COMMUNITY SNAPSHOTS PROJECT

St. Louis, Mo.

Site Visit Report

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Overview

Powerful forces are converging to reshape the St. Louis health care market, much as the Mississippi and Missouri rivers have shaped the city itself. In recent years, these mighty rivers have breached their banks to transform the contours of the surrounding countryside. Today, new business initiatives, the imperatives of religious cultures, and the nationwide push toward managed care and consolidation are threatening to breach the "banks" of the region's reputable, traditional health system.

St. Louis is a region of sharp contrasts in terms of its people, economy, and health system. The market spans the Mississippi River to include parts of Missouri and Illinois, a nine-county area with nearly 2.5 million people. The Missouri suburban counties are prosperous, while the urban areas—especially East St. Louis in Illinois—are depressed and have very high poverty rates. The business sector includes the fifth highest number of Fortune 500 corporate headquarters in the country, but employment is largely generated by the 90 percent of firms with fewer than 100 workers. The health system has a reputation for providing high-quality care, largely because of its two medical schools, Washington University and St. Louis University. The schools' emphasis on training specialists and cutting-edge medical research has spawned a system top-heavy with tertiary, high-tech health care and one of the highest concentrations of hospital beds in the country. Yet, St. Louis also has a reputation as "the syphilis capital of the United States."

The market is being driven by three hospital-based delivery systems that have divided up the area's medical schools and children's hospitals. The 1993 merger of Barnes, Jewish, and Christian hospitals into the BJC Health System "was like an explosion" that shocked other players into action. BJC (which also owns Missouri Baptist hospitals) is allied with Washington University and St. Louis Children's Hospital. The SSM Health Care System, a four-state Catholic network, includes St. Louis University and Cardinal Glennon Hospital for Children. Unity Health Network is also a Catholic system, based in the Sisters of Mercy order. About one-quarter of the market is served by 15 still-independent facilities, including the quasi-public Regional Medical Center, whose clientele are mostly low-income people.

Managed care plans in St. Louis are relatively "unmanaged," but they are feeling pressure to change as employers and government purchase health care more aggressively. About 40 percent of all insured residents are covered by managed care plans, including 15 percent in HMOs. However, to date, most health plans have very large, nonexclusive networks and pay physicians discounted fees, not on a capitated basis. Two new employer purchasing initiatives—one for large firms and one started by medium-sized firms—have obtained significant premium reductions through competitive contracts. The state is using competitive bids to implement mandatory Medicaid managed

care in St. Louis and has recently moved many public employees from indemnity insurance to HMOs. Premium shares paid by public employees vary significantly by plan, giving employees a strong incentive to choose lower-cost HMOs; this mechanism is expected to further pressure HMOs to cut costs and improve service.

Change is less apparent in the physician community. Many hospitals are in the beginning stages of creating physician-hospital organizations (PHOs) or purchasing practices. Some health plans, such as Prudential, are also buying practices, especially primary care ones. And a few medical groups have merged to gain market power. Despite these developments, the medical community remains largely unchanged and continues to be unorganized and dominated by specialists. However, signs of change are on the horizon. As a number of observers noted, the pressures evident in many other markets for physicians to "sign up, join up, sell out, or be bought" are building in St. Louis.

While the primary market covers nine counties, both health plans and providers are stretching their networking efforts across Missouri and into other states. Pushed by public employer purchasing, each hospital system has, or is seeking, alliances in the 300,000-person market in central Missouri (where the state capital is located). The area's two children's hospitals already draw patients from a 250-mile radius. SSM Health System includes hospitals in Illinois, Wisconsin, and South Carolina, and it owns a 49 percent share of a Wisconsin-based HMO. Health insurers such as Blue Cross and Blue Shield of Missouri, Humana, and Mercy Health Plan are developing networks beyond St. Louis to cover the entire state.

