Financial Woes and Contract Disputes Disrupt Market

In February 2001, a team of researchers visited Boston, Mass., to study that community's health care system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 95 leaders in the health care market. Boston is one of the 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to Boston, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Boston market includes the city of Boston and Bristol, Essex, Middlesex, Norfolk, Plymouth and Suffolk counties.

After a period of relative stability, Boston's health care market was disrupted over the past two years by financial difficulties in the plan and hospital sectors and contentious contract disputes between the largest care system and local plans. Policy makers rapidly enacted legislation to stabilize the market and took action to ensure consumers' access to health care.

In the interest of helping local, not-for-profit plans regain their financial footing, employers accepted double-digit premium increases. Consumers continued to enjoy relatively rich benefits but faced higher copayments for prescription drugs and outpatient services. Other important developments include:

- Health maintenance organizations (HMOs) continued to dominate the plan market but were beginning to change considerably as plans and providers shed risk contracts and explored new products and payment arrangements.
- A state ballot initiative for universal health care coverage was narrowly defeated, but it prompted the Massachusetts Legislature to pass a long-debated patients' bill of rights.
- Safety net providers, with strong state support and sound management, remained relatively stable.

Boston Demographics

Boston	*Metropolitan areas above 200,000 population*
Population, July 1, 1999 [1]	
4,409,572	
Population Change, 1990-1999 [2]	
2.8%	*8.6%*
Median Income [3]	
$31,868	*$27,843*
Persons Living in Poverty [3]	
10%	*14%*
Persons Age 65 or Older [3]	
14%	*11%*

Sources:
1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

A series of events has upset the fragile balance between plans and providers, threatening disruptions for consumers and prompting policy makers to intervene.

Plans and Community Hospitals Experience Financial Distress

At the time of HSC's 1998 site visit, Boston's health care market had reached relative equilibrium after multiple mergers and acquisitions left the market consolidated largely around three locally operated, not-for-profit health plans and two large academic medical center (AMC)-based provider systems. Since then, a series of events has upset the fragile balance among these organizations, threatening disruptions for consumers and prompting policy makers to intervene.

Leading Plans Falter. Two local, not-for-profit health plans with national reputations as pioneering, high-quality HMOs—Harvard Pilgrim Health Care (HPHC) and Tufts Health Plan—experienced serious financial problems. Both HPHC and Tufts have long been a source of local pride. Their local roots and not-for-profit status have been important features in the eyes of policy makers and local providers, who have been wary of national, for-profit firms. The financial difficulties of these plans created uncertainty for the roughly 1.8 million enrollees the plans covered in Massachusetts at their peak and raised questions about the continuing viability of locally owned, not-for-profit health plans. HPHC and Tufts lost their position as market leaders as consumers switched to more stable health insurance options.

HPHC's severe financial difficulties were exposed in late 1999, when the plan unexpectedly posted a $226 million loss. The state intervened swiftly, placing the plan into receivership and thereby preventing disruptions of care for consumers and a much-feared acquisition by a national, for-profit insurer. After restructuring the plan's debt and allowing certain accounting changes, the state placed the plan under administrative supervision and will continue to monitor its financial status until 2002.

One of HPHC's downfalls was its attempt to expand regionally. Since 1999, HPHC has withdrawn from neighboring states and reduced its staff substantially. It also has moved to bring costs under control by adopting a three-tier pharmacy benefit, capping Medicare prescription drug coverage and investing in information technology to improve its relationships with providers and consumers. HPHC's turnaround efforts appear to be working, and the plan posted a small operating profit in the first quarter of 2001. HPHC lost approximately 700,000 members as a result of its withdrawal from other New England states and declines in local membership, however, and some observers question whether growing costs will outpace the plan's declining revenue.

Tufts' financial problems also were associated with failed regional expansion efforts. The plan posted a $42 million loss in 1999 and responded, like HPHC, by reducing staff and withdrawing from three neighboring states. Although Tufts lost an estimated 122,000 members and saw its reserves decline significantly, the plan is now considered relatively stable.

The financial woes of HPHC and Tufts highlighted the limited authority policy makers had to protect consumers from potentially large-scale disruptions to care. In late 1999, the Massachusetts Legislature enacted the HMO Insolvency Act, giving the state Department of Insurance authority to take over failing plans to ensure that enrollees continue to receive health care services.

