

**MARKETS AND PLAN PERFORMANCE: CASE STUDIES OF  
IPA AND NETWORK HMO**

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## EXECUTIVE SUMMARY

Independent practice association (IPA) and network model HMOs now dominate the HMO industry and have accounted for most of the industry growth during the 1990's. These plans build their managed care organizations on financial incentives and contracts with community physicians, hospitals, and other medical service providers. As the plans grow and penetrate ever deeper in insured markets, their rapid expansion critically affects local health care systems.

This report summarizes findings from case studies of six plans and three markets that grew out of an initial analysis of financial and enrollment performance of IPA and network plans over a five-year period (1988-1992) in Boston, Los Angeles, and Philadelphia. The case studies were based on field interviews which took place from April to July 1994 and analysis of available documents on local markets and individual plans. The study's two central goals were: 1) to examine emerging issues as the managed care industry and IPA/network plans evolve and differentiate; and 2) to develop a better understanding of the relationship between performance and market pressures, structural variations, and organizational characteristics.

Key findings include:

- **Risk for the costs of care are being shifted to the physician or physician group level.** In the three markets studied, IPA and network plans are evolving away from financial contracts that initially retained discounted fee-for-service payment of physicians to arrangements that shift risk for the costs of care to the physician or physician group level. In Los Angeles, a market with a long history of relatively large groups of primary care physicians, physicians are taking the full financial risk for speciality and even hospital care as well as services they deliver directly. In all three markets, plans are moving toward delegating control of practice guidelines, referrals and subcontracts where they shift financial risk for a full range of medical services.
- **Public policy lags market developments.** State regulators are concerned about the implications of widening risk contracts for quality of care and financial solvency. Pressures to approve permissive capitation arrangements are mounting as physicians and physician/hospital groups seek to gain control of budgets and rules, and plans seek to shed risk.
- **Relatively successful plans shared organizational characteristics in the three markets.** In the five years through 1992-93, plans in the case studies with relatively more successful financial performance shared four general organizational characteristics: a provider- friendly and physician-focussed philosophy; decentralized medical management; stable management, with a reputation for excellence; and a primary focus on developing an IPA/network HMO business. Early entry into the market also helped. In contrast, during the 1988-1992 period, size and financial backing, often by large indemnity fee-for-service focussed insurance companies, appeared of mixed benefit: insurance company

sponsorship hindered the HMO plans' independence and ability to mature to financial health without subsidies, as well as helped sustain the plans' survival.

- **Market success appears at best only weakly linked to quality of care provided.** Plans with relatively poorer reputations continue to grow. However, all three markets lacked systematic information for purchasers or individual patients on the quality of care provided by plans and their comparative market performance.
- **Employer demands for fewer plans covering broader markets are increasing market pressures that favor size over past performance.** Plans are merging and acquiring bases in new markets in order to offer coverage to larger employers. Plans also see size as a competitive advantage in negotiations with physicians and physician/hospital groups.
- **The pressure to grow may undermine characteristics that in the past were associated with stronger reputations.** Pressure to grow appears more motivated by being in a position to exert market power than by gains in plan ability to provide quality care or to invest in internal systems.

More generally, the case studies lead to the conclusion that as competition intensifies, there is a critical need for readily available, quality of care measures. Such information is an essential pre-condition for forging a stronger, positive link between market success and a reputation for quality patient care. Consolidating markets will make it increasingly difficult to rely on meaningful choice as a way to assure quality.

## INTRODUCTION

IPA and network model plans now dominate HMO industry enrollment nationwide.<sup>1</sup> After entering the market as a new concept in the late 1970s, IPA and network model HMOs by the end of 1994 accounted for nearly seventy percent (69%) of total HMO enrollment and 80 percent of all plans.<sup>2</sup> Together, the two types of plans enrolled some 35 million members and accounted for most of the industry growth in recent years.<sup>3</sup> Most recently IPA/network growth has accelerated to over 11 percent annually while group and staff model plans have stagnated.

The success and the rapid expansion of IPA/network HMO plans are having a critical effect on the reorganization and restructuring of the health care delivery and financing systems underway in most parts of the country. Yet, despite IPA and network plan growth and influence, few studies have focused on IPA/network HMO financial or operational performance. Although periodic industry reports provide some comparative statistics by plan type, past research studies treated IPA and network HMO plans as a cohesive group rather than differentiating among plans. As a result, little is known about structural variations within IPA and network plans or how different organizational characteristics affect market performance.<sup>4</sup>

This study seeks to enhance our understanding of the operational and organizational characteristics associated with more and less successful IPA/network model HMO market performance. The study has two central goals: 1) to provide insight into issues emerging as IPA and network plans evolve in intensely competitive markets and; 2) to develop a deeper understanding of those market and organizational characteristics that affect the performance of IPA/network HMOs, paying particular attention to common characteristics associated with more successful IPA/network plans.

The results reported below draw on market analysis and case studies of IPA and network HMOs operating in three geographic areas. The case studies complement and are a subset of a broader, ongoing study of the financial performance of IPA and network model HMOs in three metropolitan areas during the period 1988-1993.<sup>5</sup>

## **METHODOLOGY**

To select the three geographic areas, cities were initially profiled according to extent of managed care market penetration, the presence of multiple IPA or network plans (at least 7 competing plans), and availability of adequate data from public sources. As illustrated by Tables 1 and 2, the three study areas each had significant HMO penetration, a well-developed and growing managed care industry, and a sufficient number of competing plans for analysis.

Financial and membership public filings were then collected from state regulatory agencies for IPA or network plans operating in the geographic market. For a plan to be included in the data base, the organization had to be operational for at least five years (1988-92) with completed information available for all five years from the public agency. The initial study population was comprised of approximately 30 HMOs, divided fairly evenly among the three cities.