While the transformation of the health system appears very rapid, observers noted that most change in St. Louis comes slowly. This resistance is attributed to a conservative culture anchored in both the city's powerful religious organizations and a shadow government of large-business CEOs. The Catholic archbishop has explicitly sought to enforce the charitable missions of Catholic hospitals, a force that some believe has complicated the drive to find efficiencies, reduce costs, and forge financially advantageous alliances. Many corporate leaders sit on boards of directors of the major hospitals, insurers, and charities, creating a complex of overlapping interests in which "everyone is afraid to step on anyone's toes." The result is, for example, hospital alliances that are consummated at corporate management levels, but that have yet to produce true board mergers, significant clinical integration, or major bed reductions.

Change is occurring despite this resistance. Most interviewees expressed the anxieties and fears typical of a turbulent market. They predict that the rate of change will move from fast to furious as more consolidations occur among hospitals, physicians, and health plans. As one person said, "What took seven to ten years in other markets will take three years here."

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The St. Louis market consists of nine counties: seven are in Missouri (St. Louis City, Franklin, Jefferson, Lincoln, St. Charles, St. Louis, and Warren) and two are in Illinois (Madison and St. Claire). The 1995 population, which is 2,453,900, represents a 2 percent increase since 1990 and is projected to grow another 3.5 percent by 2000. Based on the 1990 census, just less than 13 percent of the population is age 65 and over, which is about the same as the proportion nationwide. Within the St. Louis market, 17.5 percent of the population is African American (1990), 5 percentage points higher than the national average. St. Louis City has the region's highest percentage of African Americans, 47 percent (1994). The next largest population of color is Hispanics, who make up 1.0 percent of area residents (1990). The St. Louis region has a relatively low poverty rate—10.8 percent of the population has an income below the federal poverty level, compared with the national rate of 13.5 percent.

The St. Louis economy has been stable and relatively healthy overall. The number of jobs has increased by 143,000 in the past 10 years, a 13 percent increase. All parts of the region, however, are not enjoying economic health; East St. Louis, in particular, is viewed as a depressed area plagued by job loss and high rates of unemployment and poverty. For example, the median family income in St. Clair County, Illinois, home to East St. Louis, is $31,900, compared with St. Louis County's $45,200 (1990), which is nearly 50 percent higher; their respective poverty rates are 17.4 percent and 5.6 percent. This economic dichotomy is also reflected in the differences between prosperous St. Louis County and the less well-off city of St. Louis (a separate county). In 1990 the nine-county St. Louis region's unemployment rate stood at 5 percent, somewhat lower than state or national figures, but the rate in the city was nearly 25 percent.

The fact that 33 of the nation's largest companies are headquartered in St. Louis heavily influences the regional economy. McDonnell Douglas and Anheuser-Busch are two of the area's largest employers, and their conservative fiscal and social policies set a tone for the region. Symbolic of the current health system consolidations, the BJC Health System has become the second largest employer in St. Louis. Notably, these large firms do not employ the bulk of people in the region; job growth is driven primarily by the market's 60,000 small businesses.

Health System History

The health systems of Missouri and the St. Louis region changed little until the 1990s. The conservative health care purchasing practices of the many corporate home offices buffered the market from increases in managed care that

began in other parts of the country in the 1980s. The two medical schools, at which 80 percent of the area's practicing physicians were trained, held off the national shift to primary care. Only recently did either have a family practice program, a reality reflected by the fact that a number of hospitals have historically refused privileges to primary care doctors. Religious-based, not-for-profit hospitals have dominated the market throughout its history, and their strength has staved off entry by for-profit institutions. The result is a very stable hospital sector that numbered 37 in 1984 and 38 in 1995.

By around 1990, national and state health reform debates and the expectation of purchaser initiatives began to chip away at the foundation of the St. Louis market. Constraints on Medicare spending and anticipation that businesses would become aggressive health care buyers led providers and insurers to focus on the most visible symptom of cost increases, hospital use rates. Lengths of stay for Medicare dropped from 10.0 days per stay in 1984 to 9.6 in 1990 and 8.5 in 1993. For all patients, stays averaged about 7.5 days until they began to drop in 1989; in 1993, the average length of stay was 6.4. During this same period, profit and operating margins for St. Louis hospitals dropped steadily.

