CENTER for STUDYING HEALTH SYSTEM CHANGE

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HEALTH CARE COST AND ACCESS CHALLENGES PERSIST: *INITIAL FINDINGS FROM HSC'S 2007 SITE VISITS*

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Little has changed in local health care markets since 2005 to break the cycle of rising costs, falling insurance coverage and widening access inequities, according to initial findings from the Center for Studying Health System Change's (HSC) 2007 site visits to 12 nationally representative metropolitan communities. As intense competition among hospitals and physicians for profitable specialty services continues, employers and health plans are looking to consumers to take more responsibility for medical costs, lifestyle choices and treatment decisions. While consumer-directed health plans have not gained widespread adoption, other developments—including a heightened emphasis on prevention and wellness, along with nascent provider cost and quality information—are advancing health care consumerism. However, concerns exist about whether these efforts will slow cost growth enough to keep care affordable or whether the growing problem of affordability will derail efforts to decrease the rising number of uninsured Americans and stymie meaningful health care reform.

Little Hope for Cost Control, Improved Access to Care

Across the 12 communities tracked by HSC since 1996, little has changed in the past two years to address rising health care costs, declining insurance coverage and growing access gaps (see Data Source). Two years ago, HSC researchers identified several important trends that promised to set the stage for growing cost and access problems, including a hospital building boom; intense competition among hospitals and physicians to expand profitable specialty services; growing stress on community safety nets; and few cost-control strategies on the part of employers and health plans.

For the most part, those trends continued into 2007, although employers and health plans have stepped up efforts to engage consumers and the hospital building boom appears to have abated somewhat. Nonetheless, already-planned expansions of medical-surgical capacity, especially in profitable specialties and in affluent suburbs with well-insured populations, continue to come on line. Competition among hospitals and between hospitals and physicians for profitable service lines, such as cardiac and orthopedic care, remains intense in most markets, fueling concerns about increased use of health care services and rising costs.

Although the level of physician organization varies considerably across the 12 communities, in some markets, physicians increasingly are organizing into larger, single-specialty practices to attain the scale needed to add profitable services to their practices and to gain leverage in health plan negotiations. As other HSC research has shown, marked disparities in the relative profitability of services under both Medicare and private plan payment policies appear to be a key force driving hospital and physician competition for certain specialty services.[1] Medicare has changed hospital and physician payment systems to better reflect relative costs of different services to reduce inadvertent incentives for providers to favor certain services at the expense of others. But market responses to these policy changes are not yet apparent, with some market observers indicating that the changes have not been substantial enough to alter provider behavior.

Many providers' competitive strategies also include shedding less profitable services, such as mental health care, and more clearly delineating and sometimes tightening policies around care provided to Medicaid or uninsured patients. These actions place additional stress on community safety net providers. Faced with continuing fiscal challenges and growing demand, many safety net providers also are taking steps to maintain financial viability. Such steps include instituting more formal application processes for free care, implementing patient copayments, actively seeking a more favorable payer mix, and competing with private hospitals and entrepreneurial physicians for profitable service lines.

Unlike two years ago, when employers and health plans focused on increased

Community Tracking Study Site Visit Researchers

HSC conducted its 2007 site visits in collaboration with researchers from other research organizations. Researchers are organized into three teams, each covering a major area of interest.

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patient cost sharing to try and curb rising costs, employers and health plans envision a broader consumer-based strategy, where consumers take more responsibility not only for costs, but also lifestyle choices and treatment decisions. The heightened emphasis on prevention and wellness activities, along with growing availability of provider cost and quality information, arguably was the most striking development observed across the 12 communities in 2007. But whether the so-called health care consumerism movement can produce results—improved health and cost savings—remains to be seen.

