COMMUNITY SNAPSHOTS PROJECT

Boston, Mass.

Site Visit Report

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Overview

Cost pressures from health plans and employers, and a frenzy of consolidation discussions among providers, are challenging Boston's powerful academic medicine ethos. The speed and chaotic nature of change is reflected in the widely divergent views of key players about what is happening, what is going to happen, and what the changes will mean for the residents of eastern Massachusetts.

The Boston area is noted for its high quality health care and notorious for its oversupply of hospital beds and high costs. Despite extensive managed care penetration in the market, many area plans historically functioned more like preferred provider organizations (PPOs), with only modest management of care and little capitation. Today, health plans are growing, instituting more stringent managed care tactics, capitating providers, and steering patients to selected hospitals. Yet, observers expect the area's high costs, oversupply of beds, and provider-dominated system to continue for a few years to come.

The Boston market includes about 3.8 million people living within the boundaries of I-495, about 25 miles from downtown. The market's western boundary is Worcester, where the strength of the fully integrated Fallon Health Care System has deterred competitors from entering Boston-based systems. However, the market *is* broadening as hospitals, physician groups, and health plans expand their service areas to neighboring states, adding 700,000 people to the total market population.

The structure of Boston's health system and the current rapid pace of change have been strongly influenced by public policy. Until 1991, hospital rate regulation fueled hospital expansion by ensuring high reimbursement rates, and it encouraged managed care growth by allowing only HMOs to negotiate rates with hospitals. Favorable state-set payment rates also fostered a strong system of 25 community health centers (CHCs) in Boston. Repeal of the hospital rate-setting structure in 1991 was a green light for all insurers to find ways to reduce hospital use and costs. The state Free Care Pool has provided safety net financing for the care of uninsured people, giving hospitals and some CHCs added financial security in the shifting marketplace. However, some advocates fear that a new Medicaid 1115 waiver could undermine the state's long-held commitment to care for uninsured patients.

These developments primed the delivery system for change, which was ignited in 1993 when Harvard affiliates Massachusetts General Hospital (Mass. General) and Brigham and Women's Hospital—the region's two largest facilities and two of its five academic medical centers—announced a strategic alliance. That move sent almost every other player, including CHCs, in search of a partner to "bulk up with" in the impending fight for survival. The drive to find the right strategy and partner was and is so strong that pending mergers and the people involved in them are changing almost daily—indeed, one

merger dissolved and three of the area's top managers left key jobs in the course of this short review.

The dominance of Boston's academic medical centers—which insulated the market from change in the past—is also evident in new hospital and health system alliances. The new Mass. General-Brigham and Women's parent company, Partners Healthcare System, inspired other hospitals affiliated with Harvard, Tufts, and Boston University medical schools to seek their own partners. A possible New England Medical Center-Deaconess Medical Center merger has, according to recent newspaper reports, evaporated, leading to renewed talks among Deaconess, Beth Israel, and Children's hospitals. Two of the city's other major institutions, Boston City and Boston University hospitals, are also in merger negotiations.

Physicians and community clinics are pursuing horizontal and vertical consolidations. The Partners system has spawned a regional network governed largely by physicians, while other hospitals, such as Beth Israel and Cambridge, have created medical service organizations to contract with or employ providers. Significantly, hospitals and health plans are courting Boston's CHCs to bolster referral bases and compete for Medicaid managed care clients. The Lahey Hitchcock Health Care Network (a merger of large medical clinics in Massachusetts and New Hampshire) and the Massachusetts Alliance of Physicians are examples of physician-driven consolidations. Interviewees are not certain whether these consolidations will lead to the complete integration of service delivery and insurance functions.

Growth and more aggressive cost management are the bywords among health plans. The sentinel event was the merger of Harvard Community Health Plan (HCHP) with Pilgrim Health Care in fall 1994. The new organization has nearly one million enrollees, enough to rival Blue Cross's 2.1 million members. Harvard also shook the Boston area health system in 1994 when it moved all of its pediatric care from Mass. General to Children's Hospital. Blue Cross, in turn, is seeking a preferred alliance with Partners. Tufts Associated Health Plan's fully capitated Secure Horizons Medicare risk plan is expected to spur more extensive risk sharing by providers throughout the market. Some observers predict that the dominant, not-for-profit HMOs will become for-profits to obtain capital for further expansion.

