COMMUNITY SNAPSHOTS PROJECT

Portland, Oreg./Vancouver, Wash.

Site Visit Report

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Overview

The Portland/Vancouver health care market is changing rapidly. Providers are consolidating, health plans are competing for market share, and the line between the functions of providers and insurers is blurring. By and large, providers and health plans have initiated these changes. Though rapid, they are not viewed as traumatic because the market, as one interviewee said, "had a head start [and is] built on a solid base." The history of managed care in this market is long, and the process of consolidation has been gradual. In the past few years, insurance premiums have flattened or, in some cases, declined, and hospital use rates have dropped despite the absence of organized or widespread employer pressures. Public policy initiatives have spurred much of the change by promoting competition among health plans and expanding the managed care market through Medicaid and other programs. Yet despite the turmoil, the outlook of the various "players" in the system is surprisingly positive.

The Portland/Vancouver market spreads over two states and comprises four counties with about 1.5 million people: Washington, Multnomah, and Clackamas counties in Oregon, and Clark (Vancouver) County in Washington State. This market is divided by the Columbia River, and the states have different regulatory and legislative approaches to health care. Despite this split, provider systems and employment markets in the area overlap. Vancouver and several outlying communities on the Portland side of the river are submarkets in the metropolitan area.

Three major delivery systems—Providence Health System, Kaiser Permanente, and Legacy Health System—provide the vast majority of health care in the Portland area. Clark United Providers (CUP) in Vancouver is positioning itself to become a fourth major system in this market. Each Oregon-based system has a primary relationship with a health maintenance organization (HMO) through ownership or contract, but the contracts are not yet exclusive. A major change in the marketplace in the past two years has been the rapid development of provider alliances, as well as the horizontal and vertical integration of health systems.

Portland/Vancouver—like Oregon and Washington, generally—has a long history of managed care, dating back to the founding of the Kaiser Permanente Health Plan in 1947. Today, this area has one of the most extensive managed care markets in the country; its penetration rate is more than 50 percent. Four health plans dominate the market: Providence's Good Health Plan, Kaiser, Blue Cross and Blue Shield of Oregon, and PacifiCare.

Although the Portland/Vancouver market does not have an active employer coalition or purchasing group, individual employers have taken advantage of stiff competition among health plans to reduce or stabilize rates and negotiate multi-year agreements. As insurers scramble to increase market share, their products are becoming more alike and include restricted-panel HMOs, pre-

ferred provider networks, point-of-service plans, and Medicaid and Medicare options. All use the same (or overlapping) networks. Health plans are increasingly seeking to differentiate themselves from one another.

Public policy has stimulated changes in Portland/Vancouver through both comprehensive health system reform and initiatives targeting low-income populations. Health system reforms based on managed competition and universal coverage based on an employer mandate have been legislated in both states. These laws accelerated the consolidation among health plans and providers in Portland and Vancouver, and despite the repeal of health reform legislation by the 1995 Washington State legislature, consolidation has continued. In the past few years, the Oregon Health Plan (OHP) and Washington's Medicaid "Healthy Options" program and Basic Health Plan (a state-subsidized program for the working poor) have brought many new low-income individuals into managed care and have further stimulated competition and network development throughout the two states.

Changes in the health care market are having far-reaching effects on providers. The medical hierarchy has been rearranged, with primary care practitioners rising to the top as specialists slip downward. In fact, primary care providers are in short supply in some parts of the market (e.g., Clark County), while there is a surplus of specialists. Solo and small-group practices are giving way to larger groups as physicians sell their practices or affiliate with provider networks. The mind-set of physicians has changed as their focus has shifted from affecting legislative initiatives to gaining market influence. In general, interviewees report that physicians are confused, frustrated, and less satisfied with their jobs. Hospitals no longer view themselves as independent inpatient facilities but as multi-loci service providers within regional or statewide networks.

