Community Report

THIRD VISIT
2000-2001

SYRACUSE · N.Y.

Winter 2001

Insurers Consolidate, Hospitals Struggle Financially

In October 2000, a team of researchers visited Syracuse, N.Y., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 60 leaders in the health care market. Syracuse is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to Syracuse, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Syracuse market includes Cayuga, Madison, Onondaga and Oswego counties.

After a flurry of competitive maneuvering in 1997-1998 in anticipation of managed care growth, the Syracuse health care market has settled into an uneasy calm, as consolidation among local insurers has muted concerns that aggressive managed care will take hold. Indeed, a series of health plan exits and mergers have left indemnity insurer Excellus Blue Cross Blue Shield with about 40 percent of the Syracuse market, which has produced a new stabilizing force in the local market. Nevertheless, hospitals have struggled financially in face of reduced payment rates, operational problems and long-term debt.

Other developments in Syracuse include the following:

- Under mounting financial pressure, the largest local hospital system has filed for bankruptcy, while it and others are taking steps to cut costs.
- Physicians are increasingly concerned about how they will be affected by the growing clout of Excellus.
- New York State has continued to expand access to health insurance and strengthen the local safety net.

Syracuse Demographics

Syracuse	Metropolitan areas above 200,000 population
Population, July 1, 1999[1]	
732,920	
Population Change, 1990-1999[2]	
-1.3%	*8.6%*
Median Income[3]	
$24,619	*$27,843*
Persons Living in Poverty[3]	
14%	*14%*
Persons Age 65 or Older[3]	
14%	*11%*

Sources:
1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

The acquisition of the Syracuse region's largest HMO by Excellus Blue Cross Blue Shield will bring an estimated 40 percent of the Syracuse market under one insurer.

Health Plan Shakeout Leaves One Dominant Indemnity Insurer

Even the limited presence and influence of managed care in the Syracuse market appears to be diminishing. In a market where hospital rate regulation and lack of employer interest stymied the growth of managed care products for many years, Syracuse has long been a bastion of indemnity insurance. Since 1998, plans with tight managed care products have downgraded their activities in Syracuse, left the market entirely or been absorbed by Excellus.

The most dramatic of these developments came in late 2000, when Excellus announced plans to acquire Univera, the largest health maintenance organization (HMO) in Syracuse, with 130,000 members. Univera was formed in the late 1990s from a merger of HealthCarePlan of Buffalo and PHP, the latter a product of the national HMO movement that began in the 1970s. The acquisition of Univera by Excellus will bring an estimated 40 percent of the Syracuse market under one insurer.

Even before the Excellus-Univera deal was announced, plan exits and reconfigurations had reduced managed care options in Syracuse. CIGNA withdrew its HMO product from the market, remaining largely to provide looser products to major national accounts. Kaiser left the Northeast altogether. North Medical Community Health Plan, a local HMO developed by a physician-entrepreneur, sold out to Excellus because of increasing financial difficulties. United Healthcare consolidated its central New York operations with those in New York City and downgraded its Syracuse operations to a submarket. And Aetna's attempt to launch an HMO product in this market has stalled, reportedly because of the firm's inability to form an adequate provider network.

The Syracuse market appears to have embraced consolidation among insurers as an antidote to the competitive pressures that were unleashed in the aftermath of New York State's 1996 deregulation of hospital rates. This transition from one form of stability to another has been relatively easy because of the regulatory heritage in New York and the general antipathy for outside, for-profit health plans.

Managed care penetration in the Syracuse market—including preferred provider organizations (PPOs), which state laws had prohibited until the late 1990s—is now less than 40 percent. Moreover, the area's moderate HMO enrollment has been migrating to point-of-service (POS) and PPO products. Managed care's weakness in Syracuse is typified by the experience of Blue Cross Blue Shield of Central New York. This Excellus subsidiary has grown approximately 20 percent since the Excellus acquisition two years ago, mainly in its indemnity and PPO/POS products.

