

COMPETITION IN THE SEATTLE HEALTH CARE MARKET

by

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VITA

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ABSTRACT

Since the mid 1960's health care costs have consumed an ever larger share of GNP, prompting calls for cost containment. Most observers have advocated regulatory measures to control costs, but these measures have not proved effective and may have enhanced costs. Other observers have advocated market perfecting measures to establish a framework for competition among well-defined provider groups.

The Seattle-Everett market provides an opportunity to examine a market where some competition has existed during most of this century. Most indices indicate that in comparison to other Standard Metropolitan Statistical Areas (SMSAs) the Seattle-Everett health care market provides cost-effective care.

Since World War II the Seattle fee-for-service sector has faced competition from Group Health Cooperative of Puget Sound (GHC), a pre-paid group practice. Enrollment growth at GHC has averaged over eight percent annually since 1953, increasing GHC's market share by the end of 1978 to 14.5 percent of the Seattle-Everett SMSA population. Studies done in the early 1970's indicate that GHC's costs were approximately 30 percent below the fee-for-service sector, which in turn is very cost-effective in comparison to other SMSAs. More employers are offering GHC as a health care benefits option each year, extending competition and thereby consumer choice to more of the population.

The organization of Northwest Health Care (NWHC), an innovative individual practice association (IPA) of primary care physicians, is a dynamic addition to the metropolitan Seattle health care market. NWHC is cost-effective, and has grown rapidly. The growth of GHC and NWHC may call forth other well-defined provider groups adding further to the competitive ferment. The prospect of more provider groups competing for consumers by giving cost-effective care could be limited by several factors. Among these factors would be anticompetitive legislative or regulatory restraints, loss of internal cost control by GHC, indifference of employers to the benefits of choice for employed consumers, and loss of nearly all incentives for consumer cost consciousness as in the case of the Boeing production workers who have nearly 100 percent employer paid benefits for themselves and dependents.

The development of competition in Seattle-Everett will be important not only for cost-effective health care in that market, but as an example to health care providers, employers and policy makers in other parts of the U.S.

Chapter 1

INTRODUCTION

This report has five objectives:

1. To discuss the performance of the market for health care services in metropolitan Seattle, Washington, defined as the Seattle-Everett Standard Metropolitan Statistical Area (SMSA);
2. To document developments in the delivery of medical care in that city;
3. To analyze these developments as they pertain to a particular method of reform of the health care system referred to as the "competitive" approach;
4. To identify existing barriers to competition in health care delivery and suggest actions or policies which could reduce these barriers; and
5. To consider possible scenarios that may develop as a result of existing competition in the Seattle market.

Chapter 2

THE COMPETITIVE APPROACH

Analysts identify and generally agree on several goals for a well-functioning health care delivery system¹:

- It should provide access and financial protection to all.
Consumers should have access to necessary medical care regardless of socio-economic status or place of residence. No one should be bankrupted by receiving necessary health care.
- Medical care should be delivered equitably so that no group is receiving substantially less than adequate care.
- The health care system should be organized and financed to produce cost-effective results, producing the greatest possible health for the dollars expended. To emphasize, the quality of care should be maximized for a given amount of money expended on care.
- Cost escalation must be curbed for the nation to achieve the above goals at an affordable cost.

For the first three goals to be achieved, rising health care costs must be slowed. Over the past 25 years, health care costs,

¹McClure, Walter, "The Medical Care System Under National Health Insurance: Four Models," Journal of Health Politics, Policy, and Law, Vol. 1, No. 1, Spring 1976.

inflating at roughly twice the rate of the national economy, have increased from 4.6 percent to 8.5 percent of the national product.² Public sector spending, between 1965 and 1977, increased from \$9.5 billion to \$68.4 billion, foregoing other expenditures in the national interest or the opportunity to diminish taxes.³ Business has directly felt the impact too. Between 1965 and 1975, the average weekly salary of an employee increased by 8.5 percent, yet employer contributions for health related benefits rose by 180 percent.⁴

Resistance from taxpayers and businesses to further increases in health care expenditures will force a change in the present system. Two major alternative courses of action are emerging. The first (the regulatory approach) is to use increased government regulation, due to the lack of effective competitive market restraints on costs, and the second (the competitive approach) is to restructure the private system to reestablish a suitable competitive environment. Experience with direct, process-oriented regulation suggests that it stifles innovation, imposes uniformity, and indeed probably increases

² McClure, Walter, "Health Care Cost Commission: Choices for Medical Care," Minnesota Medicine, Vol. 61, No. 4, (1978), pp. 261-271.

³ Enthoven, Alain C., "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There from Here," National Journal, (May 26, 1979), pp. 885-889.

⁴ Nation's Business, October, 1976.

costs.⁵ As several published discussions of these two alternatives are available, they will not be contrasted in this report.⁶ The Seattle health care market will be discussed within the framework of the competitive approach.

The present American health care system typically gives little reward to a consumer who chooses an efficient, i.e. cost-effective provider. Whether a consumer chooses the most costly or least costly hospital or physician is of little matter: typically insurance covers most of the cost, and premiums for individuals are not directly affected by individual decisions. So the consumer is not rewarded for choosing an efficient provider. However, as all consumers face the same incentives, the net result is to force the health insurance premiums up.

On the other hand, efficient providers are penalized for their efficiency. If providers choose a treatment that is less costly, or order fewer services resulting in less costly care, neither the

⁵ Shultze, Charles L., The Public Use of the Private Interest, Washington: The Brookings Institution, 1977. Shultze discusses at length the pitfalls of costly process-oriented regulation and suggests that a framework be established for private actions in order to achieve public goals.

⁶ Enthoven, Alain C., "Consumer Choice Health Plan," New England Journal of Medicine, Vol. 298 (March 23, 1978), pp. 650-658, (March 30, 1978), pp. 709-720.

physician nor the consumer he serves receives the reward of that efficiency. This is true even when the lower cost treatment is as appropriate or more appropriate than the higher cost method. The savings disappear in the common pool of funds in which all providers and consumers share. The common pool is funded by consumers and disbursed to providers. A consumer, facing the common pool resource, has an incentive to urge his physician to overexploit or overuse the resource even though the consequences of overuse may result in higher per capital health costs for the community as a whole. As noted, the physician, apart from his role as the consumer's agent, faces incentives to overexploit the common pool resource of insurance funds. Economists have referred to this type of overexploitation as the "tragedy of the commons." And tragic it is for health care costs.

One can conclude that the nation will be caught in a vicious circle of increasing costs unless the present incentives facing consumers and providers can be restructured. This can be accomplished by creating well-defined groupings of providers (call them "health care plans") among which consumers can choose for care.⁷ Each grouping or health care plan would need to charge premiums high enough to cover the costs of the care they provide. Cost-effective providers would have lower premiums. Consumers who chose those plans would realize premium

⁷ McClure, Walter, "Comprehensive Market and Regulatory Strategies for Medical Care," report to BHPRD, Department of Health, Education, and Welfare, Interstudy (April 1979).

savings or broader benefits. Quality would be controlled by the health care plan's staff and manager and by the opportunity for a consumer to choose a different health care plan if he so desires. Cost-effective plans would gain subscribers and prosper, while less cost-effective plans would languish or dissolve. In short, the essentials of a competitive marketplace would be present.

The form or structure of the health care plans should not be prescribed in too detailed a manner. The most tightly organized type of plan might be a multispecialty group practice HMO, while a more loosely structured plan might be an alliance between hospitals and independent fee-for-service doctors. It is important to note that these health care plans are fundamentally distinct from traditional health insurance plans because they actually provide the care; health insurance plans only pay for it. Nevertheless, insurance companies might participate, as indeed some already do, in collaboration with a grouping of providers - physicians and/or hospitals.

The ferment of a competitive market will give rise to a richer diversity of health care plans than can be devised beforehand. Certain characteristics of firms which would predictably give rise to anti-competitive behavior would be proscribed, however. The essentials of a competitive market follow:

- a diversity of health care plans, in order to preserve for consumers a wide range of alternatives, to lessen the

possibilities of collusion, and to promote further innovation in delivery systems;

- a maximum of provider participation in order to expose the entire medical community to the restraints of competition. In the regard competition is not encouraged by a doctor's participation in several plans (for then he does not feel the loss of a patient who moves from one plan to another) nor by the participation of the majority of physicians in a single plan, as that is the basis for price-fixing and restraint of trade;
- a lack of barriers to new health care plan formation, in order to keep existing plans efficient and conscious of consumer desires;
- a regard for consumer cost consciousness in the choice of health care plans in order to stimulate premium and benefit competition among plans. (This can be accomplished if the employer contributes the same dollar amount to whichever plan is chosen by the employee);
- the offering of multiple health care plans by employers in order to ensure that consumers have a choice and can thereby reward efficient plans with their business;
- flexibility for health care plans in determining their premiums and benefits, in order to insure that consumers can choose a plan which matches their preferences for mode of care,

comprehensiveness of benefits, self-management, and risk;

- fully disclosed comprehensible information on provider prices (hospitals and physicians) and on health care plans.

When these conditions are present, one would expect health care expenditures to increase only as fast as the public wishes and demonstrates through the prices they are willing to pay in the marketplace. Access for consumers could be expected to improve as facilities locate to better provide consumer convenience (including small-town and low-income areas). Health care plans might be open more days or more hours than traditional providers. Health care plans could be expected to offer less time-consuming care for those consumers who value their time, by shortening office waiting time, appointment waiting time, and claims procedures.

The Seattle-Everett health care market performs well in comparison to many other cities. A possible explanation is that competition has existed and continues to exist in Seattle-Everett. In fact, many of the essentials of competition are in place. How the market will evolve is, as yet, uncertain, but the promised "tomorrow" of the competitive model may be near at hand in Seattle-Everett. The rest of this report will discuss the characteristics of the area at present, the participants in the market, some historical highlights, obstacles to competition, and likely scenarios for the future. First the

characteristics of the market will be discussed.⁸

⁸For a discussion of recent performance in a market where the essentials of competition are in place, see Christianson, Jon B. and Walter McClure, "Competition in the Delivery of Medical Care," New England Journal of Medicine, Volume 301, No. 15 (October 11, 1979); pp. 812-818.

Chapter 3

SEATTLE - AN OVERVIEW

The demand for health care services is an important factor in the emergence of health care plans. Demand is influenced by the size, growth, mobility, income, and employment characteristics of the population. The supply of physicians' services, the supply of hospital services, and the way physicians and hospitals combine in organizations to provide health care, jointly determine the supply of health care services.

Population

Metropolitan Seattle includes King County of which the city of Seattle is the heart, and Snohomish County of which Everett is the center. The two county area comprises the Seattle-Everett Standard Metropolitan Statistical Area (SMSA); it will be referred to as "Seattle-Everett" or "metropolitan Seattle." King County includes all of Seattle and most of its adjoining suburban areas. A part of suburban Seattle, the Lynnwood area, lies in southwest Snohomish County. Everett is separate from Seattle in some respects but in many respects is a part of the same health care market.

The service area of the principal health care plan in the area, Group Health Cooperative of Puget Sound (GHC), now includes Tacoma (Pierce County) and Olympia (Thurston County) as well as those portions of Lewis, Grays Harbor, and Mason County that lie within twenty-five

miles of Olympia, and a small area near Port Orchard in Kitsap County (See Figure 1). Enrollment figures for GHC include the entire area; therefore, the narrative will sometimes refer to the entire area.

As Table 1 illustrates, population grew rapidly from 1940 to 1970 in metropolitan Seattle, averaging an annual 2.96 percent increase. Layoffs at Boeing, the dominant employer in the area, contributed to a small decline in population in the 1970-1974 period. Population growth resumed late in the decade resulting in an estimated average annual population increase thus far in the decade of 0.47 percent. Future population growth (see Table 2) is forecast to be much higher than the 1970s.

Comparisons in Table 3 indicate low unemployment rates in Seattle-Everett in December, 1978 relative to other selected SMSAs. Employment by type of firm is not unusual when compared to the other cities, although the proportion of manufacturing employment is higher than in most. Relative prosperity is indicated by Seattle-Everett's high per capita income and low AFDC population. The population is 3.1 percent Black, while those of Asiatic, Spanish or Indian descent comprise 6.1 percent of the population.⁹ Deaths per one-thousand in 1975 were 8.0 compared to 8.9 nationally. In 1975, 9.7 percent of the population

⁹ Puget Sound Health Systems Agency, Fact Book (February 1979) based on State of Washington, Office of Financial Management, Population Trends 1978 (August 1978).



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■ The Seattle-Everett SMSA

Figure 1: Seattle-Everett SMSA

Table 1

POPULATION OF WASHINGTON STATE AND SEATTLE-EVERETT SMSA*

	<u>Census</u>					<u>Estimates</u>	
	1940	1950	1960	1970	1974	1978	Avg. Annual % Change 1970-78
Washington State	1,736,191	3,378,963	2,853,214	3,413,250	3,501,100	3,774,300	1.26%
King County (Seattle)	504,980	732,992	935,014	1,159,375	1,155,300	1,186,900	0.29%
Snohomish County (Everett)	88,754	111,580	172,199	365,236	268,500	292,300	1.22%
Seattle Everett SMSA	593,734	844,572	1,197,213	1,424,611	1,423,800	1,470,200	0.47%

*SOURCE: Puget Sound Health Systems Agency, Research Section, Fact Book (February 1979). The estimates in the Fact Book are taken from State of Washington, Office of Financial Management, Population Trends 1978 (August 1978).

Table 2

POPULATION FORECASTS*

	1978	1985	% Increase 1978-1985	Projected Average Annual Increase - 1978-1985
Washington State	3,774,300	4,253,911	12.7%	N.A.
King County	1,186,900	1,339,327	12.8%	N.A.
Snohomish County	292,300	350,663	20.0%	N.A.
Seattle-Everett SMSA Total	1,479,200	1,689,900	14.3%	1.92%

*SOURCE: Puget Sound Health Systems Agency, Research Section, Fact Book (February 1979).
 1985 project population figures are from the State of Washington, Office of Financial
 Management, Washington State County Population by Age and Sex 1970-2005 (December 1977).

Table 3

SELECTED SMSA COMPARISONS: POPULATION CHARACTERISTICS

	Per Capita Income (1974)*	% Employees Manuf.**	% Employees Wholesale/ Ret.**	% Employees Services**	% Employees Government**	Labor Force in Military	Unemployment Rate **	% Population AFDC (1976)**
Atlanta	\$5128	16.1	34.0	18.9	18.1	.75	5.1	5.3
Baltimore	5001	18.5	22.6	19.0	22.5	3.33	n/a	7.5
Boston	4928	20.6	22.9	27.0	14.6	.56	5.2	6.0
Denver/Boulder	5386	16.2	26.0	21.1	17.1	2.63	5.1	4.0
Honolulu	5065	5.3	26.0	23.3	24.0	17.22	6.7	5.8
Milwaukee	5176	31.7	23.1	19.9	11.1	.17	n/a	5.7
Minneapolis/St. Paul	5206	22.5	25.4	20.8	14.7	.25	3.0	...
Philadelphia	4877	23.9	22.6	22.8	15.5	2.15	6.1	8.1
Portland	5148	20.1	26.2	18.9	15.4	.25	4.9	4.6
San Diego	4837	15.0	24.1	21.7	22.6	22.16	5.8	5.1
San Francisco/Oakland	5940	14.1	25.6	23.3	20.2	2.62	5.5	5.9
Seattle/Everett	5416	21.0	25.0	18.6	15.9	.69	5.0	4.0

*Source: U.S. Bureau of the Census, County and City Data Book, 1977, United States Department of Commerce; based on rate of population change from 1972-1975.

**Source: U.S. Bureau of Labor Statistics, Employment and Earnings, Vol. 26 (3), March, 1979, United States Department of Labor; data applies to December, 1978.

was 65 or older compared to 10.5 percent nationally.¹⁰ An age adjustment would modify the deaths per one-thousand figure somewhat. Military bases in nearby Tacoma and Bremerton may mean that the military dependent population is higher than Table 3 would suggest.

Comment: High employment, particularly in the manufacturing industries where fringe benefit levels tend to be high, is a positive factor for health care plan growth. Health care plans generally offer quite comprehensive benefits; if employer contributions cover a significant portion of the premium, employees are more likely to enroll.

Relative prosperity in Seattle-Everett indicated by a low AFDC population and high per capita income is a positive factor as the population should be able to purchase necessary health care services. A growing, mobile population is more likely not to have established ties to physicians in the fee-for-service sector and thereby be more willing to enroll in a health care plan.

Retired military with access to Veterans Administration Hospitals have no incentive to join health care plans. Military dependents covered by the Department of Defense CHAMPUS program cannot select a health care plan instead of indemnity coverage and do not contribute

¹⁰ Statistics for States and Metropolitan Areas, 1977, U. S. Bureau of the Census.

to the development of a competitive market. The size of these two groups could not be determined. However, three Federal hospitals, the Public Health Service Hospital of Seattle, the V.A. Hospital of Seattle, and the V.A. Hospital of Tacoma provide over 12 percent of the days of hospital care that residents of the three county area of Seattle-Everett and Tacoma (Pierce County) receive (see Table 4). Health care costs in federal facilities are protected from the cost restraining effects of a competitive market; conversely those consumers cannot participate in a competitive marketplace.

Providers

The supply of physicians in Seattle-Everett is relatively high (see Table 5). There are more GP's per thousand residents than in other selected SMSA's. Most notable, however, is the rapid growth of physician supply between 1971 and 1976 (see Table 6). There has been both an absolute and relative decline in the number of general practitioners, but this has been swamped by an increase in specialists, most particularly hospital based specialists. Nearly all doctors in Everett continue to have office-based practices. Seattle doctors, traditionally office-based, seem to be shifting rapidly to hospitals.¹¹

The Mason Clinic is a large, prestigious multispecialty clinic

¹¹ Physician Distribution and Medical Licensure of the U.S., 1976,
Center for Health Services Research and Development, American Medical Association, Chicago.

Table 4

PATIENT ORIGIN OF THREE SELECTED FEDERAL HOSPITALS IN SEATTLE-TACOMA

	P.H.S. Seattle*	V.A. Seattle*	V.A. Tacoma*	Total Three Hospitals
Total Patient Days	49,483 (100%)	93,894 (100%)	147,339 (100%)	290,716 (100%)
Patient Origin				
King County	23,658 (42.81%)	56,092 (59.4%)	24,782 (16.82%)	104,532
Snohomish County	3,929 (7.94%)	5,587 (5.95%)	4,125 (2.80%)	13,641
Pierce County	<u>703 (1.42%)</u>	<u>6,188 (6.59%)</u>	<u>50,817 (34.49%)</u>	<u>71,349</u>
Three County Total	28,290 (57.17%)	67,867 (72.28%)	79,724 (54.11%)	189,522 (65.19%)
Out-of-Area Origin	(42.82%)	(27.71%)	(25.37%)	(34.81%)
Source of Patients by County	Patient Days All non-Federal Hospitals**		Patient Days in Three Federal Hospitals as a % of non-Federal Patient Days	
King County	1,058,585		9.87%	
Snohomish County	159,574		8.55%	
Pierce County	<u>293,243</u>		<u>24.33%</u>	
	1,511,402		12.54%	

*Source: Puget Sound HSA, Research Section, Fact Book, February 1979, p. HS-14.