Employers have not played an active role in shaping the health system, possibly because of the decline of large manufacturers in favor of smaller service firms. A few large businesses have tried innovative strategies, such as General Electric's drive to "co-manage" care through sole-source HMO contracts, but most have conservative purchasing policies. However, the formation in 1993 of the Massachusetts Healthcare Purchasing Group (which has issued public "challenges" to health plans to hold down premium increases) portends a greater influence of the employer community over the future of the health system.

The snapshot of the Boston market shows everyone holding their breath, waiting to see whose merger marriage will succeed and whose will fail, which academic medical center will close, which HMO will turn for-profit, and what state and federal policies will mean for teaching and research programs, and other health care providers.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The Boston market comprises primarily five counties (Essex, Plymouth, Suffolk, Middlesex, and Norfolk) and had a population of 3,764,000 in 1992. Expanding health service areas add another 700,000 people to the market from northern Rhode Island, southern New Hampshire (where low taxes attract commuters), and southern Maine. After small gains during the 1980s, the Boston Metropolitan area lost 0.3 percent of its residents between 1990 and 1992. About one-eighth of the region's population is age 65 or over, slightly higher than the national average. African Americans make up about 6 percent of the market population, compared with 12 percent nationally; however, nearly 24 percent of Suffolk County (in which Boston lies) is African American. The Boston area also is home to a sizeable Hispanic population and new immigrants from Southeast Asia.

The Massachusetts economy as a whole is relatively healthy, having recovered from a recession in the late 1980s. During that period, service enterprises replaced manufacturing as the mainstays of the Boston area economy; the economic base is also changing from large corporations to smaller firms. The state added about 60,000 jobs between 1994 and 1995, a 2.1 percent growth rate. Statewide unemployment in May 1995 was 5.0 percent, third lowest among the 11 largest industrial states. The Boston market's civilian unemployment rate was 8.2 percent in 1991, compared with national rates of 5.5 percent (1990) and 7.4 percent (1992). About 8.5 percent of the area's population had an income below the federal poverty level in 1990, compared with the U.S. rate of 13.5 percent (1990).

Health System History

The health system in Boston has long been known as a locus of high-quality care, the reputation of its medical institutions on par with others such as the Mayo Clinic. Central to this reputation are the area's three medical schools and five academic medical centers, which led to a system heavily oriented toward high-tech, specialty care. The high quality was matched by high costs and use rates. For example, in 1992, adjusted expenses per admission and expenses per inpatient day in Massachusetts were higher than the national

average by 18 percent and 23 percent, respectively. Medicare inpatient use was 2,200 days/1,000 people age 65 and over, nearly twice the rates in some West Coast markets.

Managed care also has a long history in Boston, beginning in 1969 with the formation of HCHP, one of the nation's oldest staff model HMOs. Large employers tended to offer HCHP—which moved to a mixed model in the 1980s with the addition of some nonsalaried physician groups—along with more traditional indemnity products, giving many area residents experience with the restrictions inherent in managed care. However, significant growth in HMO enrollment did not begin until the 1980s.

The more recent shift to managed care has been an important factor in hospital consolidations statewide. Since 1985, 19 hospitals in Massachusetts have closed, while 12 others have merged, 10 have been acquired, and 29 corporate or contractual affiliations have taken place. Most of this consolidation activity has occurred since 1992.

Another side of Boston's health care history is the strong network of CHCs and city government. The first neighborhood clinic was created through the federal Office of Economic Opportunity in the mid-1960s. Now consisting of 25 clinics, the network was developed with the financial and political support of the city's Health and Hospital Corporation, which operates the public health agency and Boston City Hospital. CHCs evolved with different levels of autonomy and affiliation: 14 are free-standing, 4 are licensed through Boston City Hospital, and 7 are licensed through private teaching hospitals. Traditionally, the clinics have been viewed as unique safety net providers whose primary affiliation was with, and whose primary clientele were from, the neighborhoods in which they operated.

▼ ▲ ▼ Health System Changes

Public Policymakers

Public policy has strongly influenced the shape of Boston's health system, and recent policy changes—primarily up to 1992—have enabled the current drive toward horizontal and vertical consolidation and managed care. By and large, the generous hospital rates were set by the state-supported institutions regardless of their cost structure. The regulatory framework provided enough financial security to enable hospitals to initiate services already available in the community and add new beds despite an existing oversupply. The result is a market with 11,000 staffed hospital beds—4,000 to 5,000 too many, according to many interviewees.

