COMMUNITY SNAPSHOTS PROJECT

Des Moines, Iowa

Site Visit Report

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▼ ▲ ▼ Overview

Des Moines is a close-knit community where business is often done with a handshake, and old ties are not lightly broken. The health care market is no exception. Major stakeholders in this market have long and loyal working relationships, and there is a history of generous indemnity health insurance coverage. Insurance companies are prominent players in the employer community, and several are headquartered in Des Moines. The restructuring now beginning to take place in the health care system—the development of managed care, hospital consolidation, hospital-physician integration, and direct contracting of employers with providers—portends big changes for this market.

Despite these developments, enrollment in managed care has been limited to date and largely centered in preferred provider organizations (PPOs). In addition, most HMOs resemble independent practice associations (IPAs). Before 1992, employers had taken limited actions to lower health care expenditures or to enroll employees into managed care for several reasons. Health care costs in the Des Moines area were relatively low compared with the national average. Furthermore, there was a great desire on the part of employers to maintain good relations with employees because of the low unemployment rate and the large number of "headquarters employees" accustomed to generous indemnity benefits packages. Thus, until recently, employees made small out-of-pocket premium contributions and few copayments for their health insurance. Given this history, employers have been understandably reluctant to accept change in their health insurance, particularly restrictions on provider choice and covered benefits.

When the national debate on health care reform heated up in the early 1990s, so did pressure for change in Des Moines. Large employers formed an advisory group for government officials to help stem the growth in health care costs. But not until 1994 did they form a purchasing coalition to contract directly with delivery systems instead of working through insurers. In the meantime, insurers had developed HMO plans. In response to these changes, hospitals began to consolidate, and two major health systems now dominate the Des Moines area market. However, consumers have resisted efforts to restrict their access to one of these delivery systems.

Although there are multiple insurers in Des Moines, only The Principal Financial Group and Blue Cross and Blue Shield of Iowa are major players in the managed care market. Principal's HMO subsidiary, Principal Health Care, began in 1993 to use employer price incentives to move enrollees out of products that did not restrict access to physicians, into products that do. They have doubled the fraction of enrollees in gatekeeper arrangements from one-quarter to one-half their HMO enrollment. Blue Cross and Blue Shield took a very different approach in the same year. They started a joint gatekeeper plan,

Unity Choice Health Plan with one of the two dominant delivery systems in the area, Iowa Health System. Their approach included 20 percent provider equity in the start-up, with plans to increase the provider share in the financial risk. Growth in the gatekeeper plans of both insurers has been slower than hoped, largely because of employer reluctance to restrict the access of employees to providers.

Public policy has encouraged some changes in the health care system, although policymakers have generally adopted a voluntary, incremental approach to reform. Three recent state laws have facilitated reform. First, the country's first statewide voluntary purchasing cooperative of independent insurance agents was formed. Second, a new state licensure category for health plans was created: "organized delivery systems" (ODS) are provider-sponsored health plans that contract directly with employers, essentially bypassing insurance companies. Third, a new system, developed in partnership with employers, will provide purchasers, providers, and the public with information previously held solely by insurers about the cost and quality of health plans. The new system is intended to establish competition on the basis of quality as well as price.

As a health care purchaser in its own right, the state government is moving tentatively toward managed care. While Medicaid recipients are being aggressively enrolled into primary care case management (PCCM) programs, efforts to enroll eligibles in HMOs have not been as strong. The state government is examining various incentives to encourage public employees to enroll in managed care plans.

The Des Moines market has lost much of the momentum for change spurred by the prospect of national health care reform. Even though managed care penetration is limited (especially with regard to capitated plans), and very little clinical integration and management of care has occurred, an infrastructure designed to accommodate anticipated changes in the marketplace is being built.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

Des Moines is the largest and fastest growing city in a state that lost 3.8 percent of its population between 1980 and 1992. The Des Moines market has two geographic components: the metropolitan area of the city and its suburbs of Polk County, which had a population of about 340,000 in 1992, and the 43 primarily rural counties of central Iowa that surround the capital, which have a population of about 1,000,000. Des Moines dominates the larger market area of central Iowa. The border cities along the Missouri and Mississippi rivers to the west and east, and the corridor of counties along the

northern border of the state are not major participants in the central Iowa market, nor is Des Moines a major force in their markets.

