COMMUNITY SNAPSHOTS PROJECT

Indianapolis, Ind.

Site Visit Report

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Overview

The Indianapolis health care market is characterized by an array of players trying to take full advantage of the city's location well away from the health care markets on the two coasts and south of the managed care domination in Minneapolis. The market is conservative, cautious, and increasingly competitive, with much action in the past 18 months but little change to date in managed care penetration and other measures of market change. A strong sense of "Hoosierness" has inspired major moves that are consistent with national trends but are couched in homegrown ("keeping outsiders out") terms.

The market encompasses Marion County and the seven surrounding counties. For some institutions, such as the Indiana University Medical Center and Methodist Hospital of Indiana, the market is the entire state, and many market strategies include alliances with hospitals in counties outside the eight-county region. The more broadly the market is defined to the north and south, the more Indianapolis-based providers run into market overlap with Chicago, Louisville, and Cincinnati.

Local observers describing the market report that two major systems have emerged and a third could be on the horizon. In reality, one system, an alliance between Community Hospitals Indianapolis and St. Vincent Hospitals & Health Center, is in place formally, and another, a proposed merger of Methodist Hospital and the two hospitals in the Indiana University Medical Center (IU), is being appraised. Local observers suggest that a third system could develop out of local health plan and hospital activity, or it could be initiated by external actors that enter the market, such as Columbia/HCA or another national for-profit interest.

Market changes in the past 18 months have been hospital driven—the role of physicians in the alliances and mergers is negligible. Instead of instigating the structural changes, physicians have gone along out of a sense of self-preservation. As networks and alliances have taken hold in Indianapolis and the state's Medicaid budget has been slashed, the role of the physician has changed. Primary care physicians are being courted by hospitals and health plans. Specialists, concerned about their role in the system, have begun to form their own provider organizations and to purchase primary care practices themselves, to assure referral sources.

All market observers feel that the city's public hospital—Wishard Memorial—is critical to the future of the Indianapolis system because it provides care to the greater part of the area's indigent population. But Wishard, which has been managed and staffed by IU since 1974 and has an affiliation with IU dating back to 1969, has been left out of the Methodist/IU merger talks by IU. Aggressive and savvy political leaders, however, have kept the hospital solvent, even growing, and it is a continuing factor in market discussions.

Insurers are following the hospitals' lead in restructuring the Indianapolis market. Most insurers and health plans define their market as the state, and the changes they are making in their products are not necessarily geared toward any one regional market. Managed care products enjoyed a 30 percent increase in enrollment statewide between mid-1993 and mid-1994, but enrollment has been flat since then. These products are predominantly point-of-service (POS) plans and preferred provider organizations (PPOs). Blue Cross and Blue Shield is the largest insurer in the state—and in the Indianapolis market—doing most of its business in indemnity care; it has not been a leader among the insurers, however, in product development or direction.

The public sector is not perceived as a major force in local market discussions. The state legislature is seen as neither an advocate for nor an impediment to market changes, although it passed three health care related pieces of legislation in 1995. The state's recent move to Medicaid managed care inspired affected hospitals to collaborate to retain their market share, but there is no evidence that it is having broad market effects.

The church—Protestant and Catholic—is influential in the Indianapolis market. The Methodist church has become increasingly involved in Methodist Hospital's various market strategies, and its bishop recently convened a meeting to discuss the direction in which the institution is moving. The Catholic church intervened in collaboration discussions between St. Francis Hospital and Methodist Hospital, suggesting that St. Francis work with the local Catholic institution, St. Vincent's Hospital, instead.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

Indiana has a population of about 5.6 million people. Its three largest cities, and health care markets, are Indianapolis, located in the central region; Fort Wayne, in the northeastern sector; and Evansville, located along the border with Kentucky to the south. Indianapolis is the state capital and shares a border with Marion County; the two entities also have a unified government structure. About 1.3 million people reside in Marion County and the seven contiguous counties: Boone, Hamilton, Hancock, Shelby, Johnson, Morgan, and Hendricks. This area generally defines the Indianapolis health care market.

About 835,000 people (1995 estimate) reside in Indianapolis, a 1.8 percent increase over 1990 that mirrors a 1.7 percent population increase statewide over the same period. Greater Indianapolis becomes rural very quickly as you move out in any direction from its urban core—some small dairy farms still operate within the Indianapolis/Marion County limits. Unemployment in

Indianapolis was at 4.5 percent in 1990, below the 5.5 percent national average. About 12 percent of Indianapolis families had an income below the federal poverty level that year, compared to 13.5 percent nationally.

Indianapolis has a large proportion of African-American residents—22 percent—and nearly all of the rest of the population is white. Only a very small proportion of residents of other ethnic backgrounds, such as Asian and American Indian, reside in Indianapolis or any of the seven surrounding counties. The surrounding counties also have very small populations of African Americans, ranging from none in Morgan County, on the southwest corner of Marion County, to 0.9 percent in Hendricks and Johnson counties, on either side of Morgan. These proportions essentially have not changed over the past 15 years.

