CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

Findings from HSC

NO. 103 • JANUARY 2006

DO SPECIALTY HOSPITALS PROMOTE PRICE COMPETITION?

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Policy makers continue to debate the correct public policy toward physician-owned heart, orthopedic and surgical specialty hospitals. Do specialty hospitals offer desirable competition for general hospitals and foster improved quality, efficiency and service? Or do specialty hospitals add unneeded capacity and increased costs while threatening the ability of general hospitals to deliver community benefits? In three Center for Studying Health System Change (HSC) sites with significant specialty hospital development—Indianapolis, Little Rock and Phoenix—recent site visits found that purchasers generally believe specialty hospitals are contributing to a medical arms race that is driving up costs without demonstrating clear quality advantages.

Medicare Moratorium Stalls Specialty Hospital Growth

The 18-month moratorium on new physician-owned heart, orthopedic and surgical specialty hospitals imposed by the Medicare Modernization Act of 2003 (MMA) temporarily stalled the rapid growth of specialty hospitals. After the moratorium expired on June 8, 2005, the Centers for Medicare and Medicaid Services (CMS) indicated it would not approve any new specialty hospitals for at least another six months while the agency reviewed its enrollment procedures for specialty hospitals. Legislation expected to be enacted in early 2006 would further prohibit specialty hospital enrollment in Medicare for up to another eight months.

CMS also plans to revise payment policies for inpatient and outpatient care to reduce price distortions that have helped spur specialty hospital development.

Congressional interest in specialty hospitals remains intense but divided. As part of the MMA, the Medicare Payment Advisory Commission (MedPAC) and CMS were directed to study specialty hospitals to help decide whether Medicare policy should promote or impede specialty hospital development. MedPAC found that physician-owned specialty hospitals treat patients who are less severely ill than average and concentrate on relatively profitable conditions. MedPAC also found that specialty hospital costs for inpatients were not lower than general hospitals, although specialty hospital patients had shorter average lengths of stay. The CMS study concluded that specialty hospitals generally provide good quality of care, with somewhat lower complications and mortality rates in cardiac specialty hospitals than in general hospitals, but with a higher rate of readmissions.

To date, the MedPAC and CMS findings have not produced a consensus on the correct Medicare policy stance regarding physician-owned specialty hospitals.[1] Further, these reports do not focus on whether specialty hospitals promote useful marketplace competition related to the care of patients covered in employer-sponsored health plans.

In three Center for Studying Health System Change sites with significant specialty hospital development—Indianapolis, Little Rock and Phoenix—purchasers have had time to observe the impact of specialty hospitals on overall costs; price competition and quality among hospitals; whether contract negotiations with general hospitals are affected by the market entry of specialty hospitals; and whether employers want specialty hospitals included in health plan networks (see Data Source).

Although employers and health plans are predisposed to favoring new hospital entrants to produce greater competition, in the three sites studied, they generally believe that specialty hospitals are contributing to a medical arms race that is driving up costs. Moreover, purchasers believe specialty hospitals have unfair advantages that create an unlevel playing field for hospital competition, and some suggested that certificate-of-need regulations be used to limit the growth of specialty hospitals.

Price Competition

Purchasers expressed somewhat conflicting views on whether specialty hospital entry to the market resulted in price competition

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among specialty and general hospitals for services offered by the specialty hospitals, as economic theory would suggest. Some described receiving significant price discounts on specific cardiac or orthopedic services because of the new competition, while others did not.

Although previous research indicates that purchasers believe specialty hospitals have lower unit costs,[2] some believe that referring physicians, especially those with a financial interest in the specialty hospital, increase volume by inducing patient demand for elective procedures. The higher volume more than offsets the savings achieved from lower prices from competition, leading to increased aggregate costs. The ability of physician specialists to induce demand through self-referral for procedures that had once been within the domain of the general hospital was captured by one Indianapolis respondent who said, "We joke about drive-through angioplasty." Health plans indicated they had few tools to restrain the induced utilization that physician ownership of specialty hospitals can engender.

Purchasers observed that general hospitals responded to the loss of "profitable services" by raising prices on services where there is less competition. In general, purchasers thought that the current level of specialty hospital competition was too limited to interfere with general hospitals' ability to raise prices on other services to offset losses from specialty hospital competition.