Despite the rapid changes in the Portland/Vancouver area, nearly all interviewees believe that the health system has improved. Most believe that quality of care has improved and that the changes have brought more choice and better access for consumers, even for lower-income families. Competition is not seen as having yet led to cutthroat tactics or draconian measures. Interviewees identified only a few clouds in this picture: some perceive that consumers do not always understand their options well; some fear access and choice will be eroded as competition heats up; and some emphasize that health care for the uninsured remains a problem and that the changes have strained the network of safety net providers.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The four-county market area, which has grown steadily in the past decade, had 1,548,000 residents in 1993. The region's poverty rate is slightly below the national average, while the proportion of elderly (age 65 and older) is close to the national average but higher than that of other western states. The region has a higher proportion of white residents than many American cities, though there are large communities of Hispanic people and recent Asian immigrants in some parts of the four-county area. In addition, the population in Washington County is rather fluid because of its many agricultural migrant workers.

The Portland/Vancouver area has a generally healthy economy. Portland-area businesses created 20,000 new jobs between July 1993 and December 1994, primarily in the non-manufacturing sector, and growth is expected to continue. Clark County has experienced similar growth, particularly in the biotechnology, electronics, and computer industries.

The employer community is characterized by small and medium-sized firms. The largest employers are in the public sector: federal and state governments, public schools, and Oregon Health Sciences University. Of the few large private employers, U.S. Bancorp, US West, Hewlett-Packard, and Intel are headquartered out of state and make many health care purchasing decisions centrally. Large local employers include the three major health systems and Tektronix.

Health System History

The Portland/Vancouver area has a long history of managed care, dating to 1947 when the Kaiser Permanente plan and facilities were established in Portland. By the late 1970s, Kaiser was firmly positioned in the market, and other HMOs had begun to operate. Managed care gained market share in the early 1980s when Portland became the site of three demonstration Medicare risk contracts operated by Kaiser, Good Health Plan, and PacifiCare.

The federal government also financed Health Choice, a demonstration education and marketing program in Portland designed to inform Medicare beneficiaries about the availability of managed care. Health Choice, a private, not-for-profit company, was given the mailing list of all Medicare beneficiaries and thus had direct access to the entire target market. As a result of this outreach effort and the availability of three HMOs, Medicare enrollment in risk contracts in the Portland area is now more than 50 percent—higher than anywhere else in the country.

The Medicaid programs in Oregon and Washington stimulated the growth of managed care when they began to move recipients of Aid to Families with Dependent Children (AFDC) into fully or partially capitated managed care plans about 10 years ago. More recent policy changes in both states have further expanded the enrollee market.

The growing presence and acceptance of managed care has affected the private-sector market in the Portland area. By the mid-1980s, employers began to purchase coverage from HMOs other than Kaiser. As HMOs have extended their reach into the public and private sectors, the public has come to view managed care more favorably. In addition, growth in the number of HMOs meant that more physicians—beyond those employed by Kaiser—began to share the financial risks of providing care through non-fee-for-service payment methods, especially capitation.

The market penetration of managed care has been associated with a steady 12-year drop in the use of inpatient care. By 1994, Medicare inpatient use was 1,311 days per 1,000 people age 65 and over in Portland, about half of the national average; the rate for all local residents was 38 in 1,000. Despite recent reductions in inpatient capacity, most interviewees said the system still has too many hospital beds.

Managed care developed more slowly in Vancouver than in Portland. With the exception of Kaiser, Medicare risk contracts were not extended into Clark County until 1994 because of lower Medicare payment rates. In addition, managed care plans have only recently competed aggressively for market share in Vancouver. However, the pace of change and the level of competition are increasing since PacificCare introduced its Secure Horizons Medicare risk contract and area providers have grouped together to form CUP.

