COMMUNITY SNAPSHOTS PROJECT

Columbia, S.C.

Site Visit Report

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Overview

Long accustomed to their roles, players in the Columbia, South Carolina, health care market now face challenges from outside ideas, outside concepts, and outside players. Market participants have heard and read about national changes in the way health care services are financed and delivered. They do not welcome such change coming to their market from beyond its borders, and they do not want such change to alter their long-practiced and long-held market roles. In an effort to keep up with health system reform, while preventing such reform from being forced upon them by outsiders, players in the Columbia market are taking tentative steps toward health system integration and managed care.

The new activity in the Columbia market is being generated by players acting independently of one another, with little alignment across health care sectors and no leadership from the public sector or the community. Hospitals are developing alliances with one another in an effort to increase market power through an appearance of collaboration while protecting and promoting each facility's individual identity. Physicians are joining provider networks to protect and expand their client base, but they are not prepared for the changes that participating in a managed care environment might bring to their practice patterns. In an effort to capture market share, insurers and health plans are developing managed care products that look like indemnity insurance. Acting independently, these sectors are on the verge of coming together to create integrated delivery systems, but they are not quite there. What they have achieved thus far is an appearance of system integration that they hope will discourage bearers of health system reform—such as national managed care plans—from approaching the area. Each sector is also counting on the new system to protect its long-held market share and deep-rooted market role.

The Columbia market comprises four counties in central South Carolina: Richland, Lexington, Newberry, and Fairfield. This area of the state is referred to as the Midlands. About 15 percent of South Carolina's 3.6 million people (1994 base year) reside in the Midlands, and nearly 20 percent of Midlands residents live in the city of Columbia in Richland County. Columbia was established in 1786 as one of the first planned communities in the country.

The Columbia market is dominated by four large hospitals with a history of religious and social missions that have guided the health care services they provide, the way they provide them, and their financing and governance structure. Each hospital employs its mission as a way to define its role in the community and to maintain that role. As the hospitals have shifted their focus from patient needs (as expressed by their missions) to financial success, anxiety, strain, and mistrust have emerged within the provider community. At the same time, insurers and health plans are trying to expand their managed

care business independent of the hospital activity, neither leading the market nor following the hospitals' lead. Together, Columbia's hospitals, physicians, insurers, and health plans have created a new environment of risk taking, and there is great uncertainty where this environment might take them.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

The four counties comprising the Columbia market have about 537,000 residents (1994 estimate). Nearly 90 percent of the population resides in the more urban Richland and Lexington counties, which are separated, in part, by the Congaree River. Although they are adjacent and have similar urban land uses, the two counties have dissimilar demographic profiles. Some study respondents suggest that the river is not only a geographic boundary but also symbolizes the differences in the population of the two counties: Richland (population 297,870) is almost evenly divided between people of white (56 percent) and African-American (42 percent) descent. The county has a small population of people of Korean, Vietnamese, and Hispanic descent, as well as Native Americans (of the Catawba Tribe). Across the river, Lexington (population 182,048) is predominantly (88 percent) white. Only about 11 percent of Lexington residents are African-American, and a very small proportion (about 1 percent) is of Asian or Hispanic descent.

Fairfield and Newberry counties have far smaller, more rural populations than their urban neighbors to the south (57,000 residents, combined). Fairfield County, bordering Richland, is the only county of the four that has a majority (about 58 percent) African-American population. The adjacent Newberry County, like Lexington County to the south, is predominantly white (65 percent).

The four-county region has experienced moderate population growth since 1990. Lexington County experienced the most growth, increasing by nearly 9 percent between 1990 and 1994 compared with the average 5 percent growth across South Carolina, and is expected to continue to outpace its neighbors over the next five years.

The greater Columbia region, which includes Columbia—the state capital and county seat—and Fort Jackson—one of the largest Army facilities in the United States, has a stable economy with a large public-sector employment base. The primary employment sectors are state and county government, including the University of South Carolina (USC), insurance, banking, and health care. The state is the largest public-sector employer; the largest private employers include Blue Cross and Blue Shield of South Carolina; Colonial Life and Accident; Carolina Eastman, a division of Eastman Chemical Company; Mack Truck, Inc.; and Policy Management Systems Corporation, an insurance

software firm. In the last 18 months, the Interstate 77 corridor through northern Columbia, Richland County, and Fairfield County has undergone substantial industrial and manufacturing development. The interstate connects Columbia to Charlotte, North Carolina.