Residents of the area tend to be older and more ethnically homogeneous compared with most other metropolitan areas in the country. Though the elderly in Iowa are disproportionately located in rural areas, 6.1 percent of Des Moines residents are 75 and older, which is higher than the national average. The vast majority of the residents in the Des Moines area (89 percent) are white. The primary minority ethnic group is African American (6.9 percent). Hispanics and Asian/Pacific Islanders each constitute about 2 percent of the population of the city, and Native Americans constitute less than 1 percent.

Iowa's economy is generally healthy. Income is comparable to the national average, and the unemployment rate is low. In 1990, the median family income was slightly higher in Des Moines ($32,800) than the national median ($30,000). The proportion of households with an income below the federal poverty level is the same as the national rate (10 percent in 1992). These statistics belie some indications of economic problems. The Medicaid-eligible population grew at a rate of 5 to 7 percent annually from the 1980s through the early 1990s, in part because of the growing number of people with a low income. About 20 percent of older Iowans have an income of less than $10,000 a year. Although most Iowans over 65 years of age report that they have little difficulty paying bills, about 35 percent of them report that cost is a deterrent to obtaining health care.

The economy in Des Moines is healthier than that in the surrounding rural areas. The unemployment rate (3.0 percent in 1993) in Des Moines is also less than half the national rate, and in recent years, people from the rural areas have moved to Des Moines to work primarily in the service industry. The large private employers in Des Moines tend to be insurance companies, and the largest is the Principal Financial Group, with more than 7,500 employees. Only state and local government come close to employing this many people. More than half of the 13,000 businesses in Polk County employ fewer than 5 employees, and only 15 employers in the county have more than 1,000 employees.

Health System Composition and History

The Des Moines health system is a traditional market dominated by private insurance, not-for-profit hospitals, and the fee-for-service system of payment. Two hospitals have historically influenced the Des Moines health care system. The Iowa Methodist Medical Center (now Iowa Health System) and Mercy Hospital Medical Center are locally noted for their specialty care. Des Moines is an unusual metropolitan center in that its hospitals are not as heavily involved in tertiary care—largely because the state's academic health center at the State University of Iowa is located one hundred miles east in Iowa City.

Hospitals in Des Moines have twice as many beds as this health center, but four times as many people live in Des Moines as in Iowa City.

Insurance companies dominate the landscape and the health care system in Des Moines, which is home to Principal's national headquarters and Blue Cross and Blue Shield of Iowa's regional headquarters. These two companies insure the majority of Des Moines residents. One large self-insured employer, John Deere and Company, introduced managed care to Des Moines 1985, but few other employers or insurers followed suit. John Deere is one of the city's 15 largest employers, although only 1,350 of its 7,500 employees statewide live in the Des Moines area. The company founded Heritage National Healthplan in 1985 as a wholly owned subsidiary and marketed the HMO to employers in Iowa and out of state. Provider choice is essentially not restricted, since members of the HMO can see any participating physician without a referral, and many Des Moines providers, including three of five hospitals, participate in the plan. When the HMO failed to persuade the academic health center in Iowa City to serve as the tertiary referral hospital, the Mayo Clinic in Minnesota stepped in and agreed to act as the referral hospital and as a resource for primary care providers. The Heritage National Healthplan continued to grow, but other employers and insurers have not rushed to follow suit and develop other managed care plans.

Once the national health care reform debate began in the early 1990s, large employers initiated a flurry of activity to change the traditional health system of Des Moines. They pressed state government to intervene, helping to slow the growth in health care costs. In 1991, a leadership advisory group of large employers formed to advise government on reducing health care costs. In 1993, the advisory group was reconstituted by the governor to assist state government in building a consensus on health care reform in Iowa. The new council included representatives for large employers but expanded to include representatives for consumers, state legislators, providers, insurers, farmers, and other employers as well. The traditional health care system of Des Moines was poised for change. The two dominant insurance companies began to experiment with HMOs. Yet, enrollment grew slowly, and consumers largely rejected restrictions on benefits and provider choice. The "culture" of the market posed one obstacle to the development of both managed care and cost-containment initiatives, for even business deals in Des Moines are subject to small town chivalry:

> If you are working for a proprietary hospital, what you would [ordinarily do after a hospital merger] is shut down one hospital and take the physicians, but you do not do that kind of thing here in Des Moines; that does not fit well here. Things are very community focused—people focused. It is a very soft approach to doing business. It is the kind of place where you can still do business on a handshake.
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> —*Hospital spokesperson*

Health System Changes

Public Policymakers

Policymakers in Iowa have instituted health care reform in the private market through an incremental, voluntary approach. Before 1993, state officials had proposed centralized reforms based on the national health care reform model. These reforms, which called for a larger role for government, were rejected. The state legislature eventually enacted more modest laws aimed at improving the availability of insurance in the small group and individual market, and at developing a single electronic claims form and data collection standards. In a similar vein, the 1995 legislature rejected several proposed insurance mandates, which would have required employers to provide more benefits and insurers to accept "any willing provider."