**Ibid., p. HS-4.

***Weighted Average.

Table 5

SELECTED SMSA COMPARISONS: PHYSICIAN SUPPLY (1976) PER 1000*

	Total	GP	MS	SS	OS	HOS
Atlanta	1.42	.12	.30	.38	.25	.39
Baltimore	2.00	.15	.30	.39	.25	.92
Boston	2.08	.17	.37	.40	.32	.84
Denver/Boulder	1.93	.21	.35	.41	.34	.62
Honolulu	1.43	.17	.35	.39	.24	.29
Minneapolis/St. Paul	1.60	.26	.25	.32	.25	.52
Milwaukee	1.52	.17	.28	.34	.27	.46
Philadelphia	1.75	.19	.31	.33	.27	.65
Portland	1.85	.21	.35	.47	.30	.51
San Diego	1.61	.27	.29	.40	.35	.30
San Francisco/Oakland	2.27	.23	.52	.52	.50	.50
Seattle/Everett	1.90	.29	.35	.43	.35	.40

*Source: Physician Distribution and Medical Licensure in the United States, 1976. Center for Health Services Research and Development, AMA (Chicago, 1977); GP = general practice, MS = medical specialties, SS = surgical specialties, OS = other specialties, HOS = hospital practice.

Table 6

SEATTLE/EVERETT PHYSICIAN SUPPLY PER 1000*

Year	Total	GP	MS	SS	OS	Hospital
1971	1.69	.31	.30	.38	.31	.39
1973	1.84	.30	.33	.41	.34	.47
1976	1.90	.29	.35	.43	.35	.49

*Source: Distribution of Physicians in the United States, 1971.
Distribution of Physicians in the United States, 1973
Physician Distribution and Medical Licensure in the
United States, 1976.
Center for Health Services Research and Development,
American Medical Association. Chicago.

of over one hundred physicians in Seattle which obtains referrals from throughout the northwest and Alaska, including many self-referred patients. The Associated University Physicians Clinic is another multispecialty group of about 140 physicians who have teaching appointments at the University of Washington. Other multispecialty clinics are much smaller, although the physicians of Everett Clinic (about thirty) are a significant proportion of the physicians in that city.

Seattle-Everett hospitals differ from hospitals in most of the nation along several dimensions (see Table 7). The average length of stay of 5.8 days is notably low, suggesting major differences in the practice patterns of physicians in Seattle versus the rest of the nation. Although admissions per thousand residents are in the middle range for the SMSA's in Table 7, the low average length of stay in Seattle-Everett causes the hospital days per thousand residents to be lower than all listed SMSAs except San Diego and Honolulu. Data for those markets are distorted by the large amount of care received in military hospitals (see footnote, Table 7).

Only Honolulu and San Diego have fewer beds per thousand residents than Seattle-Everett (footnote 2, Table 7 applies here, too). Despite the low number of beds, occupancy is also low, averaging 69.9 percent in 1977. Excepting Atlanta, Seattle-Everett has the lowest average expense per hospital admission, again because of relatively short lengths of stay. Annual hospital expenses per capita in Seattle-

Table 7

SELECTED SMSA COMPARISONS: NON FEDERAL HOSPITALS (1977)*

	# of Hospitals	Beds/1,000	Admissions 1,000	Days/1,000	Occupancy Rate (%)	LOS	Surgical Op/ 1,000
Atlanta	36	4.09	161.53	1047.19	70.2	6.5	90.99
Baltimore	28	4.10	138.79	1241.08	83.0	9.1	95.86
Boston	58	3.44	113.05	1016.13	80.9	9.0	68.32
Denver/Boulder	23	4.37	163.82	1133.36	71.1	6.9	88.75
Honolulu**	10	2.43	99.05	695.56	78.6	7.0	67.71
Milwaukee	27	4.89	155.66	1303.04	72.9	8.4	97.67
Minneapolis/St. Paul	35	5.38	171.71	1412.78	71.9	8.2	90.61
Philadelphia	73	3.59	124.32	1066.72	81.4	8.6	72.54
Portland	21	3.86	146.63	1006.85	71.5	6.9	91.38
San Diego**	28	2.93	112.85	738.22	69.1	6.5	66.40
San Francisco/Oakland	64	4.00	140.29	994.44	68.3	7.1	77.64
Seattle/Everett	29	3.36	147.23	853.98	69.9	5.8	83.61

Table 7 - Continued

	Payroll/ Day	Payroll/ Admission	Expense/ Day	Expense/ Admissions	Annual Expenses/ Per Capita
Atlanta	\$103.03	\$ 687.92	\$207.71	\$1346.53	\$217.51
Baltimore	123.24	1124.78	214.07	2149.52	366.25
Boston	165.12	1484.18	325.35	2924.33	330.60
Denver/Boulder	122.06	844.49	226.22	1565.10	256.39
Honolulu**	11.35	781.97	223.94	1572.56	155.76
Milwaukee	127.42	1066.61	242.88	2033.14	316.48
Minneapolis/ St. Paul	113.45	933.42	221.34	1821.10	312.71
Philadelphia	111.99	960.89	218.74	1876.84	233.33
Portland	122.91	844.02	239.91	1647.42	241.56
San Diego**	116.13	759.66	257.41	1683.84	190.03
San Francisco/ Oakland	148.62	1053.44	300.50	2130.06	298.84
Seattle/Everett	130.21	755.24	256.37	1487.04	218.94

*Source: Hospital Statistics, American Hospital Association, 1978 edition.

**The relatively low values for admissions, beds, hospital days, and surgical operations per 1,000 result almost certainly from the high proportion of military members and their dependents in the population figures for Honolulu and San Diego (see Table 1). These individuals receive treatment primarily at military installations and therefore should be "netted out" in forming the estimates in this table. However, accurate data on military personnel and dependents were not available, so this adjustment was not made. The figures in these four categories therefore are clearly underestimates of the true values.

Everett are roughly equal to those in Atlanta. Again, only San Diego and Honolulu, with large military populations, have lower non-federal hospital costs per capita than Seattle-Everett.

In Seattle-Everett, all costs - hospital and physician - of medical care have been rising faster than the Consumer Price Index (see Table 8). San Diego, Portland, Denver and Minneapolis-St. Paul have all seen medical costs rise less rapidly. These cities all have active, growing health care plans (HCPs). The index of medical costs, however, is calculated on the basis of cost per service rather than costs of all services. Because of evidence that health care is provided in Seattle-Everett using a different input mix the ratio of medical costs to all costs would be biased upward in Seattle.

Another index of interest is the Medicare Index of Medical Costs in which Seattle-Everett shows remarkable hospital performance (see Table 9). In 1977, for example, Medicare hospital costs in Seattle were only 85.6 percent of the national average while in Everett Medicare hospital costs were only 81.8 percent of the national average. In 1977 physician costs in Seattle were comparable to the U.S. average. Physician costs in Everett were 92.1 percent of the national average. Because metropolitan costs are typically higher nationally than non-metropolitan costs, physician costs in the Seattle-Everett SMSA would be below the typical national SMSA.

Performance indicators for all Seattle-Everett hospitals have

Table 8

SELECTED SMSA COMPARISONS: PRICES AND WAGES

Cities	All Urban Consumers (1978)*		
	CPI- All Items	CPI- Med. Care	Ratio MC/AI
Atlanta	198.6	228.0	1.15
Baltimore	203.0	226.8	1.12
Boston	199.7	219.5	1.10
Denver/Boulder	211.4	210.7	1.00
Honolulu	188.8	221.6	1.17
Milwaukee	199.0	219.4	1.10
Minneapolis/St. Paul	206.2	204.3	.99
Philadelphia	199.7	243.6	1.22
Portland	207.1	222.8	1.08
San Diego	209.8	218.8	1.04
San Francisco/Oakland	203.2	226.3	1.11
Seattle/Everett	202.6	220.1	1.09

*Source: CPI Detailed Report, U.S. City Average and Selected Areas, October-November, 1978, U.S. Department of Labor, Bureau of Labor Statistics.

**Source: Industry Wage Survey: Hospitals, August 1975-January 1976, U.S. Department of Labor, Bureau of Labor Statistics, 1977, Bulletin 1949, pp. 7-12.

Table 9

MEDICARE INDICATORS OF MEDICAL COSTS: 1972-1977*
(In Seattle-Everett SMSA)

Year	Geographic Index for Hospital Costs (Part A)		Geographic Index for Physician and Other Costs (Part B)	
	Seattle (King Co.)	Everett (Shohomish Co.)	Seattle (King Co.)	Everett (Snohomish Co.)
1972	.935	.878	1.029	.870
1973	.967	.959	1.017	.837
1974	.834	.836	1.012	.892
1975	.987	.845	1.028	.892
1976	.840	.823	.957	.845
1977	.856	.818	1.006	.921

*The age/sex index is divided into the per capita cost to determine an "adjusted" reimbursement per capita. The ratio of the "adjusted per capita" to the "all U.S. adjusted per capita" describes the geographic index.

$$\text{Geographic index} = \frac{\text{Reimb. per capita}}{\text{Age/Sex Index}} \div \frac{\text{All areas reimb. per capita}}{\text{All areas Age/Sex Index}}$$

Source: Health Care Finance Administration, Office of Policy Planning and Research, "Table 1.3.1. Geographic Index, Age/Sex Index, and Average Reimbursement for Aged," 1972-1977.

changed over time (see Table 10). Of some concern is the gradual increase in days of hospitalization per one thousand persons from 827 in 1973 to 839 in 1978. Days per one thousand in turn is a result of average length of stay multiplied by admissions per one thousand. Admissions have moved unevenly but average length of stay jumped from 5.8 days to 6.1 days in 1978. Other notable changes are the increased numbers of personnel per bed. Nationally personnel per bed has increased and has been one of the principal sources of increasing per capita sources.

Comment: A higher proportion of general practitioners to specialists is associated with lower hospital costs, according to a well-known study by Martin Feldstein.¹² On the average, the addition of one G.P. to the physician population was associated with a decrease of \$39,000 per year. Feldstein's study used national data of the 1960s, data characteristically resulting from markets with no health care plans. It is unclear that physician mix causes lower costs; an alternative explanation is that competition induces lower costs by changing incentives, and physician mix is changed in the process.

¹²Feldstein, Martin S. "Hospital Care Inflation: A Study of Non-Profit Price Dynamics," American Economic Review, (December 1971), Vol. 61, pp. 853-872.

Table 10

SEATTLE-EVERETT HOSPITALS: AVERAGE PERFORMANCE INDICATORS*,**

	1973	1976	1977	1978
No. of hospitals	29	29	29	29
Average hospital size	157	162	164	164
Beds/1000	3.22	3.27	3.29	3.21
Admissions/1000	141.61	143.39	143.93	138.61
Days/1000	827	834	835	839
Occupancy Rate	70.2	69.6	69.6	71.6
LOS	5.8	5.8	5.8	6.1
Surgical Op/1000	80	81	82	78
RN's/bed	0.67	0.78	0.74	0.77
LPN's/bed	0.19	0.22	0.22	0.21
Other personnel/bed	1.74	1.88	2.08	2.20
Payroll/Day	\$ 77.87	\$ 117.32	\$ 130.21	\$ 143.06
Payroll/Admission	454.51	682.03	755.24	865.69
Expense/Day	146.30	226.19	256.37	280.88
Expense/Admission	853.88	1,314.90	1,487.04	1,699.63
Expense/Capita	120.92	188.54	214.03	235.59

*Source: Hospital Statistics, American Hospital Association, 1972-1978.

**Population estimates are from the Puget Sound Health Systems Agency, Research Section, Fact Book (February 1979). The estimates in the Fact Book are taken from State of Washington, Office of Financial Management, Population Trends 1978 (August 1978).

To the extent that a competitive market operates in Seattle-Everett, increasing physician numbers should result in increased competition between physicians. Competition might cause physicians to join or form efficient health care plans, join or form multispecialty group practices to achieve the efficiencies associated with group practice, lower prices, or become more accessible to consumers, possibly by accepting primary care patients or by practicing in underserved areas. Existing clinics such as the Mason Clinic in Seattle or Everett Clinic in Everett may be moved to form health care plans to better market their services. Teaching clinics such as the University Clinic are not often a base for cost-effective health care plans, because of the extra costs that teaching imposes. Any physician-controlled health care plan could be expected to seek out cost-effective hospitals with which to combine services.

As occupancy increases fixed costs are spread over more patients thereby lowering total costs per patient. If competitive pressures increase, hospitals with low occupancy rates, particularly in Central Seattle or the city of Everett, with associated specialists, may be moved to market their excess capacity through a health care plan to increase occupancy. Hospitals in other metropolitan areas have found it difficult to start Health Maintenance Organizations (HMO's) because HMO's seem to achieve much of their savings through reduced hospital-

ization, a result that is opposed to the goals of most hospital administrators.¹³ Seattle-Everett hospitals, however, are accustomed to low hospital utilization; thus they may not find it as difficult to adjust to the incentives in a health care plan as hospitals in other areas of the nation. Nevertheless, the experience of Comprecare in Denver, originally a hospital based plan, is illustrative of difficulties that hospital-based plans face.¹⁴ Cost-effective hospitals may be particularly interested in forming or associating with a health care plan (see Table 11). Average figures such as those in Figure 11 are not by themselves a guide to choosing cost-effective hospitals. Providence Medical Center is believed to have, for example, a greater proportion of coronary procedures.

¹³ Luft, Harold S., "How Do Health Maintenance Organizations Achieve Their Savings?" The New England Journal of Medicine, Vol. 298, No. 24, June 15, 1978, pp. 1336-1343.

¹⁴ Christianson, Jon B., "The Potential for a Competitive Medical Care System in Denver, Colorado," (forthcoming) InterStudy.

Table 11

STATISTICS OF SELECTED SEATTLE-EVERETT HOSPITALS, 1977*

	Virginia Mason	Swedish Med Center	Providence Med Center	St. Francis X. Cabrini	Valley Gen (Kenton)	Providence (Everett)	Stevens (Edmonds)
Beds	292	460	376	235	254	195	159
Occupancy Rate (%)	77	73	68	45	69	68	79
Length of Stay (days)	6.8	6.2	7.4	6.8	4.7	5.7	4.6
Personnel/Bed (FTE)	2.99	3.24	2.91	1.70	1.70	2.75	2.94
Payroll/Admission	\$ 716.28	\$ 731.71	\$ 905.49	\$ 662.88	\$539.83	\$ 627.93	\$450.73
Expense/Admission	1,379.23	1,435.64	1,767.85	1,165.34	927.81	1,191.15	821.33
Peer Group**	5	5	5	3	4	4	4

*Source: Staff reports on Budget and Rate Analysis, State Hospital Commission, State of Washington. Group Health Cooperative was not included because analysis of its budget follows a different procedure in recognition of its different structure

**The State Hospital Commission classified hospitals into five peer groups using "cluster analysis" techniques. Case-mix and number of beds are two of the variables used in determining peer group. Budget review and rate approval is then based on comparisons within peer groups. Special hospitals and Group Health Cooperative are unclassified but go through the review process.

Chapter 4

THE DEVELOPMENT OF HEALTH CARE PLANS

The cost effective performance of the metropolitan Seattle health care service market is sometimes explained as a curiosity, the result of a community that prefers less intensive health care. A credible alternative explanation is that the Seattle area market is organized differently than most markets in the nation and that this organization has produced different incentives. Indeed, evidence of competition between different health care delivery systems can be found throughout the century. A brief sketch of the historical background will be helpful in understanding existing health care plans, contemporary patterns of health care, and competition in today's market-place.

Historical Background: Contract Medicine in Washington State.

About the beginning of the twentieth century certain industries of the Pacific Northwest - railroads, logging, and mining among them - required that large groups of workers live in isolated areas far from the usual sources of medical care.¹⁵ The employer would often maintain

¹⁵ This entire section draws heavily on Shipmen, George A., Lampman, Robert J., and Miyamoto, S. Frank, Medical Service Corporations in the State of Washington, A Study of the Administration of Physician Sponsored Prepaid Medical Care, Cambridge: Harvard University Press, 1962.

a hired physician to provide emergency service. More complete care was sometimes arranged on a prepaid basis in neighboring towns. In some cases a small payroll deduction (fifty cents per month is mentioned) was made to purchase a "hospital ticket" which entitled the employee to hospital services.

The Washington Workmen's Compensation Law, passed in 1911, set up a state insurance plan funded by payroll-deduction. As amended in 1917 the law permitted that "...with the consent of a majority of his workmen, an employer could enter into written contracts, with physicians, surgeons, and owners of hospitals, for medical, surgical, and hospital care to injured workmen."¹⁶ It is interesting to note that the consent of the employees was required; presumably that was to assure some minimal level of quality in the contracts. Contractual coverage was often extended to medical care for non-job accidents and illness. These arrangements, referred to as "contract medicine," continued to grow even as Washington became more populated. In some cases, coverage was extended to the workmen's dependents and also financed by payroll deductions.

Although it was judged "...unlawful for a corporation to engage in the commercial practice of medicine, even if conducted through

¹⁶Shipmen, Lampman, and Miyamoto, *ibid.*, p. 7.

employees who were licensed physicians and surgeons,"¹⁷ entrepreneurs emerged who became involved with the delivery of contract care. This occurred because several exceptions to the above rule were allowed, two of which were "(1) industrial corporations which maintained medical departments for their employees; and (2) benevolent organizations, such as fraternal, labor, religious, and other groups, furnishing medical services to their members."¹⁸ These two exceptions provided a basis for most of contract medicine.

Contracts were attractive to a physician because they produced certain income. Non-covered dependents of workmen were often secured on a fee-for-service basis as well. One doctor could serve a larger population, so that even though his contract fees were lower total income was higher.

Health care contracts evolved. One doctor signed numerous contracts and hired other physicians to provide the services in different towns. The prepaid clinic, a more complex form of contracting firm, emerged. One example, the Western Clinic and Hospital Association in Tacoma, was organized in 1912 and endured until 1977 as a state

¹⁷ Rubenstein, I. R., "Legal Aspects of Corporation Medical Practice," Industrial Medicine and Surgery, November 1951;20, 513-519, p. 513. Quoted in Helgerson, Steven Dale, "Contract Practice and the Medical Service Bureaus of King and Pierce Counties, 1900-1933." Unpublished Masters Thesis, University of Washington, 1971.

¹⁸ Helgerson, *ibid.*, p. 5.

qualified prepaid health care service contractor. (It was offered as an option by the Federal Employees Health Benefits Program, FEHBP, as recently as 1976.)

Many doctors disliked the impact of contract practice because it reduced the number of patients in the fee-for-service sector. As the number of contracts increased, the pressure increased on remaining physicians to participate. As more participated, the contracts were bid down, diminishing profits. Overall, the results bore a resemblance to a competitive marketplace: innovation in the organization of delivery systems, competition among contractually well-defined providers or provider groups, rewards to those physicians who supplied cost-effective care, and a choice between contract medicine and fee-for-service for groups, as groups. However, because the employed group chose by majority vote between contract providers and fee-for-service, any difference in preference among employees for mode of service was not allowed for. That is, there was no dual or multiple choice among health benefit options for employees. Any worker unhappy with the services of the contracting doctor(s) was forced to bear the full costs of seeking alternative care. Some observers believed that certain employers may have subtly coerced their groups of workers to choose contract care. The lack of choice of mode of care by individuals, is a crucial difference between historical contract medicine in Washington State and the present HMO market.

In addition to the lack of choice, two other objections were raised by physicians:

- (1) That contract medicine lowered physician income by forcing them to compete for patients.
- (2) That poor quality care resulted.

The second objection seemed to be documented with no more than anecdotal evidence; testimonials to the contrary were also offered. The lack of choice of mode of care surely made the control of quality more difficult. Although the first objection probably had some merit, physician's incomes were most certainly affected as well by the supply of physicians and general economic conditions. The physician supply problem could only be addressed nationally by restricting medical school admissions.¹⁹ Concern with contract practice fluctuated with general economic conditions; during prosperous times less note was made of it.²⁰ For example, the County Medical Societies of Seattle and Tacoma organized Industrial Service Bureaus in 1917 in response to the Medical Amendment to the Workmen's Compensation Law (see Table 12). In 1925 during conditions of economic prosperity, the Seattle

¹⁹ Flexner, A., "Medical Education in the U.S. and Canada," Bulletin No. 4, Carnegie Foundation for the Advancement of Teaching, 1910. Quoted by Reuben A. Kessel, "Price Discrimination in Medicine." Journal of Law and Economics, (October 1958), pp. 20-53.

