Health System Change in Lansing, Mich.

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The Lansing area is known as the Capital Area of Michigan, a three-county region that includes the state capital. At the time of the site visit, area hospitals were competing for market share, a national for-profit hospital chain was considering entering the area and two of the three major hospitals were proposing a merger.

These events, coupled with recent studies comparing the cost and quality of hospitals, have motivated several major employers to be more aggressive health care purchasers, signaling the first step in a shift from a hospital-driven to a purchaser-driven system. Moreover, because the role of health plans in this market is closely related to the plans' relationships with hospitals, pending hospital consolidations and changes are likely to have an impact on the health plans and their positions in the market.

In addition, the advent of Medicaid managed care has increased the prevalence of capitation and other risk-sharing arrangements and has attracted players from outside the Lansing area to compete in this market, one historically dominated by Blue Cross/Blue Shield of Michigan (BCBSM) and health plans affiliated with the local hospitals. A strong sense of community accountability and a culture resistant to outsiders are likely to have an impact on how Lansing's health care changes play out.

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The current competitive environment among hospitals and health plans has developed over time. Until the early 1990s, there was considerable cooperation and collaboration among the four major hospitals, each with its own mutually agreed-upon specialty and geographic niche. Up to that time, the market was clearly hospital-driven: Decisions about health care services were made primarily by hospitals, whose administrators were major community leaders; physicians and purchasers were not regularly a part of these decisions, nor were they given much choice in decisions.

Two major events shifted Lansing's cooperative environment to one of intense competition: the establishment of Michigan Capital Healthcare Corporation (MC^2), the result of a merger of two hospitals—Lansing General and Ingham County

Medical (the county-owned facility)—and the departure of long-time administrators at the major hospitals. Past collaborative initiatives were rapidly replaced with competitive ones and systems development activities. These efforts included increased outpatient and home health services, acquisition of physician practices and insurance product development, either through ownership or strong contractual relationships.

The new era of hospital competition has been reinforced further by the financial difficulties of two of the three remaining hospitals—MC² and St. Lawrence. Both are seeking different arrangements to survive in the Lansing market. The St. Lawrence effort appears to be an imminent merger with the Sparrow Health System. MC², on the other hand, has rejected potential arrangements with the local systems, and instead is seeking a partner from outside the area: Columbia/HCA, a for-profit hospital corporation. MC²'s move has generated considerable debate about for- profit enterprises and the role of "outsiders" in this relatively insular and locally based market. Since the site visit, MC² and its Board decided to end its negotiations with Columbia/HCA and instead pursue another partnership with a regional system in Flint, Mich.

Meanwhile, purchasers in the market, dominated by the "Big Three" employers (General Motors, the State of Michigan and Michigan State University) and their associated unions, have become more concerned with cost and quality of care and the available benefit packages for their employees. In pursuit of better rates with providers, these purchasers are supporting the analysis of comparative hospital data on cost and quality. Union bargaining power has led to expansive benefit packages and an emphasis on choice. Consequently, area insurance products are expensive, especially for small employers. According to respondents, the high cost of insurance is one factor contributing to an exodus of small employers, who cannot afford the coverage necessary to attract employees, and to an increase in the number of uninsured, particularly among dependents.

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BCBSM maintains a strong presence in this market as well as throughout the state. The insurer offers a variety of products, is the major indemnity player and is the third-party administrator for many self-insured plans, including those of the Big Three. While indemnity products play a substantial role in the insurance market, managed care, primarily in the form of HMOs, is increasing penetration into the commercial and Medicaid markets. HMOs in the market appear to be used by hospitals to enroll covered lives, and by purchasers to control costs. In fact, ownership of HMOs by local hospitals or strong affiliations with local hospitals appear to be important to the success of HMOs in the market and to discourage outside plans' entry into the market.

The relatively loose structure and extensive networks of area HMOs appear to

satisfy purchasers' and employees' needs for flexibility, making HMOs the managed care product of choice. Small employers tend to offer point-of-service (POS) and preferred provider organization (PPO) plans.

In general, the various players believe that a two-hospital system works best for this market. However, the characteristics of that two-hospital system are expected to have major effects on the local economy, labor force and issues of community accountability. In addition, until the actual entities, their ownership and relationships are determined, the current level of hospital competition is expected to escalate, with the roles of physicians and various health plans remaining unclear.

Given this scenario, the impact of hospital consolidation, system formation and competition among hospitals and health plans on the delivery of care, its cost, quality and accessibility is not certain. In the short run, competition is likely to have positive and negative effects. On the one hand, the health care industry is expected to put greater emphasis on efficiency and cost of services and the quality of care. On the other hand, providers could potentially increase duplication of unneeded specialty services, which, if they operate at low volumes, may decrease quality. As the level of hospital competition increases, various strategic decisions and efforts by hospitals, physicians, health plans and purchasers will affect relationships among these entities and will likely increase exclusivity of relationships.

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The Lansing Community

The Lansing area is made up of three counties in the lower peninsula of Michigan. Nearly 65 percent of the area's 432,674 residents[1] are concentrated in Ingham County, home to Lansing, the state capital. The county also includes East Lansing, where Michigan State University (MSU) is located. The other two counties, Clinton and Eaton, are largely rural, in contrast with the more urban Ingham County.

