

## Houston, Texas

### Site Visit Report

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## ▼ ▲ ▼ Overview

In Houston, employers are reluctant to move enrollees into health plans with more restrictive networks, and the physician culture is largely opposed to constraints of provider organizations and managed care plans. This has led to slow changes in the health system. Nevertheless, insurer and provider anticipation of a rapid shift to capitation has affected the actual pace of change. Insurers and providers are positioning themselves for rapid change in the future. In Houston, change and change agents from outside the area have had an important effect on a market. Insurers and health plans, for-profit hospital chains, physician management companies, and consultants from other markets with higher levels of health maintenance organization (HMO) penetration or national strategies are bringing changes to the Houston health system.

For years, many expected HMO enrollment to grow rapidly, given the relatively high cost of health care and health insurance plan coverage in Houston. Yet many large unionized employers were reluctant to restrict employee choice of provider. Employers have been willing to reduce indemnity plan benefits, which has helped move enrollees into preferred provider organization (PPO) plans. Moreover, employer coalitions elsewhere in the United States have had success with premium negotiations, which probably led Houston employers to expect the same. Although employers have not aggressively worked for greater influence, despite the absence of aggressive employer actions, the excess of hospitals and specialist physicians has altered the balance of economic power in Houston in favor of payers and against hospitals and physicians that had dominated the market for years.

The influx of new HMOs into the Houston market acted as a managed care catalyst; it signaled to providers the likely future importance of capitation and stabilized premiums to employers after years of rapid increases. These health plans (including two California HMOs, some national insurers, and Texas plans) stimulated competition, as new plans have been willing to buy market share and accept initial losses. However, slow HMO enrollment growth has adversely affected new plans. HMO plans do not have a great cost advantage to the employer or enrollee, as employers offer PPO and indemnity insurance products with reduced benefit coverage so premiums remain competitive with HMOs. Enrollees seem willing to pay for services covered by PPO and indemnity products rather than lose their choice of providers.

Two major hospital systems have recently emerged in Houston (Memorial/Sisters of Charity Network (SCN) and Columbia/HCA), and one or two more systems may emerge. None has a dominant position in the

Houston market. The 600-acre Texas Medical Center (TMC), with eight general care and six specialized hospitals, has dominated historically but has lost its dominance due to the emergence of these systems out of the surrounding community hospitals. The private community hospital systems are leading the way in system building and orientation to managed care.

For some of the leading private teaching hospitals, success under the old system has reduced the sense of financial urgency that can drive change. Nevertheless, they are cutting costs and attempting to expand and become part of integrated delivery systems, despite physician opposition and a lack of experienced physician managers and leaders. Outside forces have affected the Houston market. Over the past two years, Columbia/HCA, a large, national, for-profit corporation, has bought, merged, and closed Houston hospitals. It has acted as a catalyst setting off merger discussions among hospitals and accelerating plans for physician-hospital organizations. Nevertheless, major realignments have not yet occurred.

Only one delivery system has attempted to offer its own HMO plan. While providers would like to capture all of the premium dollar, they fear that HMOs may retaliate by directing enrollees to other providers.

Physicians slow down HMO market penetration in Houston in part because of a concentration of teaching hospitals and university faculty in the TMC and in part due to a culture of physician individualism that opposes the corporate practice of medicine. Top physicians prevented a key hospital merger in the high profile TMC, and the Texas Medical Association actively attempted to counteract HMO growth by using its influence in the state legislature to arrange passage of an anti-managed care bill. Although the governor vetoed the bill, some of its provisions were written into regulations.

Physician organization has grown slowly. Physician management firms from outside Houston have taken over the management of local Individual Practice Associations (IPAs), as well as one of the two large multispecialty medical groups. Houston hospitals have assisted in the formation of their own affiliated IPAs, physician-hospital organizations, and hospitals, and some national insurers have acquired primary care physician (PCP) practices, which have driven up their price.

Despite discussions about managed care, the largest HMO and most of the smaller ones seem reluctant to directly manage the delivery of care and prefer to contract with organizations that do. Few physician organizations are able to do so. With the possible exception of two larger medical groups, clinical integration is a concept, not a reality.

A shift to Medicaid managed care is being discussed but has not yet occurred. Funding streams for the uninsured and underinsured are increasingly threatened. It is unclear whether existing changes have had an effect on the quality of care.