The Consumers are Coming

To report on trends in consumerism, one must distinguish between the broad concept—consumers having larger financial incentives, information on prices, quality and treatment alternatives, and taking more responsibility for their health—and a particular approach to health benefits design—so-called consumer-directed health plans (CDHPs) that include large deductibles and a tax-preferred savings account. Employers' and health plans' expectations for growth of CDHPs continue to expand. Most health plan respondents interviewed during HSC's 2007 site visits reported launching new products with health reimbursement accounts (HRA) or health savings accounts (HSA). While consumer take up of employer-sponsored CDHPs continues to be limited, many health plans expect these plans to be more important in the future.

When large employers offer CDHPs, they tend to be offered as a choice rather than as a total replacement of existing benefit options. In 2006, fewer than one in five employees chose an HRA or HSA plan over another type of plan.[2] Health plans attribute the low take up to the product's complexity and the extensive education required. Furthermore, premium savings in CDHPs have been less than expected. Respondents listed these reasons, along with lower premium trends in general and concerns about antagonizing employees in a tight labor market, as factors limiting employer interest in CDHPs.

But most employer and health plan respondents believe, in time, CDHPs will be important products. Many believe that more large employers will shift to CDHPs, offering them as the only option for employees, once another large employer in their community takes the plunge. In Indianapolis, for example, market observers are watching Marsh Supermarkets, a large local chain, which recently moved to a high-deductible plan with an HRA as its only employee health benefit option, believing if Marsh's experience is successful, other large employers in the market will follow suit.

While CDHP enrollment growth has not been as rapid as some had expected or hoped, the concept of consumerism has advanced. For example, consumer responsibility for costs continues to increase through changes in cost-sharing requirements, even if not in conjunction with a CDHP. Some respondents noted that the magnitude of cost-sharing increases has moderated from previous years because of smaller recent premium increases.

Plans are making significant investments in consumer-support tools, ranging from information on provider prices and quality to resources about medical treatment, such as through WebMD and 24-hour nurse phone lines. Expectations for now are low about how extensively these tools will be used or how they will affect consumers' decisions, but plans expect this to change as the tools evolve and consumers become more comfortable taking a more active role in their health and health care.

High-performance physician networks, for example, are a recent addition to the consumer-support tools that plans are using to provide information to enrollees about physician performance on efficiency and quality measures. Although the availability of these networks is limited to select markets, plans expect to expand them to additional markets. Consumers may eventually receive financial incentives to use physicians deemed high performing, but for now, these networks are largely offered only as a source of information.[3] Nonetheless, physicians and regulators are scrutinizing how health plans designate physicians for inclusion in high-performance networks. For example, the New York Attorney General recently asked three national health plans—Aetna, CIGNA and UnitedHealthcare—for additional information about their high-performance networks.

An Ounce of Prevention

Interest in prevention and wellness strategies by employers has increased sharply, and health plans are racing to build or acquire the capabilities to deliver these services. Employers want to intervene earlier to prevent disease, hoping to reduce health care costs, lost productivity and absenteeism. Among the strategies being pursued, employers have shown particular interest in health risk assessments, where employees or dependents answer questions about their health and lifestyle. The health plan or vendor then responds with suggestions for treatment or other interventions, such as participation in a weight-management program.

Although most employers think of these activities as support for pursuing healthier lifestyles, some also see this in terms of personal accountability for employees to take steps to improve their own health. While employers often encourage the use of health risk assessments by offering rewards for completion, others are beginning to apply incentives to results. UnitedHealthcare recently announced plans to offer a product to employers where the employee can reduce the size of the plan deductible through verified absence of smoking and meeting objectives for body mass index, blood pressure and cholesterol levels.

Recasting Managed Care as Care Management

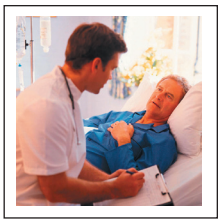
In addition to supporting the broad strategy of consumerism, health plans also perceive opportunities to contribute to more effective care delivery through management interventions. Plans have emphasized integrating various components of care management, for example, by having data from health risk assessments trigger disease management activities, which in turn may identify patients needing more support to manage chronic conditions. Many plans have invested in claims processing technology so that they have "real-time" data to achieve this integration. Although plan strategies are clear, it is less clear how extensively these tools are being used and how much they actually change care delivery for patients.