Lansing area residents are relatively young, with less than 10 percent of the population over age of 65,[2] perhaps due to the large university population. Fewer minority populations reside in the area compared with national averages, and most of them live in Lansing. The median household income is slightly higher and the percentage of families living below the poverty line is slightly lower than national averages.[3] The unemployment rate generally fluctuates between 3 percent and 5 percent, based on work force adjustments at General Motors.[4] While the area is dominated by the automobile industry, state government and higher education are also major employers. General Motors, the state of Michigan and MSU account for 57 percent of the labor force.[5] Health services account for the second largest private industry employment in the tri-county area at almost 11 percent.[6]

Respondents in the community consider the capacity of their health services to be greater than what is needed, given the relative youth and good health status of the population. In fact, use of health care ser-

vices is low compared with other communities nationwide. The Lansing area's staffed beds, admissions per 1,000 population and inpatient days per 1,000 population are below national averages (24 percent, 13 percent and 17 percent lower, respectively).[7] Not only are residents' overall age-adjusted mortality rates 21 percent lower than national rates, so are death rates among these individuals from diseases such as malignant neoplasms and ischemic heart disease.[8]

The Lansing area also has a more than adequate supply of physicians, heavily weighted toward primary care. Compared with national averages, the number of physicians per 1,000 residents is almost 26 percent higher, and the number of primary care physicians per 1,000, almost 47 percent higher.[9] This strong primary care emphasis is attributed to the primary care orientation at the two MSU medical schools, one allopathic and one osteopathic, and the absence of a major tertiary hospital.

THE HEALTH CARE MARKET

The market for health services in and around Lansing is well-defined, with the bulk of the population obtaining most of its care within the tri-county area. Despite the availability of a wide range of specialty services in Lansing hospitals, however, many residents travel to Ann Arbor, Chicago, Grand Rapids or Kalamazoo for highly specialized care because Lansing is not considered a major tertiary center in Michigan. In fact, the number of out-migrations has exceeded the number of in-migrations by an average of 16 percent between 1990 and 1993.[10] Area hospitals' current efforts to increase specialty services are directed at recapturing some of these patients.

The major hospitals primarily serve the tri-county area and are located within different Lansing neighborhoods with which they have long-standing relationships. Each of the three Lansing hospitals assumes a historic and continuing responsibility for indigent care. In the more rural areas outside of Lansing, three small (under 45-bed) hospitals have relationships with the three Lansing hospitals that include referral relationships and shared services. Good roads facilitate access to Lansing, and the rural hospitals often send patients to Lansing for specialized services and trauma. The Lansing hospitals are also establishing relationships with other hospitals outside the tri-county area to expand their service area and sources for patient referrals.

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Most area physicians are in solo or small practices, although a relatively large number of primary care physicians are on hospital staffs as a result of area hospitals' efforts to purchase such practices. The market consists of allopathic and osteopathic physicians with admitting privileges at all hospitals and who may practice together. Physicians are primarily located in Lansing/East Lansing and the immediate suburban areas, and are more concentrated within Ingham County than either Eaton or Clinton counties. In Ingham County, the health department provides direct services through its clinics as do the various hospitals that have staff physicians. Hospital-

based physicians provide primary and specialty care services. In Eaton and Clinton counties, physicians are primarily located near the hospitals, often in practices and clinics that are hospital-affiliated.

A unique feature of this market is the presence of two medical schools, one allopathic (College of Human Medicine) and one osteopathic (College of Osteopathic Medicine), within MSU. Because both medical schools have decided not to operate a teaching hospital, they rely on community institutions for clinical training. This arrangement includes various staff relationships for MSU faculty at the Lansing hospitals and various staffing structures at the local clinics. In addition, the faculty practices provide clinical services to the large student (and faculty) population on the East Lansing campus in a university facility.

LEADERSHIP AND DECISION MAKING

The historically strong local focus on addressing and solving community problems has been based on the population's relative insularity, homogeneity and small size. In the past, providers' and purchasers' solutions were often collaborative, and relationships and decision making were informal and based on personal relationships. Leadership was described as hospital-driven. However, hospital consolidations have changed the nature of this leadership and decision-making style related to health care in this community.

Still, all the major players—providers, employers, unions, local government and other community groups—continue to see community accountability as a strong value, and each group plays a role. For example, the Ingham County Health Department (ICHD) plays a central role in assessing health problems. With area hospitals as a historically important force for change in the community, major hospital CEOs are well known and viewed as part of the community leadership. Business and union leaders have been involved in various community efforts and serve on hospital and other community-based boards such as the United Way and the Chamber of Commerce, which have been active in health issues. MSU has also played a significant role in the community, especially through the community involvement of its two medical schools and its role as a major purchaser.

To counter rising competition among hospitals, business, government and community leaders are placing a growing emphasis on broadly representative groups to address community health issues and accountability of Lansing's institutions. Among these are the Capital Area Health Alliance (CAHA), a purchaser-driven organization; the Health Status Advisory Group (HSAG), established by the area health departments to assess health problems and develop collaborative initiatives; and the Public Health Advisory Committee (PHAC), established to address continued responsibilities resulting from the sale of the county hospital. The HSAG, under the leadership of the director of the Ingham County Health Department, continues to support the major assessments and collaborative efforts in the area. The PHAC has played a very limited role in monitoring MC^2 community efforts, although its role is currently being re-examined as additional ownership changes are considered.

Of these three groups, CAHA is perhaps the most involved in community decision making, but has generated debate about its composition, positions and role. When area purchasers established CAHA, they created what they saw as a centralized entity that would address pertinent issues as they concerned cost and quality of care. As a result,

CAHA was organized as a purchaser/provider organization, with purchasers holding 60 percent of the voting power. Activities include reviewing certificate-of-need (CON) applications to the state, staffing recent purchaser-supported cost and quality studies and cosponsoring a public hearing on the proposed MC²/Columbia merger. While CAHA has the potential to serve as a formal source of leadership and influence, respondent opinions about CAHA were mixed. Current limited union participation and potential conflicts among provider members and between providers and purchasers represent major challenges to CAHA's future role. In addition, some consumer groups reported they are concerned that consumers have little input into this organization.