## ▼ ▲ ▼ **Community and Health System Background**

### **Demographics and the Economy**

Houston is the fourth largest city in the United States, with a population of 1.7 million within city limits and 3.6 million in Harris County and the greater Houston area. Between 1980 and 1992, the population grew by 20 percent in suburbs and communities surrounding the city of Houston, but not in the city itself. Ethnic populations within the city have experienced the greatest growth; they account for more than 70 percent of the population. Non-hispanic whites (44 percent) are the largest minority; African Americans and Hispanics each constitute 28 percent of the population. Because of the city's proximity to the Mexican border, 18 percent of Houston residents were not born in the United States, and 31 percent do not speak English in their homes.

Since the oil industry declined in the 1980s, the economic recovery and expansion of Houston has been healthy. However, job growth has not included a return of the upstream energy jobs. Instead, growth in energy-independent industries has insulated the economy from subsequent oil price shocks. The number of jobs in the area rose steadily from 1987 to 1991, leveled out between 1991 and 1994, and has risen in the past year. New jobs in medical and professional services represent more than half of the net gain in Houston's payroll employment since 1987. The largest fraction of jobs in the private sector is in retail trade (17 percent), followed by public education and government (14 percent). The city of Houston's recent unemployment rate, 6.1 percent, is comparable to the nationwide rate, but the Harris countywide rate is 5.7 percent, reflecting somewhat lower unemployment in surrounding suburbs and communities.

Houston is well-known as the home of large national and international corporations. More than 3,000 Houston-area firms are involved in international business, 58 foreign governments have consular offices in the city, and 26 governments maintain trade and commercial offices in Houston. Such economic ties help explain why the city has such an international reputation for its high technology, service-oriented medical centers.

Income distribution in Houston differs from that in the rest of the country, with a larger percentage of high- and low-level income households than in the country as a whole. While the median household income is slightly higher (\$30,900) than the U.S. median (\$30,000), 21 percent of households have incomes below the federal poverty level, twice the national rate of about 10 percent.

## Health System History

Houston medical providers have a long history of high technology, specialty care, and high level of service. For years, providers in the very large TMC dominated the Houston health care system. The center's tertiary care hospitals and highly reputed specialists provided a high quality of care with little regard to cost. The service-oriented approach, fueled for years by ample funding, led to a steady stream of national and international referrals.

Although hospitals in Houston have talked about horizontal and vertical integration and restructuring in response to growing payer pressures for efficiency, there has been little action. The ratio of hospital beds per 100,000 residents was 429 in Houston, higher than the Texas average of 338 and the national average of 366.

The three groups of hospitals—TMC private hospitals, community hospitals, and Harris County District public hospitals—responded differently to the growing market pressures. Until 1993, flagship hospitals at the TMC were unmoved by external pressures to integrate or restructure. General hospitals such as Methodist and St. Luke's and specialty hospitals such as M.D. Andersen and Texas Children's drew from an international market of payers, as well as the local market. Their affiliations with the Baylor and University of Texas schools of medicine added substantially to their prestigious reputations for high quality care. Several hospitals built up hundreds of millions of dollars in financial reserves.

In the 1990s, national referrals slowed as managed care penetrated the country. Hospital administrators began to examine what was happening in the rest of the country and wondered if it would affect Houston's local business. They began discussions about horizontal and vertical integration and streamlining hospital services, but they found their realm of influence and control constrained by the physicians' role in the hospital structure. Financial pressures were insufficient to counteract the view that Houston's internationally renowned hospitals would be able to continue without major changes. Hermann Hospital was the main exception to the TMC rule of prosperity, which forced it to change earlier than other hospitals in the center.

Community hospitals outside the TMC responded to new market pressures by becoming more receptive to managed care. By 1989, Memorial Hospital had built a horizontally integrated multi-hospital suburban system of nonprofit hospitals. Subsequently, it added hospital capacity and reorganized to cut costs.

The historical availability of local government and teaching hospital funding protected Houston public hospitals from serious pressures to change dramatically. The public hospitals and neighborhood health centers functioned in an integrated health care system governed by the Harris County Hospital District rather than either the city or county. Through their affiliation with the University of Texas School of Medicine they had added Lyndon B. Johnson

Hospital in 1989. The district also added neighborhood clinics to their system in the early 1990s.

Physicians have traditionally been powerful in the Houston health care market because their opinion of how medical services should be delivered and how much it should cost had gone largely unchallenged. Houston has a large supply of specialists. Heart specialists Cooley and DeBakey remain the models of quality and competitive success in the area. There are more than 5,000 specialists and 3,000 primary care physicians in the metropolitan area. The ratio of physicians per 100,000 residents was 268 in Harris County, 223 nationally, and 173 in Texas. By 1993, managed care had penetrated the Houston market enough that some specialists saw a decline in income. Fear, distrust, and misunderstanding of further pressures to change practices stirred an angry physician backlash against managed care.

