COMMUNITY SNAPSHOTS PROJECT

Wilmington, Del.

Site Visit Report

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Overview

Because the Wilmington, Delaware, health care market remained stable for many years, even small developments in the past two to three years represent accelerated change. The impetus for health system change came primarily from E. I. du Pont de Nemours & Company (DuPont), by far the largest and most influential employer in Wilmington. After offering a rich, fee-for-service health benefits package for decades, DuPont surprised the community by introducing and promoting managed care options for its employees. These options included point-of-service (POS) and closed-panel managed care plans, and the company offered incentives for employees to choose these options.[1] Since DuPont's pathbreaking actions, Wilmington's health plans, providers, and other employers have scrambled to prepare themselves for the new health care market now taking shape. The state, in its role as a health care purchaser, is also entering the managed care market by placing most of its Medicaid enrollees in managed care plans under a Section 1115 waiver beginning January 1, 1996.

Despite these events, which are shaking up the major stakeholders in Wilmington's health care market, managed care is only beginning to penetrate the market; there is little clinical integration or aggressive management of care by health maintenance organizations (HMOs). Estimates of managed care penetration vary from 15 to 40 percent, largely due to differences in the definition of managed care. According to our respondents, the term "managed care" may refer to insurance products with only some of the following features: financial incentives for patients to use network physicians; closed provider panels; primary care physician gatekeepers; utilization review and prior authorization requirements; and discounted fee-for-service or capitated payments to providers.

Wilmington providers have maintained a significant degree of control over their clinical practices and the type and level of reimbursement they receive from insurers. The hospital market is highly concentrated, with only two major systems, and hospitals are powerful market players. The dominant hospital system's newest strategy is to bypass insurers; it has established a physician-hospital organization (PHO) that offers an insurance product. Although some primary care physicians in Wilmington are increasingly receptive to capitated reimbursement, specialists and hospitals remain opposed to it.

[1] In Wilmington, local observers use the term "point-of-service" to refer to managed care products that allow enrollees to go to out-of-network providers, albeit with higher cost-sharing requirements. Physicians in these POS plans are not necessarily capitated; they may be reimbursed on a fee-for-service basis.

It is not yet clear who will be the ultimate winner in the struggle for power between providers and insurers. The outcome will depend, in part, on how fast and to what extent Wilmington's local health care market expands to the urban areas outside Delaware's borders. The Wilmington market's boundaries are blurring, especially with regard to tertiary care, after many years as a self-contained health care community. The locally dominant hospital—the Medical Center of Delaware—now defines its market in regional terms to include affiliations with, and acquisition of, hospitals in Pennsylvania and Maryland. Conversely, neighboring Philadelphia's hospitals and health systems are signing contracts with insurers that enable them to provide tertiary care to Delawareans. The transition from an insular, localized market to a competitive, regional one is the force behind managed care development and health system change in Wilmington.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The Wilmington area contains about two-thirds of Delaware's total population of 700,000 people and includes an African American community and a growing Hispanic community. Delaware's 1.2 percent average annual rate of population growth has been about equal to the national rate.[2]

The ethnic composition of the Wilmington area has been changing in the past several years. There has been a recent influx of Hispanics who work as agricultural laborers, although the available data indicate that they make up only about 2 percent of the state population. In contrast, the African American population has remained relatively stable, at about 17 percent of the state population. About half of the state's African Americans reside in the Wilmington area.

According to several major health status indicators, the health of people in Wilmington compares unfavorably with that in other areas. Wilmington's infant mortality rate of 20.9 deaths per 1,000 live births is more than double the national average. Delaware ranks 10th in the United States in estimated new cancer cases per capita for 1995. A state official reports that Wilmington's rates of illicit drug use, teenage pregnancy, and crime are comparable to several major urban centers in the United States.

DuPont has historically dominated the local economy, and Wilmington for many years could be described as a classic, conservative "company town."

[2]Because a high proportion of the state's population is concentrated in the Wilmington area, state-level information is likely to be highly relevant on the local level.

DuPont's strategic decisions, including the management of its health benefit programs, often have a ripple effect in the employer community and local economy. Wilmington also is the headquarters of other major corporations, such as Hercules, Inc.; MBNA America Bank; Wilmington Trust Bank; Delmarva Power; and Zeneca, Inc. Many of these large employers, including DuPont, cut back their workforces several years ago. Although DuPont's relative size and influence have diminished, it remains an important market player. Another major employer is the Delaware state government; it is one of the few major employers that has expanded its payroll in recent years. Before the rapid growth of MBNA America Bank, the Medical Center of Delaware was the second largest private employer in Wilmington. The Medical Center is a key player in the health system, enjoying the majority of inpatient admissions in the state and sound financial resources.

Delaware's unemployment rate is lower than the national average, and its proportion of people covered by employer-sponsored health insurance (71.2 percent) is high. About 13 percent of Delawareans have no health insurance, compared to 17.4 percent nationally. However, the state's uninsured rate is higher than other states in the mid-Atlantic region, such as Pennsylvania (7.8 percent) and New Jersey (10.8 percent).