In the meantime, community health care leadership is shifting from the hospitals to purchasers as the latter increase their visibility and efforts to reduce costs and improve quality. Purchasers testified at public hearings on the MC²/Columbia merger and influenced the negotiations to establish new hospital rates. Purchasers' leadership role is linked to their relationship with their respective unions. In turn, unions continue to play an important role and may be the primary way in which consumers influence this market. Union power has meant that purchasers must take into account employee preferences for affordable and comprehensive health benefit packages and broad provider networks. Outside of the unions' influence, there is little organized consumer advocacy in the Lansing area, although consumers sit on almost all of the organizations that have influence in the market. There was a flurry of consumer activity in response to anticipated changes in the Lansing hospitals, but in general, consumer power vis-à-vis purchasers is meted out through the collective bargaining process.

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External Forces Affecting the Health System

PUBLIC POLICY

In general, regulation and state policy do not seem to be major forces in shaping the market or in driving market change in Lansing. However, because issues concerning mergers are within the purview of the state Attorney General and the courts, the future shape of the Lansing market may be determined in part by those decisions, which may be highly political since judges and the Attorney General are elected officials.

The effectiveness of Michigan's CON regulations in Lansing appears mixed. At first glance, the relative lack of duplication of services across the major Lansing hospitals seems to be due to CON requirements; however, most respondents were not willing to attribute this to the impact of regulations. In fact, duplication of various hospital services is increasing as applicants redefine their service areas to justify the need for a new service. On the other hand, CON appears to be highly effective in limiting nursing home beds. In addition, many believe that CON has also led to a shortage of these facilities, as evidenced by very high occupancy rates and difficulties in reducing hospital lengths of stay.

In a recent reorganization, the state government created a new Department of Community Health that combines public

health, mental health and Medicaid under one authority. The new department is now solely responsible for state health policy, and officials expect the office to do all health purchasing for the state, which would also create a powerful statewide market force. In addition, state Medicaid reforms, including a 1915b (managed care) waiver and changes to the way Medicaid funds graduate medical education (GME), are likely to have an impact on the Lansing area.

The transition to Medicaid managed care is already affecting the entry of various health plans into the market and increasing the presence of capitation and risk-sharing. The state plans to reallocate $35 million of the current $220 million in state funding for GME to promote training in primary care and to address the needs of the managed Medicaid population. To do this, the state issued a competitive request for proposal (RFP) to solicit bids from HMOs and hospitals to offer training programs that support these goals. While the outcome of this solicitation is not yet known, some respondents hope they will attract additional training dollars to the area because of their primary care emphasis and extensive primary care training capacity.

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PUBLIC AND PRIVATE PURCHASING

Employing over 50 percent of the labor force, the Big Three and their associated unions dominate the Lansing region purchasers. Portrayed as "sleeping giants," the Big Three are just awakening to the issues in this market and becoming active and dominant players. Recent negotiations to lower hospital rates are evidence of their potential power. Other major employers include the health and health-related services, retail, education and government sectors. Many of the small employers depend on General Motors as contractors to the automobile industry, and the overall labor force is heavily unionized with the major unions, especially the United Auto Workers, involved in health benefit issues statewide.

Lately, most respondents have turned their attention to health care. Many indicated that until recently, Lansing was considered a low- to mid-cost health care market by most purchasers and therefore received less attention or pressure to reduce costs than other markets. However, employers and unions have zeroed in on the Lansing area, and are comparing it with the lower-cost "benchmark" market of Grand Rapids. Purchasers are also beginning to identify those providers and plans with high costs and are demanding reduced rates and premiums.

Purchaser concerns extend beyond cost to performance and quality. Last year, purchasers supported a study of cost and quality and efforts to establish a system to adequately monitor and compare the major hospitals. Respondents viewed these initiatives as the basis for increasing the emphasis on quality in the future. However, current views of quality of services in this market are mixed, especially tertiary services. Some respondents cite continuing out-migration as evidence of the area's concern with local care while others report a high degree of confidence in the area's services. Perceived quality, however, is viewed as an important issue for competing hospitals to gain more mar-

ket share. Therefore, hospitals are all emphasizing quality and consumer satisfaction as they compete for patients and plan contracts.

Decisions reached in union negotiations strongly affect employer purchasing decisions. As a result, health insurance products are strongly influenced by the union philosophy, particularly that espoused by the United Auto Workers (UAW), that health care is a right and that it should be provided by nonprofit entities. Consequently, most health benefit packages among major Lansing employers generally reflect extensive coverage and emphasis on consumer choice. This consumer choice issue has led to large, overlapping provider networks for all products.

The Big Three and the UAW have a significant relationship with BCBSM, which includes membership (by some of these entities) on the BCBSM board and use of BCBSM as their third-party administrator. Increased concern on the part of the Big Three about the cost of health benefits has placed new demands on BCBSM to negotiate better rates and has involved the purchasers more directly in negotiations. In 1996 negotiations, for example, the Big Three took advantage of the results of a study of hospital costs they commissioned that identified Sparrow as the highest-cost hospital (20 percent above the others). As a result, the employer trio demanded that BCBSM keep its overall indemnity rates steady, in part by negotiating better rates with Sparrow.

These most recent negotiations have focused on hospital rates. BCBSM's negotiations with the hospitals appear to be product-specific, and the results extend beyond these three large employers. For example, negotiations conducted several years ago helped reduce HMO rates, providing indirect benefits to medium and smaller employers, who were then able to offer an HMO option.

In addition to their involvement collectively, MSU and the State of Michigan are pursuing individual strategies to strengthen their negotiating power. The new MSU president is actively involved in various strategies to keep health care costs down as part of his promise to avoid tuition increases. Among the strategies MSU is exploring is a statewide university consortium designed to increase the university's negotiating power. The State of Michigan is considering addressing cost control issues by pooling its health care purchasing for public employees.

