones"

plans were not popular. In 1992, the state created the Health Care Initiative, which proposed the development of a central state health authority and regional health councils that would award competitive contracts to accountable health plans (AHPs) in each region. Although the initiative was not adopted, the debate spurred health plans and hospitals to develop vertically integrated systems that could evolve into AHPs capable of serving a broad patient base, including many of the uninsured.

The state legislature enacted several laws in 1994 to strengthen the purchasing sector and increase financial access. One law set up a state-sponsored health purchasing cooperative for small businesses. This cooperative got off to a strong start, but it is unclear if it will significantly affect insurance coverage or affordability for the small-group market. The state legislature also authorized expansion of Medicaid eligibility to include all children below age 19 living in families earning less than 185 percent of the federal poverty level, potentially adding 60,000 children to the Medicaid program over the next two years and significantly reducing the number of uninsured children.

Another law requires Medicaid to expand managed care statewide by 1997. Since there has been no prior experience with capitated Medicaid contracts, all provider systems and health plans are attempting to increase their capacity to do so by extending their networks of clinics and ambulatory care centers into indigent communities. Gaining access to new managed care enrollees could shift the balance of power in the system from one provider to another or from providers to an independent health plan if the state uses competitive bidding.

In late 1994, state health care reform efforts slowed as the federal health care reform effort failed. Additionally, Governor Bruce King (D) was defeated by Gary Johnson (R), a fiscal conservative whose priorities do not include health care reform. While many of the state's previous initiatives remain in place and are being implemented, comprehensive health care reform efforts no longer have broad political support.

Purchasers

Purchasers' impact on the market has been limited so far. The scarcity of large, locally based private employers and relatively stable, low premium rates have made it difficult and unnecessary for purchasers to organize collectively. They are generally able to take advantage of healthy price competition between health plans; large purchasers in particular have been able to get reduced or constant premium rates, as well as new point-of-service (POS) products. Several large purchasers are becoming more sophisticated, and a few are beginning to consolidate their purchasing power to gain greater leverage.

Employers and Employer Coalitions

Despite the relatively low premium rate increases and employee benefit costs in Albuquerque, a few employers are forcing annual premium rate reductions.

Public purchasers are leading this trend, in part due to state and local government pressures to reduce public spending. Within the last few years, a few large public employers (e.g., the UNM, the state of New Mexico) negotiated well-publicized rate reductions that set an example for other large employers.

It remains unclear, however, if premiums are being reduced because large purchasers are using market leverage to negotiate lower rates or because health plans are offering lower rates to gain more of the market share. Some purchasers believe that health plans are offering significantly reduced rates to steal business away from competitors. These employee benefit plan managers are worried because they do not believe that insurers can sustain financial health with such steep discounts. Several purchasers are anticipating premium price increases in the next year or two. Some employers are also concerned that price competition among plans could lead to lower quality and decreased availability of primary care appointments. But the employers have not taken specific action to address potential quality and access problems.

Employers are also beginning to ask health plans to offer a greater range of product options, especially POS products. The greatest growth in offerings of POS products is because large purchasers have obtained such options for their employees.

Employers with high-cost indemnity plans view POS products as a way to provide less-costly managed care with fewer restrictions than traditional HMOs. Employers that have limited their HMO option to a staff-model HMO view POS products as giving employees more choice. Some employers see POS products as a way to contain costs and expand employees' choices. For example, prior to 1992, the state employee benefits plan offered an indemnity plan and a staff-model HMO. In 1993, the state's plan replaced them with Blue Cross and Blue Shield's POS product.

Large employers report that employees, unions, or other groups prefer a wide choice of plans and providers for workers and their families. For example, many employers offer Lovelace's HMO because the organization has engendered substantial consumer loyalty over the years. Other employees choose the Presbyterian or St. Joseph's systems' plans because of long-standing physician/patient or hospital/patient relationships. In its most recent contract negotiations, the UNM required all health plans to contract with or allow patients to use the University Hospital and University Physician Associates (UPA) to ensure choice and keep health plans from shutting university-based providers out of their networks.

