COMMUNITY SNAPSHOTS PROJECT

Minneapolis/St. Paul, Minn.

Site Visit Report

Prepared by:

Alpha Center
Washington, DC

Authors:
Debra J. Lipson
Jeanne De Sa

The authors are on the staff of the Alpha Center. This report was prepared with input and editorial assistance from Lynn Etheredge and Naomi Naierman, consultants to the Alpha Center. Reviewers included Mary Jo O'Brien, independent consultant. The authors are solely responsible for the selection and interpretation of information in this report.

Overview

The dynamics of the Twin Cities health care market, one of the most advanced managed care markets in the country, will quickly change as its consolidated health plan sector faces challenges from purchasers and providers. Business and government strategies for contracting directly with providers and developing less restrictive insurance products, as well as the state's easing market regulation, have stopped further consolidation. These trends signal the weakening market power of the large health plans.

Three years ago, private and public purchasers and the state legislature fostered mergers and consolidation among the hospital and insurance systems. In 1991, after the governor vetoed the state's health reform bill, the Business Health Care Action Group (BHCAG), an employer coalition comprising about two dozen of the state's largest self-insured businesses, was formed to negotiate with health plans for better health insurance coverage for their employees. State policy adopted in 1992 and 1993 provided strong incentives for all providers and insurers to form integrated service networks (ISNs), which were designed to deliver a comprehensive set of services for prepaid rates.

As a result of horizontal and vertical integration in the insurance, hospital, and purchasing sectors over the past few years, the market is currently dominated by three health plans (HealthPartners, Allina, and Blue Cross and Blue Shield), which have a combined 80 percent of the insured market. These health plans, two of which are vertically integrated with hospitals and physicians, pursue different strategies. Allina, an alliance of an HMO and a large hospital system, is trying to merge its two lines of business into a more integrated system. HealthPartners, the product of several HMO mergers, emphasizes close working relationships with its owned and affiliated physician group practices. Blue Cross and Blue Shield does not own any hospitals or physician groups, but it has sought contractual arrangements with providers. Aggressive competition among these three health plans and pressure exerted by large, organized purchasers have led to increased price competition.

Recent trends indicate that market consolidation may have gone too far. Purchasers are increasingly uncomfortable with the high level of consolidation in the health plan market, believing that it reduces their ability to hold health plans accountable and that increased leverage for health plans could lead to higher prices in the future. The BHCAG (renamed the Buyers' Health Care Action Group) is developing a new purchasing strategy that would allow purchasers to contract directly with providers that organize into competing care systems that are separate from the health plans.

Public purchasers are also increasing their efforts to obtain better value for their health care dollars. BHCAG gained more power in the marketplace when Minnesota state employees joined the group. The state employee health plan will coordinate direct contracting strategies with private sector purchasers.

The state also continues to aggressively purchase health care for its own employees and for enrollees in Medicaid and MinnesotaCare—low-income, uninsured people who are ineligible for Medicaid but eligible to receive public subsidies for health coverage. Medicaid and MinnesotaCare enrollees throughout the state will be gradually enrolled in managed care plans according to a federal Section 1115 waiver approved in May 1995.

Meanwhile, several of the major hospital-based systems are beginning to position themselves to compete with health plans by contracting directly with large employers. Some of these hospital systems, as well as a number of organized physician group practices, believe that the health plans do not provide sufficient incentives for cost-savings. While most health plans are developing clinical practice innovations to reduce costs and improve quality (e.g., chronic disease management techniques), only about 35 percent of all of their HMO payments to providers are capitated. Savings from any clinical practice efficiencies accrue to the managed care plans rather than to providers, which explains the providers' interest in direct contracting.

The influence of state policy has decreased since the 1995 legislature's retreat from some MinnesotaCare[1] provisions. The state continues to play a role in moderating the extent of consolidation
to ensure that the market works effectively. The state is making it easier for organizations such as preferred provider organizations (PPOs) and community integrated service networks (CISNs) to compete with the large health plans. It is also working closely with the private sector to develop consumer report cards and obtain more consistent data from health plans.

Over the next two or three years, the market is expected to become less consolidated and more quality conscious and consumer oriented. While managed care enrollment will likely increase as more low-income and underserved individuals enroll in managed care organizations (MCOs), large health plans will lose some of their former dominance. Purchasers will become even more value conscious as they seek direct contracts with high-quality, efficient providers. Provider groups that are able to deliver what purchasers want will likely gain great advantage. It is not clear if the state will regulate care systems as insurers if they assume some financial risk from purchasers.

[1]To reduce confusion regarding the name MinnesotaCare, which refers to the state-subsidized program for low-income uninsured people, and the state's annual health care reform legislation, which has passed each year since 1992, we will refer to the former as the MinnesotaCare program and the latter as the MinnesotaCare legislation.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The Minneapolis/St. Paul region covers seven counties in the metropolitan area and has a population of about 2.4 million people, a little more than half of the state's 4.5 million people. Minneapolis and its western suburbs are in Hennepin County, which has a total population of about 1 million. St. Paul and its northern and eastern suburbs are in Ramsey County, which has a population of about 480,000 people. The other five counties in this metropolitan are Anoka, Carver, Dakota, Scott, and Washington.[2]

During the 1980s, the two major cities lost some of their population as more people moved to the suburbs. The overall population grew by 15.4 percent, which was a boon to the health industry. The Twin Cities area is predominantly white, but it has several minority groups. Access to care for these groups is of concern to public health and consumer advocates. Hispanics comprise 2.2 percent of the population in Minneapolis and 4.2 percent in St. Paul. Between 1980 and 1990 the African American population grew, primarily through migration from Chicago and other midwestern cities. The Twin Cities have the largest Native American indigent population of any metropolitan area in the country. There is also a sizable Southeast Asian community, which is made up of predominantly Hmong Cambodians.

The metropolitan region has a fairly high per capita income: number 41 out of more than 300 metropolitan areas. The median family income in 1989 was slightly higher in St. Paul than in Minneapolis. St. Paul also had a slightly lower percentage of families receiving public assistance than did Minneapolis.

As the regional center and state capital, Minneapolis/St. Paul has a large portion of the state's employment base; major industries include light manufacturing, government, education, and services including finance, health care, advertising, theater, and hi-tech industry. Four of the state's largest employers are public: the state of Minnesota, the federal government, the University of Minnesota, and Hennepin County. Large private employers include 3M Company, Dayton Hudson Company, Northwest Airlines, Inc., Allina Health System, and Norwest Corporation. All of the largest nonprofit companies in Minnesota are health related.

[2]The metropolitan statistical area (MSA) is growing to include 12 or 13 counties in western Wisconsin. The parameters of this market study remain the 7-county area.

Health System History

The Minneapolis/St. Paul health care system is regarded as one of the most advanced in the country. Its HMO enrollment rate of 44 percent is one of the highest in the country. It also has a significant PPO penetration and a high level of consolidation in the insurance, hospital, and physician sectors. A leader in health care reform, Minnesota has a long history of promoting managed care and marketplace competition within a structured regulatory framework. Minnesota has also been in the forefront of state health care reform and has relatively large state-sponsored programs that subsidize coverage for the uninsured.

