Health System Change in Little Rock, Ark.

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Little Rock is on the brink of significant health system change. While established insurers and providers are looking for new ways to control health care costs, national health care companies are entering the market and seeking to unseat the dominant local players by driving down health care spending. Despite the increasing pace of change, however, Little Rock-based nonprofit providers exercise significant control over a system that continues to be characterized by the prevalence of fee-for-service payments, significant levels of excess capacity and limited enrollment in managed care plans.

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Perhaps the most potent force in the market today is the recent alliance between two established, home-grown institutions: Little Rock-based Baptist Health, the largest hospital system in central Arkansas, and Blue Cross and Blue Shield of Arkansas (BCBSA), which covers close to half of all commercially insured lives in the metropolitan area. These entities joined forces in 1994 to form the area's most highly subscribed HMO. Baptist Health is also the preferred hospital provider for BCBSA's sizable PPO business, a business that stands to gain from the insurer's successful bid for the newly combined state employee and public teacher pool.

Significant changes are unfolding in the way health services are organized and paid for in Little Rock as well as in the locus of control of key entities in Little Rock's health care sector. Over the last several years, the dominance of the local institutions has been challenged by the market entry of several national health care companies seeking to build market share by taming what many informants perceive to be high and rising health care costs. The 1994 merger of health care giants Columbia and HCA brought under their control Doctor's Hospital, a medium-size institution located in the heart of Little Rock's medical-industrial complex.

Shortly after, Columbia/HCA purchased the biggest group practice in town, a move that reportedly set off a spate of physician practice acquisitions by the two major

locally owned hospitals. In February 1997, Columbia/HCA acquired a smaller community hospital south of town, adding yet another institution to the company's portfolio in central Arkansas. All eyes are also on the Arkansas Heart Hospital, an institution being built by MedCath, a Charlotte-based health care company, which opened its doors in early 1997 and is positioning itself to lure lucrative cardiology patients away from several other area hospitals.

National health insurance companies are also a growing presence in the Little Rock market. These companies include New Hampshire-based Healthsource[1]; Prudential, an Atlanta-based concern; and United HealthCare, a Minneapolis-based company that owns the most rapidly growing HMO product in the area. At the same time, respondents say that intensifying competition for covered lives and employers' sensitivity to health insurance premiums have contributed to a recent decline in the rate of premium growth.

These dynamics have led to a profusion of provider profiling activities, something that distinguishes Little Rock from other markets with moderate levels of HMO penetration and a fee-for-service-dominated payment system. While most profiling initiatives are being used to encourage increased efficiency through provider education, a growing number of health plans in Little Rock are using profiling data to adjust physician payment rates. Little Rock's leading HMO also plans to use its profiling system to select its network physicians based on analysis of those providers' utilization patterns. However, plan officials are reportedly considering suspending further implementation of that profiling initiative due to resistance of local doctors.

In light of these activities, Little Rock physicians are beginning to organize into independent practice associations (IPAs) and other types of organizations, a trend that marks a shift from a market previously dominated by small-group and solo-physician practices.

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It is difficult to predict the course of these changes or the likely impact of change on cost and quality of and access to care. Despite respondents' concern about high health care costs, many also expressed concern over the prospect of reduced provider choice and the influence of managed care companies over physician decision making. And, while the entry of national health care companies was not considered to be a major issue, their influence may be approaching a critical point, leading to a bigger impact on the local marketplace and an intensified public discussion about the future of Little Rock's health care system.

The Little Rock Community

This case study focuses on the four-county Little Rock/North Little Rock metropolitan statistical area (MSA). With a total population of approximately 550,000, the metropolitan area includes Pulaski County, which contains the cities of Little Rock and North Little Rock; Faulkner County to the north;

Lonoke County to the east; and Saline County to the southwest. Interviews were concentrated in the cities of Little Rock and North Little Rock, which include a large share of the county's health care resources.

The community is demographically and socioeconomically heterogeneous, but some important aspects of its profile may predispose the population to poor health status due to the established link between race/ethnicity and poverty on one hand and health status on the other. For instance, while unemployment in the area is low compared with state and national norms, Little Rock has a relatively low median household income compared with the nation as a whole.[2] Almost 20 percent of the MSA's population is African American compared with a national average of about 12 percent. A relatively small proportion of the population is made up of other racial and ethnic minorities. Little Rock does not differ significantly from the U.S. average with respect to other socioeconomic variables, including levels of educational attainment and the proportion of the population that is elderly.[3]

Arkansas ranks as the fifth highest state in terms of its overall rate of preventable diseases.[4] With regard to morbidity among Little Rock-area residents, the major sources are high levels of substance abuse, hypertension, diabetes and sexually transmitted diseases, according to respondents.

Data indicate a significant problem in maternal and child health: Little Rock's overall infant mortality rate is almost 10 percent higher than the national average. Moreover, the infant mortality rate for nonwhite residents exceeds the rate for white residents by 173 percent, also somewhat higher than the national norm for nonwhites.[5] High rates of infant mortality may be related to high teenage pregnancy rates, high proportions of low-birth-weight deliveries and low levels of prenatal care compared with U.S. norms and public health goals such as Healthy People 2000. Overall, Little Rock's age-adjusted mortality rate is comparable to the U.S. average.[6]

THE HEALTH CARE MARKET

Little Rock is a self-contained health care system that includes the state's largest insurer, 10 acute care hospitals and physicians practicing in most major specialties. High levels of inpatient utilization and an oversupply of acute care hospital beds characterize Little Rock. The number of hospital beds and inpatient days per 1,000 residents is more than 50 percent higher than the U.S. average. Hospital occupancy rates are also low.[7]

These statistics suggest significant opportunities for cost savings, opportunities that may help explain the growing presence of national hospital and health insurance companies in the Little Rock market.