Choices of plans and products are much more limited for employees of small firms. Mid-size and small employers more frequently limit employee choice to one or two more restrictive plans in exchange for lower premium rates. Until the creation of the state-sponsored purchasing alliance, association-based plans available to small businesses have been limited to those offered by the Albuquerque and Hispano Chambers of Commerce.

While there are no private employer coalitions in the Albuquerque market, two public employers have been pursuing a partnership to increase their negotiating leverage. The city of Albuquerque and Bernalillo County, two of the region's largest employers, recently banded together to develop a purchasing strategy for their combined 6,600 employees. They are also investigating the possibility of joining forces with the UNM and the Albuquerque Public School System to negotiate collectively with health plans.

The New Mexico Health Insurance Alliance, a state-sponsored purchasing cooperative for small businesses of 2 to 50 employees, also attempted to organize purchasers. The Alliance began operation in February 1995; after just three months, nearly 800 small businesses, representing approximately 3,000 employees, had purchased insurance through the Alliance. Only half of the firms previously offered health insurance benefits. Currently, initial premium rates offered through the Alliance are somewhat higher than initial offerings in the general market. However, the Alliance premium index rate will most likely become more competitive with renewal rates outside the Alliance, forcing rates down in the market overall.

State and Local Government as Purchasers for Low-Income People

The state government has promised to convert most Medicaid recipients to managed care by 1997, so provider systems and health plans are gearing up to serve this new market. Managed care initiatives in New Mexico's Medicaid program have previously been limited to the Primary Care Network (PCN) program, a primary care case management model implemented in 1991. The state plans to enroll Medicaid recipients into capitated managed care plans in Bernalillo County in July 1996 and on a statewide basis in 1997. In Bernalillo County and other areas already served by managed care networks, the state would prefer to negotiate full- and partial-risk contracts with three or four HMOs.

Providers and health plans in the Albuquerque area are preparing for full-risk capitated Medicaid managed care. For example, two hospital systems recently built ambulatory care centers in low-income neighborhoods. The University Hospital recently added two clinics to expand its outpatient capacity. Additionally, a managed care plan is working with the community health center to gain experience serving low-income and Medicaid recipients.

Insurers and Health Plans

Competition for market share has increased between provider system-sponsored/owned health plans and independent health plans. While much of the competition is focused on big contracts and self-insured plans, small groups represent important targets for competition among the plans. Insurers offer low premium rates and new products that offer more choice of providers and hold down costs through integration or closer relationships with providers. A few

insurers are also considering quality improvement initiatives that could lead to reduced costs.

Six major health plans operate in the market. Lovelace Health Plan, a staff model HMO, has the largest market share, with 49 percent of all HMO members in the market. Combined with CIGNA PPO products, Lovelace has 33 percent of the total area managed care market (HMOs and PPOs). Although the state's largest HMO, Lovelace is no longer perceived as the market leader because it lost the state employees contract two years ago. HealthPlus offers HMO and PPO products and controls about 19 percent of the total managed care market. FHP, a mixed-model (staff and IPA) HMO, controls 11 percent. QualMed, an IPA-model HMO, controls about 7 percent. Blue Cross and Blue Shield has most of the state's indemnity market, a large PPO product, and the greatest popularity in the non-Albuquerque market. Prudential is a relatively new entrant into the PPO market.

Only one of the six managed care plans is owned locally: Presbyterian Health System owns HealthPlus, a for-profit subsidiary of the non-profit hospital-based system. The rest of the plans are owned by out-of-state companies. Lovelace was bought by CIGNA in 1990. FHP is a California-based corporation that has been expanding throughout the Southwest.[2] Qual-Med is owned by publicly traded Health Systems International, which will soon merge with WellPoint, the Blue Cross HMO of California. The state's Blue Cross and Blue Shield plan—which is part of Rocky Mountain Blues Health Care, a holding company based in Colorado—is about to convert from non-profit to for-profit status.