Hospital regulation also provided some impetus for the growth of HMOs in Boston and statewide. The law prohibited insurers, but not HMOs, from nego-

tiating rates with hospitals. HMOs could therefore obtain more favorable reimbursement agreements and, hence, offer purchasers better deals. This special status of HMOs helped the Boston area attain one of the highest managed care penetration rates in the country, more than 50 percent today.

The 1988 Health Security Act—former Governor Michael Dukakis's employer "pay-or-play" universal coverage law—was the first step in deregulating the hospital industry by removing caps on inpatient revenue.[1] The act gave hospitals greater ability to expand patient volumes. According to many interviewees, this policy shift prompted huge increases in net hospital revenues and led to numerous capital projects and large reserves.

The second policy shift came in December 1991, when the legislature backed a market-oriented approach to health system reform with Chapter 495. The law did the following:

- Repealed hospital rate control. Repeal was pushed by Governor William Weld and supported by the state hospital association (the large business community was ambivalent about this change and did not support it). The law allows hospitals to compete on price with any health plan or purchaser.
- Created a reinsurance pool.
- Revised insurance regulations by mandating guaranteed issue and renewal of small group policies and capping rate variations at 200 percent of the lowest premium in each rating class (classes are based on age, sex, industry, and group size only).

Numerous interviewees also said the national debate over the Clinton health plan fueled local competition by focusing attention on efficiency, financial stability, and market share.

In December 1994, lawmakers postponed the employer pay-or-play mandate until 1996 and created a special commission to study methods of achieving universal coverage. The employer mandate had already been made moot by the shift in state policy emphasis from regulation to competition and by Congress's inaction on health reform.

Public policy in Massachusetts also reflects a strong commitment to access for low-income and other disenfranchised people. The Free Care Pool, created in 1985 and financed by a surcharge on private-pay hospital bills, pays hospitals for the care of uninsured patients. CHCs affiliated with some hospitals

[1] "Pay-or-play" is a model of employment-based health reform in which government (either state or federal) levies a tax on employers ("pay"), but provides tax-credits to employers who provide health coverage to their employees ("play").

were able to tap into the pool to finance some of their nonhospital services. The 1988 reform law Health Security Act capped employer contributions to the pool, leaving it with $330 million for 1993. While Governor Weld shifted the orientation of state health policy from regulation to a market focus, thus raising concerns among advocates of low-income consumers, many advocates also noted that Weld appears to have sustained state support for safety net providers.

The state's commitment to access is also revealed in *Community Benefits Guidelines for Nonprofit Acute Care Hospitals*, issued by the state attorney general in June 1994. The voluntary guidelines—one of the few attempts by states to set such standards—are intended to "encourage nonprofit hospitals, in partnership with their communities, to make resource commitments consistent with their individual institutional strengths and with formally assessed needs of their community." While the document allows each hospital, with its community, to decide how to measure community benefits, it suggests the use of quantitative standards, such as percent of operating expenses spent on charity care. The attorney general's office, concerned about the effects of growing competition, is in the process of developing similar guidelines for HMOs.

Purchasers

Boston's public and private purchasers traditionally approached the health system conservatively; they did not want to risk "unraveling" the system for the sake of cost-cutting. The advent of a new coalition of purchasers marks a change in this approach and offers a vehicle for business and the state to cooperate in their efforts to seek better value.

Employers and Employer Coalitions

In 1993, 25 large private and public employers formed the Massachusetts Healthcare Purchasing Group (MHPG). This event signaled a change from business's conservative approach to purchasing employee benefits, an approach that reflected both strong support for the reputedly high-quality health system and a tendency for business to identify with the local hospital rather than networks or systems. MHPG members include Medicaid and the state employees insurance program, and its purpose is to promote value purchasing through collective pressure on health plans and providers. The impact of its actions is as yet unclear.

The group's highest profile effort has been an annual challenge to insurers and managed care plans to keep premium increases below a certain ceiling. In its first year, the ceiling was the inflation rate plus 3 percent; actual increases (including inflation) that year averaged 8 percent (compared with 17 percent in 1990), which fell within the limit, according to a representative of MHPG. Average premium growth of 3.4 percent was also within the 1994 limit. The

group then challenged plans to hold premiums steady in 1995, and some interviewees predict this goal will be met as well. The 1996 challenge is a 3 percent premium *cut*.

In addition to the premium challenge, MHPG is developing the health plan report card for consumers based on HEDIS (Health Plan Employer Data and Information Set) and National Committee on Quality Assurance data. One report has been published. The group is also negotiating quality improvement goals with health plans on the basis of the report card. Some interviewees predicted that MHGP's next initiative would be group purchasing.