The City of Little Rock contains nearly all of the metropolitan area's inpatient resources. Little Rock hospitals draw patients from throughout a multistate region for highly specialized care. For example, Little Rock's Children's Hospital is the only hospital in the nation with a mobile pediatric heart-lung bypass machine that can transport sick children from a several-hundred-mile radius. Moreover, two of the biggest area hospitals are seeking to affiliate with hospitals outside the metropolitan area, a move that could significantly extend their geographic coverage. Local organizations currently retain control over the hospital sector, but that control is loosening, particularly with recent acquisitions made by Columbia/HCA, the nation's biggest hospital chain.

Like hospitals, physicians are concentrated in the Little Rock/North Little Rock area. Approximately 85 percent of the physicians practicing in the state have their principal offices located in the city or in close proximity. Outlying areas have very little primary care capacity and even fewer specialist resources.[8]

BCBSA, a not-for-profit corporation that dominates the local insurance market, covers more than 40 percent of commercially insured lives in the area. However, like the hospital sector, control of Little Rock's HMO market is mixed, with an increasing number of national, for-profit insurance companies and HMO chains, including United HealthCare and Healthsource, making substantial inroads over the last several years.[9] While most businesses in Little Rock are small, many of the larger businesses in the area use these national or regional carriers for one or more insurance products and supplement the list with local HMOs. For instance, Alltel, a national electronics company with employees in a number of states, offers its Little Rock employees three local HMOs in addition to a self-insured fee-for-service plan administered nationally by United HealthCare's Minnesota-based parent.

LEADERSHIP AND DECISION MAKING

Many respondents said that local hospitals and other health care providers retain much control over the community's health care system because no formal or informal community-level decision-making processes exist. The hospital sector's influence is reportedly a function of several factors:

- the importance of hospitals to the economic vitality of the community;
- the significant resources hospitals have at their disposal;
- the dominance of specialists in Little Rock's health care system; and
- hospitals' success in seating prominent boards of directors made up of business and other leaders.

Although Little Rock business leaders sit on the boards of the major hospitals, some respondents said that they do not use their influence to encourage hospitals and affiliated physicians to operate more efficiently.

Physicians are also reported to have considerable influence in shaping the health care system, but like hospitals, most of this influence appears to be exercised in an ad hoc fashion. One major exception is the Arkansas Medical Society's success in the 1995 legislative session lobbying for passage of the state's "any willing provider" law. Recently struck down by a U.S. District Court judge, the law would have limited the ability of managed care plans to exclude physicians from their panels.

As a group, purchasers do not appear to exercise collective influence over the health care system, either through advocacy or market-based activities. However, the business community established the Arkansas Health Care Coalition, a statewide organization, in an effort to forestall attempts to enact anti-managed care legislation, such as the any willing provider statute, a measure the group believed would have limited HMOs' ability to hold down health care costs had it not been struck down by the court. The coalition includes major Arkansas insurance companies and two hospitals that are active sponsors of managed care products. The coalition's first act was to hire the former governor's chief of staff as its executive director; however, the organization's clout has yet to be tested. Moreover, at the time of the site visit, the group had not succeeded in recruiting some of Little Rock's major employers.

Organized consumer groups and grassroots organizations appear to play a very limited role in community-level decision making about the health care system. Several organizations advocate for vulnerable populations: the Legal Aid Society of Greater Little Rock, which has wielded significant political influence in the past on behalf of the poor; the Arkansas Minority Health Commission; Seniors United for Progress; and the Arkansas Advocates for Children and Families, a statewide group that has influenced state Medicaid policy.

External Forces Affecting the Health System

PUBLIC POLICY

In past years, Arkansas state and local policy makers have been relatively quiescent on matters concerning health policy. State policy, with respect to regulation of the private health care system, has often favored market forces over government action. For example, the state insurance market reforms enacted in 1991 permitted wide variation in health insurance prices and unlimited pre-existing condition exclusions, and state legislators rejected coverage expansions and other elements of former Gov. Jim Guy Tucker's 1995 health reform agenda. Legislators also repealed the state's certificate of need program (CON) for acute care facilities shortly after the sunset of a federal requirement mandating states to implement such programs.

State policy makers have pursued a relatively conservative approach with respect to the state's Medicaid program. Until recently, state officials have not sought to expand the Medicaid program to "optional" populations such as school-age children and adults above certain levels of poverty. State Medicaid policy has also embraced primary care case management (PCCM) as a way to control costs and improve access to care rather than offering risk-based Medicaid managed care programs that other states have pursued. Under Arkansas's PCCM program, primary care physicians are paid a set fee to manage referrals and coordinate care for each assigned Medicaid patient. Arkansas's Medicaid program is also notable for having one of the highest match rates in the country: The federal government provides the state with $.73 out of every Medicaid dollar it spends, a reflection of Arkansas's historically low per capita income levels relative to other states.

More recently, however, state health policy activity has increased. As indicated above, in 1995 Arkansas enacted one of the nation's most sweeping any willing provider laws, which requires all health plans to accept physicians and other licensed health professionals into their network as long as the provider agrees to the plan's fee schedule and other contract terms and conditions. The law was never enforced, however, and was struck down by the court. Proponents of the legislation have appealed the decision. Also in 1995 the legislature merged state employees and public school teachers into a single insurance pool, the only major provision of Governor Tucker's more sweeping health reform initiative to survive.

In 1997 state legislators enacted an initiative called ARKids to provide subsidized insurance coverage to uninsured children across the state. Close to 20 percent of the state's population has no health insurance, with children and young adults comprising a disproportionate share of that figure.[10] Under the ARKids program, which is awaiting

approval by the U.S. Health Care Financing Administration and slated for implementation in the fall of 1997, general revenues will be used to subsidize the purchase of insurance for children in families whose income is up to 200 percent of the federal poverty level. The program will be run through the state's Medicaid program. Policy makers estimate that 90,000 children are eligible for the program statewide; ARKids aims to enroll more than half of these children during the program's first two years.