For the small business and individual insurance market, Iowa enabled the formation of voluntary purchasing cooperatives and enacted a series of insurance reform measures. Health insurance purchasing cooperatives (HIPCs or alliances) authorized by the legislature in 1993 were intended to make more affordable insurance products available to small businesses by collectively pooling risk and lowering their administrative costs through economies of scale. The cooperatives give small groups additional market clout for negotiating prices and contracting with high-quality health plans. Insurance reforms followed in 1994 and 1995 to promote access to and portability and continuity of coverage between state-regulated small group and individual health plans regardless of pre-existing conditions. New standards were developed to encourage insurers to use community rating as an alternative to the risk avoidance approach associated with experience rating.

The Community Health Management Information System (CHMIS) was established in 1994 to develop a single electronic claims form and data collection standards for continuous quality improvement. CHMIS is considered an essential tool for evaluating progress toward health system reform, cost containment, and improved access and health insurance coverage. Information in these areas is collected from public and private entities. A task force is reviewing Health Plan Employer Data and Information System (HEDIS) and other quality measurement systems that could be incorporated into CHMIS.

Potentially the most significant public policy development was the 1993 new licensing category for "HMO look-alikes," or organized delivery systems (ODS), in which providers contract directly with purchasers. In an ODS, providers bear financial risk for capitated lives covered by the plan and hire an insurance company as a third-party administrator to perform such functions as claims processing, enrollment, and rate-setting actuarial analyses. The ODS was a key innovation in Iowa, because it was intended to lower requirements for providers for financial reserves that apply to HMOs that had previously limited their sponsorship to insurers and large self-insured employers like John Deere.

Purchasers

Large employers were the initial force behind health system change, but they have been unable to enroll large numbers of employees in HMOs. Their efforts to encourage employees to select HMOs were hindered because (1) the growth of costs for indemnity insurance and PPO plans slowed, (2) employers' costs for new HMOs were sometimes higher than their indemnity insurance rates, and (3) the low unemployment rate and tight labor market makes employers reluctant to anger employees by restricting expected health benefits, such as provider choice. As cost pressures on large employers eased, they lost much of their initial momentum to reform the health system.

Employers and Employer Coalitions

Large and small employers have joined purchasing cooperatives to negotiate with managed care plans and insurers in order to control their health care costs.. To date, however, too few employees have enrolled in managed care to significantly reduce costs for the employer community.

Large-Employer Purchasing Cooperative

Large employers have only recently formed a purchasing cooperative. In 1994, nine large employers in Des Moines started a voluntary purchasing group called the Community Health Purchasing Corporation (CHPC). These employers had discovered that HMOs were "price followers" of the insurance companies, offering rates only about 5 percent lower than those of insurers. The CHPC, representing about 20 percent of private-sector employees in the area (22,000 employees), contracts directly with providers for services and with an administrative service organization for insurance management activities. The CHPC states that its goals are to make providers and employees more cost-conscious. Providers share in the financial risk for service utilization that exceeds established claims targets. Employers base their contribution on the lowest-cost plan, and employees pay the difference for any higher-cost plan they choose. In 1994, the CHPC issued a Request for Proposals to providers interested in developing integrated delivery systems, and twelve provider groups responded. Currently, the CHPC is contracting with only one large system (the Iowa Health System) to form a plan (IA Care) that was first offered January 1, 1995, but they hope to add two more delivery systems soon (Mercy's Accountable Health Plan, Inc. and John Deere's Family Health Plan).

Enrollment in IA Care in the first six months of operation has been disappointing, illustrating the substantial problems that purchasing cooperatives face in the Des Moines area. IA Care was able to enroll only 2,000 of the 20,000 eligible employees and their family members to whom they were given exclusive rights. Part of the problem was that two of the nine member companies did not offer IA Care as an option to their employees in 1995. An additional problem, however, was that the cost of the plan to some employees

actually exceeded the low-cost plan already available. Company executives have committed to enrolling 30 percent of eligible lives by the end of 1996. To meet this objective, they will probably ensure that IA Care is the lowest-cost option for their employees.

