GREENVILLE · S.C.

Spring 2001

Hospitals Compete for Specialty Care

In November 2000, a team of researchers visited Greenville, S.C., 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 50 leaders in the health care market. Greenville 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 Greenville, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Greenville market includes Greenville, Spartanburg, Anderson, Cherokee and Pickens counties.

Greenville's continued population growth and economic development have kept the area's health care providers busy and profitable. Hospitals have expanded specialty services while abandoning efforts to build primary care capacity. Health maintenance organization (HMO) enrollment has remained low over the past two years, and distinctions between HMOs and preferred provider organizations (PPOs) have diminished. Rising insurance premiums have prompted some small employers to drop coverage for dependents, raising concerns about growth of the uninsured population. Fortunately, access to care for underserved populations has continued to improve through cooperative efforts among safety net providers and other community organizations.

Other significant developments over the past two years include:

- Several area hospitals have received state approval to offer tertiary care services, leading to more intense competition for patients.
- Providers have discontinued efforts to build infrastructure for managed care risk contracting.
- Projected state budget shortfalls have begun to threaten the long-term stability of government health insurance programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).

Greenville Demographics

Greenville	*Metropolitan areas above 200,000 population*
Population, July 1, 1999 [1]	
929,565	
Population Change, 1990-1999 [2]	
12%	*8.6%*
Median Income [3]	
$24,967	*$27,843*
Persons Living in Poverty [3]	
14%	*14%*
Persons Age 65 or Older [3]	
13%	*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

Area hospitals have strengthened their ability to provide profitable specialty services such as cardiology, oncology and orthopedics.

Competition Intensifies as Hospitals Strengthen Specialty Care

Greenville's hospital systems have remained financially sound and powerful in the local market over the past two years. Steady population growth has kept most hospitals operating at full capacity, strengthening their negotiating leverage with health plans and physicians. After a failed merger attempt among three of the region's largest hospital systems in 1996, hospitals have concentrated on relatively distinct submarkets generally defined by the municipal boundaries of Greenville, Spartanburg and Anderson. Historically, the competition for patients across these submarkets has been fairly limited, and Greenville Hospital System (GHS) has been the dominant local provider of tertiary care and other specialty services.

Since 1998, however, most area hospitals have strengthened their ability to deliver profitable specialty services such as cardiology, oncology and orthopedics. Consequently, hospitals have begun to compete more aggressively for patients and revenue in these services. Spartanburg Regional Healthcare System, for example, built a new cancer center and increased its capacity to perform cardiac surgery. Spartanburg's other major hospital, Mary Black Memorial Hospital, recently formed an alliance with a national oncology service provider to expand the hospital's cancer services. Similarly, Anderson Area Medical Center received state approval to open a cardiac surgery center.

During this same period, Greenville's Bon Secours St. Francis Hospital opened new cardiac surgery and bone marrow transplantation centers and received state approval to provide an expanded array of neonatal intensive care services. These new services were expected to improve the hospital's competitive position relative to the nearby GHS, which has continued to offer deep discounts to health insurers that exclude St. Francis from their networks. These exclusive contracts have remained in place despite the expanded array of services available at St. Francis, helping GHS to retain its dominant position in the market.

Historically, state certificate-of-need (CON) regulations have restricted competition in the provision of tertiary care services such as cardiac surgery and oncology, but the area's steady population growth has prompted the state to approve recent hospital requests to expand service offerings. There has been little evidence to suggest that recent service expansions have resulted in unnecessary duplication and excess capacity, as some local employers and health plans feared. To the contrary, many observers expected the recent expansions to help alleviate emerging capacity constraints caused by the region's population growth.

Providers Discontinue Preparations for Managed Care

While expanding specialty services, Greenville-area providers have discontinued efforts to prepare for risk contracting with health plans. Before 1999, most hospitals in Greenville were actively purchasing primary care practices across the region and investing in care management and quality-improvement initiatives—activities that were designed to help hospitals attract and manage risk contracts with health plans. Providers that experimented with risk contracting, however, found these arrangements to be unprofitable given the area's limited HMO enrollment, low capitation payments and the high overhead costs associated with managing these contracts. Consequently, most providers have lost all interest in risk contracting. For similar reasons, Greenville's only provider-sponsored health plan, HealthFirst, was dissolved by its three hospital owners at the end of 1999 after only two years of operation.