To attract and retain enrollees, health plans often cut premium prices offered to large accounts. To operate with lower revenues, plans attempt to cut members' monthly costs in a variety of ways. For example, plans sometimes renegotiate contracts with physicians to reduce payments or salaries. Some health plans are developing more stringent methods of utilization review and close monitoring of physicians. One health plan is downsizing its specialty physician staff, and several are seeking to "right-size" their primary care physician (PCP)/specialist ratio by encouraging specialists to assist in primary care. Some plans are trying to cut administrative overhead.

Health plans do not appear to be pressuring hospitals to reduce capacity, perhaps because fee-for-service payments from Medicare and Medicaid still bring in substantial revenue to their wholly owned or closely affiliated hospitals. But several health plan executives predicted that, in the long term, they would have to reduce hospital days per 1,000 members from the current average of 250 (not including Medicare) to below 200.

[2]Its national office has recently announced that it will spin off the staff-model HMOs into medical groups managed by a subsidiary known as Comprecare.

Greater risk-sharing with network providers has become a health plan strategy to contain costs. Currently, most health plans pay providers through a variety of negotiated fee arrangements, primarily discounted fee-for-service or per diem rates. These plans are beginning to explore capitated payments to providers, but they have not pursued it aggressively partly because there are fewer large physician groups that have the capacity to assume risk. Capitation would involve greater profit-sharing with the physicians, something now held almost solely by the health plan/hospital.

Health plans are also attempting to bolster their physician networks. Blue Cross and Blue Shield, one of the independent health plans, is pursuing a possible alliance with a new IPA and has been discussing a more exclusive contract with one of the health systems. HealthPlus is trying to secure more "exclusive contracts" with its affiliated physician groups. Even health plans with salaried (Lovelace) or closely aligned physicians (FHP) are trying to broaden their physician networks so they can offer commercial POS plans outside the Albuquerque area.

Health plans are developing new products to increase market share. Managed care organizations are developing POS products to respond to the demands of employers. They have also moved into the profitable Medicare risk market. FHP has the largest Medicare enrollment among the five HMOs; about half of its business is currently in Medicare risk contracts, with a zero-supplemental product that includes prescription medications. Lovelace developed a Medicare risk product to serve members of its plan when they reach age 65.

While all managed care plans have a reputation for good quality of care, each is seeking to be the leader in this area. FHP is the first National Committee for Quality Assurance (NCQA) accredited plan in New Mexico;[3] other plans are in the process of seeking NCQA accreditation. Lovelace is instituting an "expanded medical management model" to replace Total Quality Management (TQM) programs, clinical practice guidelines, and "caremaps." The new model will target the diseases that account for the majority of costs and apply practice guidelines across the continuum of care. Lovelace will also seek to manage the health risks of all enrollees by assigning a recently-created group of case managers to work closely with physicians of high-risk patients. In the future, physicians' capitation rates and panel sizes may be risk-adjusted.

Providers

Competing providers have more influence on market dynamics than purchasers or insurers. Hospital-based provider systems have maintained control

[3] NCQA accreditation for one year only; another review is scheduled for October 1995.

of the market by sponsoring or co-opting health plans to increase patient enrollment, hospital revenues, and system market share. They also control the physicians, specialty providers, and other providers. Some independent physicians are trying to gain more control by forming IPAs and merging practices, but their influence on the major hospital-based providers is minimal so far.

In the Albuquerque market, the power of providers compared to that of the insurers is significant. Three of the four major hospital-based systems own their own health plan or are closely aligned with one through a principal contractual arrangement (the only exception is the University Hospital). This creates a vertically integrated market structure. The hospitals (in one case, the multi-specialty group practice) dominate each system; referrals are bolstered by hospital ownership of physician practices and satellite clinics.

The Lovelace Health System includes a hospital, a satellite clinic system, a health plan, and a multi-specialty group practice of more than 300 physicians (80 percent of whom are salaried). It is the only for-profit health system in the market. Presbyterian Health System owns 2 hospitals in Albuquerque; owns or manages 6 rural facilities; and owns the HealthPlus health plan, a multi-specialty center, and 11 managed care physician practices.

St. Joseph's Health System, part of the Sisters of Charity Health System, owns three hospitals and a rehabilitation hospital in Albuquerque and contracts with the FHP health plan. It directly employs 30 physicians. Its subsidiary, MEDNET, is a physician practice management company that services 500 physicians in numerous specialties. The University Hospital is the main facility at the University of New Mexico. The UNM School of Medicine has a faculty of 400 physicians and 350 residents. The staff is organized under the faculty practice plan.