Prior to undertaking the case studies, we analyzed the financial and enrollment performance of the IPA and network HMOs over the five year period 1988-1992. Financial and enrollment information reported to state agencies was supplemented by organizational structure profiles published in Group Health Association of America and Interstudy HMO Directories. In addition, we surveyed all plans by phone to determine predominant methods of paying primary care physicians, specialists, and hospitals.

Analysis of financial and membership data was used to identify HMOs that had relatively superior performance and those whose performance was less competitive over the time period. Based on this analysis, we selected two IPA/network plans in each city for more detailed study, for a total of six case study plans. In each city, one HMO was categorized as relatively more successful financially than the other, its competitor, either on an absolute basis or in terms of trends. However all six HMOs are financially robust and quite successful in the marketplace. We initially hoped to include financially weak HMOs in our case studies, but found that, of the 30 plans in our data base, most of the truly weak plans had already merged by the time we were ready to do the cases. Thus we chose to study two of the largest competitors in each area, and

have classified one as more successful than the other in relative terms. Table 3 presents a few summary financial statistics for the 6 plans as well as membership growth rates.

We conducted field and telephone interviews with HMO managers, physicians, hospital representatives, purchasers and regulators to develop case studies of plans and market areas. Those interviewed were promised confidentiality to encourage frank discussion and elicit comparative, qualitative assessments of competing IPA and network plans in the context of the broader markets. We augmented personal interviews with internal and published financial and organizational documents, including investment analyst reports, published studies, and media accounts.

Six background case studies were prepared of the individual plans along with a general market study for each of the three market areas. One of our key objectives was to develop a clear understanding of the local market in which each HMO operated. The study sought to understand how markets have influenced HMO developments as well as how the HMOs have shaped their markets.

The background studies followed a standard outline, describing the managed care market in each area, including provider capacity and organization, health care costs and utilization, the managed care regulatory climate, and an analysis of the performance of each HMO. A brief summary of the background market analysis is included in Appendix A.

## **FINDINGS**

Major findings of the case studies of IPA/network plans and their market clusters are summarized in this paper. We have categorized them into four topics:

- The Interaction Between Plans and Local Market
- Shared Attributes of More Financially Successful Plans
- Quality and Market Success: Are they linked?
- Implications for the Future

### **Interaction Between Plans and Local Markets**

IPA and network model HMOs contract with physicians, hospitals and other providers to provide services in the local community. IPA/network plans historically have entered into non-exclusive, short term financial contracts with providers in the community. To succeed such plans compete for provider contracts as well as members.

The three areas differed markedly in the market structure of providers and insurance industry. Table 1, Table 2, and Appendix A, provide descriptive comparisons of physician organization, hospital industry organization, traditional insurance markets, HMO industry structure, and resources per population. These differences have significant influence on the structure and operation of the HMO industry as a whole as well as upon individual IPA and network plans.

Three market characteristics appear to have the most important and long lasting impacts: the organizational structure of physicians; the structural characteristics of the insurance industry, including traditional carriers and early entrant, dominant HMOs; and public regulations. The following discussion highlights case study findings regarding each of these market influences.

*The structure of the local physician market has been a key determinant of the structure of IPA/network HMOs: IPA/network HMOs have initially adapted to the structure of the provider market rather than shaped it. The direction of influence begins to change only as HMOs gain significant market share.*

In particular, the HMOs' methods of paying physicians were shaped by the historical structure of physician practice in each area.

In two of the market areas (City 1 and City 2), most physicians were organized in solo practice or small groups. The stability of the population in each area contributed to the structure of physician practice; both areas had little population growth, and a high proportion of patients had long-standing relationships with their physicians. To enter these markets, the IPA/network model HMOs adapted to the configuration of physician practice by structuring themselves to directly contract with individual physicians. Physicians were paid using either fee-for-service (City 1) or primary care capitation (City 2). In turn, the direct-contract and payment methods permitted the independent physician in private practice to flourish.

In contrast, most physicians in the third market area, particularly primary care physicians, practiced in groups, many of which were very large. This configuration of physician practice had its historical roots in the area's rapid population growth and expansion into geographic areas which had few medical resources, particularly hospitals. As a result, the physician groups provided the capital necessary to develop laboratory and other ancillary services not available from hospitals.

The pre-existence of large physician groups provided IPA and network HMOs with unique contracting opportunities, including an ability to adopt broad capitation arrangements and shift risk and organizational functions down to physician groups. Physician groups also served as an impetus and a model for solo physicians to form "individual physician associations" (also called IPAs) and other such legal associations of physicians so that they too could contract with HMOs on a group rather than on an individual basis. As a result, IPA and network plans in Area 3 built networks based on contracts with groups rather than individual physicians. These organizations provided a ready administrative and financial base for capitation contracting for the wide range of services offered by the group.

Most recently, market pressures on physicians appear to be converging across the three areas. In reaction to growing HMO market penetration, physicians and hospitals in all three markets were discussing horizontal and vertical arrangements with other providers in an effort to create "integrated" systems of care. However, although the pressures of change in the physician markets were similar, as of 1994, organizational forms and IPA/network plan internal structures continue to differ significantly across the three markets.

*The historical structure of the insurance market had a major effect on the structure and development of IPA/network HMOs.*

Two of the insurance markets were dominated by Blue Cross-Blue Shield plans. In these two markets the Blues' market shares historically exceeded fifty percent. As dominant insurance carriers pre-"managed care," the plans enjoyed long-standing deep discounts with hospitals and fee-for-service arrangements with local area physicians.

To enter these markets, non-Blue Cross IPA HMOs had to devise financial contracts that would attract physicians into networks. In both markets, fee-for-service patterns set the general parameters for entry and IPAs generally adopted fee arrangements similar to the Blue Cross carrier.

In Area 2, the early IPA entrant chose to pay primary care physicians using a capitation model for primary care services; it was one of the first IPA plans in the country to do so. The payment strategy was experimental and attracted a small segment of the physician market looking for new patients. Initially the plan offered a relatively restricted network of physicians and competed on price for enrollees to gain a foot-hold in the market. As the plan's enrollment grew, it was able to expand its network by offering primary care physicians stable income for a growing patient population. This payment method has since been adopted by virtually every other IPA/network HMO in Area 2.