▼ ▲ ▼ Health System Changes

Public Policymakers

Major health system reform laws in Washington and Oregon have been a catalyst for consolidations, mergers, and alliances among health plans and providers. In Oregon, concerns about the affordability of and access to health care led to the enactment of three laws in 1989 (and recent amendments), known collectively as the Oregon Health Plan (OHP). OHP represents a broad-based, bipartisan consensus on health care policy. The plan was designed to provide universal coverage (largely through an employer mandate); establish a basic benefit package by ranking and limiting covered Medicaid services; reform the small group insurance market; and control costs through managed care. The most significant accomplishment of OHP to date has been extending Medicaid coverage to an additional 125,000 people with an income below the federal poverty level and enrolling them, together with

AFDC eligibles, in managed care. As of January 1995, other Medicaid groups (the elderly, disabled, blind, and foster children) were also being moved into managed care.

By mandating the enrollment of Medicaid recipients in managed care plans, OHP has stimulated the development of statewide provider networks and has offered new provider-controlled competitors a foothold in the market. The state, in effect, acts as a reinsurer for at-risk networks in that physicians and other provider groups can contract directly with the state rather than going through insurers to cover Medicaid enrollees on a capitated basis.

Public policy emphasis on managed care in Washington State was galvanized by the creation of the Basic Health Plan (BHP) in 1987. BHP, started as a demonstration project for up to 25,000 people, now offers a choice of managed care plans in all areas of the state to people with an income below 200 percent of the federal poverty level as well as to some businesses. The state subsidizes an income-related sliding premium contribution, and enrollees have modest copayments. In BHP, as in OHP, a unit of state government contracts with managed care plans to provide a set of basic benefits to individuals who meet certain income guidelines. BHP drew a number of existing managed care plans into the market to serve low-income populations and prompted the development of a few new ones.

Like Oregon, Washington State has enrolled some Medicaid recipients in HMOs for at least 10 years, mostly on a voluntary basis and in only a few locales (including Clark County). However, in 1992, the state began to make managed care mandatory for most Medicaid recipients in all counties (1993 in Clark County). This initiative, called Healthy Options, depends primarily on capitated plans. Primary care case management contracts are used in a few rural areas.

The Washington Health Services Act, passed in 1993, set out a seven-year phase-in of managed competition and universal coverage. The latter was to come about through an employer mandate and an expansion of the BHP. The act also mandated a strengthening of the public health system[1] and coordination between the public health system and the reformed medical care system. The law set off a flurry of activity as health plans prepared to compete for a share of the new market and moved to establish themselves statewide. It also stimulated network development and alliances between providers themselves, as well as between providers and local public health agencies.

[1]The 1993 Health Services Act required that the state health department and local public health agencies develop and implement a "public health improvement plan," which sets standards for public health agency performance and community health improvement. The legislature has provided additional funds to enhance the ability of these agencies to meet these standards.

The 1995 legislature repealed most of the Health Services Act, leaving intact only small-group and individual insurance reforms (modified community rating, portability, renewability) and BHP expansion (up to 200,000 people by 1997). Community rating now applies only to small groups and individuals, with adjustments for age and wellness factors. The use of exclusions for pre-existing conditions is limited for people who change jobs and have continuous coverage, and insurers are required to renew policies except for reasons of non-payment. Although the political backlash against comprehensive reform included concerns about managed care, the movement toward consolidation, capitation, and integration has not been significantly altered.

Private Purchasers

Portland/Vancouver employers have not acted as aggressively (or as collectively) as employers in some other cities (e.g., Minneapolis) to affect the health care market, but their sensitivity to prices has spurred competition among health plans for market share. The business community is dominated by small to mid-sized employers who tend to make purchasing decisions with the help of brokers. Larger locally based employers tend to self-fund because they have employees throughout Oregon and in other states, and they need to make purchasing decisions appropriate to the health care markets in the areas in which their employees are located.

Business has been a willing participant in managed care but has not driven the market. No employer coalition or purchasing group exists in the Portland/Vancouver area (the Portland Business Group on Health dissolved itself a number of years ago). A Pacific Business Group on Health—encompassing Oregon, Washington, and California—is reportedly being developed, but group purchasing is unlikely as long as employers continue to get what they want from the market: price stability and choice.