²⁰ Helgerson, *ibid.*

"Bureau" was disbanded only to reemerge in 1933 after the Depression had caused physician's incomes to drop. In sum, the Medical Service Bureau seem to have been engendered by declining physician income and the competitive threat of contract medicine.

The Formation of the King County (Seattle) Medical Service Corporation:

The King County Medical Society voted in April 1933 to establish the King County Medical Service Corporation to serve as the contracting and administering agent for Society physicians who wished to participate in a prepaid medical program that it was to offer to "low wage income" groups. These were groups most often attracted to contract practice. Most Society physicians agreed to participate; they formed a voluntary association called the King County Medical Service Bureau. For practical purposes little distinguished the Corporation from the Bureau, indeed in most Washington counties only one group was formed. The two organizations normally are referred to indiscriminately as the "Bureau" in Seattle, a convention followed in this paper except when it is necessary to distinguish between them.

Participating doctors signed an agreement to accept as payment in full the percentage of fee schedule that the "Bureau" deemed payable that year. Thus physicians as a group were "at risk." Prices were "fixed" by the fee schedule for all participating physicians. Physicians' services were covered for subscribing workers for home,

office, and hospital. Hospitalization was covered initially on a service, i.e., prepaid, basis by agreement with seven Seattle hospitals. Subscribers were offered "free choice of physicians," a response to the lack of choice of physician in contract medicine. As noted the flaw in contract medicine was more fundamentally no choice of mode of care. Contract medicine was competed against by restraining the percentage of reimbursement to participating Bureau doctors thereby permitting low premiums. Physicians, some of whom marketed individually, were then encouraged to turn their contracts over to the "Bureau". Most did so, possibly because they recognized that given established patient-physician relationships most of their patients would continue with them given the Bureau's objective of free choice of physicians and the absence of price competition. They seem to have accepted that an end to competition could result eventually in reimbursement of a higher percentage of the fee schedule established by the Bureau.

The Society and the "Bureau" were successful in ending most contract practice. A favorable decision in the Porter vs. King County Medical Society case in 1937, (see Table 12) upheld their right to expel members who held contracts. This was followed in 1940 by formal requests to cease contract practice to twenty-two of the remaining contract doctors. Eighteen did so, two resigned from the Society, one agreed to make no new contracts and the remaining

Table 12

HISTORICAL HIGHLIGHTS

Date	Events
Late 19th Century	Contract practice emerged in lumber, mining, and rail industries.
1911	The Washington Workmen's Compensation Law was passed; coverage was made compulsory.
1912	The Western Clinic and Hospital Association, a health care service contract firm, was organized in Tacoma.
1917	The legislature passed the Medical Aid Act Amendment to the Workmen's Compensation Law, which required a compulsory contribution for medical care (funded by employer and employee). At the choice of the employer, and given the consent of 50 percent of the workers, coverage could be provided by contracted physicians.
1917	The King County Industrial Service Bureau (Seattle), was organized in response to the Medical Aid Amendment and to provide contract coverage to workers. It was followed by the Pierce County (Tacoma) Industrial and Surgical Bureau. The first languished and dissolved in the mid-20's; the latter survives today as the Pierce County Medical Bureau.
1933	The King County (Seattle) Medical Service Corporation was organized to offer prepaid care. All Society members were eligible; physicians accepted a percentage of an established fee schedule as payment in full; subscribers had free choice of participating doctors.
1933	The Snohomish County (Everett) Physicians Corporation was organized. (Variously listed as 1937.)
1933-40	Doctors or groups of doctors abandoned contracts or transferred them to the King County Medical Service Corporation.

Table 12 - Continued

Date	Events
1937	In Porter vs. King County Medical Society, et. al., the court upheld the right of the Medical Society to force the termination of contracts held by members of the Society.
1940	A formal request was made by the King County Medical Society to twenty-two doctors to abandon contract practice; eighteen did so, two resigned from the Society, one agreed to sign no new contracts, and one was expelled from the Society.
1941-45	The threat of prepaid closed panel plans appears to have caused expansion of benefits by the King County Medical Service Corporation and to have sustained support of the Corporation by physicians.
1947	On January 1, Group Health Cooperative of Puget Sound (GHC) began operations.
1948	The King County Medical Service Corporation (the "Bureau") raised the individual income limit for contract coverage.
1951	In Group Health Cooperative of Puget Sound vs. King County Medical Society, et. al., the Washington Supreme Court found the practices of the Society to be monopolistic; the court ordered that GHC physicians be admitted to membership in the Society and that other discriminatory practices cease.
1950's	Indemnity insurance carriers emerged as a competitive threat to the Medical Service Bureaus.
1954	GHC hired its first general practitioner staff member.
1955	The King County Medical Service Corporation offered coverage to <u>dependents</u> of Boeing workers.
1960-61	The Federal Employees Health Benefits Program (FEHEP) offered GHC as an option for the first time. Enrollment

Table 12 - Continued

Date	Events
	jumped. Hospital beds increased from 86 beds to 137 beds as a response to overall growth. This period marked the beginning of the period of rapid growth in group enrollments for GHC.
1974	GHC suspended enrollments for fourteen months because of pressure on facilities.
1974	Sound Health, the nation's first federally qualified HMO, began delivery of services in Tacoma.
1976	Northwest Health Care first offered services in the Seattle area.
1978	The Snohomish County Physician's Corporations organized a Health Maintenance Plan.
1979	Sound Health was acquired by HMC on January 1, 1979.

individual was expelled from the Society.²¹

From 1933 to the World War II period the percentage of reimbursement was increased from 40 percent of fee schedule to 90 percent of the fee schedule.²² Whether there was an increase in the fee schedule as well could not be determined.

In summary, the King County Medical Service Corporation:

1. Offered prepaid care to subscribers covering, on a service basis, physicians' services in home, office, or hospital.
2. Allowed subscribers free choice of participating physicians.
3. Fixed fee schedules for all physicians.
4. Put physicians at risk as a group.
5. Included nearly all Society physicians.

What was devised, for practical purposes, was a monopoly Individual Practice Association (IPA).

One view is that contract medicine resulted in a competitive situation in which doctors competed with quality, cost, and accessibility. This resulted in utilization that, given physician supply and the overall demand for services, was too low to give physicians what they considered to be an adequate income. In this view, low utilization in the Seattle areas has its roots in contract practice.

²¹Shipman, *ibid.*, p. 25.

²²*Ibid.*, p. 27.

The "Bureau's" response was to break down well-defined competing groups of physicians and set up a common capitalization or revenue fund to which all physicians had a claim according to the services they performed (see Figure 2). Incentives for low utilization were replaced by incentives for high utilization of physician services, restrained only by remaining competition from contract doctors. The consumer would no longer see the reward of choosing a low cost physician and physicians would not see the reward of being cost-effective practitioners.

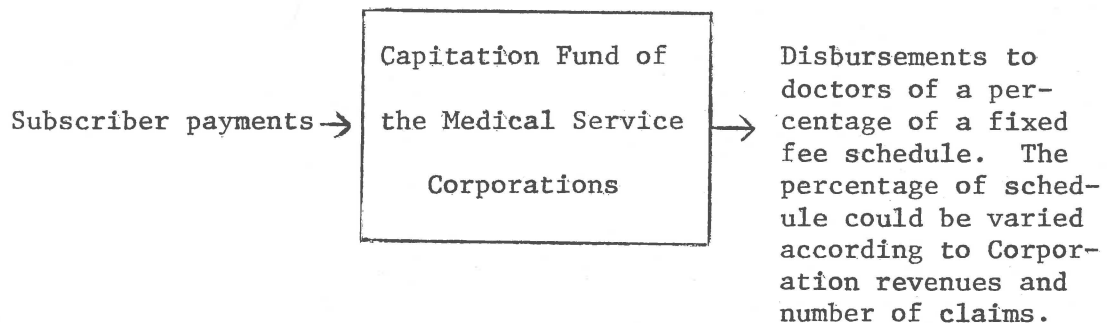


Figure 2

The capitation fund is similar to the common property resource described in the discussion of third party payments earlier. Common property resources produce incentives for over-exploitation; in this case physicians had an incentive to use the fund as much as possible. Surely physicians were restrained by peer group pressure, their own habits, and the approval of bills by the Medical Director of the

Corporation. Nevertheless, the result was higher demand for physician services. The size of per capita premiums was restrained by competition, and disbursements were adjusted accordingly to reimbursing a percentage of a set fee schedule. In fact, as competition disappeared, the capitation payment per subscriber could be increased, and the percentage of fee schedule paid to physicians could be increased, an increase that did take place. Seattle physicians could look forward to a practice environment similar to the rest of the United States. But it never quite arrived because competition never completely disappeared.

Bureau incentives also had implications for hospitals. The seven Seattle hospitals that participated initially on a service basis soon became dissatisfied and discontinued their service participation. Henceforth, they were reimbursed on an indemnity basis.²³ The Bureau's fund, by definition, was controlled by physicians. Economists would expect that physicians would attempt, within the limits of adequate care, to maximize their incomes and minimize the amount paid out for hospital services.

²³Shipman, *ibid.*, p. 24.

Comment: In summary, the results of the formation of the "Bureau" were:

- the near elimination of competition among well-defined provider groups; those who continued contract practice were expelled from the Society;
- the change of the incentive structure to reward high utilization physicians more than low utilization physicians;
- the establishment of a set fee schedule for all doctors, eliminating price competition;
- reimbursement of fees could be made by the Bureau as a monopolist. The "Bureau" set the percentage of fees to be reimbursed and imposed a common fee schedule.
- replacement of choice, by groups, of modes of care (fee-for-service or contract) with free choice of physicians by individuals. This responded to contract practice's biggest flaw: the lack of dual or multiple choice for individuals.
- the creation of incentives to maximize physician income and to minimize hospital expenses. This is a possible explanation for current metropolitan Seattle hospitalization patterns.

An Aside on Kaiser: The contract medicine ferment in Washington State produced other innovations besides the Medical Service Bureaus. In

1938 Henry Kaiser hired Dr. Sidney Garfield to establish a prepaid plan for workers involved in the construction of Grand Coulee Dam.²⁴ Apparently the plan was not continued in Washington after the completion of the dam, but it grew to prominence elsewhere during the World War II years. Opened to the public after the War, it has grown to provide approximately half of the comprehensive prepaid care in the U.S. in its operating areas of California, Portland (Oregon), Honolulu, Denver and Cleveland.

World War II: Prosperity returned to Seattle and with it greater demand for medical services. Those who continued contract practice were few and expelled from the Society so demand was largely directed to the King County Medical Service Bureau and the fee for service sector. The percentage of reimbursement was raised to 90 percent of the accepted fee schedule. Bureau listing was extended to physicians who were not members of the County Society or who had not practiced the probationary period. Benefits too were expanded.²⁵ Facing strong demand, why wasn't the Bureau allowed to languish? One explanation is based on wartime wage controls; companies tried to attract workers with fringe benefits, health care coverage included. Prepaid contracts with

²⁴Goldberg, Lawrence G., and Greenberg, Warren, Staff Report, Federal Trade Commission, (August 1977), p. 75.

²⁵Shipman, p. 16.

broad benefits for employees and dependents were attractive. The Bureau may have been viewed as an effective way to market high levels of service. Shipmen suggests that the Bureau feared the entry of industry sponsored closed panel plans similar to the Kaiser Plan.²⁶

The Formation of Group Health Cooperative of Puget Sound:²⁷ In 1931, the Western Clinic and Hospital Association of Tacoma opened a clinic in Seattle which they called the Medical Security Clinic. In 1938 the clinic was sold to a businessman named Prendergast who operated it until 1945. Despite opposition from the Medical Society with the contracts it obtained, the clinic prospered during the war years and then purchased St. Luke's Hospital. At the end of the war, Prendergast, doubtful of the future of contract medicine in the postwar era, sold the clinic to five members of the clinic staff. In the following year, the clinic encountered financial difficulties.

During this time a group of Seattle area people were involved in the formation of a medical cooperative. Dr. Michael Shadid, the founder, in 1929, of one of the first prepaid group practices in the United States, was invited to speak at different places in the State

²⁶ Shipman, p. 27.

²⁷ MacColl, William A., M.D., Group Practice and Prepayment of Medical Care, Washington: Public Affairs Press, 1966. Dr. MacColl was on the staff of the Medical Securities Clinic and later became Executive Vice-President of Group Health Cooperative. This section draws on his book, interviews, and printed material of GHC.

of Washington by the Pacific Supply Cooperative. Dr. Shadid's tour inspired several organizational groups throughout the state with the idea of cooperative, consumer-controlled medical care. The Seattle group was to make a reality of this idea. At a public forum on health care organized in Kirkland, two of the speakers on the panel were a lawyer, Mr. Jack Cluck of the nascent Seattle cooperative and Dr. William (Sandy) MacColl of the Medical Security Clinic. The evening's discussion brought the two speakers together, and merger discussions were soon underway. The two groups agreed to form the Group Health Cooperative of Puget Sound. The Cooperative needed doctors and facilities, the doctors needed a population base and administration. The Cooperative purchased the clinic and hospital, and most of the doctors agreed to work for the Cooperative. Contracts held by the clinic were transferred to the Cooperative.

Dr. MacColl notes that GHC "succeeded as an anomaly of the times."²⁸ Consumer-sponsored groups in other areas of the county were not generally successful. Several critical factors were present for GHC one or more of which were often missing in other areas: possession of a hospital and clinic, already staffed; the willingness of people to try something new in the post-World War II era; an existing enrollment which provided an actuarial base for premiums and expenses, and

²⁸ MacColl, *ibid.*, p. 41.

solid organization as a not-for-profit corporation (501(c)3).

Operations began on January 1, 1947. By the end of 1948, 10,406 subscribers were enrolled. In these first years, the King County (Seattle) Medical Society denied membership to physicians on the staff of the Cooperative, an action which, de facto, denied staff privileges at most hospitals in the community and specialist certification. The County Medical Society objected to the prepayment plan because subscribers didn't have "free choice of physicians," the same objection that had been the basis for the attack on contract medicine. To overcome the effects of the Medical Society's ostracism, the Cooperative brought suit against the Medical Society charging "that the defendants had conspired against them in an effort to force the Cooperative out of business."²⁹ The State Supreme Court found in the Cooperative's favor, "The purpose of the Society has been primarily to benefit the members of the Society and its affiliates through the elimination of such competition. The means employed has . . . been oppressive in the extreme. . . ."³⁰ The court further argued that the activities of the Society were designed to eliminate competition in the contract medicine field and ordered the Society to admit GHC doctors to membership in the Society if otherwise qualified. With the

²⁹Kessel, *ibid*.

³⁰Group Health etc. vs. King County Medical Society, 39 Washington, 2nd 586, 237 P 2d 737 (1951). Quoted by Kessel, *ibid*.

Court decision, Group Health had overcome a major obstacle to successful operation.

Growth - The Foundation Years, 1947-1960: From year end 1948 to year end 1953 enrollment increased at an annual average of 28 percent (see Table 13), reaching 35,873. More emphasis was placed on enrollment of individual members than the enrollment of groups. By 1955, individuals constituted about 80 percent of the entire enrollment.³¹ The importance of individuals as a source of membership diminished, though, as employed groups gained broader, employer-funded health benefits. In that period, the Cooperative established its basic structure and operations mode, hired its first general and family practitioners, began to decentralize operations away from the initial Capital Hill site (see Figure 3), grew to a solid base of 60,000 subscribers, and expanded the medical staff and physical facilities accordingly.

Growth - The Young Dynamic Organization, 1960-1973:³² The period from 1960 to 1973 can be characterized as the years of youthful dynamism. In these years, the Cooperative grew rapidly and achieved acceptance

³¹ Correspondence with Dr. H. Frank Newman, Ex-Executive Vice President of Group Health Cooperative from 1965 to 1976.

³² Dr. H. F. Newman was particularly helpful in furnishing an overview on this period of GHC's operations. Dr. Newman is presently a national consultant on HMO development for HEW.

Table 13

ENROLLMENT AND AVERAGE ANNUAL RATE OF GROWTH BY PERIODS:
GROUP HEALTH COOPERATIVE*

Year Ending	Enrollment	Average Annual Growth During Preceding Five Years
Dec. 1948	10,406	N.A.
Dec. 1949	16,587	
Dec. 1950	N.A.	
Dec. 1951	N.A.	
Dec. 1952	32,301	
Dec. 1953	35,873	28.08%
Dec. 1954	36,178	6.54%
Dec. 1955	38,578	
Dec. 1956	41,739	
Dec. 1957	45,424	
Dec. 1958	49,230	
Dec. 1959	54,515	7.05%
Dec. 1960	61,135	
Dec. 1961	63,053	
Dec. 1962	63,878	
Dec. 1963	69,208	
Dec. 1964	76,030	9.89%
Dec. 1965	85,166	
Dec. 1966	91,819	
Dec. 1967	100,769	
Dec. 1968	110,879	
Dec. 1969	121,716	11.26%
Dec. 1970	135,725	
Dec. 1971	148,640	
Dec. 1972	173,004	
Dec. 1973	189,055	
Dec. 1974	194,973	6.17%
Dec. 1975	208,082	
Dec. 1976	217,714	
Dec. 1977	241,811	
Dec. 1978	254,983	

*Source: Group Health Cooperative, Research Department. In January 1979 GHC acquired Sound Health of Tacoma, which had 12,781 members on December 31, 1978. For this reason, growth in 1979 will probably be above recent levels. Through June 30, 1979, enrollment has increased to 273,956 from 254,983 at the end of 1978, an increase of 7.4% in 6 months. Removing the effect of the Sound Health acquisition, enrollment appears to be growing at approximately the recent trend level of 6%.

in the community. The enrollment of individuals was no longer a source of substantial growth; if GHC wished to grow, it needed to focus on group enrollments, and that required coming to terms with the insurance brokerage community, which controlled most of the health and welfare plans for larger businesses and industries. Commissions had to be negotiated, and the broker needed to be informed of the nature of prepaid group practice. In 1960, GHC was offered as a health care plan option by the Federal Employees Health Benefits Program (FEHBP). This group has been a major source of enrollment for Group Health and continues to expand (see Table 15, p. 60). Other government groups, such as the employees of King County, City of Seattle, and the State of Washington, became additional important sources of enrollment.

The business community apparently wasn't hostile towards GHC in this period, but was largely indifferent. For example, GHC received little support from Boeing management; GHC's entry there was due to the professional association of engineers, SPEEA, and to the Aero Mechanics union. On the other hand, GHC had a rough quota on Boeing enrollment because of the cyclical nature Boeing's employment and logistic limitations on the growth of GHC's service in those years. This quota was removed in 1975. GHC targeted large employers for enrollment, often successfully and also was successful in enrolling small groups who were not particularly attractive to brokers and the insurance industry.

