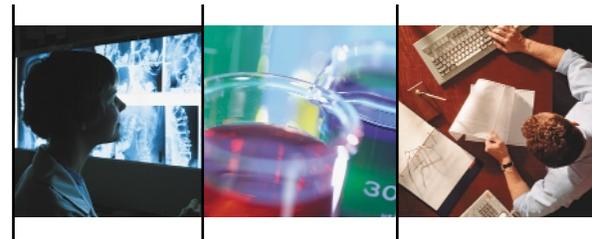


Issue Brief

Findings from HSC



HEALTH CARE COST AND ACCESS PROBLEMS INTENSIFY:

Initial Findings From HSC's Recent Site Visits

by Cara S. Lesser and
Paul B. Ginsburg

Continued high-cost trends are threatening the affordability of health insurance and many consumers' access to care. Early findings from the Center for Studying Health System Change's (HSC) 2002-03 site visits to 12 nationally representative communities show the retreat from tightly managed care continues to shape local health care markets. Employers are aggressively shifting higher health costs to workers, and absent tight managed care controls to limit the use of care and slow payment rate increases, hospitals and physicians in many markets are competing fiercely for profitable specialty services. These developments have sparked growing skepticism about the potential for market-led solutions to the cost, quality and access problems facing the health care system today.

Déjà Vu All Over Again

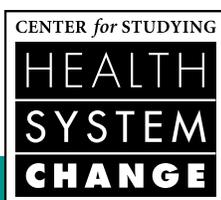
Two years ago, new cost and access problems emerged in the U.S. health care system as managed care lost its bite in the wake of a powerful consumer backlash. Health plans responded to consumer demand for broad choice of doctors and hospitals and loosened restrictions on care. Fewer restrictions on care led to higher utilization and taxed the capacity of many hospitals and physicians to meet demand. With broad provider networks and tighter capacity the norm, plans lost leverage over providers to negotiate price discounts—a key element in lower health cost trends throughout much of the 1990s. Facing rising premiums and reduced profits, some employers began to increase patient

cost sharing in a bid to control health benefit outlays.

Along with higher costs, consumers confronted new barriers to care. Providers' greater clout sparked contract showdowns between prominent hospitals or physician groups and health plans, jeopardizing continuity of care for patients. Hospital capacity problems emerged for the first time in decades, causing emergency department diversions and endangering patients' access to timely care. Competition for high-margin specialty services, especially cardiac, cancer and orthopedic care, heated up among hospitals and physicians, prompting some providers to expand capacity for select profitable services rather than address broader

capacity problems. Indeed, the aggressive copycat behavior and one-upmanship observed in many markets suggested a new medical arms race was underway.

Over the past two years, these trends have intensified. Higher cost sharing is widespread, affecting more employees and a greater number of services. Traditional strategies for managing care have continued to lose ground, and providers have stepped up expansion of lucrative specialty services, escalating concerns about costs and the implications of possible excess capacity in some areas. At the same time, many states face substantial budget shortfalls, prompting some immediate cuts in public health insurance programs and proposals for deeper cuts.





Site Visit Update

Every two years, HSC conducts site visits in 12 nationally representative communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed over the past two years. Approximately 70-100 interviews are conducted in each community with representatives of local health plans, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, consumer advocates and state and local policy makers.

Shortly after each site visit, HSC issues a Community Report describing the major changes in each community since the previous site visit. HSC is currently conducting the fourth round of site visits; field work began in September 2002 and was completed in May 2003.

This Issue Brief is based on findings from visits to the first eight sites: Indianapolis; Cleveland; Seattle; northern New Jersey; Lansing, Mich.; Greenville, S.C.; Syracuse, N.Y.; and Little Rock, Ark.; and initial information gathered on Orange County, Calif.; Phoenix; Miami; and Boston. Visits to the last four sites were not completed when this Issue Brief was written. All Community Reports are available on the HSC Web site at www.hschange.org.

Access at a Cost: A New Deal for Employees

With the slow economy and three consecutive years of double-digit health insurance premium increases cutting into firms' bottom lines, employers are moving more aggressively to shift more health costs to workers. In some respects, this confluence of events recalls the early 1990s when employers struggled with rapidly rising premiums during an economic downturn and responded by aggressively shifting health benefit offerings to tightly managed care.