Indianapolis has a diverse economic base that includes the public sector (state and Indianapolis/Marion County government and Indiana University), health care, business services, light industry, and durable goods distribution. The city/county region is a large distribution hub for manufactured goods—75 percent of the United States population is within one day's truck drive from Indianapolis—and many companies with a national market have distribution centers located within the city limits. Goods distributed from Indianapolis range from mail-order music and books to tanning beds and truck and bus diesel engines. Federal Express and United Parcel Service have distribution hubs at Indianapolis International Airport, and United Airlines recently moved its maintenance center to the airport, bringing 2,000 employees from California and adding 1,000 new jobs.

The largest private employment sector in Indianapolis, by number of employees, is the health care sector, followed by business services and wholesale trade and durable goods. Eli Lilly & Co., a pharmaceutical manufacturer, is the largest private employer; other manufacturers include General Motors (Metal Fabricating Division), Ford Motor Company, and DowElanco.

For each large firm in the Indianapolis region there are many smaller businesses, and it is these businesses that make up the bulk of the employers. This mirrors the state as a whole: according to the Indiana Department of Workforce Development, nearly 70 percent of Indiana businesses have fewer than 10 employees; 27 percent have between 10 and 100 employees, and slightly over 3 percent have more than 100 employees (1994 counts). Yet businesses employing more than 100 employees account for 52 percent of the total employees in the state.

Health System History

Proposed federal health care reform initiatives in the early 1990s and national trends toward integrated delivery systems—especially in California and Minneapolis—spurred hospitals in Indianapolis to consider their future in a new light. Hospitals led the charge to restructure the Indianapolis health care

system, in no small part out of a sense that they either must lead change or be run over by it. Medicare spending constraints also inspired their activities, as did state cuts in the Medicaid program. Yet lengths of stay in all Indiana hospitals have shown little change since 1990: from 1990 to 1993 the average length of stay declined from 6.6 days to 6.4; hospital admissions statewide dropped by only 2 percent over this same period.

The Indiana Program for Statewide Medical Education, established in 1967, was instrumental in developing a role for IU in the Indianapolis market and across the state. The program's goal was to strengthen internship, residency, and continuing medical education programs in community hospitals. The IU School of Medicine was assigned responsibility for implementing the program's recommended Statewide Medical Education Program in 1969. This program established seven new centers for medical education in conjunction with the major universities of the state. By 1992, the number of interns or residents in Indiana hospitals had increased by 270 percent (from 428 in 1967 to 1,154 in 1992). Between 1970 and 1990, the number of physicians per 100,000 people in the state increased from 102 to 171, and the total number of physicians increased by 81 percent, to 9,573.

▼ ▲ ▼ Health System Changes

Public Policymakers

Most of those interviewed for this analysis asserted that the state's public policy role in the Indianapolis health care market has been limited. The governor's office has visibility through several health care commissions, but respondents do not expect that these commissions will wield influence in public policy. Public policy has had some impact on the local health care market as it has been applied to the state's Medicaid program and to two public providers of health care services: Wishard Hospital and the Marion County Health Department.

Before the 1995 legislative session, insurance reform legislation had been introduced routinely in the Indiana House and Senate, but little had been enacted. Three health-care-related bills were passed in the 1995 session, however, and were signed by the governor. Only one was mentioned during the course of interviews for this analysis, and by only one person: a small-group reform bill that guarantees insurance renewability and portability and places an upper limit on pre-existing condition exclusions for businesses with 3 to 50 workers. The other two bills, medical savings account and physician property tax legislation, were not mentioned by any study respondents. The property tax legislation allows physician practices that have been acquired by not-for-profit hospitals to be exempt from property taxes if they support provision of charity care or community benefits, including research and education.

According to American Health Line's recent *50-State Report on Health Reform Activities* (October 1995), Indiana is the first state to create such an economic incentive for hospitals to use acquisitions to further charitable care.

To all appearances, legislation passed in the 1995 session either has not yet affected the Indianapolis health care community, is considered to be unimportant, or simply is being disregarded. In fact, many study respondents expressed the opinion that the legislature will "continue" to play a minor role in the market at least into the near future, as nothing is forcing specific action on health care issues.

Governor Bayh has convened a task force, chaired by the attorney general, to advise him on the proposed Methodist/IU merger. The health care community sees the task force as having little or no effect, however, on whether the proposal will go forward. The governor also has appointed a Commission on the Working Poor, which has just begun its work, and commissions to examine insurance portability and health care financing. Many of those interviewed expressed the opinion that these commissions, with the possible exception of the health care financing one, will probably become important sources of useful information but will not engender public policy.

Recent changes in the state's Medicaid program reflect a state policy of reducing program costs, a policy first introduced by the governor in 1993 and reinforced by promises made in 1994 by Republican candidates for the state House (the "Contract with Indiana"). After significantly reducing payments to health care providers in 1994 to achieve cost efficiencies, the state introduced managed care to the program in early 1995 only as a way to reduce costs—not to expand access or increase services. This recent move to managed care by a state program did not bring new managed care plans into the Indianapolis commercial insurance market, however, because local hospitals quickly formed a coalition to bid for the central Indiana Medicaid managed care contract and were awarded an exclusive one.