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Most smaller employers say these larger-employer negotiations set the standard for insurance plans, with benefit packages that are often cost-prohibitive to them. Some small employers have responded by purchasing health insurance through the Chamber of Commerce, although this is also reported to be expensive. The smaller employers feel they have very little choice in insurance products, but they have not been able to organize sufficient influence to "get a better deal."

Medicaid is widely believed to be the leader among purchasers in moving toward

greater HMO enrollment and capitation. The state's three-year plan to shift its Medicaid population into managed care includes implementing the state's 1915b waiver and developing population-specific approaches. The 32,000 Medicaid recipients in the Lansing area may choose between a primary care physician through the state's Physician Sponsor Plan (PSP) or an HMO.[11] In Ingham County, which has the greatest Medicaid managed care penetration of the three counties, more than half of the county's enrolled population is in one of the area's three HMOs participating in Medicaid. In contrast, the other counties' enrollment is primarily in PSP.[12] The transition in the Medicaid program has led to competition between providers for Medicaid patients; established plans and new plans entering the Lansing market are developing specific Medicaid products. Respondents felt that the increased enrollment in HMOs has improved access to care for the Medicaid population.

Organization of the Health Care System

Area hospitals are rapidly consolidating in the Lansing area, which has prompted the larger hospitals, MC^2 and Sparrow, to develop health systems and downsize their inpatient capacity. For the most part, mergers that have taken place or are currently being considered have been financially driven. The most significant merger in the area took place in 1992 when Lansing General Hospital, an osteopathic provider, purchased the then county-owned facility Ingham County Medical—and MC^2 was created. The acquisition's high cost fueled financial difficulties and is driving MC^2's current need for a new arrangement. Another major hospital, St. Lawrence, recently announced a memorandum of agreement to merge with Sparrow Health System, a move that comes after a considerable period of searching for a reliable and compatible partner. The two resulting systems—MC^2 and Sparrow—while heavily focused on the tri-county area, are also pursuing arrangements with outside hospitals to support their development of expanded and specialized services and with smaller hospitals in the market to expand their market share. As they develop and increase their level of competition, the hospitals are also re-examining their relationships with physicians and with health plans.

While change in the hospital sector seems to be occurring rapidly, physicians are slowly moving from their solo practices and small groups to larger multispecialty groups. The largest group has 25 members. Hospitals have been buying physician practices and establishing offices on or near their campuses to attract doctors to their facilities. The increasing number of employed physicians are generally primary care physicians at the hospitals or at the one staff-model HMO. Physicians also affiliate with the hospitals either through physician-hospital organizations or the one physician organization. In addition, MSU has a faculty practice plan. Some physicians, however, are beginning to rethink these close ties with the hospital systems and are developing networks to contract independently with hospital systems and/or plans.

At the same time, competition is increasing among the health plans in the market. Until recently, BCBSM has dominated the market, particularly with its indemnity product. However, managed care products, primarily HMOs, are becoming more significant players, with plans such as BCBSM and its competitors offering a variety of products.

The five HMOs in the market are all not-for-profit; most are owned by or contract with area hospitals. Of the five plans, those

owned by BCBSM (Blue Care Network) and Sparrow Hospital (Physicians Health Plan) hold the most market share, followed by Care Choices, part of St. Lawrence through its corporate sponsor, Mercy Health Services. The other two plans are from outside the area, M-CARE, which is part of the University of Michigan, and the Wellness Plan of Detroit. Because of the relationships of the major plans with local hospital systems, the current consolidations among the hospitals are likely to affect the relative positions of plans in the market. Moreover, the community bias favoring local entities continues to discourage new entrants from other parts of the state who are primarily interested in the Medicaid market.

PROVIDER ORGANIZATIONS

MC^2 and Sparrow Health Systems are the two dominant provider organizations in the area. The third major player is St. Lawrence Hospital. Until recently, these hospitals have had distinct areas of specialty and little duplication of services. The three rural hospitals are closely aligned with the larger hospitals in Lansing. Clinton Memorial's shared arrangement with Sparrow has resulted in a merger of their durable medical equipment companies and arrangements for home care services. A merger of these two facilities is anticipated at some later point.

With approximately 45 percent of the area market share and the highest patient volume, Sparrow Health System would like to be the dominant hospital system and is already viewed as such by other players in the market. This current perception is based in part on Sparrow's market share, size, the services it offers and its sound financial condition, which allow the system to aggressively pursue an expansion strategy. For example, Sparrow is upgrading its existing Level 2 trauma center to Level 1, an effort that has been used to support development of a new cardiovascular surgery program. The Sparrow system also includes an HMO and two PPOs, a home care company and an ambulatory care center outside of Lansing.

MC^2, the other major health system in the capital area, has two campuses, 483 licensed beds and the second highest patient volume in the area. In addition to its inpatient services, it offers a continuum of services, including primary care, outpatient rehabilitation, home health and hospice services. The last is a result of its merger with the Greater Lansing Visiting Nursing Services. MC^2 is a Cardiovascular Center of Excellence, with a long history of open-heart surgery.

St. Lawrence, the smallest of the three hospitals, is part of Mercy Health Services and has been seeking a merger over the past six years with one of the two major hospitals. The hospital is known in the area for geriatric services, behavioral health (it has a psychiatric partial hospitalization program) and wellness programs, including the well-known Michigan Athletic Club and Health Services Pavilion, subsidiaries of the Mercy System, which are managed by St. Lawrence. St. Lawrence is affiliated with the Mercy HMO, Care Choices, which is primarily active in Medicaid managed care. Capital Area Physician Entity (CAPE), a PHO, was established as part of the Care Choices effort, with Care Choices providing administrative services to the PHO.

