Summary 1

The Twin Cities (Minneapolis and St. Paul, Minnesota) are frequently identified as a community where a competitive health care market has developed. Consequently, they have been the focus of a substantial number of empirical studies through the years and have sometimes served as a '*model" for various elements of cument "managed competition" approaches to health care reform. If, indeed, the Twin Cities are at the vanguard of managed competition in health care, it is important to understand how their health care delivery system has evolved over the past two decades, why it is now undergoing a relatively dramatic transformation, and the effects of these changes. [1]

MANAGED CARE AND INTEGRATED DELIVERY SYSTEMS IN THE TWIN CITIES

The health care delivery system in the Twin Cities is best known national] y for its reliance on health maintenance organizations (HMOs), and for the proportion of community residents enrolled in HMOs. A variety of hypotheses have been offered in explanation of why HMOs were formed and prospered in the Twin Cities, but no definitive answer to this question is possible. It is clear, however, that during the past two decades HMO enrollment grew rapidly. From .197.1. to.1978, HMO enrollment grew at an annual rate of 27 percent. Enrollment continued to grow during the 1980s, reaching 50 percent of the population by the end of the decade.

[1] This background paper focuses on the organization of health care delivery and on health care costs and although it discusses issues such as consumer satisfaction, health outcomes, and access, and recognizes that these are critical issues, it does not focus on these issues.

The HMOs in the Twin Cities encompass a variety of organizational forms and sponsorship arrangements, with most physicians affiliated with one or more HMO by the early 1980s. The 1980s saw important changes in Twin Cities HMOs and their relationships with providers. These changes included the development of new products, such as preferred provider organizations, and the institution of more aggressive management strategies, such as concentrating patients at lower cost hospitals.

A number of HMOs merged during the 1980s and as a result of the merger activity it appears likely that three or four large organizations will dominate health care delivery in the Twin Cities. Managers of Twin Cities' health plans point to the recent passage of state health reform legislation (Minnesota Care), with its emphasis on the formation of integrated delivery networks, as an important catalyst for consolidation. However, the trend toward consolidation began prior to MinnesotaCare, in part in response to the demands of employers as interpreted by health plans. Employers encouraged HMOs to develop a range of benefit options, and to broaden the geographic coverage of their networks. One way for an HMO to expand geographically was to merge with another HMO. Some employers also believed that larger HMOs had greater potential to efficiently integrate service delivery. The responsiveness of HMOs to employer concerns was heightened by the formation of a series of buyers' coalitions among private firms and the adoption of a new buying approach by state government for its employees.

In addition to HMO consolidation, the 1980s witnessed considerable consolidation among Twin Cities' hospitals. Four major, multihospital systems were formed in the late 1980s through a series of consolidations and mergers. Some hospitals reported pursuing the development of multihospital organizations as a means of negotiating more effectively with HMOs over prices and of positioning themselves to offer broad geographic coverage for HMO enrollees.

DEVELOPMENT AND ROLE OF PURCHASING COALITIONS

During the past decade, several private and public employers in the Twin Cities made significant changes in the way they purchase health care. One often-cited example is the formation of the Business Health Care Action Group (BHCAG), a consortium of major private sector employers in the Twin Cities. In 1991, these self-insured firms joined together to create a new health plan option for employees and dependents. Through an extensive negotiation process, one plan was selected by BHCAG. BHCAG has taken a very proactive approach to the delivery of health care to its employees. It is actively collaborating with the health plan in the development of practice guidelines, and the institution of programs to improve quality of care.

A second approach to buying is exemplified by the State of Minnesota's Group Insurance Program, which covers 144,000 individuals, including employees, dependents, and retirees. Until 1985, this program offered health benefits in much the same way as many other large employers. Its contribution to premiums was tied to the premium for the fee-for-service insurance option in the program. In 1985, the state consolidated its HMO offerings and instituted a new contribution formula under which employees were required to pay the premium difference out-of-pocket if they did not enroll in the low-cost plan. The 1985 reforms were followed by a substantial shift in enrollment from traditional indemnity plans to managed care plans. Over time, HMO premiums declined relative to premiums of other options, and recently the overall rate of increase in premiums has been quite low. Two other purchasing programs, directed at individuals and smaller employers, have been initiated recently. The state legislature created the Minnesota Employees insurance Program (MEIP) as part of the 1992 MinnesotaCare legislation. Private businesses with two or more employees are eligible to enroll their

employees in MEIP. Four health plan options are available, and employers must pay at least 50 percent of the premium for single coverage, but cannot pay more than 100 percent of the cost of the lowest priced plan. The Minnesota Employers' Association is a nonprofit association of approximately 1,300 businesses that offers a health insurance program to its members. Services are delivered through a preferred provider network currently managed by the Prudential Insurance Company and enrollment consists of approximate y 5,000 employees and dependents. Because these programs are so new, it is difficult to predict the ultimate impact of the MEIP and Buyers Coalition efforts.