Public policy also has affected the operation of Wishard Hospital and the Marion County Health Department. The mayor of Indianapolis is making a national reputation for himself as an advocate of privatization, and in 1994 he installed a close associate as the president of the Marion County Health and Hospital Corporation, a municipal corporation that oversees Wishard and the Health Department. The focus of the corporation shifted to private sector management and marketing techniques and away from traditional public sector approaches. For example, Wishard Hospital is emphasizing customer service and is actively marketing it to the community. The corporation compelled the Health Department to "re-engineer" its administration and services, which resulted in an 11 percent staff reduction and consolidation of several divisions. The corporation also was instrumental in acquiring disproportionate share financing from the federal Medicaid program for Indianapolis hospitals

that provide care to Medicaid clients, which has, at least for the present, assured the financial viability of Wishard.

Purchasers

Employers and Employer Coalitions

Historically, employers have taken a conservative approach to purchasing health care in Indianapolis. Few large businesses are headquartered in the region, and long distance decision making by large firms with branches in Indianapolis has perpetuated traditional indemnity coverage for their local employees. Larger employers in the region generally are satisfied with the costs of medical care in the Indianapolis market, which for them have been stable. The few firms, such as General Motors, that offer a managed care option do offer incentives to make that choice.

Businesses local to Indianapolis are primarily small to mid-size and, until very recently, have not applied pressure in the health care market. Smaller employers are cost sensitive and shop for health care plans on this basis—with the intention of switching plans, not adding new ones. A survey conducted by the Indiana Chamber of Commerce about three years ago revealed that 75 percent of small employers that offered health care benefits had switched plans in the past year because of cost. According to one respondent interviewed for this analysis, this proportion probably still holds true for the number of employers currently shopping for health plans, but not all of those shopping now are buying.[1]

The only Fortune 500 company headquartered in the region—Eli Lilly & Co.—has had a close relationship with the medical system by virtue of its product lines and research staff. About 18 months ago, Lilly departed from its traditional stance that fee-for-service indemnity was the only form of health insurance it would provide when it initiated a plan to move 90 percent of its employees into managed care. Lilly is the first large employer in the state to make such a move.

Recently, a group of employers in central Indiana, concerned about the lack of information with which to make purchasing decisions, formed the Indiana Employers Health Care Coalition (IEHCC). Discussions about forming such a group began in 1989, and the idea became a reality in mid-1994. The IEHCC

[1]Although accurate information on employer health care costs, such as group rates, was not available for this analysis, the 1996 adjusted average per capita cost (AAPCC) for Medicare beneficiaries in Marion County suggests that health care costs are higher in the Indianapolis market than in the Evansville and Fort Wayne markets. For example, the nondisabled, aged Part A plus Part B AAPCC, not adjusted for demographic cost factors (e.g., age and institutional status), is $456.36 in Marion County, $363.61 in Vanderburgh County (Evansville), and $325.35 in Allen County (Fort Wayne).

has 21 members, including some large employers such as General Motors, Cummins Engine Company, and the city of Indianapolis. Some of those interviewed feel the coalition was responsible for the Indiana Hospital Association and the state Department of Public Health releasing hospital-specific information on charges and lengths of stay for 10 hospital diagnostic related groups (DRGs) in January 1995. The coalition has sent a clear signal to the provider community that it intends to become more aggressive in its oversight of medical care rates and changes in the system. It also might move into collective purchasing of health care services. The influence of the IEHCC might be blunted, however, by the fact that some of its members also serve on the boards of local hospitals.

State and Local Government as Purchasers for Low-Income People

Public sector endorsement of managed care appears to have had limited impact on the market. The state of Indiana has provided managed care options for state employees for several years, but few take advantage of them because there are no incentives for them to do so. Indiana University only recently began to encourage its employees to move into managed care.

Medicaid is the arena in which the state has made the most dramatic moves as a purchaser of health care services. The state cut $500 million from its Medicaid program budget for fiscal years 1993 to 1995. Until January 1995, these savings came solely from reducing provider fees. The state then implemented Hoosier Healthwise, its Medicaid managed care program, after receiving federal approval of a waiver of section 1915(b) of the Social Security Act. The state Office of Medicaid Policy and Planning divided the state into north, central, and south regions; for the first phase of the program, it requested proposals from managed care plans for the central region only. Facing the prospect of losing Medicaid market share, several Indianapolis hospitals—Indiana University Medical Center, Wishard Hospital, Methodist Hospital, and St. Francis Hospital—and one local health care plan—M-Plan, offered by Methodist Hospital—formed a holding company to bid for the contract. The bid of this company, the Central Indiana Managed Care Organization, Inc. (CIMCO), was successful, and the state offered the company an exclusive contract. CIMCO now operates the program under the HMO license held by Healthsource Indiana, which also has a statewide commercial insurance market. The enrollment projection for the first year is 45,000 covered lives. Because of the exclusivity of the CIMCO contract, the state will pay on a fee-for-service basis for Medicaid clients who present at hospitals other than the four that make up CIMCO. The state is reconsidering this approach and hopes in the next phase to contract with more than one health care plan.

