III. STRUCTURAL CHANGES IN THE HEALTH CARE INDUSTRY

ALPHONSO O'NEIL-WHITE*

I am delighted to be here on behalf of Group Health Association of America (GHAA), the oldest and largest trade association representing health maintenance organizations (HMOs) and managed care networks in the country. I bring you greetings from our President and CEO, Karen Ignagni, who was unable to attend and sends her regrets. I am personally pleased to be here because in one of my prior lives, I was a labor lawyer and had the privilege of arbitrating a few cases before some of your distinguished members. I spent the first 10 years of my legal career in labor-management relations, representing labor as well as management, and I look upon those years with great fondness and appreciation.

I have been asked to speak today about some of the structural changes taking place in the health care industry. Believe me, there are many. GHAA represents a segment of the industry that, I believe, is at the leading edge of the many changes taking place. I must say at the outset that we are experiencing a virtual revolution in the health care marketplace that will impact the lives of each and every American.

GHAA represents roughly 377 HMOs and managed care organizations that provide health care to the majority of Americans who receive their care in HMOs. Today, there are about 50 million Americans enrolled in HMOs. We are projecting that enrollment will increase to about 56 million by the end of 1995. HMO enrollment has quadrupled since the 1980s. If one uses the broader sweep encompassed by the term "managed care," there are roughly 100 to 150 million Americans enrolled. HMOs and managed care are fast becoming the dominant forms of health care delivery in the United States, changing the very nature of health care delivery.

What one must keep in mind, and many try to ignore it, is this: the reforms generated by HMOs and managed care are market-driven. HMOs and managed care are becoming the dominant form of health care delivery, not because doctors want it, not because hospitals want it, not because insurance companies want it, but because health care consumers demand it.

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*Vice President and General Counsel of Group Health Association of America, Washington, D.C.

According even to the most liberal estimates, HMOs and managed care make up a small portion of the overall health care industry. In 1960 the health care industry accounted for only 5.3 percent of the gross domestic product (GDP). By 1993 it had grown to more than 14.1 percent. Total national spending for health care has increased dramatically and continuously for more than 30 years, rising from $27 billion in 1960 to an estimated $898 billion in 1993. The Congressional Budget Office projects that health care spending will continue to grow rapidly in the near future, exceeding $1 trillion in 1995 and reaching $1.6 trillion by the year 2000.

Despite the enormous rise in health care spending, many people lack access to even basic health care services. On any given day during 1995, an estimated 40 million people, or nearly 15 percent of the population, had no health insurance. This is so even when individuals covered under huge government programs such as Medicare and Medicaid are included. Faced with spiraling health care inflation, increasing concern about the uninsured, the potential bankruptcy of the Medicare program, and the need for expanded access to care, the federal government attempted but failed to reform the system. The states have taken up the mantle but have focused much of their attention, seemingly, on antimanaged care measures. However, the Republican sweep in the 1994 elections may bode well, at the federal level at least, as the nation grapples with the persistent issues related to rising health care costs. How will the Republicans help? Some suggest that they will rise to the occasion because of their traditional faith in the free market. We will have to wait and see.

Compared with government, the market is actually moving at a much faster pace in dealing with the necessary structural and systemic changes. We are seeing, for example, many of the reforms that were sought by government being implemented without government intervention. For example, a number of states have implemented purchasing alliance programs, small and individual market reforms, and in a few cases, comprehensive health care reform.

We are seeing a definite shift from a "fee-for-service" system to capitation. Work force distribution is yet another shift. For example, physician specialists, once at a premium, are now in serious oversupply and being replaced by primary care providers. This particular shift is being driven by managed care's emphasis on prevention and health promotion rather than on illness, as has been the case in the fee-for-service system.

Midlevel practitioners, such as nurse-midwives, nurse practitioners, and physicians' assistants, are also gaining prominence in health care delivery. Most notably, we are witnessing the demise of the solo physician practitioner as physicians move rapidly into group practice medicine. I will expand on this below.

