MEDICARE BENEFICIARIES & HMOs

A Case Study of the Tampa, Florida Market

prepared by

MATHEMATICA
Policy Research, Inc.

July 1998
The Kaiser Family Foundation, based in Menlo Park, California, is an independent national health care philanthropy and not associated with Kaiser Permanente or Kaiser Industries. This study was conducted as part of the Medicare Policy Project which was established to provide a framework for the Foundation’s ongoing work related to health coverage for the elderly and disabled.
MEDICARE BENEFICIARIES AND HMOs:

A CASE STUDY OF THE
TAMPA-ST. PETERSBURG MARKET

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Preparation of this report was supported by a grant from The Henry J. Kaiser Family Foundation, Grant #96-1473A. The views expressed in this report are solely those of the authors and do not necessarily represent those of The Henry J. Kaiser Family Foundation nor Mathematica Policy Research, Inc.
ACKNOWLEDGMENTS

Many people helped bring this case study report to fruition. Foremost among them are the numerous individuals and associated organizations in Tampa-St. Petersburg, including plan representatives, providers, advocates and analysts who generously contributed their time, granted interviews, furnished written materials and reviewed drafts. For their efforts we are deeply grateful. Special thanks to Dr. Bruce Siegel who was especially helpful in providing an orientation to the market.

We are especially grateful to Michelle Kitchman of The Kaiser Family Foundation and Patricia Neuman, Director of the Foundation’s Medicare Policy Project, who conceived of the project and provided guidance as it evolved. We would also like to thank Patricia McCall at Mathematica Policy Research who provided administrative support.
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EXECUTIVE SUMMARY

OVERVIEW

This case study of the evolution of Medicare managed care in Tampa-St. Petersburg, Florida, is one of four in a series being prepared by Mathematica Policy Research, Inc., for the Kaiser Family Foundation to examine the growth and impact of Medicare managed care. The Medicare risk (HMO) program has developed at different rates and with different degrees of success across the country. Understanding these differences may help to predict how Medicare risk contracting will evolve and to identify some impediments to growth. Furthermore, understanding the reasons for these differences and their possible effects on beneficiaries may suggest policy alternatives or indicators to monitor as managed care grows.

The four unique market areas selected for the project include two with high Medicare plan payment rates (defined as 95 percent of the adjusted average per capita cost or AAPCC) and two with moderate rates. The two with high AAPCC rates are Los Angeles and New York City. In both areas, plans offer prospective enrollees zero-premium coverage and extensive benefits, but while in Los Angeles nearly 40 percent of Medicare beneficiaries are enrolled in a managed care plan, in New York City, where Medicare managed care is relatively new, enrollment is still low. The two areas with more moderate AAPCC rates are Portland, Oregon, and Tampa-St. Petersburg, Florida. In Portland, the Medicare HMO market is mature and penetration is high, as it is in Los Angeles, but plans in Portland reportedly have been experiencing financial difficulties for several years. Similar to the NYC Market, Medicare managed care plans in Tampa-St. Petersburg have developed only recently, and they appear to be growing rapidly and prospering. This case study explores the development of Medicare managed care in the Tampa-St. Petersburg market.

CASE HIGHLIGHTS AND DATA SOURCES

Tampa-St. Petersburg is a popular retirement community and as such is home to a significant and growing number of elderly. The 350,000 Medicare beneficiaries in the market account for nearly one in four residents, making Medicare a very important payer in the market. Medicare managed care has had a long and somewhat rocky history in the Tampa-St. Petersburg market. Humana Medical Plan, the largest risk contractor in the market, entered the Tampa Bay area in 1988 through the purchase of the failed HMO International Medical Centers (IMC), which at the time enrolled 40,000 Medicare beneficiaries in the area. Humana was the only plan in the market until 1993 when a second plan entered. Despite the high concentration of elderly in the market, Medicare risk enrollment grew slowly until 1995. At that time, due to decreasing resistance to managed care (among consumers and providers), greater provider organization and familiarity with managed care processes, as well as HMO desire to expand out of the main Florida market (Miami) six new plans entered the Tampa-St. Petersburg market in quick succession and enrollment began to climb. By June 1997, enrollment had increased to nearly 100,000, or 30 percent of the Medicare population in Tampa-St. Petersburg. Except for two statewide plans (Blue Cross and AvMed), most of the plans currently serving the Medicare market in Tampa-St. Petersburg are national plans, and nearly all of the plans operated successful Medicare risk contracts in Miami before entering the Tampa-St. Petersburg market. There are no local plans serving the Medicare population in Tampa-St. Petersburg.
This case study profiles the Tampa-St. Petersburg Medicare managed care market, including how the market has evolved and how health plans within the market operate. In particular, the report examines Medicare risk plan development, including the recent significant growth, given the market’s moderate AAPCC rates.

We found that in addition to the effects of local market dynamics on the growth of Medicare managed care in Tampa-St. Petersburg, the development of risk plans in the market was also affected by the experience in nearby Miami (another large Medicare market, but one with considerably higher AAPCC payment rates). Miami represented an obvious starter market for plans interested in managing the care of Medicare members in Florida. After gaining confidence in their ability to manage the care of Miami’s elderly population, many plans were ready to try expanding to markets with more moderate plan payments. All but one of the eight Medicare risk plans currently in Tampa-St. Petersburg operated successful Medicare risk plans in Miami first.

Even after gaining experience in Miami, however, plans hesitated before expanding into Tampa-St. Petersburg. Widespread negative publicity associated with managed care, particularly in Miami, had made beneficiaries and providers in Tampa-St. Petersburg wary of HMOs. In 1990, 1994, and 1995, prominent press reports in the *Fort Lauderdale Sun Sentinel* documented marketing and other abuses that were later confirmed in one case by the General Accounting Office (GAO) and in another by the state monitoring agency. Only when the chilling effects of these scandals eventually subsided were beneficiaries and providers in Tampa-St. Petersburg open to the prospect of HMO membership.

Another likely barrier to Medicare managed care in Tampa-St. Petersburg was the structure of the provider community there. Providers historically were not well organized and hospital utilization (including use by those over 65) was higher than average. More recently, in response to the growth of commercial and Medicaid managed care in the market, providers began to organize in various ways in order to widen their service areas, capture market share, and facilitate managed care contracting. Providers began to view their ability to capture Medicare market share as critical to their overall success. They saw the delayed development of Medicare risk plans in the market as an opportunity to organize themselves so as to enhance their leverage, something many providers were unable to do before Medicaid managed care was implemented in the early 1990’s.

Hospital systems have been forming, largely in response to the entrance of Columbia HCA to the market in 1993, and inpatient utilization has fallen. Now two-thirds of hospitals in the greater Tampa area are aligned with one of three major systems: Columbia Health Care, Tenet, and the Bay Care Health Network, the self-described “nonprofit response” to Columbia. Hospital utilization by those over 65 is down and is now lower than in many other Florida metropolitan markets. Physicians are likewise organizing and creating affiliations with each other and with hospitals to facilitate managed care contracting.

The Tampa-St. Petersburg case study is based on data from three sources: interviews conducted over the course of a three-day site visit in July 1997, a review of written materials, and a review of published data specific to the market. We focused on the two counties in which the cities of Tampa and St. Petersburg are located (Hillsborough and Pinellas counties, respectively), but consider them in the context of the surrounding market. We interviewed key stakeholders representing health plans, providers, beneficiaries, and purchasers of retiree benefits. For the most part, this case reflects
the experience in Tampa-St. Petersburg as of July 1997. A previous draft of this case was reviewed
by key stakeholders, including those we interviewed.

THE TAMPA-ST. PETERSBURG HEALTH CARE MARKET

A number of distinctive features of the market and the population in Tampa-St. Petersburg are
key to understanding why the growth of Medicare managed care has lagged there and how it may
evolve in the future.

High Concentration of Elderly Makes Medicare an Important Payer

The sheer size and concentration of the elderly population in Tampa-St. Petersburg makes
Medicare a very important payer, prompting one provider to note "In Tampa, if you don't have a
Medicare strategy, you don't have a strategy." In 1996, Medicare paid for more than half of all acute
care discharges in the greater Tampa area, compared with a third nationally. Medicare's importance
varies by county, increasing in those with a higher proportion of elderly residents. Medicare pays
for a high of 69 percent of all acute care discharges in one of the outlying area counties and a low
of 38 percent in Hillsborough County. Even in Hillsborough, where Medicaid is an important payer
because of the large proportion of low-income residents, Medicare is still the single largest payer in
terms of the number of admissions and patient days, with a share greater than the U.S. average.

Medicare Beneficiaries Older, Wealthier and Often Part-Time Residents

Sixty-three percent of Tampa-St. Petersburg's seniors (defined as those age 65 and older) are
over age 74, compared with 46 percent nationally. Given the recent development of managed care
in the commercial market, the typical Medicare beneficiary in Tampa-St. Petersburg is less likely
to have experienced managed care and HMOs as a commercially insured person than is a newly
eligible 65-year-old Medicare beneficiary or a retiree relocating to Tampa-St. Petersburg from an area
with higher managed care penetration. In addition, older Medicare beneficiaries may be more
reluctant than younger, healthier beneficiaries to change doctors, as sometimes required with HMO
enrollment, or to relinquish their supplemental coverage. The elderly in Tampa-St. Petersburg also
have slightly higher incomes than those elsewhere in the nation, and thus may face less of a financial
incentive to discontinue costly supplemental insurance in favor of low or zero premium Medicare
HMOs.

In addition, the elderly in southwest Florida where Tampa-St. Petersburg is located are more
likely than those elsewhere in Florida to reside in the area for only part of the year, which can reduce
their interest in Medicare risk enrollment. Often referred to as "snowbirds," these retirees spend
their winters in Florida but leave during the summer months. At least two of the national plans in
the Tampa-St. Petersburg market are developing "portability options" for their Medicare members.
This will enable Medicare members to receive plan services from contracted plan providers both in
Tampa-St. Petersburg and in other parts of the country.

Historical Lack of Provider Organization

Providers in the Tampa-St. Petersburg market historically have not been organized into
systems. Physicians have admitted to multiple hospitals (though this varies somewhat by
geography), and consumers have not readily identified with “name brand” hospitals or systems as
they do in a market like Portland. The market’s only public hospital (which recently gained its
independence from the county) also serves as the only teaching affiliate for the University of South
Florida. Hospitals have traditionally drawn their patients from the immediate area and have not
focused on promoting their services more widely.

The lack of narrowly defined referral patterns between physicians and hospitals limits the
development of physician-hospital relationships. Some hospitals reportedly face continued difficulty
formalizing relationships with providers, with physicians and hospitals in Pinellas enjoying greater
success than those in Hillsborough. The level of provider organization and integration has likely
delayed the development of Medicare managed care in this market by making it difficult for plans
to shift risk to providers. The delegation of risk is reportedly common among plans in the market
driven by the lower AAPCC and desire to minimize exposure to risk.

National Orientation of Health Plans

In the Tampa-St. Petersburg Medicare managed care market, three of the five largest plans are
national plans, the other two (AvMed and Health Options) are Florida HMOs. The dominance of
national firms appears to have significantly influenced the organization and structure of the area’s
health care system and development of managed care. Many of the strategic decisions made by
players in the market appear to be part of broader strategies, rather than a strategy based exclusively
or even primarily on a single market. Because all the Medicare-serving plans in the Tampa-St.
Petersburg market are either national plans or statewide plans based in Miami, their corporate
offices, with the exception of Cigna, are located outside of the market. As such, much of the
planning, particularly for the Medicare program, is conducted elsewhere. Thus, the timing of market
entry in Tampa-St. Petersburg is informed as much by corporate strategy and experience in other
markets as by local market dynamics.

MANAGED CARE DEVELOPMENT IN TAMPA-ST. PETERSBURG

Growth Among all Payers (Commercial, Medicaid, and Medicare)

Managed care in the Tampa-St. Petersburg area has had a relatively rocky history since its
introduction in the mid-1980s. Financial failure and scandal plagued plans in the late 1980’s.
Between 1991 and 1995, three managed care plans in the Tampa market were either acquired or
closed. Since 1995, however, managed care’s share of the market has climbed steadily, with growth
in all major market segments led by expansion in the commercial market. By February 1997, 39
percent of the commercial population, 43 percent of the Medicaid population, and 30 percent of the
Medicare population in Pinellas and Hillsborough counties combined were enrolled in an HMO, with
penetration slightly higher in Hillsborough than in Pinellas across all payers.

History of Medicare Risk Plan Entry and Enrollment Concentrations

In 1988, Humana was the first managed care plan to enter the Tampa-St. Petersburg Medicare
market through the purchase of IMC, and it remained the only Medicare managed care plan until
1993 when AvMed entered the market. Since 1995, six additional plans have obtained Medicare risk
contracts. Humana however, continues to dominate the market, having captured 57 percent of the
Medicare managed care market in Hillsborough County, 44 percent in Pinellas County, and 53 percent in outlying Pasco County. HMOs, including Medicare HMOs, tend to begin operation in the two core counties, Hillsborough and Pinellas, where the greatest number of elderly reside and the provider system is more developed. Humana and AvMed so far have expanded the furthest into the outlying counties beyond Hillsborough and Pinellas, though others are following.

**ENROLLMENT TRENDS IN MEDICARE MANAGED CARE**

We identified the following factors as largely responsible for the overall course of the development of Medicare managed care in Tampa-St. Petersburg. While some of these factors likely affected the development of commercial managed care in the market as well, their effect on the development of Medicare managed care may be more profound because of the unique risks and benefits of managing care for the Medicare population. The risk of managing the care of the elderly is greater than that of the commercial population because the cost of caring for the elderly tends to be, on average, three times higher than the cost of caring for the commercial population. The potential to gain from properly managing care may likewise be greater for the Medicare population compared with the commercial population.

**Tampa-St. Petersburg's Proximity to Miami**

The Tampa-St. Petersburg Medicare market has always been attractive to health plans because of the size of its elderly population. The Miami market to the south, however, has an even larger elderly population and much higher AAPCC rates. As one plan executive noted, because the AAPCC in Miami is so much higher than in Tampa, Medicare managed care plans were better able to “cut their teeth” there. While plans may have entered the Medicare market in Miami first, expansion to other Florida markets, such as Tampa-St. Petersburg, was often a long-term objective. However, expansion was not realistic for most plans until the local provider environment became sufficiently mobilized for managed care contracting and beneficiaries less resistant to the concept. This does not appear to have happened until the mid-1990s. One exception was IMC/Humana. It may be that the staff model structure of this plan and its ability to work with a small subset of salaried providers rather than developing a large, broad network to deliver care to members may have enabled it to survive in the market before other plans, most of which tend to be IPA/network models. However, in part because the appeal of the staff model plan is limited, Humana saw very little Medicare enrollment growth until the 1990s when it diversified its network offerings.

**Scandal-Plagued Start in Florida**

Scandals have plagued the managed care industry in Florida since the late 1980s when IMC failed financially. IMC was eventually bought by Humana Medical Plan. Humana, too, suffered from negative publicity surrounding a 1990 report in the *Fort Lauderdale Sun Sentinel* about alleged widespread abuse of Medicare beneficiaries enrolled in their plan. In 1994 and 1995, another newspaper series documented widespread abuses among Medicaid-serving HMOs, with a focus on the Miami market. These widely publicized allegations (substantiated in many cases) reportedly had a chilling effect on managed care enrollment in Tampa-St. Petersburg, which took many years to dissipate.
Provider Organization and Infrastructure

The lack of provider organization, integration, and experience with managed care in Tampa-St. Petersburg limited its attractiveness as a Medicare expansion market. Plans’ ability to shift to providers some or all of the responsibility or risk for caring for plan members has emerged as an important strategy for some plans in the market, given the moderate AAPCC and desire to limit plan exposure or risk. Though IMC/Humana had been in the market since the 1980s, its staff model structure at that time required the participation of a relatively small number of salaried physicians.