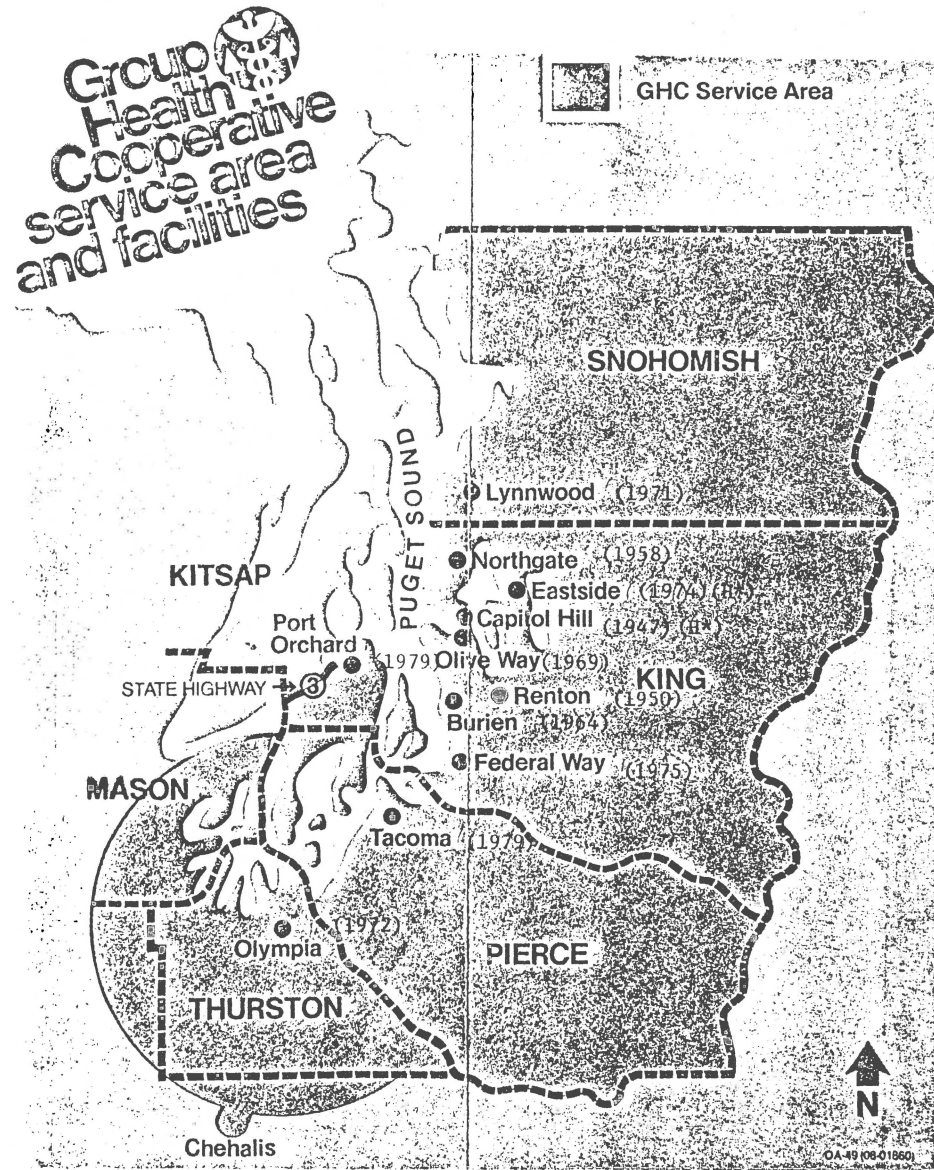


Figure 3. Group Health Cooperative Service Area¹

¹ Date of opening of Medical Centers is listed in parentheses. Two locations include both Medical Centers and Hospital Facilities, marked with (H*). The Capitol Hill hospital has operated since the formation of the cooperative, going through several expansions. The Eastside Hospital opened in 1977.

Group Health has been least successful in enrolling intermediate groups of one hundred to one thousand employees.

Enrollment increased from 69,209 to 189,055 people from 1963 to 1973 (see Table 13). Medical centers and hospital facilities were expanded concurrently. All of Group Health's expansion was based on fully controlled facilities; this meant that financing had to be arranged, land acquired, zoning approval received, facilities planned and built, in addition to the logistical implications of staffing and equipping the facilities. This emphasis on "bricks and mortar" was a result of the difficulties of working with other health care facilities in the earlier years and perceived operating efficiencies.

Had Group Health sought to grow faster by, for example, leasing hospital facilities, they would have found it difficult to coordinate patient management and surgery schedules for the staff of the hospitals. In addition, by owning and operating its own hospital facilities, Group Health could realize savings by coordinating laboratory, X-ray, purchasing and management services for inpatient and outpatient facilities. Ownership also facilitated quality control and the modification or expansion of facilities to meet plan needs. Dr. Newman, an observer of HMO development nationally, credits GHC's low premiums compared to Group Health Association of Washington, D.C.,

another consumer owned group, to ownership of hospital facilities.³³

External financing for expansion was not generally available until recently. In the past, debentures sold to members, margin from operations, and depreciation funds were used. These are not adequate for the large requirements of the present, however, and financing has been sought from banks or insurance companies.

During these years the location of facilities was a spontaneous process which can be characterized in four steps:

1. Consumers from adjoining areas with a strong preference for the GHC mode of care would enroll and travel to Group Health facilities;
2. As enrollment continued to grow in the adjoining area, membership would pressure the Board of Trustees to construct facilities;
3. Facilities would be built;
4. Marketing would be done to make use of the new facilities;
5. The process then would be repeated.

Some have characterized this process as "reactive" growth; that is, reacting to consumer desires rather than anticipating them.

The cooperative membership presumably is indifferent to growth for its own sake yet is supportive of specific expansion. For example, the extension to Olympia came because a consumer group in that city secured

³³Personal communication, August 27, 1979.

a commitment from the Board of Group Health that if an HEW-funded feasibility study were favorable, GHC would extend services to the area. Olympia consumers who were already members of the Cooperative were active in this process. A positive feasibility study committee GHC to construction of a medical center in Olympia which was completed in 1972.

Figure 2 (page 53) shows the dates of construction of GHC medical centers in the area. Renton in 1950 and Northgate in 1958 were the earliest to be added to the original Capitol Hill facilities. During this second period expansion took place at existing delivery points, and medical centers were added in Burien (1964), Olive Way (1969), Lynnwood in Snohomish County (1971), and Olympia in Thurston County (1972). The average number of hospital beds in the Capitol Hill complex increased from 86 in 1960 to 258 in 1973. Construction of new facilities could not keep up with demand so a "moratorium" on new enrollments was in effect throughout 1974. Some natural growth took place due to existing commitments but enrollment was not encouraged by active marketing.

Dr. Newman feels a plan must grow for actuarial reasons. If growth does not occur:

1. The membership ages, causing utilization to rise.
2. The staff ages, causing salaries to increase.
3. The plan becomes less dynamic, and loses its best people, both members and staff.

Growth brings problems as well, some noted above:

1. The expansion of facilities, particularly when a plan is small, is an uneven process. Some facilities will be overcrowded awaiting additional expansion, while newly completed facilities may be underutilized until further growth occurs.
2. Growth financed out of present operating margin causes premiums to rise.
3. A growing organization must constantly be restructured in the management of its internal organization, in the delivery of services, in marketing, and financially.
4. The logistical problems of constructing, equipping and staffing facilities are complex.
5. As size increases, data management, planning, and legal counsel require full-time specialized staff.

Continued Growth, The Maturing Organization, 1973 to the Present:

During the "moratorium" on growth in 1974, medical center facilities in Federal Way and Redmond (Eastside) were readied to serve the expanded enrollment. In 1975, a decision was made to penetrate as many groups as possible focusing on expanding the traditional base of teachers and government workers to include more labor and white-collared private sector employees. The decision was surely aided by

the passage of the State HMO Act of 1976. GHC became a state-qualified HMO. State qualification permits an HMO to "mandate" large employers, or require that the employer offer an HMO alternative to its employees. Even granting the support the HMO Act provided, the enrollment results for a sample of private firms are quite impressive (see Table 14). Compared to growth in the traditional sources of enrollment (schools and government workers) recent growth has been much faster in the sample of private firms. Overall growth in the number of Groups which offer GHC as an option has been impressive as has the growth in group enrollees (see Table 16). Typically, in the past, initial offering of GHC by an employer was followed by rapid expansion of the proportion of employees who chose GHC up to a 25-30 percent share, followed by a period of slower growth until a stable share was reached. The extent to which that will be repeated in large private firms is impossible to predict. Emerging competition, the experience-rating of each group, and business attitudes will all surely play a role.

Individual enrollments have been nearly static in this decade. Group conversions have grown but still account for only a small part of the total enrollment, approximately 13,000 people. In 1977 the Eastside Hospital and Specialty Center was completed in Redmond. This relieved pressure on the Capitol Hill facility, and will permit growth in the Eastside area in the future. Group Health also acquired Sound

Table 14

GHC ENROLLMENT AT SELECTED NON GOVERNMENTAL
FIRMS (CONTRACTS ONLY)*

	<u>Year End</u>				<u>June</u>
	1972	1976	1977	1978	1979
Northwest Airlines	-0-	-0-	-0-	-0-	-0-
Pacific Northwest Bell	1,110	1,359	1,471	1,683	1,857
Puget Sound Power and Light	14	176	308	394	333
General Telephone and Electronics	-0-	-0-	-0-	-0-	127
Pay N' Save	-0-	-0-	-0-	-0-	37
Safeway	-0-	-0-	-0-	51	69
Nordstrom	-0-	15	26	45	55
Seattle First National Bank**	-0-	-0-	-0-	221	280
Rainier Bank	-0-	83	174	244	274
Peoples Bank	-0-	-0-	101	166	198
Safeco	-0-	-0-	125	167	208
Tally Foods	-0-	-0-	-0-	41	63
Paccar	-0-	-0-	331	420	414
Pacific Coast Shipyards and Metal Trades Union (Mainly Lockheed)	-0-	-0-	112	228	418
St. Francis X Cabrini Hospital	-0-	-0-	-0-	55	58
Swedish Hospital	-0-	-0-	-0-	-0-	-0-
Sears (Self-insured)	-0-	-0-	-0-	-0-	-0-
Weyerhaeuser (Self-insured)	9	58	73	56	57
TOTAL ALL SELECTED FIRMS	1,133	1,691	2,621	3,671	4,448

Average Annual Increase 615 years: 23.4%

*Source: Enrollment figures given by the Group Status Report, GHC. Includes both group enrollees and coop members. This figure includes only the number of employees selecting GHC, not the number of covered dependents. With the exception of Boeing, this list includes most of the larger employers in the Seattle area listed by the Chamber of Commerce. Smaller firms of interest were also selected.

**Data provided by Personnel Office, Seattle First National Bank.

Table 15

GHC ENROLLMENT AT SELECTED GOVERNMENT AND SCHOOL DISTRICT GROUPS*

	<u>Year End</u>					Avg. Annual Growth 1972-79
	1972	1976	1977	1978	June 1979	
Federal Employees Health Benefits Program (all contracts)	5,305	7,719	8,296	8,655	9,234	8.9%
King County	1,318	1,158	1,338	1,461	1,507	2.1%
City of Seattle**	2,563	2,800	2,714	2,859	3,048	2.7%
City of Everett	-0-	-0-	-0-	-0-	-0-	-0-
Seattle Schools	2,878	2,248	2,656	2,677	2,766	-0.6%
Everett Schools	-0-	-0-	-0-	-0-	86	N.A.

*Source: Enrollment figures given by the Group Status Report, GHC. Enrollment includes group enrollees and cooperative members.

**Some small City of Seattle subgroups are not included.

Table 16

GROWTH OF MARKET SEGMENTS, GROUP HEALTH COOPERATIVE*

	1971	1976	Avg. Annl. Increase 1971-76	1977	Annual** Increase 1976-77	1978	Annual Increase 1977-78	Avg. Annl. Increase 1971-78
Groups Enrolled	367	607	10.59%	791	30.31%	903	14.16%	13.73%
Total Groups and Sub-Groups***	430	821	13.81%	1,151	40.19%	1,328	15.38%	17.48%
Employee Contracts	30,651	59,041	14.01%	69,589	17.89%	75,429	8.39%	13.73%
Enrollees covered by group con- tracts****	77,461	141,333	12.94%	166,689	17.11%	179,218	7.52%	12.73%
Coop members and group conversions	71,117	75,381	1.17%	75,122		75,765		0.91%
Overall enrol- lees (coop members, group conversion and group enrollees)	148,640	217,714	7.93%	241,811	11.07%	254,983	5.45%	8.01%

*Source: Marketing Department, Group Health Cooperative, Year-end data.

**The year of passage of the Washington State HMO Law.

***Different bargaining units in the same firm may form different sub-groups.

****This figure includes the employee and his covered dependents.

Health of Tacoma as of January 1, 1979. This brought the addition of a medical center in Tacoma and a mini-clinic in Port Orchard (Kitsap County) to the existing network of nine delivery points. Three additional medical centers will be opened in the next two years to increase accessibility for consumers in growing suburban areas near Kenmore, Rainier Valley and Fostoria.

Prior to discussing other health care plans in the area, the structure and performance of Group Health will be described in greater detail.

The Structure of Group Health Cooperative

The alliance between consumers and medical staff agreed on in 1946 has resulted in thirty-two years of remarkably steady enrollment growth (see Table 13). The cooperative is built on the Rochdale cooperative principles:

1. Open membership with no preferential treatment for those who joined earlier.
2. Democratic control, one vote per member.
3. No racial, religious, or political discrimination.
4. Operation for service rather than profit.

On a practical level, the Cooperative is organized as a nonprofit, charitable organization of 501(c)3 type. This status allows tax-free gifts to be given; it also obviates the need to pay patronage refunds

to coop members. Instead all surplus monies are required to be invested in the provision of health care. This is a major source of expansion funds. For example, the three new primary care centers will be financed internally from operating margin, bond sales to members, and depreciation.

Only members have a vote. Presently they comprise about twenty-five percent of the overall enrollment.³⁴ To become a member one must provide a \$200.00 contribution to the cooperative, \$25 of which is an enrollment fee, and \$175 of which is a purchase of a share. The \$175 can be paid in monthly installments. Employees of firms that offer GHC as health benefits option do not need to become members of the cooperative in order to elect coverage. They are called group enrollees and make up about seventy percent of the total enrollment. They have no vote but can participate in cooperative meetings. Of course, they can become members by paying the enrollment fee and purchasing a share.

Group Health is a community-rated organization; one rate is charged of all enrollees regardless of age or sex. Group enrollment premiums are thus nearly equal to member premiums; a small additional charge is made to group enrollees to make up for the \$200 capital

³⁴ Annual Report, GHC, 1978.

contribution that members make. In effect this makes group enrollment slightly more costly for long-term enrollees. Group conversion enrollees, about five percent of the total enrollment, are made up of those who are unable to pass the health screening for membership prior to or upon termination of group coverage. Their premiums are typically about ten percent higher than those of group enrollees (see Table 17).

At the annual meetings of the Cooperative, the members elect the Board of Trustees and vote on amendments of the by-laws, or resolutions that are proposed. The eleven member Board of Trustees meets monthly to set policy and review the operations. They select and hire the Executive Vice President of the Cooperative (the Chief Executive Officer) and approve medical staff hirings. In short, the organization has consumer control. The Medical Staff is also democratically organized. An elected Executive Committee is the formal governing body of the Medical Staff. A chief of staff is elected by the physicians to coordinate matters with the Executive Vice President. Each of the hospitals has an elected chief of staff, as do each of the area medical centers. So GHC is also physician controlled.

Essentially consumers and medical staff have veto power over each other. Action emerges from the area of common agreement, as it has since the initial alliance of doctors and consumers was formed. This results in a cumbersome decision process, but the results are assured to reflect the interests of both medical staff and consumers. During

Table 17

MONTHLY PREMIUMS GHC - 1979*

	Individual**	Family of Four**	Maternity Fee**
Member	\$36.80	\$103.75	\$415.00
Group Enrollee	36.75	104.40	520.00
Group Conversion Enrollee	42.70	116.95	520.00

*Source: Dues and Fee Schedule, GHC, effective April 1, 1979.

**The coverage is very comprehensive, including prescription drugs. There is no deductible and only the maternity co-payment. Coverage includes ten free mental health visits; additional visits are charged \$10.50.

the first years of operation, all matters were brought before the full Board of Trustees and medical staff. Recalcitrants in each group caused conflict and delay. In the mid fifties, to overcome this problem, a Joint Conference Committee, composed of three members of the Board of Trustees and three members of the Medical Staff, was formed to work out basic compromise positions on delicate matters such as salaries, hiring policy, and working conditions. These positions are presented to the full Board of Trustees and the Executive Committee of the Medical Staff. This mechanism has served to facilitate the common interest between the consumers on the Board of Trustees and the Medical Staff. Facilitating this common interest is also what distinguishes the Executive Vice President position, the Chief Executive Officer in Group Health Cooperative from a CEO position in other firms. Otherwise his duties are typical managerial duties.

The area Medical Centers have considerable local autonomy. Their performance is monitored internally with management comparing performance among the medical centers. District executive committees, made up of members of the Center's medical staff and consumer public, make policy recommendations to the Board of Trustees and review local activities.

Consumer views on three issues have overcome initial Medical Staff resistance and perhaps contributed to the strength of the Cooperative:

1. Prescription drug coverage - when GHC covered prescriptions large savings for enrollees were achieved by volume purchase. This has been attractive to enrollees.
2. Consumers have consistently pushed for more comprehensive care. Doctors have often resisted going too fast on coverage. But comprehensive coverage has been an advantage in marketing.
3. The trustees wanted general or family practitioners added to the all-specialist staff. Initially the Medical Staff opposed the idea, but in the mid 1950s, a general practitioner was hired and the concept gradually won acceptance.

Performance and Personnel

The addition of GP's to the staff has been effective in controlling costs. As the proportion of GP's increased, the days per thousand of hospitalization decreased (see Table 18). Until 1960, there were but three GP's on the staff (for a membership of 60,000). Beginning in the early 1960s GP's were hired in increasing numbers and now make up about forty percent of the entire GHC staff. The relationship between GP's and lower hospitalization that Feldstein pointed out again comes to mind in the case of GHC. GHC had 431 days of hospitalization per thousand enrollees in 1977 (see Table 19), compared to an SMSA average of 845. Again, the question can be posed,

Table 18

DAYS OF HOSPITALIZATION PER 1,000 ENROLLEES,
GROUP HEALTH COOPERATIVE*

1950 - N.A.	1960 - 600***	1970 - 420
1951 - N.A.	1961 - 584***	1971 - 463
1952 - N.A.	1962 - 584***	1972 - 432
1953 - 642**	1963 - 577	1973 - 428
1954 - 610**	1964 - 516	1974 - 431
1955 - 573**	1965 - 537	1975 - 438
1956 - 556**	1966 - 507	1976 - 410*****
1957 - 540	1967 - 482	1977 - 431*****
1958 - 547	1968 - 472	1978 - 442*****
1959 - 526	1969 - 456	
Average***** for decade - 571	Average***** for decade - 531	Average***** for decade - 433

*Source: Data furnished by Research Department, GHC, a table titled Bed Occupied at Midnight (and Same Day Discharges) in GHC and all Community Hospitals, in the GHC Service Area Per 1,000 Enrollees, Monthly and Annual Averages, 1960 to Date. (Prior to 1960 only annual averages are available.)

**Group Health Hospital only. Does not include hospitalization in Community Hospitals.

***Major expansion of hospital bed capacity.

****The strike of the nursing staff in August 1976 lowered utilization below trend.

*****Does not include the use of the 20 bed Progressive Care Facility (PCF) opened in 1976 or nursing homes in the area. Days of hospitalization in 1976-1978 including PCF and nursing homes in the community is:

1976 - 429

1977 - 457

1978 - 470

*****First complete year of operation of the Eastside Hospital.

*****Average is not weighted by annual enrollment.

Table 19

RESOURCES AND PERFORMANCE FOR GHC AND THE SEATTLE/EVERETT SMSA*

	Beds/1,000	Days/1,000	LOS	All Physicians/ 1,000	GP's/1,000
GHC	1.45	431	4.9	1.06	0.42**
Seattle/Everett SMSA***	3.36	854	5.8	1.91	0.29
Seattle/Everett SMSA removing the GHC population***	3.68	926	6.0	2.05	0.27

*Source: Source of GHC data is the Research Department, Group Health Cooperative, 1978 Data.