PURCHASING

Competing forces have limited private purchasers' influence over the shape of Little Rock's health care system. Many employers are small, low-wage firms that either do not offer health benefits or are extremely sensitive to premium increases. On the one hand, this local economic feature, along with the recent consolidation of public purchasing power described above, tends to drive competition among health plans to hold down premiums. On the other hand, other factors, the importance of the health sector in the area's economy, tend to temper demands for lower costs and, as a result, health system innovation that brings about cost reductions.

• Private Purchasing

Demand for health insurance—or the lack of demand—among private employers is influenced in large measure by the nature of Little Rock's economy. While unemployment is low and competition for workers high, a dynamic that typically increases purchasers' demand for health insurance, many Little Rock-area firms are small companies with low profit margins, thereby reducing demand. Moreover, many new jobs being created appear to be non-unionized and low wage. Between 1990 and 1996, the manufacturing, finance, real estate and insurance sectors posted relatively anemic job growth gains in the 4 to 8 percent range compared with increases in excess of 30 percent among the construction and service jobs, sectors that are less likely to offer health benefits.[11]

These economic forces have driven private employers to be extremely price sensitive regarding their health benefits. Several informants reported that employers have responded to premium increases by cutting back on benefits, moving to self-insured arrangements to reduce their health benefits costs or dropping coverage altogether, an action that many said has led to a decline in employer-based health insurance. As a result, many health plans have begun to redouble their efforts to control costs by, for example, reducing provider payments and controlling utilization. In addition, a number of major insurers, including BCBSA and Healthsource, are increasing their capacity to service self-insured arrangements, indicating that health plans are taking this trend very seriously.

While these dynamics tend to keep Little Rock's health sector focused on bottom-line costs, other factors serve to defuse this pressure:

- A large number of Little Rock's biggest employers are health care providers. After state and local governments, most of the remaining large employers in Little Rock are hospitals, which view health care spending as a principal source of revenue as well as an expense. These institutions, combined with the University of Arkansas for Medical Sciences and BCBSA, employ 11 percent of Pulaski County's total work force.

- Given the prominence of health care in the area's economy, many non-health-related firms, especially utilities and those in the service sector, view hospitals as valued customers and are loath to push too hard on costs.
- A number of large firms' headquarters are out of state, leading to what one respondent described as an "absentee landlord" problem. These employers include the federal government (with 9,900 workers), the U.S. Air Force (6,890), Union Pacific Railroad (2,000) and Southwestern Bell (1,980).[12]

In addition, employers in Little Rock are reportedly extremely sensitive to restrictions on provider choice, diminishing the market appeal of HMOs featuring limited provider networks. Such concerns have also led to a proliferation of point-of-service (POS) plans, which allow employees to receive services from non-network providers. However, this growth may be due more to a requirement applicable to the public employee pool (described below) than to preferences expressed by private purchasers.

• Public Purchasing

Perhaps the most potent purchasing force throughout the state is the Arkansas State Employee and Public School Personnel Insurance Board, created by state law enacted in 1995. The Board purchases health insurance for 70,000 state employees and public school teachers, with the largest number residing in the Little Rock area.[13]

The Board's purchasing process appears to have stimulated the growth of managed care in the Little Rock area. Within the first year of the program, 22,000 of the 38,000 teachers participating in the pool migrated from indemnity products to point-of-service (POS) plans. This transformation has had the biggest impact outside of Little Rock where providers have been more resistant to managed care. According to respondents, many of these providers are now finding that they have to sign up with managed care plans in order to retain their patient volume, a large portion of which is public employees.

The Board also introduced a pharmaceutical benefits management program despite vocal protest by local pharmacists and key state legislators. Finally, public employees are making more cost-conscious choices among plans due to a change in the employer contribution formula, which increases employees' share of the premium for more expensive plans. Respondents predicted that, over time, this contribution method will drive more employees into managed care plans.

The market impact of the pool has been limited by law, which requires the pool to offer all POS plans in the area, and by a decision made by the Board to eliminate the closed-panel HMO offerings after those bids came in uniformly above premium bids for the carriers' POS products. This decision had the effect of moving thousands of state employees from closed-panel HMO arrangements to plans with looser network arrangements. The Board's selection of a PPO vendor also had important implications for the market position of several key health plans in Little Rock, including QualChoice, the University of Arkansas for Medical Sciences-sponsored plan that lost the state contract, and BCBSA, which won it.

Compared with the Board's program, Medicaid is a less active public purchaser and, as noted earlier, has not expressed interest in replacing its primary care case management (PCCM) program for the Aid

to Families with Dependent Children (AFDC) population with a risk-based Medicaid managed care program. In fact, its advocates claim that the PCCM program has saved the state substantial sums. Moreover, the state legislature recently refused to grant the Medicaid Department authority to contract with a managed care firm for behavioral health services. Until recently, the state has taken a more assertive purchasing posture by directly contracting for inpatient obstetrical services with Columbia Doctors' Hospital and University Hospital—a purchasing arrangement that reportedly provides the state with significant discounts over list prices for these high-volume procedures. In April 1997, however, the state moved away from selective contracting for these services. The state now pays 85 percent of per diem rates to any Medicaid-qualified hospital that agrees to provide care at such a discount.

Organization of the Health Care System

Little Rock's health care system is marked by strong alignments between a number of leading hospitals and health plans. Links between hospitals and physicians remain relatively weak despite recent acquisitions of many area practices. Relationships between hospitals and health plans are driven in large part by shared equity arrangements with limited administrative or clinical coordination or integration across the participating organizations. The dominance of fee-for-service payments and purchasers' demands for broad physician panels have created a physician sector that is not organized into highly defined networks or large practice arrangements. Yet at the same time significant changes appear to be taking place in the way physicians are paid and organized. The market entry of several well-capitalized national health insurance companies and hospital chains is likely to alter this current balance of power.