As of mid-1995, HMO market penetration had reached only 12 to 14 percent of the population. PPOs have dominated the managed care market, and POS plans have also done well.

In this environment, only five HMO plans had any market share by the end of 1992. Prudential and Sanus have had most of the HMO enrollment and have different HMO models.

Employers, consumers, and government purchasers have not acted collectively to change the health care system in Houston. Although costs of health care in Houston were higher to employers than elsewhere in the country, this excess cost was usually not passed on to employees.

## ▼ ▲ ▼ Health System Changes

### Public Policymakers

Public policy has not been an important factor in recent health system changes in the Houston area. There has been little state legislation or regulation to affect health systems. Anti-managed care legislation was passed by both houses of the legislature in 1995. The Texas Medical Association, considered by some the strongest lobby in the state, having made \$2.4 million in contributions to legislators, expressed its anger at the control that managed care organizations could exercise over the practice of medicine. The association backed a bill that would have required letters to physicians explaining why they were not allowed to become part of an HMO panel. It would have also required that an HMO explain its criteria for denying procedures or treatments to patients. Although the governor vetoed the bill, he proposed several of its provisions as rule and regulation changes. They are likely to be enacted in that way. These changes include a due process clause for physicians not selected for, or deselected from, a managed care panel of physicians.

As a result of Texas Medical Association power, protection against the corporate practice of medicine is taken seriously in Texas. Formation of physician-hospital organizations, direct contracting of providers with employers, and global capitation of physician and hospital services are all regulated or prohibited by existing Texas law. The Texas Hospital Association, Texas Medical Association, and HMO trade organizations have competing interests in the development of public policies important in restructuring service delivery systems. Responding to hospital market developments, legislation passed in 1994 enabled cooperative agreements of hospitals to share services, facilities, personnel, and equipment to decrease costs and increase accessibility for communities.

Recent insurance reforms in the state have been limited. The Texas Small Employer Health Availability Act was meant to guarantee affordable health insurance coverage to employees of small businesses in Texas. Most provisions of this statute went into effect in January 1994. The act does not place mandatory requirements on small business owners to provide insurance to their employees, but it requires that insurance carriers in the small business market offer an HMO plan. An insurer/health plan must provide coverage to the entire group; renewability options are regulated. Although the Texas Department of Insurance has established a public insurance purchasing alliance, the Texas Health Benefits Purchasing Cooperative, its member companies have relatively few enrollees.

## **Purchasers**

### **Employers and Employer Coalitions**

In Houston, employer reluctance to move enrollees into managed care (HMO and PPO) plans has slowed health system change. There are no powerful purchaser coalitions, and employers do not generally provide enrollees with incentives to choose lower-cost plans that restrict choice of provider. There are a variety of reasons employers have not moved to managed care more aggressively: international oil companies want to simplify and standardize health benefits for their far-flung workforce, oil companies are not focusing on wage benefits because their wage bill is not a large percentage of operating costs, and the culture is generally resistant to forcing people to change.

Houston employers have benefited from start-up HMOs, including some from California or national insurer/health plans, that have kept down all insurance premiums in Houston. According to one respondent, annual growth peaked at 15 to 20 percent some three years ago, fell to about half that rate last year, and disappeared entirely this year. Premium reductions that out-of-state purchasing coalitions recently negotiated with HMOs helped change Houston employer expectations about premium increases.

Larger firms offer employees a range of health insurance options, and HMO market penetration is substantially higher in the larger firms. Medium-sized firms often offer one HMO and one PPO, or one HMO, PPO, and POS plan, at times from the same insurer/health plan. Generally, employers do not offer many incentives for enrollees to choose lower cost plans, and there is no general move in that direction. For years there were few premium differences to employers among various types of plans. In fact, until recently, HMOs had a higher premium price and better benefits than did PPOs and POS plans. Currently, HMOs have a lower price and equal or better benefits. Some indemnity and PPO plans increased their premium prices while they reduced their benefit levels. Even so, there still is little new movement into HMOs.