In the second Blue Cross-dominated market, the early entrant IPA plan used a discounted fee-for-service payment model to attract a very broad network of physicians (nearly every provider in the state); the unrestricted choice attracted enrollees. This strategy set the pattern for those that followed. In the words of one observer, it was impossible for other IPA HMOs, "...to get physicians to look twice at a capitation contract." This observer noted wryly that now that this HMO has gone insolvent, it will be easier for other HMOs to move to capitation arrangements.

In both Areas 1 and 2, patterns once set were slow to change. Coming into a traditional insurance market dominated by one carrier, the HMO industry itself evolved quickly into a highly concentrated industry. A few plans now dominate the HMO industry, setting the patterns for more minor players. As illustrated by Table 2, the top two plans in the two markets (City 1 and 2) enroll over fifty percent of all HMO enrollees.

In Area 3, a more fragmented insurance market at the outset allowed easier entry into the market. In this market, no indemnity insurance carrier dominated the industry. Fragmentation among multiple indemnity plans with multiple payment practices set the tone for a competitive HMO market with greater receptivity to innovative payment and product arrangements, and greater provider market power.

Here too, however, the early successful HMO plan set the tone for those that followed. In this geographic area the historically dominant plan was a large group/staff model plan that enrolled 13 percent of the statewide population as early as 1979. The long term survival and growth of this plan provided a successful alternative to fee-for-service insurance contracting.

Coupled with ease of market entry, the highly visible capitation alternative opened the door to a variety of competing plans and structural arrangements. A range of capitation payment methods are now widely used by IPA and network plans in the region.

*Industry regulation can have a major effect on the structure and operation of IPA/network HMOs.*

The state laws and regulations in each area generally supported and promoted the growth of HMOs. However, the states varied significantly in terms of their regulatory climate, from fairly laissez faire to quite regulatory. The content of regulations also varied significantly.<sup>6</sup>

In one state, a long-standing legal prohibition on the corporate practice of medicine helped strengthen the formation of physician groups, which in turn strengthened the bargaining power of primary care physicians with HMOs and provided a physician-controlled organizational structure for capitated payment arrangements. State HMO regulations permitted a wide variety of capitated payment arrangements, including substantial risk sharing and shifting of administrative functions from the HMO plan to the physician group. The structure and scope of these capitation payment arrangements have, in turn, been influenced by a state regulation which limits the range of services for which physicians may be capitated to those services provided directly by physicians or through networks under physician group control. For example, physicians may be capitated for hospital services only if they own the hospital. Many capitated medical groups are now functioning as "mini-HMO systems" with their own referral networks, utilization rules, financial contracts and claims payment systems.

In Area 2, HMO regulators were unwilling to approve provider payment arrangements in which an HMO passes comprehensive risk to providers. Capitation arrangements were approved for only a limited range of primary care services. The policy prohibited IPA/network HMOs from developing more fully capitated payment arrangements, or payment contract based on a percent of premium. Although regulators recently approved several new risk arrangements on a "pilot basis," they continued to have concerns about comprehensive risk-sharing arrangement, for both quality and financial solvency reasons.

In Area 1, state regulations were relatively silent regarding risk-sharing arrangements. Regulations were thus relatively permissive. However, early dominance of discounted fee-for-service contracting slowed development of capitated arrangements.

Despite differing developments, concerns about comprehensive capitation arrangements were shared by regulators in all three states. Among their specific concerns were that providers may encounter financial difficulty under comprehensive risk-sharing arrangements and may not be aware of these difficulties until too late; that providers will limit care if they encounter financial problems; and that HMOs will be unable to retain adequate oversight of the clinical quality of services provided to their members. Regulators in each state pointed to instances in the past where capitated subcontractors encountered serious financial difficulties and had to be bailed out

by the HMOs. HMOs did not dispute that such problems had occurred in the past or that they were possible in the future.

In the two states that prohibited capitation payment arrangements for services not directly provided by the contracting physician or group, a number of physician and hospital providers indicated that they would like to enter into more comprehensive risk arrangements with HMOs, and pressure on regulators intensified to permit global capitation arrangements. Both states have efforts underway to develop formal standards that would govern the delegation of greater risk and administrative functions to providers.

### **Shared Attributes of More Successful IPA/Network Plans**

As described above, financial and enrollment performance data were used for screening and selection of IPA/network plans for field case studies. Plans were initially categorized as "more successful" relative to their competitor in terms of objective financial performance; thus, it is important to remember that "less successful" plans are only less successful in terms of their performance relative to their competitor in the case study area.

The case study HMOs differed significantly in their organizational structures, membership size, methods of provider payment, and market environments. Despite these differences, we found that the three HMOs with "more successful" performance shared a number of common attributes, as did the three plans with "less successful" financial performance.

#### *A philosophy of being provider-friendly and physician-focussed*

Two of the three financially successful case study plans were viewed by the physician community as being the most "physician friendly" plans in their markets. Both of these HMOs had a long-term explicit corporate philosophy of being physician-focussed, and each had a variety of formal and regular mechanisms to inform providers about changes, get their feedback and try to achieve consensus. These mechanisms ranged from having significant provider representation on the HMO Board of Directors to including community leader physicians on other HMO policy-making committees. These two plans were viewed by physicians as trustworthy long-term partners whose goal was shared success.

The third financially successful case study plan had a more antagonistic history with its providers. But in recent years, the plan was widely viewed as having changed its attitude, in part as a result of increased competition from other HMOs. In fact, many in its market now regarded the HMO as the premiere plan for physicians because of its development of innovative quality improvement and pragmatic practice management techniques.