Because risk contracting failed to develop, hospitals have slowed their drive to acquire primary care capacity over the past two years. Moreover, some hospitals have scaled back efforts to develop care management initiatives designed to reduce utilization and improve service delivery. In 1998,

several of Greenville's leading hospital systems had begun to develop and implement such initiatives for complex and high-cost medical conditions. According to hospital administrators, some of these programs could not be sustained financially because health plan contracts did not reward hospital efforts to prevent readmissions and improve outpatient recovery. A few care management initiatives have continued to operate in hospitals—such as Spartanburg Regional Healthcare System's programs for congestive heart failure and diabetes—but efforts to expand these programs to new disease areas have been suspended. Some community leaders have become concerned that local providers no longer face significant external pressures to improve the quality and efficiency of clinical practice.

Physician-Hospital Relationships Remain Strong

Physicians have remained tightly aligned with Greenville-area hospitals, despite the hospitals' waning interest in building primary care capacity. During the mid-1990s, hospitals pursued close relationships with physicians to prepare for risk contracting, either through physician-hospital organizations (PHOs) or by acquiring physician practices. By 1997, nearly 75 percent of Greenville's primary care physicians were employed by hospitals, and most hospitals had developed active PHOs. Though no longer focused on risk contracting, many of these arrangements have remained intact and have become important vehicles for exercising negotiating leverage with health plans.

Indeed, most Greenville-area hospitals have succeeded in negotiating substantial payment increases from health plans over the past two years, and plans have attributed these successes in part to the tight alignment between physicians and hospitals. For example, GHS has continued to employ nearly 180 physicians in both primary care and specialty disciplines, helping the system to remain an indispensable provider in health plan networks. Similarly, Spartanburg Regional Healthcare System's PHO, Regional HealthPlus, has become an important vehicle for both HMO and PPO contracting. Because the hospital and its participating physicians share financial risk through a withhold arrangement, the PHO reportedly is able to negotiate fee-for-service payment rates collectively on behalf of the participating providers without raising antitrust concerns.

To date, the only Greenville-area hospital that has decided to sell its physician practices is St. Francis. This hospital has not been successful in using its 20 primary care practices and 75 employed physicians to gain negotiating leverage with health plans, largely because two of the state's largest plans exclude it from their networks to obtain discounts from GHS.

Physicians have found few nonhospital-based strategies for exerting their leverage collectively in the Greenville market. Large independent physician groups have remained absent from the Greenville area since the demise of Carolina Multispecialty Associates (CMA) at the end of 1998. CMA had been organized several years earlier to participate in risk contracts with health plans, but its administrative infrastructure proved too costly to sustain once these contracts failed to develop in the market. With CMA's demise, several small single-specialty groups have gained negotiating leverage with plans and hospitals because of their local dominance in specific lines of service.

Some of these single-specialty groups have developed independent outpatient surgery and imaging facilities that potentially could compete with hospital-based services, but so far these ventures have remained limited in scope and scale. Greenville-area hospitals generally have been successful in using the state's CON regulations to block competition from freestanding facilities. However, hospital administrators expressed concern that proposed changes to the state's CON regulations could allow more of these facilities to develop, ultimately compromising the financial viability of hospitals by stripping away profitable specialty service lines.

Health Insurance Status

Greenville	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	
13%	*15%*
Children under Age 18 with No Health Insurance [1]	
9%	*11%*
Employees Working for Private Firms that Offer Coverage [2]	
88%	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	
$158	*$181*

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

Health System Characteristics

Greenville	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	
2.8	*2.8*
Physicians per 1,000 Population [2]	
1.7	*2.3*
HMO Penetration, 1997 [3]	
8.4%	*32%*
HMO Penetration, 1999 [4]	
13%	*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

Premiums for HMOs have risen sharply over the past two years and have become comparable to the premiums charged for PPOs.