▼ ▲ ▼ Health System Changes

Public Policymakers

The absence of proactive public policy, more than its presence, has been an important factor in the changes taking place in St. Louis. In 1994, state lawmakers proposed the "Show Me Initiative," a managed competition reform proposal (involving integrated service networks) that would have insured all state residents, encouraged managed care, eliminated self-funding, expanded primary care, and coordinated public health programs. This effort was fueled by the national focus on the Clinton reform plan, an aggressive state insurance commissioner who favored community rating, and strong leadership from the director of the state health department. The business community killed the initiative at the end of the legislative session, but the threat of government-led reform spurred purchasers, health plans, and providers on to greater levels of competitive activity.

Leadership in local public policy is lacking, according to numerous interviewees. The political division between St. Louis County and the city of St. Louis hampers efforts to cooperate. The city is seen by interviewees as impotent because, although its health department director is strong, it has no resources. (Both agencies have acquired new directors since the site visit.) The county, on the other hand, has resources but weak leadership. The void in local leadership has traditionally been filled behind the scenes by Civic

Progress, a group composed of the heads of the region's largest businesses. Observers noted that little is done without the consent of this group, and it has not yet provided direct leadership in health policy.

Interviewees identified the Missouri Department of Health as the one active leader in public policy. In addition to having been the point agency for the Show Me Initiative, the department is attempting to bring public interests into the managed care arena. It is working on analyses to show health plans how public health problems—especially hepatitis A, syphilis, and rabies—affect their costs and profits. In addition, it successfully inserted a provision in the Medicaid managed care contracts to encourage hospitals and HMOs to use secondary data to identify the health problems of the communities they serve. The health department is also working with the Missouri Hospital Association to develop a program that will publish data on hospitals' community benefits activities (e.g., charity care and free community services).

Purchasers

Largely passive until 1993, both public and private purchasers of health care are now pushing the St. Louis health care delivery system toward more, and more aggressive, managed care.

Employers and Employer Coalitions

St. Louis's purchaser community did not historically exert its strength in the health care market. Some large firms with paternalistic employee benefits policies have simply not wanted to force their employees into restrictive managed care plans. Other companies, with headquarters in St. Louis but production facilities elsewhere, have tended to focus new purchasing strategies on the latter locales. As some observers said, the executives did not want to limit their own choices for care. This conservative approach to purchasing permeated the behaviors of health providers and plans because many business leaders served on their boards. According to a 1994 study by St. Louis University, representatives of every one of the region's largest 58 companies were directors of at least one health care organization. In many cases, individual firms were represented on more than five boards, including those of hospitals and insurance companies.

Small employers have also been relatively passive. Most small companies can offer only one health plan to their workers. Although these employers complained bitterly about annual premium increases of 25 to 30 percent in the 1980s, their rates have stabilized in recent years. No longer squeezed by escalating rates, small businesses just want health insurance "out of their faces."

Although employers have been using traditional purchasing strategies, they have not been dormant in health care. In 1982 the large companies behind Civic Progress started the St. Louis Business Health Coalition (BHC)—one of

the nation's first such groups—in response to sharp increases in the cost of health benefits. The coalition, which has 40 members, specifically excludes enterprises in the health industry (such as insurers and hospitals) and is governed by corporate benefits executives. Its mission has been to foster value-driven competition by developing and disseminating information about the health care industry. BHC studied the use of hospital data to assess performance for four years. Using financial data from Medicare cost reports, it published its first report in 1987. The coalition's 1995 report presents a wide range of information and trends concerning St. Louis area hospital financial performance and service use rates. The coalition has also been an active participant in state-level discussions about health policy and, according to a number of interviewees, was responsible for defeating the 1994 state health system reform proposal.

The business community's conservative approach to health care purchasing began to change in 1992, when 45 medium-sized companies formed the Quality Healthcare Buyers Coalition to purchase health insurance collectively. The coalition was created under the auspices of AAIM Management Association, which provides management support to 900 large and small companies (half manufacturing and half service organizations). Its purchasing strategy has been relatively low-key: the buyers coalition has used a preferred provider organization (PPO) through Blue Cross and Blue Shield, which aggressively manages care only for the sickest 3 to 5 percent of enrollees. The coalition claims it has attained savings of 7 to 8 percent for its member firms. Beginning in 1996, the coalition is replacing the Blue Cross and Blue Shield PPO with a direct contracting managed care contract with the Mercy Health Plan.