The formation of the purchasing group served notice to insurers and managed care plans that large employers would no longer be passive, but interviewees have mixed views of the group's real effect on system costs and quality. Some health plan representatives suggested that MHPG's premium challenges were too high—that HMOs were prepared to cut premium growth even more. These interviewees noted that the area's large plans were already involved in the New England HEDIS Coalition and other efforts to improve and report data on quality. One MHPG member was skeptical about the group's effectiveness, suggesting that slowed growth in premiums may have cut into hospital and HMO margins and physician salaries, but had not yet affected the practice of medicine. He said that any changes in premiums or quality may be part of a national wave rather than a result of the actions of employers. Most informants, however, agreed that, at the very least, the group's existence signalled to insurers and providers that "someone was watching."

State and Local Government as Purchasers for Low-Income People

Massachusetts is becoming a more aggressive purchaser, primarily through its Medicaid program. The state took a large step toward managed care through a 1915(b) Medicaid waiver program, MassHealth Managed Care, implemented in 1992. The program serves 470,000 Medicaid recipients (mostly AFDC-eligible people) in managed care arrangements: 97,000 are enrolled in HMOs, and the remainder are in a primary care case management (PCCM) program called Primary Care Clinician Plan. The state recently hired Value Health Management to oversee the clinician plan, which operates like an independent practice association (IPA) through contracts with 3,000 physicians statewide. All hospitals in the Boston market participate in this plan. Medicaid has introduced geographical restrictions on PCCM enrollees in a reportedly successful attempt to reduce patient flow from surrounding communities to the large and expensive tertiary hospitals in Boston.

For HMO coverage, the state Medicaid agency issues requests-for-proposals by region. Capitation payments are case-mix adjusted, so health plans in Boston tend to receive higher rates. The Neighborhood Health Plan—an HMO owned by CHCs and the area's largest Medicaid managed care contractor—and HCHP have by far the largest Medicaid enrollment in the

Boston area, where recent negotiations led to a 10 percent premium cut. The state is requiring quality and outcome goals in these contracts. The state also holds semiannual meetings with each health plan to review progress toward the goals. The focus on quality received mixed reviews from interviewees; in particular, some HMOs view the effort as unproductive micromanagement.

The state's approach to financing care for low-income people may change dramatically with a new Medicaid 1115 demonstration waiver, approved by the federal government in April 1995. MassHealth seeks to expand health insurance coverage without raising taxes or mandating employer coverage. The program is designed to combine or coordinate many existing Medicaid and state-only funded programs, and to subsidize coverage for new populations as follows:

- Medicaid expansions provide coverage to children younger than 18 and their parents to 133 percent of the federal poverty level, and to 185 percent for pregnant women and infants. The expansion includes long-term unemployed people without children.
- The Insurance Reimbursement Program provides tax credits to low-income workers and their employers for purchase of a basic benefits package.
- The Medical Security Plan subsidizes benefits for short-term unemployed individuals with an income below 400 percent of the federal poverty level.

MassHealth is expected to cover 350,000 people through managed care arrangements, about half of the state's uninsured population, recently estimated at 12 percent in 1993. Governor Weld's proposed authorizing legislation, which would repeal the employer pay-or-play statute, finances the program with two-thirds ($231 million) of the Free Care Pool, disproportionate share hospital funds (the waiver requires some continued funding for the Cambridge Hospital and Boston City Hospital), savings from managed care, and existing appropriations. Hospitals, CHCs, and consumer advocates are especially fearful that many patients will remain uninsured, despite the waiver's eligibility expansion, and that their care will be jeopardized with the reduction of the pool. Democratic legislators have introduced competing implementation legislation that would use less of the Free Care Pool.

Insurers and Health Plans

As managed care in Boston rapidly expands, its nature is also changing dramatically. As in markets such as Portland and Seattle, Boston's long history with managed care evolved from the old staff model HMOs. HMO enrollment increased steadily but slowly until the 1980s; growth picked up in the late 1980s after changes were made to hospital rate regulations. Plans also grew by signing up as many providers as possible, an alternative model to the closed-panel HCHP. By the early 1990s, nearly 50 percent of the state's insured popu-

lation was served by managed care, one of the highest rates in the country. However, until recently most area plans functioned more like PPOs: care was managed only modestly, and providers were seldom paid on a capitated basis; "managed care in drag" was the term used by many interviewees.