White collar and manufacturing are by far the largest employment sectors in each of the four counties. Agricultural jobs comprise only between 1 percent (Richland County) and 4 percent (Newberry County) of total employment. They include timber farming (for national firms with headquarters outside the region) and truck crop harvesting by migrant workers. Lexington and Newberry counties also have large poultry (chicken and turkey) raising and processing operations.

Health System History

The history of the Columbia market is essentially the history of its four largest hospitals: Baptist Medical Center, Richland Memorial Hospital, Providence Hospital, and Lexington Medical Center. These are not-for-profit institutions with long histories in the market; Richland and Lexington are county hospitals, and Baptist and Providence are affiliated with religious organizations.

Baptist Medical Center began its life in the early part of the century as Knowlton Hospital, a small, privately owned facility. The South Carolina Baptist Convention purchased Knowlton in 1914 and renamed it South Carolina Baptist Hospital.[1] In 1994, Baptist Hospital essentially severed its ties with the Convention to gain more flexibility in governance, administration, and service provision. The medical center still is guided by its mission to focus on the mental, spiritual, and physical well-being of its patients, envisioning itself as a provider "driven by a vision of holistic health and challenged to serve the residents of this region with a spirit of Christian service."

Richland Memorial began in the 1920s as Columbia Hospital, the original public hospital for Richland County. In the late 1970s, after relocating the aging hospital in new facilities several years earlier, Richland's staff and services expanded through a strategic alliance with the then-new University of South Carolina (USC) School of Medicine. This began Richland's transformation from a small county hospital to a large, tertiary-care and teaching hospital. Part of Richland's mission is service to the entire community, in particular to the poor, who currently comprise about 40 percent of its patients. One interview respondent suggested that Richland adheres to the creed that hospitals are intended to be a community service vehicle, not a business.

[1]The Baptist Convention was founded in 1821 and consists of members of the state's 1,850 Baptist churches who work cooperatively for mission and evangelism purposes.

Providence Hospital was founded in 1938 by the Sisters of Charity of St. Augustine, a Catholic order headquartered in Cleveland, Ohio. The Sisters' philosophy of health care, which has been the mission of Providence Hospital, is "to meet the needs of the times by an expression of Christian concern for sick, suffering and dying; to manifest love, truth and justice in health care; and to promote the advancement and application of new knowledge about health care." In May 1995, the Sisters signed a letter of intent for a joint venture partnership between four of the order's hospitals, including Providence, and Columbia/HCA Healthcare Corporation. The business venture, which was approved by the church in late October 1995, brings together a private, not-for-profit hospital with a for-profit health services corporation.

Lexington Medical Center, the youngest of the four hospitals, was created in 1971 as Lexington County Hospital. Prior to this, Lexington County had been the largest county in South Carolina without a hospital. Two referenda in the 1960s to build a hospital were defeated, the result of a dispute between urban/suburban and rural advocates about location. Ultimately, the hospital was located in the city of West Columbia; it has expanded its services and facilities over the last 20 years and has added clinic sites in rural parts of the county. The medical center is now the largest employer in Lexington County.

The history of the Columbia health care market also includes a tradition of indemnity insurance. The region, as well as the state, has a long history with indemnity insurance and a short history with managed care. Blue Cross and Blue Shield of South Carolina is the oldest and largest health insurer in the state. Until about six years ago Blue Cross and Blue Shield primarily sold indemnity insurance. Since then, the insurer stopped selling such products—while continuing service on its existing contracts—and shifted its market focus completely to managed care products, including health maintenance organization (HMO) and preferred provider organization (PPO) products.

HMOs entered the Columbia market in the mid-1980s. Blue Cross and Blue Shield formed Companion HMO in 1984, and in 1985 a group of local physicians formed Physicians Health Plan. Both organizations faced challenges in the first few years as they adjusted to the new financing and service provision structures they were developing to implement managed care. Since these first plans entered the market, HMO growth in the region and in the state has been fairly slow. Currently, seven HMOs operate in South Carolina, only one of which is not headquartered in the state.