Large employers made their move with the formation of the Gateway Purchasing Association in October 1994. Gateway was created by 21 of the largest St. Louis employers (membership is 26), who sought influence in the market akin to what they saw employers accomplish in Minneapolis and San Francisco. Members considered direct contracting with providers as a vehicle for forcing greater value and efficiency, but they found that providers were too disorganized to offer the full range of services. Instead, Gateway chose to issue a request for proposals (RFP) from managed care plans. The member companies (23 of which already offered HMO coverage to employees) agreed to buy health benefits only through this RFP process, which would control coverage for 280,000 lives, or 10 percent of the St. Louis market. Gateway does not currently include small employers in its membership but plans to share information with AAIM's buyers coalition.

Eight managed care plans submitted price quotes for a model benefits plan (tiered by number of dependents) and for a set of 50 plan modifications designed by Gateway. The plans also agreed to perform some common activ-

ities, including reporting plan-specific performance data and having a third party conduct member satisfaction surveys. Plans could lose up to 2 percent of their premium income (0.1 percent for each of 20 performance items) if they fail to report the performance data, which will be given to employees in the form of spreadsheet comparisons. According to early estimates, the first round of the bidding process generated quotes that were 12 percent lower (weighted average) than the premiums the same plans had charged the same employers a year before.

Public employers have also coalesced into an aggressive purchasing group. The Missouri Consolidated Health Care Plan was formed in 1993. The plan covers all state employees and is available to other public employers within the state. In just 18 months, more than 60,000 state and 10 to 15,000 local government workers have been shifted from long entrenched indemnity coverage into HMOs. By summer 1995, nearly 75 percent were enrolled in managed care plans. This rapid shift is due to two factors: (1) Missouri state employees are not unionized, so their benefits could be changed unilaterally; and (2) the employee's premium share varies by as much as $90 per month from lowest to highest cost plan, a strong incentive to choose HMOs with low premiums.

State and Local Government as Purchasers for Low-Income People

The state Medicaid program is rapidly moving most recipients in the St. Louis area into managed care, sending tremors through the health system. This pilot program was intended to implement managed care and expand coverage to children and adults with incomes at or below 200 percent of the federal poverty level on a statewide basis. The proposal, for which a Medicaid 1115 waiver has been requested, was whittled down, according to some observers, because of state budget pressures and the expected federal block granting of Medicaid. The waiver request will now expand coverage only for children; expansions for adults are a future possibility. A separate 1915(b) Medicaid waiver has been requested to implement mandatory managed care starting in a five-county area around St. Louis.

The Medicaid benefits package in the 1915(b) program includes a carve-out for public health services that is unique in the nation. Enrollees can go to their HMO or to any local health department to receive tuberculosis and HIV screening and diagnosis (not treatment), screening and treatment for sexually transmitted diseases, environmental lead assessment, and immunizations. If a health department provides services, it can bill the relevant health plan at Medicaid reimbursement rates. The state Department of Health, which negotiated this contract provision, considers it a transitional approach while Medicaid enrollees adjust their care-seeking behavior under managed care.

About 150,000 Medicaid-eligible people began receiving service in September 1995 through one of seven HMOs whose bids were accepted (two bids were rejected). Individuals were able to choose their plan beginning in

July; those who failed to choose were "auto-assigned," with more of such enrollment going to the lowest bidders. Missouri contracted with a West Virginia firm, First Health, to implement the enrollment process.

Interviewees raised serious concerns about the entire process. Some questioned the state's estimate of the number of Medicaid enrollees in the region. Others doubted First Health's understanding of, and sensitivity to, Medicaid and low-income families, as well as that of some health plans and providers. Still others expressed fear that the new contractors would draw resources away from current safety net providers, threatening their existence. The prospect of a new 150,000-person market "brought the worst out in everyone," according to one insurance representative. In fact, many reported that only one of the HMOs actually had a real provider network to accommodate the new enrollees; in the race for Medicaid dollars, the plans had letters of intent from providers but no contracts in place.

