Highly Consolidated Market Poses Cost Control Challenges

In October 2000, a team of researchers visited Lansing, Mich., 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 85 leaders in the health care market. Lansing 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 Lansing, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Lansing market includes Ingham, Clinton and Eaton counties.

One health plan and one hospital system now control much of Lansing's health care market. Blue Cross and Blue Shield of Michigan (BCBSM), the dominant plan, covers about 70 percent of commercially insured individuals. The dominant hospital system, Sparrow Health System, which was created by the merger of two local hospitals in 1997, now controls more than 60 percent of the hospital market. It also owns Lansing's second major health plan, Physicians Health Plan of Mid-Michigan (PHP).

Recent developments suggest that controlling health care costs in Lansing's highly consolidated market may be challenging. Since 1998, employers have been hit with double-digit health plan premium increases and have responded only modestly. Other important developments include:

- Hospitals have expanded some clinical services and have negotiated payment increases from health plans.
- Controversies over freestanding ambulatory surgery centers (ASCs) have reignited.
- Physicians have adopted strategies to increase their leverage with plans and hospitals.
- The county health department has continued to lead efforts to improve care and coverage for the uninsured.

Lansing Demographics

Lansing	*Metropolitan areas above 200,000 population*
Population, July 1, 1999 [1]	
450,789	
Population Change, 1990-1999 [2]	
4.2%	*8.6%*
Median Income [3]	
$30,830	*$27,843*
Persons Living in Poverty [3]	
11%	*14%*
Persons Age 65 or Older [3]	
10%	*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

Since 1998, Sparrow Health System and the Ingham Regional Medical Center have invested significant resources to build new tertiary care facilities and to add or expand clinical service lines.

Hospitals Compete Aggressively in Certain Clinical Service Lines

Since 1998, Lansing's two hospital systems—Sparrow Health System and the Ingham Regional Medical Center (IRMC)—have invested significant resources to build new tertiary care facilities and to add or expand clinical service lines. The expansions are targeted at gaining community recognition as the highest-quality, "brand-name" hospital to build loyalty and enhance profitability.

Sparrow, which had started a cardiovascular surgery program to compete with IRMC, recently added a Level I trauma unit and a neurosurgical care unit. With an infusion of capital from its parent organization, McLaren Health Care Corporation, IRMC added a $21 million women and children's center to compete with Sparrow in obstetrics/gynecology and pediatrics to attract younger, middle-class families. IRMC also recently established the Great Lakes Cancer Institute, a joint venture with Michigan State University (MSU) to enhance cancer research, services and teaching programs. The arrangements also will move MSU's clinical faculty practice and oncology fellowship program from Sparrow to IRMC.

Sparrow has mounted an aggressive advertising campaign to market its new and improved facilities and services to the community, and IRMC is expected to launch similar efforts. According to respondents, Sparrow is now regarded as the premier hospital in the community, but IRMC has advanced in recent years to become a more formidable competitor.

The increased competition between Sparrow and IRMC in clinical services was viewed positively by most respondents, with a few exceptions. Most of those interviewed considered the new or enhanced services valuable to the community, noting that competition between the two hospital systems extends to outreach, prevention and charity care. On the other hand, some respondents were concerned about the long-term effects of service competition on costs and access to more basic services.

Freestanding Ambulatory Surgery Centers Reignite Controversy

Three freestanding ASCs were started by physician entrepreneurs between 1996 and 1998, generating controversy over the role of such ASCs in the provision of ambulatory surgery services. A March 2000 ruling by Michigan's state insurance commissioner reignited that controversy.

The debate about whether to include freestanding ASCs in commercial plan networks illustrates the complex issues raised by facilities that compete to provide services traditionally provided by hospitals. Proponents argue that freestanding ASCs should be given the opportunity to compete with hospital-based ASCs. More specifically, they contend that, compared with hospital-based ASCs, freestanding ASCs have substantially lower costs and higher consumer satisfaction and are of equal or better quality.