Several important market shifts in the early 1980s set the stage for rapid consolidation and growth in managed care that followed in late 1980s and early 1990s. The 1980s witnessed the first mergers of health plans: MedCenter Health Plan merged with Nicollet-Eitel Health Plan (and the St. Louis Park Medical Center merged with Nicollet Clinic) to form MedCenters Health Plan, a group model HMO. Blue Cross and Blue Shield of Minnesota's HMO acquired a smaller HMO to form its Blue Plus plan. Hospitals were beginning to feel the effects of managed care as total hospital days began to decline from 672 per 1,000 in the population in 1986 to 535 in 1992. Several facilities closed, and others consolidated into four major multi-hospital systems. Already largely organized into group practices, physicians began forming even larger groups, selling their practices to hospitals or health plans, and affiliating with one or more managed care networks.

A significant market change occurred in 1989 when Minnesota's Employee Group Insurance Program decided to change its health benefits policies in response to a $50 million deficit and a projected 42 percent increase in annual premium rates. The program, which covers nearly 150,000 people, is the largest employment-based group in the state. Negotiating with all major state employee unions and using its market leverage, the state was able to devise a far less costly approach to health care benefits. Instead of paying the full price of whichever plan was chosen by the employee, as it had done previously, the state pegged its maximum contribution at the level of the lowest-cost plan in each region. It also eliminated all fee-for-service options, replacing them with a PPO plan. In addition, the state began collecting and publishing information about each plan's benefits, costs, provider network, and patient satisfaction.

These moves caused significant changes in the health plan market. The lowest-cost plan in the Twin Cities, a staff-model HMO, doubled its share of enrollment. The number of health plans offered to state employees in each region was limited, which gave the ones that were competing a strong incentive to offer lower rates. HMOs were no longer able to shadow price the indemnity plan rates, as state benefit plan managers suspected they had, and the plans had greater incentive to expand into rural areas to capture more

enrollees. After two years, premium increases averaged 2 percent less than prevailing market rates for comparable coverage.[3]

Between 1991 and 1994, hospital and insurer consolidations and competition between plans increased, spurred in part by state policy. In 1992, the state enacted MinnesotaCare, a series of laws designed to control health care costs, increase insurance coverage, and improve access to health services. These laws created the Minnesota Health Care Commission, which developed a cost containment plan to set limits on the annual growth in medical spending and subject fee-for-service providers to rates the state has set. The threat of spending limits put pressure on plans to control health care premium increases and spurred some providers to join capitated health plans. In addition, the state authorized the MinnesotaCare program to subsidize premiums for low-income, uninsured children and their parents who are not eligible for Medicaid and have incomes up to 275 percent of the poverty level. The state also committed to financing coverage for all residents by 1997.

One of the most important instigators of stepped-up integration and consolidation among health plans and providers was the state's mandate, subsequently revoked, that all health plans reconfigure as ISNs. Plans were given until 1997 to meet the requirements for ISNs, which included accepting capitation, providing a comprehensive array of services, offering community rating, and improving community health status.[4] Like HMOs, ISNs were required by Minnesota law to be non-profit. The state planned to promote competition between ISNs by collecting and publishing data on performance, quality, and patient satisfaction. Providers that chose not to join ISNs would have been subject to state-set reimbursement rates.

Consolidation and mergers in the health industry were also prompted by changing expectations of large employer groups. The BHCAG stimulated competition among the major HMOs and insurers by issuing a request for proposal (RFP) that requested bids for a single health plan offered by each member company that would promote BHCAG's key principles: consumer responsibility, provider accountability and continuous improvement, common plan design and administrative structure, and meaningful quality and utilization data. This action stimulated further mergers among plans since few would be able to serve the entire group without wider geographic coverage.

As a result of these three initiatives—changes in the state employees' plan, MinnesotaCare legislation, and the BHCAG RFP—health plans began to merge and consolidate. This meant being better able to serve enrollees across a

[3]See Klein, John, and Robert Cooley. "Managed Competition in Minnesota." *Managed Care Quarterly*, vol. 1, no. 4, 1993, pp. 58–67.

[4]The state has never prescribed how providers in an ISN would be paid. In designing the original legislation, the commission and the legislators expected that there would be more use of capitation payments to providers or provider networks.

wider geographic area, become ISNs, and serve more low-income people. In 1991, two of the largest HMOs in the market, SHARE and Physician Health Plan (PHP), merged to form Medica in 1992. This first merger of two large HMOs in the Twin Cities gave them substantially more market share than their competitors had. Within the next two years, two other large HMOs, Group Health and MedCenters, and Ramsey Health Care Systems (hospital and clinics) merged to form HealthPartners. In 1994, Medica joined with the HealthSpan hospital system to form an integrated delivery system, called Allina. By 1994, HealthPartners and Medica accounted for 90 percent of HMO enrollees in the Twin Cities. Blue Cross and Blue Shield has most of the remaining HMO enrollees in this area and the majority of HMO enrollees in the rest of the state.

At the same time, providers also merged to increase their negotiating power with health plans or to develop their own managed care products. Health One and LifeSpan hospital systems merged in 1991 to form HealthSpan Hospital Systems and developed their own PPO. This was the most significant merger among hospital systems. It raised concerns about concentration of market power for inpatient services because the hospitals had a combined 28 percent market share. Methodist Hospital and Park Nicollet Medical Center merged to form HealthSystem Minnesota.

There are currently 20 general acute care hospitals in the Twin Cities metropolitan area, down from 26 hospitals in the mid-1980s. The number of beds in the Twin Cities is 5,348, down from 10,000 beds in the early 1980s. Most hospitals are now concentrated in three systems: HealthEast with four hospitals, HealthSpan with five (part of Allina), and Fairview with four hospitals. HealthPartners owns one hospital. Only seven other hospitals are unaffiliated with either a hospital system or a health plan.[5]

Group practices have become the predominant form of organization for physicians. Since 1979, the percentage of physicians participating in a group practice has increased from 58 to 95 percent. Most of them are in groups of 3 to 15. Almost 36 percent of group practices are multi-specialty, and 40 percent have between 6 and 15 physicians. Since 1979, prepayment has grown more popular as a method of payment to group practices. In 1979, only 4 percent of the group practices had a large proportion of their practice in prepaid arrangements, compared to 61 percent in 1993.

[5]North Memorial remains independent (although it owns 20 percent of Preferred One PPO). The two children's hospitals have merged into Children's Health Care. Methodist Hospital is part of HealthSystem Minnesota. There are three publicly owned hospitals: The University of Minnesota, Hennepin County Medical Center, and the VA Hospital. Another five independent hospitals are located just outside the Twin Cities metropolitan area.