Insurers and Health Plans

Competition among health plans is growing as public and private purchasers get more active, and new entrants and provider-sponsored plans take on the "old boys." Some plans are attempting to buy market share and power. United Healthcare, a national, publicly traded HMO company, became the largest managed care player when it purchased GenCare in 1995. Combined with United's Physicians Health Plan, the new organization boasts nearly 500,000 enrollees in the St. Louis market. Blue Cross and Blue Shield, whose 400,000 insureds include 77,000 HMO enrollees, is buying HealthLink, a PPO with 490,000 covered lives.

Other plans are focusing on shoring up their primary care networks. Taking the acquisition route, Prudential has purchased a reputable, independent medical group to anchor a new group model HMO. Prudential plans to add 19 physicians next year and up to 100 by 1999 in order to add to PruCare HMO's 120,000 St. Louis area enrollees (most of whom are in the market's first point-of-service product).[1] Group Health Plan, a 15-year-old for-profit staff model HMO, has been hampered by a reputation for poor-quality care. To overcome this handicap, Group Health recruited the CEO of Physicians Health Plan and a new medical director to focus on improving the quality of its primary care physicians. Strategies include strong peer review processes, aggressive development of clinical guidelines, and individual physician profiling.

[1]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.

New managed care plans have not yet affected existing insurers, but they have been noticed. Humana entered the market as one of the lowest bidders for Medicaid enrollment in St. Louis and may attain very high enrollment due to the auto-assignment provisions that favor lower cost plans. Some observers think Humana's bid—$110 per enrollee per month compared with $130 to $160 for established plans—is a ploy to develop a statewide presence, after which it will drop Medicaid for more lucrative markets. Humana has signed up very few providers, although it has contracts with most health departments. Community health centers formed an HMO, the Alliance for Community Health (Alliance), with Deaconess Hospital as the major inpatient and financial partner, and St. Louis University. The clinics created the plan to try to keep their Medicaid (i.e., paying) patient base; the fact that Alliance was the second highest bid may undermine this objective. Grace Hill Neighborhood Health Center was the one clinic that did not join Alliance but went with BJC Health System's Partners HMO, one of two managed care plans created by hospital systems in the past year (the other is Mercy Health Plan, formed by the Unity Health Network.

The heightened competition is spurring health plans to focus on quality and improved service as well as price. Group Health Plan has instituted member surveys in addition to its physician profiling and hopes to produce auditable HEDIS (Health Plan Employer Data and Information Set) report cards by spring of 1996. GenCare/Physicians Health Plan have provisional accreditation by the National Council for Quality Assurance. These United Healthcare plans are also taking some innovative steps to better manage resources in anticipation of a resource-constrained environment. For example, they are purchasing telephones for people without phones who need care at home after a hospital discharge; although telephones are not covered by most benefit plans, management decided it was cheaper to pay for telephone service than for hospital readmissions due to problems that could be addressed through a phone call.

At this time, most of the larger health plans have decided not to seek exclusive relationships with hospital networks. In fact, some insurer representatives explicitly said that they are working to avoid exclusivity, for fear "it would polarize the market." Physicians also expressed concern over the potential power of restrictive hospital-health plan contracts. Many interviewees noted that choice of provider is still of paramount importance to consumers and employers, which would discourage exclusivity in the near future.

Providers

Hospitals

By any measure, the hospital community of St. Louis was ripe for change. The area's 38 inpatient facilities contain nearly 11,000 beds, 40 to 50 percent

too many, in the eyes of many observers. One insider put it this way: "Even if we had use rates twice as high as California, we would need a population of 11 million to support the current number of beds." A 1995 study by KPMG Peat Marwick LLP found that hospital costs in St. Louis are nearly 10 percent higher than the national average. Health plans and purchasers see the excess hospital capacity as a target for wringing large savings out of the system. Hospitals see the excess as a threat, recognizing that if beds must be eliminated, there will be winners and losers among the hospitals.