Nonetheless, some local companies have negotiated aggressively with health plans, taking advantage of competition to obtain favorable rates and rate guarantees. For example, Precision Cast Parts received a five-year rate guarantee from the Legacy system. This price sensitivity has recently caused health plans to reduce or stabilize premiums: for example, Kaiser retroactively decreased premiums by 3 percent in the past two years, and Providence cut premiums by 5 percent.

Like large employers in other American cities, many of the larger employers in Portland/Vancouver self-fund their employee health coverage.[2] The flexi-

[2]The largest employers are the Oregon and U.S. governments (12,500 and 18,600, respectively, in 1994) and the health systems themselves (each about 7,000). Most of the largest private employers (with the notable exception of Tektronix) are headquartered in other states; thus, their health care purchasing decisions generally are not locally controlled.

bility of self-funding has allowed employers to obtain what they perceive to be greater efficiencies. They also believe that it makes providers more accountable. In response to self-funding, health plans and provider networks are developing new products that will be attractive to self-funded purchasers. For example, some insurers are developing HMOs designed specifically for these purchasers, and some HMOs are developing third-party administration capability in addition to their insured products.

OHP provides assistance to small employers through a conventional insurance plan and an HMO that is available to all companies employing 3 to 25 people. The response to this provision has been limited: from April 1989 to June 1994, the plans served 7,100 of 38,000 eligible employers and covered more than 27,000 individuals. OHP also includes an employer mandate; though scheduled to be implemented in 1996, it may yet be repealed.

Unlike in some other markets, health plans and providers rather than employers in Portland/Vancouver have taken the lead in quality monitoring. With premiums remaining stable, and product differentiation decreasing, health plans and providers see quality evolving into a more important point of competition. One benefits consultant who works with large companies reported that businesses are not paying attention to Health Plan Employer Data and Information Set reports (HEDIS) or quality monitoring; with flat prices, employers may believe they are getting better value without these additional data. On the other hand, US West, GTE, and Tektronix are teaming up with Kaiser and the Good Health Plan to measure patient outcomes. Health plans are producing HEDIS data and reports on quality, and some providers are developing internal quality measures and evaluation systems. This information will be available if and when employers seek greater accountability from the health system.

Insurers and Health Plans

The insurance market in Portland/Vancouver continues its strong, steady push toward managed care. The largest health plans are competing for market share by developing a complete menu of managed care products for various public and private purchasers. They are also seeking greater financial security through closer relationships, involving cost- and risk-sharing contracts, with provider networks. The growth of risk-based provider payment is blurring the distinction between the functions of insurers and providers.

The Portland area is more heavily dominated by managed care than most markets in the country. Enrollment in managed care plans accounts for more than 50 percent of Medicare beneficiaries (about 34 percent in Vancouver), more than 40 percent of enrollees covered by private insurance (75 to 80 percent if preferred provider organizations [PPOs] are included), and virtually all Medicaid enrollees. In addition, Portland/Vancouver's insurance market is

becoming consolidated: five HMOs comprise at least 100,000 enrollees statewide, and three PPOs have an enrollment that is greater than 150,000.

The product lines offered by insurers are becoming similar as each develops a full menu of offerings: restricted-panel HMOs, point-of-service plans, plans tailored to Medicare and Medicaid enrollees, products for small groups, and PPO indemnity plans. Even Kaiser, the prototypical closed-panel HMO, is developing an array of choices for enrollees in response to market pressures. In addition, the major insurers either have the capability to administer self-funded plans or, like Kaiser, are moving to build it. Insurers such as Blue Cross and Blue Shield have actively moved enrollment to their HMO. Three years ago, 15 percent of Blue Cross and Blue Shield's enrollment was in HMO-Oregon; now at 33 percent, enrollment is expected to rise to 50 percent in the next year.