Working with providers, the CHPC has played a fundamental role in designing integrated systems, and it also has been involved in providers' quality assurance efforts. For instance, the CHPC will produce report cards comparing delivery systems and individual providers on the basis of consumer satisfaction, quality, and utilization patterns. In exchange for expanding quality assurance efforts, the employers will develop wellness programs for their employees.

Small-Employer Purchasing Cooperative

Currently unique to Iowa is a statewide voluntary purchasing group formed by an organization of independent insurance agents—the Independent Health Alliance of Iowa (IHAI). This purchasing cooperative negotiates with health plans for small businesses (currently those with fewer than 50 employees) and also offers plans to self-employed individuals. It is gradually expanding its market to larger businesses and has insured over 700 employer groups, but only about 6,500 covered lives. The IHAI states that it has lowered costs to small businesses by negotiating competitive prices with health plans. Like the large employers purchasing cooperative, CHPC, the IHAI structures rates so that employees pay more for unrestricted access to physicians and broader benefit packages.

Some observers are reserving judgment about IHAI's success. They doubt that the group has captured sufficient market share to survive in an increasingly competitive market. In addition, they point out the danger of potential adverse selection of small groups already rejected by a large commercial insurer. Finally, neither of the two dominant insurance companies in Des Moines offered a plan through the IHAI. While these companies can develop and market their own small employer or sole proprietor products to compete with IHAI, only Blue Cross and Blue Shield has done so.

Government as a Large Employer

Iowa is developing a strategic plan to modify the current state employee health benefit program for its 30,000 employees and their dependents. The health plan options for public employees have remained unchanged for several years. Most public employees choose indemnity insurance through Blue Cross and Blue Shield of Iowa because the state pays the entire premium for indemnity coverage. Employees do not have copayments, even for packages with comprehensive benefits, and they enjoy access to a broad network of providers (including nearly 100 percent of the hospitals and 85 percent of physicians in the area). While the state is required to offer its employees managed care plans that meet the state's contracting specifications, only a PPO of Blue Cross and

Blue Shield is available, and employees have no financial incentive to choose this product.

The traditional concerns of labor unions have contributed to a delay in changing the health benefits of public employees. Because providers agree not to bill employees the balance of the charges not paid by Blue Cross and Blue Shield, any change in providers is regarded as a change in employee benefits subject to collective bargaining. In addition, because employees at the managerial level have traditionally been covered under the same benefit packages as union employees, managed care will be introduced slowly to non-union employees because of union resistance. The state Department of Personnel plans to develop a new, more flexible benefits system so that savings in health benefits are redistributed among employees as income or other benefits. The state is considering several options for achieving the savings: converting to self-funding and contracting directly with delivery systems; persuading providers to assume financial risk for service utilization; and instituting benefit carve-outs for certain products or services, such as pharmaceuticals.[1] In addition, the state intends to join the CHPC as a voting member and obtain access to the CHPCs' integrated delivery systems. However, it does not appear that these changes will happen rapidly.

State and Local Government as Purchasers for Low-Income People

Iowa has been successful in moving Medicaid eligibles into case management programs but not HMOs. MediPass is a primary care case management (PCCM) system that operates throughout the state, but the HMO program covers only 43 of 97 counties in the state. In the PCCM, physicians serve as gatekeepers of high-cost care. The program grew from 60,000 Medicaid recipients (mostly people receiving Aid to Families with Dependent Children) in 1992 to 95,000 in 1994. In 1994, there were only 130,000 Medicaid eligibles who had yet to be enrolled. MediPass is credited with lowering emergency room use through triage and referral to sources of care more appropriate than that offered in an emergency room.

Iowa has not been as successful in purchasing HMO coverage for its Medicaid recipients as it has been at enlisting case management physicians for them. Although Iowa began to enroll Medicaid recipients in HMOs in a pilot

[1]Managed care organizations or other groups providing comprehensive packages of coverage for health services may have agreements (similar to subcontracts) with firms or organizations that specialize in providing specific plan benefits (e.g., mental health services, chemical dependency services). The health services provided by such specialized firms are referred to as carve-out benefits. Pharmacy benefits are often covered in this manner due to some unique and specialized activities associated with processing prescription claims and providing pharmacy services as a benefit. Specifically, the high volume of drug claims and the large variety of drugs covered, with each prescription being a service encounter, has prompted the development of firms that specialize in processing and administering pharmaceutical services.

project in 1986, Des Moines was not included. After that pilot project returned $3 million to the state from its unspent reserves during one year of operation, allowing Medicaid to lower its capitation rates the next year, the project was expanded to 10 areas in the state. There are now plans to enroll Medicaid eligibles in the Des Moines area in HMOs.