Health System History

Wilmington has a long history of high-quality, fee-for-service medical care and a highly concentrated hospital market dominated by two major systems, both of them non-profit. In addition, one full-service pediatric facility is located in Wilmington.

Blue Cross and Blue Shield of Delaware has been Wilmington's dominant insurer for many years, but it is now facing stiff competition from other insurers' managed care products. Some observers believe that the state's health care market is ripe for the entrance of out-of-state, for-profit HMOs. In 1994, there were eight HMOs in the state with a combined enrollment of 121,000 people.

Between 1980 and 1991, Delaware was among the top 10 states for growth in health care spending. Delaware's annual rate of health care spending growth (12 percent) is also the highest in the mid-Atlantic region.

▼ ▲ ▼ Health System Changes

Public Policymakers

Delaware's two recent health care reforms focus on expanding access to health insurance but also address cost containment issues by emphasizing managed care and leveraging state dollars to gain additional private or federal funding.

These reforms were prompted by concern about cost-shifting;[3] some reports indicate that Delaware's private payers subsidize public payers to a greater extent than in any other state except South Carolina.[4] Much of the public policy discussion about health care in Delaware has come from the nine-member, public-private Delaware Health Care Commission, established in 1990. Both of the state's Medicaid reforms were based on work by this commission.

The first of these reforms, in 1993, expanded Medicaid to include all children under age 18 whose families had incomes below the federal poverty level. This expansion was tied to the establishment of the Nemours CHILD plan, a unique partnership between the state and the du Pont family's Nemours Foundation. This managed care program includes plans for a network of pediatric primary care clinics, with referrals to the Alfred I. du Pont Institute, Delaware's pediatric hospital. Medicaid covers the cost for uninsured children age six and under with family incomes below 133 percent of the federal poverty level and children under age 18 from families below the poverty level; the Nemours Foundation covers the cost for uninsured children with family incomes up to 175 percent of the poverty level; and all other uninsured families pay on a sliding scale. A total of 12 to 15 clinics across the state is planned, 10 of which have already opened. Three of these 10 clinics are located in Wilmington.

The second significant state reform is the Diamond State Health Plan (DSHP), Delaware's Section 1115 waiver program. This program, which begins operation on January 1, 1996, will expand Medicaid eligibility to all adults below the poverty level. About 9,000 new Medicaid enrollees will join the current Medicaid population in a managed care program that will offer at least three health plans in each of Delaware's three counties.

In addition, the Delaware Health Care Commission developed a small-employer insurance reform bill, based on language by the National Association of Insurance Commissioners, that was enacted by the legislature in 1990 (with amendments in 1992 and 1994). The intent of these laws is to increase access to health insurance coverage for employees in small businesses (3 to 25 employees) by means of guaranteed issue and renewability, rating restrictions, limitations on pre-existing-condition exclusions, and a small-employer reinsurance program. An expansion was enacted last year to include employers with 50 or fewer employees. Due to implementation delays, it is too soon to evaluate the impact of these reforms.

[3]For example, a planning document for key state health policymakers noted that "no plan to curb rising costs would be successful unless a means of dealing with the costs of providing health care for the medically indigent was found."

[4]Delaware Health Care Commission. "Cost Containment Committee Report on Medical Malpractice Reform for the Delaware Health Care Commission." May 1, 1995.

In contrast to the Delaware Health Care Commission's comprehensive approach, recent activity in the state legislature has responded more to consumers' and providers' specific complaints about insurance plan restrictions. For example, an "any willing provider" law for pharmacists was enacted in 1994.[5] Recent legislative proposals would require insurers to pay for a specified minimum number of hospital days for all new mothers and prevent insurers from using mandates or cost differentials to steer enrollees to lower-cost tertiary care facilities outside the state.[6]

Purchasers

Employers and Employer Coalitions

DuPont is the dominant force in the business community and the local economy, although its influence has been diminishing during the past decade. The absence of a strong employer coalition in Wilmington enhances DuPont's role as a market leader whose decisions about health benefits have a direct effect on the local health system. In general, Wilmington's large employers, including DuPont, are responsive to their employees' demands for comprehensive and high-quality health care coverage.

Much of DuPont's market clout stems from its size and historical role in Wilmington's economy. Large numbers of Wilmington residents are employees, dependents, and retirees who receive health benefits from DuPont. The company is the largest private employer in Wilmington, even after reducing its workforce to 17,000. There is a history of close ties between Wilmington's major employer and its major health care provider. Until recently, a senior executive at DuPont traditionally served as chairman of the board at the Medical Center of Delaware.

Wilmington's workforce contains an unusually large proportion of headquarters employees of large corporations. These employees are well educated and sophisticated consumers who value comprehensive health benefits coverage, unrestricted physician choice, and responsive providers. The local presence of corporation headquarters also explains why many people in the Wilmington workforce (150,000 to 200,000) are covered under these large employers' self-insured plans.