Plans have brought more care management activities in-dhouse, emphasizing to their employer customers, who have a range of vendor options for such services as health risk assessments and disease management, the potential benefits of integrating these efforts with activities dependent on plans' claims data. Some of the major health plans have acquired disease management vendors in recent years, presumably as part of this strategy.

Although many of the tools that were abandoned in response to the managed care backlash have not reappeared, plans have increased the use of some, such as prior authorizations. The increased use of prior authorizations targets specific services, most prominently high-end imaging services, such as magnetic resonance imaging (MRI) scans. Sensitive to past missteps, plans are attempting to make these activities less intrusive and frustrating for physicians. For example, some plans have used credentialing to identify referring physicians who can be excused from prior-authorization requirements. Nonetheless, many physicians view increased health plan oversight negatively, and, in some cases, have successfully thwarted plans' efforts to reintroduce prior-authorization requirements. Plans have often used utilization-management vendors for these services, but the strategy appears to be well enough established that some plans are now acquiring these vendors. WellPoint recently acquired American Imaging Management, a utilization-management vendor already covering 20 million enrollees. Prior authorizations also are being used for other services, including specialty pharmaceuticals and bariatric surgical procedures.

Plan Consolidation Increases

Local health insurance markets continue to consolidate, a development that may lead to lower provider payment rates as health plans gain greater leverage over providers. For the most part, increased health plan concentration is not the result of mergers between plans in a market but from deterioration in the competitiveness of smaller, locally based health plans. This is a change from the early days of managed care when many local plans thrived because they had pioneered health maintenance organizations (HMOs) and were often better at delivering such a product than regional Blue Cross Blue Shield (BCBS) plans or national commercial plans, which were sometimes reticent about developing HMO products. But the market has changed considerably, and HMOs are a much less popular



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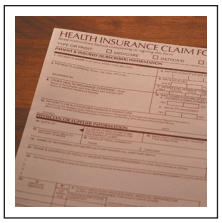

Across markets, physicians are less willing to serve on committees, provide emergency on-call coverage or carry out other voluntary activities that have typically accompanied hospital admitting privileges.

product today, turning an earlier competitive advantage for locally based plans into a disadvantage. With consumer preference for preferred provider organizations (PPOs) now entrenched, the larger plans, especially BCBS plans, are better positioned to offer broader networks and obtain more favorable contracts with providers.

The shift toward PPOs has allowed employers to change strategies in offering health care benefits, including CDHPs, which are typically based on a PPO model. Employers operating in multiple markets, which in the past might have required contracting with different health plans in each market, now prefer contracting with a single plan that can offer access to broad provider networks wherever a firm's employees work or live. BCBS plans can offer such networks, despite exclusive territories, because of arrangements developed by their association through the Blue Card. National plans, especially UnitedHealthcare, have gained market share and strengthened their provider networks in selected markets by acquiring local or regional health plans, such as PacifiCare.

The result of these market forces is erosion of local plan market share, in some cases through ceased operations or sale to a large national plan. Many local plans have pursued strategies to try and compete in the new environment by developing and offering new products, such as PPOs. Some have merged with plans in adjacent markets and developed alliances with national insurers. MVP Health Plans in New York—serving Syracuse—for example, merged with Rochester-based Preferred Care to expand its service area. MVP also has contracted with CIGNA so that enrollees outside of MVP's service area have access to the CIGNA provider network. In turn, MVP's provider network is accessible to CIGNA enrollees covered by employers in other parts of the country. Similar arrangements exist in Boston between CIGNA and Tufts Health Plan, as well as UnitedHealthcare and Harvard Pilgrim Health Plan.

Strained Relations: Hospitals Align with Select Physicians

Hospitals historically have worked to gain physicians' allegiance, including adding new equipment, and more recently, other activities, such as providing electronic access to patients' diagnostic testing results. But market observers say that hospital-physician relations are increasingly strained as more physicians compete directly with hospitals for patients. Across markets, physicians—most notably specialists—are less willing to serve on medical staff committees, provide emergency on-call coverage or carry out other voluntary activities that have typically accompanied their hospital admitting privileges. Hospitals are responding by seeking closer alignment with select physicians, including those in such specialties as cardiology, neurology and orthopedics.