Hospitals

Albuquerque hospitals are subject to nationwide trends of rising costs and declining lengths of stay. In response to these trends, Albuquerque's major hospital systems have bought or become aligned with health plans to ensure a sustained patient base. They are also creating strategic alliances with other hospital-based systems and managed care plans, developing closer relationships with physicians, expanding specialized services and networks of clinics, and improving the delivery of care.

Seven of Albuquerque's 17 hospitals are non-federal acute care facilities that are all affiliated with one of four major health systems.[4] The University

[4]The rest are specialized centers (psychiatric or rehabilitation) or federal institutions (Kirtland Air Force Base/VA, Indian Health Service). Independent hospitals include a Columbia/HCA psychiatric facility and a Charter Psychiatric facility that have entered into a joint venture. They also include Memorial Hospital, a private, for-profit psychiatric facility, and a HealthSouth rehabilitation hospital.

Hospital serves as a primary teaching hospital for the UNM School of Medicine, as the major tertiary care center for the state, and as the county/public hospital providing a greater portion of care for indigent populations.

After several years of trying to become one-stop shopping centers, Albuquerque hospitals are developing strategic alliances with other provider systems to deliver specialty services and referrals. For example, the University Hospital is developing partnerships with the other systems to provide trauma and tertiary cancer care or neurosurgery.[5] It has established a residency training program with Lovelace and serves as a referral source for cardio-thoracic and neurosurgery specialties. The University Hospital is also trying to develop closer referral relationships with rural hospitals around the state, by helping struggling rural hospitals with management challenges, providing locum tenens (i.e., holding a place),[6] and helping recruit doctors from the UNM School of Medicine.

At the same time, hospital-based systems are seeking more limited or exclusive affiliations with physician groups to ensure a steady flow of referrals and to maintain their leverage with health plans. Some of the systems have increased starting salaries for PCPs; others are offering a full range of risk-sharing arrangements and management services to attract PCPs. One hospital is trying to build exclusive relationships by asking physicians to sign "single signature contracts," which would authorize the health system to negotiate for their services with any health plan or PPO. Another hospital offers physicians affiliation options including total ownership, management service contracts, risk-sharing agreements, and other options, depending on physicians' needs.

Hospital systems are also attempting to improve efficiency and reduce excess capacity. Some of the hospitals are reorganizing and reducing staff. One hospital converted an inpatient center to an administrative facility two years ago and has tried to transfer surgical services to outpatient settings. All of the systems are exploring collaborative strategies to share services and equipment. Several systems are paying more attention to home care, and many observers expect hospitals to convert more of their excess beds to long-term care use in the future. Although there has been a slow-down in duplication of high-tech equipment and services, this trend has not stopped completely; one hospital system recently added more beds and built a cardiac facility.

Physicians

As provider systems have assimilated physicians into their networks and as managed care has grown, the physician sector has been subject to declining

[5]The University Hospital's efforts have been aided in part by a provision in the UNM employee health benefits contract that requires all participating health plans to contract with the University Hospital.

[6]This term refers to arrangements that temporarily replace physicians who are on vacation, fill slots that are temporarily vacant, or supplement heavy seasonal workloads in some hospitals.

incomes and loss of clinical autonomy. Many physicians not already part of one of the hospitals or health plans are forming IPAs and merging practices. Their influence remains limited, however, largely because of physician oversupply and the tendency for physicians to join one of the hospital-based systems or health plans.

Albuquerque is experiencing an oversupply of physicians. In 1980, there were 266 physicians per 100,000 residents in Albuquerque; by 1993, the number had risen to 359 per 100,000. The percentage of specialists in the market among all physicians is also higher (70 percent) than the U.S. average (60 percent).[7] For physicians not affiliated with Lovelace or UPA, there are few large medical group practices. One notable exception is the New Mexico Medical Group, which was formed eight years ago and now includes 40 physicians and represents 18 specialties in 29 separate care centers. The group negotiates contracts with HMOs; jointly operates lab, x-ray, and home health ventures; and performs quality assurance functions. Although primary care doctors' incomes are reported to be rising, specialists have felt the brunt of the decline in reimbursement over the past few years. Managed care plans tend to negotiate for higher discounts at each contract renewal. Along with strict use management by several health plans and other intrusions into clinical decision-making, the strain on physicians has clearly increased.