The other major public purchasing initiative concerns state disproportionate-share Medicaid payments, especially to Wishard and Methodist hospitals. These hospitals are paid an additional 35 percent on top of their usual

Medicaid service rates, because they serve many low income patients. Nine hospitals statewide have benefited from disproportionate-share payment adjustments. This reimbursement system has helped make Wishard Hospital financially solvent. Wishard also successfully advocated in Marion County for a property tax increase that provides the additional local dollars required to match federal Medicaid dollars, at a rate of $1.00 for every $1.60 federal.

Providers

Indianapolis hospitals have long been a cooperative community, with substantial social contact among their leaders. In the past 18 months, the larger hospitals in the metropolitan region have begun to skirmish with one another, however, as they maneuver to consolidate and expand their market share and put themselves in a position to offer capitated managed care. Their activities have affected both primary care and specialist physicians, many of whom have become anxious about their future role in the market. As a consequence, the once cooperative social structure within the provider community is beginning to fray.

Hospitals

The major hospitals in the greater Indianapolis area are changing from passive market participants to market drivers—forming alliances with one another, courting and acquiring physician practices, and negotiating for contracts for insured patients. In the process, the larger hospitals are transforming themselves from individual, competing hospitals into composite medical care systems. From the "big five" hospitals in the metropolitan region, two large systems are emerging: a collaborative network arrangement between Community Hospitals Indianapolis and St. Vincent Hospitals, and a proposed merger between Methodist Hospital and the two hospitals of the Indiana University Medical Center—University Hospital and Riley Hospital for Children.

The Community/St. Vincent alliance integrates the services, administration, and information systems of five hospitals in Indianapolis: Community East, North, and South; St. Vincent Hospital; and St. Vincent Carmel Hospital. The collaboration among the hospitals, which began in 1992 and won federal antitrust approval in early 1994, does not integrate finances or medical staff. The hospital network provides services to about 35 percent of the Indianapolis (regional) market. The three Community hospitals bring a tradition of family practice to the network, and the St. Vincent hospitals, owned by the Catholic Daughters of Charity National Health System, offer general, broad-based services and a strong cardiology specialty. A third hospital—St. Francis, owned by the Catholic Sisters of St. Francis Health Services—would like to join the Community/St. Vincent alliance; this prospect is being examined by the Department of Justice. St. Francis would bring occu-

pational health and rehabilitation and sports medicine to the network. The three hospitals combined would control 45 percent of Marion County's acute-care market.

The proposed Methodist/IU merger would unite a private, general services, United Methodist Church-affiliated hospital with a public, university-based teaching facility. The merger would integrate the assets, staff, and governance of the three hospitals, but the structure of the merged entity has yet to be determined. Because the IU facilities are public institutions, the merger will require the governor's signature. Methodist is one of the 15 largest hospitals in the country; it would bring to the merger a broad portfolio of hospital services with a strong specialty base and about 20 percent of the central Indiana market (IU has about 6 percent). IU operates the state's only medical school; it would bring a strong teaching facility in University Hospital and a state-wide market for pediatric care through Riley Hospital (a Level One pediatric trauma center). The merger discussions still must determine the future of medical education programs operated by IU's two hospitals and the future of services and facilities at IU that are duplicated at Methodist. Whether and how Methodist merges its health care networks—MetroHealth Plan and the Indiana Medical Network—also has yet to be determined.

The proposed Methodist/IU merger brings into question the future of Wishard Memorial Hospital, Indianapolis' only city hospital. Wishard provides care to 90 percent of Indianapolis/Marion County's indigent population. The hospital contracts with the IU School of Medicine for staff and hospital management and provides emergency care to IU patients. When Methodist and IU began merger talks, however, Wishard was excluded. IU maintains that the medical school, not University or Riley hospitals, contracts with Wishard, and because the medical school is not part of the hospital merger talks, Wishard is not affected. Yet exclusion from either of the emerging Indianapolis medical systems could threaten Wishard's ability to compete for paying customers: 10 percent of Wishard's revenue comes from commercial insurance, 23 percent from Medicare, and 33 percent from Medicaid. The balance of Wishard's revenue—about $42 million—comes from Marion County property tax support.

In spite of its uncertain future, Wishard is in good financial shape right now. The hospital is implementing a strategic plan for vertically integrating with health centers and nursing homes in the community and is building a 240-bed long-term care facility. Wishard is talking with the Community/St. Vincent alliance about collaborative opportunities and, through the Indiana Hospital Association, is opening a dialogue with the other hospitals in the Indianapolis community to discuss its continued financial well-being. Ultimately—as several people interviewed for this analysis suggested—the other hospitals in the market do not want to see Wishard closed because it serves a population that they do not want to begin serving: the uninsured.