Hospital initiatives toward more tightly aligned physician relationships are often part of a larger set of strategies to compete with other hospitals, such as initiating service lines to attract more patients. Hospital employment of physicians is becoming more prevalent, sometimes as a way of pursuing the service-line strategy and, in many cases, to respond to the growing reluctance of staff physicians to provide emergency on-call coverage and to treat uninsured patients. For its cardiovascular service line, a hospital in Phoenix, for example, moved away from using community-based physicians to employing physicians. For some physicians, employment is attractive because it eliminates the administrative burden of a private practice, offers relief from high malpractice premiums, provides a more supportive infrastructure, such as electronic medical records, and allows for a better work-life balance.

Engaging physicians who specialize in caring for hospitalized patients—known as hospitalists—also is gaining momentum. In addition to employment, hospitals are obtaining hospitalist services by contracting with a medical group, a vendor or individual physicians. Sometimes health plans employ or contract with hospitalists to care for their enrollees.[4] Inpatient care provided by hospitalists is now the norm in some markets, such as Seattle and Orange County. A chief medical officer at a Seattle hospital, for example, estimated that hospitalists now care for three-quarters of all general medical admissions in that community. And because of the growing use of hospitalists, community-based primary care physicians in many markets now have minimal, if any, relationships with hospitals.

In the seesaw relationship between many hospitals and physicians, where competition and collaboration teeter back and forth,

some hospitals are using joint ventures as a strategy to more closely align with physicians. In many cases, this is a defensive strategy to respond to the threat of physicians establishing separate ambulatory surgery centers or freestanding diagnostic centers that compete directly with hospitals. But other hospitals take a hard line, eschewing joint ventures and actively dissuading physicians from investing in competing facilities. Concerns about running afoul of federal anti-fraud-and-abuse laws have tempered some hospitals' enthusiasm for joint ventures with physicians. But as one hospital chief executive officer in Phoenix noted, hospitals are increasingly willing to pursue joint ventures rather than lose the business altogether, a sentiment shared by others across markets. In Orange County, because California's corporate practice of medicine law precludes hospitals from employing physicians, joint ventures have often been the preferred vehicle to create tighter affiliations.

In markets where the alignment between hospitals and physicians is most advanced, physicians' ability to forgo a declaration of allegiance to a particular hospital or to practice independently, particularly in solo or small-group practices, is becoming more difficult. In Cleveland, for example, the two major hospitals systems—the Cleveland Clinic and University Hospitals Health System—continue to employ more physicians. As a result, there are fewer independent physicians practicing in the market, and those that do, confront a number of pressures, including comparatively lower reimbursement. Because larger hospital systems usually negotiate with insurers on behalf of both their affiliated hospitals and physicians, affiliated physicians obtain higher payment rates than do independent physicians. In some markets, physicians in solo or small-group practices are consolidating into larger groups to gain more leverage with both health plans and hospitals. For example, in Miami, where physicians historically practiced solo or in small groups, large cardiology, oncology and other single-specialty practices have formed.

Increasing Focus on the Uninsured

States face mounting pressures to address health care for the estimated 47 million uninsured people nationally, and while they are pursuing a number of strategies, the impact on local communities remains to be seen as many of these efforts are still evolving. In Massachusetts, for example, the state recently launched a landmark effort to reach nearly universal health insurance coverage. The reform requires most uninsured adults in the state to have health insurance and provides free or subsidized coverage for the lowest income and most vulnerable people.[5] Other states, such as California, that are contemplating similar reforms are closely monitoring the developments in Massachusetts.