Community Hospitals Struggle. After struggling for more than a decade, the financial health of Boston's community hospitals also has deteriorated over the last two years, leading two hospitals to close and threatening service reductions and closures elsewhere. Community hospitals' financial woes stem from a variety of problems. First, as in many markets nationally, hospitals in Boston have faced declining reimbursement from private and public payers, increasing labor and pharmaceutical costs and losses from unsuccessful merger and physician integration strategies. Second, patients' growing preference for the Boston area's prestigious AMCs—the so-called flight to quality—reportedly has drained community hospitals' patient base and

eroded essential revenue. According to the state, teaching hospitals' share of total inpatient discharges in the Boston area grew from 34 percent in 1990 to 42 percent in 2000. Third, all hospitals are required by the state to contribute resources to an uncompensated care pool, but many are not reimbursed for the charity care they provide.

Hallmark Health, a struggling community hospital system in the northern Boston suburbs, closed inpatient services at its 210-bed Malden campus in 1998 and announced that it would close outpatient services there in 2001. Hallmark also announced that, because of its financial difficulties, it would close Everett Whidden, a 121-bed facility in North Boston, this year. Other struggling community hospitals included Symmes Hospital, a 111-bed freestanding community hospital also in a northern Boston suburb, which closed in 1999; Quincy City Hospital, a 282-bed hospital in a southern suburb, which announced in 1999 that it would close; and a large Catholic community hospital system—Caritas Christi—which announced plans to reduce services at three of its hospitals.

These actual and threatened hospital closures raised new concerns about access to care and costs in a market historically noted for its excess hospital capacity. One concern was that closures in particular communities would limit access to care for nearby residents, especially those unable to travel. Another was that the growing phenomenon of emergency room diversions signaled the possibility of emerging inpatient capacity constraints that would be exacerbated by closures and service reductions. Finally, there was concern that community hospital closures and service reductions could accelerate the trend toward providing routine care in relatively expensive AMCs.

After Malden and Symmes closed, the public outcry led policy makers and leaders of local hospitals to save other endangered hospitals. Both the city and the state intervened with financial assistance to save Quincy City Hospital. In addition, Quincy entered into an affiliation with Boston Medical Center, a key safety net hospital system, which allowed the community hospital to remain open, though at reduced capacity. Cambridge Health Alliance, another major safety net hospital system, stepped up to help maintain services at Everett Whidden and certain essential outpatient services at Hallmark's Malden campus, with the expectation that Cambridge's higher Medicare, Medicaid and state uncompensated care pool reimbursements would help finance these services. Finally, state policy makers helped Caritas Christi keep its hospital services intact by awarding the system approximately half of the $10 million distressed hospital funds the state disbursed in 2000.

State policy makers have since taken steps to ensure that there is greater community say in reorganizing local health care services by passing a law that requires providers to notify the state and hold a public hearing 90 days before closing essential community services. Although it is unclear how far the state might push to prevent closures, the new law provides a mechanism to demonstrate the potential impact of a service cutback on the community and makes the decision-making process more transparent.

In addition, policy makers are grappling with long-term solutions to hospitals' financial problems. One strategy would involve increasing Medicaid reimbursement rates to cover hospital costs of care. A recent report commissioned by the Legislature concluded that this would cost $200 million annually. However, some observers note that pressure on Medicaid to address severe financial problems in the state's nursing home industry may take precedence over payment increases to hospitals.

AMCs' Consolidation Strategies Yield Mixed Results

Developments among Boston's premier academic medical systems also caused considerable turmoil in the market. In

Health Insurance Status

Boston	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	
8.1%	*15%*
Children under Age 18 with No Health Insurance [1]	
3.0%	*11%*
Employees Working for Private Firms that Offer Coverage [2]	
88%	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	
$198	*$181*

Sources:
1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

Boston	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	
2.7	*2.8*
Physicians per 1,000 Population [2]	
3.3	*2.3*
HMO Penetration, 1997 [3]	
46%	*32%*
HMO Penetration, 1999 [4]	
48%	*36%*

Sources:
1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes non-federal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1

Health plans, facing new pressures from providers and employers, are exploring innovative ways of managing care and controlling costs.

the mid-1990s, many Boston AMCs embarked on ambitious consolidation strategies to shore up their positions and withstand the expected growth of managed care. For one system, consolidation has caused serious financial strain, while for another it has helped to tip the balance of power away from health plans.