MINNESOTA CARE

In concert with the rapid developments in the private sector, the Minnesota state legisture has been pursuing major reforms which are likely to have a significant effect on the Twin Cities market. In 1992, the Minnesota state legislature enacted Minnesota Care. The general objective of Minnesota Care is to enhance the availability of insurance for uninsured people in the state, while at the same time reducing health care cost increases. Although the legislation is still evolving, as it now stands it aims to encourage the development of integrated service networks (ISNs), to be formed by providers or purchasers of medical care, with the charge of providing a comprehensive set of health services to a designated population for a prospectively set budget. The State Health Commissioner has the power to approve ISN arrangements and can issue state exemptions from antitrust liability that might arise in forming such relationships. Each ISN will be subject to an overall limit on the rate of growth in its annual expenditures. A regulated all-payer option will apply to providers delivering health care outside an ISN. In addition, Minnesota Care will create limits on total state health care spending, and the Commissioner of Health is charged with enforcing annual limits on the rate of increase in health care costs.

HEALTH CARE EXPENDITURES IN THE TWIN CITIES

Given the dramatic transformations in the Twin Cities health care market, how do health care expenditures in the Twin Cities compare with other metropolitan areas? Two recent studies have found that the level of health care expenditures is lower in the Twin Cities than in other metropolitan areas, while a third study found the opposite. Unfortunately, all three of the studies have serious flaws. None controlled for differences in benefit coverage, nor the size and characteristics of groups in the metropolitan areas. Moreover, one study only looked at indemnity insurance and excluded HMO coverage. Another only compared costs across *selected* cities (e.g., omitting Boston, Massachusetts, and Washington, DC).

Some data indicate that health care costs and expenditures in the Twin Cities may be rising at a slower rate than in the nation as a whole. The medical price index in the Twin Cities was above the national average from 1981 until 1987. However, since 1987 it has been below the national average. One study found that between 1971 and 1990 the annualized rate of increase in hospital costs per capita in the Twin Cities was 10.0 percent, compared with 11.2 percent nationwide. Overall, the evidence on health care costs in the Twin Cities is limited and, in some cases, contradictory. Whether expenditures for health care in the Twin Cities are higher or lower than in other metropolitan areas is unclear.

Another important question is how HMOs have influenced the level of health care expenditures in the Twin Cities. Several studies done during the late 1970s and early 1980s examined how HMO enrollment in the Twin Cities affected health care costs. Because they used data from different sources and covering different time periods, the results of these studies are sometimes difficult to reconcile. In general, however, it appears that studies based on data from the late 1970s and early 1980s offer little support for the hypotheses that HMO growth and competition among HMOs

would control premium increases or induce community providers to contain their costs. For example, group and staff HMOs during this period appeared to benefit from a "favorable selection" of relatively healthy enrollees. As a result, one study concluded that employers who offered employees a choice of HMOs and fee-for-service insurance plans saw total health insurance costs increase. Other studies found that the hospital market for HMO enrollees was not price competitive in the late 1970s.

Studies conducted using data from the mid-to-late 1980s present a somewhat different picture. Group and staff model HMOs appeared to concentrate their patients at selected hospitals, with the price of hospital services playing an important role in the selection of hospitals. Lengths of hospital stays for enrollees in these plans were significantly shorter than for indemnity plans. Although these results suggest that health care expenditures may be reduced as plans deal more aggressively with providers, no recent studies have directly examined the effect of these changes on health care expenditures in the Twin Cities.

Some evidence, although imperfect, suggests that HMO enrollment may have contributed to the reduction in hospital beds in the Twin Cities. Although hospital capacity declined nationwide during the 1970s and 1980s, hospital capacity in the Twin Cities declined even more dramatically and has continued to decline in the 1990s.

RELEVANCE OF THE TWIN CITIES EXPERIENCE

The well-known limitations of the ● "case-study" methodology suggest that drawing general conclusions from the experience of the Twin Cities health care market is difficult. However, several tentative conclusions are suggested by the health care delivery system's evolution and performance in the Twin Cities. They are:

- Development of managed competition is likely to be associated with reconfiguration of community hospitals, such as the creation of multi-hospital systems.
  - Managed care organizations will respond competitively to even moderately sized purchasing coalitions, for example, by merging to provide greater geographic access.
- Organization of the demand side of the health care market under managed competition is likely to encourage the consolidation of providers and managed care plans, suggesting that specific public and private sector strategies may be needed to maintain a competitive market structure.