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HOSPITALS

The Little Rock metropolitan area is home to 10 short-term, acute care hospitals, eight of which are located within the city limits of Little Rock and North Little Rock. The most powerful area hospital system is Baptist Health, which owns Baptist Medical Center in Little Rock and Baptist Memorial Medical Center in North Little Rock. Together these institutions have more than 1,000 acute care beds, accounting for 42 percent of the MSA's total.[14] The system also owns Baptist Medical Center of Arkadelphia and the 120-bed Baptist Rehabilitation Institute. One way in which Baptist Health has secured its position in the Little Rock market is through its strategic partnership with BCBSA, and its physician affiliates are equity partners in the area's biggest HMO, Health Advantage HMO. In return for its equity share, Baptist retains the exclusive contract for general inpatient services for the HMO's 40,000-plus members. In addition, Baptist serves as the preferred provider for BCBSA's PPO products and is actively developing a statewide provider network of hospitals outside the area.

Perhaps the most significant competitor to Baptist in terms of size and market clout is St. Vincent's Medical Infirmary, a 566-bed hospital owned by the Kentucky-based Sisters of Charity of Nazareth.[15] St. Vincent's is aligned with Healthsource Arkansas Ventures, Inc., through a joint venture with the HMO's New Hampshire-based parent, and is the exclusive hospital provider for the health plan in the Little Rock service area.

St. Vincent's is also reported to be the prime force behind an attempt to establish a regional provider network called Novasys with out-of-area hospitals, most of which are owned by Tenet, a large national hospital chain. Respondents described the goals of this network as twofold: to check the growing influence of the Baptist/BCBSA alliance outside the metropolitan area and to establish a regional provider base that could help St. Vincent's secure direct contracts with regional employers.

While St. Vincent's is a full-service hospital that reportedly enjoys a substantial degree of patient loyalty and a reputation for being patient-focused, its position in the market may be weakening due to high costs and a rocky relationship with its managed care partner. In fact, several respondents noted that the institution recently underwent a round of layoffs and reductions in hours to reduce its costs.

Several other acute care hospitals operate in the area:

- University Hospital, operated by the University of Arkansas for Medical Sciences (UAMS), which provides a large share of Little Rock's charity care and many of the area's most sophisticated procedures, such as bone marrow transplants and experimental procedures;
- Arkansas Children's Hospital, a regional center of excellence for pediatric tertiary care, which, like St. Vincent's, has reportedly laid off staff to bring down costs;
- two smaller community hospitals in Saline and Faulkner counties;
- two small military hospitals; and
- a large Veterans Affairs Medical Center complex with more than 900 beds and specialty ambulatory care clinics that generate among the highest numbers of outpatient visits in the VA system.

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Among the most significant changes unfolding in Little Rock's hospital sector is the emerging presence of Columbia/HCA. In 1994, control of the 340-bed Doctor's Hospital shifted from HCA to the newly merged Columbia/HCA. Doctor's Hospital was previously owned by HCA. Doctor's has a reputation as a high-quality hospital with a favorable payer mix and a strong obstetrics program: it held the state Medicaid contract for inpatient obstetrical and newborn care until April 1997, when the state terminated selective contracting for these services.

Around the same time as the 1994 merger, Columbia/HCA purchased Columbia Family Practice, the largest medical group in town. While these acquisitions caused many in the health care system to take notice, they did not receive a great deal of public attention for two reasons: First, the acquisitions did not raise the specter of for-profit conversion of valued public institutions, an issue in other communities

where Columbia/HCA has been active. Second, many consider Doctor's Hospital to be weak due to its limited range of service offerings and its high number of unfilled beds, leading some to downplay the significance of Columbia/HCA's control over that institution.

Stakeholders' interests were piqued early in 1997, however, when Columbia/HCA announced its intention to acquire Southwest Hospital, a 125-bed community hospital also located in Little Rock proper. News reports of the company's underlying area strategy may have done more to sound an alarm than the transaction itself did. In press interviews, a Columbia/HCA spokesman described his company's newest acquisition as part of a strategy to build critical mass in central Arkansas—a strategy similar to one being pursued in Northwest Arkansas where Columbia/HCA now owns or manages several hospitals and home health care facilities.

In the article, the Columbia official went on to name the four biggest hospitals in Little Rock, all not-for-profits, as potential acquisition targets, stating further that he didn't want to "strike fear into the hearts of the existing facilities, but if none of these institutions was willing to sell, building a new hospital in the area is definitely an alternative."[16] In news reports, hospital executives either declined comment or denied any interest in a sale.[17] Indeed, respondents interviewed for this study reported that the Southwest Hospital transaction has sparked concern among nonprofit institutions and stimulated discussions in many quarters about how best to keep Columbia/HCA at bay.

Another major development with a potentially significant impact on local institutions was the March 1997 opening of Arkansas Heart Hospital. Like the new hospital, a number of hospitals in town, including Baptist, St. Vincent's and University Hospital, offer full-service cardiology and cardiovascular surgery programs. The Arkansas Heart Hospital was built by MedCath, a Charlotte-based health care company specializing in cardiac care and management of specialty hospitals. More than a dozen local cardiologists with ties to both Baptist and St. Vincent's are equity partners in the venture. The Arkansas Heart Hospital poses a significant threat because cardiology programs are reportedly big moneymakers for these institutions, generating as much as one-third of each hospital's total revenues.

Arkansas Heart Hospital has yet to secure a managed care contract, and its investors anticipated limited success in this regard given the equity position of its major competitors in two of the area's most highly subscribed HMOs. However, a lack of managed care contracts does not restrict Arkansas Heart Hospital's ability to compete for patients enrolled in traditional health insurance plans, who represent the largest share of Little Rock's commercially insured population. Arkansas Heart Hospital's presence has touched off an intense advertising blitz by local hospitals to secure their existing share of the cardiology and cardiovascular surgery market. Respondents also reported that the new hospital's opening has generated significant competition for specialized nursing and mid-level technical staff.