Due to changes in its usury laws about a decade ago, Delaware attracts financial services companies, such as MBNA America Bank, which is now located in the Wilmington area and employs 12,000 people. Two other major

[5]This legislation requires health plans to include in their network any provider who is willing to meet the plan's contract terms.

[6]Several respondents mentioned that this proposal was introduced after one legislator (a DuPont employee) realized that he would pay more for his coronary bypass surgery if he used Wilmington's Medical Center rather than a Philadelphia hospital.

private employers in Wilmington—Zeneca, Inc., a pharmaceutical and chemicals company, and the Medical Center—each employ about 5,500 people. The second largest employer in Delaware is the state government, which currently employs 13,000 people.

Although large employers are a dominant force in Delaware's communities and economy, the state is also home to thousands of very small employers. There is a total of 16,000 employers statewide, many of which employ fewer than five people.

The most significant event in Wilmington's health care market has been DuPont's decision to move to managed care and increase its employees' cost consciousness. On December 31, 1992, DuPont sent a letter to all its employees, dependents, and pensioners announcing changes in the delivery and financing of their health insurance.[7] The letter informed them that beginning in 1994, only three health plans would be available. Two of these are managed care plans: a "lock-in" (closed-panel) plan with a 90 to 95 percent employer contribution and a POS plan with financial incentives to use network providers (the employer pays 90 percent for in-network services and 70 percent for out-of-network services). The third plan offers catastrophic benefits coverage. DuPont's letter brought a new focus to health care cost issues by announcing that, starting in 1997, beneficiaries would share equally with DuPont any yearly increase in health care costs. This letter sent shock waves through the entire community. DuPont executives felt this surprise was necessary to avoid the resistance they expected from the provider and insurance sectors and DuPont employees.

Many respondents spoke of DuPont's announcement as having had major and still unfolding repercussions in the employer, insurer, provider, and consumer communities. It has affected all stakeholders, driving both hospital systems to reposition themselves to compete in the changing market. Using the provider network Aetna established for the contract with DuPont, the Delaware Chamber of Commerce now provides health coverage to about 35,000 employees of small businesses.[8] The health care community currently awaits DuPont/Aetna's move to capitation for primary care, expected in 1996, which is expected to further stimulate market change.

DuPont's impact on the Wilmington community has been heightened by the absence of other major employers acting as proactive health insurance purchasers. The obvious vehicle through which large employers would purchase insurance is the Delaware Health Care Coalition, representing 26 member

[7]The trigger for DuPont's move to managed care was new Financial Accounting Standards Board guidelines for estimated future post-retirement health care costs for employees and pensioners.
[8]In fact, our DuPont respondent reported that the company decided against an exclusive network with Aetna because the company feels a responsibility to allow other employers the opportunity to use the same network.

companies that include both large (more than 2,000 employees) and small employers. However, in the coalition's 15-year history, it has functioned primarily as a forum for employers to discuss health care benefits. It has no paid staff and has not been aggressive in pursuing purchasing strategies, benefits design, general cost containment, or potential changes in the Employee Retirement Income Security Act of 1974 (ERISA) that would affect self-funded employers. The lack of aggressive action on cost containment is attributed, in part, to fears that large employers might take advantage of small ones by shifting costs instead of truly containing them. Moreover, employers may be relaxing because, although health insurance premiums in Delaware are still increasing, their rate of increase has slowed.

State and Local Government as Purchasers for Low-Income People

The biggest news in Wilmington about health insurance for low-income individuals is the Diamond State Health Plan (DSHP), Delaware's Section 1115 waiver program scheduled to begin operation January 1, 1996. Delaware's current Medicaid program has stringent income eligibility requirements that have limited the number of people who are eligible for coverage. DSHP will move a large portion of the state's Medicaid population into managed care and will expand Medicaid eligibility to all uninsured adults with incomes at or below the federal poverty level (amounting to 9,000 new Medicaid recipients). All current and new Medicaid recipients will be enrolled in managed care, except long-term-care clients in nursing facilities who are covered under home- and community-based waivers, people eligible for both Medicare and Medicaid, and individuals in all eligibility categories who have already voluntarily enrolled in managed care.

Delaware will pay the same capitation rates to all plans chosen to participate in the DSHP. The rates are based on three years of cost data, aggregated by 12 variables based on age, gender, and aid category. Plans will compete for state contracts based on their capacity, their ability to provide all Medicaid services (e.g., Early and Periodic Screening Diagnosis and Treatment (EPSDT) services for children and adolescents, high-risk pregnancy services), their quality assurance programs, their grievance programs, and their ability to communicate electronically with the state Medicaid office. The plans are required to make good-faith efforts to contract with the two community health centers (CHCs) and one rural health center in the state.