There is no powerful purchasing coalition in Houston. For years, the Houston Area Healthcare Coalition (HAHC) acted as an educational forum for Houston area employers, including some of the largest ones. The HAHC spun off the Houston Healthcare Purchasing Organization (HHPO) as a separate, independent entity that has negotiated case-rates with a majority of Houston area hospitals and acts as a PPO plan that competes with other health plans that employers offer. HHPO has requested and received some care-related hospital data, but the data may be too limited to support informed choice by employers or enrollees.

A state-sponsored purchasing coalition for small employers, the Texas Insurance Purchasing Alliance (TIPA), began operations in Houston in mid-1994 and has very few enrollees. The recent burst of insurer/health plan price competition has reduced the immediate need for an alliance, as small employers have benefited from the recent flattening of premiums. Moreover, the Houston TIPA had to overcome an excess of plan offerings and commissions that were too small to interest insurance brokers.

### **State and Local Government as Purchasers for Low-Income People**

For years, Texas took limited steps toward managed care for those eligible for Medicaid. Faced with a \$2.2 billion deficit in the Texas Medicaid program, the legislature recommended in 1995 that the state apply for a federal waiver to allow it to move the Medicaid population into managed care. The proposed Medicaid managed care program would require cost sharing and guarantee clients 12 months of eligibility. For the first three years, it would also require that managed care organizations pay the standard provider reimbursement rate and include providers that traditionally served Medicaid and charity care patients. Several hospitals and affiliated physician organizations are developing plans to seek Medicaid managed care market share.

Prior to 1995, there were Medicaid enrollees in only one HMO demonstration project in the state, although there were plans to expand it. While there are no Medicaid eligibles enrolled in HMOs in Houston, one of three



Primary Care Case Management pilot projects in the state began late in 1993 in Chambers County, which is adjacent to Houston and contains several of its outlying working class and lower income communities.

In an attempt to reduce the annual cost of Medicaid in Texas, the state began contracting with hospitals in 1994. The state first asked Houston area hospitals to lower the price of treating Medicaid patients or risk losing that lucrative patient base. In 1994, Texas received a Medicaid waiver, LoneStar Select, to initiate selective hospital contracting for reduced rates. Only hospitals that win contracts through this process will be able to treat nonemergency Medicaid patients in Houston. Selective contracts feature fixed per diem payments. Houston hospitals hardest hit by these changes include Texas Children's Hospital, where Medicaid accounts for 48 percent of total patient days, as well as Harris County District hospitals (33 percent of patient days), and Hermann Hospital (21 percent of patient days).

### **Insurers and Health Plans**

The movement of new HMOs into the Houston market has decreased all commercial health insurance premium growth. HMO enrollment continues to grow slowly at this point and accounts for approximately 14 percent of the total population. HMOs account for perhaps 20 percent of the employer-based insurance market, with the remaining 80 percent divided between PPO and indemnity insurance. HMO market penetration is low in the Medicare population and non-existent in the Medicaid population.

By the end of 1994, two insurers accounted for more than 80 percent of the HMO enrollees. Sanus Health Plan (a subsidiary of New York Life) had 235,000 HMO enrollees in the Houston area, compared to 65,000 with Prudential. Both were quite profitable in 1994. Three national insurers—MetLife/Travelers (now MetraHealth), CIGNA, and Aetna—had between 15,000 and 25,000 capitated enrollees each, and California-based Pacificare had approximately 19,000 enrollees. Several other HMOs had smaller enrollment figures.

HMOs rushed to Houston to take advantage of a mostly untapped market. At least one other California-based plan—FHP, Inc.—recently entered the market and by mid-1995, more than 15 HMOs had entered or had filed applications, compared to 5 HMOs operating in 1992. The start-ups tend to be unprofitable as they try to buy market share.<sup>1</sup> Although the PPO market is twice as large as the HMO market, no PPO player is dominant.

National insurer and health plan strategies are being played out in the Houston market. The large national insurers—Prudential, New York Life

<sup>1</sup>*Houston Business Journal*, May 5–11, 1995.

(Sanus), Aetna, CIGNA, and MetraHealth—are attempting to convert sizable PPO and indemnity insurance enrollment into HMO enrollment, as is the Texas Blue Cross and Blue Shield plan. Similarly, two California HMOs are attempting to convert their success and expertise into success in Houston. These companies are following strategies that reflect what they are doing in other markets.