Neither purchasers nor consumers have displayed much interest in HMOs or other tight managed care products. Unlike employers in nearby Rochester and Buffalo that have long supported community-rated HMOs, Syracuse employers have favored open network products and initiated few efforts to influence either costs or quality in the market. More than two-thirds of Excellus' business is in its traditional indemnity products, which have the advantages of a broad network PPO, such as wide choice and open access, and few disadvantages from a consumer perspective. Moreover, with considerable leverage over providers, Excellus has displayed little interest in downstreaming risk to promote managed care incentives.

Hospitals Struggle Under Growing Financial Pressures

The financial condition of Syracuse hospitals has worsened over the past two years, culminating with the February 2001 bankruptcy filing by the largest hospital system. The 566-bed Crouse

Hospital filed for Chapter 11 bankruptcy protection after facing declining payment from both public and private payers and more than $90 million in long-term debt. The hospital had recently joined forces with Community General Hospital in an effort to gain operational efficiencies. Under a parent holding company called the Health Alliance of Central New York, the two hospitals had embarked on a number of cost-cutting initiatives to address mounting losses at both facilities. However, the two hospitals did not merge assets and remain distinct facilities operating under their original names, without consolidating the clinical services offered by each institution. Under its bankruptcy protection request, Crouse Hospital maintains that no services will be closed and that patient care will go uninterrupted during the restructuring. Rather, Crouse views this action as necessary to obtain relief from creditors while reorganizing its finances.

Meanwhile, Syracuse's other major hospitals also have experienced financial woes, dampening their longstanding collaborative spirit as hospitals focus on improving their bottom lines. Though area hospitals continue to work together on quality and disease management issues through a collaborative group called the Hospital Executive Council, these issues have become less pressing, while competitive pressures have mounted. Fueled by the deregulation of hospital rates in 1996 and expectations of growing HMO penetration and provider risk-sharing, Syracuse hospitals prepared cautiously in 1997-1998 to negotiate competitive rates with health plans by cutting costs and exploring alliances. Two years later, however, this activity has resulted in little change in the structure of the local hospital market, and Syracuse hospitals remain focused largely on internal operational issues.

Like Crouse and Community hospitals, Syracuse's two other major hospitals—St. Joseph's Hospital and University Hospital—have not embarked on any major initiatives to increase market share, revenue or clout since 1998. Instead, facing budget deficits and Medicare payment reductions, the hospitals have focused on cutting costs, reducing outpatient services and programs and enhancing inpatient clinical capacity in areas of historic strength. St. Joseph's, for example, has cut operating costs in its outpatient clinics, which serve many low-income individuals, to keep the clinics open, while University Hospital reduced staff by 300 full-time equivalents (FTEs) over the past few years, which helped it to avoid red ink in 1999.

The effects of Medicare payment cuts on Syracuse hospitals have been exacerbated by a growing shortage of nurses. All four hospitals have significant nursing staff vacancies, which limit their inpatient and outpatient capacity and thus their ability to generate revenue. An ongoing emergency room diversion program—which directs ambulances to a hospital with available inpatient beds—has gained importance as hospitals' ability to staff units has eroded. This program stands as an important remnant of hospitals' collaborative approach to community health problems.

As in the past, there is some sentiment among local observers that Syracuse has too many hospitals—and the Crouse/Community General alliance has not dramatically changed the Syracuse hospital environment in this regard. Local observers disagree about whether or when a hospital closure might actually occur, and if it does, which hospital would close.

Five smaller community hospitals serve the suburban counties outside of Syracuse. Neither these community hospitals nor the four Syracuse hospitals have sought formal alliances to shore up referral networks or otherwise expand market share the way hospitals in other markets have. The reason may be that the suburban hospitals are sole community providers that have considerable bargaining clout with insurers, and the city hospitals are

Health Insurance Status

	Syracuse	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	***9.7%***	***15%***
Children under Age 18 with No Health Insurance [1]	***3.7%***	***11%***
Employees Working for Private Firms that Offer Coverage [2]	***83%***	***84%***
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	***$163***	***$181***

Sources:
1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

	Syracuse	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	***2.9***	***2.8***
Physicians per 1,000 Population [2]	***2.4***	***2.3***
HMO Penetration, 1997 [3]	***19%***	***32%***
HMO Penetration, 1999 [4]	***21%***	***36%***

Sources:
1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1

Syracuse has enjoyed lower health insurance premiums than many other markets, but rates have increased by 15 percent for two straight years, confronting employers with rapidly rising costs.

satisfied with the referrals and transfers that they now receive from outside Syracuse.