Health plans showed a high level of interest in obtaining DSHP contracts. Delaware's Medicaid agency has contracted with two statewide plans, Amerihealth and Principal, as well as two regional plans. Medicaid recipients who live in New Castle County (a primarily urban area that contains the city of Wilmington) also may enroll in First State Health Plan—the Medical Center's health services corporation. Recipients in Kent and Sussex counties (mostly rural areas) may enroll in a plan offered by Blue Cross and Blue Shield. Participating plans must be licensed in the state as managed care orga-

nizations or health services corporations. The state expects that existing health plans will consider expansion and new health plans will form in response to the DSHP.

Insurers and Health Plans

History

Blue Cross and Blue Shield of Delaware has historically dominated the state's health insurance market, and it remains Delaware's largest insurer. Although Blue Cross and Blue Shield is now facing increasing competition from for-profit HMOs and other insurers such as Aetna, its various insurance and HMO products cover about one-third of the people employed in the state. Although Wilmington's providers have historically exerted considerable influence over the insurance sector, the balance of power now appears to be shifting as providers sign insurers' contracts that impose discounted payment rates, prior authorization requirements, and other restrictions.

Blue Cross and Blue Shield began offering an HMO product in 1983. This product was perceived as physician-friendly due to its minimal prior authorization requirements and relatively high reimbursement levels. The plan has not contained costs, but Blue Cross and Blue Shield reports that its product helped head off consumer and provider complaints. Principal HealthCare, another early entrant in the managed care market, followed Blue Cross and Blue Shield's lead and also gained a reputation as physician-friendly. However, these approaches set a precedent that made market penetration difficult for HMOs trying to reduce costs by contracting selectively with providers, implementing strict physician oversight mechanisms, and sharply discounting payment rates. An observer in the physician community reported that these aggressive HMOs had difficulty finding providers in Wilmington to join their networks. When Aetna initiated prior authorization requirements that participating physicians considered onerous, the uproar forced the insurer to back down and reduce the types of services for which prior authorization was necessary.

Some observers note that as long as Wilmington's health care market remains a local one, the city's two dominant hospitals will wield more power than purchasers or insurers. The Medical Center's minimal number of competitors and high occupancy rates have enabled it to resist insurers' pressures to cut costs or offer steep discounts. Although St. Francis Hospital is less powerful, it too has taken a bold stance with insurers. In late July 1995, 8 of its 15 trustees, including the hospital's president and CEO, resigned in order to avoid signing a contract with U.S. Healthcare. Franciscan Health System, St. Francis' parent company, had supported the new contract, which would have

implemented capitated payments for hospital care.[9] The trustees who resigned felt there were "fundamental differences" between the mission of the hospital and U.S. Healthcare. For example, one observer reported that St. Francis has criticized the HMO for spending less than 73 cents of each premium dollar on health care, compared to Delaware-based HMOs, which spend about 90 cents of each premium dollar on health care. Some St. Francis administrators and physicians assert that U.S. Healthcare's profits are excessive, and they resent a perceived loss of autonomy to the HMO in clinical decision making and patient care.[10] At the time this report is being prepared, the conflict between St. Francis' trustees and its parent company and U.S. Healthcare remains unresolved.

As insurers force the market to compete on a regional level, especially in response to employers' increased attention to cost containment, local providers may see fewer of their demands met. For example, the new management at Principal is implementing some of the stringent prior authorization requirements whose earlier absence earned the physicians' approval. Large employers, such as DuPont, are also a potentially formidable impetus for change. As one respondent commented, "The first rate-limiting step [in managed care development] is what the major industries in town want. The day that DuPont says, 'We're moving to capitation,' everyone will ask, 'How?'" If the current trend continues, the course of health system change in Wilmington will be decided more by insurers and employers than by providers.

Market Share

Based upon reports from the state's eight HMOs, 17.2 percent of Delawareans are enrolled in their plans. Aetna Health Plans' market share recently surged when it signed on as Third Party Administrator for DuPont's self-funded plan. Aetna's success in winning the regional DuPont contract from CIGNA contributed to the latter's exit from the Delaware market. Principal HealthCare, which operates in both the Delaware and Maryland markets, also has a significant presence in Wilmington. More than half of Delawareans enrolled in HMOs were covered by Principal in 1993. Currently, Principal has an application pending in Pennsylvania; its approval would help the insurer secure a regional base. Pennsylvania-based U.S. Healthcare has begun to penetrate the market and is quickly increasing its market share by means of price-driven

[9]In contrast to its small market share in Wilmington, U.S. Healthcare is a significant presence in other markets, such as Philadelphia, which are served by Franciscan Health System facilities. The insurer will not contract with any Franciscan facilities unless all sign the current contract, which stipulates capitated payment.

[10]Harriman, J. "St. Francis: Tradition, Corporatizing Clash." *Sunday News Journal*, vol. 21, no. 30, August 20, 1995, p. A1.

competition. In 1993, 13 percent of individuals enrolled in an HMO in Delaware were covered by U.S. Healthcare.