▼ ▲ ▼ Health System Changes

Public Policymakers

Historically, the public purse has most influenced the evolution of Columbia's health care system. The growth of Medicare in the 1970s and 1980s spurred significant growth in the size and services of area hospitals, and Medicaid disproportionate share funds made substantial contributions to the success of many of them.

Many interview respondents suggested that race and religion have traditionally played important, although seldom publicly acknowledged, roles in both public and private policymaking in the state. These respondents did not cite particular events or policy initiatives to explain their observation; instead, they explained that attitudes and beliefs about race and religion permeate the culture of South Carolina, including Columbia and its health care system. Issues such as financing and providing social and health care services for low-income, uninsured people and whether and what kind of family planning services are provided by the state and by private institutions are influenced by the attitudes and beliefs of the people making policy decisions. That attitudes and beliefs affect the decisions of policymakers is, of course, not unique to South Carolina or Columbia. The respondents felt, however, that it is important to understand that in Columbia, which is in the "deep south," race and religion are dominant influences, fundamental to the character of their community.

The state had been relatively quiet on health policy issues until 1992, when Governor Carroll A. Campbell (R) took an interest in health system reform. Campbell's interest was advanced by his chairmanship of the National Governor's Association and his reported desire to hold national office. In that year, Campbell inaugurated the Palmetto Health Initiative, an application to the federal Health Care Financing Administration for a waiver of Section 1115 of the Social Security Act. The waiver would have allowed the state to implement mandatory capitation for its Medicaid population and expand the number of people covered.

The initiative brought mixed reaction from players in the Columbia market. The potential of several hundred thousand more people in a mandatory capitated program inspired at least seven new applications for HMO licenses in the state, some filed by health care plans beyond the state's borders. This was a concern to local provider networks and health plans, which were not interested in sharing this market with new entrants. Hospitals were concerned about losing disproportionate share funds, which would have been redirected from hospitals into purchasing a full range of health care services for uninsured and partially insured citizens. In response to these pressures, Richland Memorial Hospital, the recipient of the largest amount of disproportionate share funds in the region, created a coalition of public and private health care

purchasers and providers intended to develop and market a risk-bearing product to provide services to the poor.

Ultimately, the state retreated from its waiver application, but this presence of public policy in the health care market was only interrupted, not extinguished. In the second half of 1995, the state redesigned the mandatory nature of the initiative to allow voluntary participation by Medicaid clients beginning in January 1996. Repercussions of this shift from a mandatory to a voluntary program among health plans inside and outside the state, as well as with Richland's hospital-purchaser coalition, all of which wanted a portion of the program, were unknown in June 1995. Some observers suggest that local health plans might have had a part in the initiative's demise through their access to the legislature. In late June one interview respondent compared the status of the waiver program to Snow White: "Is she dead or is she sleeping?"

In 1994, Governor Campbell appointed two committees to investigate health care issues in the state. The Committee on Health Reform was charged with examining the advantages and disadvantages of several possible health reform initiatives, including voluntary health insurance purchasing cooperatives, health insurance rating changes, and medical savings accounts. The committee's recommendations, combined with the interest in HMOs brought about by the Palmetto Health Initiative, spurred the legislature and the governor to create an ad hoc subcommittee to evaluate the state's 20-year-old HMO regulations. This subcommittee, which includes legislators, employers, representatives of the insurance industry, state agencies, and providers, is conducting a comprehensive review of South Carolina law and regulations concerning health insurance, HMOs, managed care, and provider networks.

Since the November 1994 legislative elections, South Carolina health policy has been fairly quiet. The state now has a first-term Republican governor who campaigned for smaller government and privatization. The state also has, for the first time since Reconstruction, a Republican House of Representatives. Health care is not one of the governor's primary issues and no burning issues on health care are before the legislature. Consequently, in spite of the work of the subcommittee, very little activity is expected in this arena, at least in the near future.

According to several respondents, it is possible that health care policy in South Carolina will not remain quiet. The state has just completed a two-staged restructuring of its government into a cabinet form; the agency heads will now report to the governor, rather than to commissions and boards jointly selected by legislators and the governor. The Health and Human Services Finance Commission, the state agency responsible for the Medicaid program, will become the Department of Health and Human Services. This change in structure is causing concern among agency personnel, legislative staff, and

consumer advocates, who see the transition as a dramatic and potentially alarming shift in the traditional power structure.