The case of Bay State Health Care exemplifies both the origins and future of the Boston market. Bay State was a physician-controlled IPA that had contracts with nearly every provider in its service area and little utilization control. Its broad choice of providers forced other health plans to broaden their provider lists to avoid losing market share. According to some interviewees, this dynamic furthered the lack of care management (e.g., relatively unrestricted provider panels, few financial incentives for providers) by health plans in the region. These observers identified Bay State's looseness as the reason the health plan came close to bankruptcy. In 1992, the state brokered the sale of Bay State to HMO Blue (owned by Blue Cross), which then cut provider payments and restricted the list of participating providers.

Many of the area's major health plans are similarly seeking greater market share through regionalization, mergers, and acquisitions. HCHP has grown quickly with two recent consolidations, both of which extended its service area into neighboring states: Matthew Thornton, New Hampshire's oldest managed care plan, agreed to merge with HCHP in 1994, and in 1995, HCHP merged with Pilgrim Health Care, a fast-growing IPA (with a PPO option), to form Harvard Pilgrim Health Care. In August 1995, Blue Cross announced an alliance with Blue Cross plans in the five other New England states to develop and market uniform products to multistate, self-funded employers. Neighborhood Health Plan has developed an HMO for clinics in Rhode Island.

Boston area managed care plans are using more rigorous tactics for managing care in addition to offering a greater variety of products and provider choice. Tufts Associated Health Plan (TAHP) has explicitly avoided merger-fueled growth in favor of expansion through new products. Tufts developed the area's first point-of-service product in 1986, which now covers 25 percent of the plan's 400,000 enrollees. Many interviewees identified Tufts' Secure Horizons (a franchised Medicare risk plan first offered in 1994) as "the wedge into [true] capitation," the first plan in which primary care physicians are in control. One observer believes that by making the primary care physician the resource manager (i.e., decision maker over specialty and inpatient care), Secure Horizons could change the insurance market overnight.[2] "Bedded outpatients" is a new care management strategy in which very intensive care is

[2]With the exception of Secure Horizons, Harvard Pilgrim medical staff and groups, and some groups associated with Lahey Hitchcock, most Boston area physicians have been paid discounted or negotiated fees, with little financial risk or efficiency incentives. Hospitals are usually paid per case or per diem rates.

provided in order to discharge a patient in less than 24 hours. For example, Tufts reportedly pays one hospital 50 percent less for a bedded outpatient than for previous inpatient care for the same diagnosis.

Harvard Pilgrim is deliberately moving beyond its traditional staff model HMO, which has 400,000 enrollees, to offer more choices to purchasers. In fact, most enrollees of Harvard Pilgrim are in large medical groups (200,000) or the Pilgrim IPA plan (400,000). The plan serves self-funded employers and also has Medicaid managed care contracts in two states, and Medicare risk, cost, and supplemental products.

Blue Cross's primary strategy to secure its dominance—it insures 2.1 million of the state's 5.8 million residents—is stronger care management and service orientation. The plan's new leadership is focusing on "control of the desktop" in physician offices through a uniform, computer-based information system and a standardized quality assurance process. Greater emphasis is being placed on customer service and on performance-based evaluation and compensation at all levels of the organization.

Health plans are also moving to secure their primary care bases as a means to maintain or gain market share. Blue Cross has created Physician Partners of New England to develop, acquire, and affiliate with primary care practices. Harvard Pilgrim has a joint venture with the Lahey Clinic to develop and acquire primary care physician practices, and it has actively sought and marketed affiliations with Boston area community clinics.

Providers

Boston providers of all types are consolidating vertically and horizontally at breakneck speed. In most cases, these efforts are resulting in regional networks, although consolidations are sometimes designed to shore up very community-specific market shares.

Hospitals

The Boston hospital community is highly fragmented, but a flurry of negotiations could lead to as few as three major systems. All interviewees said the Massachusetts General-Brigham and Women's alliance was the destabilizing event in the Boston market that led to a "feeding frenzy" of merger negotiations and network development. Interestingly, the advent of this alliance was described by several observers as "serendipitous," the product of offhand discussions between two hospital executives. As a result, much skepticism was expressed about the wisdom—and staying power—of this and other arrangements perceived by some as being too quickly hatched or the product of fear rather than strategic thinking.