In recent years, hospitals have reacted to this threat at breakneck speed—by getting bigger in order to be a winner, not a loser. In the past two years, three networks that now control more than three-quarters of the market were formed (BJC, 30 percent; Unity, 27 percent; and SSM, 20 percent). BJC, Unity, and SSM are now clearly identified players in the market because of sheer size—each involves hospitals in multiple states, more than 2,000 beds, and $800 million in annual revenues. However, it may take years for consolidation to influence the structures and processes of clinical service delivery. Whether such integration actually occurs depends largely on whether the diverse organizational cultures and religious orders involved come to mutually agreeable terms.

The challenge of cultural consolidation is most evident in BJC. Led by influential board members, Barnes and Jewish hospitals decided to merge in 1992 to capture the market served by non-Catholic providers and to preempt any encroachment by Catholic systems.[2] The merged organization then recruited the administrator of Christian Hospital to be its CEO, consolidated the assets of the three entities, and formed a systemwide governing board. However, this high-level marriage has not yet broken down the walls built on the traditions of the four religious groups that founded the hospitals. These original hospital groups (representing nine facilities) have retained their own governing boards, each of which continues to show a high degree of commitment to its own religious community and institutional scope of service. The boards do not even view the marriage in the same way; according to one informant, Barnes directors see it as a merger, while Jewish directors see it as an affiliation.

The Catholic-based hospitals reacted by seeking partners for the impending competition with BJC, consolidating into two separate networks within six months of the BJC merger. Mercy Health System combined with two other strong Catholic hospital groups and an Episcopalian system to form the seven-hospital Unity Health Network. The Sisters of St. Mary further tightened its

[2]Interviewees characterized the St. Louis market as Catholic dominated. Four of the nation's 10 largest Catholic systems—Mercy, Carondelet, St. Joseph, and Sisters of St. Mary—are active there.

hospital network, SSM Health Care System, by combining some management functions and adding at least one hospital. Like BJC, Mercy and SSM face a significant challenge in the effort to consolidate strong organizational cultures; for example, the archbishop gave SSM responsibility for managing Cardinal Glennon Hospital for Children, but the hospital's board remains fiercely independent. In addition, SSM and Unity are under considerable external pressure to join forces as the "Catholic network," but their leaders do not agree that such an alliance is needed nor that their respective missions are even compatible.

The major networks have developed plans—now in early stages of implementation—to reduce service duplication, downsize capacity, and otherwise reduce costs. Unity is pushing the substitution of ambulatory for inpatient care (in part through a possible merger with Visiting Nurse Association), new management and clinical information systems to reduce paperwork, and aggressive development of clinical pathways. Unity has also consolidated the management of some, but not all, of its facilities. SSM has consolidated management at two hospitals; however, much of its drive toward greater efficiency centers around patient-focused care, in which services are clustered around patients instead of moving patients from one discrete service unit to another. This model is expected to result in the creation of centers of excellence (e.g., lab, x-ray), as well as a need for fewer staff because clinicians will be cross-trained and department managers will be eliminated. SSM also plans to consolidate services across its facilities. BJC's goal is to cut $200 million in fixed costs out of its $1.5 billion revenue stream by eliminating 2,400 jobs (to date, 500 have been cut), consolidating its six open heart programs as well as women's and children's services, and closing as many as 800 beds and at least one hospital.

All St. Louis hospitals are seeking to control patient bases and resources. Most are attempting to strengthen ties to physicians. For example, Unity is organizing physician-hospital organizations, employs 45 primary physicians in St. Louis, and is a minority investor in a multi-site primary care group practice. Deaconess Health Systems has helped a number of primary care groups form the 100-physician St. Louis Medical Group. The major networks are also trying to extend their geographic reach by shoring up their geographic "holes" in the St. Louis region (each is weak in one of the four geographic quadrants) and by broadening their scope of services (e.g., more home health and ambulatory care).