**This is a crude estimate of GP's/1,000 enrollees based on an estimate that 40 percent of GHC physicians are GP's.

***Physician estimates are for 1976. See Footnote, Table 6. Hospital estimates are for 1977. See Footnote, Table 2. These figures are not corrected for removal of the GHC population. This disparity would be wider were this done as it is in the third row. GHC market share is estimated at 14.5 percent of the SMSA. Out of plan usage by GHC members is not considered.

"Is the increase in GP's the cause of the decline in hospitalization days per thousand, or does cost consciousness result in fewer days of hospitalization and more health care provided through GP's?" The answer may well be that a combination of the two factors explain the correlation. GHC provides health care with many fewer physicians per thousand enrollees than the SMSA in general; however the number of GP's per thousand enrollees is approximately 50 percent higher than for the SMSA overall.

The result of lower hospitalization is fewer beds per thousand GHC enrollees than in the overall Seattle-Everett SMSA. This is despite the good performance of this SMSA relative to other SMSAs. (See Table 7, p. 22). The age-sex distribution could be an explanation of lower hospitalization but GHC's age-sex distribution does not differ greatly from that of the general community and is becoming more typical thereof as time passes (see Table 20). GHC in 1978 had 1.45 beds per thousand compared to an overall average of 3.68 per thousand for the SMSA in 1977. Average length of stay in GHC hospitals is also lower than the fee-for-service sector.

Studies of Performance

Different studies done in the late 1960s and early 1970s showed cost advantages for GHC over other providers in the community. The most thorough of the studies was probably the Model Cities study of

Table 20

AGE/SEX DISTRIBUTION OF HMO ENROLLEES AND SMSA

	Under 5	5-14	15-44	45-64	65 and Over	Total Male	Total Female
Group Health, 1978*	7.0	17.1	49.3	19.7	6.0	47.3	52.7
Northwest Healthcare, 1978**	7.5	18.9	56.6	16.6	0.4	46.4	53.6
Metropolitan, 1970*	8.4	20.0	42.8	20.1	8.6	49.0	51.0

*Source: Research Department, GHC. Data includes all the GHC service area: Thurston, Snohomish and King Counties. Variation is small from the SMSA distribution because the population of Thurston County is small relative to the others.

**Source: NWHC figures were as of December 1978. Data furnished by NWHC.

1971-1974.³⁵ The study compared a near-poor population offered fully paid comprehensive health care services from either GHC or a program jointly covered by King County Medical Blue Shield and Blue Cross on a fee-for-service basis. Participants could choose the plan they wished, but the resulting distribution was approximately even in age-sex characteristics. The ratio of costs under the two programs was 1 to 1.52, GHC to KCM/BC. Appointment waiting time was longer for GHC, seven days compared to three days for KCM/BC. Office waiting time was shorter for GHC. At the time of the study, GHC was under extreme pressure in its Capitol Hill and Olive Way Medical Centers to which the bulk of this population went for care. In fact, the Cooperative suspended general enrollments in 1974, the final year of the study. Enrollees from the study population, however, were still accepted.

The enrollees divided roughly thirty to seventy between the two coverages, giving some indication of potential HMO market share under fully paid comprehensive coverage similar to some national health insurance proposals. The reasons for choice of plan are interesting (see Table 21). Those who selected King County Medical/Blue Cross often selected the fee-for-service sector for reasons that stressed established patient-physician relationships, such as "have doctor in

³⁵ Richardson, William C., et.al. "The Seattle Prepaid Health Care Project," Department of Health Services, School of Public Health and Community Medicine, University of Washington, 1977.

Table 21

DISTRIBUTION OF INDIVIDUALS BY
FAMILY'S REASON FOR CHOICE OF PLAN*

Reason for Choice	<u>Plan</u>	
	GHC	KCM/BC
Closest, most convenient	24.0%	4.8%
Had it before	22.5	14.3
Friends recommended	18.7	6.8
Have doctor in system	13.5	31.9
Outreach worker convinced	6.3	5.9
Patient/doctor relationship	1.2	4.0
Reading pamphlets	7.6	16.9
Choice of doctors	0.6	9.3
Other	5.7	6.2
Total	100.1%	100.1%

*Source: Richardson, Wm. C. et. al. "The Seattle Prepaid Health Care Project," Department of Health Services, School of Public Health and Community Medicine, University of Washington, 1977.

system," "patient-doctor relationship," or "choice of doctors." The study has surely encouraged GHC's recent stress on choice of physician, a "panel" of patients for each primary doctor, and increased accessibility of facilities.

A study by Mildred Corbin and Aaron Krute,³⁶ comparing reimbursements for a Medicare population based on 1970 data, showed costs about \$100 lower for GHC. (\$196.33 for the GHC group vs. \$295.52 for the fee-for-service control group.) These savings resulted entirely from reduced hospitalization, since more dollars were spent on physicians and related services in Group Health. Again savings of about one-third were realized by GHC. Group Health compared favorably to other Group Practice Prepayment Plans elsewhere in the nation.

Another study by Gaus, Cooper, and Hirschman³⁷ compared Medicaid families receiving coverage from HMO's with control groups receiving care from fee-for-service providers in 1974. GHC was one of the HMO's in the study, and it compared favorably with the control group for hospital and surgical utilization (see Table 22). Again,

³⁶ Corbin, Mildred and Knute, Aaron, "Some aspects of Medicare experience with Group-Practice Prepayment Plans," Social Security Bulletin, Vol. 38:3, (May 1975), pp. 3-11.

³⁷ Gaus, Clifton R., Cooper, Barbara S., and Hirschman, Constance G., "Contrasts in HMO and Fee-For-Service Performance," Social Security Bulletin, Vol. 39:5, (May 1976), pp. 3-14.

Table 22

HOSPITAL AND SURGICAL UTILIZATION BY MEDICAID ENROLLEES
IN GHC AND A FEE-FOR-SERVICE CONTROL GROUP*

	Admissions 1,000	Average LOS	Days of Care 1,000
All Hospitalization			
GHC	74	4.7	346
Control	146	5.8	844
Hospitalization for Surgical Care			
GHC	50	5.1	256
Control	84	4.0	338

*Source: Gaus, Clifton R., Barbara S. Cooper, and Constance G. Hirschman, "Contracts in HMO and Fee-For-Service Performance," Social Security Bulletin, Vol. 39:5 (May 1976), p. 9, Table 4, Annualized Rate.

notably lower in GHC.

All of the above studies were done in the early or mid-1970s. Is GHC still relatively cost-effective? Although direct comparisons of premiums are not possible because the level of benefits is higher in GHC than in the average "Bureau" plan. Nevertheless trends are important. Average premiums at GHC have been going up more rapidly than in the competing Medical Service Bureaus (see Table 23). To what extent this is due to expanded benefits, or the financial pressures of investments in expansion cannot be determined. However, this raises the issue of some weakening in GHC's internal cost control. Further suggestion of increasing costs can be found in the breakdown of costs over-time which show a gradual increase in the percentage of administrative costs followed by a discontinuity in 1976 (see Table 24). The upward trend is credited by GHC management to a strengthening of the administrative staff at GHC in recent years, a move considered necessary for an organization of its size. The sharp increase in administrative costs in 1976-1977 is credited to a change in accounting procedure which reassigned certain Medical Center (outpatient clinic) administrative costs. Still the question is begged, "Is the balance of power in this alliance of consumers and medical staff shifting away from cost-conscious consumers toward the medical staff or toward an emerging administrative staff with objectives of its own?"

Table 23

SELECTED HEALTH CARE PLANS
COMPARATIVE CAPITATION REVENUES,* PER MONTH

	1972	1974	1976	1977	1978	Avg. Annual Rate of Increase
King County Medical Blue Shield**	11.24	12.56	18.36	19.50	20.87	10.86%
Snohomish County Physician's Corp.	11.39	13.41	19.65	22.93	23.06	12.47%
Group Health Cooperative	13.73	17.15	23.57	25.97	30.16	14.01%

*Source: Health Care Service Contractors Reports (1972-1978) Office of the Insurance Commissioner. All Income (Premiums, Dues, Payments) is divided by 12 times year-end enrollment for monthly capitation revenues. This understates premium per month for a health care plan with growing enrollment. Figures are not comparable between plans as coverage under GHC is much broader than for some of the "Bureaus" groups.

Table 24

COST BREAKDOWN, GHC*

	1973	1974	1975	1976	1977	1978	1979
<u>Amount (\$)</u>							
Inpatient	7,324,951	8,782,388	9,609,157	11,257,002	14,430,037	18,522,623	11,165,142
Outpatient	20,819,971	25,218,243	30,771,888	38,722,528	41,164,745	48,708,601	29,304,087
Administrative	<u>4,154,887</u>	<u>5,069,923</u>	<u>7,127,308</u>	<u>8,491,267</u>	<u>15,997,027</u>	<u>20,374,768</u>	<u>12,715,856</u>
Total	32,299,809	39,070,556	47,508,353	58,470,797	71,591,809	87,605,992	53,185,085
<u>Percent (%)</u>							
Inpatient	22.68	22.48	20.23	19.25	20.16	21.14	20.99
Outpatient	64.46	64.55	64.77	66.23	57.50	55.60	55.10
Administrative**	12.86	12.98	15.00	14.52**	22.34**	23.25	23.91

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*Source: Controller's Office, GHC. 1979 figures are for the first six months only.

**Two factors seem to play a role in the shift of administrative and outpatient costs: (1) the strengthening of GHC's managerial and administrative staff; and (2) changes in accounting practices which allocate more clinic costs to administration.

Until now, GHC's advantages in cost-effectiveness have been large enough that the Cooperative could grow as fast as it was able to bring necessary facilities on line. Emerging competition from Northwest Healthcare (see below), and effective cost control by the Medical Service Bureaus are powerful external influences that have been lacking. If GHC is forced to measure itself against something other than its own past performance, improved cost control can be expected.

Medical Staff

Many years have passed since the 1951 court decision ordering the King County Medical Society et.al. to cease anti competitive practices and to admit GHC physicians to membership. Most GHC physicians are now members of the Medical Society. The ostracism and strong division of earlier times has passed; recently a GHC physician served as president of the King County Medical Society. GHC has been accredited for two resident training programs, one in family practice, the other in pediatrics. About a third of the medical staff is on the teaching faculty of the University of Washington. In short, the physician staff of GHC is now recognized as a high quality group.

Entering doctors go through a two-year probationary period in which peer review and self-selection are stressed. About fifteen percent of the probationers do not become full staff members. Annual attrition among full staff is about five percent. Death and retirement

are major reasons for termination but dissatisfaction or release also play a role. All things considered, turnover is remarkably low. Thus, many who join the staff will probably spend their entire subsequent active career at GHC. Therefore, they are interested in the survival and improvement of the institution. The peer review is intense, providing an aspect of quality control difficult to attain outside a group practice setting. Incentives are well-structured for the role of internal quality control. A primary care physician in GHC has no incentive to keep under his care a patient who may require referral. Care, of course, in a group practice setting has continuity. These will be important advantages as competition grows in the Seattle area.

Physicians choose to work at GHC because of some preference on their part for the mode of practice. The chance to have control over their free time is attractive. Freedom from administering an office is a factor as well and the costs of establishing a practice are avoided. Practice in a group setting with intense peer review and consequent opportunities for professional growth are other major factors.

GHC will be discussed further in the context of the competitive setting. First another view of the King County Medical Service Corporation (now renamed King County Medical Blue Shield) and an introduction of Northwest Healthcare will be necessary.

Comment: A surviving remnant of contract medicine combined with a consumer group to keep competition alive, if not flourishing, throughout the 1950s. Group Health Cooperative has been an increasingly important factor in the market from 1950 to the present and has surely been a factor in the overall cost effectiveness of the Seattle market particularly in terms of hospitalization. Studies done during the period of GHC's fastest growth concurred in estimating approximately thirty percent savings by the prepaid group practice care that GHC provided from the cost of the fee-for-service sector. Evidence of a weakening of internal cost control by GHC in recent years is inconclusive, but the issue is raised. There are alternative explanations based particularly on the costs of internally financing rapid expansion and the need to strengthen the organization administratively (in data management, planning, and marketing) to properly manage complex problems faced by a large organization.

Competitive pressure on GHC for cost control has been lacking until now. GHC has important strengths for a fully competitive environment including a membership now nearly typical of the broader community, control of all its own facilities, a committed and high quality staff, continuously increasing geographical accessibility, and strategic positioning for growth by virtue of its rapid penetration of new groups, particularly in the private sector.

In view of business and industry's role in the emergence and

growth of contract medicine, it is ironic that GHC's growth has been despite the indifference of much of the private sector. Active marketing to firms has generally been necessary despite the health care cost control possibilities provided by GHC's presence in the market. The passage of the state HMO Act in 1976 resulted in a large surge in the number of firms that have offered GHC (see Table 16, page 61).

The King County Medical Service Corporation, The Post War Years

From the beginning the "Bureau" was always an alliance between general practitioners and specialists. It was founded and was held together to counteract the effects of contract medicine on the fee-for-service sector. The "Bureau" was an effective way to market a high level of services in the World War II years and served to reduce the possibility of industry-sponsored panel practice plans such as the Kaiser Plan. The formation of Group Health Cooperative from a base of consumers and a remnant of contract medicine served as a reminder of the possibility of a reemergence of an effective closed panel threat to the monopoly IPA structure. Competition between doctors on the basis of price, quality, and mode of care was still a reality. The 1951 court decision in favor of GHC was convincing evidence that the threat would continue although GHC's market share was still small (see Table 25).

Table 25

MARKET SHARE OF GHC IN THE SEATTLE-EVERETT SMSA

	1950	1960	1970	1978
Population Seattle/Everett SMSA*	884,572	1,107,213	1,424,611	1,479,200
Average Annual GHC Membership	16,587	57,867	130,146	249,292
Less Membership from outside SMSA (est.)**	-0-	4,000	15,000	35,000
GHC Membership in SMSA (est.)	16,587	54,000	115,000	214,000***
Percentage of SMSA population enrolled in Group Health Cooperative	1.9%	4.9%	8.1%	14.5%

*Source: SMSA population figures from the Puget Sound HSA Fact Book, February 1979 based on U.S. Census 1950 and 1960. 1970 and 1978 figures are based on State of Washington, Office of Financial Management, Population Trends 1978 (August, 1978).

**Source: The average annual enrollment of Group Health Cooperative was furnished by the Research Department of GHC. Out-of-SMSA membership estimates are my own estimates.

***Rough estimates of out-of-SMSA members in 1978 were provided by Richard Handschin,

Research Director, GHC:	Olympia area	25,000
	Pierce County	4,500
	Kitsap County	3,000
	Other areas	2,500
		<u>35,000</u>

Penetration is relatively greater in King County (15.5% est.) than in Snohomish County (10.0% est.). The acquisition of Sound Health on January 1, 1979 raises GHC penetration in Pierce County to roughly 4%. Penetration of the Olympia market (Thurston County and immediate environs) is about 40%.

Shipman concluded that the "operating management (of the "Bureau") was monitored from the standpoint of the effects of its proposals on the medical profession rather than in terms of the strategic objectives of the plan."³⁸ (This parallels Pauly and Redisch's description of the Not-for-Profit Hospital as a Physician's Cooperative.³⁹)

The indemnity carriers emerged in the post war years as serious competitors of the "Bureau". The coverage they offered was fundamentally different than the coverage offered by the "Bureau". Office calls and home visits, both services of particular interest to general practitioners, often were not covered. On the other hand, indemnity reimbursement allowed specialists freedom from the requirement that the reimbursement be accepted as payment in full, thereby allowing some discretion in the pricing of services. The pricing discretion had two aspects; 1) sometimes there was an acceptable range of fees rather than the fixed fee schedule of the "Bureau", and 2) the physician could bill the patient for the portion of payment not covered by insurance. Shipman notes that many physicians, particularly specialists, preferred the reimbursement of the indemnity plans.

There were other sources of dissension. Some physicians were unhappy

³⁸ Shipman, *ibid.*, p. 141.

³⁹ Pauly, Mark and Redisch, Michael, "The Not-for-Profit Hospital as a Physician's Cooperative," American Economic Review, Vol. 63, No. 1 (March 1973), pp. 87-99.

with the increase in the maximum income level for "Bureau" subscribers, which resulted in an encroachment on the fee-for-service sector by the service plan which was originally limited to the "low wage income" groups. A "Bureau-owned" hospital, to which only specialists had access, was another cause for dissention and was sold in 1957.⁴⁰ Shipman found that support of the "Bureau" was strongest from GP's, obstetricians, pediatricians, and anesthesiologists. Least support for the Bureau was expressed by the surgeons, internists, and orthopedists.⁴¹ "Most of the attitudes critical of the plan seem to be rooted in economic considerations; without the service plan arrangement, the physician could price his service at will and his income would be improved."⁴² Specialists disliked the fact that GP's and specialists were reimbursed alike for the same services. The seventeen-member Bureau advisory board of physicians was dominated by specialists, consisting of three general practitioners and fourteen specialists.⁴³

The overt dissatisfaction of thirty percent of the physicians samples was noted by Shipman, but the study concluded that as long as

⁴⁰Shipman, p. 26.

⁴¹Ibid, p. 140.

⁴²Shipman, *ibid.*, p. 142.

⁴³Ibid., p. 34.

equal proportion of physicians was supportive and a middle group continued to cooperate the discontent could be contained. If the latest group could be stimulated to seek a different structure, Shipman felt, a new alignment of values would appear in the "Bureau." The ambiguity of support for the plan limited its potential for innovation. However, the market share of the "Bureau" has been increasing in recent years after a decline in the 1960s (see Table 26). The original "Bureau" of King County, the King County Medical Service Corporation, recently renamed the King County Medical Blue Shield (KCMBS) is currently considering sponsoring an IPA type HMO, as a response to Northwest Healthcare.

Comment: The Bureau in the post-war era increased its market share by extending coverage to higher income groups, capturing a sizable portion of the employed groups, and enrolling individuals for the first time, the latter action probably in response to Group Health's initial emphasis on enrollment of individuals. Certain groups of physicians, particularly the more specialized, preferred the indemnity carriers' payment because it allowed flexibility in fees, thereby increasing physicians' income. Other physicians, particularly general practitioners, were strong supporters of the "Bureau."

This division of attitudes of member physicians left the "Bureau" unable to act quickly or innovatively on the basis of consensus except

Table 26

PERSONS COVERED BY KING COUNTY MEDICAL SERVICE CORPORATION*

Year	Persons Covered (Subscribers and Dependents)
1935	30,000**
1940	40,000 (about 8 percent of the King County population)
Peak Wartime Enrollment	90,000
Immediate Post War	70,000
1950	130,000
1958	226,629 (about 25 percent of the King County population)
1972	263,827*** (about 23 percent of the population)
1978	334,702*** (about 28 percent of the population)

*Source: Shipman, op.cit. The name of the King County Medical Service Corporation is now King County Medical Blue Shield.

**Enrollment estimates from 1935 to 1958 are from Shipman, et.al.; Shipment also estimated market penetration in 1940 and 1958.