According to several of those interviewed for this analysis, the Community/St. Vincent alliance inspired the proposed Methodist/IU merger. Many predicted that a third integrated medical system will emerge, and they indicated they would welcome and encourage such a system because it would increase market competition. Several theories were posited about who might initiate such a system. Blue Cross and Blue Shield, through The Associated Group (TAG)—a diversified insurance and financial services umbrella company for Blue Cross and Blue Shield in 25 states—has indicated it would like to move into health care provision and is purchasing primary care practices across the state. Although it could develop into a competing medical care system in the Indianapolis market, some observers questioned whether this is one of TAG's goals.

Another candidate for the third system is Suburban Hospitals, Inc., a nine-year alliance of hospitals (nine county-run and one private) that ring Indianapolis. The Suburban alliance originally was created to give the member hospitals a price negotiating position with insurers that would allow them to compete with the larger hospitals in the market. The two emerging systems are pressuring the Suburban alliance to affiliate with one of them as a group; if the alliance won't do this, the systems will split the alliance and form affiliations with member hospitals individually. Under this pressure, Suburban began about 18 months ago to revise its strategic plan and its mission, partially with the intent of strengthening the group as an alternative to the two networks. The alliance is trying to get a four-year commitment from member hospitals not to contract with anyone else. Several rural hospitals also have approached it, seeking participation in the network.

In addition to forming alliances with one another, the large Indianapolis hospitals have developed other strategies to retain and expand market share. One such strategy is further horizontal integration with hospitals outside, and on the outside edges of, the regional market. The pressure on Suburban Hospitals to affiliate with the Community/St. Vincent alliance or Methodist Hospital is one example. The large city hospitals also are seeking alliances with rural hospitals outside the metropolitan region. Methodist, for example, has formed a clinical affiliation with Howard Community Hospital to the north and has acquired Bedford Regional Medical Center to the south. Methodist, which intends to enlarge its share of the statewide market (currently about 5 percent), also has formed a network with five large hospitals in other large markets in the state—Columbus Regional Hospital, Deaconess Hospital in Evansville, Home Hospital in Lafayette, Parkview Hospital in Fort Wayne, and Union Hospital in Terre Haute—for the purpose of negotiating with employers and insurers for contracts to provide managed care. The network probably will allow some integration of administration but not of services or staff.

The large hospitals in the Indianapolis market also are working toward vertical integration by purchasing primary care practices and opening community clinics. Community/St. Vincent and Methodist hospitals are acquiring primary care practices aggressively throughout the Indianapolis region. Community/St. Vincent hospitals intend to increase the ratio of primary care to secondary services across their collaborative network. The five hospitals participating in the Community/St. Vincent alliance have a joint strategy of developing partnering opportunities with physicians with the goal of establishing an integrated delivery network. Methodist also intends to increase its ratio of primary care providers to specialists and is developing outpatient centers around the city within easy access of Interstate 465 (its "beltway strategy"). IU is building its primary care capabilities as well, by expanding staff ("producing" primary care physicians) and expanding facilities. In the last three years, IU and Wishard Hospital have opened six neighborhood clinics throughout the city (Wishard operates the clinics and IU provides the professional staff).

The hospitals' movement toward horizontal and vertical integration has been motivated primarily by the vision of the individuals leading them. Action by the executive of one hospital and reaction by another have played a significant role in instigating and furthering market change. But various alliances that some viewed as "natural" in this market—for example, Methodist Hospital (specialty niche) with Community Hospitals (primary care niche)—did not occur, and some interviewees suggested that this was largely the result of the personalities involved.

The church also influences the direction that Methodist Hospital and the Catholic hospitals—St. Vincent and St. Francis—take. The Methodist church, with significant representation on the hospital board, initially supported the Methodist/IU merger as long as it would result in an integrated system that provided better care for patients. But the merger brings the role of the church in a merged, for-profit medical system into question. The hospital has hired a nationally known ethicist to help the church and the hospital to determine the best course for each with regard to the proposed hospital system. The Catholic church also is influencing the emerging medical systems: St. Francis Hospital initially talked with Methodist about a possible collaboration, but the Catholic church advised St. Francis to cease these discussions and work with a Catholic institution instead. St. Francis now intends to join the Community/St. Vincent alliance.

Physicians

Historically, physicians were powerful in the Indianapolis market in traditional ways: they were at the center of a fee-for-service system, and they were infor-

mally in control of Medicaid reimbursement rates because the program essentially paid their charges rather than set their fees. The new alignments of hospitals in the Indianapolis market and aggressive courting by both hospitals and insurers now have physicians confused and worried.

About a third of the physicians in the market are primary care providers. As increasing overhead costs and declining reimbursements made them "ripe for plucking," nearly 80 percent have become affiliated in some way with a hospital system or provider network (for example, some have sold their practice to a hospital, others have joined a network). One observer suggested that within a year there will be no unaffiliated primary care physicians in Indianapolis. But now that they have been become aligned, primary care physicians are grappling with what the new network environment means to their practices. Although most understand that the structure of the health care system is changing and they need to move with it, many do not understand what physician networks and integrated systems are or how being an employee of a system or operating under a managed care contract can affect their clinical practice.