The three hospitals compete on the basis of services provided and their relationships with health plans, the smaller area hospitals and physicians in the community. Assuming the merger of Sparrow and St. Lawrence,

each of the remaining two systems has some unique services but they compete in such areas as open-heart surgery, MRI, home health and rehabilitation services. By merging with St. Lawrence, Sparrow will add geriatrics, outpatient rehabilitation and sports medicine to its competitive arsenal. Most view Sparrow as the entity least willing to cooperate, as evidenced when it pulled out of a community collaborative effort to create a single joint program in radiation oncology. As a result, there will be two separate competing services. Sparrow also uses its position in the market to keep its prices high and limit entry of outside health plans by not participating in their networks. Since most respondents agree that networks need Sparrow Hospital to be successful in marketing, this strategy has limited the success of those plans unable to contract with Sparrow. A recent study identifying Sparrow as the highest-cost area hospital, and consequent demands by the Big Three and BCBSM, have pressured Sparrow to lower its hospital rates, but not to lower its HMO rates.

The ownership or strong affiliation with health plans by two of the hospitals is part of their systems' strategies to capture greater volume and market share. Sparrow's ownership of Physician Health Plan (PHP) provides the system with several managed care products in the market and strong incentives to limit its participation in other plans. Currently, PHP has a strong market presence, although a number of employers remain concerned about its high costs and do not offer this product. GM recently dropped PHP as a health plan offering to its management staff because it was unable to get lower rates. The automaker also does not offer PHP to its other employees because the UAW objects to PHP's management contract with a for-profit entity, United HealthCare. Of the three major hospitals, MC^2 is the only one that does not own or have an affiliation with a specific health plan; instead it contracts with various plans, including those of St. Lawrence's Care Choices, M-CARE and the Wellness Plan. The future Sparrow/St. Lawrence merger will present some issues related to the Care Choices plan and the current competition with the Sparrow plan for the Medicaid market.

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The three major hospitals also have been purchasing physician practices with a major emphasis on primary care. Several respondents indicated that this strategy has not always been financially successful, and as a result, fewer purchases are occurring. Instead, hospitals appear to be focusing on developing and supporting physician hospital organizations and establishing physician office space close to their inpatient facilities. These activities include Sparrow's new office building and attempts by MC^2 to develop a clinic on one of its campuses, an expansion issue that is meeting some community resistance. The rural hospitals have implemented similar strategies and own a range of practices.

Changes in the physician sector have been less dramatic. Physicians are primarily moving away from solo and small-group practices to larger ones, and many primary care physicians are shifting from private practice to salaried positions at hospitals and with plans. Generally physicians in this market have been viewed as following the

hospitals rather than actively organizing themselves. In fact, several PHOs exist but only one physician organization operates in Lansing.

In response to concerns among some physicians that they need to have a strong, independent presence, a small number of physicians are developing multispecialty groups to contract independently with hospitals and plans. For the most part, specialty physicians participate in overlapping networks of the various plans while primary care physicians are more likely to be affiliated with a single hospital and plan. Some plans, especially PHP, are trying to develop exclusive arrangements with specialty physicians. Consumer preferences and purchaser pressures have limited the success of such efforts to date, but it is expected that as the competition between Sparrow and MC[2] increases and spills over to the plans in the market, exclusive arrangements will become more prominent.

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A unique feature of the physician market in this area is the strong presence of both allopathic and osteopathic physicians, due in part to the two medical schools but also resulting from a long community and state tradition of using osteopaths. The osteopathic presence is credited in large part for the market's emphasis on primary care. However, there are mixed views as to the extent of integration of these two groups and their relative roles in providing specialty services. At the medical schools, students pursue largely separate paths after the initial non-clinical training. The faculty practices operate separately and are not administratively integrated, with the exception of a few departments. On the other hand, all hospitals give admitting privileges to both groups, there are some "mixed" practices and there is a single medical society.

HEALTH PLANS

The Lansing area insurance market is still dominated by a single plan, BCBSM, which is the primary indemnity carrier and offers a number of other products. As previously noted, BCBSM also serves as the third-party administrator for many of the self-insured employers. While in the past all employers had often offered only BCBSM as their insurance plan, they now offer other health plans or may contract with other third-party administrators. HMO penetration in the area is high, at 38.3 percent[13] and will increase as the Medicaid market moves rapidly into managed care arrangements.

Health plans in the market are characterized by their not-for-profit status, a strong emphasis on and bias toward "locally grown" products and a focus on HMOs. This bias and the unwillingness of Sparrow Hospital to contract with newer entrants are the major barriers to entry. The most successful plans are locally owned or strongly affiliated with a local group: the Blue Cross plan; the Blue Care Network (BCN), the Blue Cross plan; Sparrow's PHP; and the St. Lawrence/Mercy Health Services Care Choices.

BCN and PHP currently have approximately 80 percent of the HMO market,[14] and only recently have entrants from other parts of the state, including the Wellness Plan and M-CARE, come in, primarily to pursue the new Medicaid market. With a small elderly population and low Medicare managed care penetration ranging from 4 to 8 percent in the three counties,[15] Lansing is not viewed as a particularly attractive market for Medicare risk products.

Indemnity plans and HMOs are preferred by many employers. For example, among the Big Three, which account for almost 60 percent of the labor market, the state and MSU offer BCBSM indemnity and two HMO options, PHP and BCN, while GM offers the BCBSM indemnity and BCN only. HMOs are not restrictive, so there is less reason to have other products, such as preferred provider organizations or point-of-service plans. Nonetheless, various plans, including BCBSM and Sparrow's PHP plan, offer these products. While there is often little differentiation in terms of cost to purchasers, the plans do differentiate their products, primarily by the way they compensate providers and design risk arrangements.