Finally, hospitals are developing the ability to assume and manage financial risk by owning managed care plans. BJC is seeking to expand its 70,000-member HMO, Partners, through the Medicaid managed care program; Unity's Mercy Health Plan is also a Medicaid contractor and has expanded into central and western Missouri; SSM is studying whether and how to use its 49 percent share of a Wisconsin HMO to enter the St. Louis managed care

market; and Regional Medical Center is a minority owner of Health Care USA's Medicaid HMO.

Despite the frenzy of consolidation, 25 percent of the hospital market remains in 15 independent facilities, a situation some interviewees say leaves room for new players. For example, Columbia/HCA is rumored to be interested in acquiring the 650-bed Deaconess hospital system and has expressed interest in an equity partnership with St. Louis University Hospital. And a for-profit group from Texas has helped some local osteopathic physicians obtain a certificate of need to re-open a 90-bed hospital.

Academic Medical Centers

Of the two universities, only St. Louis University operates its own hospital, but the policies of both institutions are universally seen as important drivers of the system. Washington University is one of the top-ranked medical schools for specialty training and research: "Wash U is a good place to go with a mystery disease," said one interviewee. Until St. Louis University recently started a program, neither school trained family practitioners, a fact reflected in the dominance of specialists in the St. Louis market.

The high prestige and long-held philosophies of the medical schools act as both strengths and weaknesses in the new market. The medical schools have competed fiercely for many years. It is not surprising, then, that Washington and St. Louis universities have chosen exclusive partners as the delivery system has consolidated. BJC and SSM, respectively, highly value academic training programs for their prestige and the care provided by trainees. However, representatives of these systems have expressed frustration that the medical schools are slow to adjust to the rapidly changing market, which demands increasingly greater emphasis on primary care and efficient delivery of medical services.

In an effort to succeed as a service provider, St. Louis University Hospital has implemented several new strategies. In two years, it has merged 13 medical departments into one group—a feat unheard of at most academic medical centers—and it has dropped 20 to 30 clinical faculty. Managers hope to merge the physicians and the hospital into a separate organization as the next step in becoming more competitive. Externally, the university is developing a physician network and trying to cut operating costs in order to be attractive to potential partners.

Physicians

The consolidation of the hospital industry and more aggressive tactics among health plans have instilled much fear and anxiety in physicians. This fear has led some physicians to sell their practices, and others to join physician-hospital organizations. Interviewees have mixed opinions as to whether these sales would be advantageous or whether the physicians were simply "trading one set

of problems for another" (hazards of independent practice in a competitive market versus loss of control to large health care bureaucracies).

Concern over market power prompted a few physician groups to consolidate—all in 1995. The most-watched consolidation is the merger of Health Key and Beacon Health Care. With 65 primary care physicians, it has become one of the largest medical groups in the market not owned by a hospital or HMO. The new Synergy Health Care Management has plans to affiliate or add more practices in St. Louis and East St. Louis. Seven obstetrician-gynecologist groups combined into the 30-doctor Generations Health Care, and two cardiology practices formed the St. Louis Metro Heart Group of 12 physicians. These consolidations are designed to attain administrative efficiencies and strengthen negotiating positions for managed care contracts. However, many people questioned their longevity in the face of the much greater financial resources of hospital networks and health plans.

As of yet, the heightened competition in St. Louis has neither shifted power among physicians nor changed their clinical decision making. Major networks and plans have begun economic profiling of doctors, which has helped to make physicians more cognizant of utilization issues. However, most interviewees do not think medical care has become more efficient, since most physicians are still paid on a fee-for-service basis. Physician capitation is still rare in this market and the traditional power of specialists has not yet been threatened. Indeed, some observers doubt it ever will be.

Safety Net Providers

The safety net for the vulnerable residents of St. Louis is, according to most interviewees, frayed or nonexistent. The central thread in this tattered net is St. Louis Regional Medical Center. Regional was created in 1986 when the public hospitals owned by St. Louis City and St. Louis County were merged into a not-for-profit institution. Regional is now known as the "Medicaid hospital" and serves most of the area's working poor. In addition, the institution is a primary resource for St. Louis's African American community; about 80 percent of its patients and 80 percent of its employees are African American.