Similarities between most health plans are also growing as the plans increasingly integrate with providers. For example, Providence and Kaiser are becoming more alike as the former purchases primary care practices and the latter moves to contract with them, and as Kaiser contracts for inpatient care, rents its network as a PPO, and builds third-party administration capability. Legacy can also perform hospital, PPO, and insurance functions as it develops a stronger link with Blue Cross and Blue Shield. The recent alliance of Legacy, Blue Cross and Blue Shield, and the Cascade, Metropolitan, and Mullikin PMG medical clinics are other examples of formal links between insurers, hospitals, and physicians.

As prices and products grow more alike, competition is beginning to turn on the issue of customer service and other value-added factors, such as breadth of provider panels and quality of care. This change prompted Kaiser—a traditional, closed-panel HMO—to contract with community physicians and PacifiCare to enlarge its focus beyond large clinics. Health plan representatives say they also compete on quality even though they are not sure if purchasers or consumers think quality is important. All health plans are emphasizing the production of quality measures and reports, and a number of plans are committed to producing HEDIS data.

Financial risk-sharing among insurers and providers is well-established in Portland/Vancouver. Physicians are often paid through capitation. Most hospital contracts involve risk-based payment, such as diagnosis-related groups (DRGs), per diem rates, or, less frequently, capitation. Legacy reports that 15 percent of its business is fully capitated and 35 percent is partially capitated.

Risk-sharing among providers is accelerating—especially in Clark County, where Medicare risk contracting is growing rapidly. PacifiCare introduced Secure Horizons (which shifts financial risk to primary care physicians through capitated payments) through the Vancouver Clinic in fall 1994 and reached the clinic's target enrollment of 2,000 in 45 days. The clinic is now taking

another 100 members each month. PACC Health Plans and Qual-Med are preparing to market their Medicare risk products, and the Good Health Plan is evaluating the market. Kaiser previously capped Medicare enrollment in Clark County but may now open up the plan.

Partly as a result of the growth of risk-based payment methods, the distinction between insurance and provider functions has become less clear as alliances and mergers cross the insurer-provider line. For example, physician groups on both sides of the Columbia River are invading the insurers' territory by contracting directly with purchasers. In Portland, the Coordinated Healthcare Network (CHN) was formed by the Metropolitan, Suburban, and Portland clinics in order to receive OHP capitation directly. CHN sees an opportunity for creating administrative efficiencies and eliminating the overhead of health plans. CUP, which includes Clark County's only hospital and major medical clinics, is similarly motivated and has obtained a state insurance license. Tuality Community Hospital, located 30 miles from downtown Portland, has created a physician-community-hospital organization (PCHO) to contract directly with OHP and to negotiate with other health plans on behalf of all community providers.

Multi-state affiliations are also developing. Blue Cross has formed an interregional agreement with King County Medical Blue Shield, Pierce County Medical Bureau/Blue Shield (both of Washington), and MSB-Blue Shield of Idaho, collectively known as The Benchmark Group. This group, which represents more than 2.3 million enrollees, will look for administrative efficiencies, create a combined utilization database, and invest in a shared information system. PacifiCare has merged its Washington and Oregon plans into one regional entity, which is also pursuing efficiencies.

Providers

Providers in Portland/Vancouver are consolidating and integrating management and service delivery structures among entities that were once separate (e.g., hospitals and physician clinics). Some providers in outlying areas of the market are using this strategy as an alternative to affiliating with a large health system or plan.

Hospitals

Portland/Vancouver's hospital system is highly consolidated. Most of the 17 facilities are linked in some way to the three large delivery systems (Legacy, Providence, and Kaiser), each of which has 25 to 27 percent of the market, or to the newly formed CUP. Legacy owns four hospitals and has a strategic partnership with a fifth. Providence owns three hospitals, Kaiser owns two, and CUP includes the one hospital in Vancouver. All but two of the hospitals are not-for-profit organizations.