In contrast, providers tended to be highly critical of their relationships with the three plans with less successful financial performance. Those interviewed used terms such as "autocratic" and "unresponsive" to describe the way in which the plans interacted with physicians. Physicians believed they were not involved or consulted by the HMO about important decisions that affected them. They also felt that there was no sense of partnership between the HMO and providers, citing examples of the HMOs playing providers off one another in search of better

short-term payment rates, and switching providers for fairly insignificant cost savings. A physician network participant of one of these plans described the corporate philosophy as "Just Say No." Another said the same HMO was "more concerned about its daily stock price than a long-term relationship with providers." Others spoke of contracts terminated for marginal gains with alternative providers and of aggressive, difficult network contract negotiations.

#### *Decentralized medical management*

Sharing control with primary care providers appears to be linked to market success. The three more successful HMOs adopted decentralized administrative and medical management arrangements with their primary care physicians. These arrangements varied among the three HMOs, but generally involved shifting greater autonomy over clinical decision making to providers along with financial risk. Despite the greater risk, network primary care physicians appeared to regard these three plans as supportive, and as striking the right balance between pushing financial risk and responsibility for clinical management to providers and giving providers the tools they needed to manage effectively. In the words of a senior executive of one of these HMOs, "we do what we do well and let the physicians do what they do well."

The three less successful plans were uniformly criticized for their philosophy of centralized control. Providers commonly used terms like "intrusive," "heavy-handed," "controlling," and "micromanagement" to describe the clinical management systems of these plans.

#### *Excellent management*

Management at the three more successful plans was widely credited with being one of the most significant factors in the HMOs success. Each of the three plans enjoyed a stable top management team, and there was also stability and continuity among mid-level managers. The leaders of each HMO were well-known and well-respected (although not necessarily liked) throughout the health care community. HMO management was successful at creating a team philosophy and at articulating a shared vision and shared strategy at the HMO. The more successful plans seized new market opportunities before their competitors, and capitalized on these opportunities in creative and innovative ways. For example, two plans were among the first in their markets to develop managed care workers compensation products. One plan had a large and highly successful Medicare product for years, and another recently developed a new product for the Medicare market through an innovative franchise agreement with an HMO in another state.

In contrast, there was a widespread perception that the management style and turnover of the three plans with less successful performance hampered the performance of the plans. Both providers and purchasers often described these inferior HMOs as "bureaucratic", "not entrepreneurial", and "risk averse." Turnover of senior management was high, and the plans had frequent reorganizations, often in response to their acquisitions of other HMOs.

The three plans were generally regarded as having poor operational capabilities, particularly in the area of management information systems. Physicians in particular expressed concerns and frustration that these HMOs linked physician payment to performance but were not

able to provide adequate information on how the physicians were doing or what they should do to improve their performance.

#### *Primary focus on the IPA/network HMO business*

A focus on IPA and network plan business emerged as a significant contributor to longer term success. The three "well managed" and financially successful plans were started as independent free-standing IPA/network HMOs rather than as a new product or line of business of an existing health insurer or other parent company. All three plans remained focussed exclusively on HMO business until recently, when each diversified into other types of managed care products. For these three plans, an IPA financial contracting philosophy has been at the core of organizational strategies, management information systems and development of contracts with network providers.

In contrast, two of the three plans with less successful performance were started by large insurance carriers whose predominant business was, and remains, indemnity fee-for-service health coverage. These two plans had to adapt methods and management systems originally developed for indemnity insurance systems. Different approaches and innovations necessary to serve IPA networks have developed slowly. One long-time observer of one of these two HMOs believed that the affiliation of the plan with its large insurer parent was a major factor in its poor performance. He observed, "The parent company wants to be all things to all people; it operates like a ward leader and there are a lot of trade-offs. The HMO is constantly having to do things against its own interests for the good of the parent, such as having to include certain providers in its delivery system. HMO management cannot work single-mindedly toward success like [its superior HMO rival] because the goal is to build the parent company not the HMO."

The third less successful plan attempted to run a mixed model HMO. This plan began as a staff model HMO and expanded into the IPA/network HMO business through networking and the acquisition of other plans. Operating with two substantially different operating structures contributed to their internal conflict, frequent re-organizations and shifts in policy direction.

#### *Early entry: an advantage*

Early entry is viewed by the HMOs and others in each market as a distinct advantage for long-term survival. In support of this belief, all of the HMOs in our case studies entered the HMO market in its early stages. Each was able to grow rapidly because of the significant membership opportunities available to HMOs before market penetration rates reached current highs, and each HMO is now among the largest HMOs in its respective market area.

Early entry provided each HMO with an opportunity to build the early support and allegiance of physicians and other providers. Early entry also permitted the HMOs to experiment with innovative payment and contracting arrangements that may not have been acceptable to providers if the HMOs had been bigger or better understood entities. For instance, one of the HMOs was able to adopt a capitation payment model when it first started, because, in the words of one physician, "we did not understand it and the HMO enrolled lots of members before the

physicians woke up and realized what the plan was doing to us. By the time we knew we were in trouble, they had too many of our patients for us to do anything about it." A hospital in the same market echoed this view, "The HMO came into the market when hospitals were doing quite well and were willing to price on the margin to get additional patients. Now the HMO is huge and we are locked into rates of payment that barely cover our direct costs."

#### *Size and "big parents" are not enough*

While size and market share may provide an initial advantage, this advantage is not sufficient to assure financial success, even in the short run. The three less successful plans in our case studies were the largest or second largest IPA/network HMOs in their market areas. In fact, it appears that size can amplify the effects of poor performance because negative attributes such as antagonistic provider relationships and poor management, especially poor operational capabilities, have a greater impact on providers and purchasers the larger and more dominant the HMO. Conversely, two of the three more successful HMOs we studied were not the largest IPA/network HMOs in their areas.

Similarly, having a big parent with deep pockets may hinder rather than assure market success. As discussed above, two of the case study plans performed poorly despite larger corporate parents. In fact, an affiliation with a large parent can be a significant disadvantage if the interests of the HMO are required to be subordinated to the perceived "greater good" of the parent company. One of the major advantages of being affiliated with a larger organization, access to additional resources, particularly capital, had historically not been important for IPA/network HMOs in most markets because historically IPA plans have not had significant needs for capital.