Managed care penetration, primarily HMOs, has been on the rise in the Lansing area, but managed care has been a very loose construct, with little capitation and few overlapping networks, except in the Medicaid market. In the commercial sector, most physicians, especially specialists, participate in the various plans, although there has been some move toward exclusivity among primary care physicians. While the plans attempt to include all area hospitals in their networks, Sparrow has limited its participation in some of the networks. Plans' attempts to limit networks have been largely unsuccessful, although new attempts are expected as more exclusive hospital/physician and hospital/plan relationships are established.

The picture for the Medicaid market contrasts with that of the commercial market. Fewer plans offer a Medicaid product and networks established by these plans are more limited. Only three plans offer a Medicaid product. The three Medicaid plans have generally established exclusive arrangements with community-based providers, such as the health department and neighborhood health centers. Physician panels are also defined within the Medicaid market based on their hospital affiliations. For example, the Wellness Plan uses physicians affiliated with MC^2, and Care Choices mainly uses physicians affiliated with St. Lawrence.

Provider payments in the commercial market remain largely discounted fee-for-service, with some capitated arrangements with primary care physicians and the expectation that the public sector (Medicaid HMOs) will provide pressure to move to various risk arrangements, including capitation. At least one plan reported that primary care physicians are assuming some risk for hospitalization. One plan reported using diagnosis related groups (DRGs) for hospital payments, but is moving to per diems. PHP and BCBSM differentiate payments based on the product as described below.

BCBSM has a complicated position in this market, particularly given its roles with major employers. This position particularly affects its relationship with area hospitals because it may, at some point, negotiate with the hospitals on behalf of employers and then compete with the hospitals and their health plan products. BCBSM's major products include its indemnity, Blue Managed

Traditional; an HMO, Blue Care Network (BCN); a PPO, Blue Care Preferred; and a point-of-service product, Blue Choice. BCBSM maintains a competitive edge by keeping premiums down, although some products may be losing money. BCN is a staff/IPA model that has a 30 percent market share of the commercial HMO market.[16] It competes well on price in part based on its ability to manage care through utilization review and the staff component of its model and on its use of primary care capitation. BCN's ability to use BCBSM's name recognition to market itself and its strong union support are its major advantages in the market. BCBSM views its major competition for BCN as its own indemnity product, not Sparrow's PHP, which actually has a larger market share at 50 percent.[17]

PHP is an IPA owned by Sparrow Health System with a management contract with United Health Care. It covers 95,000 lives in the capital area, including the commercial HMO and a point-of-service product.[18] The point-of-service product is offered to provide choice to employers, but most utilization occurs within the HMO. PHP prices are generally higher than those of its competitors, which has contributed to recent problems in obtaining contracts. PHP's high costs are viewed as its major problem, and pressures by employers are influencing the plan to develop a variety of strategies designed to bring costs down, including improved clinical management and changes in its current discounted fee-for-service arrangements with providers.

The three remaining HMOs in the market trail far behind these two market leaders. They include: Care Choices, affiliated with Mercy Health Services; M-CARE, affiliated with the University of Michigan; and the Wellness Plan, based in Detroit. As discussed previously, bias against "outsiders" and Sparrow's refusal to join these plans are two major reasons for their current position. Only three of the plans currently offer a Medicaid product: PHP's Family Care; Care Choices, a Mercy Health Services plan affiliated with St. Lawrence; and the Wellness Plan located in Detroit.

Because of the strong relationship between area hospitals and health plans, the emerging hospital system ownership changes will strongly influence the nature of plans and physician relationships to hospitals and plans.

ORGANIZATIONAL CHANGE: PROVIDERS AND PLANS

Two major underlying issues in the Lansing market will influence health system change: a strong desire to maintain the current ownership and control of key health care organizations as local and not-for-profit, and efforts to reduce costs and emphasize quality.

Because of the strong relationship between area hospitals and health plans, the emerging hospital system ownership changes will strongly influence the nature of plans and physician relationships to hospitals and plans. Sparrow/St. Lawrence and MC^2 are currently making these strategic choices. The Sparrow/St. Lawrence merger appears to be headed toward a full-scale integration and partnership, proposing a potential scenario in which St. Lawrence will become the system's outpatient center and Sparrow, the inpatient center. Questions remain, however, concerning the relationship between each hospital's health plan (PHP at Sparrow and

Care Choices at St. Lawrence) since they have been competing aggressively with each other for Medicaid patients. In addition, it is unclear what will happen to the PHOs at each hospital and the relationships St. Lawrence has established with plans such as M-CARE and the Wellness Plan. Change resulting from the resolution of MC²'s current poor financial shape is highly dependent on the nature of the solution.

In contrast to the hospital market, change within the plans does not center around ownership. Instead, market impact is more likely to relate to changes in provider arrangements, including limited provider networks, expanded use of capitation and newly developed risk arrangements. Hospital ownership changes, however, will likely affect health plans. To the extent that indemnity and HMO or other managed care products become more differentiated, either in terms of cost or their networks, the penetration of various products may shift over time.

Clinical Practice and Delivery of Care

The organizational changes described above appear to have some effect on administrative integration but a more limited impact on clinical practice. Current efforts at administrative integration seem to vary among area hospitals. For example, the Sparrow System has centralized many of its administrative functions across the hospital and other entities and is in the process of developing a new information system and electronic medical records to support its efforts to become an integrated delivery system. MC², whose most recent merger is now five years old, is just beginning to integrate its administrative and clinical operations. MC²'s major concerns are integration of the separate medical directors and staffs remaining from the two hospitals that formed this new entity and development of a common culture. Administrative integration is expected to escalate with major upcoming major organizational changes at MC² and Sparrow/St. Lawrence.