Developments in financing, new markets, legislation, regulation, and especially consumer service expectations are contributing to this change. The health care consumer, the patient, is beginning to play a much larger role in the health care equation than ever before. A foreseeable result of this will be competition within the industry to meet consumer demands. I always take great pleasure in noting that HMOs and managed care are concepts that were not only created, but also developed by health care consumers. Let me provide some history. It should be noted that California played a significant role in that history. HMOs were first established in the early 1930s specifically as an alternative to fee-for-service medicine. Consumers were disheartened with the lack of coordinated care, the escalating costs, and the piecemeal manner in which they received care. They gathered in small groups across the country to develop a way to address these concerns. In Washington, D.C., for example, they formed the first staff-model HMO. In Oakland, California, they formed the first group-model HMO. In all cases, they did this with the assistance, support, and active participation of physicians.

I should point out that labor unions were also early supporters of prepaid health care as they continue to be today. They were and are significant partners. They designed these care systems to focus first on maintaining wellness. What a concept! How unlike the fee-for-service system with its expensive focus on illness. They set up these organizations to deliver comprehensive health care services, and they financed it through the concept of prepayment rather than fee-for-service in order to ensure affordable service.

As these systems evolved, infrastructure was added to protect patients from the dangers of undertreatment as well as overtreatment. In addition, these systems selectively contracted with providers to ensure a precise mix of providers given their enrollment, to include only those who were committed to the HMO style of practice, and to ensure high quality care.

Forgive me for saying so, but the rest is history! Managed care was a way of delivering health care that made sense 50 years ago and still makes sense today. This is why patients consistently give HMOs high marks. Health care delivered in a way that makes sense,

comprehensive benefits, high quality care, all at an affordable price—a simple formula for success.

An obscure piece of history that you should be aware of, if you are not already, is that as soon as these fledgling alternatives to fee-for-service were getting off the ground, organized medicine set out to destroy them. However, these efforts were foiled by the Department of Justice, which stepped in during the late 1930s and not only prosecuted organized medicine for their activities, but more importantly, established the principle that competition in health care would benefit consumers. This paved the way for the full development of the HMO industry and allowed the industry to innovate and respond directly to consumer demands without the fear of reprisals from organized medicine. The development of managed care was further validated by the passage of the HMO Act of 1973 and subsequent state laws protecting and fostering HMOs. The HMO community has also been influenced by the shift from solo medical practice to group practice and enactment of health care finance laws (Medicare and Medicaid) that increased corporate control of medical care delivery by third-party payers through government-mandated regulation of fee-for-service and indemnity payments for health care.

What all this adds up to is this: Over the last few years, this nation has had it eyes opened to what health care consumers have known all along—that we can provide high-quality health care to large numbers of people without breaking the bank or acquiescing to spiraling health care costs; that there is a format for delivering that care that can efficiently deliver comprehensive high-quality care that is affordable.

HMOs take a number of forms, but the primary feature of these plans is that they are organized health care systems that are responsible for both financing and delivery of a broad range of health services to an enrolled population. The primary focus is on prevention and keeping people healthy, rather than on providing quality health care when people get sick. A key feature, in my view, is the team practice of medicine with all providers in the system being accountable to each other and most importantly to the patient. There are five types of HMOs, in addition to a number of emerging models that have yet to develop fully:

1. The staff model: those that employ all of their physicians and providers;
2. The group model: those that contract with large multispecialty groups to provide the care to the enrolled population;

3. The IPA model: those that contract with Independent Physician Associations;
4. The network model: those that contract with a network of individual physicians and/or physician groups; and
5. The mixed model: those that do some or all of the above.

Profound changes in the health care industry have occurred as a result of the increased variety of plan models, the changing incentives for health care providers, the shift in focus from illness to health promotion and prevention, changes in the way physicians work together, and the opening of new markets as well as the closing of old ones.

These changes are driven by competition and competitive forces:

1. Greater emphasis on quality health care as consumer demands intensify and as components of the health care system compete in terms of price and quality of service to meet those demands.
2. The financing of health care, especially the way providers are reimbursed. These changes, particularly the shift to capitation versus fee-for-service, have facilitated the shift from the previous sky-is-the-limit medicine. The new paradigm directly addresses the realities of limited and sometimes scarce resources.
3. Public programs (such as Medicare, Medicaid, and workers' compensation) are being modified, as we speak, to take advantage of the efficiencies of managed care and to expand access to these systems. Medicare has been described as the last bastion of fee-for-service medicine. Currently, Congress is pondering how to incorporate managed care as a key component of Medicare reform.
4. Physicians and all providers, large and small, individual and institutional, are embracing competition as the only means of survival in a rapidly changing marketplace.