The three more successful case study plans were also evidence that a big parent is not a necessary pre- condition for market success. All three plans started as independent plans.

However, market participants concurred that growing competitive pressures were likely to increase the importance of access to capital in the future for IPA/network plans. These pressures come from two sources: a possible strategic imperative to use capital to purchase physician practices or to invest in the development of integrated delivery systems; and capital to acquire plans in local and other markets as it becomes more difficult to grow locally due to HMO market penetration.

#### **Quality Services And Relative Market Success (Financial and Growth)**

Is a reputation for quality important for market growth and financial success? Ideally, a reputation for quality care and service would be associated with the rapid enrollment and financial health, and a poor reputation with a shrinking market share and financial troubles.

Unfortunately, no systematic information on quality of care or services was available to link plans and compare them to market performance. "Report cards" on plans based on external audits and reviews of patient care and service were not yet available. Nor would state agencies share internal files tracking plans by enrolled complaints or appeals or results of field audits. Even enrollee satisfaction surveys were not widely available by plan name and geographic area.

Our field work suggests that the link between quality and market success was at best weak. When asked to cite an example of an "excellent plan" or a plan with quality "problems," interviewees from various perspectives often concurred and offered the same plan examples. However, plans with relatively poorer reputations continued to grow despite their local reputations.

Similarly, all six plans remained financially robust despite uneven or even poor quality reputations. In each of two markets, a specific plan was named frequently, from multiple points of view, as an example of a plan with quality of care problems. These same two plans ranked middle to low among state-wide comparisons of enrollee satisfaction with different plans in the same market.

Currently, purchasers have little to go on other than price and network availability. As population based quality measures become available, quality may play a more critical role in achieving market success.

### **Future Performance of Successful IPA/Network HMOs**

Competition among managed care plans is the cornerstone of most federal and state health reform proposals. Even without legislative reform, however, the health care market in most states is being transformed by competitive forces. Our case studies suggest that the IPA/network HMOs that have been financially successful and innovative in recent years have generally shared a number of common and encouraging attributes, including a philosophy of partnership with their providers and an emphasis on increased decentralized control and clinical decision making. The case studies also found that in the past smaller, independent HMOs without substantial capital resources have been able to perform as well, and in many cases, better, than larger HMOs controlled by corporations with deep pockets.

At the same time, the case study of the three market areas and current pressures on the six plans revealed that changes underway in each of our market areas may make it more difficult for plans with strong reputations to succeed and thrive in the future, despite past financial success. Particularly disturbing was a shared perception that plans were able to grow and succeed in the market despite local reputations of poorer patient care quality and service. Indeed, pressures could, ironically, create a managed care environment that favors size over past performance and creates "niches" for plans with lower quality reputations.

#### *Market trends favoring size*

The health care market in each of the three areas is going through a time of rapid transformation. Terms like "turmoil," "absolute chaos," and "revolution" were used frequently by observers in each market area. Intense competition by managed care plans for members and market share, increasing pressures for cost reductions by payers, and excess capacity in the hospital and specialist sectors are major factors underlying these changes. The health care industry in each area is in the midst of rapid changes as all organize and reorganize in an effort to protect or improve their relative positions.

Although the three market areas are quite different in their structure and characteristics, there are a number of common changes occurring in each. Among the changes that are likely to have the most effect on future performance of individual IPA/network plans are the following:

*Acquisition and consolidation of health plans:*

Small and medium sized HMOs in each market have been acquired by larger regional and national managed care plans. There is also a movement toward regionalization of the HMO market in each state.

Two pressures fuel these trends. Plans share a perceptions that size is critical to increase or protect their competitive position. At the same time, plans are responding to pressure from many employers to have the capability to provide regional/national coverage for their employees.

Even large, financially successful plans are under pressure to restructure. Pressures are strong to convert from non-profit to for-profit status. The pressure results both from plans seeking to grow by sale and merger with a larger entity and from plans converting to gain access capital and the ability to offer equity in forged partnerships and alliances. IPA and network plans seek capital for investment in the development of information systems, the creation of integrated delivery systems and for the purchase/acquisition of other health plans.

Our case studies suggest that this trend toward consolidation and for-profit status could result in the growth of HMOs that have the characteristics of the less successful HMOs we studied--domination by a large parent company, a mixed model structure resulting from acquisitions and mergers, and unstable organizational structures and management.

These larger HMOs could also have the resources to drive better performing but smaller HMOs out of business, both through negotiating power with providers and through the ability to underprice competitors. In the three markets we studied, there were allegations that the HMOs with inferior reputations used their significant financial resources to engage in predatory pricing. In at least one market, there is growing concern that the best-performing and most highly regarded HMOs may not be the ones that survive.

*Affiliation and integration of providers and health plans:*

The pace of consolidation, integration and affiliation among providers is accelerating in all three study markets. Hospitals are attempting to secure referral bases and develop integrated systems of care through merger, acquisition, alliance, and/or purchase of physician practices. Traditional relationships between hospitals and IPA/network managed care plans are beginning to change. Mergers and alliances between health plans and hospitals, and the development of preferred, if not exclusive, contracting arrangements has created a volatile search for new long term structures. In addition, the balance of power

among physicians is shifting away from specialists to primary care physicians with the growth of managed care.

Health plans and hospitals in each market are taking a number of actions to strengthen their relationships with primary care doctors, including increasing physician support activities (e.g., practice management), developing retraining programs for specialists, and acquiring primary care physician practices.

The trend toward purchase of physician practices in each market is relatively new and it is, as yet, unclear how significant it will become. Although the most successful IPA/network HMOs we studied have adopted a philosophy of partnership with their physicians rather than control, it will be increasingly difficult for them to compete in a market in which physicians are owned by larger integrated delivery systems.