In the past, there were few physician group practices in the Indianapolis market. Family practice physicians tended to be in solo practice or in small groups of two or three. About four years ago, a group of 22 internists affiliated with Methodist Hospital formed a primary care group called Aegis. Although Aegis was an independent group with no direct financial or administrative connection with Methodist, the public identified it as having "Methodist" physicians. Aegis has since become a subsidiary of Methodist Hospital and has merged with a management service organization (Practice Management, Inc.). The new network, an independent practice association (IPA), is known as Indiana Medical Network; it is one of two networks offered by Methodist's M-Plan HMO.

Generally, physicians who have joined networks have not yet changed their practice or referral patterns or shifted their perception of their relationship with hospitals or health plans. Most physician business is in "discounted" reimbursement schemes, and these have not influenced them to modify their practice patterns. Interviewees report that primary care physicians also have yet to exercise the power that hospital and health plan restructuring offers. Hospitals and health plans are shifting their focus to primary care physicians as the point of entry into the medical system. Methodist Hospital, for example, has created an umbrella organization—the Methodist Health Group—that is intended to shift the hospital out of the center of the Methodist system, making it just one in the array of services the system offers. Methodist's M-Plan is experimenting with physician clusters (or "point-of-care teams") that manage and provide coordinated care.

Interviewees suggest that such restructuring has yet to change the practice of medicine in Indianapolis much, and is not expected to over the short term.

Specialists are beginning to feel pressure in the Indianapolis market, as the vertical integration strategies being played out by the hospitals and TAG focus on the primary care physician. Historically, the few Indianapolis-area specialist groups have been single-specialty clinics, such as radiology groups or neurosurgery clinics. Recently, however, specialists have begun to form multi-specialty groups to position themselves to accept capitated managed care contracts. Two groups of heart specialists, for example (Northside Cardiology and Nasser, Smith and Pinkerton), have purchased a number of primary care practices, and eight specialty groups in the Indianapolis area are discussing forming a multi-specialty network.

Safety Net Providers

Providers in the Indianapolis safety net are being forced to redefine their roles in the market in the wake of the hospital activity and as the public sector pushes for privatization of services. The safety net is small, comprising community health centers (CHCs), hospitals, and the Marion County Department of Health.

The community health center system is defined by the institutional affiliations of its members. Methodist Hospital operates HealthNet, a system of three clinics in south Indianapolis. Wishard Hospital is affiliated with six community health centers, five of which were moved from the Marion County Department of Health along with their federal program financing. The relationships between the CHCs and the two hospitals significantly influence the CHCs' market and operational strategies. For example, Methodist and Wishard's involvement in Hoosier Healthwise, the Medicaid managed care program, has forced their affiliated CHCs into exclusive referral arrangements. The Indiana Primary Health Care Association, an association of primary care clinics throughout the state, supports CHCs in their planning and marketing strategies. For example, the Association assists CHCs in becoming federally qualified health centers (FQHCs). It also assisted several CHCs as they worked with the state and local community-based organizations to develop an application to the U.S. Department of Housing and Urban Development for an Enterprise Community designation for a neighborhood in the near eastside of Indianapolis. The Association also received a $2 million allocation from the 1995 state legislature for organizational and educational activities.

The Marion County Department of Health began to focus more on population-based services (i.e., services that support the health status of populations, as opposed to clinical services to individuals) when a large part of its clinical presence—the five community clinics—was moved to Wishard about four years ago. The department still operates two free-standing clinics and two school-based clinics. Since its change in focus, the department has been exploring ways to collaborate with the large Indianapolis hospitals to improve community health and is enlisting the hospitals to help with strategic planning. Among the many collaborative efforts that have emerged are a community

needs assessment process and a program to give immunization data to each of the "big five" hospitals (along with computer systems to track the data). Consumer advocates suggested that the collaboration between the department and the hospitals is improving the health of poorer communities in Indianapolis and that the department is providing needed leadership on the special needs of particular neighborhoods.

Academic Medical Centers

The Indiana University Medical Center provides 6 percent of the hospital care in the Indianapolis market and is the dominant source of complex medical care for children in the state. In addition to providing staff for its two hospitals, University and Riley, the IU School of Medicine faculty and residents also staff and manage Wishard Hospital and its affiliated clinics.

IU has become involved in the local market alliance and merger discussions as it seeks to maintain a balance between service, research, and education in a changing market. The Medical Center recently concluded that, as occupancy rates decline and hospital-based medical care costs increase—with no accompanying increase in public subsidies—it must seek "economic integration" with another organization to create a single large health system. This decision led to the proposed merger with Methodist Hospital. With the merger, IU believes that it will become part of a large, programmatically diverse hospital system. The IU Medical Center has not included Wishard Hospital in discussions about merging, and Methodist Hospital has expressed concern about the consequences of Wishard closing its doors; as one observer commented, indigent patients currently seen at Wishard probably would go to Methodist if the city hospital closed.

Several of those interviewed for this analysis commented on the difficulty of integrating IU and Methodist medical staff. The two staffs have different organizational cultures, including different views of the relative importance of family medicine (an emerging area at IU) and specialty care (an historically strong area at both institutions). Physicians associated with IU are also concerned about the relative importance research and teaching will have after a merger based on market pressures. Financing such non-clinical programs will continue to be a problem in the foreseeable future.