In the absence of state-collected data, there is abundant (and sometimes conflicting) anecdotal information on enrollment trends in managed care.[11] Most HMOs are independent practice association (IPA)-type plans that enroll all credentialed physicians who wish to join the networks; preferred provider organizations (PPOs) are less common; and staff and group model HMOs are rare. The fastest-growing product type is the POS plan. Some for-profit HMOs, such as U.S. HealthCare, have had to add POS options to remain competitive in Delaware's market. One observer remarked that the popularity of the POS option stems from its "transitional" approach to managed care. The POS approach allows both providers and consumers to acclimate to the idea of managed care and some of its restrictions. For example, health plans currently manage costs with mechanisms such as primary care gatekeepers, fee schedules, utilization review, clinical pathways, and an emphasis on outpatient care.

Recent Actions and Outcomes

Consolidation among insurers is beginning in the Delaware market, but this activity is currently confined to small, local HMOs. An upcoming merger will fold three HMOs—Delaware Valley HMO, Healthcare Delaware, and Keystone—into one HMO owned by AmeriHealth. Larger-scale consolidation is predicted within the next several years, primarily because the state's market may be too small to support six or seven major insurers.

At this stage of managed care development, health plans in Wilmington are not aggressively selecting or excluding physicians. Provider networks in Wilmington remain open to all primary care physicians, and new networks are open to all interested specialists. In general, older networks are neither recruiting additional specialists nor dropping physicians. However, an over-supply of specialists in the networks may become a problem in a few years, as the next stage of managed care development unfolds.

At present, Delaware insurers have not been able to contract solely with one hospital system. Although St. Francis is a low-cost hospital, it cannot offer the tertiary services provided by the Medical Center and thus is not a good candidate for an exclusive contract. It would appear that such a contract would be possible with the Medical Center, but employee dissatisfaction about restricted choice caused both Blue Cross and Blue Shield and Principal to drop their plans for an exclusive contract.

[11]Obtaining accurate information on market share by health plan product type is difficult in Delaware. The Department of Insurance does not require insurers, who may offer a range of indemnity and managed care products, to report enrollment broken down by product type.

Insurers have historically offered generous payments to providers. For many years, Blue Cross and Blue Shield calculated its fee schedule each year based on the 90th percentile of charges submitted during the previous year. Physicians could raise rates at the end of a given year so that the 90th percentile reflected the reimbursement they sought in the coming year.

In recent years, however, Blue Cross and Blue Shield has introduced new payment strategies. Primary care physicians in its HMO and POS plans are capitated. Blue Cross and Blue Shield began to reimburse some participating physicians based on a modified resource-based relative value system (RBRVS) scale in 1994, a change that angered many specialists and surprised the physician community.12 As Wilmington physicians are forced to accept managed care plans' increasingly discounted reimbursement rates, they look to Blue Cross and Blue Shield to fill the gap by keeping its reimbursements "appropriate." However, Blue Cross and Blue Shield's high premiums attract to the market competing insurers who easily can undercut its rates. If it wishes to remain competitive in the long run, Blue Cross and Blue Shield will find it difficult to sustain its historically generous physician reimbursement levels.

Only recently have insurers begun to significantly discount payments to physicians. With a significant market share endowed by its DuPont contract, Aetna negotiated 20 percent discounts with network physicians. Until then, most physicians' fees had been discounted only 3 or 4 percent, even by Principal and other HMOs.

Employers' recent interest in POS plans represents a significant new trend and has led insurers to introduce POS products. To maintain its market share by meeting employers' demands, Blue Cross and Blue Shield developed several types of insurance products, including a POS plan. Blue Cross and Blue Shield reports that its resources have been stretched thin by this approach, in contrast to for-profit HMOs, which may focus on developing and marketing a single product. A new player in the insurance sector is the PHO affiliated with the Medical Center, whose POS product is too new to predict its success. In addition, the regional for-profit organizations may have an opportunity to enter the market during the next two years. Their success will depend, in part, upon whether Wilmington's market boundaries remain intact, which would preserve the power of local hospitals and physicians. Moreover, DuPont and other employers seeking to further reduce their health care expenditures may create opportunities for lower-cost insurers.

Providers

The Wilmington workforce enjoys enough clout with employers to guarantee employees' right to choose providers. In turn, this has granted providers leverage with the insurance sector, both for obtaining contracts and for influencing the terms of those contracts. Although Wilmington's providers have

preserved much of their autonomy, they are concerned about impending pressures from managed care. Providers realize that these pressures will capitalize, in particular, on excess capacity in the hospital sector and the specialist physician community.

Hospitals

Wilmington is essentially a two-hospital market. Each of the two major Wilmington hospitals has adopted a different strategy in anticipation of a more competitive, regional marketplace. The Medical Center obtained an insurance license and began operating a PHO, called Mid-Atlantic Health Systems, Inc., in April 1995. It also has formed a health services corporation to participate in the state's new Medicaid managed care program, in addition to exploring affiliation agreements with smaller hospitals in the region. In contrast, St. Francis Hospital sold its affiliated HMO several years ago to Independence Blue Cross, a Philadelphia-based Blue plan, and is now focused on developing a network of primary care clinics.