Approximately 80 percent of the Twin Cities' 2.6 million people are enrolled in HMOs, PPOs, or self-funded employer plans. Ten percent remain in fee-for-service arrangements and about 10 percent are uninsured. Those in fee-for-service arrangements are primarily Medicare beneficiaries, since HMOs in the Twin Cities have been reluctant to sign Medicare risk contracts because of relatively low Medicare adjusted average per capita cost (AAPCC) rates. The number of Medicaid recipients enrolled in HMOs was five times higher in 1994 than it was in 1989. Nearly all enrollees reside in the metropolitan area.

▼ ▲ ▼ Health System Changes

Public Policymakers

The previously strong influence of state policy on the market has subsided recently. Several provisions in the 1995 MinnesotaCare legislation repealed or delayed previous plans because of the newly elected, more conservative legislature. For example, the deadline for health plans to qualify as ISNs was postponed, the state's commitment to achieve universal coverage was redefined at 96 percent instead of 100 percent, and full community rating was deleted as a long-term goal, ISNs are no longer subject to annual premium rate limits, and the regulated all-payer option (RAPO) provisions (regulated rates to providers not part of ISNs) were repealed.

The effects of these changes on the market are not yet known. Without the annual premium rate limits, some believe that the health plans will no longer have a strong incentive to control costs. Others believe that private purchasers will exert countervailing pressures that will contain cost increases. Without full community rating, insurers may revert to traditional risk selection as a competitive strategy. On the other hand, rate bands may have been narrowed enough to eliminate the worst of these practices.

The state is still trying to actively influence the market, particularly in four key areas: easing market entry rules; giving private employers an option to share risk with providers if they contribute to state funds for the uninsured or hard to insure; actively pursuing enrollment of Medicaid and MinnesotaCare participants into managed care plans; and increasing the public responsibilities that HMOs (and their competitors) must fulfill.

Easing Market Entry Rules

Recent MinnesotaCare laws attempt to make it easier for groups other than HMOs to enter the market and compete with the three major health plans. Policymakers were concerned about market consolidation and reduced competition. In 1994, the state authorized the licensing of community ISNs (CISNs) two years prior to the licensing of other ISNs. This alternative class of ISN was designed to give providers in rural communities an opportunity to enter the

managed care business with less capital and fewer enrollees. CISNs can be sponsored by provider groups, but they cannot enroll more than 50,000 members and are not subject to the same financial reserve rules that apply to HMOs. At this time, three CISNs have been licensed by the state;[6] two of these are fully owned by existing insurers.

Two provisions in 1995 legislation, adopted in May 1995, make it easier for non-HMOs to compete. The state repealed the RAPO, which would have set rates that all payers must pay for providers not in an ISN. According to one PPO executive, this makes it easier for PPOs to continue paying providers on a discounted fee-for-service basis on behalf of their employer clients. If the provision had not been repealed, PPOs would have been forced to assume risk, and some may have opted to get out of the market completely. The legislation also authorized a pilot program for health care cooperatives (provider-led organizations) to contract directly with self-insured employers. The state intends to evaluate whether such arrangements make it easier for such co-ops (similar to CISNs) to obtain contracts and enroll members. The pilots will also give the state a chance to study regulation of such contracts.

Cooperation with Self-Insured Employers

The shift toward self-insurance concerns policymakers because it diminishes the pool of people protected by state-regulated insurance programs. In addition, as fewer people are covered through state-regulated insured arrangements, the state receives lower premium taxes that have been used in the past to fund Minnesota Comprehensive Health Association (MCHA), the state's high-risk pool.[7] Moreover, the state loses access to data on cost and quality otherwise available from regulated HMOs and other insurers.

In recent years, the state has addressed these problems in several ways. First, the state chose a financing mechanism for its state-subsidized MinnesotaCare program for low-income uninsured people that relied on provider taxes instead of premium taxes. Provider taxes affect all payers, including self-funded plans, which enlarges the pool of funds. Some large corporations acknowledge the importance of contributing to the costs of the

[6]Preferred One, Central Minnesota Group Health (part of HealthPartners), and New Pioneer, which is half owned and fully administered by Blue Cross and Blue Shield.

[7]The tax that supports MCHA is an assessment against members of the association that all insurers must join. It is based on the amount necessary to offset the deficit on claims. The amount has been about 2 percent of premiums in recent years. MCHA is one of the largest high risk pools in the country (34,000 in August 1994), although enrollment growth showed a slight decline in 1994, suggesting the effectiveness of small group reforms that limit exclusion of groups based on their health status.

uninsured and affirm their willingness to pay the tax. Other large corporations disagree; some have even filed a lawsuit to challenge the legality of this tax.[8]

To help cover losses to the state's high risk pool, which is funded by a premium tax on HMOs, Blue Cross and Blue Shield, and indemnity plans, the state passed a law allowing large self-insured businesses to purchase coverage directly from HMOs and health provider cooperatives. The law permits purchasers to make capitated payments and transfer some risk to the plans without losing Employee Retirement Income Security Act (ERISA) protection. In return, the companies must pay premium assessments to help fund the MCHA program and abide by all data reporting requirements that apply to health plans. To ensure that employers retain substantial risk, they must cover all costs between 110 and 120 percent of monthly payments. While most employers have not taken advantage of this new option, it remains an alternative for self-insured plans and HMOs to share financial risks.

The state also authorized the creation of a Health Data Institute, an organization supported by public and private funds to facilitate the electronic exchange of data, conduct consumer satisfaction surveys, develop health outcome measures, and protect confidentiality. The institute was planning to release the results of the first HMO consumer satisfaction survey in October in time for open enrollment.

Increasing Public Responsibilities of HMOs

Minnesota has long required HMOs to abide by certain requirements that make them more publicly accountable than HMOs in most other states. As the only state that requires HMOs to be nonprofit, Minnesota has prevented the influx of for-profit out-of-state companies. In addition, the state sets not only minimum financial reserve requirements but also maximum reserve levels to keep premiums low. In exchange for protecting them from competition from for-profit plans, the state requires HMOs to file action plans specifying how they intend to promote community health. In 1994, the state added another provision requiring HMOs to file collaboration plans that must specify how the HMO will work with public health and community agencies to develop community health promotion programs.

[8]A recent Supreme Court ruling in another case (*New York State Conference of Blue Cross and Blue Shield Plans* v. *Travelers Insurance Co.*) suggests that the Minnesota provider tax may withstand court appeals.

Purchasers

Employers and Employer Coalitions

While employer coalitions and public purchasers have contributed to important changes in the health care market from 1985 to 1994, their power has increased recently to the point that they now influence the market's direction. Through the collective efforts of large self-insured plans of private and public employers, the market remains highly price competitive. To ensure that low cost does not come at the expense of quality care, and to make providers more accountable, purchasers have embarked on three new strategies: (1) laying plans for direct contracting between purchasers and providers, (2) strengthening the purchaser coalition by adding the state employee system, and (3) requiring more information from health plans and providers about quality and outcomes of care, to use in purchasing decisions. In addition, employers are shifting from insured to self-insured status to lower their costs.

The Twin Cities has always had comparatively low costs. Health care spending per capita is lower in Minnesota than the national average. Private employer health care costs are substantially lower in the Twin Cities than in other markets. For example, 3M, the largest private employer in Minnesota, has employee health benefit costs of $3,300 per employee in the state, compared to its U.S. average of $4,700. Benefit costs are far lower in Minnesota than in California ($8,000) or New Jersey ($7,900) markets.