Recently, a few specialty groups have formed to negotiate with health plans directly. For instance, 22 of the state's top heart surgeons and cardiologists in competing practices recently created the New Mexico Heart Institute. The Eye Associates of New Mexico represents a recent merger of 24 ophthalmologists. At the end of 1994, a new group of 160 physicians (40 primary care and 120 specialists) formed a physician-owned and controlled Physicians Healthcare Initiative IPA to negotiate with several different health plans directly. Not all of these mergers have been financially successful. Some observers believe that the newer groups are also subject to failure, especially if they are unwilling to change clinical practice patterns to effectively manage costs.

At this point, observers are unsure if the groups will try to negotiate contracts directly with purchasers. A group of psychiatrists and psychologists contracts for "carve-out" mental health benefits with certain large employers on a discounted fee-for-service basis, but none of the other groups has negotiated direct contracts.

Safety Net Providers

The major provider of ambulatory care to uninsured people, the Albuquerque Family Health Center, is competing more aggressively with the provider

[7]This information comes from Area Resource File figures for 1992. It is unclear, however, whether the physicians per 100,000 figures for Albuquerque represent only active physicians or if they also include residents and federal government employees. If the latter is true, the region's VA, DoD, and university residents would inflate the figure.

systems to provide services to Medicaid and low-income patients. The Center is a federally funded 330-physician clinic located in predominantly Hispanic South Valley and other neighborhoods. The UNM developed the Center in the 1970s, and it spun off shortly thereafter. The Center has improved and expanded its facilities and hired many new health care professionals. It served more than 36,000 patients at seven clinic locations in 1994.

As the largest community-based primary care provider, the Albuquerque Family Health Center has been trying to strengthen its internal systems and position itself to compete more effectively. In the late 1980s, the Center went through a period of financial and management difficulty. However, under the leadership of a new executive director, the Center has regained its status as an important ambulatory care provider. It recently improved the physical plant at its main clinic and instituted a continuous quality improvement (CQI) system and a new management information system (MIS). The Center is also trying to strengthen its relationship with University Hospital since many of its patients use the hospital's emergency room and inpatient facilities. The goal is for the Center's physicians to obtain admitting privileges at the University Hospital and participate in a collaborative practice model.

The Center faces competition from private health systems, two of which built new clinics near the Center's sites in the South Valley to serve Medicaid patients more effectively. In response, the Center is building a new site in the affluent North Valley and plans to expand two of its other sites. The Center is also seeking partnerships with managed care plans to serve Medicaid and other low-income patients enrolled in those plans. As part of its strategy, it recently renamed itself First Choice and is trying to capitalize on its primary advantage: PCP capacity. The Center recently negotiated a contract to participate in one health plan's PCN.

Consumers

Market changes in Albuquerque have different effects on individual consumers, depending on whether they work for large or small employers, whether they are part of a union, whether they are insured or uninsured, and whether they are enrolled in a managed care plan or not.

Albuquerque's public employees and private employees at large firms have several choices of managed care and indemnity plans that require minimal cost-sharing. Their choices appear to be increasing and might include a more flexible POS plan. Out-of-pocket costs do not increase unless patients use out-of-plan providers. Union representation helps maintain relatively generous benefits and employer premium contribution levels. Employers also believe they must maintain high benefits to retain non-union, highly educated workers.

The majority of workers in Albuquerque, who work for small companies, have more difficulty obtaining health insurance, have more limited choices, and probably have greater out-of-pocket premium-sharing costs. Consumer

representatives report that plans offered by small companies are cutting benefits or requiring greater employee cost-sharing. And because Chambers of Commerce frequently change carriers, participating employers must often switch health plans. This sometimes means that employees must change their physicians. While there is optimism about the new Health Insurance Alliance offering affordable coverage to some workers in small firms for the first time, premiums will probably still be too high for some low-income workers, particularly single women with children.