PHYSICIANS

Little Rock has a healthy supply of physicians. In 1994, for instance, the metropolitan area had 11 percent more primary care physicians per capita than the U.S. average and 47 percent more physicians in non-primary care

specialties than the national norm.[18] This supply may reflect the fact that the area is home to several medical training programs. UAMS trains physicians and sponsors residency programs at University Hospital, Children's Hospital and the VA. Baptist Health trains a large number of the state's nurses at its two Little Rock-based acute care institutions. While physicians in Little Rock tend to practice in small, single-specialty practices, several larger group practices exist: Columbia Family Practice, a primary care-dominated practice with 35 full-time-equivalent (FTE) medical staff that has hired a number of specialists over the last two years, and the Little Rock Diagnostic Clinic, an independent 27-member multispecialty clinic located near the Baptist Medical Center campus.

One of the most visible changes in the organization of Little Rock's health care system is the recent acquisition of physician practices by several leading area hospitals. According to respondents, Columbia/HCA set off the buying spree when it purchased Columbia Family Practice, the area's largest physician group.

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Other hospitals, including Baptist and St. Vincent's, reportedly followed suit in a series of defensive maneuvers. Despite the community's focus on these acquisitions, however, many respondents questioned whether their impact is proportionate to the attention they have generated given two aspects:

- Many respondents reported that only a small proportion of physicians in the area actually work in practices owned by the hospitals.[19]
- There is a widely held perception that these acquisitions were not part of a well-thought-out strategy, and that hospitals are now realizing they may have acted too precipitously.

Physicians have also played a major role in a number of lower-profile, but potentially important, changes in the organization of Little Rock's health care system. Respondents reported that over the last year or so, a large number of physicians have joined together in formal independent practice associations (IPAs) and in less formal practice groups, marking a significant shift in the traditional organization of physician practice in the community. Examples of some of these new arrangements include the recent establishment of two separate primary care IPAs; an informal affiliation of all the practicing urologists in town; the formation of a new large multispecialty group; the merger of two cardiology groups associated with the Arkansas Heart Hospital, a prelude to the opening of that institution; and a merger of several OB/GYN practices that plan to practice together and, perhaps, to undertake collective contracting. Respondents noted that these endeavors reflect an attempt by physicians to combat potential reductions in income and clinical autonomy.

INSURERS AND HEALTH PLANS

While the dominant forms of commercial insurance in Little Rock are traditional indemnity-based coverage and PPO plans that allow enrollees to see out-of-network providers for an additional copayment, more individuals are moving into man-

aged care arrangements. Roughly 18 percent of the metropolitan area's population is enrolled in HMOs.[20] These plans tend to be loosely structured IPA-type models in which health plans contract with providers who see HMO patients and non-HMO patients, and under which payments remain predominantly fee-for-service. According to respondents, only 10 to 15 percent of provider payments in the area are capitated; most physicians in managed care arrangements are paid on a discounted fee schedule in combination with withholds that are returned to physicians only if they meet predetermined performance targets.

A number of health plans competing in the market are relatively new to the Little Rock area. In fact, none of them had a presence in the market prior to 1992. These plans include:

- United HealthCare, the second-largest HMO in the metropolitan area and reportedly the fastest-growing health plan in the market (22 percent enrollment growth between 1995 and 1996);
- Healthsource, with a strong base of HMO enrollees and a large number of individuals enrolled in products offered by its newly acquired third-party administrator; and
- Prudential Healthcare, a national insurance company that offers both HMO and PPO products in the market.

Supplementing these national insurers are three homegrown HMOs: Health Advantage, the biggest HMO in central Arkansas; American Health Care Providers, in operation since 1985, making it the area's oldest HMO; and QualChoice, an HMO sponsored by the University of Arkansas for Medical Sciences, which, until recently, has focused on public employees and received a commercial HMO license in the fall of 1996.

Respondents noted that the entry of these new health plans has led to increased marketing efforts and premium competition. A number of respondents asserted that several health plans are "low-balling" their rates to build market share even though the underlying rate of increase of medical costs has not slowed. As a result, revenues collected from insurance companies have not always kept pace with amounts they pay to medical providers. For instance, several respondents accused United HealthCare's parent company of subsidizing premiums quoted in Arkansas, a charge refuted by local company executives. Others noted that in 1996, BCBSA announced a $22 million operating deficit and a $5 million operating deficit for Health Advantage. This is another indication that competitive pressure may be holding down premiums, perhaps below a sustainable level.

Purchasers interviewed for this study, however, had mixed views about whether premium costs are really abating in Little Rock. Some asserted that the rate of premium growth is accelerating for many plans in the market.

Despite the mounting competitive challenge posed by out-of-state plans, BCBSA appears to retain a relatively strong position in the local market for several reasons:

- BCBSA still enjoys strong name recognition, and BCBSA-affiliated products reportedly cover more than 40 percent of all commercially insured lives. With 5,000 members enrolled in its Medicare HMO, and three-fourths of the area's large and growing managed workers compensation market, BCBSA's large base of covered lives gives it a great deal of leverage in negotiating rates with local providers.

- The insurer's successful PPO bid for the state employee and teachers pool increased its enrollment base and market clout, particularly in areas of the state outside Little Rock and North Little Rock, where teachers represent a large share of the commercially insured population.
- BCBSA has forged a strategic joint venture with the Baptist system, the region's dominant hospital provider.

One significant change health plans are making is use of more sophisticated payment arrangements to encourage participating providers to practice medicine more efficiently and to increase patient satisfaction. Such initiatives supplement discounted fee-for-service payment methods rather than replace them. For example, in January of 1997, Health Advantage introduced a controversial payment system that adjusts physician payment levels using provider-specific "quality index" scores. These scores are numeric values that indicate the extent to which a provider's practice varies from the health plan's explicit practice guidelines. Physicians with above-average scores receive an increased payment for each service billed (for example, 115 percent of the fee schedule), while providers with scores at the lower end of the range receive discounted payments as low as 80 percent of the basic fee schedule. The health plan also considered using the profiling system to remove physicians with consistently low scores from the HMO's list of participating providers. Given the high level of physician concern about the profiling effort, Health Advantage is reportedly reconsidering its use of index scores altogether.

