Issue Brief
Findings from HSC

BACK TO THE FUTURE? NEW COST AND ACCESS CHALLENGES EMERGE

Initial Findings from HSC's Recent Site Visits

by Cara S. Lesser and Paul B. Ginsburg

Every two years, researchers at the Center for Studying Health System Change (HSC) interview health care leaders in 12 nationally representative communities to assess changes in local health care markets. The third round of site visits is underway, and early findings from 2000-2001 indicate significant changes in health care financing and delivery are taking place across the country. This Issue Brief discusses developments in managed care, hospital consolidation, physician-hospital tensions, risk contracting and health plan premiums. State and federal policy makers charged with balancing cost, coverage, access and quality of health care should consider these emerging trends in their decision making.

Changing Market Dynamics

As technological change and increased consumer demand are starting to drive up health care costs again, there is emerging evidence that changes in the organization and dynamics of local health care markets also may contribute to this phenomenon—and perhaps exacerbate it in the future. Over the past two years, several important developments have taken place in local health care markets across the United States:

- Managed care has been losing its power to control costs, as health plans attempt to respond to consumer demand for less restrictive products and to restore profitability in the current stage of the insurance underwriting cycle.
- Extensive consolidation of hospitals has increased their negotiating leverage with health plans, helping hospitals successfully push back against aggressive plan payment policies.
- Tensions between physicians and hospitals have escalated as competition to provide high-margin specialty services heats up. At the same time, an increased emphasis on physician-owned facilities threatens to drive up costs.
- Increased provider clout and the move away from tightly managed products have led to a precipitous drop in risk-based contracting arrangements, eroding a key mechanism to control costs.
- Health plans have responded with premium increases that have gone largely uncontested by employers and by dropping certain lines of business that have become unprofitable, especially Medicaid and Medicare.

For consumers, these trends have resulted in rising costs, fewer choices for coverage for many and, in some cases, considerable turmoil.

Managed Care Loses Its Bite

At the time of HSC's visits to local health care markets in 1998-1999, health maintenance organization (HMO) enrollment was stagnating or making only modest gains. Recent visits indicate that this trend has intensified, and plans are increasingly moving away from pure HMO products in favor of less restrictive ones such as open-ended HMOs and preferred provider organizations (PPOs). In fact, over the past two years, it appears that the benefits and features of HMOs

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A Collaborative Effort

HSC is conducting its 2000-2001 site visits in collaboration with researchers from Mathematica Policy Research, Inc. (MPR), the University of Washington and individuals from selected academic institutions. The staff is organized in four research teams, each covering a substantive area of interest.

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All of these individuals have contributed to the data collection and analysis captured in this Issue Brief. More detailed analyses on these and other trends are underway and will be released shortly after all 12 site visits are completed.

SITE VISIT UPDATE

As part of HSC's mission to provide objective information about how the health system is changing and the effects of that change on people, researchers conduct site visits every two years in 12 nationally representative communities. Through intensive interviews with local health care leaders, representing health plans, providers, policy makers and employers, HSC collects information that allows researchers to describe and analyze how health care markets are changing locally and nationally.

Shortly after each site visit, HSC issues a Community Report describing the major changes in each community since the previous site visit. HSC is now conducting the third round of site visits and has published four Community Reports, detailing the changes in the Indianapolis, Ind.; Cleveland, Ohio; Seattle, Wash.; and Phoenix, Ariz., health care markets. This Issue Brief draws on the four completed third-round Community Reports and preliminary analysis of completed site visits in Syracuse, N.Y.; Lansing, Mich.; Greenville, S.C.; and Little Rock, Ark. Site visits and analysis of the Orange County, Calif.; Boston, Mass.; Miami, Fla.; and Northern New Jersey health care markets are also underway and will be completed in late 2001. All Community Reports are available on the HSC web site at www.hschange.org.

and PPOs are converging and differences in premiums are diminishing.

In a number of communities, plans are introducing direct access HMOs that do not require a gatekeeper and have broad provider networks that leave them virtually indistinguishable from PPO products. One of the leading plans in Seattle, for example, now uses the same utilization management processes across both its HMO and PPO products. Meanwhile, costs have increased more quickly under HMOs, eroding the price gap between the two products.

At the same time, health plans have shifted their emphasis from gaining market share to restoring profitability, reflecting the turn in the underwriting cycle. As a result, plans are no longer holding prices down to increase market share and are eliminating less profitable business, which for many now means exiting Medicaid and Medicare. These trends foreshadow premium increases that potentially will exceed already higher increases in underlying costs and threaten the viability of public sector managed care programs.