Albuquerque's uninsured rate is higher than the national rate. While Medicaid eligibility expansions for children promise to increase their coverage in the next few years, low-income uninsured adults have few options for obtaining affordable coverage. The uninsured may receive low-cost or free care at the University Hospital and the Albuquerque Family Health Center. Other hospitals report serving uninsured people, but their numbers are much lower than at the University Hospital.

The increasingly competitive nature of the Albuquerque health system has put pressure on the University Hospital and the Family Health Center. This competition threatens their ability to serve the uninsured and provide appropriate access and quality. For example, the University Hospital receives $23 to $25 million annually from the county mill levy (tax). This does not cover the estimated cost of $60 million for indigent and charity care. As the gap widens, some consumers report that the hospital discharges some uninsured patients, such as homeless people, earlier than is medically safe.

Furthermore, as the University Hospital strives to become more competitive, other Albuquerque hospitals have begun to question the equity of the county funds being limited to the University Hospital. For the moment, the University Hospital's $7 million in Medicaid disproportionate share hospital (DSH) funds from the state, which represents about 90 percent of total state DSH funds, is committed, but it is not clear whether the state will protect this allocation when it shifts to capitated managed care next year.

Volunteer organizations, such as Health Care for the Homeless, also provide outpatient care to special populations. The local health department is a field office of the state health department that offers public and personal health services but does not provide primary care. The Indian Health Service, located adjacent to the University Hospital, treats large numbers of Native Americans from Albuquerque and the state and contracts with the hospital for specialized services.

Consumers enrolled in managed care express concern about access to and quality of care provided by these organizations. It often takes months for patients to get routine appointments; physicians spend only limited time with patients; and some primary care physicians are not willing to take new patients. Advocates for seniors report that some elderly people in Medicare risk contracts have so much difficulty getting appointments that they go to a non-

plan physician and pay out-of-pocket expenses just to be seen. Advocates also report that seniors still medically at risk are discharged early from hospitals without adequate home care. Some physicians leave HMOs out of frustration with plans' control of clinical decisions. Additionally, managed care enrollees report being more confused about their choices among plans and providers and believe they need more information and education about their alternatives.

▼ ▲ ▼ Future Developments

Although the Albuquerque market is currently stable, anticipated changes over the next few years could eventually shift the balance of power from the provider-based systems. Many observers believe that the market is simply not large enough to sustain all the current participants.

Some have predicted that in the insurance/health plan sector, plans might merge or close. A small PPO might evolve into a market leader if the preference for POS plans becomes even stronger. One of the independent health plans could secure large enough market share to break the equilibrium, especially if several large purchasers switch their health benefit contracts to the lowest-cost health plan in response to rising premium rates.

In the hospital sector, any one of the four health systems could fail, be sold, or be merged with another if one of the provider-sponsored health plans loses substantial market share. The University Hospital and the Albuquerque Family Health Center, as they encounter increased competition from other systems to establish Medicaid managed care systems, may be particularly vulnerable. Both have made important headway in positioning, but neither has faced a real test of its ability to contract with or establish a Medicaid managed care plan. Some are concerned about the future of the University Hospital and the likelihood that a state as small as New Mexico can afford to maintain a medical school.

Furthermore, federal budget cuts that force the closure of Kirtland Air Force Base or downsizing at Sandia and Los Alamos Laboratories (funded by the Department of Energy) would also affect the health care system. Layoffs at either or both of these facilities would harm the local economy, including the health care system.

Even if none of these developments occurs, there is considerable pessimism about the future. There are a few areas of hope—access to community-based mental health services should improve, for example, due to changes in the state's funding system. But consumer advocates, hospital administrators, and state officials agree that the population growth has leveled off and the market has little potential for growth; that the market has lost its "edge" as one of the more advanced and competitive managed care markets; that overall measures of the health status of the population remain poor; and that significant harm might result from government program cuts in Medicare, Medicaid, and other areas because of the large numbers of elderly and low-income individuals.