- Sanus, Aetna, CIGNA, and others with wide physician networks contract with Kelsey-Seybold Medical Group, the two larger IPAs, and other IPAs. Some even contract directly with individual physicians.
- Prudential uses a narrow network for most of its enrollees, the result of an exclusive, long-term agreement with MacGregor, a large multispecialty group. IPA physicians serve the remainder of its enrollees. Prudential had historically been the low-cost HMO, able to shadow-price the upwardly spiraling indemnity insurance premiums. For the first time, other HMOs have met or beaten Prudential's prices. Faced with price-competitive opponents with larger networks, Prudential's enrollment has stagnated since 1992.
- Aetna and CIGNA are attempting to create a network of clinics. They also contract with existing physician organizations.
- Memorial/Sisters of Charity Health Plans is a start-up HMO jointly owned by two Houston hospital systems that have entered into an increasingly close alliance. Some HMOs have indicated that they will punish the hospital systems if the HMO is successful by directing enrollees to other hospitals and clinics.

Insurers and health plans compete mostly on the basis of price, which has led to the flat premiums in the past year. Some new HMOs are attempting to buy market share with low premiums to new accounts, although employers fear that these low premiums will skyrocket in subsequent years. Insurers and health plans also compete partly on the basis of quality of services as they expand their networks of primary care physicians (PCPs) and clinics and some provide quicker access to specialists. Insurers and health plans usually contract with Columbia/HCA and the nonprofit Memorial/SCN, as well as at least one TMC hospital. Hospital network appears to be significantly less important to employers and enrollees than the physician network.

It is unclear as to the extent to which most HMOs have been able to change practice patterns, as IPAs appear to be structured loosely internally and HMO enrollees are often a small portion of a physician's overall business. The effect of HMOs on quality of care is also unknown.

## Providers

### Hospitals

For some of the leading Texas Medical Center teaching hospitals, previous success has reduced the sense of financial urgency that can lead to change. Two major hospital systems have recently emerged in Houston, and one or two more systems may emerge as well. All hospitals are cutting costs, and some are beginning to integrate primary care physicians into their systems.

Some community hospitals have led the way in system building, orientation to managed care, and cost cutting. Although Columbia/HCA and Memorial/SCN (with its large endowment) are the two largest hospital systems in Houston, they do not dominate the Houston market, singly or in combination. Most of the hospitals in SCN are located outside the Houston area. Private hospitals located in the TMC include Methodist, St. Luke's, Hermann, M.D. Andersen, and Texas Children's Hospital. One public hospital is located in the TMC, the other elsewhere. Excess inpatient bed capacity in Houston, particularly the great concentration of beds in the TMC, has led to cost cutting and system building activities. In 1993, only an average of 54 percent of community hospital beds in the Houston area were occupied.<sup>2</sup>

Although there have been no recent major hospital mergers, Memorial and the Sisters of Charity hospitals have strengthened their alliance by engaging in joint physician and HMO ventures. Methodist and St. Luke's almost merged. Both TMC hospitals are profitable and have very large financial reserves so they are not forced to merge with a system and each can consider building its own system. The governing boards of not-for-profit hospitals may be slowing hospital sector change, as some are not used to making important decisions quickly in a health system environment characterized by rapid, and at times discontinuous, change.

The three groups of Houston hospitals have responded differently, or at least with different timing, to managed care market penetration. Columbia/HCA directly competes with Memorial/SCN as community hospital systems. Both have responded to the managed care environment by cutting costs and expanding geographic coverage. They are discussing merger possibilities with TCM hospitals since each system would like at least one such hospital to enhance its image, provide a few more specialized services, and supply a strategic location.

Columbia/HCA's acquisition of more than 15 Houston area hospitals accelerated the pace of merger discussions among hospitals. Columbia/HCA has benefited from the high-cost hospital inpatient environment (or price

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<sup>2</sup>1994/95 Hospital Statistics, American Hospital Association, Chicago, Ill., 1994.

umbrella) that the TMC hospitals created. Columbia/HCA can profit from this situation in several ways, including by reducing administrative, other non-patient care, and patient care staff; eliminating duplicative hospitals and equipment; and attempting to increase volume with managed care contracts.

Past success of the prestigious first tier TMC hospitals has slowed their response to managed care, as they have experienced little financial pressure to change. One executive of such a hospital observed that it was very profitable for that hospital to continue under the old, high cost system for as long as possible. Financial concerns can lead hospitals to prepare to compete for managed care contracts. Hermann Hospital provides a good example. Severe financial problems in the late 1980s caused Hermann to restructure early, creating efficiencies in administration and service delivery and becoming a lower cost competitor for managed care contracts. Eventually, Hermann created its own physician organization, OneCare.