For example, not only are physicians and other providers coalescing into groups, but there is a clear trend toward physician-owned/sponsored or provider-owned managed care companies. Let me give you some examples. A growing number of physicians are forming large group practices and multiprovider networks in order to position themselves to provide the range of services required by employers, HMOs, and other managed care entities. According to a 1994 report in the *New England Journal of Medicine*, many large multispecialty group practices operate their own health plans and derive more than half their total patient care revenues

from these sources. In fact, proliferation of physician-controlled health plans and networks has been a prominent feature of California's highly competitive health insurance market.

Three-fourths of the 50 state medical societies are either developing or considering a physician-sponsored managed care network. Some 3,500 New Jersey physicians have raised $17.5 million to organize their own HMO, according to a recent *New York Times* article. Hospitals and other specialty groups (e.g., chiropractors, podiatrists, dentists, and pharmacists) are joining the chorus. These organizations, although physician- or provider-owner, will be subject to the same forces as all other companies in the economy and will be compelled to employ the same business and management practices. More importantly, they will employ the same techniques, such as utilization management, that have made HMOs and managed care plans successful thus far. All signs point to the establishment of vertically and horizontally integrated health care systems that incorporate the fundamental principles of HMOs and managed care.

Developing a rational environment for purchasing health care coverage in this rapidly changing marketplace, however, requires substantial data-collection efforts. In order to accurately compare health plan performance and value, the data must first be consistently defined and measured. This will require significant investments in management systems, technology, and personnel, as well as agreement among health plans, purchasers, and most importantly consumers, about which data elements should be measured and the methodologies to be employed to derive them. The task of addressing the massive data and information needs in health care has been likened to the Human Genome project designed to map the human genetic code. In health care this means the creation of a whole new industry.

Health care delivery is moving from a "cottage industry" made up of individual physician entrepreneurs to a vertically and horizontally integrated system of providers, where relationships between providers, health plans, employers, and patients are governed by contracts, not by employment or other social relationships.

Some physicians are reacting by pursuing legislated "job security" structures that resemble highly enhanced "collective bargaining" agreements. The Federation of Physicians and Dentists based in Tallahassee and the United American Physicians and Dentists as well as the American Medical Association support such structures. Others respond through an entrepreneurial lens in order to take advantage of available opportunities.

These structural changes, which will produce huge power shifts from providers to payers to consumers, will continue until the shakeout is over. When that will occur is unknown, but I can assure you that it will continue and it will be difficult, particularly for physicians.

In the 21st century, dispute resolution in the health care environment will present a particularly compelling challenge for your profession, given the new structures that are developing almost on a daily basis, and the new complexities that arise from them. Your challenge is to seize these opportunities and to strive for innovative dispute resolution techniques and structures to keep pace with the change. Alternative dispute resolution mechanisms must do more than reduce costs, and its viability will also rest on its ability to produce creative, yet permanent and effective outcomes.

IV. CONCURRENT SESSIONS
SESSION 1—EDUCATION

ROBERTA L. GOLICK*
RICHARD N. FISHER
LEO GEFFNER
PAUL STAUDOHAR

Roberta Golick: It's my pleasure to introduce our panelists. You'll recognize Clark Kerr. In the last hour we were fortunate to have him share with us some of his insights, as well as some of his foresights, into the field of education. A prolific author, nationally renowned authority on industrial relations in education, Dr. Kerr is President Emeritus at the University of California and Professor Emeritus of Economics and Industrial Relations at the University of California, Berkeley. Dr. Kerr has graciously agreed to join us for this informal session where we will be hearing from practitioners who will respond to his remarks this morning and offer some comments of their own.

To Dr. Kerr's left, to bring us the management perspective on the issue, is Richard Fisher. Richard joins us from the Los Angeles law firm of O'Melveny & Myers where he represents employers in labor relations and employment matters. Dick has for many years

*In the order listed: R.L. Golick, Member, National Academy of Arbitrators, Sudbury, Massachusetts; R.N. Fisher, Partner, O'Melveny & Myers, Los Angeles, California; L. Geffner, Senior Partner, Taylor, Roth, Bush & Geffner, Burbank, California; P. Staudohar, Member, National Academy of Arbitrators; Professor of Business Administration, California State University, Hayward, California.