Purchasers

Employers and Employer Coalitions

Employers in the Columbia market are happy with recent cost trends, but do not necessarily understand their source. They have watched their health care premiums shift from a 25 percent annual increase two years ago to a 10 percent decrease over the last year, primarily without any action on their part. Many interview respondents assert that employers do not understand the benefit plans being marketed to them; they are simply passive purchasers, reaping cost savings that they did not necessarily seek. Columbia has no business coalitions, and the Chamber of Commerce is not active in the health care arena. Employers, for the most part, are not a force for health system change.

Out-of-state employers, such as Carolina Eastman, have had some influence on the Columbia market, as have some of the larger employers that self-fund their employee health coverage. Multi-state companies with branches in the region generally want to offer consistent health care benefits across their workforce, regardless of location, and some self-insured employers have begun to seek greater efficiencies from providers. In response, insurers, health plans, and provider networks in the Columbia market are developing products to address the benefit needs expressed by these employers. They are marketing these products to other local employers as well, which has led start-up plans and provider networks to create similar, competitive products.

The state has not been a force for change in the Columbia health care market even though it is the largest participating employer. Through the Office of Insurance Services, South Carolina purchases health care for about 306,000 people, approximately 60 percent of whom are current or retired employees. The state self-funds the products it offers, which include the State Health Plan, a PPO for which Blue Cross and Blue Shield provides administrative services, and up to three HMOs per defined service area. The PPO includes about 94 percent of practicing physicians statewide, and the state selects HMOs annually based on their provider panel (not on their price). The employee share of premium for the state's PPO and the participating HMOs is the same (set by the legislature). This uniform premium among insurance products, combined with the wide provider panel in the PPO, offers little incentive for employees to choose an HMO—and only about 12 percent have.

When it created the State Health Plan provider network, the state developed a provider fee schedule based on usual and customary provider

charges up to that time. According to several respondents, these charges to the state had been quite a bit higher than market rate. The share of the premium for employees and employers (such as state offices, universities, and the schools) for the Plan and the HMOs has been constant over the last three years. Consequently, employees have not pressured the state to reduce premium costs. The state in turn has not turned to providers for reduced service costs. Pressure to reduce costs likely would come from the legislature as a budget reduction measure, which does not appear to be imminent.

State and Local Government as Purchasers for Low-Income People

Medicaid clients across South Carolina have trouble finding a medical home. Although the Columbia area has numerous health care providers, Medicaid clients have limited access to health services. Richland Memorial Hospital has traditionally provided services to the largest proportion of the market's Medicaid clients and uninsured residents because of its central location in Columbia, its broad range of services, and its teaching hospital function. With the exception of Richland, Medicaid clients in the market usually find better access at community hospitals or health centers in the surrounding rural communities.

South Carolina's current Medicaid program is traditional fee-for-service. It provides health care services to between 10 percent and 12 percent of the population in any month; the largest group of recipients are those with incomes below 100 percent of the federal poverty level. The state had sought to restructure the program through the Palmetto Health Initiative to improve access, increase the number of people covered, and reduce costs. The state's Section 1115 waiver would have provided each Medicaid client with a primary care provider through fully capitated plans or a partially capitated enhanced physician program (primary care case management).

Providers

Hospitals

Hospitals in the Columbia market are talking about and experimenting with new alliances, mergers, and networks among themselves and with other health care providers. They are beginning to buy primary care practices and hire primary care physicians. They are contemplating collaborating with insurers and are flirting with starting their own managed care plans. But the impetus for this talk and experimentation is neither obvious nor clear cut.

The Columbia market has considerable duplication of services and an excess of beds (possibly as high as 40 percent). The number of inpatient days is decreasing, and hospitals face the possible elimination of disproportionate share financing. In response to these pressures, Richland Memorial and Lexington Medical Center initiated reengineering processes that will redefine the services they provide, the way they are provided, and the providers (staff

reductions are possible). The goal is to reduce costs, enhance patient satisfaction, and protect and increase market share. Baptist Hospital contracted with a national consulting organization and has implemented more than half of 33 cost savings recommendations that affect the health care products the hospital offers and alter the way the hospital uses medical products and equipment. To many interviewed for this analysis, however, the changes occurring within Columbia's hospital community cannot be fully explained by market forces.