Expansion of Tampa-St. Petersburg’s commercial and Medicaid managed care markets in the early and mid-1990s spurred the development of hospital networks, physician organizations and changes in care delivery patterns, with consequences for Medicare managed care development. New plans expanding in the market in the early 1990s differed in structure from that of IMC/Humana at the time. These plans had large and more loosely structured networks of physicians instead of the smaller network of salaried physicians maintained by Humana and thus were more dependent on broad-scale physician organization in the market. The prospect of this newer model of managed care combined with the entrance of national chains (Columbia HCA and national physician management companies) has encouraged providers to organize in ways that encourage continued growth. For example, in reaction to the entrance of Columbia, existing independent hospitals have adopted a more regional outlook and affiliated as the Bay Care Health Network. Formed in 1997, Bay Care has aggressively sought to distinguished itself as the nonprofit response to Columbia, with distinct attributes and qualities. Physicians who have traditionally practiced alone or in small groups have likewise begun to consolidate and formalize relationships with hospitals, facilitating managed care contracting and the assumption of risk.

During this period, delivery patterns also began to change in the Tampa-St. Petersburg area. Specifically, inpatient utilization began to fall. Among the elderly, hospital utilization (measured by the number of hospital days per 1,000) fell 25 percent between 1992 and 1996, from 2,250 days to 1,700. Inpatient use among the elderly in Tampa-St. Petersburg now compares favorably with other similar metropolitan areas in Florida, encouraging the growth of risk-based contracting.

The HMO market for Medicare thus became increasingly competitive beginning in 1993. AvMed joined Humana in the market that year. Since then, six other plans have either independently filed for Medicare risk contracts or purchased existing plans with Medicare contracts. These include PCA and Prucare in 1994, HIP and Cigna in 1995, and most recently Blue Cross Health Options and United Healthcare in 1996, bringing the total number of plans serving Medicare beneficiaries in Tampa-St. Petersburg to eight.

OPERATIONAL EXPERIENCE WITH MEDICARE MANAGED CARE

Enrollment Generally from the Individual Market

Competition in the Medicare HMO market in Tampa-St. Petersburg has primarily been for the individual market; however, plans are developing products to appeal to group purchasers, which have shown increasing interest in Medicare risk for their retirees. For example, Humana noted that today roughly 5 percent of its Medicare membership comes from group contracts, up from less than 1 percent five years ago. Increasing interest among group purchasers is largely a response to
Financial Accounting Standards Board (FASB) regulations. These regulations require corporations to account for their retiree health care benefits on an accrual basis, increasing the accounting costs of their retiree medical benefits by a factor of six to eight or more, and thereby prompting employers to explore less costly alternatives.

**Impact on Beneficiary Access and Satisfaction**

Medicare HMOs' provision of $1,000 annual prescription drug benefit, partial coverage of hearing and vision care, and reduced co-payments at zero premium increases financial access for Tampa-St. Petersburg beneficiaries who would not otherwise be able to afford such coverage. Though we lack hard data, beneficiary advocates believe that Medicare HMOs have in fact appealed to those in the market with lower incomes (as they have nationally).

Others note that enrollment in a Medicare HMO is not without some costs. For those beneficiaries who join HMOs and relinquish their supplemental Medicare insurance, access to supplemental policies if they should choose to disenroll at a later date is limited. Florida state regulations guarantee issue but do not require community rating of policies (including Medicare supplemental policies). As such, some beneficiaries who enroll in an HMO but are dissatisfied may not be able to resume their previous supplemental policy at affordable rates.

There are no available data on the satisfaction rates of Medicare HMO enrollees in the market. However, because the Medicare HMO program is entirely voluntary, enrollment and disenrollment may provide some indication of the level of satisfaction. Plan officials believe Medicare risk disenrollment to be higher than average or desirable. Beneficiary advocates believe the majority of plan disenrollment results from restrictive plan networks. Plan staff believe that the high level of re-enrollment in other Medicare risk plans after disenrollment that they have witnessed means that beneficiaries are not dissatisfied with the Medicare risk program, but rather with the plan options available. In response, plans are developing additional benefit options.

**Multiple Benefit Options Growing**

The benefits offered by all eight plans in the market quickly approached the same structure and level. However, now the offering of multiple Medicare options in an attempt to reach additional members appears to be a growing trend. Blue Cross Health Options is leading the effort by offering Medicare risk, Medicare Select (a demonstration product that provides supplemental benefits through a restricted network of providers), and traditional Medigap products. Humana, which offers a Medicare risk plan and traditional Medigap coverage, is developing a point of service (POS) product that gives beneficiaries the option of using out-of-network services at an additional cost. Both Blue Cross's and Humana's strategies are intended to attract more traditional supplemental policyholders to a Medicare risk product. As previously rated, Blue Cross's “triple option” enables supplemental policyholders to enroll in its Medicare risk product but return to their Medigap coverage with minimal financial penalty should they choose to disenroll. Humana's POS is likewise designed to appeal to the Medigap policyholder that has thus far resisted HMOs because of the network restrictions.

**Approach to Network Development Differs Among the Largest Plans**

The networks of the three largest risk contractors are similar in terms of providers included;
however, relationships between the plans and contracting providers vary in their risk-sharing arrangements and in their management philosophy. Because plans in the Tampa-St. Petersburg market see an inherent tension in creating integrated systems, they try to avoid “giving providers too much leverage.” This tension in plan-provider relations is manifested in negotiations over exclusivity and the transfer of risk and care management functions from plans to providers. Developing exclusive relationships with providers and delegating more risk and management functions to them would encourage provider integration and care management. However, it would also encourage plan dependence on providers and potentially afford providers greater power or leverage in future plan negotiations, thus giving rise to varying levels of tension. The degree of tension depends on the market position of both the plans and the providers with whom they contract.

Among the three plans, Humana is the only one pursuing exclusivity in its relations with providers and delegating both risk and care management responsibility to Medicare-serving provider systems. As the dominant plan, especially in Hillsborough and the surrounding counties where there is less competition, Humana’s size enables it to negotiate favorable and exclusive contracts that delegate risk and certain management functions. In turn, it sees these arrangements as valuable in maintaining its dominant position in the market.

More recent plan entrants, with less-developed provider relations and previously poor financial experience with this product in other markets, such as AvMed and Blue Cross Health Options, have resisted exclusive contracts with providers and retained greater control over medical management. In fact, both Health Options and AvMed prefer that their members not constitute more than 20 to 25 percent of a physician’s practice to prevent a physician or group of physicians from gaining too much leverage. In order to control utilization and quality in the plan, AvMed does not delegate risk or any management functions to providers. Health options does transfer risk, though separately to physicians and hospitals, but retains control of all management functions.

Providers View Medicare Managed Care as a “Ground-Floor” Opportunity

With the commercial market increasingly saturated, many providers are now organizing and affiliating specifically to position themselves for Medicare managed care. Because of its delayed growth, Medicare managed care represents an opportunity for providers in the market to “get in on the ground floor” in terms of managed care contracting and retaining their patients. Unlike the commercial and Medicaid managed care contracts that have been in place for some time, Medicare managed care contracting is still in flux, with many of the recent plan entrants still building their networks. This sentiment also was expressed by providers in New York City, another market that experienced late Medicare managed care growth. However, the organizing efforts of providers in Tampa-St. Petersburg in response to the prospect of continued managed care growth appears to be motivated more by a desire to increase provider leverage with HMOs than to form a truly integrated delivery system.

Network Formation, PHO Development, and Physician Group Formation

Providers in the Tampa-St. Petersburg market are responding to the growth of Medicare managed care by affiliating with hospital networks and by developing provider-hospital organizations (PHOs) and physician groups. However, provider organization and sophistication varies, with a subset of providers in Pinellas County considerably more advanced than those in Hillsborough County. Many of the provider affiliations that exist so far, we were told, exist more
Three hospital networks (Columbia, Tenet, and Bay Care) and eight PHOs have emerged in the Tampa-St. Petersburg area. Two-thirds of all hospitals in the market are now aligned with one of the three networks and some speculate that a fourth may emerge. The three networks vary in size with Columbia and Bay Care considerably larger than Tenet. The eight PHOs likewise vary in size from 80 member physicians to nearly 500, and most are still in the formative stages. In addition, four physician groups in the Tampa-St. Petersburg market (three in Pinellas County and one in Hillsborough County) have greater than 100 physicians each. More recently, a number of IPAs, large and small, have formed in both Hillsborough and Pinellas counties. With the exception of the three large multispecialty groups in Pinellas County that account for 350 physicians total, however, we were told that most of the newer entities could be better described as loosely formed IPAs with limited authority and infrastructure. In contrast, the three groups in Pinellas County have existed for many years, have formed strong relationships with the hospitals with which they share a campus, and have experience managing the care of commercial and Medicare HMO members. Two of the three have recently been purchased by national physician practice management companies. These national companies have purchased groups across the market, particularly in Pinellas County, forging new alliances among previously unaffiliated groups.

Provider Weakness and HMO Concerns about Leverage Hinder Integration

Even among providers with significant experience and ability to manage care, attempts to create truly integrated systems in the Tampa-St. Petersburg market have been hindered by two factors: (1) multiple alignments and competitive tension among the different groups of physicians and hospitals and (2) HMOs’ stated aim to avoid giving providers “too much leverage,” limiting the ability of some models to successfully negotiate managed care contracts.

The experience of Columbia Largo Hospital and the Diagnostic Clinic located on the hospital campus is an example of how multiple alignments and competitive tension can hinder managed care contracting with integrated systems. Diagnostic Clinic, a 130-member group now owned by Med Partners physician management corporation, has significant managed care experience and a history of working with the Key Largo hospital before and after it was acquired by Columbia. In contract negotiations with Humana, Diagnostic sought to assume full risk for the care of Humana patients and negotiate with Columbia Hospital to deliver inpatient care. Columbia, however, rejected this arrangement, seeking to assume full risk for the care of Humana patients itself, an arrangement Humana rejected. As a result, the two organizations (Columbia and Diagnostic) separately manage parts of the health care delivery system with no risk sharing and limited joint care management.

THE FUTURE OF MEDICARE MANAGED CARE IN TAMPA-ST. PETERSBURG

About to “Take Off”

The Medicare managed care market we observed during our visit to Tampa-St. Petersburg in July 1997 appears to many like a market on the verge of “taking off” for three main reasons.
• The concentration of elderly in the market is large and expected to grow, especially in Hillsborough County where the number of elderly is projected to increase by 35 percent in the next 15 years (faster than the average rate of growth for Florida).
• Commercial and Medicaid premiums have remained constant or declined while Medicare payment rates have risen gradually, making the Medicare market attractive to plans.
• The recent increase in managed care’s share of the commercial market in the area may mean that those who turn 65 in the future already will be familiar with managed care systems, increasing the likelihood of Medicare risk enrollment.

Growing Market for Group Retiree Plans

Though the historical emphasis on individual enrollment of Medigap policyholders in risk HMOs will likely continue, some larger employers are beginning to more aggressively pursue Medicare risk plans for their retirees. Medicare HMO options with enhanced benefits at little or no additional premium are attractive to employers that currently help finance Medicare supplemental coverage for their retirees. Health Options, Humana, and United are each developing Medicare risk products for large employers. With experience, plans will also continue to expand into the surrounding counties. These counties typically have AAPCC rates similar to those of Hillsborough and Pinellas counties, but less sophisticated provider systems that will pose a challenge to Medicare risk contractors.

Newer Plans with Minimal Presence Struggling

Whether some of the newer plans that currently have only a minimal presence in the market will exert greater influence in the future is unclear, especially in light of Humana’s large enrollment base and recent focus on developing multiple products to appeal to an even wider range of beneficiaries. Though the six recent plan entrants are large national firms with experience in the Medicare market and substantial financial resources, only Blue Cross Health Options appears to have attracted any significant enrollment thus far. Two of the newer plans (HIP and Prucare) recently announced an unlimited prescription drug benefit for zero additional premium. To date, both plans have minimal enrollment and though their Medicare enrollment may increase in the short term as a result of the new benefit, their long-term prospects are unclear. Given the reported plan-switching propensity of enrollees in the market and the moderate AAPCC payments. There is some doubt whether the new benefit is financially feasible without a premium increase. However, current trends in hospital utilization among Medicare managed care enrollees suggest that additional savings may accrue to well-managed plans.

Impact of the Balanced Budget Act of 1997

Anticipated changes in plan payments as a result of the Balanced Budget Act of 1997 will likely have a small immediate impact on managed care growth though its long term impact could be larger. The Act’s provision that restricts AAPCC premium growth will mean that the annual increase in the AAPCC in the market will be lowered to 2 percent in 1998, a significant decrease over previous years’ increases of 8-10 percent. The other change in plan payments is the carve-out of GME payments from calculation of the AAPCC. Because of the limited academic medical orientation in
the market, the carve-out provision will not substantially alter AAPCC rates in Tampa-St. Petersburg.

While no plan has announced an intention to exit the Medicare market, plan executives perceive that the new limits on the annual AAPCC increase will severely impact Medicare HMOs’ financial viability in the future, particularly in markets such as Tampa-St. Petersburg where plan payments are already moderate and margins small. This expectation is further enhanced by the perception that cost control through a further decrease in inpatient utilization among the elderly (witnessed over the previous four years) is not substantial. The recent decline was partly responsible for the increased interest of HMOs and growth in Medicare risk in the area. However, neither the Medicaid nor commercial markets appear particularly attractive at this time, potentially mitigating any shift of managed care plans away from Medicare risk in the market.

The Tampa-St. Petersburg market may be affected by another provision of the Act that authorizes provider sponsored organizations to contract directly with HCFA to care for Medicare beneficiaries on a risk basis. Hospital systems in the market were clearly interested in this as an option. Whether hospitals systems are truly committed to developing the administrative systems that are necessary to contract as PSOs, or whether they are posturing in an effort to increase their bargaining leverage with HMOs is not clear. Nor is it known whether hospitals in Tampa-St. Petersburg would even be able to build the comprehensive delivery and other systems necessary. Their limited experience managing risk and care under current Medicare HMO contracts and difficulty affiliating with physicians pose considerable barriers, though more so in Hillsborough than Pinellas.
PART I

INTRODUCTION TO THE MARKET

Part I of this report introduces the market in Tampa-St. Petersburg with an overview of why it was included in this study, our definition of the market, and its distinctive features. These features are key to understanding the development of Medicare managed care thus far and how the market may evolve in the future. We also trace the development of managed care in the market, with an emphasis on Medicare managed care, including its timing and recent growth. Our focus here, as elsewhere in the case study, is on the acute care system, which is central to the Medicare program.

A. RATIONALE FOR SELECTING THIS MARKET

Tampa-St. Petersburg is a diverse metropolitan area with a large retirement community. As such, it is home to a large and growing number of Medicare beneficiaries. The elderly in Tampa-St. Petersburg account for about a fifth of the population. In total, there are just under 345,000 elderly in Pinellas and Hillsborough counties (where St. Petersburg and Tampa are located, respectively), (Table 1). The elderly are particularly dominant in Pinellas where two thirds of the market’s 345,000 elderly reside, accounting for one fourth of the population in that county.

Tampa-St. Petersburg was selected as one of the four markets for in-depth case-study because of its rapid recent growth in Medicare risk enrollment despite its moderate AAPCC. In 1993 only 2 Medicare risk plans were operating in the market. Since then, an additional 6 have contracted with HCFA to serve Medicare beneficiaries on a risk basis in the Tampa-St. Petersburg area. Most of the enrollment growth has been even more recent. In the seven month period between November 1996 and June 1997, Medicare risk enrollment has increased 34 percent and 57 percent in Hillsborough and Pinellas, respectively, with total Medicare risk penetration climbing to 30 percent.
TABLE 1
THE TAMPA-ST. PETERSBURG MEDICARE
HMO MARKET IN BRIEF

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, Hillsborough and Pinellas Counties</td>
<td>1.8 Million</td>
</tr>
<tr>
<td>Population Change (%) 1990-1995</td>
<td>5%</td>
</tr>
<tr>
<td>Population Change (%) 1980-1995</td>
<td>29%</td>
</tr>
<tr>
<td>Population in MSA (Tampa-St. Petersburg-Clearwater)</td>
<td>2.2 million</td>
</tr>
<tr>
<td>Medicare Beneficiaries in Hillsborough &amp; Pinellas (1997)</td>
<td>346,808</td>
</tr>
<tr>
<td>Medicare Beneficiaries in HMOs, June 1997&lt;sup&gt;a&lt;/sup&gt;</td>
<td>98,900</td>
</tr>
<tr>
<td>Medicare Beneficiaries in HMOs, November 1996</td>
<td>67,000</td>
</tr>
<tr>
<td>1997 Aged AAPCCs - Weighted Average, both counties&lt;sup&gt;a&lt;/sup&gt;</td>
<td>$495</td>
</tr>
</tbody>
</table>

| Dominant Risk Plans (Medicare risk enrollment, June 1997)<sup>b</sup> |
| Enrollment in Hillsborough and Pinellas counties               |
| Humana Medical Plan                                            | 38,588  |
| Blue Cross Health Options                                     | 16,076  |
| Prucare                                                        | 15,746  |
| United Healthcare                                              | 10,703  |
| AvMed                                                          | 7,457   |
| PCA                                                           | 5,291   |
| Cigna                                                          | 3,230   |
| Health Insurance Plan (HIP)                                   | 1,807   |
| Community Hospital Beds/1,000 (1995)<sup>b</sup>              | 5.0     |
| Non-Federal Practicing Physicians/100,000 (1994)<sup>c</sup>   | 221     |

SOURCE: 1996 Florida Statistical Abstract, unless otherwise noted.