Providers Gain Clout

Hospitals in many communities have experienced extensive consolidation, enabling them to exert greater leverage in managed care contract negotiations. One of the most extreme examples among HSC's 12 sites is Cleveland, where two local hospital systems now control nearly 70 percent of the area's inpatient capacity. In Indianapolis and Phoenix, hospitals have carved out strongholds in key urban and suburban areas, at times creating virtual monopolies in geographic submarkets.

With more consolidated market power, hospitals are aggressively pushing back on health plans' attempts to control costs through reduced provider payment and utilization controls. The changing balance of power between plans and hospitals has led to instances in many communities where hospitals or physician organizations could not come to terms with health plans and, as a result, left the plans' networks. Network instability often has significant effects on consumers. Indeed, in Seattle, some large employers are pressuring plans to ensure network stability; this, in turn, has given providers added leverage with health plans.

Increased bargaining power comes at a critical time for hospitals, which have endured significant cuts in Medicare revenues from the 1997 Balanced Budget Act (BBA) and several years of intense pressure from health plans for discounts. Hospitals have responded by reducing operating costs and have successfully held down inpatient costs in recent years. However, unintended consequences of these efforts are beginning

to surface, as hospitals in several communities are now struggling with inpatient capacity constraints.

In Seattle, for example, the three major hospital systems have had to close admissions periodically for lack of beds. In other communities, hospitals have implemented diversion programs to accommodate overflow in the emergency room. Many attribute the current capacity problem not only to hospitals' cost-cutting strategies, but also to growing demand for inpatient services and a severe nursing shortage that has limited hospitals' ability to staff existing beds.

Escalating Physician-Hospital Tensions

Meanwhile, hospitals in several communities have confronted increasing conflict with physicians. In Cleveland's highly concentrated hospital market, hospitals are exerting pressure on physicians to align more closely with one or the other system, spurring concerns among physicians about loss of autonomy.

In other communities, physician-hospital organizations formed to foster managed care contracting continue to decline in importance. Instead, physicians are focusing on independent strategies that emphasize opportunities for enhancing revenue rather than building capacity to engage in risk contracting. This is seen most strikingly in Phoenix, where specialists are cutting back on affiliations with local hospitals and devoting more time to ambulatory surgery centers or specialty hospitals in which they have an equity interest. This trend threatens traditional hospitals with the loss of some of their most lucrative services and their ability to cross-subsidize less profitable services such as emergency care.

At the same time, there are concerns that the proliferation of physician-owned facilities will induce greater utilization, particularly at a time when health plans' efforts to constrain utilization are weakening. For this reason, some observers suggest that this trend will lead to higher underlying health care costs.

Providers Shun Risk Contracting

With health plans moving away from tightly managed products and providers gaining more clout, there is a discernible shift away from capitation and other risk-based payment arrangements that health plans and some providers had embraced not that long ago. At the time of the 1998-1999 site visits, risk contracting had grown less than anticipated, but now it appears to be in serious decline.

Early findings indicate a strong trend among hospitals to revert to per-diem or diagnosis-related group (DRG) payments, while physicians appear to be returning to fee-for-service payment. There is some experimentation with hybrid payment arrangements, such as withholds and utilization-adjusted fee schedules, but these developments are not widespread.

Although risk contracting was seen by some as a potential boon for providers—allowing them to share in the benefits of managing care—most providers now view risk arrangements as automatically leading to losses. Indeed, many observers point to risk-bearing contracts as a key contributor to the failure of independent physician organizations, a phenomenon that was observed two years ago and continues today. For example, in Seattle, the two largest independent practice associations recently folded after struggling financially under their health plan contracts and failing to achieve the administrative and clinical integration necessary to offset overhead costs.

The failure of these organizations has contributed to providers' reluctance to accept risk and has left health plans with fewer opportunities to transfer risk downstream. Yet, in the absence of risk arrangements, there are concerns that providers will not have incentives to manage utilization, setting the stage for higher costs and limited provider accountability.

Employers: No Clear Vision

As underlying health care costs increase and health plans attempt to restore profitability, employers across the markets visited are experiencing large premium increases. However, because the economy remains strong and labor markets tight, most large employers are not changing purchasing strategies, benefit packages or cost-sharing arrangements significantly in response, other than increasing pharmacy cost sharing and adopting three-tiered prescription copayments.