However, there are some key differences today. While labor markets have loosened since the late 1990s, they are not as severely depressed as a decade ago. The current 6 percent national unemployment rate is not high by historical standards, so employers are still somewhat cautious in responding to rising health costs. In addition, there was a great deal of optimism in the early 1990s about managed care and integrated delivery as an effective strategy to control rising health care costs and rationalize the health care system.

Today, a more modest vision is emerging as employers pin their hopes on the fledgling consumerism movement in health care to help rein in costs. The price and quality information consumers will need to make informed choices about the trade-offs among costs, quality and accessibility of care are still lacking for the most part, making the idea of consumer-driven health care a long-term strategy at best. Furthermore, some question whether incentives can be made powerful enough to lead to substantial changes in behavior without being perceived as barriers to care.

In the meantime, more employers are increasing cost sharing than two years ago, and employers are applying this strategy to a broader scope of services. Some employers, especially unionized firms and public sector employers, for the first time are requiring employees to make up-front contributions to health insurance premiums. Employers that already required premium contributions are increasing copayments and deductibles. And, in many cases, employers are replacing copayments, or fixed-dollar payments, with coinsurance, where patients pay a percentage of the

price for services. The end result: Employees are seeing more of their paycheck going to premiums and paying more out of pocket when they fill a prescription or see a doctor.

Indeed, employers and benefit consultants interviewed in the 12 sites comment that, under the premise that managed care would control costs, employers assumed a much larger proportion of their employees' health care costs over the past decade. They now hope to readjust employee expectations and significantly increase workers' share of costs. However, unlike the move to managed care in the early 1990s, there is less confidence this strategy will have significant, long-term effects on care utilization patterns and delivery system efficiency.

Health Plans Prosper, Managed Care Wanes

Most health plans are more profitable than they were two years ago, mainly because premium increases have exceeded medical cost trends and plans have exited unprofitable lines of business, such as Medicare and Medicaid. But they are still reeling from the vigorous managed care backlash, and without a strong mandate from employers to reintroduce aggressive cost-control measures, plans have few tools to control costs.

Broad provider networks are now the norm, leaving plans with little credible threat of excluding hospitals as a way to negotiate lower payment rates. Global capitation arrangements, where providers assumed total financial risk for patients' care in return for a fixed payment, have all but disappeared in most communities, and even primary care capitation has declined substantially, eliminating a key financial incentive for providers to control care utilization. Many plans have scaled back traditional utilization management techniques, such as prior authorization and primary care gatekeeping, and some have moved away from conventional disease management programs. Most plans continue to pursue case management for the small percentage of high-cost patients who account for a large share of health care services, but the effect of these efforts is still quite limited.

Quality Improvement Takes a Backseat to Costs

Although strong proponents of quality improvement and patient safety efforts exist in many local markets, by and large quality of care remains a secondary issue for most purchasers in the 12 HSC sites. Employers generally are focused on cost containment, and few are actively pressing plans and providers in their communities to demonstrate high quality of care or to improve patient safety.

Two factors appear to limit employers' push for quality improvement:

- employers' general belief that the quality of care is already high in their communities, and
- their view that significant reform is beyond the typical employer's reach.

Notably, even in communities with the active presence of the Leapfrog Group—a national coalition of purchasers committed to reducing medical errors and improving patient safety in hospitals—employers appear to have had only a limited effect on quality and patient safety efforts in their communities.

Nevertheless, the extensive publicity surrounding the Leapfrog Group and Institute of Medicine reports on quality and patient safety has captured the attention of hospitals in many communities, and there is a noticeable increase in hospital activity on this front, particularly regarding patient safety. A number of hospitals are building on existing quality initiatives to respond to Leapfrog recommendations and Joint Commission on Accreditation of Healthcare Organizations requirements for patient safety standards.