<sup>a</sup> Medicare beneficiary and managed care enrollment from HCFA Medicare Managed Care Enrollment Report, June 1997

<sup>b</sup> FHA Inpatient Utilization Report, May 1997, based on MSA.

<sup>c</sup> NIHCM Health Care System DataSource, 1996, based on MSA.
and 27 percent in each of the two counties. This rate of growth is comparable to that recently seen in New York City, a market that also had little Medicare risk enrollment until recently, but significantly higher Medicare AAPCC rates. In addition, we selected Tampa-St. Petersburg because it is located in Florida, a major retirement center which also has a long and varied history of managed care, not all positive, especially in Miami. We felt that it would be useful to examine the Florida experience from the vantage point of Tampa-St. Petersburg, a large Florida Medicare market like Miami, but one whose experience has been less studied and may share more similarities with other markets. We sought to compare the experience in Tampa-St. Petersburg with another market with modest AAPCC payments but with very different, and less favorable, growth patterns, Portland Oregon.

The development of Medicare managed care in the Tampa-St. Petersburg market raises a number of interesting questions: What accounts for the recent rapid growth and why didn’t it develop sooner? Why, given the moderate Medicare capitation rate, is penetration now twice the national average? What are the effects of Medicare managed care on providers and beneficiaries? In this case study we describe the course of the development of Medicare managed care in the Tampa-St. Petersburg market in order to understand the timing of Medicare managed care development in the market, the reasons behind it, and its effects on various market players. We also explore the implications of the development of Medicare managed care in the Tampa-St. Petersburg market for its development in other moderately-sized markets with similar characteristics.

B. GEOGRAPHIC DEFINITION OF THE MARKET

The cities of Tampa and St. Petersburg, located in the neighboring counties of Hillsborough and Pinellas, are situated on either side of Tampa Bay, a relatively large body of water spanned by 3 long bridges. They are geographically close (roughly 20 miles apart) and are part of the same larger metropolitan statistical area (MSA), Tampa-St. Petersburg-Clearwater. The MSA includes four
counties: Hernando, Hillsborough, Pasco and Pinellas and a total of 2.2 million people with 80 percent of the population residing in the core counties of Hillsborough and Pinellas. Tampa and St. Petersburg are the largest cities in their respective counties.¹

Market players define the market differently for their own purposes. Health plans consider Tampa-St. Petersburg part of a larger and broader market extending North and East into the neighboring counties of Pasco and Hernando that comprise the MSA and in some cases beyond. Yet the delivery of care has traditionally been more local in nature. Natural barriers (namely, the Bay) separate Tampa from St. Petersburg and residents of the two counties do not typically “cross the bridge” to seek care except in special circumstances. The limited number of major roadways in the area also restrict geographic access and effectively divide Pinellas county into northern and southern regions along Almerton Road, a major roadway in Pinellas.

For the purposes of this study we will focus on the two core counties of the MSA (Hillsborough and Pinellas) and their main cities (Tampa and St. Petersburg), but consider them within the broader surrounding market of which they are a part. The two core counties are not only the largest in terms of population, but are also the most highly evolved in terms of managed care system development. Plans expanding to the Tampa market begin operations in the two core counties before expanding into the surrounding counties. This occurs for 2 main reasons: (1) the large size of the elderly population in both counties, and (2) the greater level of sophistication among providers and receptivity to managed care in the two counties. Thus, concentrating on the core counties of Pinellas and Hillsborough also allows us to extrapolate out to the surrounding counties where development is subject to many of the same influences as those in Pinellas and Hillsborough.

¹Tampa’s 285,000 residents represent 32% of Hillsborough county’s population and St. Petersburg’s population of 242,000 represents 27% of Pinellas’ population.
C. POPULATION CHARACTERISTICS

1. Demographic Characteristics

The 345,000 elderly in Hillsborough and Pinellas counties account for 20 percent of the entire population in aggregate compared with 13 percent nationally, but they are not evenly distributed across the two counties, nor is their concentration the same. In Pinellas, the 224,000 elderly account for one quarter of the population. Only half as many elderly reside in Hillsborough: 120,000 or 13 percent of the county’s population (Table 2). In the broader market, the highest concentration of elderly in the area reside in Pasco county just north of Pinellas and Hillsborough. In contrast, the elderly in Dade county where Miami (another large retirement community) is located, comprise a proportion of the population similar to that for the nation (14 percent).

The profile of the elderly in Tampa-St. Petersburg differs in important ways from that of the nation. First, Tampa-St. Petersburg’s Medicare beneficiaries are substantially older than those nationally. Sixty-three percent of the elderly (defined as those 65 and over) are over the age of 74, compared with 46 percent nationally. Second, there are fewer people age 65 and older who identify themselves as African American or “other” in Tampa-St. Petersburg than there are elsewhere in the US. And third, there are proportionately fewer elderly with very low incomes (measured as annual household incomes below $10,000) than there are nationally.

The socio-demographic income distribution of the area’s residents varies across the 2 counties. In terms of income, Hillsborough has a substantially higher proportion of low income individuals than Pinellas. Among the elderly, 11.2 percent in Hillsborough are eligible for Medicaid compared with just 5.6 percent of the elderly in Pinellas. The black and Hispanic populations in Hillsborough are also substantially larger in number and as a proportion of the elderly population than in Pinellas.
### TABLE 2

DEMOGRAPHIC PROFILE OF TAMPA-ST. PETERSBURG IN CONTEXT  
(Data for Hillsborough and Pinellas Counties)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total Population</th>
<th>65+ Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tampa-St. Pete</td>
<td>US</td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>30%</td>
<td>38%</td>
</tr>
<tr>
<td>25-44</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>45-64</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>65+</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>65-74</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>75-84</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>85+</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>White</td>
<td>87</td>
<td>80</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 10,000</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>10,000-24,999</td>
<td>40</td>
<td>26</td>
</tr>
<tr>
<td>25,000-49,000</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>50,000 or more</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td><strong>Percent Medicare (1997)</strong></td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Percent Uninsured (non-elderly) (1994)</strong>*</td>
<td>16%</td>
<td>17%</td>
</tr>
</tbody>
</table>

**SOURCE:** 1996 Florida statistical Abstract and US Census Bureau except where noted

*Estimates from the NIHCM Health Care System DataSource, 1996.

N/A = not applicable
2. **Migration Patterns of the Elderly**

As a retirement community that draws people from throughout the US, Tampa’s elderly residents have had varying degrees of exposure to and experience with managed care. Anecdotally, beneficiary advocates have found those retirees relocating to the area from the east coast more receptive to managed care than those who lived in the area before retirement or relocated from markets where managed care has historically been less common such as the midwest, where many of Tampa-St. Petersburg’s retirees lived prior to retirement. In addition, the elderly in southwest Florida are more likely to reside in the area for only part of the year compared with those in other Florida regions, which may reduce their interest in Medicare risk enrollment (University of Florida, December 1994). Often referred to as “snowbirds,” these retirees spend their winters in Florida but leave during the summer months. HCFA regulations mandate that Medicare risk enrollees who move out of the service area for a period of 90 days or more be automatically disenrolled. Interrupted coverage can pose a barrier to Medicare HMO enrollment, frustrating plans and confusing beneficiaries; plans are in the process of responding to this with special options for Medicare enrollees (discussed later).

3. **Industry and Employment Base**

Retail, services and the government are the largest industries in the Tampa-St. Petersburg market, employing nearly 70 percent of all non-farm workers. Combined, the top 10 public employers have 114,000 workers (FHA July 1997). Health services are a large segment of the employment base, employing nearly 10 percent of all residents in the market.

Outside of the large firms, employers appear not to have aggressively pursued more competitive processes in health care purchasing. Approximately 65 percent of all workers are employed by firms with greater than 50 employees. The Employers Health Coalition (formerly known as Florida Gulf
Coast Health) is a Tampa-based business coalition that reportedly focuses on consumer education, rather than on group contracting or negotiating. Florida established Community Health Purchasing Alliances or CHPAs in the early 1990s to pool purchasing power for smaller employers; however, their impact has been disappointing thus far. The 2 CHPA districts in the Tampa-St. Petersburg markets have reported only an 8 percent employer penetration.

4. Sources of Supplemental Health Care Coverage for the Elderly

The elderly in Tampa - St. Petersburg, as elsewhere in the county, have the option of purchasing supplemental or Medigap policies for coverage of co-insurance and deductibles under Medicare. Hard data on the number of supplemental policies in effect in the Tampa-St. Petersburg area are not available.

As is the case nationally, the elderly in Tampa-St. Petersburg may either purchase supplemental coverage individually or they may be covered by their previous employers. For those in the Tampa-St. Petersburg market without retiree coverage of health benefits, beneficiary advocates believe that the cost of most supplemental policies is prohibitively high for many of Hillsborough county's elderly, where 11 percent of the elderly have sufficiently low incomes to qualify for Medicaid. Medicaid, like a supplemental product, covers Medicare premiums, co-insurance and deductibles. In contrast, the elderly in Pinellas generally have higher income levels and are less reliant on Medicaid than their Hillsborough counterparts. Advocacy groups perceive that they are better able to afford supplemental policies, thus facing less of a financial incentive to join HMOs that offer enhanced benefits for zero additional premium.

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²Activities include the recent publication of the Health Care Buyers Value Report comparing area hospitals and preparation of satisfaction report cards.
Among those retirees in Tampa-St. Petersburg with coverage through their employers, however, there is reportedly little incentive (or even opportunity) for Medicare HMO enrollment. Given Tampa-St. Petersburg’s employment profile, firm structure and limited degree of purchaser organization, it is not surprising that employer coverage of retirees in the area has not been subject to the more competitive processes that often encourage Medicare risk enrollment. In addition, because many of the market’s elderly moved to Tampa-St. Petersburg upon retirement, their previous employers are not likely to be located in the market, further complicating the purchase of retiree health benefits.

D. HEALTH CARE DELIVERY SYSTEM

1. Hospitals

As in other areas of the county, Tampa-St. Petersburg and its surrounding area has an over-supply of acute care hospitals. With 34 acute care hospitals and 5 beds per 1,000 residents in the greater MSA, the market has greater hospital capacity than the national average (3.5 beds per 1,000) (Table 3). Inpatient utilization in Tampa-St. Petersburg measured in days/1,000 is similar to the national average (744 and 756, respectively) but occupancy rates are very low at 41 percent compared with 63 percent for the nation. Compared with Miami, utilization and occupancy rates are both considerably lower (particularly for the over 65 population) in Tampa-St. Petersburg.
<table>
<thead>
<tr>
<th></th>
<th>Tampa-St. Pete-Clearwater MSA</th>
<th>Miami MSA</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Hospital Beds Per 1,000 Population, 1995</td>
<td>5.0</td>
<td>4.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Admissions Per 1,000 Population, 1995</td>
<td>129</td>
<td>164</td>
<td>117</td>
</tr>
<tr>
<td>Inpatient Days Per 1,000 Population, 1995</td>
<td>744</td>
<td>1020</td>
<td>756</td>
</tr>
<tr>
<td>Occupancy Rate, 1995</td>
<td>40.9</td>
<td>59.2</td>
<td>62.7</td>
</tr>
<tr>
<td>Average Length of Stay, 1995</td>
<td>5.8</td>
<td>6.2</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Physicians</strong> (per 100,000 population, 1994)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Active Non-federal Physicians</td>
<td>222</td>
<td>332</td>
<td>222</td>
</tr>
<tr>
<td>Primary Care</td>
<td>76</td>
<td>124</td>
<td>86</td>
</tr>
<tr>
<td>Primary Care with Subspecialty</td>
<td>16</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Non-primary Care Specialists</td>
<td>130</td>
<td>186</td>
<td>123</td>
</tr>
</tbody>
</table>

NA = not available


Not surprisingly hospitals in Tampa-St. Petersburg are fairly weak. The market is not oriented towards academic medicine and has a limited public health infrastructure. For example, there is only one public hospital in the area, Tampa General Hospital (TGH), which also serves as the teaching hospital of the University of South Florida (USF). However, TGH is no longer associated with the county nor is it the major provider of indigent care in Tampa. Its planned conversion to private, non-profit status in late 1997 is discussed later. More recently, hospitals have begun to form networks in order to strengthen their position. Two-thirds of the hospitals in the area, particularly in Pinellas County, are now aligned with one of three networks: Columbia, Tenet, and Bay Care Health Network (a consortium of nonprofit hospitals).

2. Physician Organization and Supply

Physician supply in the greater Tampa-St. Petersburg market is similar to that found elsewhere in the nation (222 physicians per 100,000 residents) but considerably lower than in the state of Florida generally, especially in the Miami area where there are 350 physicians per 100,000 residents. We could find little hard data on the level of physician aggregation and organization in Tampa-St. Petersburg. Roughly 30 percent of physicians in both Hillsborough and Pinellas practice as part of a group of 3 or more physicians, according to the American Medical Association. Key market players we interviewed expressed differing opinions on the degree and sophistication of provider organization in Tampa-St. Petersburg, partly reflecting differences in how they have developed by geographic location within the market. At the time of our visit most providers in the

3 In Hillsborough, care for the indigent is publicly financed by the county through provider payments. This is unlike other parts of Florida where subsidies are directed to the public hospitals or other traditional providers of care to the indigent and Medicaid. St. Joseph’s hospital has recently replaced TGH as the main provider of Medicaid and publicly-financed indigent care in Hillsborough
area practiced independently but four models of physician organization were beginning to emerge: Columbia hospitals and physicians, physician hospital organizations (PHOs), free-standing IPAs and groups, and practice management companies acquiring or managing groups.

3. **Regulatory Environment**

The state of Florida has generally supported an entrepreneurial approach to health care delivery. For profit hospitals and health plans have long operated in the Florida market. Since the mid 1980’s the state has encouraged managed care plans, including smaller, non-HMO licensed, and typically for profit, prepaid health service plans (PHSPs) to serve Medicaid beneficiaries. However, in 1995 in response documented abuse and fraud in the program, the state halted all direct marketing, reviewed each of the operating plans and increased regulatory oversight, including requiring all PHSPs to gain commercial licensure by July 1997.

In keeping with its support of an entrepreneurial approach to health care delivery, the state of Florida currently hosts 2 Medicare demonstrations. Florida is one of 15 states that offer a Medicare Select option for Medicare beneficiaries. Medicare Select is similar to traditional Medicare supplemental or Medigap policies except that beneficiaries are limited to a network of providers. More recently, as part of another demonstration, the state Department of Insurance was the first in the country to allow a provider sponsored organization (PSO) to contract directly with HCFA to deliver care to Medicare beneficiaries on a full risk basis.

E. **KEY FEATURES AND MARKET DYNAMICS**

The Tampa-St. Petersburg market and the population residing therein are characterized by a number of distinctive features that are key to understanding why Medicare managed care has lagged in this market and how it may evolve in the future. These include the greater importance of Medicare
as a payer than elsewhere, the lack of strong provider organization and integration, and the national orientation of the health plans in the area.