Physicians Cast about for Direction and Leverage

Many physicians have been left feeling economically vulnerable in Syracuse's highly consolidated insurance market. With the expectation of growing managed care and competition, physicians formed multispecialty independent practice associations (IPAs) in the late 1990s, which they hoped would give them more leverage with health plans and hospitals. However, over the past two years, one IPA folded, and the two that remain have struggled due to low HMO enrollment and the fact that Excellus has not contracted with IPAs. As these organizations faltered, physicians have been left feeling uneasy in a highly consolidated insurance market—probably because provider payment rates have not mirrored recent insurance premium increases and, in some cases, have been cut significantly.

Overall, Syracuse remains a market dominated by solo or small-group physician practices, and most physicians tend to be affiliated with one of the four hospitals. However, some consolidation has occurred among single specialties. For example, one group, Hematology-Oncology Associates of Central New York, has grown to 12 specialists, while an orthopedics group, Syracuse Orthopedics Specialists, is reported to have 17 orthopedists, representing about 30 to 40 percent of the market. Cardiologists, on the other hand, have not consolidated and remain in many small practices around the Syracuse area, unlike other markets in which these specialists have organized into large, powerful practices.

Formal physician-hospital integration activities in Syracuse appear stagnant or are faltering. Some hospitals have reduced their ownership of primary care practices and have de-emphasized other arrangements that were expected to lead to an integrated delivery system model. Joint contracting with physicians is rare, and although some hospitals provide management services to affiliated physicians, these services are not a major part of overall market strategies. However, the recent consolidation of insurers could renew efforts to develop united negotiating strategies among hospitals and their affiliated physicians.

One area of competitive activity among physicians in Syracuse is the development of ambulatory surgery centers (ASCs). In the wake of the relaxation of state certificate-of-need rules, a number of physicians have invested in these centers to carve out a new market niche. Hospitals view the growth of ASCs as a threat, potentially diverting patients away from their own freestanding centers or outpatient departments. Health plans, notably Excellus, have voiced concern about the potential for costly overcapacity.

Employers Face Steep Premium Increases

Syracuse has enjoyed lower health insurance premiums than many other markets, but rates have increased by 15 percent for two straight years, confronting employers with rapidly rising costs. Purchaser resistance to premium increases has been muted, however, in part because of a tight labor market, and in part because Syracuse employers historically have not taken an active role in shaping the local health care system. Furthermore, efforts to contain costs are less effective in an environment in which hospitals have pushed for and are now receiving rate increases after a period of little or no growth.

Syracuse employers have shown little interest in quality improvement initiatives or other strategies that could help to shape the market. Their preference appears to be for their health plan or third-party administrator to negotiate with providers and ensure quality. Their reluctance to get

involved in the health care system is attributable to a number of factors: a lack of local leadership, because many large employers are part of national corporations with headquarters elsewhere; the dominance of small, service-sector businesses; and the influence of unions over the structure and scope of employee health benefits.

Employers in Syracuse tend to offer indemnity plans or managed care products with open networks, often PPO or POS products. HMOs' rates were once comparable to rates for these looser products, but some Syracuse employers report that recent increases in HMO premiums have made HMOs more expensive. Employers have not yet made major changes to benefit or cost-sharing structures in response to these rate hikes, except in prescription drugs. Formularies were rare in this market until 1998, but rising drug costs have led some employers to raise their prescription copayments, move to a three-tier benefit structure or even mandate the use of generic drugs. Some other employers have increased general cost-sharing amounts from, for example, $5 per office visit to $10.

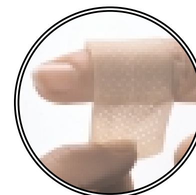
State Shifts Regulatory Focus, Expands Coverage

New York State has continued its longstanding support of programs that expand access to health insurance and strengthen the local safety net through expansions of public insurance programs and direct subsidies for charity care. Efforts in Syracuse to enroll children and adults in Medicaid and Child Health Plus, New York's State Children's Health Insurance Program (SCHIP), by and large, have been innovative and successful. The deregulation of hospital rates in 1996, with subsequent increases in market competition, has led to a new regulatory emphasis: oversight of managed care.