Opponents argue that the freestanding ASCs duplicate hospital capacity, ultimately resulting in higher total costs. For this reason, General Motors (GM) has refused to allow plans serving its employees to include freestanding ASCs in their networks. In part because of GM's position on this issue, BCBSM also has refused to contract with these entities. Over the past two years, however, a successful lawsuit filed by one of the local ASCs led BCBSM to include it in its network, although BCBSM subsequently raised concerns about the quality of care the center provided, given its low volume of procedures.

In March 2000, Michigan's state insurance commissioner ruled that BCBSM's refusal to contract with freestanding ASCs was based on inequitable access and quality standards. BCBSM's new standards, which may make it easier for freestanding ASCs to participate in BCBSM indemnity products, are currently

under review by the commissioner. If these new criteria result in BCBSM expanding its contracts with ASCs, the Lansing market is likely to see increased competition for ambulatory surgery services in the years ahead, which will help test theories of ASCs' implications for cost, quality and consumer satisfaction.

Physicians Move to Increase Leverage with Plans and Hospitals

Physicians in Lansing's highly consolidated and increasingly competitive market have relied on several strategies to maintain their autonomy and increase their leverage with plans and hospitals by: (1) consolidating into larger practice groups; (2) adopting a more aggressive negotiating stance with plans; and (3) continuing their participation in the physician-hospital organizations (PHOs) of both Sparrow and IRMC.

Although some larger physician groups have formed in Lansing in past years, small single-specialty groups have been more successful recently in consolidating than have larger ones. Over the past two years, there have been a number of instances in which specialists in solo practices and very small groups have consolidated into larger groups of approximately 10 physicians. Meanwhile, two of the three larger physician groups that had been growing—Thoracic and Cardiovascular Institute and Mid-Michigan Physicians—lost momentum in the drive to grow because they had to focus on other management issues related to declining Medicare reimbursement and developing information systems to support their practices.

Physician groups also have asserted themselves recently by demanding changes in their contracts with health plans. Having found that extensive risk-sharing arrangements with plans are unprofitable for them, most physician groups have shown little interest in capitated arrangements (other than for primary care services) with health plans. Several physician groups have renegotiated or pulled out of the few capitated contracts they had. In addition, physicians have taken steps to improve their fee-for-service contracts, securing better contract terms and improved payment rates.

Finally, physicians have improved their position compared to local hospitals as pressure to align exclusively with one of the two hospitals' PHOs has waned. Because PHOs have not become the major contracting vehicles in the market as anticipated, hospitals have less leverage to push for exclusive physician membership. As a result, physicians have been successful in maintaining relationships with both Sparrow and IRMC's PHOs, reducing physicians' dependence on any one hospital.

Hospitals Negotiate Small Payment Increases from Plans

Faced with declining reimbursement from Medicare and Medicaid and rapidly rising costs, Lansing's hospital systems have pushed back on commercial health plan contracts and finally secured small payment increases after years of considerable discounts.

Hospitals nationally have confronted declining Medicare revenues under the Balanced Budget Act (BBA) of 1997, and as teaching institutions, Sparrow and IRMC have experienced additional declines because of the BBA's provisions regarding graduate medical education. These problems have been compounded by difficulties in Michigan's Medicaid managed care program, including payments that providers allege are too low and too slow. At the same time, hospitals have experienced substantial cost increases driven by labor shortages, pressure to acquire new technologies and information systems and rising inpatient pharmaceutical costs.

Now that they are the only two hospital systems, Sparrow and IRMC have more leverage in their negotiations with

Health Insurance Status

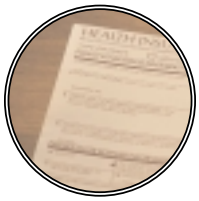
Lansing	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	
8.2%	*15%*
Children under Age 18 with No Health Insurance [1]	
4.0%	*11%*
Employees Working for Private Firms that Offer Coverage [2]	
85%	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	
$183	*$181*

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

Health System Characteristics

Lansing	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	
2.2	*2.8*
Physicians per 1,000 Population [2]	
2.1	*2.3*
HMO Penetration, 1997 [3]	
41%	*32%*
HMO Penetration, 1999 [4]	
41%	*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



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BCBSM and PHP, especially in an environment where plans must include both hospital systems in their products to be successful. This leverage has enabled them to negotiate higher payment rates from health plans.