HMOs Fail to Gain Ground

HMOs have not gained substantial market share in Greenville's PPO-dominated health insurance market over the past two years. Blue Cross Blue Shield of South Carolina has remained the dominant insurer, with approximately 40 percent of the commercial market, largely because of the popularity of its PPO. One reason that HMOs have not grown as expected is that they have been unable to offer purchasers and consumers substantial cost savings over PPOs. Health plan administrators indicated that their short-lived experiments with risk contracting were not effective in containing HMO costs because many of the area's high-cost providers declined to participate in such contracts. Moreover, because HMO enrollment and physician supply have remained low in this market, many providers have become unwilling to offer larger discounts to HMO products than to PPO products. As a result, premiums for HMOs have risen sharply over the past two years and have become comparable to PPO premiums.

In an effort to attract additional HMO membership, several health plans have introduced new direct-access HMO products that do not require referrals for specialty care. Three of Greenville's largest insurance carriers have launched some variant of this product over the past year, largely in response to the success that one plan experienced with its direct-access HMO during 1998 and 1999. That success has contributed to a modest growth in HMO enrollment over the past two years—from 11 percent of individuals with private insurance in 1998 to 14 percent in 2000. The emergence of direct-access products, however, has blurred the distinction between HMO and PPO products. Benefits, product features and premiums have become remarkably similar across these once-distinct product lines.

As HMOs and PPOs have converged in product design, HMOs have ceased to function as low-cost health insurance options for small businesses and other purchasers challenged by rising premiums. In response, several plans have stepped up marketing of lower-priced HMO and PPO products that have higher deductibles and coinsurance levels for enrollees or that use partial self-insurance arrangements that require employers to cover a greater share of health care costs. Examples include products that require enrollees to pay 30 percent or more of each claim, and minimum premium products that require purchasers to pay all claims below an established amount. Some observers expressed concern that these types of products could leave consumers and small businesses with inadequate insurance benefits, while others believed that few employers would purchase such products.

Small Businesses Struggle with Escalating Premiums

Mirroring national trends, employers in the Greenville market have experienced significant premium increases over the past two years. Large employers have not responded to the premium increases with major changes in their health benefits programs as yet. Small employers, however, have faced more extreme premium increases than their larger counterparts, and some have begun to drop coverage for their employees' dependents.

Many community leaders expressed concern about the rapid decline in the number of insurance carriers offering affordable products to small businesses. Although six carriers offer health insurance products to businesses with fewer than 50 employees, employers considered only three of these products to be affordable. Insurance carriers have incurred large financial losses in the small group business line in the past two years, and 17 plans have withdrawn from the state's small group market since mid-1997. Many respondents blamed the 1996 federal Health Insurance Portability and Accountability Act (HIPAA) for considerable turmoil in the small group market. However, the fact that 46 insurers remain in this market

statewide suggests that exits were precipitated in part by an overcrowded market.

The Greater Greenville Chamber of Commerce and the newly formed Business Council of South Carolina are each taking steps to gain relief for small businesses in purchasing health insurance. The Chamber of Commerce is working to amend state laws that limit businesses' ability to develop associations that enhance purchasing power in the insurance market. In particular, it seeks legislation to allow small business associations to pool risk under a single contract with insurance carriers, create risk tiers for different types of association members and design and purchase customized health insurance products.

In a separate effort, the Business Council of South Carolina is attempting to increase membership in its newly formed purchasing association. Additionally, the organization is encouraging state officials to develop a high-risk insurance pool demonstration program that would provide state-subsidized coverage for small businesses unable to obtain coverage in the private market because of their high claims experience. It is unclear whether this program will go beyond the proposal stage, however, because of growing state budget pressures.

Community Mobilizes Support for Expanding Safety Net

The Greenville community has continued to expand access to care for underserved populations through partnerships among safety net providers and other community organizations. After significant gaps were identified four years ago, the United Way organized a community-wide needs assessment that found that more than 10 percent of residents were uninsured, and another 20 percent were underinsured or otherwise medically underserved. The assessment triggered several capital improvement efforts to expand local capacity to care for individuals who lack access to medical care providers. Greenville's two community health clinics renovated their facilities and expanded clinical services, and several Greenville-area hospitals committed funds to provide ongoing support for these improvements.

