Relevance of the Minnesota Experience

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This background paper has described the evolution of the health care system in the Minneapolis/St. Paul metropolitan area and has summarized the evidence regarding its performance. It has relied on published accounts of the development of that system, published empirical analyses of behavior and outcomes, and information collected through recent interviews with community informants. As such, it has many of the characteristics of the classic "case study," including some of the well–known limitations of this approach (7). The strength of a case study approach is that it can provide an in-depth understanding of how a community's delivery system evolves over time, identify the key events in that evolution, and describe the roles played by specific actors or organizations (30). However, case studies have several generic limitations that can restrict their usefulness. One limitation is that particular readers of a case study may find it does not provide enough detail on the issues that are of primary interest to them. For instance, hospital administrators may find that the case study lacks depth in the discussion of hospital motivations and roles, or employers may not find sufficient detail to inform them about specific actions taken by Twin Cities' employers to stimulate system change. This limitation is largely unavoidable. No case study can provide enough information to satisfy the interests of all potential readers without becoming so complex that it obscures the essential components of the story. Case studies can, however, set the stage for further, more focused analyses of issues that are of particular interest to different stakeholders by providing a useful overview of events and how they are interrelated.

Perhaps a more important limitation relates to the generalizability of case study findings. The dangers of generalizing from the findings of a single case study have been discussed at length in the evaluation literature (e.g. Wilson, 1979 (68)). Presumably, generalization is less risky when the comparison environment is similar in its characteristics to the case study setting. However, it is not always clear which characteristics are relevant in determining degree of environmental similarity or dissimilarity. For instance, is the health care market in Chicago similar to the Twin Cities because both contain multiple HMOs, or is it dissimilar because the population of Chicago is much larger and the employer community in Chicago is more fragmented? Obviously, determining the implications of the Twin Cities' experience for the nation as a whole is even more complicated than assessing its relevance to a single other metropolitan area.

IMPLICATIONS FOR MANAGED COMPETITION REFORMS

While the need to be cognizant of and sensitive to the dangers of generalizing from the Twin Cities' experience is obvious, there may be elements of that experience that *do* have implications for health care reform on a national scale. The remainder of this section briefly highlights and discusses several tentative conclusions suggested by the evolution and performance of the health care delivery system in the Twin Cities.

Development of managed competition is likely to be associated With reconfiguration of community hospitals, such as the creation of multihospi - tal systems.

During the 1970s and 1980s there was a reduction in the number of hospital beds nationally. During this period, hospital capacity in the Twin Cities declined even more dramatically and has continued to decline in the 1990s. As recently as January 1994, a large hospital system in the Twin Cities announced the closure of one of its hospitals for financial reasons. The increased enrollment in HMOs during the 1980s has been cited by hospital administrators in the Twin Cities as one of the reasons for reductions in community hospital capacity, both because inpatient use has declined with increasing HMO enrollment and because hospitals have been forced to contain costs by reducing capacity in order to offer price–competitive contracts to HMOs.

While the specific contribution of increased HMO enrollment to reductions in the number of hospital beds in the Twin Cities is difficult to determine in any rigorous way, the chain of events appears reasonably clear. Managed competition as structured in the Twin Cities first reduced demand for inpatient hospital services and then created price competition among hospitals for the patients of managed care plans. Hospitals responded by consolidating their operations into a relatively small number of systems in order to negotiate more effectively with HMOs and to facilitate the closure or conversion of individual facilities toreduce acute care capacity. Interview respondents associated with hospitals strongly believed that the reduction in acute care beds would continue, possibly resulting in a decline of over 50 percent in the next decade. Several respondents noted that hospital utilization would probably fall to about 200 days per 1,000 population within the next five years. From a strategic standpoint, survival in this environment has increasingly been viewed by hospitals as dependent on the establishment of strong linkages with managed care organizations or group practices, through merger or long–term contracts. Consequently, while the reconfiguration of the hospital system in the Twin Cities largely focused on the formation and merger of hospital systems in the 1970s and early 1980s, the restructuring that is now occurring has shifted to the vertical integration of hospitals, physicians, and insurance plans.

Managed care organizations will respond competitively to even moderately–sized purchasing coalitions, for example, by merging to provide greater geographic access.

In the Twin Cities, the Business Health Care Action Group (BHCAG), the State of Minnesota (group Insurance Program, and the Employers Association's Buyers Coalition all appear to have

influenced the delivery of health services to their enrollees. The BHCAG precipitated the merger of two large HMOs and stimulated collaboration among several provider groups, including the Mayo Clinic, in the development of practice guidelines. The Buyers Coalition has negotiated a long–term contractual relationship with a major insurer, instituting a total quality management approach and limits on premium increases. The State of Minnesota Group Insurance Program has managed a multiple health plan benefit offering with a fixed dollar contribution tied to the lowest priced health plan, and recently has benefited from declining increases in health plan premiums.

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 provider sector strategies maybe needed to maintain a competitive market structure.