The area's major health care delivery systems are becoming closely aligned with, or are already indistinguishable from, the region's major insurers. Kaiser and Providence are each significantly integrated—employing or contracting with physicians and owning or contracting with hospitals. The contracts often involve financial risk-sharing, considerable data reporting requirements, and compliance with quality and utilization management processes. A new network, The Alliance, links Legacy's hospital and specialty system with three major medical clinics and Blue Cross/Blue Shield of Oregon. CUP has a strong relationship with PacifiCare. Because of its wide physician membership, and because it is the only hospital in Vancouver, it has the potential to "lock up" the Clark County provider system. CUP's purpose is to contract directly with the state of Washington and private employers and to function as a contracting vehicle with HMOs.

The major hospital systems are also responding to market changes in a variety of ways: they are emphasizing quality measurement and improvement, establishing critical pathways, cutting costs, reducing staff, and providing service-related training. Reflecting the fact that these strategies are just beginning, all systems are investing heavily in information technology. They are also contracting with or buying primary care groups, or setting up physician-hospital organizations (PHOs). Expansion into outpatient services, workers' compensation, nursing homes, home health, and occupational health are other common hospital responses to the declining demand for inpatient care.

Some hospitals in Oregon communities that surround Portland are attempting to remain independent of the big systems. For example, Tuality Community Hospital has joined forces with all local primary care physicians and community members in a PCHO. The organization provides various levels of administrative support to physicians; contracts with insurers on behalf of the physicians; and handles, as a single point of contact, payment negotiations, credentialing, and quality assurance. Tuality also supports a federally qualified migrant health center and is collaborating with the local health department on population-based services.

Recent hospital consolidations and closures reflect a continued drop in hospital use rates. The Portland/Vancouver market has experienced a 12-year downward trend in inpatient use to a composite rate of 385 days per 1,000. Ten years ago, the area had more than one million patient days per year; it now has 600,000. As a result, Holladay Park Hospital closed in 1992, and Kaiser has announced the closure of Bess Kaiser Hospital in Portland.[3] In

[3]In the latter case, Kaiser has reached an agreement with the Providence system to pay a hospital "bed rental" fee, including a capital component. Kaiser gains by deferring a large capital expense (replacing or renovating Bess Kaiser), and Providence gains by increasing hospital usage and obtaining funds for future capital needs.

addition, one of two Clark County hospitals closed after they merged in 1991 to become Southwest Washington Medical Center. Most interviewees said the trend of reduced inpatient care will continue and that, despite the recent downsizing, the system still contains excess beds.

Physicians

The biggest recent change for Portland/Vancouver physicians has been a shift in power—i.e., control over money and patients—from specialty to primary care. This shift comes within the context of a market in which control has shifted over the years from individual physicians (of all types) to hospital-centered provider networks and managed care plans.

Larger groups of primary care physicians are forming alliances with other providers or creating new medical service organizations (MSOs). Others are joining networks or selling their practices to preserve or improve their income and influence. As mentioned, Portland's three largest primary care physician groups have formed CHN, an MSO able to accept financial risk and gain administrative and purchasing efficiencies. (CHN is a contracting managed care organization under the OHP.)

As control shifts to primary care providers, specialists have watched their market power diminish. They have consolidated to some degree but were by and large described as being paralyzed and panicked in the face of the new power of primary care providers. Portland has become a buyer's market for specialty care.

A substantial percentage of physicians' revenue—60 to 80 percent in large clinics—is capitated or otherwise based on risk-sharing, reflecting the high penetration rate of "real" managed care (that is, plans with restricted provider panels, resource controls, and financial incentives for efficiency). Some clinics, such as the Suburban Clinic, have been accepting risk-based payment for managed care patients for more than a decade. This expansion of provider financial risk has prompted physicians to sharpen their focus on customer service, quality improvement, and utilization management in order to improve the value of their services and maintain market share. For example, CHN has developed a physician "citizenship" survey linked to bonus payments. Quality improvement processes and measurement are common in the physician community, especially in the large clinics.