The Medical Center of Delaware, a 1,100-bed non-profit entity, provides care to 55 to 60 percent of all inpatients admitted statewide. The Medical Center has a 65 to 70 percent occupancy rate and $150 million in reserves and owns several facilities. It has a medical and dental staff of 1,200. Approximately 30 percent of the Medical Center's patients are supported by Medicare, 15 percent by Medicaid, and the remainder by commercial insurers and managed care plans. In late July 1995, the Medical Center acquired the third largest hospital in Wilmington, Riverside Hospital (35 acute care beds), and its Extended Care Pavilion, a nursing home with 99 beds. Riverside had been struggling financially due to low occupancy rates. The majority of its patients are elderly and are covered by Medicare.

The other major Wilmington hospital, St. Francis, primarily serves New Castle County; fewer than 10 percent of its patients come from other counties or states. Like the Medical Center, its occupancy rate is 65 to 70 percent. St. Francis has 395 licensed beds and about $50 million in reserves. There are 700 physicians on staff (400 specialists and 300 primary care practitioners). About 50 percent of St. Francis' patients are covered by Medicare and 10 percent by Medicaid; the remainder are privately insured. St. Francis is a flagship hospital in the Franciscan Health System, which operates 13 hospitals and 7 nursing homes in several states. Tensions have developed in recent years as responsibility for some management decisions has shifted from the local hospital to the parent company. New challenges are on the horizon as Catholic health care organizations undergo consolidation; currently, Franciscan Health System is negotiating a merger with Catholic Health Corporation of Omaha and the Sisters of Charity Health Systems of Cincinnati.

Located just outside Wilmington, the Alfred I. du Pont Institute is a pediatric acute care hospital that has evolved during the past 10 years from an orthopedic hospital. Fifteen percent of its funding comes from the Nemours Foundation, providing the hospital with financial security and the ability to purchase state-of-the-art technology, equipment, and physician services. Medicaid reimbursement constitutes 40 percent of the Institute's funding, and private insurance represents the remaining 45 percent.

Recent Actions

The two major hospitals are developing health insurance products and physician networks to remain viable in anticipation of an increasingly competitive market. The Medical Center is clearly the dominant member of a new PHO called Mid-Atlantic Health Systems. Several other hospitals in the region are involved, though not St. Francis. The PHO's 650 physician members currently include 250 to 300 primary care physicians and over 300 specialists. Physicians are paid on a discounted fee-for-service basis, and the hospitals receive discounted fees. One interviewee reported that physicians are joining the PHO to avoid having their practices bought by Philadelphia hospitals or contracting with insurers who ultimately might demand enormous discounts. The PHO contracts with an insurance company for marketing services and third-party administrative functions.

Mid-Atlantic Health Systems offers a POS product and has enrolled over 5,000 Medical Center employees and their dependents. The POS plan will probably accustom physicians to discounted fees and the concept of managed care. The PHO intends to introduce two capitated risk products in late 1995. Marketing will be directed to smaller employers because the PHO is too inexperienced to go "head-to-head" with the major insurers for the large employers' business. According to one provider, a major impediment to a shift to capitation is physicians' lack of knowledge about working in a managed care environment.

Wilmington providers seem unwilling to assume the risk traditionally born by insurers without an opportunity to share in the financial rewards. In fact, the Medical Center has created a PHO with an insurance license, on the premise that the insurance industry is becoming redundant. One provider representative commented, "What is the fundamental understanding of insurance? Well, it's a sharing of risk across a population. But when you shift all of the risk to the providers, what is the role of the insurance company? They do not have a role."

St. Francis Hospital is Wilmington's leader in primary care network development. The hospital owns 13 primary care "satellites," including family practices, an obstetrics/gynecology practice, and a pediatric practice. About 40 physicians serve the clinics, which record 100,000 patient visits per year. The

physicians are salaried hospital employees who receive benefits and participate in an incentive compensation program. The hospital reports that it views these physicians as partners.

Quality Control Initiatives

Wilmington hospitals are quick to acknowledge the importance of measuring the quality of their medical care. The hospitals have begun using quality indicators, but they admit that their measurement tools are only in the initial stages of development.

The Medical Center has allocated $400,000 toward the development of a community health information network (CHIN). This computer-based information system is scheduled to start up in late 1995. At first, the CHIN will be used mainly for insurance verification. It is expected eventually to help remove redundancies in patient care and record keeping, which will improve the quality of care.

Rather than respond to external quality-of-care reporting systems, such as Health Plan Employer Data and Information Set (HEDIS), administrators at the Medical Center and St. Francis Hospital developed clinically focused internal measures, such as the number of surgical complications or the rate of unnecessary hospital readmission. St. Francis measures quality each month using 15 to 20 indicators. Mid-Atlantic Health Systems (the PHO affiliated with the Medical Center) uses some HEDIS measures to assess quality of care but considers these indicators too narrow.

