Ten Years of Tracking Health System Change: The Evolution of Competition

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Ten Years of Tracking Competition

- 1995: Community *Snapshots* Study
  - 15 researcher-selected communities
  - 1996 thematic issue of *Health Affairs*
- 1996-present: Community *Tracking* Study
  - 12 randomly-selected metropolitan areas
    - Total of 60 communities for surveys
    - Methods: *Inquiry, Health Services Research*
  - Round 4 site visit contribution to 2004 thematic issue of *Health Affairs*
- Interviews, essays, presentations to interpret developments

Competition in 1995 (1)

- Employer-based health insurance
  - Completion of rapid shift to managed care
    - 73% in 1996 compared to 27% in 1988 (KFF/HRET)
    - HMO the largest plan type (31%) in 1996
  - Richer benefit structure from shift to managed care
    - Philosophy of minimal patient financial barriers
    - Utilization constrained by “professionals”
  - Leading employers selecting local HMOs in each community

Competition in 1995 (2)

- Health insurance industry
  - Period of aggressive expansion into new markets
    - Hospital-sponsored plans
    - Medicare market seen as most lucrative
    - Notion that only top 3-4 plans in each market viable
      - Last opportunity to become leading plan in a market
    - Classic underwriting cycle pattern
      - Industry has declining financial returns

Competition in 1995 (3)

- Restrictive managed care products
  - Narrow provider networks
  - Aggressive utilization management tools
    - Gatekeeper requirements
    - Prior authorization for hospitalizations, major diagnostic procedures specialty referrals
- Hospital industry
  - Substantial consolidation
    - Fear of competition from Columbia-HCA
    - Improve leverage with managed care plans
    - Notion that independent hospitals not viable

Competition in 1995 (4)

- Hospital acquisition of primary care practices
- Excess capacity from declining utilization
- Weak bargaining position
  - Risk of exclusion from network
- Vigorous cost cutting
  - BBA on horizon
  - Concessions to private payers
  - Declining volume

Competition in 1995 (5)

- Physician practices
  - Formation of primary care and multispecialty groups
    - Rise of primary care physicians
  - Formation of IPAs and PPMCs
  - Capitation contracting
  - Weak leverage with managed care plans
- Cost trends at historic low
  - Declining hospital utilization
  - Low hospital and physician price increases
  - Beginning of sharp increases in prescription drug trends

Summary of Competition in 1995

- Financial incentives for providers—not consumers
- Narrow networks reduce provider market power
- Market entry leads to lower margins for insurers
- Optimism about potential future of competing integrated delivery systems

Aftermath of Rapid Growth: Backlash Against Managed Care

- Many recent enrollees had not chosen to switch to managed care
  - Absence of prospective gains to offset restrictions
- Fears of excessive restriction of needed care
  - Emphasis on choice of provider
    - Keep current physician
    - Easy access to specialists

Market and Policy Responses (1)

- Employers respond vigorously
  - Companies profitable
  - Labor markets tight
  - Lack of perception of cost implications
    - Individual versus market level
- Less restrictive managed care products
  - Broader provider networks
  - PPOs instead of HMOs
  - Drop authorization requirements
  - Direct access to specialists

Market and Policy Responses (2)

- Patients bills of rights
  - Appeals procedures
  - Minimum hospital stays
  - Right to sue plans
  - Limits on gatekeeper requirements
  - Rules on network adequacy

Markets Post-Managed Care (1)

- Financial incentives for neither providers or consumers
- Reversal of nascent moves to integrated delivery
  - Failure to get past organizational changes
  - Broad network requirements limit potential
- Specialists regain dominance
- Hospitals gain leverage over plans
  - Tight capacity
  - Broad network requirements

Markets Post-Managed Care (2)

- Insurers unwind unsuccessful entry into new markets
  - Cross market mergers
  - Smaller insurers lose ground to larger ones
  - Profit margins increase
- Cost trends rise
  - Sharp but brief increase in utilization trends
  - Labor market pressures lead to wage increases
  - Extreme increases in prescription drug spending
  - Premium increases in excess of underlying cost trends

Recent Market Developments

- Employers increase patient cost sharing
  - Sharpest increases for drugs
  - Unwillingness to return to restrictive managed care
- Vision of consumer-driven health care
  - Tax incentives for high-deductible plans
  - How large is the potential?
- Concerns about consolidation
  - FTC attempts to control hospital mergers
  - Growing insurer consolidation
    - Tolerated when seen to benefit consumers

Potential Market Developments (1)

- Maturation of patient financial incentives
  - Beginning of recognition of limits to approach
  - Refinements of benefit structures
    - Incentives to use more efficient providers
    - Distinctions between standard regimens of care versus discretionary
- Return of utilization controls
  - Emphasize those that can be supported by physicians
  - Restrictions on imaging

Potential Market Developments (2)

- Medicare focus on increasing accuracy of its prospective payment systems
  - Developing political constituency
  - Private insurers follow Medicare
- Information technology becomes significant and begins to reshape markets
  - Potential for dominant health plans to become the provider of IT
  - What are implications for small practices?

Potential Market Developments (3)

- Continued hospital consolidation driven by needs for capital
  - Access to capital: the haves and the have-nots
  - Potential shift to for-profit ownership
- Hospitals retain power but exert it more cautiously
  - Threat of FTC challenge to past mergers
  - Restoration of “adequate” margins

Conclusion: Ten Years of Market Change (1)

- Some changes have appeared cyclical
  - Role of patient financial incentives
  - Utilization controls
  - Insurer/provider leverage
  - Employer attention to cost issues
- Other changes have been secular
  - Increasing consolidation
    - Providers
    - Insurers

Conclusion: Ten Years of Market Change (2)

- Vision of providers competing on value
  - Demonstration of sharp differences in outcomes and costs
  - But current structures an obstacle
  - What must be done to bring it about?

- Will competition be part of future of health care?
  - Are markets already too consolidated?
  - Is there a change on horizon with potential to disrupt consolidated markets?
  - Will public embrace or reject competition?