While many interviewees questioned the rationale and purpose of the new Mass. General-Brigham and Women's umbrella organization, Partners

Healthcare System, its sheer size ($1.7 billion net operating revenue; $1.1 billion cash and investments; 1,800 inpatient beds) is viewed as a threat to other institutions. This threat, combined with high costs, too many beds, high use rates, and more active health plans and employers, is reportedly spurring significant staff downsizing and administrative restructuring of the hospital industry.

More than simply a two-hospital parent company, Partners is the genesis of a network designed to serve fully one-third of the population of eastern Massachusetts. Partners Community Healthcare, established with the hospitals' resources, is a separate not-for-profit organization with a 15-member, physician majority board (Partners representatives did not describe this entity as a traditional physician-hospital organization). The network will contract with managed care plans and provide services through at-risk regional systems centered around primary care physicians and their hospitals.

In response to Partners, the other large medical school-affiliated hospitals[3] have sought mergers or affiliations that could shore up inpatient referrals and position them as full-service networks for contracts with health plans and purchasers.

- Deaconess Hospital, a Harvard-affiliated institution, created Pathway Health Network as an umbrella for its referral network alliance with New England Baptist and other Boston-area hospitals and their physicians.
- Tufts-affiliated New England Medical Center (NEMC) signed a preliminary agreement with Pathway in early 1995 but ended the relationship in July. NEMC then announced it would renew discussions concerning network development with Beth Israel Hospital (a Harvard teaching facility) and several community hospitals.
- Boston University and Boston City hospitals are poised to merge as a not-for-profit medical center, pending legislative approval (the city endorsed the move in mid-1995).

These mergers and other potential ones are spurred in part by health plans that are beginning to contract more selectively with hospitals. For example, Harvard Pilgrim moved its pediatric care to Children's from Massachusetts General in 1994, a loss of 25 percent of the latter's pediatric patients. That same year, Pilgrim dropped NEMC as a participating provider. These actions mark a dramatic change from the past when academic hospitals created a "brand name" presence that compelled insurers to include them.

[3]Unlike many medical schools, Harvard, Boston University, and Tufts do not own their academic medical centers. Thus, these institutions are able to act more independently than university-managed hospitals, though both types of arrangements are strongly influenced by the academic physicians who populate their medical staffs.

Beyond the "mega-mergers," hospitals of all shapes and sizes are actively consolidating. The Cambridge Hospital, a major public facility that had been attempting to stay independent, announced in July 1995 a merger with neighboring Somerville Community Hospital. Two-thirds of hospitals responding to a 1994 Massachusetts Hospital Association survey said they were forming physician hospital organizations (PHOs) of some kind. Cambridge Hospital created a PHO that now employs 85 percent of its medical staff, while Beth Israel is employing new primary care physicians to practice in local neighborhoods; some interviewees observed that this strategy is often necessary to ward off "raids" on primary care physicians by larger hospitals or insurers. Other institutions without substantial cash resources, such as New England Medical Center, are developing an alternative model to physician employment or acquisition by forming a network that provides management support for independent medical practices. This model was explicitly described by one interviewee as a way of "making a virtue out of the lack of a war chest" by behaving less like a 500-bed hospital and more like a group practice with some beds.

Interviewees expect the hospital system to be in flux for some time, as big changes have only begun. Capitated managed care is still only a small portion of inpatient business (e.g., 6 percent at Beth Israel), and hospital use has only just started to drop. Most observers said the major effect on hospitals—reductions in capacity and closures of as many as 50 percent of the market's beds—is still on the horizon because "institutions don't die easily." One new factor that could speed up changes for Boston's hospitals is the recent agreement in which for-profit Columbia HCA will purchase 530-bed MetroWest Medical Center in Natick and Framingham.

Physicians

Primary care physicians are highly valued in Boston's changing market, while specialists are reported to be angry and apprehensive. Primary care physicians are being offered handsome prices for their practices and seats on network boards, while specialists are facing reduced income and loss of business. Although this shift in power is similar to that in other markets, it is more dramatic in Boston because of the long history and high stature of academic medicine—specialists simply have farther to fall. A few interviewees are optimistic about the ability of physicians to adapt to a new world in which they will have to spend more time treating patients according to clinical guidelines and other managed care rules. However, most described the impending transformation of medicine in terms of trauma.