Insurers and Health Plans

The Indianapolis health care market has long been dominated by indemnity insurance, but in the past two years more managed care plans have been offered and enrollment in such plans has gradually increased. The largest indemnity insurer in the market, TAG is aggressively moving toward operating its own integrated delivery systems, and the larger hospitals are creating

physician-hospital organizations (PHOs) designed to compete for capitated contracts.

Indianapolis' shift toward managed care is reflected in the statewide breakdown of enrollees in various insurance products. About 87 percent of Indiana's population is covered by health insurance: 66 percent in private plans and 21 percent in publicly sponsored plans (15 percent Medicare and 6 percent Medicaid). Excluding Medicare and Medicaid, about 16 percent of the population is enrolled in commercial indemnity insurance and the balance, about 50 percent, is enrolled in managed care plans.

"Managed care" is defined in Indiana as POS plans, PPOs, and HMOs. POS plans are considered a transitional form of managed care, and their enrollment still is counted under indemnity insurance. Currently, about 40 percent of the population is enrolled in PPOs and about 10 percent in HMOs.

TAG, based in Indianapolis, has 35 percent of the health insurance market in the tri-state area—Indiana, Ohio, and Kentucky—and about the same proportion in Indiana, including the Indianapolis market. Other indemnity insurers in Indianapolis include Sagamore Health Network, Prudential, Aetna, and Travelers. The largest HMO in the state—with 95,000 enrollees—is M-Plan, offered by Methodist Hospital. Other HMOs include Principal Health Care, PruCare, Healthsource Indiana, Maxicare Indiana, and IU Health Care.

Methodist Hospital and TAG are forcing the emergence of managed care in the Indianapolis market by blurring the line between health care insurers and providers. Methodist owns and operates M-Plan, a for-profit HMO, and TAG is developing an integrated system of provider networks and insurance products that provides and manages health care and can accept capitation. Methodist started the trend in the late 1980s when it created M-Plan. M-Plan owns and operates two delivery systems: MetroHealth Plan (a provider network) and the Methodist Delivery System (a PHO that offers the Indiana Medical Network, an IPA with a primary care focus). M-Plan capitates both networks. Physicians in the two networks accept patients either directly through M-Plan or indirectly through other, non-Methodist plans and insurers; only 10 percent of their patients are M-Plan enrollees. M-Plan also contracts with physician groups established by other hospitals, including IU Medical Center, St. Francis Hospital, and Suburban Hospitals, but not Community or St. Vincent hospitals.

The other large hospitals in Indianapolis are following Methodist's lead by creating their own PHOs. Indiana University Medical Center created IU Health Care in 1992, which has opened clinical offices throughout the city. St. Francis Hospital and St. Vincent Hospitals also have created PHOs. Suburban Hospitals has formed a PHO that carries full risk for 8,000 lives and is developing a strategic plan that will allow it to market HMO products. In particular, the Suburban group of 10 hospitals is interested in creating a network with 5

other hospitals statewide—to be called Suburban Health Organization—that would obtain an HMO license under which each hospital would operate locally. Suburban also wants to partner with an insurer to develop a PPO.

TAG has been a small player in managed care in Indiana; enrollment in its HMO, Key Health, has dropped over the last three years from 100,000 to 30,000. The insurer's current strategy includes forming the American Health Network, a partnership of primary care physicians across several states, including the tri-state area (Indiana, Ohio, and Kentucky). TAG is offering physicians an equity position with American Health, which will operate as a management service organization that provides billing and other management services to member physicians. About 120 primary care physicians in Indianapolis have signed on. TAG also is merging with Community Mutual Insurance Co., a Blue Cross and Blue Shield plan based in Cincinnati. The merger will create one of the largest Blue Cross and Blue Shield health plans in the United States (with more than four million policyholders in the tri-state area). The merged company plans to establish a network of family practice centers linked by a computer information system to the insurer and to a network of affiliated specialists and hospitals.[2]

Insurers and health plans in the Indianapolis market are struggling with the concept of provider exclusivity, especially with the emergence of the two hospital-based medical systems—the Community/St. Vincent alliance and the proposed Methodist/IU merger. TAG has considered ways to enter into an exclusive contract with one or more of the local hospitals or one of the two hospital systems. Employers have difficulty contracting with insurers or health plans that restrict choice of hospital, however, because their employees want to go to a hospital near where they live or work. Because hospitals are distributed widely throughout the city and suburban areas, employers have resisted having TAG (the largest insurer) form exclusive arrangements with any of them.

TAG is not the only insurer in the tricky position of either contracting with one of the emerging systems or trying to persuade both to participate in the same insurance products. Some of the affected hospitals are insisting on exclusivity. Sagamore Health Network, one of the largest PPOs in the state, used to include Community, St. Vincent, and Methodist hospitals. As a result of the Community/St. Vincent alliance, however, Sagamore was able to continue to offer Methodist Hospital only by creating two separate PPOs, one with Community and St. Vincent hospitals (Sagamore Plus) and one with Methodist (Sagamore Select). Travelers, which used to contract with both St.