Syracuse has mobilized an impressive program of outreach and decentralized enrollment for Medicaid managed care and Child Health Plus, which preceded the federal SCHIP program by several years. Ironically, these efforts, which include all four major hospitals, local public health and many nontraditional organizations—such as schools, churches and community groups—have enrolled many Medicaid-eligible children in Child Health Plus. Now federal and state governments are pushing hard to identify and move these children out of Child Health Plus into Medicaid, a situation that has raised concern that children will lose coverage and fall between the cracks. Despite this challenge, implementation of Child Health Plus and mandatory Medicaid managed care in Onondaga and Oswego counties, which started in 1999, has gone smoothly. Four health plans, including two commercial insurers (Excellus and United) and two health plans that serve only public clients (Total Care and Fidelis), participate in both programs.

The safety net, comprising the four Syracuse hospitals and Syracuse Community Health Center (CHC), is reasonably stable and expanding modestly as a result of Child Health Plus and Medicaid managed care. The funding pools for charity care and graduate medical education, which were created in 1996, and expanded in 1998 as part of the Health Care Reform Act (HCRA) of 2000, have mitigated some of the effects that market changes and dislocation might have had on care for the uninsured. In addition, Syracuse CHC has sought innovative program expansions and revenue streams more aggressively, and Total Care, its affiliated health plan, is expanding into at least two neighboring counties through contracts with private clinics, a move that will increase the region's safety net capacity. On the other hand, in an effort to shore up their financial condition, hospitals have had to cut services in outpatient clinics used by uninsured patients.

HCRA 2000 established two new programs designed to extend subsidized health insurance coverage to additional



New York State has continued its longstanding support of programs that expand access to health insurance and strengthen the local safety net.

Insurer consolidation has replaced hospital regulation as the main stabilizing force in Syracuse, a health care market that saw considerable competitive activity for a short period in 1997-1998.

populations. Healthy New York began in January 2001 to subsidize coverage in the individual and small group markets through reinsurance pools, which will cover individuals' medical costs above a certain threshold and thus keep individual and small group premiums lower. Family Health Plus—slated to start in early 2001 pending federal approval—will expand Medicaid eligibility to adults ages 19 to 64.

Governor George Pataki's administration has brought a strong emphasis on nonregulatory solutions to health care issues, starting with deregulation of hospital rates. This marked shift in state policy led to a short period of increased competition and consolidation, but market forces and the new focus on regulating managed care have ended that phase. The state departments of Insurance and Health share—and, in some cases, compete over—responsibility for overseeing the activities of health plans and providers, most notably the new external review program and proposed regulations regarding IPAs and risk-bearing provider organizations. In addition, New York has invested considerable resources in producing and disseminating information about health plans and providers to consumers and the general public. Nonetheless, observers are unclear about the objectives and outcomes of these information initiatives.

Issues to Track

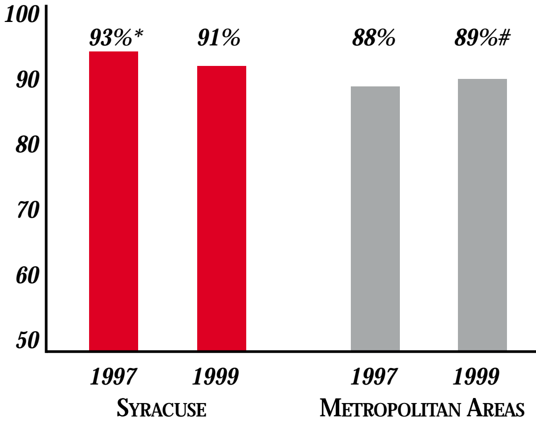
Insurer consolidation has replaced hospital regulation as the main stabilizing force in Syracuse, a health care market that saw considerable competitive activity for a short period in 1997-1998. To cope with rising premiums—due to both the insurance underwriting cycle and the lack of aggressive managed care—purchasers have been content to adjust their benefit packages on the margins rather than take steps to shape the system as a whole. Likewise, the area's hospitals have not undertaken major competitive initiatives but have focused instead on near-term efforts to reduce budget shortfalls. After a brief flirtation with greater integration, physicians are now concerned about the power of payers, especially Excellus, to determine their financial fates. Meanwhile, New York State has continued its expansion of public programs that increase access to the uninsured and strengthen the local safety net.

