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HEALTH POLICY BULLETIN

FOCUS: OUR FIRST AHP, CCN, OR CCP?

Let's straighten out the acronyms first. An *accountable health plan* (or AHP, the term coined by proponents of managed competition), a *community care network* (CCN, the American Hospital Association's term), and a *community care partnership* (CCP, Blue Cross and Blue Shield of Michigan's term) are all different names for the same kind of entity—one that features core integrated health care delivery systems, capitated rates for all services, and incentives to members to stay within the entity for all their covered medical care services. We prefer AHP, since that term is most often used.

Michigan's first AHP has been born. The partnership between Blue Cross and Blue Shield of Michigan (BCBSM) and Henry Ford Health System and the Sisters of Mercy creates a very large plan that could provide care to a significant share of the state's population. In an interview with Robert Asmussen, BCBSM senior vice-president, we were able to explore the meaning and some of the ramifications of the arrangement. Asmussen said, "If managed competition comes out of Washington, we are positioned." He also noted that the plan was ready for the auto company negotiations this fall. In his view, it is a natural for them to consider.

The partnership falls somewhere between a point-of-service plan and a health maintenance organization (HMO). It is like an HMO in that all covered services are included in one basic rate. It is like a point-of-service plan in that it gives consumers a greater choice of providers and requires copays (as much as 30 percent) for going outside the plan for services that the plan could provide. It is community rated. Asmussen pointed out that the plan has to be tolerable to everybody if it is going to have any degree of marketability.

Asmussen was quite clear that the plan will be offered in the fall contract negotiations with the automakers because they offer a large, concentrated market. Assuming the automakers buy into the AHP, they will get rates that are guaranteed to increase by no more than 5 percent each year over a three-year period, in effect, capping their costs. Almost all of the risk of premium cost inflation has been transferred from the employer to the AHP.

What are the ramifications for the core health care systems? In a more competitive world featuring discounted rates for every service, plenty. The two core systems, Henry Ford and the Sisters of Mercy, can offer just about every conceivable inpatient and outpatient service a patient might need. In addition, the two core systems would have access to a guaranteed patient population. With a possible 30-percent copay as a disincentive, what patient is likely to go outside the core systems for services?

Another aspect of the plan is that as new technologies and services come along or as service gaps are identified, the two core systems have the right of first refusal; BCBSM cannot go outside the system and contract with another provider unless both Henry Ford and the Sisters of Mercy agree to the arrangement. This provision already has other hospitals, most notably William Beaumont, howling. Other hospitals in the area could contract with the system but only through Henry Ford or the Sisters of Mercy. Asmussen says the plan builds on the "traditional managed care blend in the Midwest"; that is, it places limits on the choice of providers unless the patient pays more for an out-of-plan provider. Given the importance to most Americans of freedom of choice, a plan that preserves that value is certainly more likely to be popular than one that does not.

We asked Asmussen what health reform would mean. He said, "If reform is universal health insurance with community rating, we would rethink the contract and reprice it. If health reform is a price freeze, then the question becomes, How do a price freeze and a capitated rate mix? Where is the freeze, on premiums or on provider fees? If they go for a price freeze [on premiums], we could be out of the picture before we start."

How does he expect the plan to be received? "We are looking at a goal of 50,000 members at the end of the first 12 months," he said. What about other areas of the state? "The plan is really feasible only in urban markets," he noted. If AHPs are feasible only in urban markets, where does that leave the rest of the state's population? Asmussen indicated that this could become a problem for patients, not providers. Providers in nonurban areas would be able to do business pretty much as usual, given the absence of competitive conditions and the population necessary to support an AHP. Is the plan likely to be attractive to small businesses? "Yes, but large accounts do better," he said, because they have more people among whom risk and administrative costs can be spread.

It has been reported that the plan is looking at other urban areas—Grand Rapids, Flint, and Lansing. Asmussen commented that these are the only other areas in the state with a population large enough to meet the Blues' criteria for an AHP. In all three cities, large employers are present and the population base is large enough to support the level of competition required to make the arrangement work.

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The question is, Will there be competition? First of all, each of the three cities has at least three well-developed or developing hospital systems that have referral arrangements with smaller hospitals in the rural and semirural areas around them—in effect, minisystems. Each of the three cities has at least one hospital that is struggling to survive. As difficult as the current climate is for all of these hospitals, the emergence of one or two of them as core system members in each city could spell the end for the others—so much for managed competition. In Grand Rapids, for example, if Blodgett and Butterworth become core system providers, how long could St. Mary's, Metropolitan, and Droste-Ferguson survive? If Blodgett and Butterworth are in the same AHP, can another AHP compete in the Grand Rapids area? The key question seems to be, How many AHPs can the state of Michigan realistically support?

FOCUS: THE INCREASING CONCENTRATION OF HEALTH CARE EXPENDITURES

It has long been common knowledge that a small proportion of the population accounts for a disproportionate share of health care expenditures, a phenomenon called *concentration.* A recent article by Marc L. Berk and Alan C. Monheit in *Health Affairs*, winter 1992, calls our attention to this phenomenon once again. Berk and Monheit show that between 1927 and 1987 only 5 percent of the population accounted for close to 50 percent of health care expenditures. In 1987 a shift occurred: Five percent of the population accounted for 58 percent of health care expenditures, and the top one percent of all users accounted for 30 percent.

In 1963, before Medicaid and Medicare and the expansion of major medical insurance coverage, the top one percent of users accounted for only 17 percent of health care expenditures; however, by 1970 they accounted for 26 percent of expenditures, an increase of 9 percent in seven years. From 1970 to 1987, the same group's share of health care expenditures rose from 26 percent to 30 percent. How is this shift in concentration accounted for? Berk and Monheit say the answers are the expansion of coverage and the adoption and dissemination of new medical technologies.

What does this shift in concentration mean? According to Berk and Monheit, it means that attempts to contain health care costs by focusing on the healthy segment of the population and limiting the choices and services available to them completely miss the point. Essentially, cost containment strategies have failed because the wrong group—low-cost users—has been targeted. Why? Because heavy health care users are predominantly the elderly. For example, in 1987, 48 percent of the heavy users were over age 65.

Berk and Monheit suggest that nonusers of health care may need to have a benefits package that gives them incentives to use preventive services, while heavy users may have to have benefit packages that limit their access to costly, high-tech procedures. In their view, the hard choices that already exist concerning health care rationing are only going to become more painful in the future.

OF INTEREST

In the next 30 days, look for

- the House Committee on Public Health to report out HB 4510 (expanding Medicaid to all children in households with annual incomes below 200 percent of the federal poverty level) and HB 4039 (testing of people convicted of criminal sexual conduct and releasing the results to the victims);
- the Senate Committee on Health Policy to report out SB 396 (revises the certificate of need statute);
- the Senate to pass HB 4156 (the auto insurance reform bill); and
- intense discussions to continue over SB 270 (the medical liability bill).

The following information corrects an error that appeared in last month's issue: If the House Speaker is a Republican, the committee chairs are Democrats and vice versa. For the Committee on Public Health, one should contact Rep. Michael Bennane's office for information on bills during March, May, July, September, and November. Rep. John Jamian is the chairperson of the Committee on Public Health for April, June, August, October, and December.

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