The state is rapidly developing HMO coverage of mental health services. In March 1995, Iowa awarded a contract to Medco Behavioral Care to implement a statewide managed mental health program called the "Mental Health Access Plan" under a 1915(b) waiver. (Medco Behavioral Care is a New Jersey-based organization specializing in the provision and administration of managed mental health services.) All 130,000 Medicaid eligibles are being targeted for eventual enrollment. Now that it appears many initial difficulties have been corrected, this system may provide a model for other states.

Insurers and Health Plans

Although there are multiple insurance companies in Des Moines, The Principal Financial Group and Blue Cross and Blue Shield dominate the market in managed care. Most managed care enrollees with both insurers are in PPO plans that have broad participation by most physicians in the area. In 1993 the insurers adopted different strategies to make managed care products they thought would be more attractive to employers anxious to reduce the growth of their health care costs. The HMO plan owned by Principal Health Care, a subsidiary of The Principal Financial Group, functioned more like a PPO than an HMO: employers paid discounted premiums, providers were paid discounted fee-for-service rates, enrollees had no designated primary care physicians and they could self-refer to specialists. In 1993 they acquired United Health Care Plan with gatekeeper primary care physicians, and began to move HMO enrollees into gatekeeper model arrangements with price incentives for employers. In two years they doubled the fraction of enrollees in gatekeeper arrangements from one-quarter to one-half of their HMO enrollment. At the end of 1994, more than 40,000 enrollees were enrolled with gatekeeper primary care physicians, and more than 80 percent of those lived in Polk County and the immediate contiguous counties. Principal had expected a larger shift of enrollees to these products, but it found that purchasers were willing to pay slightly more not to have enrollees restricted to a single primary care physician, or to be required to obtain a referral to see a specialist.

Blue Cross and Blue Shield technically has no licensed HMOs, but it began in 1993 to develop Unity Choice Health Plan, a PPO with capitated payments to primary care physicians who served as gatekeepers. This plan is a joint venture of the Blues with the Iowa Health System providers, financed 80

percent by the insurer and 20 percent by the providers. Plans are to increase the provider financial equity in the plan to align the financial risk incentives of the providers with reducing the growth of health care costs even further. At the end of 1994, the plan had about 8,000 enrollees, about half of whom lived in Polk County and the immediate contiguous counties. The reluctance of purchasers to commit to a single delivery system has slowed the growth of enrollment.

Principal and Blue Cross and Blue Shield are competing heavily in terms of price and market position. The Blues had hoped to offer premiums for about 20 percent less than the cost of other products in Des Moines, but Principal bought United Health Care Plan and offered the lowest price in the market. One observer predicts that there will be an intense struggle over premium structure.

Two managed care plans in Des Moines were not developed by insurance companies: John Deere Health Care was created by an employer and SecureCare of Iowa was developed by providers. John Deere and Company, pioneer of the HMO plan in Iowa, is expanding its market by developing its own staff model HMO and opening primary care clinics. John Deere Health Care, Inc., was created in 1993 to market management services to health care programs of other self-insured employers. In 1994, it established a Des Moines-based primary care clinic for its John Deere Family Health Plan, a staff model HMO. Currently, there are four such clinics in Iowa, particularly in areas where large numbers of company employees live. Two more clinics are planned.

The newest managed care plan in the market is SecureCare, the only licensed ODS. Mercy Hospital Medical Center partnered with a physician organization formed by its own medical staff to create SecureCare, which began operation in early 1995. An organization that provides administrative services handles claims processing and financial risk management functions for the system. SecureCare, which has about 3,000 covered lives, will be offered as an option by the large employers purchasing cooperative as Mercy Accountable Health Plan, Inc., beginning in January 1996. It does not enroll Medicaid or Medicare recipients, although future participation in Medicaid is anticipated.

Plans have little incentive to move into the Medicare risk contract market largely because of Iowa's low Adjusted Average per Capita Costs (AAPCC) rates. Only rates in Mississippi are lower. Regional variations in Medicare payments are currently being debated at the federal level, and it is likely that they may end or be readjusted. Higher Medicare reimbursement rates may stimulate interest in developing more Medicare risk products in the Des Moines area and throughout Iowa.

Providers

For providers in Des Moines, the most significant change in the health system has been the shift in the control of care in their province to employers and insurers. Providers have responded to demands to reduce utilization but feel that the resulting cost savings have gone to the insurance sector. Providers feel strongly that as they assume greater financial risk, they deserve to share in the financial rewards.