In another move that could significantly transform Little Rock's delivery system, Health Advantage announced that this year it will offer global capitation to providers that organize themselves into self-selected sub-networks. Under these arrangements, patients would be able to "self-refer" within their primary care doctor's sub-network, a feature that allows members to see network providers without referral from a gatekeeper. To date, no Health Advantage providers have stepped forward to participate in such an arrangement.

Other health plans have also begun to make changes in the way they pay providers. United HealthCare has started to adjust physician payments using member satisfaction data and plans to adjust payments based on severity-adjusted utilization data sometime in 1997. The Minnesota-based health plan is also considering capitating payments to specialists in the future. Healthsource has introduced a system that rebates primary care doctors' withhold based on an "efficiency index" that reflects severity-adjusted utilization data. Healthsource is already the driving force behind much of the existing capitation in the area; its contract with St. Vincent's makes the hospital responsible for medical costs incurred by Healthsource enrollees in return for 75 percent of the HMO's premiums, leaving the hospital at full financial risk for all costs that exceed this dollar amount.[21] Last year Healthsource unsuccessfully tried to talk Southwest Hospital into a similar arrangement.[22]

RELATIONSHIPS AMONG HOSPITALS, PHYSICIANS AND HEALTH PLANS

Many of Little Rock's HMOs are jointly sponsored by insurers and hospitals through shared equity arrangements. These relationships bind together, at least in the short run, the fate of some of Little Rock's most important health care organizations. Shared equity arrangements are the foundation of both Health Advantage, a partnership between Baptist and BCBSA, and Healthsource Arkansas Ventures Inc., a joint venture

between St. Vincent's Infirmary and the New Hampshire-based HMO company. Moreover, the recently licensed QualChoice network is owned by the University of Arkansas for Medical Sciences, which also owns and operates University Hospital.

The principal characteristic that binds these organizations together, however, is a shared financial stake in the success of the products. Health Advantage is an equity arrangement among three parties that share in the operating profits or losses of the venture: BCBSA, which has a 50 percent stake in the venture; Baptist Health, which has a 25 percent stake; and the 200-member Baptist physician group, which holds the remaining equity in the HMO. Similarly, Healthsource is a 70/30 venture between the health plan and St. Vincent's Infirmary. These joint ventures have not led them to organization integration, but rather only a limited degree of financial and administrative integration. For instance, health plan and hospital officials reported that Health Advantage provides Baptist with access to up-to-date administrative information that allows the hospital to verify patients' insurance coverage on-line. Respondents had conflicting views about the success of efforts to create a "data warehouse" that attempts to combine clinical information from BCBSA's claims files with hospital records and other data sources. The goal of that system would be to enable providers to develop "episodes of care" and other analyses to aid clinical practice.

Views were mixed on the overall market impact of these hospital/health plan alliances. Some respondents asserted that the strong economic relationships between health plans and local hospitals limit the ability of plans to negotiate as aggressively on price as they would be able to if they had a more arms-length relationship with their hospital partners. Others, including health plan representatives, asserted that hospitals are willing to offer their best price to the HMOs since they have a strong interest in the products' success in the market and because the contract terms guarantee patient volume.

While the BCBSA/Baptist relationship appears to be on firm footing, a number of respondents reported that tensions between Healthsource and St. Vincent's cloud those organizations' future relationship and potentially weaken the position of both companies in the Little Rock market: Healthsource's ability to compete on premiums may be hobbled by alleged high costs at St. Vincent's; hospital officials are reportedly dissatisfied with the terms of the joint venture agreement.

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Hospitals' acquisition of physician practices is also a potentially important source of cross-sector activity, although these acquisitions are reported to have limited influence on physician referral patterns. Physicians are not required to direct patient volume to the acquiring hospital. Indeed, respondents noted that hospitals tend to tread carefully in such matters lest they run afoul of federal anti-kickback regulations; they merely purchase "good faith," as one respondent called it. In some cases, this good faith is yielding healthy returns. For example, while only 45 percent of

patients seen by doctors at Columbia Family Clinic are admitted to Columbia Doctor's Hospital, this is reportedly up from 10 percent prior to Columbia/HCA's purchase of the practice.

In addition to practice acquisitions, management service organizations (MSOs) appear to be hospitals' preferred way to build stronger links between hospitals and community doctors. Several hospitals, including Baptist and St. Vincent's, sponsor MSOs. Respondents did not emphasize the importance of physician-hospital organizations (PHOs) as a means of organizing medical practices or carrying out contract arrangements, although St. Vincent's' PHO appears to play an especially significant role in the allocation of capitated payments for Healthsource enrollees.

Clinical Practice and Delivery of Care

With a few notable exceptions, respondents did not identify significant changes taking place in clinical practice or delivery of care. Clinical practice can be characterized by the following observations:

- Physician referral patterns in Little Rock are largely informal and relatively undefined.
- Physicians—not health insurance companies or their agents—drive clinical decision making, with specialists still controlling a large number of those decisions.
- The balance of power between specialists and primary care physicians may be shifting slowly to the latter.
- Profiling information and other sources of data are increasingly being used to make clinical decisions.
- Hospitals are using case management and other techniques to reduce the cost of inpatient care.
- Formal and informal group practices are developing.

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The emerging shift in power from specialists to primary care physicians may be attributed to two different forces, respondents said: declining professional fees that discourage primary care doctors from referring to specialists as readily as they once did, and the growing number of people in health plans that use gatekeepers to control specialty care use. No quality issues were raised with regard to this shift in power. Declining fees have also reportedly led an increasing number of specialists and primary care doctors to increase their patient volume by traveling to outlying towns to maintain their income.