***Office of the Insurance Commissioner, Health Care Service Contractor Annual Reports. Includes contracts administered for the Yakima Medical Service Association that have been marketed through the state-wide association of Medical Service Bureaus, the Washington Physicians Service. Penetration of King County is thus over-estimated. In addition, some fraction of the subscribers live in nearby counties.

in response to competitive pressure. For example, a recently formed HMO, the Northwest Health Care Plan (NWHC), makes the primary care physician the key decision-maker. This has caused the "Bureau" to consider the formation of an HMO because of NWHC's attraction for primary care physicians. Consensual agreement in as large an organization as the King County "Bureau" has become very difficult to achieve given the latent division between specialists and less highly specialized physicians. It seems unlikely that an effective IPA will emerge from the King County "Bureau" because of the division. One can ask whether in the absence of GHC, the "Bureau" might not have dissolved earlier as specialized physicians were drawn to indemnity carriers; now the attraction of Northwest Healthcare, to be discussed below, will be felt by the other end of the physician spectrum. Primary care physicians in the fee-for-service sector may feel the most advantageous structure for them, in a market increasingly influenced by GHC and the specialists, is a primary care physician dominated structure such as Northwest Healthcare, which will be discussed next.

Northwest Healthcare⁴⁴

Northwest Healthcare is an HMO of the IPA type (independent

⁴⁴ Moore, Stephen, M.D., MPH, "Cost Containment Through Risk-Sharing by Primary Care Physicians," The New England Journal of Medicine, Vol. 300, No. 24, (June 14, 1979), pp. 1359-1362.

practice association). It was organized by the Safeco Insurance Company whose home offices are in Seattle. Services were first delivered in the Seattle area in 1976; enrollment had grown to 11,473 by the end of 1978. While IPA's are common throughout the nation, this is a decidedly uncommon organization for it vests decision-making control in the primary care physician. All subscribers agree to an arrangement where only those referrals to hospitals or specialists approved by the primary care physician are paid by Safeco. The primary care physician has an economic incentive to control referrals because his account is credited with a capitation payment for each subscriber which is adjusted for age and sex. Five percent of any billings beyond the amount of total capitation must be paid by the physician, while half of all savings in the individual capitation fund are his to keep, up to a limit of twenty percent above capitation. Figure 4 shows how premium dollars were divided in 1978. It is interesting to note the small proportion of total health care expenses that go to the primary care physician, yet he is the gatekeeper for most of the patients' health care.

As noted in Figure 4, the third party payment structure has incentives for overcare. The NWHC structure corrects these incentives for overcare, however the primary care physician faces moderate incentives for undercare. In part, these are checked by making cases costing more than \$5,000 payable from the general Safeco fund rather

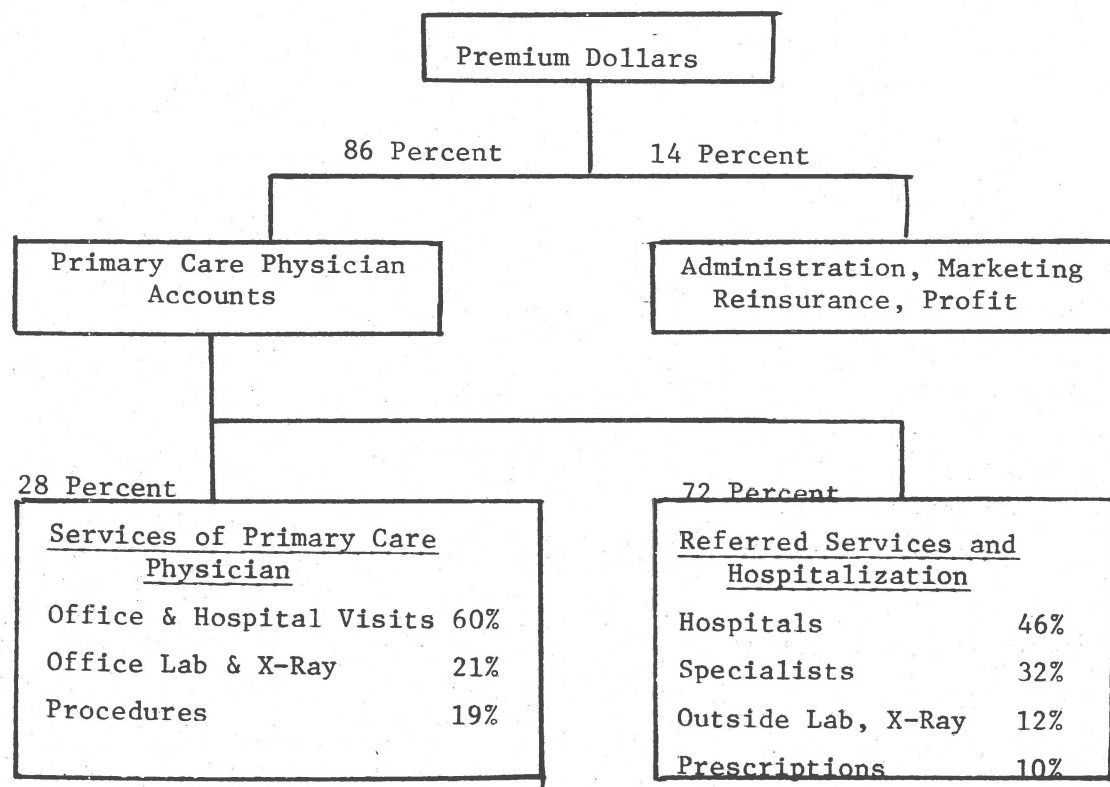


Figure 4.⁴⁵ Cash Flow in the United Healthcare System during 1978 (Northwest Healthcare is the Washington State Division of United Healthcare).

⁴⁵ Moore, *ibid.*, p. 1360.

than the individual physician's account. A utilization committee also reviews patterns of care for undercare. The most important check is that a subscriber can freely change to another NWHC physician if he is unhappy with the care he receives.

Each physician thus becomes a one-man HMO immediately subject to cost saving incentives and the necessity to satisfy patients. The advantage of this IPA structure is that it can be organized with only very small capital outlays because existing facilities, location and patient-physician relationships are preserved. Patterns of referral are modified only gradually depending on the decisions of the individual physician.

Until the primary care physician has fifty patients enrolled, his own services are reimbursed on a fee-for-service basis. Presently only five physicians in Seattle have passed this minimum to be on capitation for their services. Incentives would not be working strongly as yet on enrolled doctors as nearly all would be getting more than ninety-five percent of their income from non-NWHC sources. Nevertheless the performance is already remarkable. Hospital bed-days were below those of Group Health and Blue Cross, (see Table 27). Even when the age-sex distribution is adjusted upward to match that of Blue Cross of Washington State, the Northwest Healthcare hospital days per thousand are only 310. The extent to which patterns of care have shifted away from specialists illustrates the impact NWHC would have

Table 27

1978 HOSPITAL UTILIZATION FOR GROUPS OF
EMPLOYED PERSONS, YOUNGER THAN 65
ENROLLED IN FOUR GROUP HEALTH INSURANCE PLANS*

	Hospital Bed- Days (per 1000)	Hospital Admissions	Length of Stay
Blue Cross of Washington State	479	101	4.7
Blue Cross nationwide (1977)	733	115	6.4
Group Health Cooperative of Puget Sound	350	81	4.2
Northwest Healthcare	293	88	3.3

*Source: Moore, Stephen, M.D., M.P.H., "Cost Containment Through Risk-Sharing by Primary Care Physicians," The New England Journal of Medicine, Vol. 300, No. 24, June 14, 1979.

on specialists (see Table 28). The proportion of total payments to primary care physicians by NWHC is similar to the proportion paid to primary care physicians by GHC.

In the fee-for-service setting, primary care physicians have little information about the fees of either the specialists or the hospitals that receive their referral patients. In the NWHC structure this has changed, as the primary care physician approves payment of all bills. While NWHC is doing nothing at present to encourage physicians to use low cost physicians or hospitals, the potential and the incentive to do so exist. Available information on hospital rates from the State Hospital Commission (see below) allows relatively easy comparison of hospital rates, and the charges of specialists also can be compared. It is in the interest of Safeco, the physician and the patient that cost-effective providers of referral services be identified. Other things being equal, one would expect the physician to select the lower cost providers for referrals, particularly if those providers were of good quality.

Growth in Northwest Healthcare enrollment is the result of several steps. NWHC must first market to primary care physicians, a process now largely completed in the SMSA. Second, it must market to employers, many of whom are indifferent, ignorant, or unconvinced of the merit of NWHC. This process is underway but only Seattle First National Bank, Safeco, Tally Foods, and the two hospitals in Table 14

Table 28

DISTRIBUTION OF PROFESSIONAL-FEE DOLLARS TO
PRIMARY-CARE PHYSICIANS AS COMPARED
WITH SPECIALISTS WITHIN THREE
HEALTH-INSURANCE PLANS*

	Dollars Paid to Primary-Care Physicians (%)	Dollars Paid to Specialists (%)
Blue Sheild-Blue Cross**	29	71
Group Health Cooperative***	51	49
United Healthcare****	52	48

*Source: See Table 27, footnote 1. The table is reproduced nearly intact.

**Internist, general and family physicians, and pediatricians.

***Data from the Seattle Prepaid Health Care Project (1971-74) mentioned the text above.

****United Healthcare figures for 1977 claims paid. Northwest Healthcare is the Washington State division of UHC.

(page 59), offer NWHC presently. Third, once NWHC is offered as an option by employers NWHC must be marketed to employees. Enrollment is not immediate. The first year NWHC is selected by some employees. In the following year more enroll, but time necessarily passes before NWHC increases its penetration. In light of this process, growth has been rapid (see Table 29).

The good performance of the metropolitan Seattle healthcare market could have deterred Safeco from choosing Seattle as an early marketing area had Safeco headquarters not been there. However, Safeco officials believe that a competitive environment and the experience of Seattle physicians with Medical Service Bureaus made marketing somewhat easier than in other areas in which the plan is being marketed. The existence of GHC, they feel, was particularly helpful as many physicians are looking for a means to compete with GHC, and NWHC provides one such means.

Comment: Northwest Healthcare has grown rapidly, but is still small relative to the King County "Bureau" or GHC. Because NWHC is not dependent on physical infrastructure, enrollment growth will be limited only by marketing effectiveness. Marketing success depends in part on the effectiveness of GHC and the "Bureau", and on NWHC's access to employees in open enrollment. As noted, only a few of the selected sample of employers now offer Northwest Healthcare as

an option for employees.

As the number of NWHC subscribers increases for participating physicians, physicians will be motivated to adjust their behavior further. Selection of specialists for referrals and hospitals for hospitalization will probably receive more attention causing referral patterns to change. Some specialists and hospitals may respond by restraining fee increases. The direct competitive impact of NWHC still is nearly invisible to most providers, but continued enrollment growth would change that. NWHC already has caused concern in the "Bureau", often expressed as a worry about the "division in the medical community" that NWHC causes. The latent division of attitudes in the "Bureau" noted by Shipman suggests that if primary care physicians are drawn to NWHC, the "Bureau" would be left without its strongest supporters. The Northwest Healthcare structure offers the primary care physician a shift in the balance of power in his favor. The effect of marked changes in referral patterns involving many patients would be a very dynamic factor in the Seattle-Everett market. It would affect decision-making by hospitals, specialists, Group Health Cooperative and the "Bureau". Accommodation could be expected from some and competitive responses from others. New health care plans might even be formed as a result.

The Snohomish County (Everett) Physicians Corporation (SCPC)

The Snohomish County "Bureau" has 225 enrolled physicians, compared to over 2,000 in the Seattle "Bureau." SCPC leaders feel that smaller size makes consensus easier to arrive at. Hospital utilization by the SCPC Plan is only 470 days per thousand enrollees under age sixty-five. The index of Medicare costs shows the cost-effective care of Snohomish County providers for over-sixty-five patients (see Table 9, p. 26). Nevertheless steady growth by Group Health Cooperative, particularly in the Lynnwood area (a Seattle suburb in Southwest Snohomish County) but also in Everett, caused the SCPC to organize a state-qualified HMO as a defensive structure. Northwest Healthcare was not a factor in SCPC original HMO planning, but may be now. Operations began in 1978, and enrollment had reached 1,850 by June 30, 1979. The structure of this IPA-HMO, called the Health Maintenance Plan of the SCPC, is largely indistinguishable from the SCPC service plan itself. How it will evolve in terms of utilization review, pricing strategy, and marketing is as yet uncertain.

Comment: The competitive impact of this group, which has been established as a defensive structure, is not yet clear. For the HOM to provide more cost-effective care than presently offered through the SCPC service plan will require changes in structure that will only be undertaken because of continuing competitive pressure from GHC and

Northwest Healthcare. Cost-effective practice by "Bureau" physicians is a reality already. An IPA with effective incentives for low utilization is quite possible, because of the relatively small number of physicians in the SCPC.

Kitsap Physicians Service

Another "Bureau", the Kitsap Physicians Service, is currently finishing a feasibility study on the formation of an IPA-HMO. While the counties in their service area are across Puget Sound from the Seattle-Everett SMSA, they are affected by Seattle-Everett events. Growing enrollment by GHC in Kitsap County and the acquisition by GHC of Sound Health's Clinic in Port Orchard (Kitsap County) may have helped provide interest in the HOM concept.

Comment: It is premature to predict the form or impact of the Kitsap Physicians Service-HMO if it is formed: the noteworthy aspect is that competitive forces seem to be stimulating innovation in cost-control and marketing throughout the area. As the impact of Northwest Healthcare is added to that of GHC further innovation can be expected.

Community Health Association of Washington

The Community Health Association of Washington is a small prepaid plan of about 1,000 enrollees associated with a residency program in Doctors' Hospital, a medium sized hospital in central Seattle. Doctors

Hospital is completing a merger with Swedish Hospital, the largest hospital in Seattle and Seattle General Hospital. This group could serve as a base for an HMO sponsored by the Swedish Hospital group. Active promotion of the HMO would probably only be precipitated as a result of increased competitive pressure, according to the director of Swedish Hospital.

Comment on the Competition Among Health Care Plans

Competition appears to be increasing in Seattle. This is partly because more employers are offering their employees the option of an HMO for health care benefits, and employees are selecting HMOs in increasing numbers (See Table 29). Although Group Health Cooperative has dominated the growth statistics, Northwest Healthcare's rapid growth is noteworthy as well. In addition, the "Bureaus," which have some of the characteristics of an IPA-HMO, have continued to grow. In contrast, it seems that the number of individuals uninsured or covered by indemnity carriers has decreased somewhat in recent years if one considers that total population has grown slowly in the SMSA (See Table 1, page 13). Blue Cross's market share conceivably could be growing slowly but probably has decreased somewhat. (This is difficult to ascertain as only statewide data are available for Blue Cross.) There is no dominant indemnity plan in the metropolitan Seattle market. It is interesting to note that Northwest Healthcare

Table 29
THE GROUP HEALTH COOPERATIVE SERVICE AREA
ENROLLMENT IN HMO'S, FOUR "BUREAUS" AND BLUE CROSS, 1972-1978*

	1972	1974	1976	1977	1978	Avg. Annual Growth 1972-1978
King County Med. Blue Shield**	263,837	301,133	304,520	303,517	334,703	4.04%
Snohomish Cty. Physicians Corp.	42,757	42,000	43,266	43,155	48,087	1.96%
Pierce Cty. Med. Service Bureau	133,030	144,156	154,827	149,203	153,396	2.40%
Thurston Cty. Med. Serv. Bureau	<u>21,082</u>	<u>23,411</u>	<u>24,782</u>	<u>18,506</u>	<u>19,729</u>	<u>-1.10%</u>
Total of four "Bureaus"	460,706	510,700	527,395	514,381	555,855	3.18%
Group Health Cooperative	173,004	194,973	217,714	241,811	254,983	6.68%
Northwest Healthcare	-0-	-0-	297	2,281	11,473	N.A.
Snohomish Cty. Phys. Corp.-HMP	-0-	-0-	-0-	-0-	292	N.A.
Sound Health****	<u>-0-</u>	<u>755</u>	<u>6,028</u>	<u>10,963</u>	<u>12,781</u>	N.A.
Total of HMO enrollment	173,004	195,508	224,039	255,055	279,529	8.32%
Blue Cross (statewide)***	560,872	564,897	646,348	647,146	650,703	2.51%

*Source: State of Washington, Office of the Insurance Commission, Health Care Service Contractors and Health Maintenance Organizations Report (annual).

**King County Medical Blue Shield enrollment also includes Yakima County Medical Service Bureau enrollees, a small number. The Yakima "Bureau" does not market locally and only covers those enrollees who elect coverage from Washington Physicians Service, the state-wide marketing association of the "Bureaus."

***Blue Cross would not make local enrollment figures available.

****Sound Health merged with Group Health Cooperative as of January 1, 1979.

found that the competitive environment in Seattle made marketing of their plan easier than in other less competitive areas. The Health Maintenance Plan of the Snohomish County Physicians Service and the Kitsap Physicians Service projected IPAs demonstrate that Group Health and Northwest Healthcare are provoking further competition. One can ask whether the "Bureaus" would have held together had competition not made them a necessary marketing structure for fee-for-service practitioners. In most of the nation physician based plans such as the "Bureaus" have been superseded by Blue Cross and the indemnity plans.

The various health care plans provide health care in different ways. Group Health Cooperative stresses very comprehensive coverage with only exceptional payment beyond the capitation fee, integrated group practice delivery, and incentives for cost effectiveness. Northwest Healthcare preserves existing primary care physician ties as do the "Bureaus", but NWHC makes the primary care physician the manager of all the patient's care to achieve cost effectiveness while the "Bureaus" stress freedom of choice of physician. Group Health has responded to the strong enrollee-physician ties of the other plans by allowing enrollees to choose their primary care physician. GHC's geographic accessibility has been improved by the addition of clinics; NWHC and the "Bureaus" provide access to care wherever there is an enrolled primary care physician. In summary, those consumers who are

offered alternative health care plans are able to choose the plan with the set of attributes they prefer, a desirable characteristic of a competitive environment. Will competition result in further innovation? What is the potential for more plans? Those questions will be addressed in the next section.

Comment on the Potential for Additional Health Care Plans

Historically there has been a tradition of institutional innovation in the metropolitan Seattle medical care market: contract medicine, the Medical Service Bureaus, the Kaiser Plan, Group Health Cooperative, and most recently, Northwest Healthcare. The fee for service sector is under pressure from two sides. If GHC continues to grow, fee-for-service physicians will be forced to compete for fewer patients. If NWHC grows, physicians will witness some shift in the balance of power from specialists to primary care doctors, as specialist services are used with increasing discrimination. One might expect the specialists to respond to these two pressures. Among the responses which generally would support the development of increased competition are the following:

1. Some specialists may form or enter efficient group practices;
2. Group practices or individual specialists may attempt to join or contract with existing HMO's;

3. Group practices or groups of specialists may attempt to
or an HMO or other type of competitive health care plan;
4. Some may become "superspecialists," thereby preserving a
market niche;
5. More specialists may move into underserved areas; or
6. Specialists may accept more primary care patients.

Three groups merit discussion as possible sources of competitive response:

1. The Mason Clinic and the Virginia Mason Hospital,
2. Providence Medical Center, and
3. Swedish Hospital, now merged with Doctors' Hospital and
Seattle General Hospital.

The Mason group is well positioned for innovation in health care delivery. On the one hand, the Mason Clinic is a prestigious multi-speciality group practice of 120 physicians which received referrals from throughout the Northwest. Many patients are self-referred, evidence of the Clinic's reputation for quality care. The Virginia Mason Hospital is an open staff, non-profit hospital of approximately 300 beds. The hospital is almost entirely staffed by Mason Clinic physicians although several hundred physicians have courtesy appointments at the hospital. The efficiencies of the group practice setting and the associated hospital could be combined with primary care physicians throughout the area to form an HMO. Mason's excellent image would aid in marketing the HMO,

and the HMO could provide a source of referrals if competition increases. The principal deterrent to formation of an HMO probably would be the potential for damage to relationships with physicians not participating in the HMO, but referring patients to Mason. Presently about 30 percent of all patients are referred; any reduction in referrals would need to be offset by marketing gains from an HMO.