The most frequent explanation given for the hospital activity is fear that changes coming from the federal government and increased enrollment in managed care will disrupt the long-standing power structure of the market. Hospitals are particularly concerned about the large HMOs outside the state, waiting for the right opportunity to cross the border. This concern is leading the hospitals to work with others in the market to invent their own versions of managed care. If these home-grown arrangements do not prevent national plans from gaining entry, the strategic alliances being formed among providers should at least position them to survive capitation.

Two alliances have emerged from Columbia's hospital activity: a collaboration between Richland Memorial Hospital and Lexington Medical Center and a collaboration between Providence Hospital and Baptist Medical Center. The Richland/Lexington alliance, which unites a large, tertiary care facility with a broad portfolio of services with a smaller, general hospital with a primary care base, will take the form of a series of collaborative programs.

Richland Memorial is an urban, public hospital licensed for 649 beds. It provides the largest proportion of Medicaid-financed care and the most trauma care in the market. Richland has a large cardiac care practice that competes with Providence Hospital. Richland is also a teaching facility for the USC School of Medicine. Of the four large hospitals in the Columbia market, Richland has the broadest portfolio of services. Lexington, with 292 licensed beds, is a smaller, suburban general hospital with a strong primary care focus. Lexington provides far less indigent care; it does not receive federal funds for such care. Lexington has few Medicaid clients, partially because the hospital's affiliated primary care physicians provide emergency room services to their patients only.

The first collaborative program between the two hospitals is Carolina HealthChoice Network, incorporated in March 1994. Carolina HealthChoice is a network of hospitals that includes Richland, Lexington, and seven community hospitals from counties surrounding Columbia. The network is financed by 1.5 percent of each participating hospital's net revenue. Together, the nine participants represent all the acute care hospitals, except Providence and Baptist, in a 10-county region. The network has not yet taken any action in the market, but the intent of the participating hospitals is to strengthen their referral network and retain market share. The network is considering

setting up a regionwide management services organization (MSO) for primary care practices and entering a joint venture partnership with an insurer. The network intends to be in a position to accept full capitation, if necessary.

The alliance between Providence and Baptist hospitals is limited currently to forming Premier Health Systems in August 1994. Premier is a jointly owned physician-hospital organization. Providence, with 239 licensed beds, brings to this venture specialty heart care: 70 percent of the care provided by Providence is in cardiovascular services. This specialty gives the hospital a statewide market. Providence also has one of the largest eye surgery centers in the state. Baptist Hospital brings a broad-based general hospital that aligns itself in the Columbia market as a direct competitor with Richland. Baptist has 524 beds and is strong in obstetrics, gynecology, and maternity care. Providence and Baptist want Premier to unite them with local physicians to retain and expand market share. The organization's first product is a statewide PPO. Premier is still relatively small, having contracts with 22 hospitals, 690 physicians, and 3 skilled nursing facilities. Premier plans on developing products that accept capitation, if necessary.

In late 1994 and early 1995, after Premier was launched, Providence and Richland Memorial began to discuss the possibility of a strategic alliance of their cardiovascular programs. A combined program would have reduced duplication between the hospitals, increased efficiencies, and potentially increased market share for both; it also would have created the tenth largest cardiology center in the nation. The May 1995 letter of intent between the Sisters of Charity of St. Augustine and Columbia/HCA, however, allowed the for-profit national firm to buy 50 percent of Providence. As a direct consequence, Providence withdrew from the discussions with Richland.

The Columbia/HCA deal with the Sisters of Charity will entail an equity buyout of Providence. Columbia/HCA will provide cash to retire the hospital's debt and buy 50 percent of its buildings. Providence employees will become Columbia/HCA employees, and Providence will be managed by the national company. The effect of this deal on Premier Health Systems and on other collaborative programs Providence and Baptist were considering (including collaborations in cardiology and eye care) is uncertain. Both hospitals are optimistic that their efforts will be accepted by the for-profit entity.

All four large hospitals in the Columbia market are strengthening their primary care service provision. Lexington and Richland hospitals, in particular, are restructuring their relationships with their primary care practitioners. Lexington, Richland, and Baptist are actively purchasing primary care practices, and all four hospitals are exploring ways to form physician-hospital organizations that can accept capitation and allow them to offer their own managed care products.