Another emerging change in clinical practice is the use of physician profiling data to disseminate information to clinicians and the use of this data by health plans to alter physician behavior through payment incentives. Health Advantage appears to be going to great lengths to get physician support for the profiling initiative, with

limited success. For instance, plan officials conduct one-on-one consultations with providers to explain their own profile results and are reportedly recruiting local doctors to lead efforts to modify performance benchmarks and other aspects of the practice, guidelines based on input from other clinicians in the area. Other plans and some area hospitals are using similar profiling tools solely to provide providers with educational feedback in hopes of encouraging practice changes.

Despite these activities, Little Rock's profiling systems still appear to be at a fairly modest stage of development and tend to focus on resource use and medical transactions (for example, total spending per member, average length of stay, number of procedures per patient, etc.) rather than clinical outcomes or other measures that focus directly on quality of care. Moreover, there is no evidence that these profiling systems are looking at episodes of care, a unit of analysis that extends across treatment settings and over the course of an illness or disease. Respondents said that these limitations restrict the power of existing profiling tools.

A small number of hospitals in Little Rock also report using clinical pathways and other techniques to control the cost of hospital care and improve patient outcomes. Clinical pathways—detailed guidelines for inpatient care—are becoming important care management techniques at both Baptist and University Hospital, although to date such pathways have only been implemented for a handful of conditions. Baptist Health has also launched case management programs in each of its hospitals. Under these programs, a nurse or social worker is assigned to selected patients with conditions or procedures that tend to result in long lengths of stay. These "care coordinators" use patient care conferences and standardized care protocols, among other tools, to reduce patients' average length of stay. Respondents say this program is largely responsible for both a drop in the hospital's average length of stay of two days over the last two years and a moderate decline in average resource use per admission.

Little Rock has a large number of uninsured residents and what appears to be inadequate access to physicians and other outpatient services for the community's poor, uninsured population.

Care of the Poor

Although few respondents identified indigent care as a major health care issue facing the community, Little Rock has a large number of uninsured residents and what appears to be inadequate access to physicians and other outpatient services for the community's poor, uninsured population. University Hospital is the principal source of inpatient charity care; several other hospitals provide more limited care to indigent patients. University Hospital's ability to continue serving in this role is uncertain, however, particularly if state or federal action results in cuts in Medicaid payments, the hospital's principal source of subsidies for uninsured patients. Moreover, UAMS sources noted that University Hospital's reputation as the principal provider of care to the poor has complicated the hospital's efforts to draw more private pay patients to its emergency room and outpatient clinics.

The hospital emergency room serves as the principal point of access for many indigent patients, and the site visit team identified few other significant sources of outpatient care for uninsured persons. The only federally qualified health center in the area is a clinic located near the airport, which provides about 5,000 visits a year. Only about one-third of the center's services are provided to uninsured patients, however, and the facility was totally destroyed by a tornado in early 1997. St. Vincent's sponsors a free clinic for poor patients once a week, and the medical society organizes a program to encourage private practice doctors to see indigent patients in their offices, although this program is characterized as quite limited.

A sizable share of the indigent care burden appears to be shouldered by the state Department of Health and, to a lesser extent, by the Veterans Administration system. Although the health department is not organized or sufficiently funded to play a major role in the provision of acute care services, public health nurses and other staff frequently provide limited primary care during visits for preventive services such as immunizations. Consequently, as the de facto provider of last resort, the Health Department has been forced to divert resources from other activities such as the conduct of more regular health assessments and disease surveillance. The VA medical complex in Little Rock may also be serving a large share of indigent patients. Thirty percent of eligible veterans in the area use the system compared with a national average of about 10 percent, and the VA's ambulatory care clinics also generate 288,000 outpatient visits a year, one of the highest numbers of any VA facility in the country.[23]

Issues to Track

Though still dominated by local institutions and a fee-for-service system of provider reimbursement, Little Rock's health care system has been marked by significant changes over the last several years. Most of these changes are due to the increased degree of alignment among hospitals and health plans in the area, the market entry of powerful national health care companies, including Columbia/HCA and United HealthCare, and local employers' sensitivity to premium hikes.

Respondents report an array of perceived changes resulting from these and other market influences. Views of recent changes in insurance premiums were mixed. Some respondents report a slowdown in the rate of cost growth while others assert that premium levels are starting to rise again, especially for small businesses. Some attributed recent premium increases to an attempt by local health plans to recoup operating losses incurred over the last several years during intense price competition. Others suggested that higher premium costs reflect diminished private sector restraint in light of the demise of government health care reform. Another impact of market change is a reported decline in the number of people covered by health insurance due to a reduction in employer-sponsored coverage for workers and their dependents.

Respondents also said that problems with access to primary care leads many uninsured Little Rock residents to seek basic medical care in hospital emergency rooms. The majority of Little Rock's insured population, however, was said to be highly satisfied with quality of care as well as increased provider choice through POS plans and managed care products that do not restrict referrals to physicians within a network.

Looking forward, the pace of change in Little Rock is likely to increase. A harbinger of this change includes HMOs' use of physician profiling and consumer satisfaction reports to adjust provider reimbursement and the development of physician-sponsored IPAs and other group-practice arrangements in response to the prospect of declining physician income and reduced clinical autonomy.

Several activities bear watching as the future unfolds:

- Several new entities stand to increase their influence over the next few years. These players include the Arkansas Heart Hospital, whose success will be determined, at least in the short run, by its ability to attract Medicare patients from other area hospitals since most managed care members in Little Rock are enrolled in health plans that have competing hospitals as equity partners. Columbia/HCA also bears watching, because it has announced its intention to become a dominant force in Little Rock's hospital sector. What remains unclear at this point is whether public sentiment will tolerate Columbia/HCA's acquisition of another area hospital, particularly one of the large, nonprofit hospitals that it appears to have targeted. United and Healthsource may also be poised to increase their market presence. According to respondents, however, tension between Healthsource and St. Vincent's may weaken those organizations.