Another response to financial pressures by Lansing's hospital systems has been to cut selected clinical and administrative services and improve efficiency. IRMC, for example, eliminated approximately 80 positions by consolidating administrative functions with its parent organization and discontinuing services, such as transitional care units, that the hospital determined were no longer reimbursed adequately under Medicare.

Sparrow and IRMC also expect some relief from financial pressures in the near future, thanks to the recent restoration of some Medicare BBA funds and increases in provider reimbursement rates in Michigan's Medicaid managed care program.

Health Plans Raise Employers' Premiums

To cover increased costs and to make up for losses associated with the insurance underwriting cycle, Lansing's two major health plans—BCBSM and the Sparrow-sponsored plan, PHP—have raised employer premiums substantially in the past two years. Although this is a national trend, it is especially striking in Lansing, where premium increases occurred despite a community-wide "Save GM" campaign that was trying to demonstrate to the automobile manufacturer that Lansing was a good place to continue to do business—in part because of the area's ability to keep health care costs low. The area's largest employers—including GM—were hit with premium hikes of about 9 percent in the 1999 contract year and 12 to 15 percent in 2000. Small employers experienced a wider range of premium increases, from 10 to 25 percent, with more recent increases of 20 percent or higher.

While some argue that increased health plan competition would help restrain premium increases, this appears unlikely in Lansing in the foreseeable future. BCBSM and PHP together account for the vast majority of the local market share. The two smaller plans in the Lansing market (M-Care and Regional Community Blue) have very small enrollments, perhaps because they include only one of Lansing's two hospital systems (IRMC) in their networks.

Furthermore, one of the two Lansing hospitals is said by some respondents to quote other potential health plan entrants "unreasonably high" rates for hospital services, making it extremely difficult for new plans to enter and compete successfully in the market. (The hospital maintains that the higher rates these respondents quote reflect smaller discounts because of low volume.) The fact that Lansing has fewer than 500,000 residents also limits its attractiveness to large national plans.

Competition has failed to develop in Lansing's public sector managed care programs, as well. The only Medicare managed care provider is BCBSM's subsidiary, Blue Care Network, whose enrollment has stabilized at about 6,800 members. PHP decided not to enter Lansing's Medicare risk market, concluding that it was unlikely to be profitable.

The Medicaid managed care market is dominated by just two plans: PHP (Sparrow's affiliated health plan) and McLaren (IRMC's affiliated health plan). A third Medicaid-only health plan (The Wellness Plan) withdrew from the Medicaid managed care market in November 1999, after its contracts with IRMC and Sparrow were canceled. Two other Medicaid-only plans (Health Plan of Michigan and Community Choices) entered the market anticipating PHP's complete withdrawal from the program but are unlikely to remain because they have no provider networks and may have difficulty obtaining one given that both Sparrow and IRMC have their own affiliated plans.

Employers Take Modest Steps in Response to Premium Increases

Lansing employers' responses to premium increases by health plans have been relatively modest. The primary strategies used by employers to limit premium increases are modifying pharmacy benefits, increasing cost sharing by employees for some health maintenance organization (HMO) services and requiring higher deductibles in indemnity plans offered to employees. For the most part, Lansing's employers have been absorbing the premium increases.

Several factors may account for this muted response. First, given the strong union presence and tight labor market in Lansing, employees expect relatively comprehensive health insurance coverage with limited cost sharing for premiums and broad choice of providers. About 25 percent of those with commercial health insurance coverage in Lansing are enrolled in traditional indemnity products—a much higher percentage than the national average. Of those enrolled in managed care options, most employees select preferred provider organizations (PPOs) or point-of-service (POS) products that offer less restrictive access to providers than do traditional HMOs.

Second, collective efforts by employers to reduce cost and monitor quality through the Capital Area Health Alliance (CAHA)—a coalition comprising all major stakeholders in the local health care system—were discontinued three years ago after the public release of hospital cost information triggered providers' concerns. In the absence of this information, employers' collective efforts to contain costs and improve quality have been seriously constrained.