Public and Safety Net Providers

Public and safety net providers remain a strong element of the Portland/Vancouver health system, but their continued viability will depend on the financial commitment of state government and its support of managed care policy. Public providers in Portland (and elsewhere in Oregon) responded to the OHP and market pressures by creating CareOregon, a fully capitated Medicaid managed care plan. Its providers include Multnomah County Health Department clinics, other community health centers, Oregon Health Sciences

University (OHSU), and the Clackamas County Health Department. The Multnomah health department, which administers the plan, has a long history of involvement in clinical care, including partially capitated Medicaid. CareOregon has 20,000 enrollees.

Public providers in southwest Washington have taken a different approach. In response to the 1993 Washington Health Services Act, which reflected a commitment to strengthen public health, this district divested itself of some clinical services, such as prenatal care and well baby/sick baby care, stressing instead its community assessment, planning, and mobilization roles. This focus is epitomized by Community Choices 2010, a community-wide assessment and priority-setting process catalyzed by the district and supported by Kaiser and Southwest Washington Medical Center.

Although the OHP is viewed as beneficial overall, concern remains about access to and the future financial viability of safety net providers. OHP has reportedly reduced the number of uninsured in the state from about 550,000 to 400,000. However, further expansion of Medicaid coverage is unlikely given tight state budgets in both Oregon and Washington. The community clinics involved in managed care have seen patient volumes climb and revenues drop, resulting in less capacity to serve uninsured clients. Two Portland-area community health centers that did not join CareOregon continue to focus on the uninsured, but their future is uncertain, as public policy emphasizes funding for Medicaid managed care but not coverage for the uninsured.

Academic Medical Centers

OHSU, like academic medical centers across the country, is facing formidable market challenges to its teaching and research mission. The only academic medical center in the Portland/Vancouver area, OHSU provides a few unique services (notably kidney dialysis and heart transplants). However, many other specialty services are also available at other hospitals. OHSU physicians and services are tertiary and specialty-oriented, while managed care emphasizes primary care. The price structure of the university hospital includes the costs of health professional training and research, while competing hospitals can offer prices without this overhead. The burden may be exacerbated if graduate medical education funds in Medicare are cut. Perhaps most important, OHSU officials believe that, as a state agency, the organization is hampered by administrative and contracting rules and an inability to enter into equity arrangements.

OHSU is meeting these challenges through a multifaceted approach that mirrors the efforts of other major players in the market. It is forming provider networks, expanding primary care capacity, developing insurance products, launching quality improvement activities, and generally cutting costs. To gain more flexibility in contracting, the university developed and obtained approval from the state legislature in 1995 for an innovative plan to transform OHSU

from a state agency into a public corporation. As such, it will be able to own equity in a managed care plan—the key to success in the eyes of university leaders. The change in legal status may also allow OHSU to enter more quickly into contractual or other agreements to respond to changes in the market. Notably, the legislature's willingness to improve OHSU's market position required that even its competitors not oppose this change.

The university is also protecting its referral base and specialized services in other ways. To improve its referral network, OHSU is expanding its primary care presence in Portland and developing or strengthening provider relationships statewide. It has established two off-campus primary care centers, and two more are planned. This strategy has raised the concern of community physicians about competition from the university.

In addition to participating in CareOregon, OHSU is one of the primary organizers of Pinnacle, a PPO with Legacy's Managed Care Northwest, which is expected to become a system of 3,000 physicians. The university is also investing in Health Futures, a network of 17 hospitals outside Portland, which OHSU hopes will reinforce referral linkages that have been broken by managed care. Health Futures comprises member hospitals and their physicians (either through MSOs or PHOs) and is exploring a relationship with an insurer to market an insurance product.