- The implementation and impact of profiling initiatives now being fielded by Health Advantage and other health plans deserves watching. On one hand, these initiatives have the potential to move Little Rock beyond a largely unmanaged fee-for-service system, thereby bringing down health care costs and potentially altering both individual clinical decisions and dominant patterns of physician practice. It remains to be seen, however, how widely these systems will be adopted and whether they will be implemented without substantial compromise in order to gain the support of participating providers. Indeed, these efforts could cause a physician backlash as indicated by Health Advantage's reported reconsideration of its profiling initiative and the emergence of IPAs and other types of physician practice arrangements. Moreover, a majority of Little Rock residents are still enrolled in traditional health plans and PPOs, which exercise little oversight or influence over physician practice.

- Another development to monitor is the ability of BCBSA, Healthsource and other insurers to move more of their providers into capitated arrangements. While the bulk of Little Rock's health care payments remain discounted fee-for-service, growing HMO enrollment could increase health plans' leverage over providers who remain resistant to capitation. The leading edge of this trend may be the growth of Medicare HMOs, especially if enrollment in these plans is stimulated by federal Medicare reforms, as many predict. A move to capitation could also be stimulated, perhaps paradoxically, by successful adoption of the physician profiling initiative described above. For example, linking fee levels to utilization could reduce physician income to the point where local providers would be less resistant to capitated payments.

- Finally, as the future unfolds, Little Rock's patchwork system for providing health care to indigent patients is likely to be buffeted by a number of forces. First, increased competition in the hospital sector could cause hospitals to be less willing to provide charity care in their

emergency rooms and outpatient facilities. This situation could be exacerbated by the tenuous competitive position of University Hospital, especially if further Medicaid spending cuts are made. An increase in the number of uninsured brought about by a slowdown in the region's economic growth could challenge existing agreements among institutions currently shouldering the indigent care burden.

According to one analyst, the picture in regard to this last issue may be quite bleak. After a long stint of high economic growth, Arkansas as a whole experienced a sharp economic decline in early 1996, leading to a drop in employment during the second quarter of that year and several layoff announcements. Economic hardships were a factor, particularly in the state's manufacturing sector, which traditionally is more likely to offer health benefits than other sectors of the economy.[24] On the other hand, successful implementation of the ARKids program could ease the financial strain on University Hospital and other major providers of charity care.

For all these reasons, health system change in the Little Rock metropolitan area bears watching. While the future is hard to predict, it will likely not be placid.

NOTES

1 National news reports indicate that CIGNA, the national insurance company, intends to acquire Healthsource. The impact of this sale on Healthsource's Little Rock subsidiary is not yet clear.

2 Per capita income in Little Rock is about 8 percent lower than the U.S. average, while median household income in Little Rock is a full 29 percent lower than the U.S. average. Sources: Area Resource File as of February 1996 Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Population data are 1995. Income data are 1993; Bureau of the Census, 1990 projected to 1995 by CACI, Inc.

3 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services.

4 U.S. Health Care Financing Administration, MedPar Data, 1991.

5 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Data reflect a five-year rolling average from 1988 to 1992.

6 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997.

7 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term units in hospitals. Occupancy rates range from 37 to 75 percent of staffed beds for general acute care hospitals in the Little Rock/North Little Rock metropolitan area (excluding federal facilities). All estimates are unadjusted and therefore do not reflect differences in case mix of age/sex differences between Little Rock and the U.S. populations, or the impact of migration.

8 The Little Rock/North Little Rock MSA has 11 percent more primary care doctors per 1,000 residents and 47 percent more specialists than the U.S. average. Estimates are based on the 1996 American Medical Association Master File and the 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

9 See page 98 for more details about the entry of these companies into the Little Rock market.

10 U.S. Bureau of the Census, Health Insurance Coverage: 1993, Statistical Briefing 5B94-28; Oct. 1994.

11 Arkansas Employment Security Department, 1990-1996; Employee Benefits Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured," February 1996.

12 Greater Little Rock Chamber of Commerce, "Taking Care of Business," 1996.

13 The state maintains authority over benefits provided by local districts because those benefits are financed in large part through state contributions.

14 American Hospital Association, database of the Annual Survey of Hospitals. Figures do not include long-term care units in hospitals, beds at Little Rock's Department of Veterans Administration facility and two smaller federal facilities located on area military bases.

15 Officials of St. Vincent's Infirmary declined to be interviewed for this site visit, so impressions and observations about the institution are based on reports from other respondents.

16 Subsequent press reports announced Columbia/HCA's intention to build a new facility.

17 Plunket, Chuck. "Columbia/HCA Seeks to Expand its Presence in State," *Arkansas Democrat Gazette;* February 2, 1996, p. G- 1.

18 Estimates are based on the 1996 American Medical Association Master File and the 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

19 Some respondents claimed that less than 5 percent of all physicians in the area work in hospital-owned practices, with Baptist Health System owning the largest share. Baptist reports purchasing practices containing 80 physicians with plans to increase this number to 120 over the next several years. According to respondents, the pace of these acquisitions has slowed down significantly over the last few years.

20 InterStudy Competitive Edge Regional Market Analysis 7.1, June 1997.

21 Strategic Consulting Services, "Focus: Little Rock," Executive Bulletin, Spring, 1995, p. 5.

22 Plunket, Chuck. "Healthsource mailing fosters hospital talks," *Arkansas Democrat Gazette,* December 17, 1996, p. D-1; According to the terms of the Healthsource/St. Vincent's joint venture, Southwest Hospital is the only other general hospital provider in Little Rock that Healthsource patients are allowed to see without an additional payment for going out-of-network.

23 Greater Little Rock Chamber of Commerce, Taking Care of Business, 1996, p. 45.

24 Statement of John Shelnutt, Arkansas Institute for Economic Advancement, before the University of Arkansas at Little Rock Economic Outlook Conference, May 24, 1996.