Price competition in this traditionally low cost market has become much more intense largely because of purchasers' ability to stimulate competition among the three major HMOs. Premium rate increases, above 10 percent around 1990, dropped to an average of 5 to 8 percent between 1992 and 1993. Premium rate increases for commercial enrollees in the largest HMOs averaged 4.3 percent in 1994. Based on several recent negotiations between purchasers and HMOs or insurers, rates may hold steady or even decline in 1995 and 1996. For example, Ramsey County, which purchases health insurance for its 7,300 employees, retirees, and dependents, and for those of 12 other localities as well, recently narrowed the final bidders to two plans, one of which offered a 1.5 percent decrease and the other a smaller rate of increase than the HMO that previously held the county contract.

Purchasers Demand More Accountability and Seek Direct Contracting with Providers

Large purchasers are seeking to contract directly with groups of providers, called "competing care systems," to address three major concerns: over-consolidation of health plans and providers, which may give them too much oligopoly power; the belief that health plans spend too much on administrative expenses; and the fear that providers are becoming less accountable as they get absorbed into large plans.

BHCAG is leading the effort to shake up the existing system through a new purchasing strategy. Under the present system, a common health coverage option administered by one of the health plans is available to employees in each of the participating companies.[9] Since other choices are available to employees in each company, the coalition's power is somewhat reduced. While this system has given employers more control over health plan design and an improved ability to increase quality, BHCAG believes that the system does not give providers adequate incentive to attain greater cost efficiencies.

To reward the most efficient and highest quality providers and reduce administrative costs, BHCAG has recently unveiled the enhanced competitive model it intends to institute when the current joint contract expires in 1997. BHCAG has identified 15 to 16 potential care systems that it might contract with directly. Under the BHCAG model, care systems will consist of structurally or functionally integrated provider groups (hospitals and physician groups) able to meet BHCAG performance standards for quality and stability and assume all or a substantial portion of financial risk for their enrolled population.

In this model, care systems could either own, contract with, or subcontract with a system integrator, such as a health plan, to accept risk for the full range of services needed to care for the population. Health plans would function like third-party administrators, handling claims processing, risk management, and cost/quality data reports. Ultimately, one health plan would serve as a health insurance purchasing cooperative or alliance to provide consumers the information they need to make informed choices about health care systems.

Until this system can be implemented, some BHCAG-member employers are experimenting with direct provider contracting. For example, 3M contracts directly with Health East hospital system and a set of providers that were selected from the Blue Cross and Blue Shield network. In addition, 3M's PPO contracts include some financial risk-sharing with providers for managing referrals and controlling utilization.

State Employees Join the BHCAG

The Minnesota state employee benefits plan recently joined the BHCAG, making it one of the largest, most powerful purchasing coalitions in the country. The state considered direct contracting as a potential strategy. During recent labor negotiations, the state employee benefits plan managers and union representatives discussed the possibility of replacing the statewide PPO option, which is managed by Blue Cross and Blue Shield, with a plan that

[9]Each employer has its own separate contract with the health plan to maintain the risk by each company, as required under ERISA.

would have contracted directly with a few closed-panel networks of providers. The state employee benefits plan has also sought to contract directly with alternative provider networks to care for high-cost users so that health plans would not be penalized for enrolling such patients.

Quality and Consumer Information Initiatives

Public and private purchasers are also increasing their demands on providers for quality data and trying to make both cost and quality data more available to consumers. For example, BHCAG spearheaded the development of an Institute for Clinical Systems Integration (ICSI),[10] which has become the cornerstone of its clinical quality improvement activities. ICSI develops clinical practice guidelines and supports their implementation; develops standard measures of clinical quality; assesses medical technologies; measures population health status; and works on improved clinical information systems. By the end of 1994, participating ICSI groups had fully or partially implemented clinical practice guidelines for 26 conditions. Providers submit quarterly progress reports to BHCAG. In the future, BHCAG plans to obtain more information on relative quality, cost, and satisfaction with contracted provider groups.

Several purchasers conduct and publicize their own employee satisfaction surveys, although the surveys are currently confined to health plans and do not cover provider groups. Large purchasers request more information about individual providers participating in health plans so they can help employees make decisions about providers. So far, employers have been more successful in specifying their data expectations than in obtaining the information. Large employers are leaders in the Minnesota Health Data Institute, which is developing the first major consumer report card on health plans in the state.

Purchasers Shifting to Self-Insurance and PPO Products

At the end of 1994, the three largest health plan companies in the state reported that their HMOs were administering coverage for nearly one-half million Minnesota residents covered in self-funded groups. This represents an increase of almost 200,000 since the end of 1993. Other companies, such as Preferred One, report similar growth in self-funded business.[11] In all, 1.5 million Minnesotans receive their health coverage through employer-funded plans, nearly double the number in 1990.

Approximately 60 percent of all business firms in the market are currently self-insured. They generally contract with PPOs for claims administration and provider contracting. Employers with as few as 25 employees are increasingly

[10]The organization, which is purchaser/provider governed, was created in response to a BHCAG RFP. Its membership includes 20 medical groups, including Mayo, Group Health, and Park Nicollet.

[11]Baumgarten, Allan, 1995. *Minnesota Managed Care Review, 1995.*

taking advantage of cost-savings available from self-insured status and benefit design. With self-insurance, firms also save through exemption from the minimum benefit provisions required of HMOs and ISNs and the taxes/contributions required by state law.

State and Local Government as Purchasers for Low-Income People

Recognizing the potential for further public savings, the state Medicaid agency is aggressively enrolling more Medicaid recipients, including the elderly and disabled, and MinnesotaCare program enrollees into managed care plans. Medicaid recipients, primarily Aid to Families with Dependent Children (AFDC) or AFDC-related in Hennepin and Ramsey counties, have been enrolled in HMOs for several years. By 1992, most Medicaid recipients and all General Assistance-Medical Care recipients in Hennepin County were enrolled in one of three health plans, under a 1915(b) waiver from the federal government. Ramsey County Medicaid recipients have been enrolled in HMOs since 1994. However, Medicaid managed care enrollment outside these two counties is minimal, and none of the MinnesotaCare-enrolled families is in managed care.

To take advantage of savings from capitated contracts, Minnesota intends to accelerate significantly the rate of managed care over the next three years. It has received a Section 1115 waiver that allows it to consolidate acute care Medicaid, General Assistance-Medical (a program for low-income people not eligible for AFDC), and MinnesotaCare programs. The state planned to enroll all of these groups throughout the state into managed care plans starting in July 1995. The waiver will allow the state to simplify the application process (e.g., via on-line computers in public libraries) and establish uniform eligibility across all three programs. It will also expand Medicaid eligibility to include families with children (no single adults) whose incomes do not exceed 275 percent of the federal poverty level (FPL).[12] In its managed care contracts, the state Medicaid agency is developing payment arrangements with health plans that include incentives to produce specific outcomes. The agency is also giving higher priority to setting quality standards and measuring access, quality, and outcomes.