In fact, it appears that large employers are not actively seeking to switch to lower-cost plans because of the resulting disruption to employees, and because there are few opportunities to do so, as plans have largely abandoned their previous strategy of underpricing to gain market share. In some instances, however, small employers have responded to steep premium increases by switching plans, dropping dependent coverage or dropping coverage altogether.

With initial conceptions of managed care under siege, employers appear to be at a loss for a vision for the future. So far, the 2000-2001 site visits have not identified any innovative approaches to purchasing health benefits. Defined-contribution approaches are on the minds of consultants, but employers show little sign that this is something they are about to embrace. If premiums continue to rise or the labor market slackens, large employers may increase cost sharing for employees, but it is unlikely that they will lose coverage in the near term. For those employed in small firms, however, there is the potential for substantial erosion of employer-based coverage.

Most Consumers Sheltered from Cost Increases—For Now

The reluctance of most employers to make significant changes in their health insurance benefits has insulated many consumers from rising health care costs. At the same time, health plans' responsiveness to the managed care backlash and regulatory threats has restored greater provider choice and flexibility to consumers' health insurance products.

However, recent changes in the health care system have a downside for consumers, too. Network instability stemming from provider and health plan contract disputes is causing considerable disruption in some

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markets. As provider contracts lapse, people enrolled in closed-network HMOs are threatened with the immediate need to change providers, while those enrolled in open-network products are threatened with additional out-of-pocket costs to see providers who are no longer in their plan's networks.

Consumers covered under Medicare or Medicaid also are experiencing substantial turmoil. As Medicare and Medicaid products became unprofitable, health plans are exiting these markets in many communities, causing disruption for enrollees and leaving beneficiaries with fewer coverage choices.

For example, Phoenix, a once-thriving Medicare managed care market that attracted more than 40 percent of beneficiaries to enroll in HMOs, is now experiencing plan exits and increased cost sharing and reduced benefits from the plans that remain. In Cleveland, where enrollment in Medicaid managed care is mandatory, several plans participated in the program two years ago, but now there are just four, two of which have struggled with poor financial performance. Numerous exits by commercial plans, in particular, threaten to thwart the goals of providing access to mainstream providers for Medicaid beneficiaries and broader benefits packages and lower cost sharing for Medicare beneficiaries.

Despite turmoil in these programs, initial site visits indicate that the safety net is stable in most communities. In some cases, traditional providers of care for the uninsured have grown stronger in recent years. For example, the Maricopa County System, the public hospital system in Phoenix, has emerged from major financial difficulties under new management and reportedly is in good financial health. A stark exception is Cleveland, where the public hospital is reportedly in poor financial condition after having lost millions of dollars each month since December 1999, partly because of low reimbursement rates for Medicaid patients.

Overall, however, concerns noted in earlier years that safety net providers would perish under financial pressures have largely not been borne out. While many providers reported that the BBA and Medicaid managed care have been major financial pressures, safety net providers in a number of sites have been bolstered by increased disproportionate share hospital (DSH) funds, the infusion of tobacco settlement funds and expanded coverage under the State Children's Health Insurance Program. Some speculate that the increased consolidation of hospitals may help to boost charity care because of hospitals' greater ability to finance uncompensated care and increased motivation to demonstrate their value to the community.

A Turning Point Looms

Initial findings from recent site visits indicate that the U.S. health system is at a critical turning point. Managed care as we knew it in the early and mid-1990s appears to be in retreat in both the commercial market and public programs. With growing provider clout and increasing resistance to risk-based contracting, there seems to be a move "back to the future" in the financing and delivery of health care. However, the experience of the past decade has left its mark, as optimism about new models for the delivery and financing of care to both reduce costs and improve quality has faded. At the same time, there may be less potential for further savings through reduced payment rates to providers, given the degree to which they have been squeezed in recent years.

Nevertheless, if and when the economy softens, employers likely will step up their efforts to control costs, and, with a weaker labor market, they may become less averse to dropping coverage or passing greater cost-sharing requirements on to their employees. An economic downturn is likely to have an impact on the safety net as well, as state funds for health care diminish and private providers adjust to more limited resources. Indeed, several states are already facing Medicaid budget shortfalls.

As costs continue to rise, employers and policy makers will again confront the dilemma of how to provide broad access to care and promote quality improvement under tight budgets. At a time when backlash against managed care has become so intense, and providers have strengthened their positions to resist further change, serious challenges lie ahead. ●

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