Focused Factories or Risk Skimmers?

Given the interest in specialty hospitals as prototypical "focused factories," which are able to provide higher quality health care services more efficiently, it was surprising that health care purchasers had few opinions about the performance of specialty hospitals, even though some had been operating in the community for some time. Respondents generally agreed that it was too early to know whether quality is better or worse, although concerns were raised that specialty hospitals probably perform well on "pure cases," that is, those without complications and comorbidities, but maybe less well on more complex cases.

Some health plans and employers believe that physicians referred relatively easy cases to specialty hospitals and more complex patients to general hospitals, whether out of quality concerns or financial considerations. One respondent was concerned that small specialty hospitals might not have the same quality oversight as a larger general hospital with multi-specialty performance review. However, respondents generally thought that specialty hospitals were convenient for patients and offered more amenities, including better food, than general hospitals.

In general, employers did not expressly demand the inclusion of specialty hospitals in health plan networks, although health plans felt a need to respond to the general desire of employers for broad, inclusive hospital networks. Consistent with plans' desire for broad networks, community hospitals generally were unable to prevent plans from contracting with specialty hospital competitors, although one health plan respondent said the plan decided not to contract with a specialty hospital in part to protect the general hospital's market position. In fact, most health plans in Little Rock do not contract with the Arkansas Heart Hospital, supporting the observation of others, drawn from other communities, that specialty hospitals are often excluded from health plan networks.[3]

Competitive Juices Flow

Overall, across the three sites, with some differences of opinion expressed in Phoenix, purchasers agreed that specialty hospitals were contributing to what some cited as a "medical arms race" that would drive up health care costs.

Although there was some evidence of increased price competition, respondents observed that the more important outcome was the perceived need for general hospitals to compete aggressively with the new physician-owned specialty hospitals by developing similar dedicated centers, as distinct hospitals-within-hospitals or free-standing facilities.

Thus, in the views of purchasers and other market observers, physician-owned specialty hospitals caused general hospital competitive juices to flow, but most of those juices flowed toward capacity expansion for lucrative services and enhanced

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Specialty Hospitals in HSC Communities

Three of the 12 HSC communities—Indianapolis, Little Rock and Phoenix—have specialty hospitals that are owned in part by physicians. Overall, there are nine such hospitals in the three sites. Consistent with national findings, these specialty hospitals developed in states without certificate-of-need requirements. Four are "heart hospitals;" the others focus primarily on orthopedic surgery. One is wholly owned by physicians. The other eight are joint ventures between physicians and national firms that provide capital to physicians for specialty facility development (six) or local general hospitals (two). Exempted from the moratorium because they had begun construction prior to Nov. 18, 2003, two physician-owned specialty hospitals have recently become operational. The new Indianapolis facility, which is wholly physician owned, is an orthopedic hospital and the Little Rock facility, which is mostly physician owned, involves primarily orthopedic surgery, neurosurgery and cosmetic surgery.

specialty service branding and not necessarily toward improved quality and efficiency. The specialty hospital development is another manifestation of the medical arms race that has reappeared in recent years in most of the 12 HSC communities.[4]

A complicating factor that plans identified in the competition for heart services in Indianapolis was the influence of a large cardiology group over network configuration. One plan respondent observed that contracting with the group to provide in-network services required it also to contract with the group's partly owned hospital. Thus, both hospitals and strong physician groups were able in contracts to tie specialty services to other services that the insurer needed from the providers.

One exception to the market power of general hospitals was described. In general, in most of the 12 HSC markets, hospitals recently have been seeking shorter contracts to avoid locking-in payment rates. However, a plan respondent in Indianapolis observed that some general hospitals now were seeking longer-term contracts, even with locked-in rates, to assure that their specialty services would not be excluded by plan decisions to use alternative, specialty hospitals to provide those services.

Policy Implications

Although respondents were not specifically asked about possible policy approaches to address their perceptions about nonproductive competition stimulated in part by specialty hospitals, some employers and health plans suggested that increased government regulation to limit specialty hospital growth might be desirable.

In Indianapolis and Little Rock, respondents suggested that certificate-of-need regulation might be needed to restrict the growth of specialty hospitals. Indeed, in two other HSC sites that have not seen physician-owned specialty hospitals, Miami and northern New Jersey, health plan respondents referred approvingly to CON restrictions on specialty hospitals in their states.