A major factor related to clinical practice has been the initial purchases of physician practices and the more recent reconsideration of this strategy. Hospitals believe this strategy has achieved limited success and are considering other approaches, including introduction of financial incentives and guidelines to which physicians will be held and development of physician office space on or near hospital campuses.

Despite the recent emphasis on data and information, there is relatively limited clinical management or use of clinical tools, and clinical integration and care management are viewed as being in the "embryonic stage." With few exceptions, Lansing providers and plans appear to have neither the financial incentives nor the technologies to support changes in clinical practice. Moreover, the current overlap in networks and limited formal referral arrangements contribute to this environment. In general, providers cannot track patients across settings or entities, and clinical information systems and electronic records are just now being developed. However, efforts by selected plans and hospital systems are now underway to develop a more extensive emphasis on clinical management, such as using Health Plan Employer Data and Information Set (HEDIS) measures to initiate quality-monitoring efforts and development of a physician profiling system by BCN, which will include financial incentives and penalties. At the system level, Sparrow has a quality improvement program that is designed to address reductions in length of stay for such high-cost patients

as burn and trauma with more appropriate use of outpatient settings and primary care physicians. BCN is piloting a disease management program with a focus on conditions where hospitalization can be avoided. In the future, it is expected that purchaser interests in identifying and addressing the quality of care in the Capital Area may influence practice.

The Lansing market has a strong emphasis on primary care and prevention and health- promotion activities. The primary care emphasis is being supported further by the growth of Medicaid managed care and commercial enrollments in HMOs. The health department is taking a leadership role in addressing prevention and health-promotion efforts using the broadly representative Health Status Advisory Group and task forces to increase the clinical emphasis on these efforts. In addition to the participation of many sectors on this committee, there is also support for these activities from providers and plans with several of the systems emphasizing wellness strategies. With the planned merger of Sparrow/St. Lawrence, competition related to wellness services is likely to escalate as the new entity and MC^2 use its wellness programs to compete with each other.

Views were mixed on the overall market impact of these hospital/health plan alliances. Some respondents asserted that the strong economic relationships between health plans and local hospitals limit the ability of plans to negotiate as aggressively on price as they would be able to if they had a more arms-length relationship with their hospital partners.

Care of the Poor

The Lansing area has a strong tradition of involvement on the part of public and private providers in serving the poor, particularly the Medicaid and uninsured populations. Many initiatives involve collaborative efforts among public and private providers, local government, MSU and various foundations. This collaborative effort and strong support by the Ingham County Health Department (ICHD) and area hospitals currently form a strong base of services for the area's poor and uninsured populations.

Approximately 10 to 12 percent of the Capital Area's residents are uninsured, with a higher concentration in Ingham County and more specifically in Lansing.[19] ICHD estimates show that the area's minority populations are disproportionately represented, with approximately 20 percent of African Americans and 25 percent of Hispanics in Lansing uninsured compared with 13 percent of whites. Some neighborhoods, such as the one in which Sparrow Hospital is located, have uninsured rates as high as 26 percent. The Health Department study also suggests that the rates are increasing as the proportion of area firms providing health benefits, particularly to dependents, decreases and as Medicaid eligibility rules tighten.

Consequently, the safety net issue is a central component of the area's strong focus on community accountability. ICHD provides leadership in identifying issues related to indigent care and in serving as a major direct provider of ambulatory services. In conjunction with the other area health departments, ICHD conducts various studies related to health status, plays a leader-

ship role in development of strategies to address identified problems and provides an array of public health services.

The Capital Area safety net and indigent care system is primarily organized on a county basis, and is made up of area hospitals, health departments and a number of community-based organizations. Financing comes from the state, county, Medicare and Medicaid disproportionate share hospital payments, foundations and the hospitals. The three Lansing hospitals in particular have always played an important role in providing inpatient and outpatient services to the indigent population. In addition, the hospitals have been actively involved in their neighborhoods with broader issues such as housing, safety and economic development.

Concern with existing hospital commitments to provide indigent care was first raised with the sale of the public hospital in 1992 and more recently with the possible entry of Columbia/HCA. As a result of both of these events, ICHD sponsored a study of the hospitals to determine how the burden of indigent care was spread across the hospitals, and specifically to see if MC² was providing the level of indigent care required as part of the sale of the public hospital. The study showed that Sparrow and St. Lawrence are providing their proportionate share of indigent care in the market while MC² provides less than its proportionate share.

ICHD's role as a major provider of direct services for the indigent and Medicaid population stems in part from the fact that there are no federally funded community health centers in the area. Several community-based organizations that provide direct services work with the health department, area hospitals and, in some cases, the two MSU medical schools, to ensure a wide array of services for underinsured and uninsured residents. Various foundation grants from the W.K. Kellogg Foundation and The Robert Wood Johnson Foundation also support development of community-based systems to address the needs of these populations and strengthen the area safety net, such as "network centers," which are being developed in the four major Lansing neighborhoods to provide health care and other social and human services.

> Despite the recent emphasis on data and information, there is relatively limited clinical management or use of clinical tools, and clinical integration and care management are viewed as being in the "embryonic stage."

Access to care in the Lansing market seems to be relatively good, but there is growing concern that access may become more of an issue in the future, in part due to more stringent enrollment processes for welfare and other aspects of welfare reform. Medicaid managed care is reported to be improving access to services for the Medicaid population. Area hospitals' prior commitments and the presence of a strong health department and other community-based organizations have been the primary source of a fairly comprehensive set of services for the indigent.