The Medicaid agency is considering contracting directly with providers. While the state Medicaid program has not relied heavily on non- or partial-capitation managed care models that contract directly with provider groups, it would consider doing so to expand managed care options in rural areas where HMOs are not currently operating. Alternatively, the Medicaid agency might assume the financial risk itself, acting as an HMO and contracting with provider networks for special populations.

[12]Since this eligibility threshold is currently the standard for MinnesotaCare, it represents a substitution of federal funds for some state funds.

The 10 percent of the population that remains uninsured has several avenues to access health care and health coverage; however, they are no longer guaranteed coverage by 1997.[13] Those without coverage are eligible for the MinnesotaCare program if they are married or single parents with children, earning less than 275 percent of the FPL. The state provides sliding scale premium subsidies for these people, who now number about 85,000. However, the state withdrew a previous commitment to provide coverage to single adults with incomes up to 275 percent of the FPL setting the limit at 125 percent (or 135 percent if there is enough money). The state's Section 1115 waiver brings in some additional federal funds that permit the state to provide this level of benefits.

Further expansion has been suspended because the state is waiting for federal decisions about Medicare and Medicaid. If the federal government makes the expected cuts, the state may shift its attention to maintaining eligibility, services, and funding for current Medicaid recipients (especially the disabled) instead of expanding coverage for the uninsured.

Insurers and Health Plans

Recent trends suggest that health plans face serious challenges by purchasers and providers who view the plans as having become too consolidated. Increased premium price competition and the entry of new insurers that offer new or more flexible products to self-insured employers represent major threats to the dominant health plans. In response, insurers and health plans are trying to shore up their market share and influence by (1) integrating more closely with providers (hospitals, clinics, and physician groups) to expand geographic reach and achieve greater savings; (2) developing new quality improvement and community health promotion programs to respond to purchaser and policymaker expectations; and (3) designing new data systems that can bridge the needs of payers, providers, and consumers.

The consolidated insurance/HMO sector includes the following:

- HealthPartners, with 45 percent of the total HMO-enrolled population in the metropolitan area, is a vertically integrated delivery system with two HMO products (staff-model, group-model), a PPO, and Ramsey Health Systems (a hospital, clinic, and foundation).[14] It employs nearly 600 physicians, owns 60 medical and dental centers, and contracts with another 2,700 physicians in more than 180 locations.

[13]The 1995 legislature's amendment to the universal coverage goal now regards 96 percent coverage by the year 2000 as meeting the state's goal.

[14]The total metropolitan area population is 2.4 million. The total managed care market is 1.9 million and total (1993) insured HMO enrollment is approximately 1 million. The market shares exclude self-insured plan enrollees that may also use these same health plans' managed care provider networks and administrative services.

- Allina, with 42 percent of the total HMO enrollment in the metropolitan area, is also an integrated delivery system that includes Medica (an IPA-model HMO), a PPO (owned by HealthSpan), and other gatekeeper products for self-insured firms. Based on its merger with HealthSpan, Allina also owns and/or manages 17 hospitals and 60 clinics in Minnesota and Wisconsin, as well as 7,000 contracted providers and 336 employed primary care providers.
- Blue Cross and Blue Shield has less than 10 percent of the total HMO metro area enrollment, but it has a much higher market share outside the Twin Cities. Most of its 1.2 million members are enrolled in PPO plans, with metropolitan area PPO enrollment of about 33 percent of the market.

There are other insurers and HMOs with a lower market share. Metropolitan and U-Care, which are primarily Medicaid HMOs sponsored by Hennepin County Medical Center and the Department of Family Practice at the University of Minnesota, are not affiliated with the three major health plans. Another non-affiliated HMO is Northwestern National Life (NWNL). The Araz Group, an investor-owned health plan (PPO), has about 5 percent of the statewide market. Preferred One, another PPO, has 10 percent of the statewide market and is owned by Fairview Hospital System (60 percent share), North Memorial Hospital (20 percent) and Preferred One Physician Associates (20 percent).

Despite the incentives to compete on the basis of quality, network composition, or community responsiveness, price competition among these health plans, insurers, and PPOs remains the most compelling factor. For example, Medica (owned by Allina) recently underbid HealthPartners for several major employer contracts, which led to an increase of 100,000 enrollees in the past year. HealthPartners has acquired 30,000 new enrollees in the same period. While most employers are happy with premium savings, a few wondered whether premium reductions can be sustained and how long the health plans can deliver quality care at lower prices.

Price competition has led to the creation of market niches for new PPOs offering customized and low-cost services, particularly those serving the growing small- and medium-sized self-insured employer market. Total PPO enrollment increased from 1.4 million people throughout the state in 1990 to 2.2 million in 1993. Some of the growth in PPOs is attributable to large health plans diversifying their products for self-funded groups. Other PPOs have grown because they offer self-funded products that are less expensive than HMO policies since they are not subject to mandated benefits and MCHA assessments.

There are at least 10 PPOs in the Twin Cities market. Preferred One became the fourth major player in the market last year by renting its provider networks to commercial insurers and other plan administrators for use by

insured and self-funded groups.[15] In early 1995, Preferred One decided to expand into the risk-assuming market and serve small employers by obtaining a CISN license to operate in 45 counties. Another major PPO player, The Araz Group, rents its provider networks to commercial insurers and other plan administrators for insured and self-funded groups. Targeting medium-sized, self-insured employers with 100 to 200 employees, both PPOs offer lower prices than HMOs because PPOs are not subject to the same benefits requirements, open enrollment, or guaranteed issue as HMOs. Moreover, now that RAPO has been repealed, PPOs are able to negotiate discounted fee-for-service rates with providers.

While the PPO presence in the insurance sector has grown, other types of insurance have suffered. Travelers Insurance left the individual and small group market in 1994—a sign that the state's small group market reforms make it more difficult for some plans to compete on risk selection. Prudential also announced its intention to leave the Minnesota market in 1995. Despite its new contract with the Employers Association (a small- and medium-sized-firm group purchasing plan), Prudential did not believe it could gain what it perceived to be the necessary "critical mass" of 50,000 lives.

Point-of-service (POS) options have also emerged as important product lines.[16] Flexible products that give employees more choices are gaining popularity, while restrictive capitated network models are declining in popularity. For example, Allina's most successful product is Medica Choice, a POS product that has no gatekeeping functions. In exchange for an exclusive contract with an employer, some HMOs offer a choice from among HMO, PPO, and HMO-with-POS products.

Integration with Providers

Improving relationships with providers is a key strategy in reducing or eliminating competition from them. The three major health plans try to improve relationships with provider groups by making contracts more exclusive and developing properly aligned financial incentives. They also develop strategic alliances with hospitals or physician groups to expand geographic reach and reserve provider capacity in order to attract and retain health plan enrollees.