Until 1993, the two local governments provided $15 to $35 million annually to cover operating losses, subsidies that have now been replaced by federal disproportionate share hospital funds. In 1995, this financing was cut by one-third, endangering Regional's existence. To make matters worse, the Medicaid managed care initiative threatens to erode Regional's paying patient base, which many fear will be its death knell. To fight back, the medical center purchased a 30 percent share of Health Care USA's Medicaid managed care plan and agreed to participate in two other contractor networks.

The community health centers are also in a tenuous position. Medicaid managed care threatens their patient base and, like Regional, they started an HMO to stave off an exodus of these insured clients. They are banking on the loyalty of patients and the location of clinics where their patients live to

overcome the lower cost of other health plans. One clinic, Grace Hill (described as the "middle class" health center), broke ranks and joined with BJC to bid on Medicaid.

A new, and potentially positive, development is the overtures some community health centers are receiving from hospitals. As in other markets, such as Boston, hospitals now view relationships with clinics as a way to expand their primary care base. Family Health Center is a prime example of this phenomenon. Family, which has 10 primary care physicians serving 5 sites, is now developing clinics at some area hospitals at their request. When such a proposal was made by the clinic five years ago, "they laughed at us."

As in the hospital arena, the Catholic church is playing a leading role in community health services for underserved populations. The archbishop of St. Louis charged a Commission on Community Health to assess community needs and take a holistic approach in addressing the needs of those who are sick and at risk. Among the initiatives this charge has spawned is the Neighborhood Lay Health Worker Program of Catholic Community Services. The program trains local residents to find at-risk individuals and help them gain access to health services. This includes helping them navigate the Medicaid managed care process. The three major hospital systems are all using this program to enhance their outreach capability in many lower-income neighborhoods.

Consumers

By most accounts, residents of the St. Louis region have felt few effects of market changes. Employees still have fairly wide choices of providers despite the increase in managed care penetration, since insurers are maintaining large provider networks (e.g., there is 70 to 80 percent overlap between Blue Cross and GenCare/PHP physicians). Efforts by providers and health plans to improve quality or change service delivery have not yet come to fruition.

Still, effects are making themselves felt or are just on the horizon. Changes in a few health services have already occurred, most notably the advent of so-called "24-hour" deliveries, in which new mothers and infants are discharged 24 hours after delivery, and the shift of some surgeries from an inpatient to an outpatient setting. To some observers, Medicaid managed care is expanding choice for the 150,000 recipients in the St. Louis area who previously used only the community clinics and Regional Medical Center. On the other hand, consumer advocates expressed concern that many vulnerable people will have trouble getting care in the complicated world of managed care, and they questioned the competence of the HMOs and their providers to serve low-income people and those whose language and cultures are foreign to staff. Some interviewees predicted that more people would soon be uninsured (the current state uninsurance rate is 13 percent) as more employers hire part-time workers or use contractors.

Future Developments

The future of the St. Louis health system is difficult to ascertain amid the flurry of consolidations and managed care expansions. Some interviewees expect the mergers to continue, resulting in two or three well-established hospital-based regional networks and three or four major health plans. No agreement exists as to whether exclusive arrangements between plans and networks will evolve; some suggested that alliances will form between BJC and United Healthcare, and SSM, Unity, and Blue Cross. Other observers suggest that the natural endpoint of the competition is direct contracting between provider networks and employers as the networks develop the ability to manage financial risk. The success of the new business coalitions is seen as a key to how things will fall.

For many interviewees, however, the future is simply a list of unknowns. Will cuts to Medicare and Medicaid result in an orderly downsizing of the hospital community or rip the current hospital alliances apart? Will the Health Key-Beacon merger mark the beginning of new physician influence in the market, or will its failure symbolize the permanent demise of the power of medicine? Is it possible in St. Louis for anything to shift economic power from specialists to primary care physicians? Will the many efforts to develop performance indicators and report cards empower consumers and improve quality?

Few people in the St. Louis health care community agree on answers to these questions. At most, they agree that "the next 12 months will set the stage for the next 5 years."