OHSU is also beginning a number of internal activities in response to the cost-restrained environment. For example, it is cross-training providers, conducting area-by-area analyses, downsizing units and potentially some specialist residencies, and developing clinical guidelines and critical pathways as well as quality initiatives. It also is examining its teaching mission and looking at the types of clinicians it is training and the market demand for them.

Consumers

The diverse group of individuals we interviewed perceive consumers to be generally satisfied but confused and not knowledgeable about their health care choices. There is consensus among those interviewed that access has improved for many consumers, especially low-income people covered under OHP and Healthy Options. According to their patient surveys, health plans report high and rising satisfaction.

Choice remains an important indicator of health system performance in the eyes of consumers. For many people in Portland/Vancouver, choice has improved. Those covered under large employer health plans can generally choose from two or three HMOs, one of which is Kaiser, plus a PPO. Mid-sized employers typically offer one or two HMOs and a PPO. OHP and Healthy Options gave Medicaid enrollees more plans to choose from—especially in the Portland area, where 11 HMOs are available.

Access for low-income consumers has improved with expanded eligibility in both states' Medicaid programs and Washington's BHP. However, these public

policy initiatives have not been without problems. Despite efforts to help Medicaid enrollees understand and select among plans, several of those interviewed expressed concern that enrollees neither know how to select a managed care plan nor understand Oregon's lock-in provisions. Moreover, despite the increases in coverage, many area residents remain uninsured. Staff of Portland's Neighborhood Health Center Clinics, Inc., for example, have difficulty serving 7 to 8 people per day; before OHP, they served 10 to 12. Staff are also concerned that many in the broader community think OHP has solved the problem of the uninsured, as evidenced by the increased difficulty they are having in recruiting volunteers and maintaining voluntary support from hospitals, as well as financial support.

Some interviewees suggested that employers are narrowing coverage classes in response to the availability of OHP and BHP and that costs are being shifted to employees through increased premium shares and higher copayments. Today, employers generally cover 80 to 100 percent of the employee's premium and 50 to 100 percent of the dependent premiums; copayments and deductibles tend to be low, which is in keeping with the design of managed care plans. However, we found no indication that these developments have eroded consumer satisfaction, perhaps reflecting the region's long history of managed care.

▼ ▲ ▼ Future Developments

The Portland/Vancouver health system is characterized by widespread optimism, despite the changes and stress of a highly competitive market. Providers and health plans are perceived as being socially responsible and the care they provide as being of good quality. A spirit of collaboration and a willingness to focus on broader community health issues make the future look promising. This optimism is tempered by the concern that the commitment of both states to expanded health care coverage for low-income people will diminish as state budgets shrink.

Interviewees expect that managed care and capitation will continue to grow and that the provider community will become further consolidated. Further vertical and horizontal integration within health systems is expected, as are more links between the public health system and other providers. Consolidation is expected to strengthen physicians' bargaining power with health plans, and the continued development of direct contracting by physician groups and vertically integrated provider networks will bring them head-to-head with the health plans.

Few observers predict that there will be major new entrants to the market in the near future. The alliance in 1994 of the Mullikan medical group (from California) with Pacific Medical Group was the first time a for-profit physician

organization entered the Portland market; most interviewees are not certain that this alliance will succeed.

The trend of hospital downsizing and closures is likely to continue. Some interviewees fear that federal Medicare reimbursement policy may have a particularly drastic effect, causing an inappropriate reduction in the number of beds if such policy does not adjust for the already very low inpatient utilization on the West Coast.

Consolidation among health plans—spurred in part by investments in information systems and the capital to support such investments—is likely to reduce the number of plans in the Portland/Vancouver market to five or six. Some interviewees fear that fewer, larger health plans will become complacent and oligopolistic—or so competitive that they forget their mission. It is possible that plans and networks may become more exclusive, but movement in this direction is expected to be limited because of employer and patient demand for choice. The development of quality measurement will proceed, but it is too soon to know whether generally accepted, meaningful quality indicators will be created and used in purchasing decisions.