[15]Preferred One has arrangements with providers and third-party administrators (TPAs) as well as insurers. The enrollees belong to the TPA, the insurer, or the self-funded employer, not the PPO. Preferred One's revenues come from its network access fees and the utilization review and other services that some of its tenants choose to buy.

[16]A POS plan is a health plan with a network of providers whose services are available to enrollees at a lower cost than the services of non-network providers. POS enrollees must receive authorization from a primary care physician to use network services. POS plans typically do not pay for out-of-network referrals for primary care services.

The three major health plans have different strategies to develop positive provider relationships, including ownership and looser strategic alliances. For example, Allina owns five hospitals as a result of the merger with HealthSpan and has bought many physician practices to broaden its base outside the metro area. Allina's recent decision to ally with the University of Minnesota Hospital highlights its need to integrate with providers that have an expansive service area and product line. In 1994, Allina also formed a strategic partnership with MeritCare HealthSystem in Fargo, North Dakota, and intends to develop regional integrated care networks in other parts of Minnesota.

On the other hand, Blue Cross and Blue Shield owns no hospitals but rents networks through the purchase of reserve capacity. This defensive strategy, which involves contracting with hospitals and physician practices to prevent other health plans from buying or contracting all of a provider's available capacity, works well with surrounding rural providers who do not want to be part of the other two monoliths. The approach may not be as easy to implement in the Twin Cities area, however, where most providers are already aligned with competitors. For example, Blue Cross and Blue Shield's attempt to develop a strategic partnership with Fairview Health System and the University of Minnesota recently broke down, partly because Fairview is a major owner of a PPO, which is a Blue Cross and Blue Shield competitor.

Between ownership and strategic alliances is an approach like that of HealthPartners, which bought one hospital (the Ramsey Health System) and owns numerous clinics from its Group Health staff-model base. HealthPartners is not planning to acquire more physician clinics, but it is beginning to explore how existing provider components fit into the direct contracting model.

Health plans are seeking more restrictive relationships with physician groups whose physicians are not owned or employed by one of the major plans. A 1994 provision in MinnesotaCare legislation prohibits health plans from forcing physicians to sign exclusive contracts, but there appears to be significant pressure on providers to do so voluntarily. Last year, when one insurer established a joint venture with the Aspen Medical Group, another health plan eliminated the group practice from its network.

The efforts of health plans to align more closely with providers are not always accompanied by capitated payment rates. According to one source, capitation by health plans of participating providers is limited and may be declining; about 33 percent of all HMO payments to providers were capitated in 1993, a decrease from 1992.[17] The decline has been attributed to the switch from insured to self-insured status, which prevents HMOs or their providers

from assuming financial risk. Under the self-insured arrangements, however, employee benefits managers still believe in the importance of some risk-sharing (e.g., via withholds) so providers will have greater incentive to contain costs. If direct contracting between employers and providers becomes more popular, capitation may increase.

The relatively low level of provider capitation may be related to the reluctance of managed care plans to let providers share the profit from gains in efficiency. But that does not appear to preclude other payment approaches that allow providers to share in savings. For example, Blue Cross and Blue Shield's HMO (Blue Plus) recently announced a new policy called package-pricing, whereby it agrees to pay a consortium of providers a bundled hospital and professional fee that will give providers an incentive to provide certain cardiac care services in a more efficient manner.[18]

Quality and Health Promotion

In response to pressures exerted by large purchasers and state law requirements, quality and community health promotion initiatives have become a key component of each health plan's strategies. One of the most important quality initiatives is the Institute for Clinical Systems Improvement, which was organized by HealthPartners for BHCAG. The big three HMOs have major quality improvement initiatives focusing on disease management models of care. In these models, common diagnoses or conditions—for example, urinary tract infections—are identified and strategies are developed to improve outcomes in ways that decrease costs. After testing alternative diagnosis and treatment methods, providers devised a new protocol that reduced costs to one provider by $250,000 in the first year. In the Twin Cities, some of the health plans are further along than others in implementing clinical practice guidelines and disease management principles.

All the health plans have developed health promotion initiatives and prevention services, partly because the state requires HMOs to file annual action plans and specify how they will collaborate with community organizations to improve the general community health. For example, all three of the major HMOs are involved in a community-wide Family Violence Prevention program. HealthPartners started a program called Partners for Better Health, which encompasses a broad range of community-oriented activities designed to

[17]Baumgarten, Allan. "Doling Out Risk: How Capitation Measures Up in Minnesota." *Minnesota Medicine*, May 1995.

[18]The consortium includes Minneapolis Heart Institute, Abbott Northwestern Hospital, and Fairview Health System.

promote disease prevention and early detection. In addition, the Population Health Initiative (PHI), a regional effort including all seven county health departments, has helped the public sector develop priorities for working constructively with health plans. Through this effort, the PHI and health plans have begun to analyze health status data on avoidable hospitalizations for asthma and diabetes. PHI has also developed a comprehensive strategy for increasing bicycle helmet use. For example, one hospital bought 10,000 helmets to distribute free of charge, bicycle shops offered discounts, and a coalition of groups passed a law requiring helmet use by all kids.

Data Systems Development

Recognizing the importance of information systems, two of the health plans have strengthened their systems in the past year. Information systems are needed to manage capitated payments and deliver administrative services to self-insured plans. They will also be strategically important in the future because of the direct contracting scenario, in which health plans will be called upon to provide quality and cost data to employer groups. In the past year, Blue Cross and Blue Shield spun off its information services operations into a for-profit subsidiary that will concentrate on developing hardware and software products for health care clients. One of its for-profit subsidiaries developed electronic claims transfer systems and another administers workers' compensation programs.

HealthPartners has invested heavily in an 18-month project that is developing a user-friendly/interactive Member Choice information system, which will be installed in kiosks around the region. To help them choose their HealthPartners providers, this system will give people more information about the service components (e.g., same-day appointments, after-hours care) and quality indicators of providers. HealthPartners believes this system is an initial step for helping consumers choose from among competing care systems based on quality and efficiency.[20] As part of this process, the health plan is conducting focus groups to determine consumer needs and preferences.

Providers

The majority of providers in the Minneapolis market have faced significant pressures over the last few years, including reduced revenues, a state policy that requires all providers not part of ISNs to be subject to state-controlled rates, and purchasers' desire for wide geographic reach and array of services.

[20]BHCAG was reported to be negotiating with HealthPartners to develop the data/information infrastructure needed to implement the care systems model, but this model cannot be implemented until the current contract expires in two years (1997).

Consolidation among hospitals, insurers, and all types of providers has been the primary response to these pressures. As a result of mergers and integration, a large portion of area hospitals and almost 50 percent of all physicians are owned or employed by the three major insurers/health plans.

While the health plans seek to maintain dominance and profit, unaffiliated or aligned providers, hospitals, clinics, and physicians want a more powerful position in the market. They are attempting to secure alliances with all insurers to maintain access to patients without being confined to exclusive arrangements. To achieve this, some providers are establishing larger networks that can contract with all the health plans. In other cases, hospitals and their physician networks are seeking to assume financial risk and perform many of the functions now handled by HMOs and insurers.