1. Importance of Medicare as a Payor

The sheer size and concentration of the elderly population in Tampa-St. Petersburg makes Medicare a very important payer in the market, prompting one provider to note, “in Tampa, if you don’t have a Medicare strategy, you don’t have a strategy.” In 1996, Medicare paid for slightly more than half of all acute care discharges in the Tampa-St. Pete-Clearwater MSA, compared with 32 percent nationally. Medicare’s importance varies by county, increasing in those counties with a higher proportion of elderly residents. In the outlying counties of Pasco and Hernando with their high concentration of elderly, Medicare pays for 69 and 62 percent, respectively, of all acute care discharges. In Pinellas and Hillsborough, Medicare pays for 53 and 38 percent, respectively (FHA, 1997).

2. Historical Lack of Provider Organization and Recent System Development

Providers in the Tampa-St. Petersburg market historically have not been organized into separate, distinct systems, though this appears to be changing. Physicians have traditionally admitted patients to multiple hospitals, especially in Hillsborough. Providers report that consumers have not readily identified with “name brand” hospitals or systems in the past. There have been few distinct or niche players among hospitals in the area (i.e., hospitals known or identified as providing particular services) with the exception of a small cancer center (the Moffit Cancer Center) on the campus of the University of South Florida and the TGH trauma unit. These two hospitals are unique in their ability to draw patients from the greater surrounding areas.

This appears to be changing now as the level of competition in the market has increased and national chains, namely Columbia and other physician management companies, have entered the
market. For example, in reaction to the entrance of the Columbia hospital system, existing independent hospitals have adopted a more regional outlook and in 1997 organized into the alternative system - the Bay Care Health Network. BayCare has aggressively sought to portray itself as the non-profit response to Columbia, with attributes and qualities it hopes will be recognized as distinctly different. Likewise, the lack of organization among physicians is beginning to change. National physician management companies have purchased multiple independent provider groups, forging alliances among groups dispersed throughout the larger Tampa-St. Petersburg market and creating larger and what they too hope will be more readily identified physician networks.

3. **Provider Aggregation, Not Integration**

The level of provider organization and integration has likely delayed the development of Medicare managed care in this market and continues to affect plan strategy and operations in the area. Some market observers have noted that because of the moderate AAPCC and great potential to lose financially in the Medicare program, plans have sought to transfer risk to providers in their Medicare network to a greater extent than they have in their commercial networks. This requires a certain level of experience and ability to assume risk among providers. Many of the recent efforts to create distinct organizations and systems of care have been characterized as provider aggregation as opposed to integration. In particular, the lack of narrowly-defined referral patterns between physicians and hospitals continues to limit the development of physician-hospital relationships. Some hospitals reportedly face continued difficulty formalizing relationships with providers, with physicians and hospitals in Pinellas having greater success than those in Hillsborough. Physician groups that have formed recently appear only loosely affiliated and do not yet appear to have developed the necessary infrastructure for true integration.
4. National Orientation of Health Plans

The national orientation of health plans operating in Tampa-St. Petersburg distinguishes this market, though it is typical of other Florida markets. This dominance of national firms in the Tampa area appears to have significantly influenced the organization and structure of the area’s health care system and development of managed care. Many of the strategic decisions made by plans in the market appear to be part of broader strategies, rather than a strategy based exclusively or even primarily around a single entity or the Tampa-St. Petersburg market. Because all the Medicare-serving plans in the Tampa-St. Petersburg market are either national plans or state-wide plans based in Miami, their corporate offices, with the exception of Cigna, reside outside of the market. As such, much of the planning, particularly for the Medicare program, is conducted elsewhere. Thus, the timing of market entry and plans’ approach to serving Medicare in Tampa-St. Petersburg are informed as much by local market dynamics as by a larger corporate strategy and experience in other markets. All the plans we met with have a separate unit devoted to the development of a Medicare product housed in its corporate office. The corporate office is responsible for the development of the plan’s Medicare market in multiple sites throughout Florida and in some cases beyond.

F. THE MANAGED CARE INDUSTRY

1. Historical Development

Managed care in the Tampa area has had a relatively rocky history since its introduction to the area in the mid 1980s. HMOs throughout the state received considerable negative press in the late 1980s beginning with the financial failure of Florida’s largest HMO, International Medical Centers (IMC), which served 40,000 Medicare beneficiaries in the Tampa-St. Petersburg market at that time. IMC was eventually bought by Humana Medical Plan.

In the past 7 years, many plans have entered and left the Tampa market. In 1991, ten HMOs served the Tampa Bay area. Three of the ten (Equicor, Metlife and Partners) have since been
acquired or closed (FHA July 1997). Other managed care plans have entered the Tampa market mostly in response to the state’s move to encourage more Medicaid beneficiaries to enroll in managed care plans. Some of these were PHSPs or prepaid health service plans - plans developed specifically to serve Medicaid beneficiaries, but which were eventually required by the state to develop commercial products and gain HMO licensure. The PHSPs in Tampa-St. Petersburg have all since either been acquired by licensed HMOs or have expanded to the commercial market. Among the HMOs currently serving the market, most are either national HMOs with strong Medicare products or Medicaid plans which have expanded into the commercial market (FHA July 1997).

2. Recent Growth

Managed care penetration overall in Tampa-St. Petersburg has climbed steadily between 1995 and 1997, with growth in all major market segments. This growth has been led by expansion in the commercial market. In mid-year 1995, 19 percent of the population in Pinellas and Hillsborough were enrolled in a managed care plan. Managed care penetration in the two counties grew to 37 percent (nearly 900,000 people) over the next 20 months, with growth among all market sectors. By February 1997, 39 percent of the commercial population, 43 percent of the Medicaid population, and 30 percent of the Medicare population in Pinellas and Hillsborough combined were enrolled in an HMO, with penetration slightly higher in Hillsborough than Pinellas across all payers. Managed care penetration in the outlying counties (16-28 percent across all payers) lags that in the core counties, but is also increasing.

3. Enrollment Patterns

Though 19 HMOs serve the Tampa-St. Petersburg-Clearwater market, enrollment is concentrated in a handful of plans for each payer (i.e., commercial, Medicaid and Medicare) (Table 4). This
is particularly true in the core counties of Pinellas and Hillsborough, where 3 or 4 HMOs dominate each of the three market segments and have captured nearly 60 percent of the managed care market.

Enrollment is most concentrated among a handful of plans in the Medicare market. Humana leads Medicare enrollment in three of the four counties that comprise the MSA, controlling 57 percent of the Medicare managed care market in Hillsborough, 44 percent of the market in Pinellas and 53 percent of the market in Pasco (Table 5). Only in the outlying county of Hernando does another plan, AvMed, enroll a greater proportion of Medicare enrollees than Humana (55 percent versus 40 percent). The next largest Medicare HMO in the greater Tampa Bay area is Blue Cross Health Options which controls no more than 15 percent of the Medicare market in any one of the four counties. Even among those HMOs that dominate the Medicare market, Medicare enrollment comprises only between 8 and 36 percent of a plan’s total enrollment. However, Medicare beneficiaries are responsible for a considerably greater share of a plan’s total revenues and expenditures, as they tend to cost, on average, 4 times as much as commercial enrollees.

4. Timing of Medicare risk plan entry

Of the existing plans operating in the Tampa-St. Petersburg Medicare market, Humana was first to enter and continues to dominate that market. As previously noted, Humana entered the market in 1988 with the purchase of another HMO - International Medical Centers (IMC). IMC was a staff model plan that had filed for bankruptcy and for whom Humana hospitals represented the largest creditor.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Total Enrollment</th>
<th>Medicare Enrollment</th>
<th>Share by Payer (%)</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Commercial</td>
<td>Medicare</td>
<td>Medicaid</td>
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<tr>
<td>Cigna</td>
<td>133,175</td>
<td>1,050</td>
<td>99%</td>
<td>1%</td>
<td>0%</td>
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<td>Humana Medical Plan</td>
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<td>40,656</td>
<td>64</td>
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<tr>
<td>Prucare</td>
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<td>9,955</td>
<td>85</td>
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<tr>
<td>AvMed</td>
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<td>7,922</td>
<td>72</td>
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<td>Aetna</td>
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<td>Principal</td>
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<td>PCA and PCA Family(^1)</td>
<td>32,163</td>
<td>6,395</td>
<td>30</td>
<td>20</td>
<td>50</td>
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<tr>
<td>HIP</td>
<td>9,193</td>
<td>747</td>
<td>92</td>
<td>8</td>
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<td>All others</td>
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<td>0</td>
<td>31</td>
<td></td>
<td>69</td>
<td></td>
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<tr>
<td>Total</td>
<td>636,495</td>
<td>82,237</td>
<td>76</td>
<td>13</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** FHA September 1996 HMO Market Share Report for Hillsborough and Pinellas counties.

\(^1\)Humana Medical Plan and PCA/PCA Family have since merged.
### TABLE 5

MEDICARE RISK PLAN ENROLLMENT IN THE GREATER TAMPA-ST. PETERSBURG MARKET  
June, 1997

<table>
<thead>
<tr>
<th></th>
<th>Tampa-St. Petersburg</th>
<th>Outlying Areas</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hillsborough</td>
<td>Pinellas</td>
<td>Pasco</td>
</tr>
<tr>
<td>Humana</td>
<td>18,098</td>
<td>20,490</td>
<td>12,099</td>
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<tr>
<td>Health Options</td>
<td>3,450</td>
<td>12,626</td>
<td>7,825</td>
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<tr>
<td>Prudential</td>
<td>5,323</td>
<td>10,423</td>
<td>2,429</td>
</tr>
<tr>
<td>United</td>
<td>4,689</td>
<td>6,014</td>
<td>683</td>
</tr>
<tr>
<td>AvMed</td>
<td>2,884</td>
<td>4,573</td>
<td>3,885</td>
</tr>
<tr>
<td>PCA</td>
<td>2,545</td>
<td>2,746</td>
<td>1,196</td>
</tr>
<tr>
<td>Cigna</td>
<td>1,347</td>
<td>1,883</td>
<td>20</td>
</tr>
<tr>
<td>HIP</td>
<td>1,347</td>
<td>460</td>
<td>497</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39,683</strong></td>
<td><strong>59,215</strong></td>
<td><strong>28,634</strong></td>
</tr>
</tbody>
</table>

AAPCC (aged 1997)  | $487       | $500     | $539   | $511       |
Risk Penetration  | 30.2%      | 27.5%    | 32.9%  | 23.9%      | 28.9%   |

**SOURCE:** HCFA Managed Care Reports, June 1997.
Humana faced no competition in the Medicare market until 1993. Plans were probably reluctant to follow Humana to the Tampa-St. Petersburg market for two reasons. First, IMC and Humana operated as staff model plans and thus had very different needs from most other network/IPA model plans in terms of provider network development. The latter need a larger pool of providers familiar with managed care processes and with appropriate utilization patterns in order to develop their networks. Second, the previously poor financial experience of plans in other markets with similarly moderate payment levels was likely cause for concern. In 1993, however, AvMed, a Florida-based plan headquartered in Miami, entered the market. AvMed started as a physician-run HMO for airline employees based in Miami in the mid 1970's. With its base in South Florida, AvMed expanded north into the Tampa-St. Petersburg, Gainesville and Orlando areas as part of its stated strategy to become the largest non-profit plan in the state of Florida. Blue Cross's Health Options entered the Medicare market in Tampa-St. Petersburg soon after AvMed for similar reasons. The plan was motivated to enter the market as a result of its stated goal to serve 25 percent of the entire Florida market statewide. For Health Options, developing a Medicare risk product was essential given the large number of elderly in Florida. Health Options is one of the plans with previous poor financial performance that re-entered the Jacksonville Medicare market in 1994 and entered Tampa-St. Petersburg for the first time soon after, in early 1996. United entered the market in 1996 with the acquisition of a series of plans, one of which had only recently been approved by HCFA to serve Medicare beneficiaries on a risk basis. Cigna is the only Medicare risk plan in the Tampa market whose Florida headquarters are in Tampa. Despite its corporate presence in the market and dominance in the commercial market, it was late to enter the Medicare market and its Medicare enrollment remains low. With the entrance of so many plans, Medicare risk penetration has increased 57 and 34 percent, respectively in Hillsborough and Pinellas in the 7 months between November 1996 and June 1997.
PART II

EXAMINING MEDICARE MANAGED CARE MARKET DYNAMICS
IN TAMPA -ST. PETERSBURG

Part II discusses what we learned during our site visit about the dynamics of Tampa-St. Petersburg's Medicare managed care market. We met with several key Medicare providers, plans and beneficiary advocates to learn their views of how the system developed and the issues they face. This part is comprised of three sections: Section A focuses on the factors influencing the development of the Tampa-St. Pete Medicare managed care market. Section B reviews the operational program experience and section C examines how various market players have been affected by the development and operation of Medicare managed care.

A. GROWTH OF MEDICARE MANAGED CARE

Medicare managed care in Tampa-St. Petersburg was slow to develop but has recently grown in terms of the number of plans serving Medicare beneficiaries on a risk basis and the number of Medicare enrollees. The presence of a more lucrative Medicare market to the south in Miami, the chilling effect of managed care scandals on Medicare beneficiaries, and a lack of provider organization in the Tampa area have all worked to delay Medicare managed care development in this market. More recently, as the Medicare managed care market in Miami has continued to mature, plans have sought to expand to the Tampa-St. Petersburg market for multiple reasons. These include, most notably, changes in provider organization and delivery of care in the market that are more conducive to managed care growth and saturation of Tampa-St. Petersburg's commercial and Medicaid markets.
1. Plans Gain Experience in Miami and Then Enter the Tampa Market in Their Quest to Expand

The Tampa Medicare market has always been an attractive market because of the size of its elderly population. However, Miami, another Florida market south of Tampa-St. Petersburg with a larger population of elderly and a much higher AAPCC ($748 for the aged compared with $487 and $500 for Hillsborough and Pinellas, respectively), offered a more attractive environment for plans seeking to serve the Medicare market. As one plan executive noted, because the AAPCC in Miami was (and still is) so much higher than in Tampa, plans were better able to “cut their teeth” managing the care of an elderly population in Miami than in Tampa. Thus, while plans may have entered the Medicare market in Florida through Miami first, expansion to other Florida markets, such as Tampa-St. Petersburg, represented a long term objective. However, expansion was not realistic until the local provider environment became sufficiently conducive to managed care contracting and beneficiaries less resistant to managed care.

2. Historical Barriers: Beneficiary Reluctance to Join HMOs and Lack of Provider Organization and Infrastructure

The demographic profile of the Medicare population in Tampa-St. Petersburg likely contributes to the reported reluctance of beneficiaries to join Medicare risk HMOs. The market’s senior population is both substantially older and slightly wealthier than the senior population nationally (table 2). This combination might explain why Medicare beneficiaries in the market have historically been less likely to join HMOs. As older beneficiaries, they may have established long-standing relationships with their physicians, and thus are less willing to join an HMO if it requires

4Despite its high concentration of retirees, Tampa-St. Petersburg still has only three fifths of the elderly that nearby Dade and Broward counties (where Miami is located) has.
a change in their physician. Wealthier seniors likewise have less of an incentive to forgo their costly supplemental policies and join an HMO at zero premium.

In addition, beneficiaries’ negative perception of Medicare HMOs goes back to the financial failure in 1988 of IMC and the subsequent scandal that plagued its successor - Humana Medical Plan. As the sole HMO serving Medicare beneficiaries in the Tampa market in the 1980s, IMC was synonymous with Medicare managed care in the Tampa area throughout the 1980s. Then in 1990 the Fort Lauderdale Sun Sentinel published its report alleging widespread abuses against Medicare beneficiaries enrolled in IMC’s successor Humana, focusing on the Tampa-St. Petersburg and Miami areas where 84 percent of Humana’s Medicare members resided. The General Accounting Office later substantiated many of the alleged abuses, including improper marketing and claims payment practices as well as instances of poor quality of care, (GAO HRD 92-11, November 1991). This had a “chilling effect” on beneficiary enrollment in the Tampa area which took many years to dissipate, according to beneficiary advocates.