Although they continue to benefit from revenues from the fee-for-service, indemnity insurance system, TMC hospitals have changed their operations, sometimes with remarkable speed. TMC managers responded to changes in other markets, the entry of Columbia/HCA, the declining census, and the recent stagnating per diem and case-rate payments. For example, Methodist, a large TMC hospital, signed its first managed care contract only in January 1994 after observing other hospitals siphon off patients in PPO plans. Since then, it substantially cut costs while continuing to benefit from revenues from the fee-for-service indemnity insurance system. It obtained a relatively large capitation contract from Prudential (by offering extremely competitive rates) and appears to be using that contract as an internal means to produce greater efficiencies in its operations.

Despite sometimes large savings, most Houston hospital cost-cutting appears to stop short of reengineering. Rather than engaging in sophisticated clinical integration and reorganization of their operations, hospitals appear to have cut costs very substantially by doing many of the same tasks with fewer people and resources. However, Memorial Health System hospitals have instituted numerous clinical pathways in the hopes of cutting down on resource use.

Overall, Houston hospitals have done little to integrate hospital/physician delivery systems. No hospital system controls physician organizations with numerous capitated enrollees. Hermann Hospital, with its OneCare physician organization, and Memorial/SCN have done the most to create PCP networks. Other hospitals are taking more preliminary steps, such as setting up physician-hospital organizations that generally are loose structures created to obtain managed care contracts.

Memorial/SCN is the only delivery system that has organized its own HMO, after several years of some direct contracting. Some respondents believe that the joint venture HMO is doomed because of the hostility to the venture by

other HMO plans that are Memorial/SCN customers. Because Memorial/SCN wants to control all of the premium dollars, other HMOs may treat Memorial/SCN as a competitor and send patients elsewhere. Some TMC hospitals are seeking preferred relationships with HMOs, trading on their prestige to obtain additional business.

Local changes in health care and decisions that were made elsewhere have had a significant effect on Houston. Columbia/HCA's national strategy led to its acquisition of Houston hospitals, which spurred market change. Moreover, Houston hospital managers have learned from health system change elsewhere and hired consulting firms to guide them through their cost-cutting and physician organization-building efforts. Although some Houston hospitals have implemented cost-cutting techniques developed and tested elsewhere, some have failed to go beyond rudimentary physician organization-building efforts.

Access to capital does not appear to be a constraining factor for the major Houston participants. Columbia/HCA has great borrowing capacity, and Methodist and St. Luke's are cash rich. It is unclear whether Memorial's link with SCN likely gives it access to very large reserves. On the other hand, the lack of management expertise may be a constraining factor, especially in creating clinically integrated hospital/physician delivery systems. A number of organizations are recruiting executives from other markets.

The anticipated shift to Medicaid managed care has led some hospitals and affiliated physician organizations to position themselves to obtain Medicaid enrollees. Hermann Hospital is taking steps to become a Medicaid managed care provider since 30 percent of its admissions are Medicaid eligibles. In preparation, Hermann Hospital and its OneCare physician organization are bidding in a Medicaid managed care pilot in Travis County. Hermann is also expanding its physician network to areas in Houston where Medicaid eligibles reside, including the southeast and ship channel areas.

### Physicians

Although physician organizations have grown in size and number over the past two years as competition for managed care contracts has intensified, physicians are not well organized. Individual or small group practices are by far most common, and the individualistic Texas culture clashes with the management of managed care organizations. Nevertheless, managed care networks are expanding and the use of gatekeepers is evident. Primary care physicians are increasingly pressured and courted to sell their practices or join physician groups or physician-hospital organizations, and the values of primary practices have risen. Specialists watching patient numbers and revenues decline are joining together to negotiate for managed care contracts for survival.

Like hospitals, physicians are divided roughly into three groups: solo and small group community physicians (the overwhelming majority), TMC specialists and academic affiliated physicians, and large medical group salaried

physicians. TMC physicians have been most influential in impeding health system change. Large medical groups have generally embraced and been embraced by managed care contracts, but solo and small group community physicians are confused and divided about the change.

Although a large number of IPAs have formed, the affiliations are loosely structured, and revenue from any IPA often accounts for only a small portion of a PCP's practice income. Since most arrangements are non-exclusive, many physicians belong to multiple IPAs. Physicians in Houston have begun to develop their own groups and form limited partnerships for managed care contracting, but most groups are vulnerable and may not survive.