Many physicians are responding to hospital-led networks, as discussed above, but a few physician groups are initiating networks to compete for market share. One of the largest examples is the Lahey Hitchcock Health Care Network, which was formed by the physician-owned Lahey Clinic. Its strategy is to serve a large geographic area—indeed, all of eastern Massachusetts—with

primary care physicians and specialists, making it attractive to payers. Lahey has extended its service area by merging with Hitchcock Clinic in New Hampshire; employing clinicians in 13 multi-specialty practices; and developing a new, small hospital and outpatient facility on the North Shore. The extensive and multi-level network makes Lahey one of the most integrated systems in the Boston area, lacking only an insurance arm. To fill this hole, Lahey is seeking nonexclusive relationships with insurers, as in its joint venture with Harvard Pilgrim. (Lahey physicians may choose to be part of the health plan's provider network—Lahey and Harvard physicians practice in each other's clinics.)

Specialists are also moving to consolidate, using strategies such as the creation of one radiology and two ophthalmology networks. Interviewees identified one multispecialty group, the Massachusetts Alliance of Physicians, Inc. (MAPI), as having the potential to be a major player in the Boston market. MAPI's approach is to meld a primary care focus with physician control and vertical integration. The alliance was formed in 1992 by 180 physicians who capitalized a new, selectively chosen primary care group called Charles River Physicians. Charles River is not affiliated with any hospital; it receives capitation and purchases specialty services from MAPI. This arrangement was used by Partners Health System as a model for its planned physician-governed network, and Charles River is now part of the Partners system (the president of MAPI is a member of Charles River and sits on the Partners board).

Safety Net Providers

The forces causing upheaval among hospitals and health plans are creating new opportunities and dangers for Boston's 25 community health centers. Historically, the clinics existed largely alongside, but apart from, the rest of the health system. Their patients were mostly low income, a clientele not often sought by private providers, and their financing came from public grants and Medicaid, with little private insurance. Today, CHCs are viewed not only as safety net providers but also as attractive primary care providers that can bolster referrals and afford advantages to hospitals and health plans in the competition for a growing Medicaid managed care market.

Evidence of new opportunities is apparent in two CHC-related networks. The Boston Health Network is being formed around the proposed Boston City Hospital-Boston University merger and includes seven community clinics. The network is designed to administer all managed care contracts for its participants. One estimate of the value of referrals for the hospitals is $20 million. A number of interviewees indicated that this is not the only case in which CHCs are being courted with financial offers from hospitals in Boston.

Another type of network involves CHCs and health plans. In addition to the Neighborhood Health Plan, whose mission is to serve as the clinics' HMO, Harvard Pilgrim has added at least 12 CHCs to its provider network and is

using this fact in high-visibility marketing to low-income and non-English-speaking people. According to one interviewee, a relationship with health plans offers CHCs access to quality improvement, data, and continuing education infrastructures in addition to the private pay patient base.

Several observers have warned that such opportunities also have a downside. The corollary of large cash offers from large hospitals to CHCs is heightened competition among CHCs for this money. One clinic representative lamented the increased pressure to seek capital funds after a neighboring clinic moved to an attractive new building. Other interviewees cautioned that strong ties to neighborhoods could be weakened by managed care and by hospital pressures for exclusive referral agreements. For instance, local residents might abandon one CHC for another rather than be compelled to obtain their inpatient care at a hospital not of their own choosing. In addition, managed care capitation rates may not account for the wide range of services offered by most clinics, which emphasize a holistic approach to primary care (i.e., not just medical doctors), prevention, social services, and outreach (all of which were said to be highly valued by CHC patients). If this comprehensive array of services is eroded, CHCs may be caught between the heart and the purse string, risking the loss of special community status that has sustained them.

Some CHCs are responding to these pressures by strengthening ties to the community and by increasing their attractiveness to patients. Boston's diverse population has prompted clinics to develop strong multilingual capabilities; for example, staff at Uphams Corner speak six languages and therefore attract patients who speak these languages from as far away as Rhode Island. A number of clinics, including Uphams Corner and Codman Square, are working to become more patient friendly by expanding evening and weekend hours as well as the scope of services, and by providing nontraditional care (e.g., acupuncture, massage). Codman is also offering its facilities and resources for community meetings and redoubling its historical efforts to improve community health.

Some interviewees voiced concern over the disappearance of public hospitals, a source of care for low-income people in many communities. In the early 1980s, Massachusetts had numerous public hospitals, but if the merger between Boston City Hospital and Boston University is approved, Cambridge Hospital will be the state's last publicly owned institution.