Hospitals

Medica/HealthSpan's merger with Allina and the HealthPartners/Ramsey merger completed a period of hospital consolidation. Three systems—Health East, Fairview, HealthSystem Minnesota—were produced, leaving just a few independent hospitals. About 31 percent of all beds in the metropolitan region are owned by two of the three major health plans. While average length of stay in Twin Cities hospitals is low, excess capacity still exists. This has led to widespread downsizing and diversification.

Since the 1995 legislature delayed implementation of ISNs, the pressure for hospitals to merge with health plans has subsided. Now, existing hospital systems and independents are trying to determine a future strategy. There are also threats to existing regional hospital systems since The Mayo Clinic has begun to acquire clinics and hospitals in western Wisconsin and southern Minnesota, forming an arc to the east and south of the Twin Cities.

In this environment, independent hospitals and hospital-based systems have developed three major strategies to survive and maintain a competitive advantage in the market: (1) forging tight relationships with physician groups to ensure referrals and provide an array of choices for health plan enrollees; (2) attempting to contract with most or all insurers to avoid becoming too dependent on one insurer; and (3) preparing to bypass health plans and contract directly with purchasers in risk-sharing arrangements.

To align with physician groups and market themselves as prepackaged networks to health plans, some hospital systems and independent hospitals have formed physician hospital organizations (PHOs), bought physician groups, or developed management service organizations (MSOs). For example, Fairview created a PHO with its staff physicians in 1993; Fairview Physician Associates (FPA) is incorporated as a nonprofit integrated practice network in partnership with the Fairview Health System. Although all physicians in this orga-

nization have staff affiliation at a Fairview hospital and Fairview provides start-up funding and financial support, the two entities are autonomous. HealthSystem Minnesota has several different kinds of relationships with physician networks. Through its Park Nicollet Clinic, the organization contracts with more than 380 physicians in 19 metropolitan area locations. Through its Primary Physician Network, HealthSystem Minnesota also has contracts with 30 primary care physicians.

The ability of Allina's HealthSpan hospitals to expand their physician base has been restricted by a clause in the antitrust exemption granted to Allina for the merger of LifeSpan and Health One Corp. HealthSpan entered into an agreement with the state attorney general that featured a prohibition on entering exclusive provider contracts for 1994 and 1995.

Hospitals are trying to contract with all major insurers in the market to ensure as broad a patient base as possible. In some instances, the hospital will buy a percentage of a health plan's enrollees. For example, as part of Fairview's ownership agreement with Preferred One, 60 percent of Preferred One's enrollees go to Fairview hospitals. North Memorial owns 20 percent of Preferred One, so it gets 20 percent of inpatient admissions. Other hospitals will align with insurers in the market in less structured contractual arrangements that ensure a flow of patients to their facilities. For example, Allina's HealthSpan hospitals contract with many of Allina's competitors. HealthSystem Minnesota receives patients from both Blue Cross and Blue Shield and HealthPartners.

In some cases, provider systems are developing their own health plans while they continue to contract with the three major players. For example, Fairview Health Systems, which owns part of a PPO, still contracts with HealthPartners for inpatient care. HealthSystem Minnesota, part of HealthPartners delivery system, is forming its own health plan and will be in competition with HealthPartners for health plan enrollees.

Based on the BHCAG direct contracting plan, several of the major hospital-based systems are positioning themselves to compete directly with health plans by seeking contracts with large self-insured employers. Fairview and HealthSystem Minnesota have experience with capitation and are seeking to increase their capacity, especially if they are rewarded for improving clinical efficiencies. A 1994 MinnesotaCare legislative provision, which authorized provider cooperatives to contract directly with self-insured employers, may accelerate this process.

The competitive, insurer-dominated Twin Cities market has led to decreasing revenues and declining admissions at the region's major academic

medical center, the University of Minnesota Health System.[20] As a result, the university has adopted explicit strategies to retain its patient base. For example, it is promoting its out-of-state business of 20 to 25 percent by emphasizing its centers of excellence, such as transplants. The university is also trying to strengthen its relationships with traditional referral sources in the non-metro area of the state and is acquiring facilities in such areas as Red Wing and Hibbing, Minnesota.

The hospital has also tried to respond to the managed care market. Several years ago, the university's Department of Family Practice formed an HMO, called U-Care, which serves primarily Medicaid patients. The University of Minnesota's Health System was formed through a consolidation between the hospital and clinic with Minnesota Clinical Associates (the faculty practice plan) to facilitate managed care contracting. However, managed care revenues still comprise only about 20 percent of total revenues, which is relatively small since most of the commercial population in the Twin Cities is enrolled in managed care plans. Although the hospital has explored a number of possible alliances with insurers in the past, current discussions are in place for Allina to buy the University Hospital.[21]

Despite its challenges, the University Hospital has shown a positive bottom line for the past five years. This is the result of a concerted effort to become more cost-competitive—for example, taking $45 million out of its operating budget. Payroll has remained flat, and, through the use of benchmarks, the hospital has brought costs in most departments down to 90 percent or lower of the median. Costs are expected to be reduced further, to the 25th percentile, next year. At the same time, the university is developing a rehabilitation program, expanding home health services, and setting up system-affiliated clinics.

Physicians

Physicians respond differently to the current market dynamics depending on whether they are already employed by, or exclusively affiliated with, one of the major health plans (half of all physicians) or whether they are independent.

[20]The University of Minnesota is the only academic medical center in the Twin Cities area and serves as the primary teaching facility for the University of Minnesota Medical School and as a major tertiary care center. Mayo, located in Rochester, Minnesota, is the state's other academic medical center. Four other hospitals in the Twin Cities have major teaching or residency programs as well.

[21]Should this deal proceed, Allina will close Abbott-Northwestern Hospital, the chief competitor to the university for tertiary and specialized care, and consolidate operations at the University Hospital. This deal raises numerous questions, including how it fits into Allina's agreement not to purchase any more Twin Cities hospitals until 1996.

Concerned about access to patients and the need for capital, many physicians have already sold their practices to insurers or hospitals.

Physicians not employed by managed care plans pursue several strategies to gain access to patients and maintain their autonomy. Some physicians join PHOs or other hospital-physician entities. This way they can take advantage of a strong provider network that contracts with several insurers and works directly with employers. Other independent physicians have developed a physician-owned network that provides a network of physicians to insurers. For example, Criterion HealthCare Network, Inc., is a physician-owned integrated clinic network comprising 600 physicians that enables physicians to compete with other large multi-specialty group practices. Its members share risk through fixed price capitation contracts negotiated with health plans. Subspecialty groups in the market prefer this option since it preserves their autonomy. Some physicians align with an insurer without becoming employees. For example, Allina is developing a system whereby physicians can work in a capitated environment without committing to an exclusive relationship.

Safety Net Providers

Two dozen community-based clinics in the Twin Cities area operate independently from major health plans and have begun to work more collaboratively to respond to the pressures of a changing environment. Sixteen of the community-based clinics in Hennepin and Ramsey counties have recently come together to form a consortium that can serve as a vehicle for consolidated management services to lower administrative costs and gain leverage when negotiating joint contracts with health plans. A group of clinics in Ramsey County has joined with the county public health department to monitor Medicaid managed care access issues in the eastern metropolitan area.