Although physician organizations are growing, there is limited integration of any type, and there is significant conflict between organizations and physicians. Area PCPs have resisted many of the management attempts by hospitals and insurers. For example, frustrated by difficulties in managing physicians, in 1991 Sanus invited a southern California physician management company, North American Medical Management (NAMM), into Houston to provide management services to the growing number of IPAs. Currently NAMM in Houston and southeast Texas is one of the two largest Houston area IPAs, consisting of 18 IPAs with 400 PCPs, 600 specialists, 90,000 commercial HMO enrollees, and 15,000 Medicare risk members in 5 HMOs. NAMM has paid bonuses to member physicians each year of operation. As the fraction of the practices represented by NAMM HMO patients grew, NAMM negotiated lower capitated rates. This angered many PCPs and specialists. Many physicians have been troubled by the financial and clinical problems that other colleagues have experienced with managed care organizations.

Hospitals have had little success organizing and managing physicians. Some hospitals (e.g., Memorial, Hermann, Methodist, and Columbia/HCA hospitals) are buying primary care physician practices, and many hospitals are considering developing PHOs. But none of the systems have large or well-developed physician organizations. Many of the IPAs are trying to stay independent of hospitals rather than integrate with them, and Memorial's IPA split off from its hospital system parent last year. Some PCPs object to receiving a small fixed amount of the premium dollar for managing all of a patient's care. Some medical groups and physician-controlled IPAs want to obtain a larger share of the premium dollar and take on more risk to receive savings if they can lower resource use and promote patient health. They assert that they can make more patient friendly decisions when control is not imposed by an external third party.

The shift of managed care contracts from hospital to hospital has led to substantial physician upheaval and conflict. For example, through the years, Prudential-controlled MacGregor has been primarily associated with Hermann Hospital. Prudential's deal with Methodist Hospital means that MacGregor

must leave a hospital that has traditionally served Medicaid, indigent, and working class patients and work with a hospital that has marketed itself to the most affluent carriage trade. The cultural upheaval associated with this shift in hospital affiliation is enormous for the physician group. The Methodist staff has objected to special credentialing procedures Hermann Hospital had used for some physicians in the MacGregor group. Methodist administrators might block the credentialing of some or all members of the group.

Large physician organization ownership also is unstable. For example, after NAMM began managing many Houston area IPAs, Phycor purchased NAMM (in 1995). NAMM now has capital to expand its primary care physician network by purchasing practices and to make the Houston IPAs part of Phycor's emerging nationwide network. AHI, another physician management company, recently acquired a physician-owned IPA that Memorial helped organize, and Caremark purchased Kelsey-Seybold in 1992.

Although growth has been slow, building physician organizations appears to be ahead of the actual management of clinical care. The largest HMO and most of the smaller ones prefer to have intermediaries manage the delivery of care, and few Houston physician organizations are developed enough to do so. With the possible exception of two larger medical groups, clinical integration is not a reality.

Despite the difficulties of successfully managing physicians, there is strong competition for increasingly expensive PCP practices. Hospitals, the older large physician multispecialty groups (Kelsey-Seybold and MacGregor), some of the national insurers, and physician management companies compete with each other to buy practices. Some believe Hermann Hospital's OneCare caused the price of PCP practices to rise.

Responding to the needs of large ethnic populations in the Houston area, some IPAs consist primarily of African-American, Hispanic, and Asian physicians. Some of these doctors are adjusting to managed care and are working with managed care organizations to lower costs. When Central Physicians Network formed in March 1994 as a consortium of Chinese, Vietnamese, and Korean doctors, it was the first specifically organized group of Asian doctors. Many Asians work for small businesses and do not have health insurance, so this physicians' group hopes to increase the number of these businesses that offer coverage.

### **Safety Net Providers**

The public hospitals and neighborhood health centers governed by the Harris County Hospital District have experienced increased competition for Medicaid hospital patients, especially women giving birth. Private sector providers and managed care plans in the Houston area began recruiting obstetric patients within the past few years because of the competitive Medicaid fees associated with their hospitalization. But although pregnant Medicaid patients are

actively recruited by providers for the delivery of their babies, the providers are not as interested in providing prenatal care because the Medicaid outpatient rates are relatively low. The Medicaid managed care proposal, which includes Houston as a test site, is designed to encourage providers to ensure continuity of care, including prenatal services.

The Harris County Hospital District providers are currently reengineering operations to compensate for budget cuts and lost Medicaid revenue. A task force will develop a plan to reduce costs without reducing services. Several areas have been identified as opportunities for cost reduction. For example, emergency center visits have increased dramatically in recent years. Reducing the number of emergency visits would significantly contain costs.