In addition, the lack of provider organization, integration, and experience with managed care in the Tampa-St. Petersburg area had limited its attractiveness as a Medicare expansion market given the complexities of managing this population. Plans’ ability to shift some or all of the risk of caring for plan members has emerged as an important strategy for some plans in the area, more so for their Medicare products than commercial given the moderate AAPCC and complex health care needs of the Medicare population. IMC/Humana, a group/staff model plan, was the only Medicare risk plan in the market for many years and was able to grow its medicare membership to 40,000 by the late 1980s, but did not witness much growth after that until the mid 1990s. It is likely that its group/staff model structure which relied upon a small set of mostly salaried providers rather than a broad network of providers was the key factor enabling the plan to operate successfully in the market when other IPA/network plans did not. The network constraints of the group/staff model structure,
however, was also likely responsible for the plan’s inability to grow its membership beyond a certain point and may be the reason why Medicare risk enrollment remained stagnant in the market until the more recent entrance of IPA/network model plans. Executives of IPA/network model plans noted that not until a broader base of Tampa-St. Petersburg providers became increasing familiar with managed care in the commercial and Medicaid markets and patterns of care began to change, did they consider the Tampa-St. Petersburg Medicare market a sufficiently attractive one to enter. Inpatient utilization in Tampa-St. Petersburg remained high at 2,240 days/1000 for the over 65 in 1992. This is slightly higher than the Florida average at that time but lower than Miami utilization of 2,917 days/1000. However, though Miami utilization was 30 percent higher than utilization in Tampa-St. Petersburg, its AAPCC was nearly 50 percent higher. As noted, in 1992 only a small subset of providers in the area (those affiliated with IMC and then Humana) contracted with managed care plans and were familiar with managed care systems.

3. HMO Expansion in the Market’s Commercial and Medicaid Sectors Have Enhanced Provider Organization

Though plans were focusing their Medicare efforts in Miami, they were pursuing the commercial and Medicaid markets in Tampa-St. Petersburg. Plan expansion in Tampa’s Medicaid and commercial markets appears to have influenced both the structure of the delivery system and patterns of care, with consequences for Medicare development in the market. During the early 1990s, the state stepped up efforts to enroll Medicaid beneficiaries in managed care plans and targeted Tampa, along with a handful of other markets, for early implementation of Medicaid managed care. Medicaid HMO enrollment increased 32 percent in the 18 months ending December 1996 (FHA 1997). Commercial enrollment also expanded during this period with enrollment increasing 26 percent during this same 18 month period and now almost 40 percent of Tampa Bay’s commercial population is enrolled in an HMO. Commercial expansion was lead by Cigna Health
Plan, the only plan whose Florida operations are based in Tampa. Cigna’s pursuit of the commercial market to the exclusion of the Medicare and Medicaid markets in Tampa-St. Petersburg at this time was unique. Other plans such as AvMed and Health Options, pursued multiple markets.

The prospect of managed care has encouraged providers to organize in ways that encourage continued growth. Providers in the Tampa-St. Petersburg area began to respond to managed care on multiple levels but the response has been more pronounced in Pinellas than Hillsborough. Physicians who have traditionally practiced alone or in small groups have begun to consolidate and formalize affiliations with hospitals, facilitating managed care contracting and in some cases the assumption of risk. According to the Florida Hospital Association (FHA), Tampa Bay (which it defines as Hillsborough and Pinellas counties) is currently experiencing more physician consolidation than other areas of the state. Approximately 33 group practices serve the Tampa Bay area, though only three have greater than 100 physician members. Likewise, 8 PHOs have also formed in the area. Prior to this, according to the director of a large medical group, HMOs faced greater challenges, “If they wanted to manage care, they could only do so by increasing utilization review and lowering fees, not really managing care,” a reference to the lack of provider integration and inability to implement care management processes in the market.

During this period, delivery patterns also began to change in the Tampa-St. Petersburg area. Specifically, inpatient utilization for the over 65 declined nearly 25 percent from 2,250 days/1000 elderly in 1992 to 1,700 in 1996. In contrast, utilization for the over 65 in Miami has fallen only 8 percent during this same period, and remains considerably higher than that in Tampa-St. Petersburg. It is not possible to know whether increases in the level of provider organization and provider

5By focusing its efforts on commercial enrollment in the Tampa area, the plan was able to capture 27 percent of Tampa-St. Petersburg’s commercial HMO members, statewide, Cigna serves fewer than 9 percent of all HMO members, (FHA 1997).
familiarity or experience with managed care systems resulted in the decline in inpatient utilization, though they were likely contributing factors. As a result, current inpatient use for the over 65 in Tampa compares favorably with other similar metropolitan areas such as Ft. Lauderdale (1,904), Jacksonville (2,119), Miami (2,675), and Orlando (1,743).

4. HMOs Begin to View the Tampa-St. Petersburg Medicare Market as an Attractive Expansion Market in the mid 1990's

In their quest to expand in the mid 1990s, HMOs turned to Tampa-St. Petersburg's Medicare market for two reasons. First, plans had exhausted readily available Medicaid and commercial enrollment in the market, leaving Medicare as the only untapped source of potential enrollment. With commercial managed care penetration at slightly less than 40 percent, market observers believe that it has plateaued at least in the near future because of the lack of employer/purchaser organization in the market. Medicaid enrollment is also unlikely to increase for many commercially-based plans in the area, but for different reasons. AvMed, Humana, and United have each discontinued their contracts with the state to serve Medicaid (though only Humana and United served Medicaid in the Tampa-St. Petersburg market). Lower payment rates combined with the recent introduction of a controversial competitive bidding process, which was eventually dropped, caused 2 of the above 3 plans to exit the Medicaid market, with AvMed dropping out for unrelated reasons.

Second, plans experienced success in the Miami Medicare market and grew more confident in their ability to successfully manage the care of this challenging population. The confluence of these two factors -- evolution of the market and HMOs' quests to expand (with the exception of Humana which was already in the market, having purchased IMC) — resulted in HMO expansion from Miami into the Tampa-St. Petersburg Medicare market beginning in 1993. Though slow, HMO expansion to Medicare in the market was considered inevitable because of its high concentration of elderly.
These dynamics made the HMO market for Medicare in Tampa-St. Petersburg increasingly competitive beginning in 1993. AvMed became the second plan (after Humana) to enter the market that year. Since then a steady stream of plans has either independently filed for Medicare risk contracts or purchased existing plans with Medicare contracts. These include PCA and Prudential in 1994, HIP and Cigna in 1995 and most recently Blue Cross Health Options and United in 1996, bringing the total number of plans operating Medicare risk contracts in the Tampa area to 8. All these plans with the exception of Cigna (whose corporate office is located in Tampa) operated successful risk products in the Miami market prior to expansion to Tampa.

B. OPERATIONAL EXPERIENCE WITH MEDICARE MANAGED CARE PROGRAMS

Our discussion of the operational experience of plans and providers with Medicare managed care is based on the experience of the three largest risk contractors in the Tampa-St. Petersburg market -- Humana, Health Options and AvMed. In addition, we met with a number of hospitals and hospital systems including Columbia, Morton Plant Mease Health Care, Tampa General Hospital (TGH) and Bayfront Medical Center. Morton Plant Mease and Bayfront had recently joined the BayCare Health Network - a network of 9 nonprofit hospitals in the Tampa-St. Petersburg area. Of those with whom we met, only TGH operates independent of a larger network. Since our visit, two notable developments have occurred in the market, attesting to its rapidly changing nature. The first was the resignation of Columbia’s CEO amid allegations of Medicare fraud and abuse in the system both locally and nationally. The director of Columbia’s Tampa region has likewise resigned. The second development is the affiliation agreement reached between Morton Plant Mease Hospital (a member of the Bay Care Health Network) and Tenet. Under the agreement, for-profit Tenet and
non-profit Morton Plant Mease will form a for-profit partnership to oversee the 122-bed Tenet hospital and a Morton Plant Mease home care business (Limbacher, 1997).6

We begin with a discussion of marketing and enrollment of beneficiaries in Medicare risk plans and follow with a description of provider networks that have been developed by HMOs and those that are forming independently within Tampa-St. Petersburg’s provider community. We conclude with a discussion of efforts underway to manage the care delivery system for Medicare beneficiaries enrolled in Medicare HMOs.

1. **Marketing and Enrollment of Medicare Beneficiaries in Managed Care**

   a. **Medicare product development in context of the competition**

      Between 1987 and 1993, Humana offered the only Medicare risk product in the area. This predominantly staff/group model plan offered a basic option that included an unlimited prescription drug benefit. When AvMed first entered the Tampa market in 1993 it also offered a zero premium Medicare risk product but its prescription drug benefit in Pinellas and Hillsborough counties was limited to $400. Though AvMed’s drug benefit was considerably lower than Humana’s, its network model approach, non-profit status, and reputation for high quality care are, according to AvMed officials, the main reasons it was able to attract both FFS Medicare beneficiaries and Humana risk members to its product. In fact, in its first year, nearly half of AvMed’s Medicare membership were reportedly previous Humana members. Humana and AvMed remained the only Medicare risk products in the market until 1995-1996 when six additional plans entered the market. The benefits

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6According to published reports, Morton Plant needed an acute care presence in Pasco County (directly to the North of Pinellas) to complement its healthcare services there. Columbia owns 2 hospitals in Pasco but Morton Plant Mease preferred to partner with Tenet.
offered by all eight plans in the market quickly approached the same structure and level - zero premium with small co-payments, a $1,000 prescription drug benefit, limited hearing and eye care.

Though there has been little differentiation in the benefit packages of the 8 plans thus far, this now appears to be changing. However, the impact of current trends is still unclear. HIP and PruCare recently announced the offering of unlimited prescription drug benefits with no additional premiums. At the time of our site visit in July 1997, the new benefit had just been announced and it was too soon to gauge the impact of this shift on enrollment and financial viability of those plans or on the market. Medicare enrollment in both plans has been limited to date. Other plans with which we met did not believe the AAPCC would support an increase in prescription drug benefit, especially in light of the fact that both Prudential and HIP reported financial losses the year before.

In terms of geographic coverage, plans have expanded their service area with growing experience in the market. Cigna, the newest plan entrant serves only Pinellas and Hillsborough. Humana, having been in the market the longest has expanded further into Sarasota and Manatee counties to the south. AvMed, the second oldest plan, is the only plan to have expanded into Citrus county though Humana has plans to follow. When plans expand their service areas to include additional counties, they may not necessarily offer the same benefits, particularly when Medicare capitation rates vary. AvMed, for example, lowered its prescription drug benefit to $400 in Citrus county because of its lower AAPCC. Humana has not yet indicated whether it plans to follow AvMed in the lowering of prescription drug benefits when it expands into Citrus.

The offering of multiple Medicare supplemental options is also gaining favor among Medicare risk plans. Blue Cross is leading this effort by offering Medicare risk (through Health Options), Medicare Select and traditional Medigap products.\textsuperscript{7} According to Blue Cross plan executives, this

\textsuperscript{7}As previously noted, Medicare Select is being offered as a demonstration project that allows (continued...)

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triple option provides Blue Cross Medigap holders with the opportunity to enroll in the Health Options Medicare risk product with minimal penalty should they choose to disenroll and resume their Medigap coverage. As in most states, Florida insurance regulations do not require community rating of Medigap policies. Beneficiaries who discontinue their Medigap coverage when they join an HMO may not be able to secure Medigap coverage or may face considerably higher premiums should they decide to purchase their pre-existing coverage through the individual market.

In response to the Health Options triple option, Humana is adding an open-ended point of service (POS) product for its Medicare HMO enrollees. This POS product is designed to appeal to Medicare beneficiaries with individually purchased supplemental or Medigap policies, both its own policy holders and those of Blue Cross. Humana officials believe the reason more of the Medicare supplemental market has not enrolled in traditional Medicare risk is its limits on choice of provider. The POS product represents Humana’s response to this issue. The premium and benefit structure of this new option had not yet been finalized at the time of our visit. However, when they are, Humana expects nearly two-thirds of its own 6,000 Medicare supplemental policy holders will enroll in its POS product and that other supplemental policy holders will follow soon after.

Like Humana, United is offering a new option to appeal to those Medicare supplemental policy holders that have thus far resisted enrollment in Medicare risk. United is planning to offer a portability option that will allow Medicare risk enrollees to retain their coverage if they leave the service area. Given the prevalence of "snowbirds" in the area who leave in the summer months,

7(...continued)
Medigap insurers to provide supplemental benefits through a network of providers. Coverage of supplemental benefits is often limited to those services furnished by participating network providers and emergency out of area care. This differs from a traditional Medigap policy which does not restrict use to a specified network of providers.
United believes the option will be well-received among Medigap policy holders who would otherwise prefer less expensive coverage.

b. Enrollment Sources and Influence on Competition and Market Segmentation

More elderly reside in Pinellas county than elsewhere in the greater Tampa area. As such, Pinellas county is the largest source of enrollment for 7 of the 8 plans. Only HIP draws more of its members from Hillsborough than Pinellas, which likely reflects HIP’s NYC working-class enrollment base which is more similar to the population of Hillsborough county than Pinellas. Plans newest to the area draw a disproportionate number of enrollees from Pinellas, while Humana and AvMed draw enrollees more evenly from the four Tampa area counties. When plans enter the market, they seem to concentrate on Pinellas first and then Hillsborough, not only because the largest number of elderly reside in these 2 counties, but because the AAPCC is somewhat higher there than in the surrounding counties. With experience, a plan’s enrollment base broadens, and enrollment distribution in the new plans will likely mirror that of the older plans, Humana and AvMed, eventually.

All plans we met with targeted the same market: individual enrollees, including those belonging to other Medicare risk plans. AvMed and Health Options both reported that when they first entered the market, they drew heavily from Humana’s risk enrollees. AvMed drew nearly half of its new enrollees from Humana’s Medicare risk product and Health Options likewise drew one quarter of its new enrollees from Humana. Neither plan reported drawing as many individuals with supplemental or Medigap coverage as originally thought. Instead, plans have attracted many more of those in the market who did not have any supplemental coverage prior to HMO enrollment and were subject to considerable out of pocket expenses associated with traditional Medicare. These beneficiaries are attracted to Medicare HMOs because of their expanded benefits and minimal copayments.
The minimal variation in enrollment sources among the plans is likely attributable to the similar marketing approaches of the plans. Most plans employ their own marketing representatives who are salaried and receive commissions for each member enrolled. Health Options follows a different marketing strategy -- it has contractual relationships with roughly 100 sales agents who sell the full range of Blue Cross product offerings and are accountable to Blue Cross. Their compensation is based on the number of policies or products sold and retained.

Historically, the group market for Medicare risk plans (i.e., retirees with employer provided coverage) has been limited. This may be changing in the future, however. All the plans with which we met expressed great interest in the group market, predicting that it would become a growing source of enrollment in the near future. For example, Humana noted that five years ago, group enrollment comprised 1 percent of total Medicare risk enrollment in the Tampa area where as now it is closer to 5 percent. Humana officials attributed this mostly to the adoption of rule 106 of the Financial Accounting Standards Board (FASB) regulations. This rule requires corporations to explicitly account for their retiree health care benefits on their balance sheets as an accrued obligation, increasing the accounting costs of their retiree health care benefits by factors of six to eight or more, and thereby prompting employers to explore less costly alternatives (Hewitt Associates, 1997). To address employer interests, Health Options, for example, is offering more flexible options to employers whose retiree coverage includes more extensive benefits than those covered under the basic Medicare risk plan. Employers are finding the risk plan rates for this coverage to be substantially lower than those of Medigap and other commercial insurers.