Market pressures in recent years have been greater on hospitals than on physicians. The Des Moines area has a lower ratio of physicians (154 physicians per 100,000 residents in 1990) and higher ratio of hospital beds (506 beds per 100,000 residents in 1990), compared with national rates (214 and 366 per 100,000 respectively). For this and other reasons, hospitals have taken the lead in developing delivery systems with their medical staff to maintain bed occupancy rates and market share. Hospitals can assume this leadership role because they are business oriented and have the financial resources and administrative experience to develop new enterprises.

Physicians remained largely independent until recently and had not built a unified presence in response to market changes. As recently as two years ago, almost all physicians in Des Moines practiced individually or in small groups of no more than five. While the statewide rate of active nonfederal physicians per 100,000 residents is low, (154 compared with 214 nationally), and a majority of counties in the state (63 out of 99) are currently designated as medically underserved areas, there is an oversupply of specialists, and physicians are concentrated in counties that have metropolitan centers. In Des Moines, some specialists report having lost half of their patients and revenues in the past year.

Hospitals

Two of the five hospitals in Des Moines dominate the regional market and actively compete with each other: Iowa Methodist Medical Center (now Iowa Health System) and Mercy Hospital Medical Center. Both are private, not-for-profit entities with similar payer mixes—about 40 percent Medicare, 8 percent Medicaid, about 2 percent self-pay, and the remainder commercially insured. The three other hospitals include the Broadlawns Medical Center (the county Hospital in Des Moines), Des Moines General Hospital (a private facility), and the Veterans Administration Hospital.

Hospitals in Des Moines and the rest of the state are trying to redefine themselves as integrated service delivery systems rather than inpatient cost centers. Two distinct types of provider organizations have appeared: horizontally integrated systems in which hospitals merge and consolidate outpatient services, and vertically integrated systems in which hospitals acquire or partner with physician organizations, skilled nursing homes, home intravenous-

infusion companies, clinical laboratories, and durable medical equipment companies. Hospital mergers, acquisitions, or closings are gradually reducing excess capacity in Des Moines and other cities in the state.

Iowa Health System has become the largest integrated system in central Iowa. It was created by a merger in 1992 between Iowa Methodist Medical Center and Lutheran Hospital, then the third largest facility in Des Moines. An important objective of the merger was to reduce duplicate services, and a savings of $11.5 million was reported after the first year. After Methodist merged with Lutheran, other hospitals followed suit, and according to one respondent, "Like the first olive out of the bottle, the rest are now coming a lot easier." St. Luke Hospital in Cedar Rapids (450 beds) and Allen Memorial Hospital in Waterloo (200 beds), also merged with Methodist Hospital. Methodist Hospital is negotiating with five other hospitals around the state. These mergers could be finalized by 1996.

Mergers and acquisitions address important needs for the hospitals. With each merger, Iowa Health System helps expand the primary care base of the acquired hospital and offers technical support in finance and management to achieve cost efficiencies. In return, the acquired hospital refers its patients in need of specialist care to Methodist Hospital in Des Moines.

For the past year there has been considerable development of organized delivery systems at Iowa Health System and Mercy Hospital Medical Center. Iowa Health System includes two major sets of physicians, a large Des Moines-based group (Iowa Physicians Clinic) and a variety of smaller primary care group practices. As Iowa Health System builds clinics in small towns surrounding Des Moines, clinics from other areas of the state have expressed an interest in acquisition. Physicians are salaried, receive administrative support and benefits, and are offered financial incentives to increase patient load.

Mercy Hospital Medical Center competes vigorously with Iowa Health System. In the past six months, Mercy has purchased 11 primary care practices to form the largest private primary care clinic system in the state. Mercy purchased Westside Hospital to provide services that it formerly did not offer (e.g., mental health services) and formed a network of affiliated hospitals in central Iowa. And as mentioned, Mercy Hospital Medical Center partnered with a physician organization formed by its own medical staff to form SecureCare of Iowa, the first ODS.

Not all communities surrounding Des Moines welcomed the expansion of these health systems. At least one group of three large employers from three communities (Pella, Oskaloosa, and Knoxville) 40 miles outside Des Moines developed its own system destined to become an ODS (South Central Iowa Health Care Partners) to compete with Des Moines-based plans and provider systems seeking to establish a presence in their area. These large employers formed a partnership with three primary care physician clinics (specialists are paid on a negotiated fee-for-service basis), three hospitals in the communities,

and an insurer. Within three years, South Central Iowa Health Care Partners expects to offer a fully capitated managed care plan. In the first year of its operation, 22 percent of the employees of one of the large employers (Pella Corporation) converted their coverage to the new system.