Cost Containment Initiatives

Due in part to the two major hospitals' control of the Wilmington market, insurers were unable to force aggressive cost containment for many years. Yet both of Wilmington's major hospitals report implementing cost-cutting measures, presumably on their own initiative, in anticipation of increased competition. The Medical Center, aware of lower costs for tertiary care in some Philadelphia and Baltimore hospitals, has reduced its charges for coronary artery bypass graft surgery from $48,000 to $27,000. It reports that its charges came down an average of 10 percent overall during the past five years. Each department in the hospital has been asked to produce a re-engineering plan designed to streamline operations and increase efficiency.

St. Francis views itself as a good fiscal manager that has pursued a range of strategies designed to cut costs in both the short and long term. It has examined non-health-care industries to discover how to function efficiently and how to please customers. All of its employees are in an incentive compensation program modeled after one developed by St. Francis' neighbor, MBNA America Bank. St. Francis states that its average per-case charges are 40 percent below those of the Medical Center and 20 percent below those of Riverside Hospital. St. Francis also states that it has lowered supply costs to the 20th percentile for comparable facilities. The hospital has developed 30

clinical pathways—step-by-step, disease-specific guidelines identifying the most efficient way to provide care. Apparently anticipating managed care's financial incentives, St. Francis hopes that using clinical pathways will dramatically reduce patients' lengths of stay.

Physicians

From the perspective of the physician community, one of the most significant new trends in the Wilmington market has been insurance companies' increased pressure on physicians to accept discounted payment. This new stance is especially problematic in private practices, particularly for specialists, because these solo practitioners and small physician groups lack the ability to negotiate with insurers.

Most physicians are paid on a fee-for-service basis. However, some primary care physicians now welcome capitation. According to one observer, the few capitated plans in Delaware have tended to attract young, healthy enrollees whose low use of services has been favorable to the participating primary care physicians. No specialists are reimbursed on a capitated basis in Delaware, and these physicians remain largely opposed to capitation.

Physicians commented that the new managed care systems are very careful to recruit popular and respected physicians for their panels, thus making their plans more palatable to consumers. Well-known specialty groups are included in managed care networks, making patients' transition into managed care "almost seamless," according to one provider. However, observers predict that, within a few years, physicians will be selected based partly on economic criteria instead of solely on their medical reputations. Providers have responded negatively to DuPont's Aetna contract; although its current physician selection process is highly inclusionary, physicians are concerned that Aetna will reduce its provider network's size as it shifts to a more cost-conscious managed care strategy. From the consumer perspective, those in managed care plans may begin to notice that their access to certain physicians is restricted.

Physicians tend to serve both major Wilmington hospitals. However, with increasing competition between hospital systems, this may change. Health plans may develop exclusive relationships with physicians, leading to their alignment with only one hospital system.

According to one specialist physician, horizontal integration should be the wave of the future because it would give physicians greater leverage in negotiating with insurers. One of the first efforts to achieve horizontal integration[13] in Wilmington involved the recent merger of 22 physicians practicing in three specialties: oncology, hematology, and pathology. The first goal was to decrease

[13]Horizontal integration refers to the coordination of functions, activities, or operating units that are at the same stage in the process of delivering services.

overhead expenses by consolidating executive functions. They also intend to consolidate services and develop better information systems. This newly integrated specialty group views itself as competitively positioned for the future, especially with regard to the Philadelphia and Baltimore markets. Another proactive physician, a general internist, has formed an internal medicine group. Unlike the multi-specialty group, his strategy is to bring in "new blood"—individual physicians with no prior commitments or loyalties to other groups.

Despite the pioneering efforts of several Wilmington physicians, one observer reflected that large-scale horizontal integration of physicians is unlikely: "It's easier for physicians just to sell their practices to the hospital. That's because most physicians are business-naive. I'm afraid the opportunity for horizontal integration will probably pass us by." If this is true, the Wilmington market probably will not see the growth of powerful physician groups that has occurred in certain California communities (e.g., Orange County). Given their greater financial resources and business acumen, and their more consolidated market position, Wilmington hospitals are more likely than physicians to take a proactive role in restructuring the provider community to respond to changing health care market forces.

Safety Net Providers

Since 1990, the proportion of Delaware residents without health insurance has remained fairly steady at 13 to 14 percent. Until now, most progress has occurred in the 4-and-under age group; Medicaid expansions have reduced the rate of uninsured children age 4 and under to 8 percent—half of what it was four years ago. There is hope for similar progress for the 30-to-64-year old population after the DSHP takes effect in January 1996. Currently, this age group makes up 40 percent of the uninsured population. The combined impact of the DSHP and the growth of managed care in the private health insurance market has generated some concern among providers serving low-income people. Even after the latest Medicaid reforms, Delaware will have 65,000 uninsured people relying on private hospitals and public providers for their care. The Nemours Foundation will be able to subsidize the provision of care to some uninsured children and seniors at its clinics. However, many observers are concerned; Delaware's public health director is worried about the financial viability of the state public health clinics after they lose some of their revenues when Medicaid funds are consolidated under DSHP provider contracts.