2. Plan Network Design

The networks of the 3 largest risk contractors appear similar in terms of providers included; however, relationships between the plans and contracting providers vary considerably in 2 important respects -- the transfer of risk and care management functions from plans to providers. All 3
developed smaller networks for their Medicare members than their commercial networks. This reflects a combination of factors: the smaller size of Medicare enrollment compared with commercial enrollment for these plans, smaller geographic service area, and stated desire of some plans to maintain greater control over the Medicare network. There appears to be considerable overlap in the provider panels of each of the plans as well. For the most part, all the major hospitals and the larger physician groups (Suncoast-St. Petersburg and Diagnostic) that provide care to Medicare beneficiaries in the area contracted with most if not all the Medicare risk plans. However, plans varied in the amount and way in which risk is transferred to providers and the delegation of care management functions to them. The variation is attributable to the different underlying plan strategies regarding network development.

a. Development of the Provider Panel

The development of the 3 largest Medicare risk plans’ provider networks has been heavily influenced by the plans’ histories and current market position. Humana, the oldest and most dominant plan in terms of Medicare enrollment, maintains an eclectic network, a self-described “mixed bag” which reflects its long and varied history in the market. Though Humana originally inherited the staff model structure of IMC in the core counties, it has sought to divest itself of some of its centers and also to add many other independent physicians (practicing in groups and alone) in addition to its staff physicians. More recently in response to competition from AvMed and Health Options, among others, Humana has altered its strategy of network development from one of negotiating the lowest rate with providers to developing longer term relationships with them.

8 The one exception appears to be St. Anthony’s hospital, for which Medicare represents nearly 60 percent of its patient base. St. Anthony’s has not contracted with Prudential, Av Med, PCA or Cigna.
In keeping with this new strategy, Humana is migrating back to the more exclusive group/staff model structure for its Medicare product. Humana currently contracts with 3 types of providers: existing Humana groups and staff model centers, independent provider systems (PHOs and large groups with established relationships with a hospital), and independent physicians. The first two already have the structure necessary to assume greater control over the care management processes. In dealing with independent physicians (the third provider type in its network), Humana has implemented a process to provide them with some of the structure they lack. The plan has grouped some but not all of the otherwise independent doctors in its 8 county network into 10 “groups without walls.” Each group consists of primary and specialty physicians and their associated hospitals. Members who select a primary care physician from within one of the 10 groups will receive all care from participating group providers and no others. This new strategy has reportedly enabled Humana to differentiate its product from those of the competition, decrease administrative costs by creating one point of contact for the plan (the group as opposed to individual physicians), and streamline the care management process by developing closer, more integrated relationships among providers.

Health Options, one of the more recent entrants, followed a very deliberate strategy of network development prior to launching its Medicare product. Unlike Humana, Health Options did not inherit an existing Medicare network structure when it entered the market in 1996. Rather, the plan decided to shift its focus in Tampa-St. Petersburg from individual primary care physicians to larger and more defined networks of providers for Medicare enrollees. Blue Cross Health Options developed what it refers to as a “Care Network” pilot model for its Medicare product in Tampa-St. Petersburg that differed from the existing gatekeeper, network/IPA model developed for its commercial members. The development of this pilot model was driven by the plan’s desire to avoid
the poor financial performance for Medicare that it experienced in Jacksonville, another market with moderate Medicare plan payments.

Health Options’ Medicare network in the Tampa area is comprised of 10 care networks that each include one or two medical centers and an affiliated physician group. Health Options contracts separately with physicians and the medical centers for professional and hospital care. There are nearly 400 Primary Care Physicians (PCPs) and 900 specialists among the 10 Medicare care networks, compared with a commercial network of 1,000 PCPs and 3,200 specialists. Each Medicare member selects a PCP and a network from which he or she and receives all specialty and hospital care. The geographically-based networks are color-coded in member handbooks so they can easily identify their networks.

AvMed has intentionally retained a tight network, which is the smallest of all the risk contractors with which we met, with slightly fewer than 150 PCPs and 500 specialists. AvMed’s strategy is hospital-based: after a demographic analysis of its members, AvMed contracts with hospitals in the area and their affiliated physicians. AvMed contracts with each provider on an individual basis even if they are in groups or otherwise affiliated. Its Medicare and commercial networks are more similar to one another than is the case for the other plans with which we met. When AvMed first developed its Medicare network it invited all physicians participating in its commercial network to participate in the Medicare network. Nearly all those in service areas common to both products elected to do so.

b. Provider Relations and Payment

Plans in the Tampa-St. Petersburg market see a tension inherent in creating integrated systems. They try to avoid “giving providers too much leverage,” which is reflected in their negotiations with providers. This tension in plan-provider relations is manifest in negotiations over exclusivity and the transfer of risk and care management functions from plans to providers. Developing exclusive
relationships with providers and delegating more risk and management functions to them would encourage provider integration and care management. However, it would also encourage plan dependence on providers and potentially afford providers greater power or leverage in future plan negotiations, thus giving rise to varying levels of tension. The amount of tension depends on the market position of both the plans and the providers with whom they contract.

The three plans that we visited approach provider relations and payment differently. Among the three plans, Humana is the only one pursuing exclusivity in its relations with providers and delegating both risk and care management responsibility to them. AvMed pursues a very different strategy, retaining risk (except for primary care) and control over care management (authorizing all specialty referrals and hospital admissions). Health Options’ approach lies somewhere between the two, shifting risk but retaining control over utilization management.

As the dominant plan, especially in Hillsborough and the surrounding counties where there is less competition, Humana’s size enables it to negotiate favorable and exclusive contracts that involve the delegation of risk and certain management functions. In turn, it sees these arrangements as valuable in securing its current position of dominance. Humana has arrangements with systems that exist independently (such as PHOs) and with those that Humana has helped to develop through its grouping strategy. Rather than “micro-managing” physician practices, Humana, in its view, has devoted considerable financial resources to the development of an MIS system that can provide data to providers on the delivery of services to Humana members. Humana believes the MIS system is particularly helpful to those providers that participate in one of the 10 groups without walls, helping them to manage the care of Humana patients. Humana executives believe this strategy will further the plan’s goal of developing long term relationships with providers.

However, Humana is not pursuing exclusive relationships with providers everywhere, varying its strategy according to the local dynamics within each county. Outside Pinellas, few providers
pose a potential threat to Humana, allowing Humana to pursue exclusive relationships with providers in Hillsborough and the surrounding counties. However, in Pinellas county competition is more intense among plans, and providers are more organized and aggressive in their managed care contracting. In Pinellas, Humana contracts with 90 percent of all providers; none of these contracts is exclusive in nature.

Nor does Humana contract with all provider types, shunning some who appear more aggressive. For example, Humana does not contract with Columbia PHOs, objecting to Columbia’s desire to “own and manage the whole delivery system.” Humana also prefers independent physician groups to those affiliated with practice management companies or PMCs. Though Humana executives concede that the PMCs do in some cases add value, their financial strength and growing presence in the market are potentially threatening and represent a disincentive to plan contracting.

More recent plan entrants, with newer relationships with providers and previously poor financial experience, such as AvMed (second into this market) and Health Options, have resisted exclusive contracts with providers altogether and have retained greater control over medical management. In fact, both Health Options and AvMed prefer that their members not constitute more than 20-25 percent of a physician’s practice.

In order to control utilization and quality in the plan, AvMed officials do not delegate risk or any plan management functions. AvMed capitates its primary care providers who serve as gatekeepers and pays annual bonuses based on patient surveys and chart reviews, and pays its specialists on a FFS basis. There is no risk sharing among any of the providers. AvMed does track all referrals from PCPs to specialists, but reportedly approves virtually all of them.

Health Options, while basing the provider network around 10 individual networks, in fact uses a payment system that bypasses this structure. Though Health Options transfers risk to providers, it creates separate hospital and physician risk pools, with some risk sharing between them. Thus,
network components largely assume risk separately for professional and hospital care and the plan retains all management functions. Even if the network components are part of the same system (e.g., a PHO) Health Options will not contract with the PHO but will contract with the hospital and physicians separately. In doing so it also does not necessarily contract with all physicians (particularly specialists) in a given group. Thus, the incentives for providers themselves to manage the full continuum of care are lacking as is much of the ability to do so. However, Health Options officials believe that constructing provider network and payment in this fashion leads to increased quality of care for two reasons. First, limiting the size of the network will better enable the plan to develop the systems needed to manage care. Second, plan officials believe that network providers affiliated with hospitals face incentives to increase referrals to member hospitals which is not necessarily consistent with higher quality of care. In contrast, Health Options staff believe they face incentives to improve quality of care. In addition, plan officials consider providers to be relatively unsophisticated in their care management approaches, managing costs instead of care, similar to the “old style management of HMOs.”

This has created some tension since Health Options has delegated risk for care to providers but not delegated commensurate authority over care management. One Tampa provider characterized this medical management process as “a mother may I system,” a reference to the focus on HMO prior approval mechanisms to control costs. Whether Health Options by working with providers over time will become more flexible in its approach to medical management and sharing some of these responsibilities with providers is unknown. However, structural differences between Humana and Health Options’ network and overall strategies are likely to remain. AvMed is not at present exploring any payment arrangements other than what it already has in place and appears unlikely to do so in the future.
3. Provider Response to Medicare Managed Care: Network Formation, PHO Development and Physician Group Formation/affiliation

With the commercial market increasingly saturated, many providers are now organizing and affiliating in response to the prospect of Medicare managed care. Because of its late growth, Medicare managed care represents an opportunity for providers in the market to “get in at the ground floor” in terms of managed care contracting and retaining their patients. Unlike the commercial and Medicaid contracts that have been in place for some time, Medicare contracting is still in its early stages, with many of the recent plan entrants still building their networks. This sentiment was likewise expressed by providers in NYC, another market that experienced late Medicare managed care growth. However, though providers in Tampa-St. Petersburg have organized in response to the prospect of continued managed care growth, many consider their response motivated more by a desire to increase provider leverage with HMOs than to form truly integrated delivery systems.

Providers are responding in 3 ways generally (with some providers pursuing more than one approach): network formation, PHO development and physician group formation. However, provider organization and sophistication varies throughout the Tampa-St. Petersburg market, with a subset of providers in Pinellas considerably more advanced than those in Hillsborough. Many of the provider affiliations that exist so far, we were told, exist more on paper than in fact (especially outside Pinellas).

Even among those with significant experience and ability to manage care, attempts to create truly integrated systems have been hindered by two factors: (1) multiple alignments and competitive tension among the different groups of physicians and hospitals, and (2) HMOs’ stated fear of giving providers “too much leverage,” limiting the ability of some models to successfully negotiate managed care contracts. Following is a discussion of the experience of a subset of providers in the market that illustrate some of the issues they face in contracting successfully with Medicare HMOs.
a. Bay Care Health Network - “the non-profit response to Columbia”

The drive among providers to affiliate with each other and form regional networks is strong and growing, spurred by the entrance of Columbia Health Corporation in 1993. Prior to Columbia’s entry, there were a few limited alliances among existing hospitals in the area with most hospitals defining their immediate surroundings as their service area. The entry of Columbia with its regional outlook to care delivery inspired other existing providers to adopt a similar approach in response. The result was the formation of BayCare - a hospital network comprised of 8 non-profit hospitals, representing 32 percent of all acute care beds in the market.

Differences in the nature of affiliations among member hospitals in the Columbia and BayCare networks will likely affect how they negotiate with managed care plans. While the Columbia network is based on joint ownership, the affiliation among Bay Care’s hospitals is contractual in nature. For this reason, some market players doubt whether BayCare will be able to negotiate effectively as a single entity, given the diversity of the network hospitals in size, strength, population served and experience with managed care. Because the network was formed in August 1997, at the time of our visit it did not yet have any experience contracting as a network.

There is some speculation that a third health care system might emerge among the remaining 15 independent hospitals, centered around University Community Hospital (UCH), a non-profit hospital with 2 campuses in Hillsborough county. UCH is a non-profit, independent hospital which, despite its name, is not affiliated with the University of South Florida and does not support teaching programs. Between its two campuses, it has over 500 licensed acute care beds and reportedly has been heavily recruited by both the Columbia and Bay Care systems as a partner (cite TBBJ article). To date it has remained independent, but its movements are closely watched by others in the market. It is the largest of all the remaining independent hospitals and the third largest in Hillsborough county (behind TGH and St. Joseph’s hospital). According to a report in the Tampa
Bay Business Journal, UCH is “widely regarded as a linchpin to any hospital network formation in Hillsborough County, ” (Shepherd, August 12, 1996).

b. Physician-Hospital Organizations

We met with executives of 3 physician hospital organizations (PHOs) including 2 of the market’s 8 PHOs with the most success forming physician affiliations and negotiating HMO contracts (the Morton Plant Mease PHO and the Bayfront PHO), and Columbia Hospitals and Physicians. Morton Plant Mease PHO is a large PHO centered around 3 merged hospitals (Morton Plant, Mease Countryside and Mease Dunedin) and 500 physicians in northern Pinellas. It has contracts with Humana, Blue Cross and Cigna. Bayfront PHO is a medium sized PHO, located in Pinellas county, that is comprised of fewer than 100 physicians and participates as a PHO responsible for both hospital and professional services, in the Humana network and more recently in Health Options, Cigna and Pru Care. For both PHOs, Medicare managed care contracting is a priority - roughly half of Morton Plant Mease’s covered lives are Medicare beneficiaries and nearly 80 percent of Bayfront’s covered lives are Medicare HMO enrollees. Given Columbia’s patient base as described previously, Medicare is the single most important payer in the Columbia hospital system and Medicare managed care contracting is a priority. We describe the experiences of these 2 PHOs and Columbia in turn.

**Morton Plant Mease PHO.** The Morton Plant Mease PHO was formed by merging 2 independent PHOs (Morton Plant PHO and Mease PHO), after the merger of their respective hospitals in 1994. Morton Plant hospital in Clearwater is a 742 bed tertiary care hospital. Though an attractive plant, its isolated location prompted hospital executives to create a “corridor of care” by affiliating with other institutions more centrally located in Pinellas county that could provide a referral base. It ultimately merged with 2 primary care medical/surgical hospitals -- 258- bed Mease Hospital Dunedin and 100-bed Mease Countryside hospital. All 3 hospitals are located in Pinellas
but since our visit Morton Plant Mease has affiliated with a 122 bed Tenet hospital in Pasco in order
to expand its geographic service area.\(^9\)

The Morton Plant Mease PHO aims to negotiate full risk global contracts. Its 21,000 covered
lives include those insured through self-funded employers (including 7,000 through the Morton
Plant Mease hospital system), commercial and Medicare HMO enrollees (roughly 50 percent
commercial including self-funded and 50 percent Medicare). All PHO contracts are risk based
contracts, including those with Blue Cross Health Options, Humana, ProCare and Cigna. However,
Health Options does not delegate any utilization review (UR) or quality assurance (QA)
responsibilities. The PHO places a premium on its ability to perform UR and QA functions and
appears to have expended considerable effort in order to do so. The PHO Chief Operating Officer
(COO) previously worked for an HMO. The COO’s expertise reportedly facilitated the delegation
of responsibility for these function by the HMO to the PHO. The PHO continues to work diligently
with the plans, meeting with the plans monthly, to review PHO utilization review and quality
assurance procedures.

Morton Plant Mease PHO executives say that they have vigorously pursued physician
participation in the organization’s system development and care management processes. They
believe this participation is key to both attracting enrollees and managing care. Physicians have 60
percent ownership in the PHO and the hospitals 40 percent; physicians comprise 80 percent of the
board of directors of the PHO. Among PHO physicians, primary care physicians are the most

\(^9\)Under the agreement, the two organizations will form a for profit partnership to oversee Tenet’s
122 bed North Bay Medical Center in Pasco county and Morton Plant Mease’s home care business.
Tenet will lease its medical center to the partnership and Morton Plant Mease will transfer the assets
of its home care business to it. Morton Plant Mease will manage the medical center. How this will
affect Morton Plant Mease’s PHO and managed care contracting is not yet known.

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organized and most closely aligned with the PHO. Of the 150 primary care physicians included in the PHO, over one third are employed by the IPA Morton Plant Primary Care, Inc. in 24 locations, mostly in north Pinellas with some in Pasco County and plans to expand to Hillsborough. The remaining are independent primary care physicians who practice alone or as part of small groups of 15. The PHO’s relationship with the independent physicians is not exclusive and PHO patients represent less than 5 percent of the business for these physicians.