Providence Medical Center, a 376 bed tertiary care hospital, currently has a grant to study the feasibility of establishing a primary care group in association with the hospital. Details of the study were not available, although a health care plan might be considered. Any decision in this regard will be influenced by the new manager, hired in late 1979.

Swedish Hospital has an opportunity to consider the merits of an HMO by using the 1,000 enrollee prepaid group that has been associated with Doctors' Hospital for a trial effort. The group Community Health Association of Washington is now associated with Swedish Hospital due to the merger of Swedish and Doctors' Hospitals.

Specialists, on the other hand, might respond to competition from GHC and NWHC in ways that would not be supportive of a competitive market. Among the possible responses are:

1. Some specialists might try to extract more revenue per patient from remaining fee for service patients by raising fees or increasing services;

2. Medicare, Medicaid or CHAMPUS patients might be relied on for increased income much as in #1;
3. Anti-competitive legislation may be sought; or
4. One hundred percent employer coverage of health care premiums might be encouraged, as this would effectively create a common pool resource. That this is a real possibility is witnessed by Boeing production workers who presently have one hundred percent employer-paid coverage for workers and dependents. (See discussion below.) Any effort of this type would have to be validated by employers and employees.

Chapter 5

EMPLOYERS

In light of the active role business played in the growth of contract medicine it is ironic that much of the business community has been indifferent to the reemergence of cost-containing competition as represented by Group Health Cooperative, Northwest Healthcare and other health care plans. This is in contrast to Minneapolis, for example, where business has taken an active role in encouraging cost-containing competition among health care plans.⁴⁶

Now that such a large part of health care coverage is financed by payroll deduction, a favorable consumer choice of health care benefit option is critical to the survival and growth of health care plans. The presence of several factors would facilitate a cost effective decision by the consumer:

1. There should be alternative plans to choose among;
2. There should be adequate information about the costs and coverage of each of the alternatives;
3. There should be an annual opportunity to change plans;

⁴⁶ Christianson, Jon B. and McClure, Walter, "Competition in the Delivery of Health Care," New England Journal of Medicine, Vol. 301, No. 15 (Oct. 11, 1979), pp. 812-818.

4. Different plans should be allowed to have different premium levels and benefits levels, thus allowing each employee to best match his preferences for risk to a plan;
5. Particularly important, the employer's contribution should be the same regardless of the plan selected. This assures that the employee receives the benefit of choosing a cost-effective plan.
6. Some portion of the premium should be borne by the employee.

Together these factors form the atmosphere of consumer choice in a competitive health care setting, a condition called "fair market choice" by McClure.⁴⁷ Since the passage of the state HMO Act in 1976 the first factor, choice among alternative plans, has been largely a matter of "dual choice," that is choice between a state-qualified HMO and another plan. However, in some cases there is now "multiple choice," e.g. Bellevue Schools, Seattle First National Bank, and Tally Food. Nevertheless as neither GHC or NWHC actively seek mandates enforcing the State HMO Act, there are firms which still do not offer health care plans.

⁴⁷ McClure, Walter, Ph.D., InterStudy, "Comprehensive Market and Regulatory Strategies for Medical Care," report to BHPRD-DHEW, 1979.

The second factor, adequate information, also is not generally present. GHC marketing personnel estimate that in only about thirty percent of private firms does GHC have direct marketing access to employee orientation meetings. Boeing, by far the largest private employer in the area, is a case in point. At Boeing the employee benefits managers explain Aetna indemnity plan or the Bureau plan to employees, but only printed material on GHC is made available.

The third factor, annual open enrollment, is generally present in those firms that offer dual choice. Boeing is a notable exception, opening enrollment only once every three years.

The fourth factor, not allowing flexible premium and benefit levels for different plans, may also be a problem, particularly in collectively bargained agreements.

The fifth factor, standard employer contribution regardless of plan, is not present for all Seattle employers. Unequal employer contributions distort incentives for the employee, causing employees to select less cost effective plans and causing efficient plans to lose some of their appeal.

The sixth factor, that a significant part of the premium be paid by the employee to preserve some consumer cost-consciousness, is described above as the common property resource problem. In circumstances where the employer bears the full cost of the premium, if the employee chooses a cost-effective plan he receives only an infinitesimal

part of the social benefit of his choice. Again, this is sometimes the case among Seattle employers.

Boeing

Boeing, by virtue of its size, is a major factor in Seattle area economic relationships. Boeing employs several times as many people as the second largest private employer in the area: approximately 70,000 employees versus approximately 10,000 employed by Weyerhaeuser. Presently, a dual option is offered to employees. Hourly workers choose between the King County Medical Blue Shield "Bureau" Plan and Group Health Cooperative. Salaried workers choose between an Aetna indemnity plan and GHC. Boeing's contribution covers one hundred percent of King County Medical Blue Shield's premium for hourly workers and their dependents. For a family of four, Boeing's contribution in 1979 totaled \$1,867.44 (twelve times \$155.62). In contrast the GHC premium for a family of four is \$1,315.92 (twelve times \$109.66) (see Table 30). Only for unusually large families could the dues to GHC conceivably be greater than to King County Medical Blue Shield (see Table 30). In effect Boeing is subsidizing King County Medical Blue Shield (the "Bureau"), the high cost plan. The only incentive the employee has to choose GHC is the Bureau's small deductible for major medical benefits. As a result the percentage of Boeing hourly employees electing Group Health is small and relative stable (see Table 31).

Table 30

COMPARISON OF HEALTH CARE PREMIUMS
FOR BOEING COMPANY HOURLY EMPLOYEES
EFFECTIVE JANUARY 1, 1979

	King County Medical Blue Shield Premium	Group Health Coop. Dues	Required Payroll Deduction
Employee	\$ 63.14	\$ 38.54	\$-0-
Employee and Spouse	120.56	77.08	-0-
Employee, Spouse, 1 child	155.62	95.11	-0-
Employee, Spouse, 2 children	155.62	109.66	-0-
Employee, Spouse, 3 children	155.62	119.94	-0-
Employee, Spouse, 5 children	155.62	133.44	-0-
Employee, Spouse, 7 children	155.62	146.94	-0-
Employee, Spouse, 9 children	155.62	160.44	4.82

Table 31

HEALTH CARE PLAN SELECTED BY BOEING HOURLY WORKERS*

Year	King County Medical Blue Shield	Group Health Coop.**	Percentage of Total Hourly Workforce Covered by HMO
1973	18,909	1,605	7.8%
1974	20,562	1,792	8.0%
1975	18,744	1,455	7.2%
1976	15,876	1,101	6.5%
1977	16,455	1,316	7.4%
1978	21,513	1,902	8.1%
1979 (June 30)	25,563	2,242	8.1%

*Source: Employee Benefits Office, The Boeing Company, Seattle.

**This includes 89 employees enrolled in Sound Health in 1978.

On the other hand, Boeing salaried employees choose between an Aetna indemnity plan with a \$50 deductible, a twenty percent copayment up to a maximum of \$1,500 claims and no copayment above \$1,500 and the Group Health plan. So an individual with the exception of pregnancy and a few minor exclusions has full coverage for a maximum out-of-pocket cost of \$350. This may not be a strong incentive for cost-consciousness but it is stronger than the hourly employees face. One can contrast the effects of no incentive versus a weak incentive for cost-consciousness by comparing the percentage of salaried workers electing GHC (14.6 percent) with the percentage of hourly workers electing GHC (8.1 percent). Further, the former percentage has increased markedly since the early 1970s (see Tables 31 and 32).

Boeing could support a competitive health care marketplace by taking several steps:

1. The dual option presently offered could be expanded by offering Northwest Healthcare as well.
2. HMO marketing personnel could be given direct access to employees during open enrollment.
3. Enrollment could be opened annually rather than every three years.
4. Boeing could make the same contribution to all plans with employees paying the difference for choosing the high cost plan. Some portion of the monthly premium

Table 32

HEALTH CARE PLAN SELECTED BY BOEING SALARIED WORKERS*

Year	Aetna Indemnity Plan	Group Health Coop**	Percentage of Total Salaried Workforce Covered by HMO
1973	26,381	3,295	11.1%
1974	28,610	4,119	12.6%
1975	29,170	4,462	13.3%
1976	27,015	4,386	14.0%
1977	28,260	4,666	14.2%
1978	31,952	5,535	14.8%
1979 (June 30)	36,279	6,218	14.6%

*Source: Employee Benefits Office, The Boeing Company, Seattle.

**This includes 21 employees in 1977 and 56 employees in 1978 covered by Sound Health.

of even the low cost plan also could be borne by the employee. Even if Boeing were to continue subsidizing the high cost plan for hourly workers the firm could change incentives by refunding a portion of premium savings to workers who choose the low-cost GHC plan.

Because of escalating health care costs Boeing has requested the State Professional Standards Review Organization (PSRO) to establish a special review committee, the Professional Review Organization of Washington (PRO), for hospitalization involving Boeing employees. Although the PSRO's were founded as cost-containment structure for Medicare disbursements it has been suggested that they actually result in increased costs by raising the standard for what is usual customary and reasonable (UCR). This may be the result of the PRO of Washington as well; PRO is probably not a substitute for effective provider competition, because of the difficulty of ascertaining after the fact what the most cost-effective procedure would be.

Federal Employees Health Benefits Program (FEHBP)

The competitive market is affected differently by the various

federal government activities. For example, the CHAMPUS program of health care coverage for military dependents is not supportive of a competitive market, as enrollees cannot elect coverage from an HMO. Medicare has a pilot program with GHC for Seattle, but nationally Medicare is also not supportive of competition. In contrast, FEHBP presents a fair market choice to its employees. Nationally, about forty percent of the total premium is contributed by the employee, who thereby has a strong incentive for cost consciousness.⁴⁸ It is interesting to note Group Health Cooperative's growing market share in the setting of fair market choice (see Table 33). Although much of the state lies outside of Group Health's service area its statewide market share reached 13.5 percent in 1978. Data for the Seattle area alone were not available.

Bellevue School District No. 405

The Bellevue School District is an interesting case because it offers a four-way choice in a climate very supportive of competition. There are nine employee groups in the Bellevue School District. The school district makes different contributions for each group, but the contribution is the same for any plan chosen. The employer contribution is high enough for two (small) subgroups that employees would

⁴⁸ Enthoven, *ibid.*, "Consumer Choice Health Plans."

Table 33

ENROLLMENT OF FEDERAL EMPLOYEES IN WASHINGTON STATE IN DIFFERENT PLANS*

	Year**					Average Annual Increase 1967-78	Market Share 1978
	1967	1970	1973	1976	1978		
Blue Cross-Blue Shield***	9,061	12,054	13,700	16,382	14,993	4.68%	21.8%
Aetna****	18,296	17,183	17,403	17,291	17,264	-0.53%	25.1%
Washington Physicians Service*****	10,635	11,135	13,192	16,735	10,217*****		
Kitsap Physicians Service*****	-0-	-0-	-0-	-0-	7,004	4.47%	25.0%
Group Health Cooperative	3,560	4,220	5,532	7,731	9,271*****	9.09%	13.5%
Others*****	5,363	5,760	6,260	7,975	10,144	5.96%	14.7%

*Source: Data furnished by the Office of the Actuary, Federal Employees Health Benefits Program, (FEHBP).

**June 30 data each year.

***Government-wide service plan.

****Government-wide indemnity plan.

*****Kitsap Physicians Service participated in Washington Physicians Service until 1978.

Washington Physicians Service is the stateside marketing organization for the local "Bureaus."

*****Includes Sound Health Enrollment, Sound Health merged with GHC, Jan. 1, 1979.

*****Employee Organizations, the Western Clinic, National Hospital Association, and North Idaho Medical Service Bureau. The dominant portion is that enrolled in employee organizations.

have no payroll deduction for individual coverage or for coverage of self and spouse. Other employee groups with lower employer contributions would face strong economic incentives to choose a cost-effective plan.

Those employees who have an established physician relationship in the fee-for-service sector can preserve the relationship and switch to Northwest Healthcare as long as their physician is listed by Northwest Healthcare. It appears many employees may be making the switch (see Table 34). The Bellevue School District bears watching in the near future as a guide to what could happen in a more competitive Seattle marketplace.

Seattle First National Bank

Seattle First National Bank recently has established fair market choice offering three alternatives. Premiums for individual employees are shown in Table 35. Premiums for family coverage are higher, but still are paid in approximately the same percentage by the firm. Enrollment in the two HMO's has grown rapidly to 420 employees, that is, 75 percent of total employees. However, enrollment data includes the results of only one open enrollment period (see Table 36). This group also merits watching in the coming years as Seattle First National Bank is a major employer in the area.

Table 34

MARKET SHARES IN A SETTING OF FAIR MARKET CHOICE, BELLEVUE SCHOOLS*

	1976-77		1977-78		1978-79	
Blue Cross	319	(18.8%)	297	(17.6%)	270	(17.2%)
King County Medical Blue Shield	754	(44.5%)	642	(38.1%)	573	(36.4%)
Group Health Cooperative	621	(36.7%)	614	(36.4%)	569	(36.1%)
Northwest Healthcare	...		132	(7.8%)	162	(10.3%)
Total Employees	1,694	(100.0%)	1,685	(99.9%)	1,574	(100.0%)
Percentage of total in HMO	36.7%		44.2%		46.4%	

*Source: Data furnished by Ms. Helen Kindler, Bellevue School District No. 405.

Table 35

PREMIUMS FOR INDIVIDUAL GENERAL STAFF EMPLOYEES OF THE SEATTLE FIRST NATIONAL BANK*,**

	1978		1979 (Jan. 1-June 30)	1979 (July 1-Dec. 31)	
Payroll Deduction					
Group Health Cooperative	\$19.27	(41.6%)*	\$18.59	(40.1%)	\$18.59 (40.1%)
Northwest Healthcare	12.88	(32.3%)	12.16	(30.5%)	14.91 (35.0%)
Prudential	5.40	(20.0%)	6.95	(20.0%)	6.95 (20.0%)
Company Contribution to HMO's	27.05		27.75		27.75
Company Contribution to Prudential	21.56		27.75		27.75
Total Premium					
Group Health Cooperative	46.34		46.34		46.34
Northwest Healthcare	39.91		39.91		42.66
Prudential	26.96		34.70		34.70

*Source: Employee Benefits Office, Seattle First National Bank.

**The payroll deduction for administrative workers and officers is the same as for general staff. However, the benefit package is more comprehensive, particularly in dental benefits. The percentage of total premiums borne by the employee is, therefore, somewhat lower.

***Figures in parenthesis are the percentage of total premiums that the employee pays.

Table 36

ENROLLMENT, BY PLANS, OF SEATTLE FIRST NATIONAL BANK EMPLOYEES

	Jan. 1, 1978**		Jan. 1, 1979**		July 1, 1979**	
Officers and Administrative*						
Group Health Coopeative	-0-	(0%)	59	(4.1%)	85	(6.0%)
Northwest Healthcare	-0-		24		45	
Prudential***	<u>1,913</u>	(100%)	<u>1,966</u>	(95.9%)	<u>2,026</u>	(94.0%)
Total	1,913		2,049		2,156	
General Employees*						
Group Health Cooperative	-0-	(0%)	162	(6.8%)	195	(8.3%)
Northwest Healthcare	-0-		70		95	
Prudential**	<u>3,203</u>	(100%)	<u>3,193</u>	(93.2%)	<u>3,184</u>	(91.7%)
Total	3,203		3,425		3,474	
Total						
HMO's	-0-	(0%)	315	(5.8%)	420	(7.5%)
Prudential	<u>5,116</u>	(100%)	<u>5,159</u>	(94.2%)	<u>5,210</u>	(92.5%)
Total	5,116		5,474		5,630	

*Standard Contributions to each plan are made for each employee group as of Jan. 1, 1979.

**The open enrollment period is in November.

***Minimum premium contract with Prudential for indemnity coverage.

Experience-Rating vs. Community Rating

Group Health, as noted earlier, sets premiums almost entirely by community-rating, i.e., fixing one basic rate for everyone, adjusted for age and sex. The "Bureaus," the indemnity carriers and Northwest Healthcare all experience-rate. As competition sharpens Group Health will be quite vulnerable in marketing to relatively healthy groups, as competitors will offer their lowest rates to these groups. Presently Group Health does not have the data management capability to experience-rate. GHC justifies community-rating on the basis that the process of experience-rating itself is costly. Some even feel it may be contrary to the philosophy of Group Health. If Northwest Healthcare sustains dynamic growth, and the "Bureaus" improve efficiency, GHC may be forced to move to experience-rating in order to expand market share among healthy groups.

Higher rates for group conversion enrollees have prevented GHC from being fully community-rated, and thereby becoming a federally-qualified HMO. For a time GHC was considering seeking federal qualification but is not now doing so. Were GHC to move to full community-rating, it might adversely affect continued enrollment growth.

The Role of Commissions

Employers often seek information from outside of their firms on the actuarial, legal, and financial implications of employee health

benefits programs. Sometimes advice is sought directly from insurance plans or their agents or from health care plans. At other times, larger employers seek the services of specialized insurance brokers. Brokers may represent many different insurers and health care plans and are paid a commission by them. Large employers often retain plan consultants from brokerage firms on a fixed fee basis. In this case the consultant's fee is the same regardless of which plan he recommends. However, the incentives bearing on the broker are different. Presumably the broker is sensitive to economic incentives as well as to the employers' interests. Selected commission schedules suggest that the broker's advice might be biased, for example, against GHC and, to a less extent, against Northwest Healthcare (see Table 37). For example, consider what would happen if a broker advised a firm to offer Blue Cross and Group Health to its employees as health care plan options. If premium income during the first year were \$100,000 for each of the plans, Blue Cross would pay the broker a commission of \$2,505.50 compared to a \$1,835.50 commission from Group Health. In the second year, if premium income remained at \$100,000, Blue Cross would pay \$2,505.00 to the broker as compared to a \$917.50 payment from Group Health. Other things equal, a broker would prefer that an employee select Blue Cross. Of course, a plan consultant paid a fixed fee by the firm would be rewarded equally no matter which plan were chosen. The

Table 37

BROKERAGE COMMISSION AGREEMENTS FOR THE BROKER,
SELECTED PLANS, 1978
THREE LEVELS OF PREMIUM INCOME*

Total Premium Income	Plan	First Year	Second Yr. (Renewal)
<u>\$25,000</u>	Blue Cross of Washington & Alaska	\$1,023.00	\$1,023.00
	Indemnity Carrier (Great Western)	1,035.00	1,035.00
	King County Medical Blue Shield	1,217.50	795.00
	Northwest Healthcare	773.00	773.00
	Group Health Cooperative	773.00	386.50
<u>\$100,000</u>	Blue Cross of Washington & Alaska	2,505.50	2,505.50
	Indemnity Carrier (Great Western)	2,435.00	2,435.00
	King County Medical Blue Shield	2,807.50	1,855.00
	Northwest Healthcare	1,835.50	1,835.50
	Group Health Cooperative	1,835.50	917.75
<u>\$350,000**</u>	Blue Corss of Washington & Alaska	5,930.50	5,930.50
	Indemnity Carrier (Great Western)	5,185.00	5,185.00
	King County Medical Blue Shield	7,120.00	4,730.00
	Northwest Healthcare	3,160.00	3,160.00
	Group Health Cooperative	3,810.50	1,905.25

*Source: A Seattle area broker.