Exclusivity has become a central issue. Plans are developing strategies that use equity shares, higher payment levels, or alternatively, penalties for non-joiners, to put themselves in a position to cement ties with physicians if necessary. The need to raise capital to compete for networks may force some of the most successful IPA/network HMOs to convert to for-profit status or merge with other larger but less successful HMOs.

*Spread of more comprehensive capitated payment arrangements:*

In each market, health plans are shifting financial risk to providers through capitation. (See Appendix A for a description of the different stages of development in the three market areas). Capitation provides greater budget and profit predictability for managed care plans and their investors; as one managed care plan executive told us, "The investment community loves the nice, clean margins that result from capitation." Capitation also creates the strongest incentives for providers to reduce use of inpatient and speciality care and to increase use of outpatient and primary care services.

The growth of capitation is also putting demands on health plans and providers to develop more sophisticated--and costly-- information management and reporting systems. Much of the restructuring in the provider community--such as the creation of Physician-Hospital Organizations ("PHOs"), the purchase of physician practices by hospitals, and the creation of formal alliances between teaching and community hospitals--is the direct result of the systems necessary to support and enable growth of capitation contracting.

We discussed earlier the concerns of many HMO regulators about more comprehensive capitated payment arrangements. In addition to the provider solvency and consumer protection concerns of regulators, our research suggests a number of other issues that could arise with a widespread use of comprehensive capitation arrangements and which deserve further review and discussion by public policy makers.

One is that it is not clear that there has been any reduction in HMO administrative or overhead costs in those IPA/network HMOs that have shifted administrative functions from HMOs to physicians under capitated arrangements. One physician practice

consultant we interviewed estimated that capitated physician groups or IPAs in his market area pay 20-34 percent of their total revenue for management services relating to HMO contracting and administration, including utilization review, eligibility screening and authorization of referrals to specialists. The IPA/network HMOs with which the physicians contract continued to have administrative costs of 12-18 percent of premium despite having shifted significant administrative responsibility to capitated physicians.

The use of capitated payment may also lead to an increase in the development of "price-driven" networks of specialists and other providers. Several observers in the study area with the most extensive use of capitation expressed concern that cost considerations rather than quality or continuity of care have become of paramount importance in subcontractor arrangements, often creating unstable and unsound networks that disrupt care for HMO members.

## **CONCLUSION**

Our case studies of IPA/network HMOs with superior and inferior "objective" performance indicate that plans that have been successful in the past share a number of common attributes and philosophies. It remains to be seen if these attributes will be associated with success in the future. It is unclear whether the result of the dramatic changes underway in the U.S. health care market will be a more efficient and affordable health care system or rather a system in which power is concentrated among a few health plans, provider systems and purchasers, with the "savings" to the more powerful merely becoming the "costs" of the less powerful. Current competitive pressures on plans to grow appears to have less to do with internal system requirements or ability to provide quality care than to exert greater control over markets.

The apparent weak link between quality reputation and market success is of particular concern. To forge a stronger positive link, our ability to evaluate quality in the context of a system of care becomes ever more crucial. As markets consolidate, it will be increasingly difficult to maintain meaningful choice as a way to assure quality.

The future for IPA and network plans continues to be expansion. Our case studies indicate that the "best" HMOs shared a number of common management attributes. It remains to be seen whether these attributes will be associated with market success in the future.

Table 1: Three State and Three Metropolitan Area Comparisons

PRIVATE	U.S. AVG	STATE			CITY		
		1	2	3	1	2	3
<b>INSURANCE COVERAGE</b>							
% Medicare	13.0%	15.0%	17.0%	11.0%			
% Medicaid	11.6%	9.3%	11.3%	14.3%			
% Uninsured (under 65)	17.4%	12.4%	10.7%	22.2%			
<b>HMO PENETRATION</b>							
Total Population	17.4%	34.1%	18.9%	36.0%	32.0%	28.0%	36.0%
Insured Population	21.0%	38.8%	21.2%	46.2%	36.0%	32.0%	47.0%
<b>PHYS/POP RATIO</b>							
TOTAL	203.9	300.0	226.6	214.0	319.8	286.1	220.5
General/FP	23.0	15.2	27.9	28.3	9.9	18.2	25.6
Medical Specialists	48.9	124.7	75.8	70.4	78.5	67.9	56.2
Other Specialists	132.1	160.1	122.9	115.4	231.5	199.9	138.7
HOSP BED/POP RATIO	361.0	362.2	432.1	257.2	393.8	342.6	271.8
HOSP OCCUPANCY	65.6%	72.6%	72.7%	62.4%	73.0%	76.6%	61.7%

<sup>1</sup> HMO Penetration Data: GHAA, 1993 National Directory of HMOS. Metropolitan Data is for 1991. 2.

Physician/Population Data: Based on AMA, Physician Characteristics and Distribution in the U.S., 1993 Edition (1992 Data Patient Care Physicians. Ratios use Patient Care Physicians only). 3. Hospital Data: Based on AHA, Hospital Statistics, 1993 (Data 1992, Community Hospital Beds). 4. City Population Data from U.S. Census, Population Estimates for Counties and Metropolitan Areas, July 1, 1991, pp. 25-1108, February 1994. 5. City definitions for metropolitan areas, including counties within single state borders. 6. State population and Medicare data from Health Care Financing Administration, 1993. 7. Uninsured and Medicaid percentages from Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured, March 1993 Current Population Survey (1992 Data), Issue Brief 145, January 1994.