Many health plans in the 12 sites continue to develop and refine care and disease management programs and view this as their major contribution to quality improvement in local health care markets. Some plans also have been engaged in promoting patient safety and quality-of-care initiatives more directly in the local delivery system. For example, in Seattle, Group Health Cooperative has long-standing programs to reduce medical errors and improve clinical quality in local hospitals and among physicians in its affiliated group practice. Recently, Regence BlueShield, also in Seattle, has begun to publish information on its Web site about hospital compliance with Leapfrog standards and has signed contracts with some local employers committing to increase the proportion of hospitals in its network that are in compliance with Leapfrog recommendations.

Preferred provider organizations (PPOs) have replaced health maintenance organization (HMOs) as the platform of choice for health plan products. Plans also are experimenting with new PPO or HMO designs that sort network providers into different tiers with varying cost-sharing requirements, and they are developing consumer-driven health plans, or high-deductible plans with a personal spending account.

For the most part, these products are still on the drawing board or have been introduced only recently, with few takers to date. Although employers are now more interested in these products, most remain

skeptical and are reluctant to be the first to sign up. Tiered-network products have faced stiff resistance from hospitals, which question the methodology used to establish the tiers. In some cases, hospitals have refused to participate in tiered networks and, in other cases, have used their negotiating leverage and political influence to avoid placement in high-cost tiers, limiting plans' ability to establish different tiers.

Some plans are emphasizing more customized products, with combinations of different benefit packages and network configurations. For example, in Indianapolis and Cleveland, Anthem Blue Cross Blue

Shield has introduced a product, called Anthem by Design, that offers a choice of benefit add-ons to a base insurance product. Anthem likens the approach to buying a car, where a customer can add upgrades to a base model. As with other new product designs, such as consumer-driven products and tiered networks, these features are intended to reduce costs without sacrificing the broad choice of providers demanded by consumers. Critics, however, contend that consumers do not have enough information to make meaningful choices among these options.

Some plans are experimenting with incentive-based provider payments as an alternative to capitation. Rather than placing providers at financial risk for overutilization of care, these payment schemes reward providers for meeting quality and efficiency standards by supplementing base compensation with a bonus payment. Plans are experimenting with this approach in advanced managed care markets, such as Boston and Orange County, as well as in smaller markets with less managed care experience, such as Indianapolis, Cleveland and Syracuse. While incentive payments are more attractive to providers than financial risk, it is unclear whether the payments will be significant enough to get providers' attention and affect practice patterns and care delivery.

Providers Fuel Cost Growth

Unbridled by the retreat of tightly managed care, hospitals and physicians are making the most of the reprieve from managed care's aggressive cost-containment tactics. Providers have focused primarily on two strategies to bolster their financial position:

- pressing health plans for better payment rates and contract terms, and
- investing in select services and technology that are particularly well compensated.

While the transition to less restrictive managed care has eased financial pressures on providers, many face financial challenges on other fronts today. Declining growth in Medicare and Medicaid payment rates has

squeezed both hospitals and physicians, and providers face cost pressures from new technology and higher wage rates due to the current skilled labor shortage, especially for nurses. In some communities—but not others—rapidly rising malpractice premiums are pressuring physicians and hospitals.

Hospitals have had the most success in winning higher payment rates. Indeed, few physician groups have the clout to negotiate rates with health plans today, other than a handful of large single-specialty groups or groups with brand-name community recognition.

Not all hospitals have greater leverage over health plans today, but demand for broad provider networks has strengthened hospitals with strong geographic niches, brand-name status or tight affiliations with stronger hospitals. In addition, the extensive consolidation among hospitals over the past decade has helped some weaker hospitals to leverage the strong bargaining position of their merger partners to secure better health plan contracts. For example, in northern New Jersey, financially struggling—often urban—hospitals affiliated with well-regarded—often suburban—hospitals appear to have done better in health plan negotiations in recent years, at least in part because of their affiliations.

In general, hospitals with these competitive advantages continue to push plans for better payment rates and contract terms. In many communities, hospitals are willing to take negotiations to the brink, spurring contract showdowns that threaten patients' continuity of care. However, the outcomes of recent disputes have varied more than they did two years ago, when providers consistently emerged as clear winners or walked away from plan contracts. In some cases, plans have held the line with providers, in part because employers have shifted allegiance from providers to plans in the face of rapidly rising costs.