Whether the on-paper transformation of an individual hospital into an integrated provider system will transform hospital and physician administration

and clinical practice is not clear. The hospitals have not yet considered functioning as a key component of an integrated system, rather than as a dominant, independent force at the apex of a health care ladder—a place to which all patients come and all health care practitioners turn. This is a reflection of the hospitals' historic dominance in the market and their strong service missions that supported such dominance. The hospitals appear to be using their missions to help them develop and implement networks and collaborative programs that they hope will protect their position in the market and allow them to continue their quality and service traditions.

Physicians

The activity generated by Columbia hospitals as they prepare for managed care and capitation has shaken up the customary rhythms and patterns of physicians' practices. Primary care and specialist physicians are excited, nervous, scared, or angry, depending on who is being asked. Most physicians are not entirely convinced that the changes are necessary but feel that they must follow the hospitals' lead and reorganize to fit the new structures or be left behind, without patients or a practice. Some market participants suggest that Columbia-area physicians are not knowledgeable about managed care and capitation contracts, however, and could be making decisions without enough information.

Many interview respondents feel that primary care physicians are in a better position than the specialists. This trend is not unique to Columbia and is being played out in this market in much the same way as in other markets across the country. Hospitals are buying some primary care practices and are seeking alliances with others. Primary care physicians are holding out as long as they can, anticipating that their incomes and influence will go up as they become more valuable to the emerging hospital networks. Specialists are anxious, envisioning their power and influence in decline and unsure whether the devil they know—the hospitals—would be a better employer than the devil they don't—primary care physician groups.

Physicians in the Columbia market have historically been an independent group, working in individual private practices and usually forming relationships with more than one of the four large hospitals. Group practice has generally meant two or three physicians working together. Large physician groups have been scarce, and large multi-specialty group practices do not exist. Exclusive arrangements between physicians and hospitals are still rare, but they are growing as the hospitals begin to purchase physician practices.

Two large physician groups have practiced in the market since the 1980s: the South Carolina Heart Center, created in 1989, and Doctor's Care, a chain of clinics created in 1981. The Heart Center is the largest for-profit, physician-run business in South Carolina, employing 13 physician specialists. Cardiology is a very competitive specialty in this market; Columbia Cardiology Associates, affiliated with Providence Hospital, and the Columbia Cardiovascular Clinic,

affiliated with Richland Memorial Hospital, compete aggressively with the Heart Center. Both of these practices were developed in the early 1980s. Many health plans and insurers are interested in the Heart Center, which is actively seeking capitated contracts. Although the Heart Center's owners are not interested in Columbia/HCA, more than 50 percent of the heart procedures for Providence Hospital patients are performed by the Heart Center, so some type of relationship with Columbia/HCA appears inevitable. The center also is creating a primary care independent practice association (IPA) that includes satellite rural clinics to strengthen its referral network.

Doctor's Care is the largest primary care network in the state. Its drop-in clinics provide routine medical (including preventive) care and diagnostic screenings, but the primary focus of Doctor's Care is for work-related (workers' compensation) injuries. Blue Cross and Blue Shield, which owns 42 percent of the network, believes that Doctor's Care will continue to grow as primary care physicians seek alliances and a guaranteed client base in an increasingly managed care environment. Doctor's Care has managed care contracts with Healthsource South Carolina, Inc., an HMO headquartered in Charleston, and Blue Cross and Blue Shield's Companion HMO. The chain is unaffiliated with any single hospital.

Physicians in the Columbia market are beginning to merge into larger groups and develop networks. They hope that if a group or network gets large enough, no health plan can come into the market without interacting with it. The new group creating the largest stir right now is Lexington Family Practice, a 12-person group of primary care physicians affiliated with Lexington Medical Center. The group is aggressive in the market and is not expected to align exclusively with any one hospital or hospital system.[2] Although Lexington Family Practice is putting itself in a position to negotiate for full capitation, health plans in the market are concerned that the group's approach to putting capital into reserves indicates that participating physicians are not ready for the financial risk they would be accepting.