Some of the pitfalls of consolidation for providers are illustrated by the experience of CareGroup—a system created out of the merger of two Harvard Medical School teaching hospitals, Beth Israel and New England Deaconess, and a federation of five affiliated community hospitals. After the now-combined Beth Israel Deaconess implemented an ambitious consolidation and integration strategy, it sustained operating losses of $215 million over the past two years and lost substantial market share as dissatisfied physicians fled the system. Beth Israel Deaconess hopes to improve its position by bolstering profitable services such as cardiology and oncology and pursuing cost-cutting initiatives. However, some observers fear that Beth Israel Deaconess' sharp financial decline could have far-reaching effects on the CareGroup system as a whole. In fact, one community hospital, Deaconess Waltham, recently announced the possibility of dropping out of CareGroup—a move that may signal substantial changes for the system.

In stark contrast, the experience of Partners HealthCare illustrates the potential benefits of consolidation for providers, along with the potential downside for consumers. Partners was created in 1994 with the merger of two prestigious hospitals—Massachusetts General and Brigham and Women's—and now also includes four community hospitals and several affiliates. Partners integrated services and facilities slowly and used the strong affiliation of member hospitals and 4,000 affiliated physicians to strengthen its position in managed care contract negotiations. This strategy explicitly leveraged the strong brand-name status of the system's two flagship hospitals, while building joint bargaining power.

Over the past year, the success of this strategy from the providers' perspective became clear, as Partners won payment increases, reportedly as high as 25 to 30 percent, from all three of the major local plans:

- Partners adopted an aggressive negotiating strategy with Blue Cross Blue Shield of Massachusetts. After six months of talks, Blue Cross Blue Shield, rather than risk losing its premier provider, agreed to large reimbursement increases.
- Next, Partners turned to Tufts in late 2000, reportedly demanding close to a 30 percent reimbursement increase over three years. After three months of unsuccessful negotiations, Partners announced it would not renew its contract and advised its 100,000 patients covered by Tufts to make other arrangements for health care, threatening a major blow to Tufts as its open-enrollment period neared. Fearing disruptions for consumers, the state attorney general and an influential large employer urged the two sides to resume negotiations. The dispute was resolved nine days later, with Tufts making significant concessions to Partners.
- Finally, Partners made its case to HPHC, seeking a 28 percent payment increase over four years. Although the state attorney general weighed in again—this time out of concern for the effect of rate increases on the still-struggling health plan—Partners again succeeded in securing significant payment increases.

Partners' success in winning substantial payment increases from all three of the major plans reflects a remarkable power shift away from health plans. The system contends that years of steep discounts from health plans and reduced Medicare and Medicaid revenue left them no choice but to push back on commercial plan payment rates. Health plans caution, however, that increasing provider reimbursement will accelerate the trend toward higher premiums. From the consumer perspective, Partners' tactics have created instability by threatening disruptions to care.

HMOs Undergo Extensive Change

Facing new pressures from providers and employers, health plans are exploring innovative ways of managing care and controlling costs. Risk arrangements have fallen out of favor with providers, and health plans have begun to experiment with new product designs that can accommodate changing market conditions. Quality improvement initiatives have received added attention, in part because of urging from local employers.

Boston has one of the highest HMO penetration rates in the country, with nearly 50 percent of the population enrolled in HMOs. Boston HMOs have broad and overlapping provider networks, few restrictions on services and rely on discounted fee-for-service payment arrangements with withholds contingent on providers' meeting set utilization targets. Typically, 20 to 30 percent of provider organizations' total annual compensation is at risk. For various reasons, providers have not fared well financially under these payment arrangements, and some providers have begun to resist them.