Hospital district representatives reported that they had not been approached for contracts with health plans to provide services in the neighborhoods where they are located. They do not intend to seek such contracts.

### **Academic Health Centers**

Baylor College of Medicine, which separated from Baylor University in 1969, and the University of Texas-Houston have agreements with the state to provide medical education to Texas residents, and both compete on many levels. Baylor is the older, larger, and better financed of the two institutions. It is affiliated with Methodist, Texas Children's, and St. Luke's Episcopal private nonprofit hospitals; Ben Taub, a public hospital; and a system of community health centers. The University of Texas-Houston is affiliated with Hermann, St. Luke's, and M.D. Andersen, all private nonprofit hospitals, as well as LBJ General Hospital, a public hospital. The university began providing services in four HCHD neighborhood health centers in 1990. The difficulty in merging the Baylor and UT medical staffs contributed to the failed merger of Methodist and St. Luke's.

Methodist and Hermann hospitals have different strategies for survival as academic health centers in a changing health care market. One of the major issues in merger discussions between Hermann and Columbia/HCA concerned the network's capacity to channel enough patients, not just those needing the most sophisticated treatment, to Hermann Hospital to fulfill its missions as a teaching institution and provider of charity care.

M.D. Andersen, a specialty academic medical center, has developed different strategies than have the general hospitals. Like the other academic medical centers, M.D. Andersen has faced declining patient care revenues, which help support numerous programs in clinical and basic research, health education, and disease prevention. M.D. Andersen states that its costs of providing charity care have increased 470 percent, from \$35 million in 1985 to more than \$200 million in 1994. Its level of state support has remained stable. During the past year, it joined other hospitals in launching initiatives to enhance revenues through managed care agreements with plans and new partnerships with other providers. M.D. Andersen also embarked on cost-cutting



activities to reduce operating expenses significantly over the next three years. The hospital supported legislation introduced to enable hospitals to share the costs of indigent cancer care with Texas counties. M.D. Andersen has formed a network of cancer centers around the country to conduct research on the efficacy of cancer treatments that are considered experimental to determine which should be paid for by insurance companies. The legislation also would allow M.D. Andersen to accept patients that are self-referred, rather than relying solely on physician referrals.

### **Consumers**

It is difficult to evaluate consumer opinions of the effects of the increased market activity in Houston. Consumers have no information about quality with which to make choices. Consumers may have been slow to complain about the growth of managed care because physicians have had so much power. Physicians have reported that patients were dissatisfied with managed care, while HMO member satisfaction surveys indicate otherwise.

Employers and health plans initially sought broad provider panels to entice consumers into managed care. In Houston, the only narrow closed panel HMO, Prudential, has not grown recently. The largest growing health plan offered purchasers a variety of provider networks. Managed care restrictions are being eased upon consumers as employees find opportunities to maintain their usual providers. In spite of the high cost of health care in the area, employees with mid-level management incomes pay a low share of health care costs. Their health care cost of living is lower than that of Boston, San Diego, or Minneapolis.

Texas had the largest increase of any state in its population of uninsured in 1994, but Houston does not have formal advocacy groups for low income people. The local children's advocacy group, furthermore, has focused on the growing problem of low income families. It has not focused on the specific impact of health care changes.

### **▼ ▲ ▼ Future Developments**

If employers become more assertive in moving employees into lower cost plans, the pace of health system change in Houston could accelerate sharply over the next two or three years. Even without a shift in employer approach, the health system will change. A shakeout among new HMO plans is inevitable, as parent companies tire of subsidizing costs of plans that are not growing rapidly enough. Once the influx of new HMOs is over, it is not clear what will happen to premiums. If HMO market penetration grows and the newer IPAs and medical groups improve their physician management, physician resistance to

managed care may lessen, paving the way for more rapid HMO market penetration. Nevertheless, poor physician organization makes it doubtful that the practice of medicine will change in the near future. Columbia/HCA and Memorial/SCN likely will add to their hospital systems, possibly with TMC hospitals. Another system or two may emerge. Hospitals will continue their, at times, painful efforts to integrate with physicians. The fate of the Memorial/SCN HMO joint venture, which is unclear, is of interest to other delivery systems elsewhere. Employers and consumers will be more concerned about quality of care measurement and reporting, especially as resistance to managed care accelerates. Public funds for safety net providers and the uninsured will probably decrease, while the number of uninsured people continues to increase.