There are concerns, however, that these efforts cannot be sustained in the face of growing numbers of uninsured and an increasingly competitive environment. ICHD is taking a leadership role in developing a community-wide effort involving business and area hospitals to ensure access for the uninsured. Its objective is to develop

an approach to financing and managing care for this population. Some strategies include a pooled hospital fund to organize care and/or a managed care approach. It is not clear at this time whether the area hospitals will work together on this effort and whether other required funding will be forthcoming. This approach, however, is representative of the overall community approach to addressing key issues. The current difficulties of obtaining buy-in from all of the hospitals also reflect the impact of competition on the previously cooperative environment.

Issues to Track

The Lansing market is in the midst of major changes that are likely to set the path for its future. The consensus is that current events are leading to further consolidation and will ultimately improve the future viability of providers, especially hospitals, in this market. These changes are also expected to influence purchasers' and consumers' cost, quality and access objectives, but how this will be achieved remains unclear. In the past, the Lansing market has been locally owned and controlled, with a great deal of informal decision making based on long-standing relationships. In the midst of organizational changes, the market's major purchasers are emerging as a dominant force, citing concerns about cost and quality of health care as major issues they wish to address aggressively. Access is viewed as an important value with responsibilities currently shared among public and private providers.

The anticipation of changes resulting from decisions about ownership of MC^2 and the final outcome of the planned Sparrow/St. Lawrence merger make up one major area to track. While final decisions will most directly affect whether Lansing becomes a two-hospital system market, the nature and form of the resulting entities will define a number of other aspects of the market and the nature of the competition that is likely to ensue. Among the concerns will be the relationships these two hospital systems have with other area hospitals, with physicians and with health plans. While specialists currently tend to affiliate with multiple hospitals and plans, the intensity with which the two hospital systems compete may increase pressure for exclusivity and an increased role for existing PHOs. On the other hand, physicians may begin developing more of their own organizations rather than becoming part of a hospital system. The directions are currently not clear.

On the plan side, the affiliation and ownership relationships that currently exist are also likely to change. Whether these changes will result in opportunities for the non-local plans or strengthen the existing locally based plans remains to be seen. Equally important will be the effects that plan affiliations will have on the nature of plan and hospital competition and the potential changes in the nature of plan networks, including exclusivity in the networks and the impact of Sparrow's participation strategies with plans other than its own. While there is little capitation in the market currently outside of primary care, plans are expected to move more rapidly to capitation and risk arrangements. The resulting impact on premiums and product differentiation will be important to track and will affect relative success in the marketplace. The effects on employers, especially small ones in this market, will need to be monitored as well to determine the extent to which potentially more affordable options are available.

Community accountability continues to be a significant issue in this market with both public and private initiatives underway to

ensure it is sustained. The community is concerned that providers will not be able to meet all the service demands of indigent patients and for those employed in smaller firms who may no longer be able to afford insurance coverage. The ICHD recently initiated a study to better identify the extent of loss of insurance, and another county-funded study assessed the current contributions of the major hospitals to meeting needs of the uninsured and indigent. The issues to track involve how these data will be used, what approach will be implemented and who will take responsibility for ensuring that these issues are addressed.

Efforts to study and report on hospital costs represent a first step in increasing awareness of high-cost institutions. While from a local planning perspective the area remains overbedded, current planned consolidations are expected to reduce the number of beds by as much as 25 percent. The hospitals are also engaged in major strategies to shift services from inpatient to outpatient sites. Finally, costs are being addressed by providers in negotiations of provider and plan rates. Quality concerns are just now being raised, with no consensus on the quality of the current system and plans to monitor and influence quality not yet determined. Until cost is addressed to the satisfaction of the purchasers, it is likely that quality issues will continue to play a secondary role.

Continuing efforts to ensure community accountability will likely be a hallmark of this market, with anticipated leadership by the purchasers and unions and a continuing role by the ICHD. Areas to track will include the organizational nature of community accountability efforts, the scope of activities and the nature of participation by various sectors of the community. While the Lansing market is undergoing many changes, it is expected that a continuing strong focus on community accountability will be the basis for ensuring that access to care and the cost and quality of that care are monitored, and that these concerns are addressed by the local community.

A final area to track is potential state and local policy change on the delivery and financing of services for the uninsured. Several proposals are being debated and developed, including a managed care system for the uninsured to address potential effects of the expansion of Medicaid managed care and welfare reform and a community-wide effort to involve the hospital systems and business in ensuring access for the uninsured as a "community value." Community efforts may also intensify depending on the final results of hospital consolidation activities.

NOTES

1. 1990 Census of Population.
2. Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions. U.S. Department of Health and Human Services.
3. 1990 Census of Population.
4. 1990 Census of Population; 1995 County and City Extra; The Lansing Regional Chamber of Commerce, *The Lansing Region 1995 Metropolitan Profile.*
5. Lansing Regional Chamber of Commerce, Capital Choice.
6. *Annual Planning Information Report: Lansing Tri-County SDA.*
7. American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term care units in hospitals.
8. National Center for Health Statistics, Centers for Disease Control and Prevention (March 1997) for 1994.
9. Estimates are based on the 1996 American Medical Association Master File and 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.
10. Respondent provided information.
11. Health Management Associates, June 1996.
12. *Ibid.*
13. InterStudy Competitive Edge Regional Market Analysis 6.2, February 1997.
14. Health Management Associates, June 1996.
15. Health Care Financing Administration, 1996.
16. Health Management Associates, June 1996.
17. *Ibid.*
18. Data from respondent.
19. Ingham County Health Department, *Community Health Assessment,* September 1996; Ingham County Health Department, A Preliminary Statement of the Uninsured in Ingham County, Michigan, September 10, 1996.