Table 2: Comparison of Provider and Industry Characteristics in Three Case Study Markets

PRIVATE	MARKET 1	MARKET 2	MARKET 3
Organization of Physician	Solo Practice and Small Groups. Large groups exclusive with single HMO. A few loose contracting associations of medical staffs of hospitals.	Solo practice and small, single specialty group practices. No history of larger physician groups or associations	Large primary care groups. IPA single and multi-specialties. Solo practice dwindling.
Organization of Hospitals	Non-profit. Free standing. Major teaching hospitals.	Non-profit. Some for-profit. Most free-standing. Some systems.	For-profit and non-profit chains plus public hospitals systems.
Traditional Insurance Industry	Single dominant.	Single dominant.	Market historically fragmented.
Characteristic of Early Entrant or Dominant HMO	IPA: Direct Contract. Discounted Fee for Service.	IPA: Direct contract. Capitated primary care.	Group/staff HMO.
Number of Competing HMOs	12	7 - 9	22
HMO Market Share: A.Largest Plan. B.Sec. largest plans C.Third Largest Plan	A. 27% B. 23% C. 14%	A. 35% B. 27% C. 4%	A. 34% B. 13% C. 11%
IPA/Network Plan Market Share	73%		66%
Tax Status Majority of HMOs	Non-profit	For-profit	For-profit

Table 3: Comparison of Case Study Plans

City and HMO ID	City 1		City 2		city 3	
	HMO A	HMO B	HMO C	HMO D	HMO E	HMO F
Financial & Market Performance	strong	weak	strong	weak but strengthening	strong	strong but some negative signs
Annual Average Rate of Enrollment Growth	16%	15%	6%	(1) <sup>1</sup>	48%	25%
<b>Profit Margin, Pre-Tax</b>						
Margin, 1988	1%	3%	7%	-27%	5%	5%
Rate, 1992	4%	-4%	8%	8%	5%	3%
<b>Medical Claims as Percent Premium</b>						
Ratio 1988	88%	89%	87%	96%	87%	76%
Ratio 1992	87%	91%	87%	89%	84%	86%
<b>Administrative Cost :</b>						
Percent of Premium, 1988	13%	11%	12%	26%	8%	22%
1992	8%	7%	10%	10%	12%	14%
Cumulative Cash Generated by Operating Activities Per Member, 1989-1992	\$121	-\$134	\$73	\$103	\$108	\$134
Tangible Net Worth Including Fixed Assets/Medical Expenses, 1992	10.3%	3.3%	20.9%	2.2%	3.6%	10.9%
Tangible Net Worth, Excluding 50% of Fixed Assets/Medical Expenses, 1992	9.8%	0.0%	20.8%	1.9%	1.6%	0.3%
Principle Method Pay Primary Care Physicians	FFS	FFS	Capitate Primary	Capitate Primary	Capitate All	Capitate All Medical

<sup>1</sup> Growth in this HMO was over 100% over the period 1988 - 1992, but largely was due to the result of mergers with other HMOs. By 1991, the mergers were complete, and growth between 1991 and 1992 was 17%.

## **Appendix A.**

### **Description of the Three Case Study HMO Markets and Summary of Case Study HMO Performance**

#### **Overview Description of Three Market Areas**

The three case study markets differed substantially in terms of resources and HMO industry configuration. (See Table 1 in text for details.) Although three market areas exhibit surpluses of hospital beds (measured by occupancy rates), Area 1 and Area 2 operate with a much higher ratio of hospital beds to population than does Area 3. Similarly, although in each city those interviewed remarked on an excess supply of specialists and shortages of primary care physicians, Philadelphia and Boston physician to population ratios are generally significantly higher than in Los Angeles.

The organization of physicians and hospitals also varied across the three markets. In Area 1 physicians have organized across a wide spectrum of solo, small group, academic medical groups and some large group practices. Historically, most of the free standing large group practices have had exclusive arrangements with a single HMO. Independent Practice Associations of physicians have tended to be organized around a single hospital as a contracting vehicle with HMOs. Until a wave of recent mergers, the hospital industry was characterized by free-standing large teaching hospitals in the city and smaller, free-standing non-profit community hospitals in local communities.

In Area 2, physicians are typically in solo practices or belong to small, single specialty groups. Large groups and IPAs (of physicians) are rare. Large teaching hospitals and five medical schools dominate the hospital industry, with strong community hospitals and diversified health systems in the suburbs.

In Area 3 the physician and hospital industry is more organized. Physicians typically belong to either large primary care physician groups, IPA associations, or single specialty associations. Some of the larger physician groups own their own hospitals. Non-profit and for-profit multi-hospital chains plus a county hospital system divide the hospital market in the central city and surrounding counties.

Historically, insurance and HMO industry characteristics also varied across the three markets. In Area 2, the IPA model for HMOs predominate. The HMO industry is highly concentrated: as of 1994, two plans in the market account for half of total HMO enrollment. IPA plans in this area typically contract directly with individual physicians or small group practices rather than larger associations of physicians.

In Area 1, multiple IPA model plans compete with each other and share the managed care market with a large group model HMO. As in Area 2, IPA plans typically contract directly with individual physicians. In contrast, in Area 3, individual physician contracting is rare among IPA and network plans. Instead, such plans contract either with associations of physicians or with large, primary care medical groups. The Area 3 HMO market is characterized by multiple large plans competing with each other and with a large group/staff model that historically dominated the market.

## **Hmo Penetration In Each State and Local Market (Table 1)**

### *Area 1*

HMOs are a well-established and significant force in Area 1. There are 20 HMOs licensed in the state, half of which operate in the study area. Ten of the HMOs are IPA/network model plans. Almost all of the HMOs are non-for-profit, locally controlled plans. Thirty-four percent of the state's population is enrolled in HMOs; HMO penetration in the area is approximately 36%. The indemnity insurance market is dominated by Blue Cross Blue Shield, although the membership of BCBS has declined steadily in recent years. PPOs are not a significant factor in Area 2.

### *Area 2*

HMOs have a significant and growing presence in Area 2. There are 17 HMOs in the state, seven of which operate in the study area. Nineteen percent of the state's population is enrolled in HMOs; enrollment in the study market area is 28%. IPAs are the dominant type of HMO, accounting for 14 of the 17 HMOs in the state and all but one of the HMOs in the study area. All but one of the HMOs in the case study area are for-profit plans. Blue Cross Blue Shield has historically dominated the local health insurance market and while it is still the largest health plan its market position has been weakening. PPOs are not an important factor in Area 2.