Third, Lansing's three largest employers—GM, the Michigan state government and MSU—have adopted national or statewide purchasing strategies that shape their view of the Lansing market. For example, GM views Lansing as a good place to do business from a health care benefit standpoint, compared to Flint and other places where GM plants are located. GM is also an active member of the Leapfrog Group, a national coalition of large employers focusing on improving patient safety, and reportedly is working with Lansing hospitals to develop initiatives to reduce medication errors, a key patient safety priority identified by Leapfrog. Statewide needs and concerns similarly shape the state government's and university's perspectives on health care purchasing in Lansing.

Finally, the few mid-sized and many small employers in Lansing have little clout in negotiations with plans. Given limited plan options, these employers typically do not switch health plans in response to price increases—and even if they do switch, Lansing's other plans apparently do not compete aggressively for their business. At the same time, employers have concluded that direct contracting with providers is unlikely to result in substantial savings. Small businesses in Lansing purchase health insurance through various associations in an effort to improve their negotiating leverage, but these initiatives have met with limited success.

Care and Coverage Improves for the Uninsured

Lansing enjoys an uninsurance rate that is significantly below the national average, and the Ingham County Health Department continues to lead collaborative efforts to improve care and coverage for individuals without health insurance. In addition to leading Medicaid and MIChild (the State Children's Health Insurance Program) outreach efforts, the county health department administers the Ingham Health Plan (IHP)—a managed care program for the uninsured.

Under the IHP, the Ingham County Health Department provides and coordinates outpatient preventive, primary, specialty and ancillary care services for low-income, uninsured adults and children who are not eligible for public insurance programs. Already noted for its success at the time of the previous site

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visit, IHP has continued to grow over the past two years. Currently, it serves approximately 11,500 people—an increase of more than 50 percent since 1998. Through a new contract with the MSU faculty practice, IHP also has expanded access to outpatient services. A pharmaceutical program created by IHP in October 2000 obtains volume discounts of 20 percent on medications for low-income seniors.

On the horizon are further expansions of IHP to reach more of the community's working poor. Approximately 60 percent of the program's current participants are employed but do not have employer-sponsored health insurance coverage, either because their employers do not offer it or because they cannot afford the premiums. To reach more of the working poor who do not have insurance, IHP is planning to implement a new "third-share" program in which employers and employees each contribute one-third of the cost of premiums, and IHP subsidizes the remaining one-third. The total premium for individual coverage is expected to be approximately $120 per month, making the monthly cost for individuals roughly $40.

IHP is funded through a combination of local, state and federal matching funds—generated by a special Medicaid disproportionate share hospital (DSH) payment program—that flow through IRMC. Despite IRMC's substantial commitment to IHP, the special DSH funds available to the program were limited when IRMC was the sole hospital participant. However, after resolving some initial objections, Sparrow recently decided to participate in IHP as well, which should bolster the plan's funding base and help to support continued expansion of the number of people served and providers participating in the program. New regulations that curtail the use of federal Medicaid matching funds for certain services raised concern about IHP's continued ability to draw on DSH funds for support, but state administrators' interpretation of the ruling is that the funding stream is secure at this time.

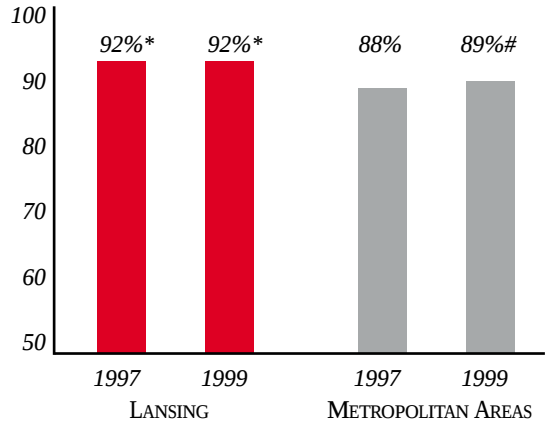
Issues to Track

Rising premiums, limited plan competition and increased service competition observed over the last two years suggest that controlling health care costs may prove very difficult for Lansing employers in the future. Consequently, employees and their unions may face difficult choices about health care coverage and benefits. In addition, state regulators may increasingly face complex questions about provider capacity and competition among plans, hospitals and physicians. As the Lansing market continues to evolve, it will be important to track the following questions:

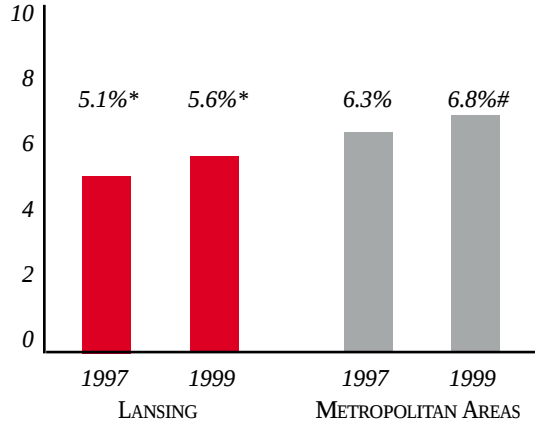
- Will hospitals continue to be able to sustain higher payment rates from health plans?
- What impact will increased competition among hospitals and physician entrepreneurs for select clinical services have on costs, quality and access to care?
- How will employers respond to rising premiums, particularly if the economy slows? What leverage can employers exert in a highly consolidated market with a heavily unionized workforce that expects comprehensive coverage and provider choice?
- Will the Ingham County Health Department's planned expansions succeed, and what impact will they have on coverage and care for the uninsured?

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

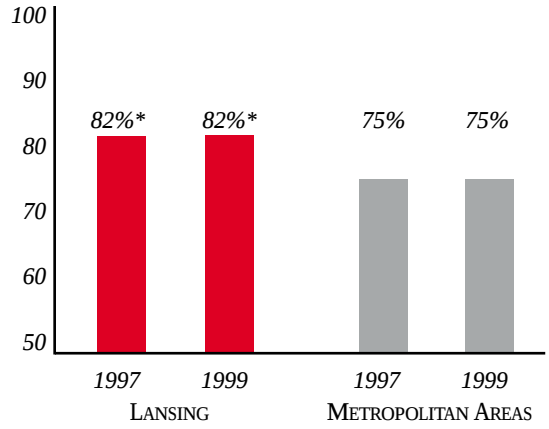
Persons Satisfied with the Health Care They Received in the Last 12 Months



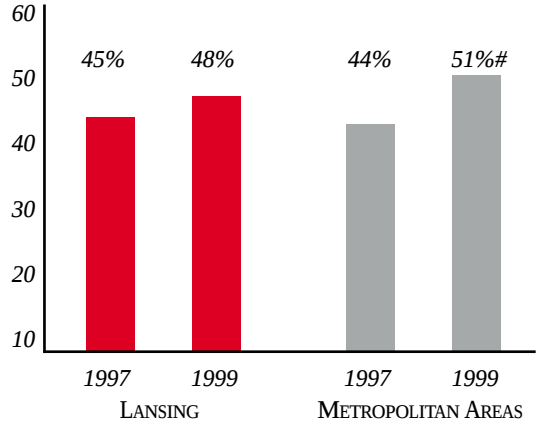
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



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.

Authors of the Lansing Community Report:
Kelly Devers, HSC
Jon B. Christianson, University of Minnesota
Laurie E. Felland, HSC
Sue Felt-Lisk, Mathematica Policy Research, Inc.
Liza Rudell, HSC
J. Lee Hargraves, HSC

Community Reports are published by HSC:
President: Paul B. Ginsburg
Director of Site Visits: Cara S. Lesser
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group

For additional copies or to get on the mailing list, contact HSC at:
600 Maryland Avenue SW, Suite 550, Washington, DC 20024-2512
Tel: (202) 554-7549 Fax: (202) 484-9258 www.hschange.org

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