Approximately 29,000 Medicare beneficiaries in Massachusetts had to switch plans or select new physicians over the past year because some providers were unwilling to accept risk contracts for Medicare products. Providers are also beginning to push back on risk in commercial plan products due in part to tensions over payment levels and referrals, and many observers believe this practice will become widespread. Indeed—in what may prove to be a harbinger of changes to come—Partners' recent contract with HPHC eliminated withholds that were contingent on providers' utilization patterns, replacing them with bonuses if certain quality standards are met.

Boston's employers, while accepting double-digit premium increases, have begun to demand patient safety initiatives and care management programs. The state employees' purchasing coalition, which represents 82,000 employees and approximately 250,000 people (about two-thirds of whom live in Boston), is an example. This coalition adopted the standards of the Leapfrog Group—a national organization that advocates purchasing directives that promote quality improvement—by including financial penalties in its recent contracts for plans failing to reach specified targets for reducing medical errors. Other employers have urged plans to supplement their own care management strategies with programs developed by national disease management companies to see which approaches work best.

To help manage costs, plans have adopted new product designs, including a three-tier pharmacy benefit and higher copayments for physician office visits. Some plans also are exploring the possibility of a three-tier hospital benefit in which consumers would pay different amounts, depending on where they received care.

Universal Coverage Initiative Fails but Prompts New Law

Health care advocacy organizations in Massachusetts sponsored a November 2000 state ballot initiative, known as Question 5, to require the Legislature to enact universal health care coverage for state residents, and to prohibit for-profit conversions of health care organizations and implement a patients' bill of rights. Plans and employers spent $5 million on an advertising campaign in a successful effort to defeat the measure. The narrow margin of defeat for the initiative—52 to 48 percent—was viewed as an indication of residents' continued strong support for universal health care coverage.

In July 2000, with the ballot measure vote looming, the Legislature passed a long-debated managed care reform law, known as Chapter 141. If voters had approved the November 2000 initiative, this law would have been superseded. Although Chapter 141 establishes a commission to research options for universal coverage, the main focus of the law is on patients' rights. It calls for an external

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Boston's safety net providers, in contrast to mainstream providers and plans, have been financially strong over the past two years.

review process and various other patient protections short of the right to sue health plans. In addition, it includes provisions regulating plan-provider payment arrangements. Some observers believe these payment provisions will dampen plans' and providers' willingness to participate in risk arrangements. One of the most controversial provisions of Chapter 141 is a requirement that plans send letters to enrollees to inform them, not only of services that are denied coverage, but also of services that are approved. Plans contend that this requirement is extremely costly and administratively burdensome.

Safety Net Strengthened

In contrast to mainstream providers and plans, Boston's safety net providers have been financially strong over the past two years, due in part to continued state support and sound management strategies. Expansions in Medicaid and the State Children's Health Insurance Program and a strong economy also helped to strengthen the safety net, causing the state's uninsurance rate to drop considerably. This trend may continue, given strong legislative support for raising the tobacco tax an additional 50 cents per pack to extend Medicaid coverage further.

The two major safety net hospital systems—Boston Medical Center and Cambridge Health Alliance—continue to receive the majority of the state's uncompensated care and Medicaid disproportionate share hospital funds. In addition, each hospital system's Medicaid managed care plan has grown because of Medicaid expansions and entry into new markets outside Boston. Indeed, the financial strength of these hospitals was evident in their ability to step in and help bolster the area's struggling community hospitals.

Community health centers (CHCs) in Boston have become more financially stable over the past two years, thanks to additional state funding and new organizational and management strategies. CHCs benefited from more than $38 million in new state funding, as well as increased Medicaid payment rates for dental services. Although the state's largest CHC, East Boston Neighborhood Health Center, declared bankruptcy in 1999, it is recovering with the help of federal and state aid and improved fiscal management. Finally, some CHCs have merged or formed alliances to share overhead expenses and have established relationships with hospital systems to obtain assistance for capital improvements such as information systems.