For the most part, Congress has been focused on the effect of physician-owned specialty hospitals on Medicare. Yet, Medicare's payment and self-referral policies also affect contracting between providers and private insurers and, therefore, the cost and quality of care for many patients in addition to Medicare beneficiaries.

Some assert that specialty hospitals represent desirable competition for general hospitals and, therefore, public policy should consistently foster competition provided by new market entrants, including specialty hospitals. These commentators call for reliance on antitrust enforcement, resist expansion of CON laws that would limit specialty hospitals and oppose general hospital efforts to restrict the hospital privileges of physicians with ownership interests in competing specialty hospitals.[5]

Others believe that specialty hospitals add unneeded, expensive capacity to the health care system, make it more difficult for general community hospitals to cross subsidize the care provided to the uninsured and underinsured, and intensify the problems associated with physician self-referral for economic gain. These advocates would design public policy to discourage the development of new specialty hospitals.[6]

It is striking that purchasers and their health plan agents, some of which themselves are for-profit, entrepreneurial ventures, who might be expected to favor increased hospital competition, generally do not view the development of specialty hospitals positively. They believe that specialty hospitals add to health care costs and have not demonstrated clear quality advantages. Further, purchasers are concerned about the opportunity for physician owners to induce demand through self-referral, to cherry pick among the patient population and to threaten community hospitals' reliance on profitable services to make up for shortfalls in other areas. To some extent, purchasers seemed implicitly to accept general hospitals' need for insured patients to subsidize care for the uninsured and underinsured, and profits from well-compensated services to support unprofitable services.

In most sectors of the economy, specialized producers foster market competition. In the airlines industry, for example, leaner point-to-point air carriers have forced aggressive price competition and dramatic changes in the traditional cost structure of the major airlines, for better or worse. In contrast, in the case of specialty hospitals, the ability of providers with market power to tie particular specialty service prices to other contracted services; the seeming acceptance by at least some purchasers that general hospitals have a legitimate need to cross subsidize services because of uncompensated care burdens; and the lack of useful measures by which purchasers can differentiate the quality and efficiency of cardiac, orthopedic and other specialty hospital services contribute to a very different result. The findings again confirm that even a competitive health care system does not function like most other sectors of the economy.[7]

It is important to note that purchasers

Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 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. In 2005, HSC researchers interviewed health plan executives, self-funded employers, local benefit consultants and individuals providing market-wide vantage perspectives on the impact of specialty hospitals in Indianapolis, Little Rock and Phoenix.

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

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also have described a medical arms race focused on the promotion and marketing of specialty services involving general hospitals in areas where there is no specialty hospital competition. Indeed, increased competition among local hospitals and between hospitals and physicians for profitable services, including cardiac, orthopedic and cancer care, has been observed across the 12 HSC sites.[8] This service-line competition has involved new facilities and dedication of existing hospital space to profitable specialty services and is taking place whether or not there are specialty hospitals, suggesting that the policy focus on specialty hospitals *per se* might be somewhat misplaced.

Marked disparities in the relative profitability of certain services under both Medicare and private plan payment policies appear to be a major force driving competition for these profitable services.[9] These pricing distortions are contributing to the current emphasis on specialty service differentiation and to escalating health care costs generally, with specialty hospitals being one prominent manifestation of such distortions. Indeed, proponents of greater provider competition and proponents of greater regulation to restrict new specialty facilities agree that distorted pricing policies create an unlevel playing field and influence providers' resource-allocation decisions for the worse. CMS has indicated that it will revise its payment systems for both inpatient and ambulatory services to reduce the artificial financial advantage that specialty hospitals currently enjoy because of the limited range of services they provide.

Up until now, specialty hospitals have not had to outperform general hospitals on costs or quality because specialty hospitals have had inherent advantages from pricing distortions, physician self-referral, favorable case-mix, and lack of an uncompensated care burden. Eliminating these advantages would provide a more meaningful test of whether there is an important role for specialty hospitals as focused factories, as some have advocated. Some believe that permanent barriers to entry of specialty hospitals through targeted CON restrictions, as some states have adopted, should await such a test, so that a better assessment could be made. But others are skeptical about policy makers' ability—or commitment—to create the conditions for a true level playing field. ■

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