Organizing the demand side of the health care market often entails offering consumers discrete choices among standardized health care coverages with the consumer bearing the additional cost associated with the more expensive option. A '"sponsor" or purchasing alliance aggregates purchasing power and manages the processes of enrolling individuals into health plans and contracting with health plans. This organization of demand is intended to create pressure on health plans to control their premium increases. Recently, it appears to have been successful in the case of the State of Minnesota Group Insurance Program.

The Twin Cities' experience suggests that providers will respond to greater organization on the demand side with greater aggregation of supply. When the demand side of the market is organized, health plans have the potential to secure larger numbers of enrollees under each contract. Their control (actual or potential) over larger numbers of patients gives them greater leverage in contracting with providers. Providers quite naturally respond by consolidating to counterbalance the negotiating power of health plans and/or by affiliating with plans through mergers or long–term contracts. In the absence of antitrust actions (or, when state anti-trust policy facilitates consolidation), and with the encouragement of buyers' coalitions that value broad geographic coverage from contracting provider networks, the consolidation of the supply side of the market can occur relatively quickly, as it has recently in the Twin Cities.

The consolidation of the supply side of the health care market could benefit consumers in several ways. It creates the potential for the reduction of excess capacity and the achievement of efficiencies in service delivery. At least some of the gains from these effciencies may be captured by payers and consumers in the form of the lower premiums, if buyers coalitions are able to use their bargaining power effectively in negotiations with health plans. These coalitions may also be able to use their bargaining power to achieve improvements in the quality of care, and to effect changes in the way care is delivered. Ultimately, while consumers may have more restricted choices among health plans and fewer options in their benefit coverages, these drawbacks may be offset by the gains they experience due to improved quality and/or lower prices resulting from the efforts of the buyers' coalitions. This is thought to be particularly true for small firms, where it may not be feasible to offer employees multiple health plans under any circumstances.

The buyers* coalitions in the Twin Cities are aware that consolidation of the supply side of the health care delivery system poses risks in the longer term. Specifically, unless entry of new health plans into the market remains feasible, coalitions may become ● *locked into" their existing plan offerings and find their leverage in negotiations with these plans diminishes over time. In the Twin Cities, the existence of multiple buyers' coalitions helps to reduce the likelihood this will happen. Also, as described previously, at the present time the affiliations among providers and health plans are not exclusive. This permits some flexibility in the market that could allow development of new, competing plans through realignment of provider groups. However, the general issue remains an important one with far–reaching

implications. Feldman, using an econometric model to predict impacts, estimated that the benefits consumers receive from the purchase of health insurance could decline by 4 to 5 percent in the Twin Cities as a result of the Group Health/MedCenters merger (20). While Feldman acknowledges several limitations in his approach, his analysis nevertheless highlights the difficult policy issues raised by consolidation of the supply side of the health care system (20).

Feldman argues that aggressive enforcement of antitrust laws is needed to ensure that mergers among health care organizations benefit consumers and are not anti-competitive (20). However, some interest groups in the Twin Cities have called for very different initiatives in response to recent supply–side consolidation activity. Senior citizen advocates have characterized the consolidation as evidence that the '*managed competition" approach to health care reform in the Twin Cities is not tenable, and that stronger regulation of providers under a "single–payer" approach is needed. Clearly, "managed competition" reform efforts will need to develop an explic it strategy for creating and maintaining a competitive structure on the supply side of the market through public policy (e.g., antitrust), or through the management policies of purchasing coalitions and large private purchasers. Without such a strategy, the effectiveness of managed competition will be open to question and its political viability in the long-run as an acceptable approach to health care reform will be threatened.

CONCLUDING COMMENTS

Previous studies of the Minneapolis/St. Paul health care market (e.g. see Anderson, et al., 1985 (6)) have noted several characteristics that may have facilitated early support for the. HMO.model of health care delivery. These include participation of a substantial proportion of physicians in group practices, a relatively homogeneous culture, civic leadership provided by a small number of large corporations, and entrepreneurial efforts of several HMO supporters. To the degree that these factors were important in the early stages of HMO formation, they probably also contributed to the development of a mature HMO market more quickly in the Twin Cities than in most other metropolitan areas. This in turn contributed to the consolidation of the hospital market, putting building blocks in place for the very rapid aggregation of providers and health plans that is now occurring. One clear stimulus to these recent events—the actions of buyers' coalitions—would seem replicable in other areas, as these coalitions now are commonplace in most large cities and quite active in many. However, the ability of providers to respond quickly to attempts to organize demand is likely to vary across communities, depending on existing configurations of local health care delivery systems. While it seems clear that the actions of purchasing coalitions can contribute to the restructuring of relationships among health care providers, they may take longer to have an impact in communities where providers lack supportive organizational structures and have little experience in managed care.

A second important caveat relates to the inevitable difficulties encountered in attempting to identify and describe the important features of a health care market when that market is in a period of rapid transformation. While the description in this report of market evolution in the Twin Cities covers the period through the beginning of 1994, continuing change appears likely, at least in the near term. There is the possibility that the observations contained in the report have been distorted by the swiftness of the change that is now taking p l
to attempts to learn from most other health care markets during the current period of restructuring that has been stimulated by state and national health care reform initiatives.