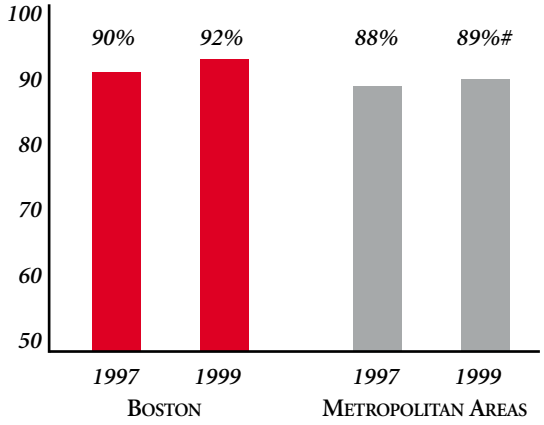
Issues to Track

Financial difficulties among Boston's health plans and providers and contentious contract disputes since 1998 have resulted in higher premiums for employers and higher out-of-pocket costs and increasing network instability for consumers. HMOs have begun to change considerably, and though use of risk arrangements and tightly managed products is waning, there is increased interest in care management and quality improvement activities that hold promise for the future. As the Boston market continues to evolve, several issues warrant tracking:

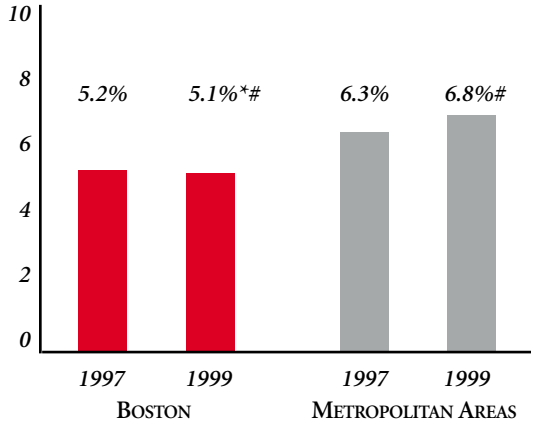
- Will plans and community hospitals continue to experience financial instability, and, if so, what effects will this have on the makeup of the health system and continuity of care for consumers?
- Will threats of care disruption from health plan-provider contract disputes become a routine phenomenon in the Boston health care market, and, if so, what will the impact be on costs and consumers' access to care?
- How will employers respond to rising premiums, and what effect will their response have on health plan products?
- Will the state be able to maintain its high levels of care and coverage for low-income uninsured despite a potentially slowing economy?

Boston's Experience with the Local Health System, 1997 and 1999

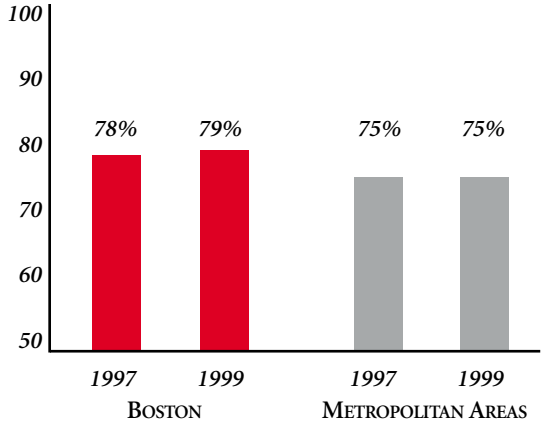
Persons Satisfied with the Health Care They Received in the Last 12 Months



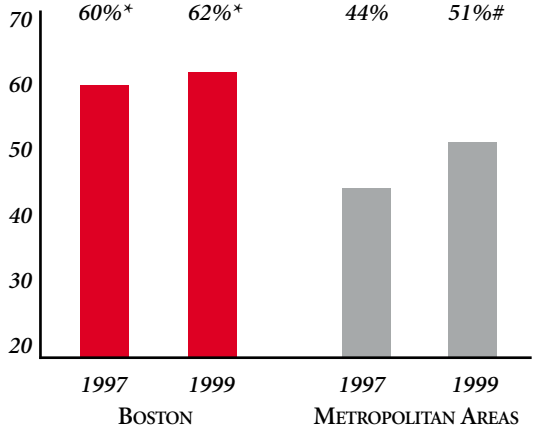
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



Physicians Agreeing that It Is Possible to Provide High-Quality Care to Their Patients



Persons with Insurance that Requires Gatekeeping



** Site value is significantly different from the mean for metropolitan areas over 200,000 population.*
 # Statistically significant difference between 1997 and 1999 at p< .05.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.

The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in Issue Briefs, Data Bulletins and peer-reviewed journals. These publications are available at www.hschange.org.

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