Efforts to expand the capacity of Greenville's safety net have continued over the past two years, with a special focus on coordinated, community-wide efforts to improve access to care. As an outgrowth of the 1997 assessment process, local organizations formed the Community Health Alliance (CHA) in 1999 to bring together a broad range of organizations interested in improving access to health care, including health, civic, business and faith-based organizations. The CHA has coordinated efforts to develop satellite community clinics in areas underserved by medical care providers. It is also working to increase the amount of charity care delivered by local physicians, in part by establishing a community-wide database to recognize and monitor physician charity care. Most recently, the CHA has undertaken a study of the health insurance benefits offered by small businesses in hopes of designing a local program to provide coverage to the uninsured employees of these businesses.

Despite recent successes, safety net providers remain concerned about access to care for the uninsured and underserved. Inadequate public transportation has continued to pose barriers to health care for many low-income Greenville County residents. In 1996, the Greenville Transit Authority was forced to reduce hours and service areas because of funding shortfalls. Community organizations subsequently pieced together a medical transportation network using public and private funding, but local policy makers have failed to adopt a permanent solution to Greenville's transportation problems. At the same time, rising health insurance premiums have raised fears among safety net providers that private insurance coverage has begun to erode and threatens to overwhelm the community's recent successes in expanding care for the underserved.

Despite recent successes, safety net providers remain concerned about access to care for the uninsured and underserved.

Recent expansions in state health care programs have bolstered insurance coverage in Greenville and statewide, but a looming state budget crisis in South Carolina has created uncertainty about the sustainability of these expansions.

Medicaid Program Faces State Budget Pressures

Recent expansions in state health care programs have bolstered insurance coverage in Greenville and statewide, but a looming state budget crisis in South Carolina has created uncertainty about the sustainability of these expansions. In 1997, South Carolina's Medicaid/SCHIP expansion for children, Partners for Healthy Children, which covers children in households with incomes up to 150 percent of the federal poverty level, brought in nearly 150,000 new Medicaid/SCHIP enrollees statewide—almost twice the number that had been expected. As a result of this new enrollment and other recent expansions in Medicaid benefits and coverage, the state's Medicaid expenses exceeded its year 2000 budget.

As a stopgap measure, South Carolina used funds from its settlement with the tobacco industry and other nonrecurring state funds to address the budget shortfall. However, this funding will not be available to meet the state's financial obligations in subsequent years. As a result, the state faces a Medicaid funding deficit that could reach $300 million in 2001.

Despite the threat of a state health care financing crisis, South Carolina's policy makers have remained cool toward health care cost-containment strategies that rely on managed care. The state has chosen not to implement a program of mandatory HMO enrollment for Medicaid recipients, and it has allowed enrollment in its voluntary Medicaid managed care program to remain low over the past four years. Statewide, only one plan currently participates in the voluntary program, and most Medicaid recipients have chosen to remain in one of the program's enhanced fee-for-service options. The Greenville area has been without a Medicaid HMO since the now-defunct HealthFirst plan discontinued Medicaid participation in 1998.

South Carolina's Medicaid program has continued to struggle with low levels of private physician participation—a problem that could be exacerbated if the state's budget shortfall leads to Medicaid payment cuts. Fee-for-service physician payments under Medicaid have remained low, discouraging physician participation in a community already underserved by private physicians. Greenville's safety net providers, therefore, have remained primary sources of care, not only for uninsured populations, but also for those covered by Medicaid. Consequently, the state's looming budget crisis has generated concerns about the financial stability of Greenville's safety net providers.