Despite rhetoric to the contrary, quality control initiatives are a lesser priority in Des Moines than cost containment. Underutilization and denial of necessary care are not being scrutinized vigorously because, in the words of one hospital spokesperson: "The romance is still with saving money, so we aren't looking at the other side of coin. It's too early yet."

Physicians

Physicians in Iowa are experiencing a transition as they join vertically integrated systems. The traditional mistrust between hospitals and physicians makes the formation of such systems difficult, but many physicians believe that vertically integrated systems help align the sometimes competing interests of hospitals and physicians. For example, paying physicians a capitated rate places them at financial risk for controlling service utilization and allows them to share in cost savings if they do. Decreasing physician use of resources associated with hospitalizations saves hospital costs, and some of these savings may revert to physicians.

SecureCare of Iowa

The ODS SecureCare gives its more than 300 shareholder physicians a role in the ownership and governance of the plan. As an example of addressing physician concerns, the plan will focus its first physician evaluations on clinical profiles, not financial profiles. If the practice profile of a physician is unsatisfactory, the plan will not automatically exclude him or her but will apply educational interventions and comparisons to peer norms for service use, costs, and outcomes. According to SecureCare representatives, five issues will determine the future success of SecureCare: (1) the ability of its specialists to better manage their resources and costs, (2) access to capital, (3) acquisition of a sophisticated medical information system, (4) the potential for a price war with competitors that might force SecureCare out of the market, and (5) the ability to expand and offer its product statewide by developing relationships with the 14 Mercy-affiliated hospitals.

Iowa Physicians Clinic

The Iowa Physicians Clinic (IPC), comprising over 100 internists, developed a relationship with Methodist Hospital about seven to eight years ago. Initially an IPA, the IPC evolved from a loose affiliation of physicians into an integrated professional corporation two years ago. A major challenge for the IPC is its relationship with specialists. An excess number of subspecialists and surgeons in the community has forced IPC to address the appropriate distribution of specialists, the affiliations these physicians should pursue, and the equity of various reimbursement methods.

The Iowa Clinic

An up-and-coming competitor for the IPC, the Iowa Clinic began as an independent physician organization approximately five years ago. In 1993, the members decided to move from a loosely affiliated organization to an integrated one, and as of July 1995, the Iowa Clinic became a professional corporation. The group is specialist dominated. Only 30 of the 120 members are primary care physicians. Medicare accounts for over 50 percent of revenues, payments from the commercial sector constitute 40 percent, and the remainder is reimbursed by Medicaid. About 65 percent of the Iowa Clinic's reimbursement from commercial insurance involves PPO/discounted indemnity products.

The Iowa Clinic's loose affiliation with the Iowa Health System may be problematic in the future. Clinic physicians are not merged with the Iowa Health System, and an administrator at the Iowa Health System noted that in the future, contractual relationships with individual specialists may be the norm. This could endanger the long-term viability of the Iowa Clinic.

Public Providers of Care for the Indigent

Public providers, such as the county hospital (Broadlawns Medical Center) and community health centers, have shifted their focus from inpatient care to outpatient primary care in the face of pressure to contain costs. The demand for public outpatient services is increasing in Des Moines. For instance, outpatient visits at Broadlawns doubled from 1980 to 1994, but emergency room use decreased 19 percent because all emergency room patients are now triaged and redirected to community health centers where appropriate. The hours of the community health centers have been expanded, and walk-in patients are accepted. In addition, Broadlawns is opening primary care clinics. Patients are encouraged to identify with a primary care physician and to use the appointment system at the clinics as opposed to dropping into emergency rooms. However, the facilities lack a computer-based information system to make records and encounter information available at all points of service where the patient may make an appointment. Without this kind of health record, quality of care may be compromised.

Academic Health Centers

There is no academic medical center in Des Moines. People needing tertiary care are referred to the University Hospitals of the State University of Iowa in Iowa City, which is about 100 miles away from Des Moines. Low-income patients in the Des Moines market counties are referred to the University Hospitals for specialist care through the State Papers Program. In this program, the state government gives every county a fixed amount of money to pay for specialist care for indigent patients at the academic medical center. For example, Broadlawns sends 300 to 400 indigent patients per year to the University Hospitals for care.