Consumers

Consumers, by and large, have not yet felt the effects of the frenetic market activity. Workers still expect employers to provide fairly comprehensive coverage and are already used to having a choice of at least one HMO. Observers do not think that competition on the basis of service and quality has reached the consumer level, although some people may have reaped savings from reduced premiums. There is consensus that choice still drives consumer deci-

sions and, therefore, purchaser and delivery system strategies. However, one business interviewee felt that employees are showing a greater understanding of different types of plans and cost-sharing arrangements and are asking more questions about quality.

Interviewees have mixed views about how market changes are affecting or would affect low-income groups and communities of color. One consumer advocate argued that, for many people in these groups, the corporate level mergers are not important, since access to needed services is affected by whether 10 or 3 institutions control the system. In some communities, market consolidation could lead to consumer dissatisfaction if community hospitals close or are converted to other uses. Many health plan and provider interviewees agreed that, beyond issues of choice, consolidations are not addressing access problems; some said that this issue must be the province of public policy, not market dynamics.

Published data suggest that the number of uninsured residents continues to rise, putting more pressure on traditional safety net providers. Many interviewees fear that this pressure, combined with competitive forces, may reduce access in the future. Representatives of low-income consumers are skeptical that the new 1115 Medicaid waiver program will be a net improvement in access because proposed cuts in Free Care Pool funding would offset the benefits of expanded coverage for poor working and unemployed people. However, no one argued that Medicaid expansion, as such, is a bad policy.

▼ ▲ ▼ Future Developments

There is little consensus among interviewees about the implications of the tremendous changes in the Boston health care market. They expressed very different views on nearly every major question. Some predict that networks created by academic medical centers will ultimately control most resources, while others argue that managed care plans are in charge; a few said employers would ultimately control the purse strings. A number of interviewees predict that Partners and Blue Cross will move toward an exclusive relationship—perhaps starting with the latter's new Medicare risk product—which would drive other providers and health plans toward exclusive alliances. However, others argue that choice and the wide dispersion of providers would counter exclusiveness.

Most interviewees predict that the delivery system will consolidate into three or four networks. Partners and Lahey Hitchcock were identified as two of the likely players, although some people doubt the stability of the Mass. General-Brigham and Women's alliance, given its large inpatient infrastructure. The future of Deaconess, New England Medical Center, and Beth Israel was questioned (Beth Israel has had ongoing discussions with Lahey concerning a possible alliance), as was the financial viability of the proposed

Boston City-Boston University merger. A number of interviewees expect one or more of these five institutions to fail.

Everyone noted that federal cuts to Medicare could have devastating effects on the Boston health care system. Most important, if Medicare payment for graduate medical education is cut, the academic medical centers could be forced to drastically cut costs or even close. Medicare could also push the insurance market further and faster toward capitation payment of providers if it requires or more strongly encourages enrollment in risk products.

Some interviewees voiced concern over the entry of Columbia HCA into the Boston market. (The Nashville-based company agreed in June 1995 to purchase MetroWest, a two-hospital system west of Boston.) Columbia HCA could, according to some observers, be the "deep pocket" that drives the downsizing and cost-cutting that many think is coming. The potential for this move to open the door to other for-profits also concerns some people. The state attorney general intends to hold hearings by the end of 1995 on the proposed purchase.

Many interviewees said the insurance market in eastern Massachusetts is ripe for more change. One person noted that US Healthcare, one of the few for-profit HMOs and a small player in the market for nine years, could be a force if it decides to expand in the market. Some health plan representatives suggested that some of the not-for-profit plans would soon turn for-profit to fund growth. ("We all have investment bankers now," said one interviewee.) Not all observers, however, agree with this prediction. Interviewees also mentioned that additional mergers among insurers are a possibility, and no one expects market changes to end anytime soon.

Although health care reform was killed at the federal level and largely dismantled at the state level, interviewees predict that public policy will remain an important influence on the Boston health care system. Whether the Medicaid 1115 waiver is implemented and how it is financed were the biggest questions raised by interviewees. The governor has garnered considerable support for his plan, but some observers think the program will be dropped if Congress approves block grants and cuts funding for Medicaid. Many are optimistic that the program will provide health coverage for a large percentage of the now-uninsured population, but others warn that use of Free Care Pool and disproportionate share funds will hamper care for the remaining uninsured. A number of interviewees also cited the attorney general's community benefits guidelines for hospitals and HMOs (proposed) as potentially important factors in how the market unfolds. The market is "sitting on the edge of a cliff," according to one interviewee, and there is little agreement as to what lies at the bottom. The only certain element in this scene is further change.