[2]TAG also merged with Southeastern Mutual, a Kentucky-based Blue Cross and Blue Shield provider, in 1993.

Vincent and Methodist, ceased offering St. Vincent in January 1995, when the hospital indicated it would not participate in a network that included Methodist. Healthsource encountered the same problem.

Insurers and health plans in the Indianapolis market are not unduly concerned about "outside" health plans entering and capturing market share. The only known exception is Humana Health Care Plans of Indiana, which has entered the Indianapolis market through an agreement with Methodist Hospital. For now, the competition is among existing plans in the market and is over which will be in a position to capture the most capitated managed care business in the future.

Consumers

According to several interview respondents in the physician and hospital communities in Indianapolis, as well as consumer advocate respondents, the structural changes instigated by the hospitals in the Indianapolis market have had little effect on consumers. Most employers offer both an indemnity plan—including POS plans—and an HMO. The HMO usually has a broad enough provider panel that employees don't have to change providers if they select this option. For the most part, consumers have remained loyal to their physicians and hospitals.

The care that consumers receive also has not changed very much, although some of their physicians now act as gatekeepers for referrals. Practice patterns have not yet changed significantly across the market, however, so few consumers have noticed gatekeeping activities. Hospital efforts to provide quality assurance and increase customer satisfaction are too recent to have had an effect on people's choice of health care plan or provider. Consumers still tend to have loyalties to certain hospitals based on history, culture, and location, and these have not yet been affected by the machinations of the market.

Consumers also have not put any pressure on the market to inspire changes in health care delivery. Several people interviewed for this analysis said that, by their nature, "Hoosiers don't demand a lot," and consequently they might grumble a little about not being able to self-refer but they "won't make a fuss." In fact, they might even apologize for being dissatisfied! A survey of Indianapolis-area consumers (in Marion and the seven contiguous counties) conducted by the Citizens Energy Coalition Education Fund, Inc., in mid-1994 indicated, however, that a large majority (about 86 percent) agreed that the health care system needs either some change or major change. This group identified the cost of care, including premiums, as the biggest problem with the system.

Future Developments

Interview respondents agreed that the rapid developments taking place in the Indianapolis market will continue into the near future. Most believed that the proposed Methodist/IU merger would be approved and that there will be at least two health systems in the market. Many felt that Wishard would eventually be included in the Methodist/IU system, primarily because of the historical staffing relationship between Wishard and IU. Once the structure for the Methodist/IU merger has been established, there probably will be greater certainty in the market as a whole. Similarly, a decision by TAG regarding hospital affiliations, which should be made in the near future, will have a calming influence on the market as another uncertainty is resolved.

A few of those interviewed suggested that the proposed Methodist/IU merger could fail. These observers believe the cultural diversity between the two organizations might be too much to overcome. If the merger fails, they suggested, government or church influence probably will not be the cause.

Many interviewees suggested that the legislature and the public sector will not play a role in creating or overseeing health policy in the near future. The commissions appointed by the governor will develop useful information, but it will languish from government inattention.

Managed care will continue to grow in the Indianapolis market, according to many observers, with penetration of risk-bearing plans at 50 percent or more by the year 2000. Medicare risk-bearing products also will grow quickly. Consolidation among the providers also will continue, but the "weight of mergers"—that is, the pressures that come with making mergers and alliances work—could begin take a toll on the administration and operation of the participating organizations. Although no hospitals in the market have closed, some might as smaller hospitals lose market share to the larger systems.

The role physicians and employers will play in the market is not clear to most of those interviewed. Many expressed the opinion that physicians will organize and become a more central force in shaping the system. An equal number said that hospital dominance would continue and that physicians would be "stuck" with this for the foreseeable future. Some believe that employers will develop PPOs and that the fledgling business coalition will become a force in the market. Most indicated, however, that they do not believe that the quiet role of these purchasers will change much in the near future.

Several interviewees pointed out that players in Indianapolis are preparing for the possibility of external actors entering the market. Columbia/HCA Healthcare Corporation already owns the small (182-bed) Women's Hospital Indianapolis. Using this hospital as a launching point, Columbia/HCA could form a third medical system by buying other hospital facilities (or their excess capacity) and by offering its own insurance products or purchasing insurance

products already in the market. Wishard Hospital already has approached Columbia/HCA about partnering opportunities; the for-profit corporation indicated it was not interested. According to one person interviewed, Columbia/HCA "would have a hell of a fight coming in here" and trying to form a third system, because "Indianans do not like outsiders."

The points of consensus about future developments—the Methodist/IU merger, the role of TAG, the increasing market penetration of managed care—seem all the more important when viewed in the context of the makeup of Indianapolis. Many of those interviewed characterized themselves and their community as conservative, cautious, wary of outsiders, and possessing a unique way of doing business. The fact that a community that describes itself this way could agree on a view of the future that includes major changes in the health care market suggests that the next year or two will indeed be significant for Indianapolis.