**For large employee groups, producing large premium income, commissions are negotiated.

difference of commission rates to brokers has probably caused brokers to be reluctant in including Group Health among health care plans that they recommend to firms. Even when Group Health is offered as a benefit option, there is certainly no incentive for the broker to promote it enthusiastically.

Initially Group Health paid no broker commissions because GHC management felt that community-rating called for few actuarial services. This may explain the slow growth in the number of groups offering GHC as an option. In the early 1960's GHC changed policy and began to pay broker commissions, but Table 37 shows that the accommodation has not been complete.

If a business wishes to control health care costs by supporting a competitive market and by directly seeking cost-effective options, it can overcome any bias in the brokerage commission structure by demanding a benefit program which gives fair market choice. If employers, particularly in the private sector, continue to play a largely passive role, the present commission structure will bias enrollment against existing health maintenance organizations.

Self-Insurance

Weyerhaeuser, a major employer in the area, is self-insured as are some other firms. Mr. Paul Hendricks, manager of an insurance brokerage firm in Seattle, believes "non-insured" would be a better

term than "self-insured," because the employer becomes the risk bearer.⁴⁹ The broad actuarial base of a firm with a large number of employees causes this risk to be small. "Self-insurance" is not generally a response to the premium costs of insurance and health care plans, but rather an attempt at cost-effective administration of benefits. Non-insured firms often are attracted primarily by the cash flow advantages that result from no reserve requirements. These advantages have become greater in recent years since cash reserves are particularly costly during periods of inflation.

The effect of self-insurance is to force third party payors to be competitive in restraining administrative costs; yet the costs are a small part of total premium dollars. Self-insured firms claim that greater awareness of the costs of health care coverage does result. The role of the broker for the self-insured firm is to be a plan consultant providing actuarial, financial, legal, and tax advice to the firm for a fixed fee. Self-insurance, as such, does nothing to promote cost-containing provider behavior.

Self-insurance could be combined, in the context of fair market choice, with health maintenance plan options. Weyerhaeuser, for example, currently offers GHC as an alternative. However, because the Weyerhaeuser employee population is young and

⁴⁹Mr. Hendricks is manager of Wm. M. Mercer, Inc., in Seattle, an employee benefits consulting firm; personal conversation, April 1, 1979.

healthy, Group Health has achieved a very low market share in competition with self-insured indemnity coverage. This underlines the vulnerability of GHC's community-rating to competitive pressure from experience-rating firms, since self-insurance is an extreme form of experience-rating. Northwest Healthcare could be a cost effective alternative for Weyerhaeuser employees because of experience-rating.

There are several employee trust funds in the Seattle-Everett area. One of them, the Carpenters Trust, is self-administering. The Carpenters were attracted by cash flow advantages and lower administrative costs, much as Weyerhaeuser was. In addition, careful claims review and enrollee education are believed to have been helpful in lowering costs. Again, as in the Weyerhaeuser setting, Group Health has achieved a minimal share of this group's enrollment.

Comment: Innovative, cost-effective health care plans are growing despite the indifference of many employers. Active business involvement in development of a competitive market would be most appropriate at this time. That means "fair market choice," or offering a multiple option of health care plans, explaining alternative plans, unbiasedly, contributing equal amounts to all plans, and permitting plans with different levels of premiums and benefits. At present only a handful of employers, Seattle First National Bank and Bellevue Schools among them, offer "fair market choice." Rapid implementation of "fair

market choice" would play a key role in developing vigorous competition in Seattle. Under those conditions cost-effective health care plans would grow according to their merits to consumers. Employers who currently are paying 100 percent of premiums would be able to reduce their share of contribution or share the savings with those employees who choose less costly plans. As competition sharpened, Group Health might be forced to adopt experience rating to compete for relatively healthy groups. If insurance brokerage services are compensated on a flat fee some of the distorted incentives of the brokerage commission structure would be overcome. This could have a positive effect on the presentation to employees of fair information about all plans.

Self-insurance may be a halfway house on the road to health care cost control by lowering administration costs, but real cost control through provider competition can only be promoted by offering effective HMO's as alternatives for employees. Cost-effective health care plans have lower costs than the fee-for-service sector that provides health services to the self-insured firms. "Fair market choice" is therefore important to self-insured firms although obviously they will not offer indemnity plans. HMO's which experience-rate, such as Northwest Healthcare, will be more attractive to self-insured groups, such as Weyerhaeuser, that have relatively healthy employee

populations. Community-rating by GHC might break down, if it is disadvantageous competitively, and be replaced by rates which reflect the cost of providing services to the groups.

Chapter 6

PLANNING AND REGULATORY AGENCIES

The Washington State Hospital Commission

Due to concern about rising hospital costs, the Legislature created the State Hospital Commission in 1973 to "... promote the economic delivery of high quality and effective hospital health care services to the people..." The Commission was to establish a uniform accounting system for hospitals, require annual financial reports, and review budgets to assure that rates were based on costs and did not discriminate among purchasers. For administrative purposes, hospitals are divided into five peer groups, roughly according to size of the hospital and the setting in which the hospital operates. Hospitals then are compared with their peers during the review process. Financially, budget, and rate information are publicly available to the purchaser. Adequate information is a requirements for well-functioning markets; yet many purchasers are not taking advantage of the Hospital Commission's rate information in their hospitalization decisions.

The Commission is going beyond the implementation of uniform accounting and budgeting to focus on the approval of budgets and rates. Certain expenditures are denied or reduced. New investment (the Planned Capital and Service Component of the budget) is reviewed very carefully. There seems to be broad acceptance of the Commission,

as no formal appeals of budget decisions have been made, much less court challenges.

Group Health Cooperative is subject to the budget and rate review. GHC is unclassified, meaning that it is not compared to any peer group, in recognition of its unique HMO structural incentives for cost containment. The budget forms that GHC completes are a shortened version of the standard forms and approval seems to have been granted readily.

Comment: The establishment of uniform accounting and budgeting procedures is the key benefit of the Commission. The Commission may have hoped that the market would more quickly use the rate information it generated, and in its impatience it may be resorting to direct regulation. But the Commission cannot create a market by itself; it only can enhance the competitive environment by providing usable information. The Commission should move toward an information-providing Securities and Exchange Commission (SEC) model rather than toward the regulation of hospital performance. The fact that the Commission has not been hostile to the HMO operated hospital, but instead has been understanding of its special requirements, is important.

The Office of the Insurance Commissioner

This office approves and registers all Medical Service Contractors. The "Bureaus", Blue Cross and the HMO's are the principal Medical

Service Contractors. The office is a model of forbearance from direct detailed regulation. HMO's that are capable of providing services have no difficulty in becoming state qualified HMO's. Success or failure is left to the market; the demise of Inland Health of Spokane and Sound Health of Tacoma witness to the ability of the market to weed out HMO's which are not effective competitors.

Comment: In contrast to some other areas in the nation, the Office of the Insurance Commissioner, as the regulatory body which approves emergent HMO's, is not hostile to Health Maintenance Organizations or a competitive market in general.

Chapter 7

ROLE OF THE FEDERAL GOVERNMENT

As noted above, the Federal Employees Health Benefits Program (FEHBP) is an excellent example of fair market choice in support of a competitive marketplace. Ironically in the past other federal programs have discouraged competition. Presently, on an experimental basis, Medicare recipients in Seattle can elect coverage from GHC under a risk-based Health Care Finance Administration (HCFA) contract. HCFA prospectively pays the expected per capita expenditure to GHC. Group Health can keep half of all excess payments up to 120 percent of actual GHC expenditures, while the other half (as well as any payments more than 20 percent in excess of expenditures) is returned to the federal government.⁵⁰ In fact, GHC has received substantial payment in excess of costs during this program. The enrollee who makes a cost-effective choice by selecting GHC receives none of the savings. However, until this HCFA contract was signed, GHC received no reward for providing cost-effective care as GHC was reimbursed according to costs.

Military dependents and others covered by the CHAMPUS program of the Department of Defense, cannot elect HMO coverage as an alternative to indemnity coverage. This part of the population is

⁵⁰ Meier, Gerald, conversation at InterStudy, Excelsior, Minnesota, June 1979.

therefore not supportive of a competitive market.

Comment: Given the national debate over health care costs the federal government should fully support fair market choice in **Seattle** to observe the competitive alternative in action.

Expanded Medicare enrollment in GHC is a measure of consumer satisfaction in the experimental HCFA Medicare Program. Ten percent net savings to the taxpayer for Medicare costs is a measure of cost-effectiveness. The program should be continued and given full support. Enrollment of the Medicare population would grow more quickly if GHC shared some of the program savings with members. Finally, the CHAMPUS covered population should be permitted to select health care coverage in the context of fair market choice.

Chapter 8

POSSIBLE SCENARIOS

Although it is impossible to predict what will emerge from the competitive ferment in Seattle, it might be helpful to consider some possible scenarios.

Continuation of the Status Quo

Three dynamic factors would make preservation of militate the status quo unlikely:

1. Further enrollment growth by GHC would increase pressure on the fee-for-service sector to compete through more cost effective organization.
2. Rapid growth by Northwest Healthcare would pressure specialists and hospitals to compete on the basis of cost and quality to secure referrals. Competitive pressure from Northwest Healthcare also might cause GHC to operate even more effectively, increasing the impact of the first factor.
3. Continued increase in the number of physicians in a competitive environment would make efficient organizations more attractive to physicians as means of securing or maintaining a competitive advantage.

In fact, the status quo in Seattle-Everett is change itself. It seems likely that institutional arrangements there will continue to change in unexpected ways.

The Worst Scenario

The worst scenario is that competition would disappear, and utilization and per capita costs would become typical of the nation as a whole. For this to happen, several of the following conditions probably would have to prevail:

1. GHC would lose control of costs and would approach the fee-for-service sector's cost levels.
2. Northwest Healthcare would grow slowly or not at all. This would remove the external challenge to GHC to control costs. The dynamic effects on the fee-for-service sector of the shift of power back to the primary care physician also would be lost.
3. Employers would become more indifferent to the escalating costs of health care, by, for example, assuming one hundred percent of premium costs for very comprehensive plans, thereby consolidating a common pool resource with no incentives for consumer or provider cost-consciousness.
4. Legislative or regulatory restraint of competition would be sought and obtained in Olympia or Washington, D.C. The Certificate of Need (C of N) process and Professional Standard Review Organization (PSRO) seem particularly vulnerable to this type of pressure.

The Best Scenario

The most positive factors for the development of competitive cost-effective competition are as follows:

1. Business and government actively promote fair market choice, such as presently exists in the Bellevue Schools and Seattle First National Bank. Employers form an effective group to promote competition.
2. Those employers who now contribute one hundred percent of premiums could reduce their contribution to reestablish some employee cost consciousness. Contributions by an employer would be standard for all plans offered. If employers are unable to avoid one hundred percent contribution to high cost plans, they could consider sharing the savings with employees who choose cost-effective plans,
3. Self-insured employers offer health care plans to employees as an alternative to fee-for-service care.
4. GHC would restrain the increases in premiums in response to competition from Northwest Healthcare, preserving its cost advantage over the fee-for-service sector. Improved data management by GHC would be considered on its merits.
5. Enrollment in Northwest Healthcare grows rapidly. Most employers offer both GHC and NWHC to employees. Physicians

participating in the NWHC plan actively select cost-effective specialists and hospitals.

6. Cost-effective specialists and hospitals respond to increased competitive pressure by forming health care plans to market their combination of cost, quality, and access. Employers, in turn, offer the **acceptable plans** to their employees. If they are successful, costs are contained, consumer choice is enhanced, and efficient providers are rewarded.
7. Increased competitive pressure makes the fee-for-service sector more conscious of cost.
8. The state and federal governments offer Medicaid, Medicare, and CHAMPUS coverage to beneficiaries in a context of fair market choice, thus eliminating these programs as refuges for high cost practitioners.
9. High quality hospital cost information continues to flow from the Hospital Commission. The Commission limits its focus to outcomes not processes. That is, it doesn't try to force each hospital to be cost-effective through regulatory means but rather concentrates on creating market conditions which produce incentives for hospitals to be cost-effective. Uniform budgeting and information are the limits of that process.

10. High-cost providers seeking to defend themselves with
 anti-competitive legislation and regulation are
 unsuccessful.

Chapter 9

SUMMARY AND CONCLUSIONS

The Seattle-Everett health care market performs well in comparison with other urban areas. A major reason seems to be that through nearly all of this century the fee-for-service sector has had to confront the threat of competition from well-defined prepaid organizations. The initial threat from contract medicine was defeated by the organization of the Medical Service Bureaus. The Bureaus eliminated price competition by a series of measures including a standard fee schedule, and, most importantly, the metering of reimbursement levels to meet competition. The County Medical Society of Seattle supported this effort by expelling and thereby effectively denying hospital staff privileges to physicians who accepted prepaid contracts from any group other than the Medical Service Bureau of Seattle's county. Incentives were changed to no longer reward cost-effective behavior by individual providers and consumers.

Group Health Cooperative of Puget Sound began when a remnant of contract medicine merged with a consumer cooperative in 1947. Group Health's unbroken growth in enrollment and service area since then has extended choice of mode of care to an increasing number of Seattle area residents. Critical to the survival of Group Health was the well-known restraint of trade decision in 1951 against the King County Medical Service Corporation, the "Bureaus". Group Health's

growth may have been a factor in the survival of the "Bureau's" service plan, for the coalition of primary care physicians and specialists could have fissured given the attraction for the specialists of fee reimbursement by Blue Cross and the indemnity carriers. In other parts of the nation, where competition was absent, the Blue Shield plans were generally absorbed by Blue Cross.

Group Health now enrolls about one of seven Seattle-Everett residents, is offered by an increasing number of employers as a health benefits option, and continues to grow at about seven percent annually. Studies early in the 1970s suggested a cost advantage of Group Health over the fee-for-service sector of approximately thirty percent. Enrollment growth implies that consumers in increasing numbers have preferred the combination of cost, quality, and access offered by Group Health to that offered by alternative providers.

The 1970s witnessed the formation in Seattle-Everett of new, well-defined provider groupings in emulation of, or response to, Group Health: Sound Health, the Health Maintenance Plan of the Snohomish County Physicians Corporation, Northwest Healthcare, and the Kitsap Physicians Corporation individual practice association. Although Sound Health merged with Group Health because of financial pressures, the rapid growth of Northwest Healthcare, promises increased competitive ferment. Other health care plans will probably emerge; indeed, some are under study at present. While particular developments or the

fortunes of specific institutions are impossible to predict in a competitive environment, competition itself promises that consumers will be better served if provider groups compete for customers by devising new ways to provide cost-effective care.

There are several threats to the development of the competitive market. First, legislative and regulatory restraints on competition by the state or federal governments are a possibility even though initially they may have a benign appearance. Second, effective internal cost control by Group Health is essential to preserve this group's effectiveness. Third, the willingness of more employers to establish a framework of "fair market" multiple choice, in which employees choose health care benefits coverage, is crucial. Fourth, Boeing's coverage of 100 percent of the cost of health care benefits for hourly employees and their dependents destroys any incentive for cost effective individual behavior. This example of a common pool resource with strong incentives for overexploitation may influence other employers to offer similar coverage. Employees of such firms would be indifferent to the cost effectiveness of health care plans. Fifth, to the extent that the brokerage community works on commissions rather than fixed fees, there will continue to be an incentive for them to structure health care benefits programs for employers that maximize commission revenues for brokers.

Because of its unique nature, developments in the metropolitan Seattle health care market deserve continued scrutiny on the part of employers, health care providers, and policy makers in other parts of the United States.

APPENDIX

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Sisters of Providence Hospital

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Robert Allen, Director - Alternative Delivery Systems

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BIBLIOGRAPHY

BIBLIOGRAPHY

Annual Report, GHC, 1978.

Corbin, Mildred and Knute, Aaron, "Some Aspects of Medicare Experience With Group-Practice Prepayment Plans," Social Security Bulletin, Vol. 38:3, (May 1975), pp. 3-11.

Christianson, Jon B., "The Potential for a Competitive Medical Care System in Denver, Colorado," (October, 1979), InterStudy.

Christianson, Jon B. and Walter McClure, "Competition in the Delivery of Medical Care," New England Journal of Medicine, Volume 301, No. 15 (October 11, 1979), pp. 812-8.

Enthoven, Alain C., "Consumer Choice Health Plan," New England Journal of Medicine, Vol. 298 (March 23, 1978), pp. 650-8, (March 30, 1978), pp. 709-20.

Enthoven, Alain C., "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here," National Journal (May 26, 1976), pp. 885-9.

Feldstein, Martin S., "Hospital Care Inflation: A Study of Non-Profit Price Dynamics," American Economic Review, (December 1971) Vol. 61, pp. 853-72.

Gaus, Clifton R., Cooper, Barbara S., and Hirschman, Constance G., "Contrasts in HMO and Fee-For-Service Performance," Social Security Bulletin, Vol. 39:5, (May 1976), pp. 3-14.

Goldberg, Lawrence G., and Greenberg, Warren, Staff Report, Federal Trade Commission, (August 1977), p. 75.

Group Health etc. vs. King County Medical Society, 39 Washington, 2d 586, 237 P 2d 737 (1951). Quoted by Kessel.

Helgersen, Steven Dale, "Contract Practice and the Medical Service Bureaus of King and Pierce Counties, 1900-1933." Unpublished Masters Thesis, University of Washington, 1971.

Kellel, Reuben A. "Price Discrimination in Medicine." Journal of Law and Economics, (October 1958), pp. 20-53.

Luft, Harold S., "How Do Health Maintenance Organizations Achieve Their Savings?" The New England Journal of Medicine, Vol. 298, No. 24, June 15, 1978, pp. 1336-43.

MacColl, William A., M.D. Group Practice and Prepayment of Medical Care, Washington: Public Affairs Press, 1966.

McClure, Walter, "The Medical Care System Under National Health Insurance: Four Models," Journal of Health Politics, Policy and Law, Vol. 1, No. 1, Spring 1976.

McClure, Walter, "Health Care Cost Commission: Choices for Medical Care," Minnesota Medicine, Vol. 61, No. 4, (1978), pp. 261-71.

McClure, Walter, "Comprehensive Market and Regulatory Strategies for Medical Care," report to BHPRD, Department of Health, Education and Welfare, InterStudy (April 1979).

Moore, Stephen, M.D., MPH, "Cost Containment Through Risk-Sharing By Primary Care Physicians," The New England Journal of Medicine, Vol. 300, No. 24, (June 14, 1979), pp. 1359-62.

Nation's Business, October 1976.

Pauly, Mark and Reidsch, Michael, "The Not-for-Profit Hospital as a Physician's Cooperative," American Economic Review, Vol. 63, No. 1, (March 1973), pp. 87-99.

Physician Distribution and Medical Licensure of the U.S. 1976, Center for Health Services Research and Development, American Medical Association, Chicago.

Puget Sound Health Systems Agency, Fact Book (February 1979) based on State of Washington, Office of Financial Management, Population Trends 1978 (August 1978).

Richardson, Wm. C., et. al. "The Seattle Prepaid Health Care Project," Department of Health Services, School of Public Health and Community Medicine, University of Washington, 1977.

Shipman, George A., Lampman, Robert J., and Miyamoto, S. Frank, Medical Service Corporations in the State of Washington, A Study of the Administration of Physician Sponsored Prepaid Medical Care, Cambridge: Harvard University Press, 1962.

Schultze, Charles L., The Public Use of the Private Interest,
Washington: The Brookings Institution, 1977.

Statistics for States and Metropolitan Areas, 1977, U. S. Bureau of the
Census.