Employer support for a health plan was a factor recently in Lansing, where a contract dispute between the area's leading hospital and dominant health plan ended with a temporary agreement that essentially accepted the plan's original terms. Although the resolution is only temporary, it demonstrated the plan's ability to withstand demands for significant payment increases. In other cases, concerns about

publicizing final contract terms have led both parties to resolve their disputes more quietly than in the past, so it is unclear whether providers' demands actually were met.

Niche Specialty Service Competition Heats Up

Both hospitals and physicians are fueling competition for profitable specialty and ancillary services, resulting in continued buildup of capacity and technology. In Indianapolis, for example, six new specialty hospitals have opened or are under development, and Seattle medical groups are opening ambulatory surgery and diagnostic centers and adding capacity to deliver radiology, laboratory and imaging services in their practices. In several communities, relatively large single-specialty groups are forming, especially in orthopedics and cardiology, primarily to achieve the scale necessary to incorporate profitable equipment into their practices.

Much of the competition over specialty and ancillary services centers on a few key service lines that are particularly lucrative. For instance, one hospital chief financial officer noted that his institution's entire 2.5 percent profit margin was attributable to cardiac services. To the extent that payment policies disproportionately value some services over others, public and private payers inadvertently may be driving niche competition for these services and undermining the ability of general acute care hospitals to maintain capacity for other services. Few markets have strong regulatory mechanisms to restrain these developments. In some markets, employers or leading hospitals have pressed dominant health plans to resist the trend by refusing to pay for services provided in the specialty facilities.

The effect of increased competition for specialty services is unclear. If demand for these services is increasing and facilities can maintain strong volume despite a growing number of competitors, this activity could lead to lower unit costs and, potentially, higher-quality care. And, if health plans can take advantage of oversupply of these services when it occurs, some expansions eventually could lead to lower prices.



**Most health plans
are still reeling
from the vigorous
managed care
backlash, and
without a strong
mandate from
employers to
reintroduce
aggressive cost-
control measures,
they have
few tools to
control costs.**



Both hospitals and physicians are fueling competition for profitable specialty and ancillary services, resulting in continued buildup of capacity and technology.

But, if volume is diffused and capacity exceeds demand, the current competition for specialty services could lead to higher unit costs and induce increases in utilization that would diminish quality of care. At the same time, continued investment in capacity and technology to support key specialty services may actually increase—not remedy—broader hospital capacity constraints, since they appear to be occurring at the expense of investment in other less profitable services, such as emergency care and trauma services, and in information technology that could promote more efficient patient care.

Safety Net Stronger, but State Shortfalls Loom

While the retreat from tightly managed care and the intense competition for specialty services appear to have destabilized the broader health care market, many traditional providers of care for low-income and uninsured people, such as public hospitals, community health centers (CHCs) and free clinics, have grown stronger and more stable in recent years. Despite dire predictions that rapid managed care growth—both in Medicaid and among the privately insured—would undermine these organizations, safety net providers’ financial viability has been strengthened by extensive public health insurance expansions, which have converted many of those served by these providers from uninsured to insured, freeing up financial resources to serve additional uninsured patients. Additionally, public and private initiatives to expand safety net capacity have bolstered providers.

Many safety net providers and consumer advocates are concerned, however, that state budget crises will reverse this progress, particularly at a time when demand for safety net services is on the rise because of the slow economy. After education, health care is the second-largest expenditure for most states. And recent Medicaid and State Children’s Health Insurance Program (SCHIP) eligibility expansions have only added to health care’s share of state budgets, leaving Medicaid and SCHIP particularly vulnerable as states grapple with strapped budgets. Surprisingly, however,

initial HSC site visit findings suggest health care programs have remained relatively protected from state budget cuts and may be cut less than other areas.

States have cut back on outreach, frozen enrollment and, in some cases, dropped certain newly eligible populations, such as immigrants and parents of SCHIP-eligible children. In most communities, state funding for direct safety net services, such as charity care pools and support for community health centers, remains intact. In some sites, one-time infusions of new funding—tobacco settlement money and federal CHC expansion grants, for example—have helped safety net providers. Nevertheless, many states are considering significant Medicaid and SCHIP cuts in the coming year, sparking a great deal of concern about the fallout for low-income people.