Both of Wilmington's two major hospitals devote 5 to 6 percent of their budget to indigent care. St. Francis' charity programs include homeless shelters, soup kitchens, and an outreach program that uses the St. Clare Medical Van. In addition, both hospitals are part of the Delaware Health Plan Consortium, whose board of directors includes five Delaware hospitals, two

insurers, two physicians, and a state representative. This public/private consortium is attempting to increase insurance coverage among low-income employed people and their families who lack employer-sponsored benefits by offering low-cost health insurance. This new program "has not taken off as it should," said one observer, and many people are still uninsured.

Wilmington's two CHCs also provide primary and preventive care to low-income people. Henrietta Johnson, a federally qualified health center (FQHC) established in 1980, is the larger of the two and serves a predominantly African American patient population. Westside Health Service, an FQHC now in its sixth year of operation, has twice as many Hispanic as African American patients and employs a bilingual medical staff. Between one-third and one-half of patients at these two CHCs are insured by Medicaid; about one-third are uninsured.

Wilmington's CHCs might have been expected to oppose the DSHP because it does not require participating managed care plans to contract with them and it specifically removes federal requirements that they receive cost-based reimbursement. However, the CHCs do not seem overly concerned about losing patients or revenues. Although participating health plans are not technically required to contract with the CHCs, the state will require them to do so unless the plans can provide all of health centers' services. Moreover, the CHCs are hopeful that some of their uninsured patients will be covered by Medicaid expansions. The CHCs seem less worried about their fate under the DSHP than they are about the operational consequences of moving to capitation. These issues can be a major challenge to health centers lacking the financial and administrative resources for restructuring their information systems and rethinking patient care delivery.

Other providers in Wilmington also offer safety-net services to the community. These providers include clinics established by the Nemours Foundation, which funds services for children (discussed previously) and low-income seniors. The Nemours seniors' clinic houses Delaware's largest pharmacy, which charges patients 20 percent of the total bill and fills approximately 1,000 prescriptions daily.

Four state public health clinics in Wilmington have been providing some basic care (i.e., maternity services, treatment for sexually transmitted diseases, tuberculosis screens) to Medicaid-insured, underinsured, and uninsured people. Some public health services traditionally provided by these clinics, such as well-child care, are now provided by the Nemours clinics. Although some people assume that state public health clinics will be unnecessary after implementation of the DSHP, the state director of public health asserts that the clinics will continue to be important sources of health care for the thousands of people left uninsured even after the DSHP's Medicaid eligibility expansion.

Consumers

Commercially insured people in Wilmington seem satisfied with the quality, accessibility, and costs of their health care. They have successfully resisted efforts to limit their choice of physicians or to send insureds to Philadelphia or Baltimore for tertiary care. This apparent satisfaction is an ironic counterpoint to Wilmington respondents' frequent mention of Delaware's poor standing on health status indicators, such as cancer incidence and infant mortality rates.

In part, privately insured Wilmington residents can resist unwelcome health system change because there are so many headquarters employees in the workforce. For example, DuPont diligently works to ensure that its employees are satisfied with its health plan's member services department and has urged Aetna to make improvements in this area. Although DuPont eventually will require its employees and retirees to share equally in health insurance cost increases, the company announced this change five years in advance.

Medicaid recipients in Delaware are in the midst of a transition to managed care under the DSHP. Delaware's economy is healthy, which lends credibility to the assertion that the DSHP's primary goal is not merely to achieve cost containment but to enhance low-income individuals' access to public insurance coverage and timely and appropriate health services. In comparison, many other states that promote expansion of Medicaid managed care have serious budget problems and are driven by cost pressures.

Individuals who remain uninsured in a community undergoing health system change face an uncertain fate. On the one hand, there may be fewer uninsured people after the state's planned expansion of Medicaid eligibility to cover 9,000 previously uninsured individuals and the Delaware Health Plan Consortium's program to offer basic health coverage to the state's employed uninsured and their families. On the other hand, expansion of managed care and increasingly aggressive "management" by health plans may erode Wilmington providers' ability to absorb the cost of charity care.

▼ ▲ ▼ Future Developments

Until now, Wilmington has been dominated by one employer and one hospital system with many formal and informal ties to each other. However, this relationship between the major health care purchaser and the major provider is beginning to unravel as both lose some degree of dominance. DuPont's proportional share of the Wilmington workforce is decreasing, and the Medical Center faces increased price competition from Philadelphia and Baltimore hos-

pitals. To date, the market has remained local and self-contained, but its boundaries are eroding to include "outsiders." As these out-of-state insurers and providers secure contracts to serve Wilmington residents, local providers and, in turn, privately insured consumers will feel increasing pressure to embrace managed care.