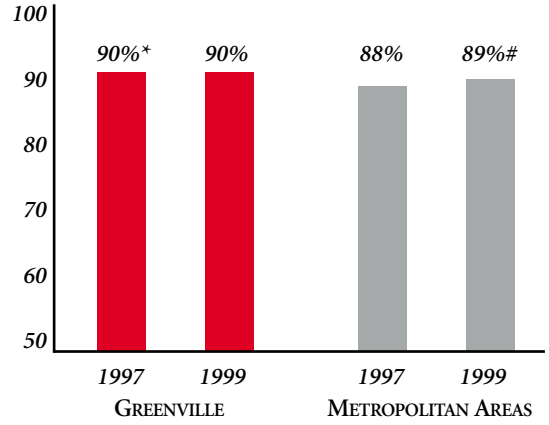
Issues to Track

Greenville's hospitals have strengthened specialty services over the past two years, while safety net providers have expanded capacity to provide care for the uninsured and other underserved populations. Rising health care costs, however, have threatened to erode private health insurance coverage at a time when South Carolina's publicly funded insurance programs face substantial budget shortfalls. These developments raise new questions about how health care delivery and access to care in Greenville may change in the future:

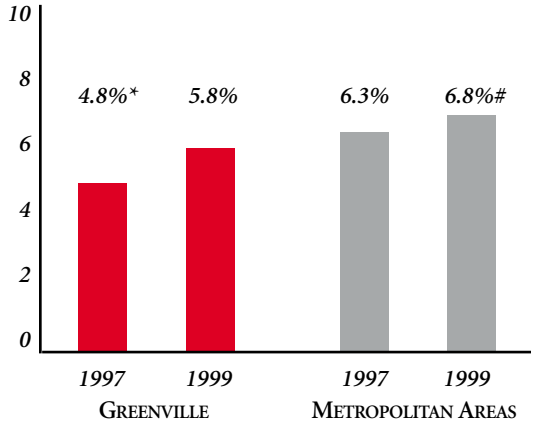
- Will safety net providers be able to meet the needs of the area's uninsured and publicly insured—given booming population growth and the expected erosion of small businesses' provision of health insurance?
- How will growing hospital competition for specialty services affect health care costs, quality and access?
- Will efforts to develop health insurance purchasing associations be successful in containing premiums and improving insurance coverage among small businesses?
- How will state budget pressures affect eligibility, benefits and provider payments under the state's Medicaid and SCHIP expansion programs?

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

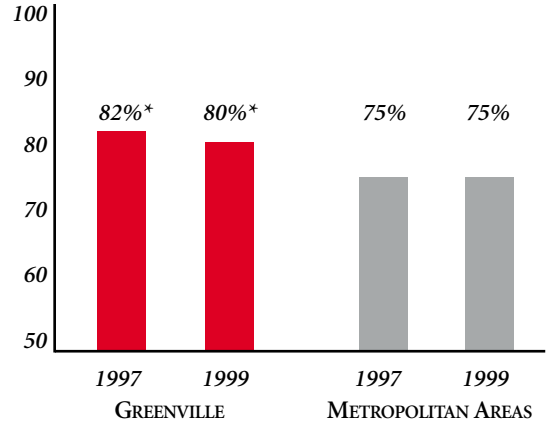
Persons Satisfied with the Health Care They Received in the Last 12 Months



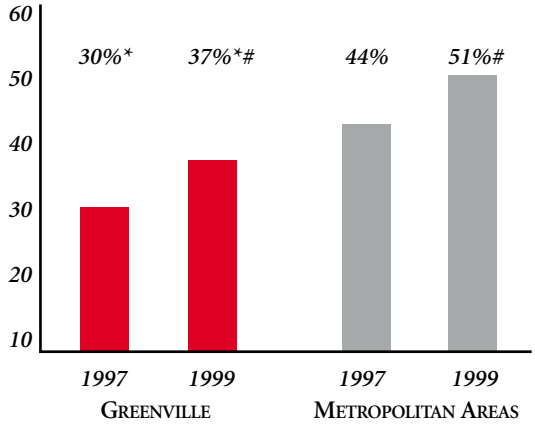
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



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 Greenville Community Report:
Glen P. Mays, Mathematica Policy Research, Inc.
Sally Trude, HSC
Lawrence P. Casalino, University of Chicago
Patricia Lichiello, University of Washington
Bradley C. Strunk, HSC
Jeffrey J. Stoddard, 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

HSC, funded exclusively by The Robert Wood Johnson Foundation, is affiliated with Mathematica Policy Research, Inc.

CENTER *for* STUDYING HEALTH SYSTEM CHANGE