As Medicaid managed care has grown and expanded to more counties, more clinics have found that maintaining Medicaid revenue requires that they become part of HMOs or subcontract with managed care plans. In fact, most health plans want to contract with comprehensive community clinics to steer to them Medicaid patients who might not use mainstream physician offices and to demonstrate to the state that they contract with essential community providers. But even when the clinics negotiate contracts, the experience has not always been good. For example, despite signing a contract to provide home health services, the Ramsey County Health Department has seen a drop in utilization because of fewer referrals, which has led to a loss of nearly $40,000 per month in Medicaid revenue. Health plans want the clinics to improve their medical management system, accept some risk or capitation, provide after-hour coverage, and handle claims and marketing more consistently. Most clinics are trying to improve their operations in these areas.

Consumers

Consumers in the Twin Cities are perceived as having the best of all possible worlds—low-cost health care, health plans and providers that are regarded as delivering high-quality care, and responsible employers and a generous state government that provide health coverage for 90 percent of the population. As plans become more conscious of the importance of population health, community-wide health promotion efforts are becoming more significant. The state's gradual expansion of its MinnesotaCare program has enabled more low-income families to have access to affordable health coverage with premiums subsidized by the state.

However, not all consumers share equally in the benefits of the Minnesota health care system. Consumer advocates note that the 1995 legislature's repeal of the universal coverage goal is a major step backward for the uninsured. Many poor and disabled people do not have adequate access to specialized services and providers within health plans. With fewer health plans available, some consumers are subject to sudden changes in provider access, especially if their employer or the state contracts with a different health plan. Consumers who participated in a focus group conducted during the site visit expressed frustration about having to change providers when employers switch from one health plan to another. Employers and consumers are also displeased by what they perceive as inadequate data to make informed choices about health plans and providers.

Employees of large companies generally enjoy a wide range of choices, including the big three health plans, PPO-developed networks, or indemnity products for an extra price. However, choices are becoming more narrow for employees of public agencies and small employers, who are increasingly offering fewer health plan options in exchange for lower prices.

Consumers enrolled in HMOs are likely to benefit from the quality improvement initiatives, although it is difficult to assess the benefits since most of the outcomes are expressed in cost savings rather than improved health status. Some consumers report, however, that managed care leads to a longer waiting period before they can schedule appointments for primary care and some specialty care.

The population has seen a dramatic increase in community health promotion efforts. Attributable in part to requirements in MinnesotaCare legislation of 1993 and 1994 and in part to HMOs' growing interest, community health promotion initiatives are increasing. Provisions that require health plan companies to develop public health collaboration plans "have catalyzed health plan companies and public health organizations to begin working together

toward common population-based goals."[22] County health departments have numerous partners—the other health departments in the region, HMOs, hospitals, community-based organizations, Regional Coordinating Boards—that are willing to help them protect and promote the health of the entire community, including low-income and uninsured residents. Collaboration on these efforts has been facilitated by having many former state and county health department employees now working for health plans.

Despite no significant decreases in the numbers of uninsured people, safety net providers (publicly supported hospitals, public health departments, and community-based clinics) appear able to take care of the uninsured. However, significant Medicaid cuts or these providers' failure to secure Medicaid-managed care contracts could limit their ability to continue doing so.

According to consumer advocates, some of the more vulnerable segments of the population are experiencing increased access problems. The chronically ill and disabled, who rely on custodial care, are especially at risk because their care is more subject to service restrictions by managed care plans and public programs. Children with disabilities and other special needs find it harder to gain access to specialists because their care requires repeated authorizations from primary care gatekeepers. Prior gains in making culturally sensitive services available are eroding as private plans take over Medicaid managed care, and populations of color are not as readily served. Senior citizens can no longer depend on health benefits as more companies drop their retiree health coverage.

The transition of Medicaid enrollees into managed care plans has led to problems. The process in Ramsey County was suspended for a year while the state investigated allegations that provider networks were inadequate to serve the Medicaid population. Consumer advocates note that some beneficiaries have not felt welcome in physicians' offices used primarily by privately insured patients. In addition, patients who need translation, transportation, and other support services have not found such services as readily available as they did with public health clinics. However, some of these problems may be prevented as a result of 1995 state legislation, which makes counties more involved in reviewing and approving Medicaid managed care contracts.

[22]"Charting the Future of Population Health." *Population Health Initiative*, May 1994 (draft).

Future Developments

A combination of purchaser pressure and state policy intended to promote competition, lower costs, and improve quality has produced in Minneapolis/St. Paul what appears to some to be a dangerous oligopoly among health insurers. Fortunately, the purchasers and state policymakers who helped move the market in this direction realize they may have gone too far or been misunderstood, and they are now revising their strategies. The market has been expanded as far as it can go through consolidation; it is about to move back in the other direction.

Purchasers, insurers, and providers are actively preparing for the next stage of market evolution—or, one might even say, devolution. Significant changes are expected in the next three years as public and private purchasers threaten the consolidated health plan industry by contracting directly with providers, who will be rewarded for improving efficiency, quality of care, and enrollee health status. The leading insurers could thereby evolve into efficient plan administrators and developers of advanced information systems that supply cost, quality, and outcome data to purchasers, providers, and consumers.

This scenario is being actively promoted by the leading business coalition, BHCAG, and encouraged by a number of providers who are willing to enter into direct contracts and able to assume financial risk. At least in principle, the concept has been endorsed by two of the three major health plans. However, all the details have not been worked out and not everyone agrees on the best way to proceed. One legislator cautioned that if new care systems offer vastly different benefit packages, it will be harder for consumers to compare benefits and more difficult for employers to compare price, quality, and value. Another observer worried that health plans' commitment to population health may decline in the process.

There are other unanswered questions. To what extent will providers, acting as risk-assuming care systems, be regulated by state government as insurers? Will they be expected to contribute to the state-sponsored programs that finance care for the uninsured and, if so, to what degree? Many remain concerned about the future for providers that cannot assume such risk or whose higher costs make them unattractive to insurers. For example, will the University of Minnesota Medical Center be able to survive competitive market pressures? Will the state continue to provide subsidies for research and teaching? Will the university need to substantially downsize and limit itself to specialized tertiary care services?

In Minnesota, these questions are not merely academic. The state favors competition as the means to achieving reasonable costs at high value, within appropriate government controls. Public policymakers are taking further steps to press the sophisticated managed care industry to care for traditionally excluded groups of elderly and disabled people. Community-based organiza-

tions and consumer advocates are working with managed care plans in innovative ways that redefine the relationships among health providers, individual patients, and the community.

The community has strong and sophisticated leaders in all sectors who actively pursue innovation. Their leadership is likely to experiment with a new combination of incentives and rules designed to reward providers who can deliver low-cost, high-quality care and exceptional service. These leaders also will likely seek to ensure that access remains high and that health plans and providers remain responsible to the entire community.