Few Bright Spots Ahead

Safety net improvements have been a bright spot in an otherwise grim picture of the health system. Although the economic downturn and state budget shortfalls have focused attention on cost control again, there appear to be few strategies developing in local markets that promise significant relief. Premium increases have helped plans to restore profitability, but they continue to grapple with limited influence over utilization and provider payment rates. Largely unchecked by countervailing pressure from plans, purchasers or policy makers, competition among providers for key specialty services has intensified, driving investment in specialized facilities and equipment that threatens to increase costs and aggravate the broader system capacity constraints already posing access problems.

Employers are generally at a loss about how to respond, other than by passing on more costs to employees. As a result, consumers are paying more out of pocket for health care at a time when many workers face stagnant or declining wages. Although higher cost sharing may help to reduce the use of inappropriate care, it also may cause people to delay needed care. And there are limits to the levels of cost sharing employers can impose on workers. While increasing cost sharing will depress



**There is increasing
skepticism about
the ability of
market-led
solutions to rein in
rapidly rising
health care costs.**

ISSUE BRIEFS are published by the
Center for Studying Health System Change.

President: Paul B. Ginsburg
Director of Site Visits: Cara S. Lesser
Director of Public Affairs: Richard Sorian
Editor: The Stein Group

For additional copies or to be added
to the mailing list, contact HSC at:
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
(for publication information)
Tel: (202) 484-5261
(for general HSC information)
Tel: (202) 484-9258
www.hschange.org

trends in spending for a few years, many observers are skeptical about its potential to lower trends substantially over the long term. But if trends in health care spending are not reduced, the cost of health insurance will rise out of more people's reach, threatening to increase the ranks of the uninsured.

Reflecting on changes in local health care markets today, health care executives, employers and state and local policy makers interviewed for this study have become increasingly skeptical about the ability of market-led solutions to rein in rapidly rising health care costs. Although there is not a strong sense of the alternatives, many stakeholders in local health systems have concluded that there are serious limits

to the effects of competition and market-led efforts to constrain health care spending, especially given the poor experience in the 1990s with managed care.

Some remain committed to realizing the vision of managed care and integrated delivery systems, building on the lessons learned in the 1990s. Many more, however, see health care organizations as responding to the immediate pressures in their environment—to generate return for investors or to generate revenue to support a mission to provide health care, for example—in ways that are often at odds with the goals of controlling overall health care spending and protecting access to high-quality care. ●

A Collaborative Effort

HSC conducted its 2002-03 site visits in collaboration with researchers from Mathematica Policy Research, Inc. (MPR), and other research organizations. Researchers are organized into four teams, each covering a major area of interest.

Health Plans

Robert E. Hurley, Virginia
Commonwealth University
Debra A. Draper, MPR
Gary Claxton, Kaiser Family Foundation
Joy M. Grossman, HSC
Glen P. Mays, MPR
Ashley C. Short, HSC
Bradley C. Strunk, HSC
Justin S. White, MPR

Providers

Lawrence P. Casalino, University of
Chicago
Kelly J. Devers, HSC
Gloria J. Bazzoli, Virginia Commonwealth
University
Robert A. Berenson, AcademyHealth
Linda R. Brewster, HSC
Sylvia Kuo, MPR
Gigi Y. Liu, HSC
Jessica H. May, HSC
Hoangmai H. Pham, HSC

Purchaser/Overview

Jon B. Christianson, University of
Minnesota
Sally Trude, HSC
Leslie Jackson Conwell, HSC
J. Lee Hargraves, HSC
Jessica Mittler, MPR
Len Nichols, HSC
Lydia E. Regopoulos, HSC
Richard Sorian, HSC

Policy

Jack F. Hoadley, Georgetown University
Suzanne Felt-Lisk, MPR
Lawrence D. Brown, Columbia University
Peter J. Cunningham, HSC
Laurie E. Felland, HSC
Aaron B. Katz, University of Washington
Kyle Kinner, HSC
Megan McHugh, MPR
Andrea B. Staiti, HSC

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.