For purposes of participating in the PHO, all primary care physicians form small 15 member clusters based in part on the working relationships already established among them (through complementary call schedules), with an assigned cluster leader. They are in turn capitated for primary care services with profit sharing at the cluster level. In order to facilitate care management among the primary care physicians that are members of the clusters, the PHO provides each designated cluster leader with the cluster’s extra utilization and expenditure profile for all services (primary care, specialty, hospital, etc.) on a monthly basis. The profile is also used to analyze over and under utilization. If expenditures for non-capitated services should be on or under budget for the members assigned to the cluster, the cluster physicians are eligible to share in the profits.

In contrast, specialists are more loosely affiliated and paid on a FFS basis only, with potential for profit sharing based on the overall performance of the PHO and the primary care clusters. There are currently 330 specialists affiliated with the Morton Plant Mease PHO and the panel was closed to specialists at the time of our visit, creating some tension between the PHO and the many specialists affiliated with the 3 Morton Plant Mease Hospitals. Subsequently to alleviate this tension, the PHO opened the provider panel (for a two month period at the end of 1997) to specialists who would like to join the PHO. As a result, 60 new specialists joined the PHO in 1998.

Bayfront Medical Center and PHO. The Bayfront PHO is a newly formed organization consisting of 100 physicians affiliated with the Bayfront Medical Center, a 502 bed, non profit
medical center, that is considered one of two dominant medical centers in St. Petersburg. It was developed to facilitate managed care contracting, including the transfer of risk and the delegation of care management functions to the medical center. Negotiating Medicare risk contracts has been a priority. Even though Medicare represents only 30 percent of the hospital’s revenues, 80 percent of the 10,000 HMO lives for which the Medical Center is responsible for inpatient care are Medicare HMO enrollees. This is a direct result of Bayfront’s strategy, since it views retention of Medicare patients as critical to its survival in a county where providers compete aggressively for Medicare business. Bayfront is surrounded by other major Medicare providers in North Pinellas, where the Morton Plant Mease Health Care system is located, and South Pinellas where Columbia hospitals are located. As part of its strategy, the Bayfront PHO seeks to include independent physicians who admit Medicare patients to Columbia hospitals.

Bayfront Medical center also contracts directly with HMOs separate from the PHO. In fact, the PHO represents only a small portion of the 10,000 lives for whom Bayfront Medical Center is at risk for inpatient care. According to Bayfront officials, HMOs continue to dictate provider contracts. For example, some contract with the Medical center for hospital care and one of two affiliated, yet separate, physician groups, (Suncoast Medical Clinic and South Pinellas Affiliated Physicians IPA) for professional services. The Suncoast Medical Clinic is a large multi-specialty medical group consisting of 60 physicians on the campus of Bayfront Medical Center. Suncoast physicians have traditionally admitted to the Bayfront Medical Center. Recently, a single practice management company purchased Suncoast and another group, St. Petersburg Medical clinic on the campus of St Anthony’s hospital, merging them to form the South Pinellas Affiliated Physicians.

Though Bayfront prefers to contract as a PHO and assume both global risk and management responsibilities, only one plan would negotiate with Bayfront as a PHO. Three of the 4 contracts in which Bayfront Medical participates (including those with Blue Cross Health Options) involve the
transfer of risk for hospital care to the medical center and for professional services to either Suncoast or South Pinellas IPA, with no delegation of care management functions. In these contracts, the plan retains control over pre-authorization of procedures, utilization review, approval of specialty referrals, etc. In contrast, in its most recent contract with Humana (February 1997), Bayfront Medical center was successful in contracting as a PHO. While Bayfront is at risk for inpatient care under all of these contracts, only the most recent contract with Humana involves the delegation of utilization review functions to the Bayfront PHO.

**Columbia Hospitals and Physicians.** At the time of our visit, Columbia was actively pursuing a nationally based strategy of affiliating and acquiring physician practices and surgery centers. Columbia’s stated strategy is not facility-based, but driven by a wider, regional view of the market and a desire to provide a continuum of care which hospitals support but of which they are not the focus. Columbia officials cited the oversupply of hospitals in the area as motivating Columbia’s efforts to broaden its scope of services. To this end, Columbia owned 10 surgery centers, in addition to its 10 hospitals, located throughout the greater Tampa area, and was affiliated with over 3,000 physicians at the time of our visit in July 1997. Affiliations are based on ownership, contractual relationships or less formal agreements. Columbia reportedly owns 20-25 practices in the greater Tampa area, mostly 1 and 2 doctor practices. At the time of our visit, Columbia had also recently launched Columbia Physician Services (CPS) to sell administrative services to Florida doctors and is also developing a proprietary MIS system to link hospitals, doctors offices, home health and other providers. The specific terms of the CPS practice contracts were reportedly not yet developed at the time of our visit.

However, despite Columbia’s efforts to provide the “full continuum of care,” it has had difficulty negotiating contracts as a system of care. This appears to be a direct result of the high level of competition in the area among providers and between HMOs and large health systems like
Columbia. As noted, Blue Cross Health options and AvMed do not contract with PHOs, generally. Even Humana, the plan most likely to contract with PHOs and delegate care management functions, contracts separately with Columbia hospitals and does not contract with Columbia PHOs, expressing concern over the degree of control Columbia seeks over the entire delivery system.

The case of Columbia Largo Hospital and the Diagnostic Clinic located on the hospital campus illustrates the difficulty negotiating contracts between HMOs and integrated health systems like Columbia seeking to manage the full continuum of care. Diagnostic Clinic, a 130 member group owned by Med Partners physician management corporation, has significant managed care experience and a history of working with the Largo hospital before and after it was acquired by Columbia. In contract negotiations with Humana, Diagnostic sought to assume full risk for the care of Humana patients and negotiate with Columbia hospital to deliver inpatient care. Columbia however, rejected this arrangement, wanting to assume full risk for the care of Humana patients itself, an arrangement Humana rejected. As a result, the two organizations (Columbia and Diagnostic) separately manage parts of the health care delivery system with no risk sharing and limited care management between the two.

Columbia’s underlying market strategy in the greater Tampa area, and elsewhere, may soon be changing, however. In November, Columbia announced an internal operating reorganization plan and that it was evaluating various restructuring alternatives which could include the divestitures of certain assets to third parties and spin-offs of certain other assets to Columbia shareholders. As part of these alternatives, Columbia is considering a restructuring that would turn it into a smaller, more focused company with fewer hospitals and ambulatory surgery centers located in strategic markets. According to Dr. Thomas Frist Jr., Columbia's chair and CEO, "By creating smaller, more independent, community-based networks, we will enhance our commitment to providing quality

c. **TGH: Planning a transformation**

TGH’s position is somewhat unique in this market as the only public hospital in the market and one with an unusual profile. Unlike many other public hospitals in Florida and elsewhere, TGH is not supported directly by hospital district taxes. Instead, Hillsborough county funds an indigent care program that functions much like an insurance program with support linked to provided payments. TGH also serves as the main teaching hospital of USF. TGH views itself as poorly positioned to survive in a managed care environment. TGH has been losing market share continually since 1992. It currently serves 16 percent of the market generally, but only 10 percent of the managed care market and its share of Medicaid and Medicare patients is falling. TGH’s large, outdated and poorly located physical plant on an island near downtown Tampa is another liability. The large size of the plant is ill suited to the current focus on ambulatory care, and its location, in its own view, is another detriment.

TGH’s main competition is St. Joseph’s, a private non-profit hospital in Tampa which has one of the best reputations in Hillsborough county. St. Joseph’s approach to managed care contracting is very aggressive. According to an article in the *Tampa Bay Business Journal*, St. Joseph’s has been successful in its efforts to include provisions in its contracts with many HMOs that prohibit the HMO from contracting with nearby hospitals that have more than 300 beds (Shepherd, May 5, 1997). This has prevented TGH from contracting with many HMOs.

In order to strengthen the TGH’s market position and ability to negotiate with managed care plans, TGH officials have attempted to form a partnership with other providers. However, special circumstances around its status as a public hospital have complicated TGH efforts to do so. Statutory provisions prohibit TGH from entering into joint partnerships with physicians. In addition,
the governing board meetings are public, making it difficult to conduct negotiations with other private providers. A potential partner hospital reportedly ultimately refused to negotiate with TGH because of the public nature of the negotiations. Because it has had so much difficulty aligning itself with another hospital or network, TGH is pursuing a long term strategy of legally restructuring itself to allow it to remodel itself as a true AMC with a smaller 400 bed plant on the campus of USF. TGH was finally granted permission to convert to private, non-profit status this winter, as the first step in its transformation.

HMOs do not perceive that TGH’s privatization strategy will significantly change its position in the market, according to an article published recently in the *Tampa Bay Business Journal* (May 5, 1997). Top executives of most HMOs in the area indicated that the conversion to private status would not make them more likely to alter HMO contracts with the hospital, especially given the current strength of neighboring St. Joseph’s Hospital. Whether TGH’s privatization strategy will enable the hospital to effectively overcome these barriers is unknown.

d. Physician Group Formation/Affiliation Spurred by Practice Management Companies

Much of the group formation in the Tampa-St. Petersburg area has been spurred by the entrance of practice management companies like MedPartners and Phycor. Physician interest in practice management companies is motivated by what one observer referred to as the feeling that doctors in the area “need to band together in order to negotiate good deals with insurers and health maintenance organizations. Doctors also increasingly believe they need more efficient management and information systems, which costs millions of dollars and require expertise developed for large scale practices” (Shepherd, June 17, 1996). In addition to the administrative services they provide, practice management companies provide considerable amounts of capital to physician groups which they can use to build and/or improve existing ambulatory care centers, surgical, CT, MRI and lab facilities.
Despite the welcome capital infusion, affiliating with PMCs is not worth the cost for some physicians and groups. Physicians from the Heart Institute of St. Petersburg, for example, severed their ties with the Suncoast Medical Clinic because they would have to pay PhyCor 15 percent of their revenues (Shepherd, Feb 17, 1997). Other negotiations between physician management companies and the 350-doctor USF physicians group and the 400-doctor Tampa Bay Provider IPA have broken down recently as well.

Even successful alliances between provider groups and practice management companies may disrupt historic referral patterns of previously integrated systems. The purchase of multiple groups by a single practice management company has resulted in the consolidation of previously independent provider groups across the market, particularly in Pinellas. This can result in shifting alliances among providers and disruption of previously established relations between physicians and hospitals.

The evolving relationship between Bayfront Medical Center and the physicians of the Suncoast Clinic on its campus illustrates this process. As previously noted, physicians of the Suncoast clinic have historically admitted to the Bayfront Medical Center. However, with PhyCor’s purchase of Suncoast and St. Petersburg Clinic on the campus of the neighboring, and competing, St Anthony’s Hospital, the primary relationship between Suncoast and Bayfront has been displaced by the alliance between the two physician groups. This replacement of Suncoast’s primary alliance with Bayfront by one with a clinic having ties to a competitor’s hospital, has (according to Bayfront executives) hindered efforts of both the hospital and the physician group to develop a more integrated system for managing the care of patients. As noted previously, many of Bayfront’s existing HMO contracts still involve the delivery of professional services by Suncoast physicians and inpatient care by Bayfront, though the underlying relationship between the 2 entities and their respective incentives and objectives may no longer be aligned. For example, the capital infusion accompanying PhyCor’s
purchase of Suncoast enabled the physician group to purchase much of the lab equipment and other machinery previously supplied by Bayfront. Now, rather than working with Bayfront to provide a full continuum of services, Suncoast and Bayfront are competing to provide many of the same services to patients, with the relationship between the two becoming more competitive over time.

Since our visit, the *Tampa Bay Business Journal* has reported that the Florida Medical Association may endorse an AFL-CIO affiliated union for Florida physicians. According to the report, the union would serve not to enable physicians to strike or collectively bargain, but rather “to strictly deal with the managed care industry, to protect the quality of the health care system,” (Shepherd, May 5, 1998). Unionizing physicians is a relatively recent phenomenon. Earlier this year 2,1000 Nassau and Suffolk County, New York physicians affiliated with the Office and Professional Employees Union and it is still too earlier to know what, if any impact, physician unions may have on the evolving managed care market.

4. **Management of the Care Delivery System**

a. **HMO Approaches to the Elderly Population**

Plans have responded to lower plan payments in Tampa and other expansion markets outside of Miami with increased emphasis on early risk assessment and member services for the Medicare population in the Tampa market. For example, AvMed’s “Healthy Seniors Program” was developed in the Miami corporate office, but piloted in Tampa with expansion planned state-wide. The program involves a health assessment to identify high risk beneficiaries, which may include a home visit by a nurse for a physical assessment of an elderly member’s environment. One AvMed official also noted that after expanding out of Miami, the plan developed separate Medicare units within certain core departments such as member services. The challenges of managing the Medicare
population within the constraints of lower plan payments prompted the plan to create separate Medicare units for each of the “core” departments dedicated to serving this population.

Health Options also initiated a health appraisal program for its Medicare members. The appraisal serves to identify certain illnesses and conditions that a member may have. The information is forwarded to the member’s PCP as is the plan’s recommendation of appropriate preventive services. Those that are identified as high risk are contacted by Health Options staff, who encourage the member to schedule a visit with his or her PCP.

Humana developed a similar program one year ago in the Tampa market in response to troubling Medicare disenrollment rates here. Humana found that early contact from a member services representative facilitating the scheduling of an initial appointment with a primary care physician very effective in member retention for the Medicare population. New Humana Medicare members receive a total of 6 telephone calls in the 90 days after the completion of an application, during which a risk assessment is completed and sent to the member’s PCP. Humana follows up with the PCP, suggesting disease management programs offered by Humana and available to the PCP.

b. Quality Management/Disease Management Systems

All the plans with which we met all stressed the importance of quality and disease management systems for the elderly population. Five of the risk plans in the market have received full 3 year NCQA accreditation (AvMed, Cigna, Humana Medical Plan, HIP and Health Options). AvMed, for example, has undertaken a number of special studies relevant to the Medicare population. The studies are undertaken by the central Medicare department located in Miami, with input from and feedback to the local Tampa-St. Petersburg office. These studies have focused on: adult immunization rates (flu, etc), mammography rates and coordination of care for post-myocardial infarction among the elderly. The plan also conducts members satisfaction surveys as well as physician surveys. For 1997, the plan will survey Medicare members specifically to determine
whether and how often they visit their primary care physicians in an attempt to uncover whether and why Medicare members are receiving primary care on a timely basis. Humana and Health Options also have development disease management programs and guidelines relevant to the Medicare population. However, they approach the dissemination of them differently. Because Humana has delegated more care management functions to providers, plan staff seek primarily to make providers aware of the disease management programs developed by the plan. Because Health Options retains responsibility for the care management process, it likewise retains greater control over the implementation of disease management programs.

C. EFFECT OF MEDICARE MANAGED CARE ON MARKET PLAYERS

1. Effect of Medicare Managed Care on Beneficiaries

a. Enrollment in Medicare Risk

Despite the growth of Medicare risk enrollment, many new enrollees are individuals without supplemental policies, according to risk plans in the Tampa-St. Petersburg market. In many other markets, Medicare HMOs attract supplemental policy holders who enroll because the plans offer the same or greater benefits than a supplemental policy at no additional cost. This represents a savings of $70 to $200 per month for enrollees. However, according to plan executives, most of the supplemental policy holders in Tampa-St. Petersburg have not, for the most part, switched to Medicare risk. Group enrollment to date represents a minimal source of enrollment as well.

Neither the under 65 disabled nor the dually eligible Medicaid/Medicare beneficiaries are enrolling extensively in Medicare risk plans, according to plan officials. They report that enrollment of the disabled in Medicare risk has grown recently, consistent with national trends. However, the dually eligible will likely remain in the FFS system for the short term. The Florida Medicaid
program does not currently include the dually eligible in its HMO program and has not developed
a formal mechanism to coordinate Medicaid payments with the Medicare risk program.

b. Access and Satisfaction

Enhanced Benefits. With their zero premiums, Medicare HMOs in Tampa offer enrollees
access to enhanced benefits at no additional cost. The provision of prescription drug benefits, partial
coverage of hearing and vision care, and reduced co-payments for inpatient care increase access to
care for beneficiaries who would not otherwise be able to afford such coverage. Though we have
little hard evidence of the characteristics of Medicare risk enrollees, beneficiary advocates believe
that Medicare risk has appealed primarily to the lower income population in the area (as they do
nationally).\(^{10}\) As such, Medicare risk improves financial access to care for lower income
beneficiaries. With the recent announcement that 2 Medicare risk HMOs will offer unlimited
prescription drug benefit for zero additional premium, beneficiaries are likely to continue to have
access to greatly enhanced benefits at least in the near term.