With some exceptions, the fiscal picture of states improved dramatically from two years ago, creating a favorable climate for public program expansions and, in some states, restoration of previous cuts. New York, for example, is attempting to expand State Children's Health Insurance Program (SCHIP) eligibility from 250 percent of the federal poverty level to 400 percent, or $82,600 for a family of four in 2007. But recent actions by the Centers for Medicare and Medicaid Services may limit states' efforts to increase income limits for SCHIP eligibility. In Indiana, a cigarette tax increase is expected to help fund a state-subsidized insurance program for uninsured residents below 200 percent of the federal poverty level. And in Arkansas, a new federal waiver provides for a limited benefit package (six physician visits a year and two prescriptions per month) for adults employed by firms with less than 500 employees that had not previously provided health insurance.

For a few states, the fiscal climate did not improve over the past two years, and there are indications that it may now be worsening in others. Economic downturns threaten to increase demand for safety net services at the same time they impair states' fiscal ability to support health care programs. In Michigan, for example, a depressed economy reduced state tax revenues and prompted a $3 million reduction in public funding of mental health services. In Ohio, state budget woes resulted in some public program cuts, including reductions in Medicaid eligibility for adults, which affected nearly 30,000 people. Safety net providers in Cleveland reported substantial increases in the demand for services, which they attributed in part to the eligibility reductions.

Like Cleveland, safety net providers across local communities are seeing increased

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Data Source

Every two years, HSC conducts site visits to 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. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Approximately 500 interviews were conducted in the 12 communities with representatives of health plans, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, community health centers, consumer advocates and state and local policy makers between February 2007 and June 2007. This Issue Brief is based on initial findings from these interviews in the 12 communities. In the coming months, HSC researchers will conduct additional interviews to follow up on specific study topics that will be published in upcoming HSC Issue Briefs and peer-reviewed journal articles.

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demand for services, including from immigrants—those who are undocumented and ineligible for public programs, such as Medicaid, as well as legal immigrants who have not been U.S. residents long enough to be eligible. Another source of increasing demand, albeit a more recent phenomenon, is what some market observers described as a growing proportion of the population—often middle class—that is underinsured and turning to the safety net for services. Observers attributed this to the larger number of people enrolled in employer-sponsored health plans with high deductibles, copayments and coinsurance. Adding more pressure on the safety net is the waning capacity and willingness of some hospitals and physicians to provide charity care, particularly specialty care. A shortage of primary care physicians in some markets is further challenging the safety net's ability to respond to the increasing demand for services.

The increased demand has intensified the ongoing financial challenges facing the safety net. Some providers have responded by pursuing strategies aimed at improving their financial health. Community health centers in Phoenix and Orange County, for example, attained federally qualified health center (FQHC) or look-alike status to access higher reimbursement rates, while those in northern New Jersey benefited from increased funding from the state's charity care pool. A safety net hospital in Miami adopted a process to refer nonemergent patients in its emergency department to its outpatient clinics in an effort to reduce costs and improve emergency department efficiency. Safety net hospitals in other markets have pursued similar strategies.

Safety net providers also have looked at capacity changes to respond to the increasing demand. In many markets, however, financial constraints have limited major expansions. In Greenville and Miami, mobile vans were placed in service, providing an alternative to expanding physical space, yet allowing services to go directly into areas with particularly poor access to care. In Cleveland, new staff were added to address the needs of a more culturally and linguistically diverse patient population. But for many low-income and uninsured people, access to specialty care remains a severe problem, including access to mental health and dental care, which many market observers described as "disastrous."

Implications

Over the past two years, change at the local health care system level largely has been incremental. Perhaps the most pervasive development has been the marked increase in employer and health plan expectations that consumers need to assume more risk and responsibility for their health and health care. But how these expectations actually pan out in terms of the ultimate impact on health care costs and access are dependent on a number of factors, not the least of which are the ability and willingness of consumers to accept this shift.

With largely incremental change, little has been done to address ongoing concerns about health care affordability and access. These concerns are likely only to worsen as health care costs continue to rise much more rapidly than incomes and the number of uninsured people continues to grow. But whether these pressures are enough to gain the attention of policy makers and others to stimulate meaningful health care reform or to support the successful attainment of initiatives already underway remains to be seen. ■

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