As the Syracuse market continues to unfold, the following issues will be important to track:

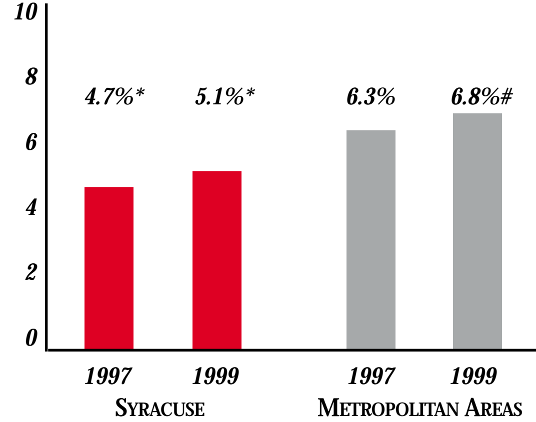
- What effects will the Excellus-Univera merger have on consumers, provider networks and relationships and other health plans?
- Will continuing financial pressures force any of Syracuse's four hospitals to close?
- Will providers organize to increase their market clout, so that they can demand higher payment rates?
- How will employers cope with rising health plan premiums for their employees?
- Will New York's new insurance expansions continue the successes of the Medicaid and Child Health Plus programs?

Syracuse's Experience with the Local Health System, 1997 and 1999

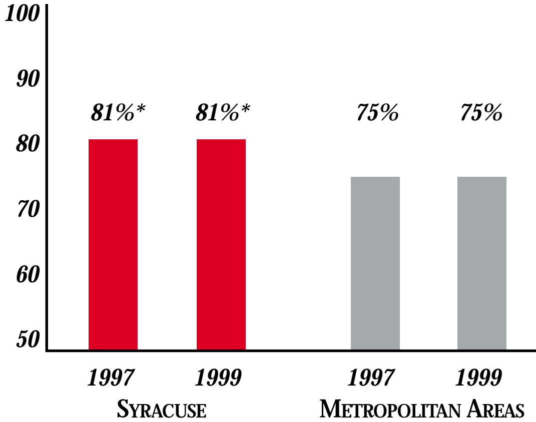
PERSONS SATISFIED WITH THE HEALTH CARE THEY RECEIVED IN THE LAST 12 MONTHS



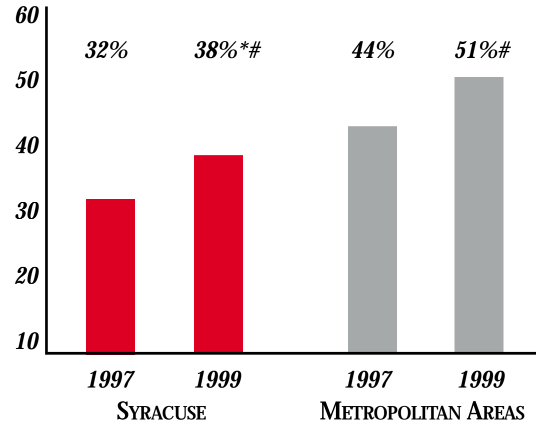
PERSONS WHO DID NOT GET NEEDED MEDICAL CARE IN THE LAST 12 MONTHS



PHYSICIANS AGREEING THAT IT IS POSSIBLE TO PROVIDE HIGH-QUALITY CARE TO THEIR PATIENTS



PERSONS WITH INSURANCE THAT REQUIRES GATEKEEPING



** Site value is significantly different from the mean for metropolitan areas over 200,000 population.*
 # Statistically significant difference between 1997 and 1999 at p< .05.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.

The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in *Issue Briefs, Data Bulletins* and peer-reviewed journals. These publications are available at www.hschange.org.

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