Consumers

> . . . The clamor for health reform is probably the same here that we thought it was at the national level. There was a lot of talk about it, but when it came down to the specifics of what it really involved, people were not that eager to make the change.
>
> —*Health plan spokesperson*

Consumers are most concerned about restrictions on their freedom of provider choice; these concerns have been a major factor impediment to the development of managed care plans in central Iowa. Employers discovered that any plan that restricted members to one of the two major Des Moines hospital systems was rejected by employees. In fact, at Polk County town meetings in 1994, when residents were asked about the most important community health concerns, "barrier-free services" ranked third after lack of individual responsibility and substance abuse.

Consumers in Des Moines, unlike those in other parts of the country, are not as concerned with health care costs. While incomes are above the national median, average health care costs per person are 18 percent lower in Des Moines than the national average. In addition, employees often do not pay more for indemnity health insurance plans that provide generous benefits than for more restrictive managed care plans. In an informal survey conducted by the local newspaper, 9 of 15 large employers neither passed on to employees any increase in health plan costs nor raised copayments or deductibles for more expensive indemnity plans.

Providing care for the uninsured has not been as pressing a problem in Des Moines as elsewhere in the country. Iowa's uninsured rate (10.5 percent in the early 1990s) is one-third lower than the national rate (15.8 percent). Of these uninsured people, 70 percent are employed or have a spouse who is employed. Most are young and have elected to go without coverage rather than pay the full cost of insurance. Of 250 new patients seen each month at the Broadlawns hospital and clinic, about 60 percent are employed full time, 80 percent of whom are offered insurance by employers but find it too expensive.

While there is no group in Des Moines that acts as an advocate in health system change, stakeholders in the system recognize that consumers could be better educated about the appropriate use of health services, benefit choices, and quality of care issues. Employers and health plans are providing education on prevention and care of chronic conditions. A former state legislator heads a consumer health education service that is marketed to employers.

Future Developments

Although managed care has not made dramatic inroads in Des Moines, market forces may accelerate its development. First, employer pressures on insurers and providers may lower health care costs. The 8 percent increase in indemnity insurance premiums on July 1, 1995—the first increase in several years—should keep health care costs on the "front-burner" and fuel interest in managed care plans. Some observers believe that employers will begin to pass on increases in insurance costs to employees in order to encourage them to make more cost-consciousness choices of health insurance coverage.

It is also likely that pressure to reduce health care costs will come from greater use of care that is expected as the population in Iowa ages. There is a projected 20 percent increase in the number of Iowans who will be between 45 and 64 years old by the year 2000, compared with the same demographic group in 1990. The over-75 population is also projected to increase substantially (26.8 percent) by the year 2000. Tensions between the shrinking number of working young and the growing number of retirees may grow. The aging and growth of the Medicare population, coupled with the expected rise in Medicare reimbursement rates in 1996, will create financial incentives for-profit Medicare HMOs to enter the market. It is not clear, however, how readily the large rural elderly population will accept managed care.

The 13-year stewardship of Governor Branstad and the bipartisan support for health system change suggest that the current administration's policies should dominate the public policy agenda in the near future. The state government is seeking to increase enrollment of Medicaid recipients in HMOs by expanding HMOs and ODS plans.

Insurers are expected to compete aggressively to increase their market share by offering a variety of managed care products, forming statewide and regional networks, and pressuring providers to lower costs while seeking ways to ensure quality of care. Competition among insurers over premium rates will be intense and is likely to cause some smaller insurers to expand their niche or exit the market.

Driven by the growing interest of employers and payers in controlling costs, provider mergers and acquisitions will likely lead to the formation of two or three major provider networks in central Iowa and throughout the state. These networks will compete on the basis of cost, access, and perceived quality. This development will be welcomed by private employers who would then absent themselves from designing, monitoring, and evaluating multiple health plans:

> The way to take out a cost is to shift the risk for doing the job right to those who are paid to do the job. You keep practice standards and quality measurement systems, but you don't have to hire someone to

> review and report. We are going to associate with organizations that assume greater risk until we can afford to be nothing but bill payers again—a 360 degree circle back to the 1950s.
>
> —*Large-employer spokesperson*

In the future, physicians are likely to develop tighter affiliations and join larger consolidated groups, such as vertically integrated systems, that may allow them to regain control of patient care and maintain or reestablish professional autonomy. However, some analysts argue that the hospitals, rather than the physicians, will ultimately dominate these systems, because of their financial resources, business expertise, and administrative acumen.