### *Area 3*

HMOs have become the dominant type of health plan in Area 3. The 40 HMOs in the state enroll approximately 35 percent of the population. Over half of these HMOs (22) operate in Area 3, which has an HMO penetration rate of almost 50 percent of the insured population. IPA/network HMOs predominate, accounting for over 83 percent of plans and 53 percent of enrollment statewide, and over 90 percent of plans and 61 percent of enrollees in the area. Although many HMOs began for not-for-profit plans, most have now converted to for-profit structures. The insurance market is highly competitive: no indemnity insurer dominates the market; PPOs have a significant market share.

## **Provider Capacity and Health Care Costs (See Table 2)**

### *Area 1*

Area 1 has a surfeit of medical resources of almost every variety. A large number of teaching hospitals has drawn a large number of physicians to the area, resulting in a physician to population ratio that exceeds the national average by 60 percent. Excess physician capacity is skewed: there is a tremendous overabundance of specialists, and a shortage of primary care physicians. The supply of hospital beds and the overall hospital occupancy rate exceed national averages.

Health care costs and utilization in the area are very high. Admission rates, per capita medical expenses, hospital expenses and physician expenses all far exceed national averages.

### *Area 2*

Area 2 has an oversupply of hospital beds and physicians. The ratio of physicians to population is high; physicians are disproportionately specialists, with a ratio of primary care physicians to population that is far below the national average. The supply of hospital beds is slightly below the national average, and the hospital occupancy rate is slightly above the national level. The area has high costs and high use rates, although physician expenses per capita are slightly below national levels.

### *Area 3*

Specialist physician and hospital capacity in Area 1 are well above national levels. In particular, declining hospital occupancy rates reflect the extent to which the growth of managed care has shifted care from inpatient to other settings. In contrast primary care physicians are in demand, with only 26 generalists per 10,000 population. Many/most primary care physicians in the area practice in group settings.

Average total health spending per person is slightly above the national average. The distribution of spending is, however, quite different. Average hospital costs are 10 percent below the national average; physician spending is far above average national rates.

## **ENDNOTES**

- 1 For the purposes of this study, we defined an IPA model HMO to include two different types of plans: one type contracts directly with individual physicians (direct contract model HMO); the other contracts with physicians through a formal independent practice association (IPA), organized by physicians as a contracting agent. A network model HMO is defined as a plan which primarily contracts with multiple physician groups, both single and multispecialty groups. Network model HMOs may, however, include some contracts with individual physicians or IPA associations to augment networks in different local markets.
- 2 Group Health Association of America, 1995 National Directory of HMOs, Washington D.C.: Group Health Association of America, June 1995.
- 3 IPA/network plan enrollment increased an average 9 percent per year from 1988 to 1993. In contrast staff and group model HMOs grew at an average annual rate of only 3 percent per year over the same time period.
- 4 Rubin HR, Gandek B, Rogers WH, Kosinski M, McHorney CA, Ware JE Jr. "Patients' Ratings of Outpatient Visits in Different Practice Settings: Results from the Medical Outcomes Study," *Journal of the American Medical Association*, 1993, 270:835-840; and, Miller RH and Luft H, "Managed Care Plan Performance Since 1980," *Journal of the American Medical Association*, 1994, 271:1512-1519.
- 5 The initial results of the financial analysis were reported to the Commonwealth Fund in April 1995 in a companion study. Financial analysis is now being updated with additional plans and years for each market and expanded to include two additional states.

- 6 One interesting regulatory issue in two of the states is growing concern about the recent high levels of HMO profitability. There has so far been no concrete legislative or regulatory action to address this concern, although legislation to limit HMO profitability has been proposed in one state.

## **BRIEFING NOTE**

### **Managed Care Plans May Not Get Better As They Grow Bigger**

Health Maintenance Organization (HMO) enrollment is surging in the 1990s, with 51 million Americans enrolled in HMO plans in 1994, compared with 37 million in 1990. News of mergers, acquisitions, and conversion to for-profit status dominates the financial headlines as plans seek access to capital for growth. In a continuing effort to inform the public understanding of issues related to managed care, The Commonwealth Fund sponsored a series of case studies on the fastest growing HMO models— independent practice associations (IPAs), and network model HMOs.

Study conclusions reinforce the findings of a 1995 Fund survey of managed care enrollees and fee-for-service members in Los Angeles, Boston, and Miami in which respondents reported negative side effects in the rush of government and employers to embrace managed care. The new Fund study, *Markets and Plan Performance: Summary Report on Case Studies of IPA and Network HMOs*, conducted by Harvard School of Public Health researchers, Nancy Kane and Nancy Turnbull, and the Fund's director of research and evaluation, Cathy Schoen, echoes that warning.

After conducting six case studies of health plans in Boston, Los Angeles, and Philadelphia, and an analysis of each of the three markets, the study concludes that size and growth may be more important for plan survival than the quality of patient care and services. Plans with relatively poorer quality reputations appear to be growing and expanding alongside those with stronger reputations. The case studies point up the lack of objective information on how plans perform in terms of quality of care, and the critical need to develop quality measures and standards, and policies to hold plans accountable as they themselves restructure in a dynamic market.

### **Highlights**

- With a combined annual growth rate of more than 11%, independent practice associations and network model plans now enroll nearly two-thirds of all new HMO members.
- IPAs operate through contracts with individual physicians, while network model HMOs contract with multiple physician groups.
- The most financially successful plans studied had a clearly articulated policy of partnership with physicians and decentralized mechanisms of clinical decision making.
- The less financially successful plans were dominated by a large parent company, unstable management, and weaker communication between physicians and management.

- Plans are shifting financial risks for medical care from the plan to physicians or groups of physicians, creating strong incentives to limit costs of care; yet state standards have not yet been developed to ensure that the necessary financial reserves are in place to absorb risks or to assure patient protection.
- Public policy to assure quality of care and comparative quality information is deficient.