Access to Supplemental (Medigap) Coverage. Supplemental policy holders may choose not
to enroll in Medicare risk plans for another reason-- the possible inability to afford Medicare
supplemental policies if they disenroll from a Medicare HMO. As is typical of most markets, in
Florida there are guaranteed issue provisions but no community rating. Thus the cost of obtaining
supplemental policy may be prohibitively high for a beneficiary with a serious health problem
However, as noted previously, Blue Cross Health Options, the major insurer to offer supplemental
policies in the Tampa market, does allow Blue Cross Medigap policy holders who join its Medicare

\(^{10}\)That Medicare risk in this market has attracted lower income beneficiaries is consistent with
the reportedly small number of supplemental policy holders converting to Medicare risk, who choose
instead to maintain their relatively expensive supplemental policies.
risk plan to return to their Medigap policies with minimal penalty upon disenrollment from the risk plan.

c. Satisfaction with Medicare Managed Care

We do not have any hard data on beneficiary satisfaction with managed care in the market. However, because the Medicare HMO program is entirely voluntary, enrollment and disenrollment patterns may provide some indication of the general level of satisfaction and dissatisfaction with the Medicare HMOs. In Tampa-St. Petersburg, some plan officials believe that Medicare risk disenrollment (especially among the older plans), may be higher than average or desirable (though we have no data that would confirm or refute this). One beneficiary advocate believes the major cause of disenrollment to be the restrictive provider networks. Beneficiaries typically disenroll upon discovery that their provider is not included in the plan network.

Plan executives have also reported high levels of plan disenrollment followed by enrollment in another plan (also referred to as “ping-ponging”). One executive interpreted this to mean that beneficiaries are not dissatisfied with the Medicare risk program but with the plan options or models in the area. Humana’s offering of a POS benefit and United’s portability option are designed to address this issue. Whether disenrollment will decline as a result is unknown.

2. Medicare Risk in Context of Other HMO Products

Medicare has always been an important payer in the Tampa-St. Petersburg market, but its importance to providers and health plans increases as competition for patients and members intensifies. Penetration in the commercial market has increased and HMO premiums are not growing as large purchasers seek to control costs. While the larger employers in the area have pushed for more competitive processes that often lead to HMO coverage, the area’s many small employers appear not to have aggressively pursued managed care, nor do they appear poised to do
so. For this reason, some market observers believe commercial penetration may have plateaued, at least in the short term. Medicaid has also become a less attractive source of membership for area plans. Humana and United, two of the largest Medicaid serving plans in the market, have withdrawn from the Medicaid market, citing dissatisfaction with the Medicaid contracting process (which recently shifted to competitive bidding) and falling premiums. AvMed never served Medicaid in Tampa-St. Petersburg but did in Miami and Gainesville, where it has likewise recently exited the Medicaid market.

These trends have made Medicare capitation rates increasingly attractive to plans. Though Tampa’s AAPCC is only moderate, it is not viewed as overly restrictive relative to the premiums of other payers. Plans that had previously lost money on their Medicare products in Tampa or other similar markets with moderate payment levels are now experiencing enrollment and financial growth even with zero premium and generous prescription drug coverage (i.e., ones with annual caps of $1,000 or more). AvMed turned a profit on its Medicare product for the first time last year at the same time it increased the generosity of its prescription drug benefit. Likewise, Health Options, which had previously withdrawn from the Medicare market in Jacksonville in the early 1990s because of poor financial performance, has since returned to Jacksonville and expanded to Tampa in 1996 with positive financial outcome thus far. Further, the Balanced Budget Act of 1997 calls for guaranteed annual increases of at least 2 percent. While this increase is considerably lower than the 6-9 percent increases historically, it is greater than that witnessed among commercial and Medicaid rates, which have held constant or declined in some cases. In addition, the number of elderly in the greater Tampa area, already 30 percent of the population, is expected to increase in both absolute and relative terms, further enhancing the importance of Medicare in this market. All these factors have encouraged plans to actively pursue the Medicare managed care market.
3. Financial Effects of Medicare Managed Care on Providers

a. Managed Care a Growing Part of Business

The number of managed care hospital discharges across all payers (Medicaid, commercial and Medicare) has grown absolutely and as a percent of all discharges. In Hillsborough, for example, the number of managed care discharges increased from 27,000 in 1992 to nearly 36,000 in 1995, an increase of nearly a third.

Data on managed care as an increasing source of payment for physicians is not available. Anecdotally, providers report that some physicians have to date been able to avoid managed care contracting in the Tampa-St. Petersburg market, particularly in Hillsborough, while other providers rely primarily on managed care.

b. Medicare an Opportunity for Providers to Realize Potential Savings

Because Medicare managed care involves the transfer of risk to providers more often than under commercial managed care, it represents both a new opportunity and risk for providers. The development of Medicare managed care in the Tampa-St. Petersburg market lagged that of the commercial and Medicaid markets and coincided with provider efforts to organize and develop systems to manage care and risk. Thus, Medicare managed care contracting represented an opportunity for providers to contract as risk-bearing entities and assume many of the care management processes that they often do not under commercial contracts. Some providers complain that the lack of true integration between the providers of ambulatory and inpatient care that results from some HMO contracting policies has prevented providers from realizing potential cost-savings. This combined with the delegation of risk but not utilization review responsibilities to providers has had a deleterious financial effect on at least one provider that will avoid all future contracts that do not delegate responsibility for these functions if risk has been transferred.
c. Practice Management Companies (PMCs) Shifting Care Delivery Patterns

The entrance of practice management companies with access to large amounts of capital has in some cases facilitated shifting care delivery from inpatient to outpatient settings, with financially deleterious effects for providers of inpatient care. For example, upon Medpartner's acquisition of the Suncoast clinic on the grounds of the Bayfront Medical Center campus, this practice management company provided the group with sufficient capital to build same day surgery centers, purchase CT and MRI imaging machinery, etc. These services were historically provided by the Bayfront Medical Center and will likely result in a significant drain of revenue from the medical center.

d. Spillover Effects

As noted previously, Medicare is a dominant payer in the market and the movement to Medicare managed care has been an important factor behind recent provider organization. Conversely, Medicare has also benefitted from the growth in the commercial market, which served to familiarize providers with managed care. The drop off in plan interest in Medicaid managed care has also made Medicare a more attractive option.

With the growth in Medicare managed care, inpatient use for the over 65, generally, has continued its decline. In fact, hospital days per 1000 Medicare enrollees is much lower than for the elderly population. According to a report by Harkey and Associates, in 1996 inpatient days per 1000 Medicare risk enrollees was approximately 1,390 in the counties of Hillsborough and Pinellas, considerably lower than rate of 2,240 per 1,000 elderly in the market. This suggests that Medicare risk enrollment may be a factor driving the decrease in hospital utilization among the elderly, generally (not just those enrolled in Medicare risk plans) recently witnessed in the market.
PART III

POLICY IMPLICATIONS

Part III includes three sections. In the first we draw conclusions regarding Medicare managed care and its future development in Tampa-St. Petersburg. In the second we discuss the potential influence of federal policy changes. We conclude with a section that provides insight for other markets.

A. THE FUTURE OF MEDICARE MANAGED CARE IN TAMPA-ST. PETERSBURG

While Medicare risk enrollment in the Tampa-St. Petersburg market has grown recently, many believe that the Medicare managed care market we observed during our site visit in July 1997 is a market on the verge of “taking off,” for three main reasons. First, the number of elderly in the market is large. Further, it is expected to grow, especially in Hillsborough where the number of elderly is projected to increase by 35% in the next 15 years (faster than the average rate of growth for Florida). Second, commercial and Medicaid premiums have been and continue to remain constant or decline while Medicare payment rates are rising slowly, making Medicare attractive to plans. Third, because most Medicare HMO enrollees have enrolled in managed care on an individual basis (rather than through their employers), the growth of Medicare managed care does not depend on the organization of employer or health care purchasing groups, which appears to be lacking in the Tampa-St. Petersburg area. In addition, the increase in commercial managed care witnessed recently in the market may serve to familiarize those who turn 65 in the future with managed care systems prior to Medicare eligibility, increasing the likelihood of Medicare risk enrollment.

Most expect that recent trends witnessed in the Tampa-St. Petersburg market will likely continue in the future: Medicare managed care will continue to grow in terms of both enrollment and product development, and physicians will continue to organize into groups, some with hospitals and
others without. Among hospitals in the market, Columbia is credited with spurring much of the organization witnessed recently in the market. Though Columbia has recently announced major reorganization plans that will may alter its role in the Tampa-St. Petersburg market, the initial response of competitor hospitals to consolidate and affiliate will likely continue.

As Medicare managed care continues to grow, Medicare risk contractors are likely to tap new source(s) of enrollment. Though the historical emphasis on individual enrollment of Medigap policy holders in risk HMOs will likely continue, there is evidence that some of the larger employers will pursue Medicare risk for their retirees more aggressively, since Medicare HMO options with enhanced benefits at little or additional premium are attractive to employers who currently help finance Medicare supplemental coverage for their retirees. Health Options, Humana and United were each developing Medicare risk products that would appeal to employers. With experience, plans will also continue to expand into the surrounding counties. These counties are typically characterized by lower AAPCCs and less sophisticated provider systems that will pose a challenge to Medicare risk contractors in Tampa-St. Petersburg.

It is unclear whether some of the newer plans which currently have only a minimal presence in the market will exert greater influence in the future, especially in light of Humana’s Medicare current enrollment base and recent focus on developing multiple products to appeal to a wider range of beneficiaries. Though the 6 recent plan entrants are large national firms with experience in the Medicare market and substantial financial resources, only Blue Cross Health Options appears to have attracted any significant enrollment thus far. Two of the newer plans (HIP and Prucare) had just announced an unlimited prescription drug benefit for zero premium. Both plans, to date, have minimal enrollment and though it is likely that their Medicare enrollment will increase in the short term as a result of the new benefit, whether the plans will be able to sustain the initial growth is unclear. Given the reported propensity of enrollees to switch plans in the market and the moderate
AAPCC payments, some doubt whether the new benefit is financially feasible without a premium increase, though current trends in hospital utilization among Medicare managed care enrollees may suggest that additional savings may accrue to well-managed plans.

The changing structure of the provider community in Tampa-St. Petersburg will influence Medicare managed care in the market. Providers continue to organize, consolidate and affiliate among each other with the aim of increasing their negotiating power and enhancing their ability to manage the care delivery process and the financial risk associated with it. We have already witnessed some tension between plans and providers in the market over the delegation of risk and care management processes. This tension is likely to increase if providers are successful in developing care management systems but are not given the responsibility to implement them. Likewise, we have witnessed tension among provider groups in the area as alliances shift among them. This too is likely to continue and may increase.

B. INFLUENCE OF FEDERAL POLICY CHANGES

Anticipated changes in plan payments as a result of the Balanced Budget Act of 1997 will likely have a small immediate impact on managed care growth although its long term impact could be larger. The Act’s provision that restricts AAPCC premium growth will mean that the annual increase in the AAPCC in the market will be lowered to 2 percent in 1998, a significant decrease over previous years’ increases of 8-10 percent. The other change in plan payments is the carve-out of GME payments from calculation of the AAPCC. Because of the limited academic medical orientation in the market, the carve-out provision will not substantially alter AAPCC rates in Tampa-St. Petersburg. None of the Medicare risk contractors in the market have announced plans to exit, but some expressed concern over their ability to remain in the market on a long-term basis if the growth in medical expenditures is not in line with the 2 percent increase in the AAPCC, and plan to re-evaluate their position in the future.
Risk contractor executives perceive that the new limits on the annual AAPCC increase will severely impact Medicare HMOs' financial viability, particularly in markets such as Tampa-St. Petersburg where plan payments are already moderate and margins small. This expectation is further enhanced by the perception that cost control through a decrease in inpatient utilization among the elderly (witnessed over the previous 4 years) is not sustainable. The recent decline was partly responsible for the increased interest of HMOs and growth in Medicare risk in the area.

However, neither the Medicaid nor commercial markets appear particularly attractive at this time, potentially mitigating any shift of managed care plans away from Medicare risk in the market. As previously noted, a number of plans have ceased contracting with the state for Medicaid. Many plans do not anticipate strong future growth in the commercial market, given the limited degree of employer/purchaser organization. While plan staff expressed pessimism over their ability to remain in the market, given the projected impact of the Act on the AAPCC, whether Medicare risk enrollment will grow more slowly or decline depends on a number of factors. These include, but are not limited to (1) increasing employer/purchaser organization and enrollment growth in the commercial market, (2) current trends in inpatient utilization among the elderly, and (3) continued maturation/integration of plan and provider systems.

The Tampa-St. Petersburg market may also be affected by another provision of the Act that authorizes provider sponsored organizations to contract directly with HCFA to care for Medicare beneficiaries on a risk basis. Hospital systems in the market were clearly interested in this as an option. The significant enrollment growth of a hospital system in another Florida market (Orlando) that is contracting with HCFA to assume full risk for providing care to Medicare beneficiaries on a demonstration basis may have had the effect of “whetting the appetite” of some of the larger hospital systems in Tampa-St. Petersburg.
Whether hospitals systems are truly committed to developing the administrative systems necessary to contract as PSOs, or whether they are posturing in an effort to increase their bargaining leverage with HMOs is not clear. Nor is it known whether hospitals in Tampa-St. Petersburg would even be able to build the comprehensive delivery and other systems that are necessary. Their limited experience managing risk and care under current Medicare HMO contracts and difficulty affiliating with physicians pose considerable barriers, though more so in Hillsborough than Pinellas. A recent article in Medicine and Health entitled “Struggling Choices Demonstration Full of Warning Signs for Aspiring Medicare PSOs” may serve to dampen PSO aspirations. The article includes an interview with the administrator of the most successful Medicare PSO participating in the demonstration (the Orlando system), who notes that “the effort, cost and length of time put into the initiative have all been significantly greater than expected.” In addition, the state of Florida, though it initially approved of the Orlando PSO’s contracting directly with HCFA to serve Medicare beneficiaries on a full risk basis, is under pressure from the HMO association to consider legislation that would strengthen the state’s PSO requirements.

C. INSIGHTS FOR OTHER MARKETS

Tampa-St. Petersburg is in many ways more typical of Medicare markets than are any of the other 3 study markets - New York City, Los Angeles and Portland, Oregon. Tampa-St. Petersburg is a market of moderate managed care penetration and AAPCC rates and one whose provider base (in both supply and level of organization) is typical of many markets in the nation. The prevalence of elderly and corresponding importance of Medicare as a payer, however, distinguish it. Tampa-St. Petersburg’s experience in terms of the development of benefit structure and provider networks available to Medicare HMO members in the market may translate to other similar markets.

Of particular interest is the potential for the experience in Tampa-St. Petersburg to illustrate the influence of cross-market interactions on Medicare managed care development. The presence of
Miami, a large dominant market to the south of Tampa-St. Petersburg, has had multiple effects on the development of Medicare managed care in the market. Miami plans are responsible, in part, for both the delay of Medicare managed care development in Tampa-St. Petersburg (as a result of the negative publicity received by plans there) as well as its recent growth. Miami plans viewed Tampa-St. Petersburg as an expansion market. As the large, mostly national, plans in Miami moved into the market, they imported their corresponding strategies. Plans tailored their strategies, however, to reflect the lower AAPCC and different provider structure of Tampa-St. Petersburg compared with Miami. Not all plans appear to have done this successfully, however, at least the first time. Health Options expanded to Jacksonville with poor results and then altered its strategy substantially before expansion to Tampa-St. Petersburg and has thus far been successful. Another plan, PacifiCare, appears not to have been able to successfully adapt its strategy and is the first and only plan to exit Tampa-St. Petersburg’s Medicare HMO market. Thus, given the dominance of large national HMOs in the Medicare managed care program and their trend toward expansion, the experience of Tampa-St. Petersburg as a secondary market seems particularly relevant.
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