Two new statewide provider networks are being created from a base in Columbia: Premier Health Systems, the joint venture PPO of Providence Hospital and Baptist Medical Center with about 690 physicians, and Physician Care Network (PCN), a 2,800-physician network created by the South Carolina Medical Association. These networks are younger and larger than other group practices in the Columbia market. The Premier PPO is a provider

[2]As an illustration of the importance of religion in the Columbia market, the mission of Lexington Family Practice commits the group to "Honor God, value our patients, respect each other, [and] support our staff."

network, not a risk-bearing health plan. By marketing to self-funded employers, however, Premier aligns itself in direct competition with health plans in the market, and it has contracted with several insurers. The PPO offers a discounted fee schedule and is focusing its marketing on small employers. PCN is a risk-bearing network and is actively negotiating for capitated contracts. PCN also contracts directly with employers and does not yet have relationships with any insurers or health plans.[3]

Safety Net Providers

Columbia's health care safety net includes community health centers, rural health clinics, and hospitals that provide care to underinsured and uninsured patients. Planned Parenthood of Central South Carolina also provides clinical reproductive health services to the public regardless of insurance and financial status, and the James R. Clark Sickle Cell Foundation, although primarily a social service and education organization, provides limited clinical services (primarily blood testing) to African Americans. Some of these safety net providers are watching as the hospitals in the market enter into alliances and joint ventures, wondering what the system changes will mean to them. Others, however, are moving energetically to position themselves as critical providers to the market so that they will be necessary whichever direction the health care system metamorphosis takes.

South Carolina has 30 community health centers (CHCs), many of which are rural health clinics. All but one of the CHCs are federally qualified health centers (FQHCs): the Eau Claire Cooperative Health Center, located in Columbia, is an FQHC look-alike. The FQHCs have the financial strength and coordination to have a significant lobbying voice in state government. Eau Claire, which became a look-alike to get cost reimbursement, joins itself to the others for their lobbying strength.

The Columbia market is served by both the Eau Claire Cooperative Health Center and Richland Community Health Care Associates, a CHC affiliated with Richland Memorial Hospital. Both provide services to Medicaid clients (between 55 percent and 58 percent of their client base) and Medicare clients (between 8 percent and 15 percent), as well as to patients with commercial insurance (HMO, third-party PPO, and indemnity) and patients with no insurance.

[3]After the snapshot interviews in Columbia took place in late-June 1995, PCN sold controlling interest to an out-of-state insurance company to improve its capacity to offer a broad array of managed care products.

The Eau Claire Cooperative Health Center has two clinics located in the Eau Claire-Greenview area of Columbia.[4] The Health Center for adult medicine and the Sterling Sharpe Pediatric Center serve a market within a 50-mile radius and refer patients to any of the Columbia-area hospitals, including Richland Memorial. Eau Claire is acutely aware of the current activity among the hospitals and physician providers and has developed an aggressive strategy to survive in the changing market. It will help as many people as possible, so that its services are so essential to the community that the hospitals and their emergency rooms cannot afford to let it fail. In carrying out this strategy, Eau Claire will build a third, family practice in the Oak-Waverly section of downtown Columbia, financed by a capital-based coalition with Providence Hospital and Baptist Medical Center.[5]

Richland Community Health Care Associates has three clinics located across the market area. The main clinic is located in rural Richland County, a second clinic is located in central Columbia and serves the homeless, and a third clinic is located in Columbia at the offices of the Department of Social Services (DSS). Richland Community is also aware of the activity in the market and is concerned that in the new environment, insurers and health plans will send the sickest patients to the CHCs by market skimming. Richland Community's strategy is to partner with hospitals besides Richland Memorial and to try to join as many HMOs as possible. Richland Community views Eau Claire as a collaborator, unless both organizations get squeezed by market activity and start fighting over clients.

The state Department of Health and Environmental Control (DHEC) has sites in all 46 counties in South Carolina. Health services are provided through 13 health districts; the Palmetto Health District comprises the four counties of the Columbia market. Palmetto provides clinical and health education services primarily to Medicaid clients and homeless people. Clinical services include immunizations, prenatal care, well baby care, early and periodic screening, diagnosis, and treatment (EPSDT) examinations, and family planning services.

DHEC is the largest home health care provider in the state. In 1994, DHEC altered an internal policy to encourage joint ventures and other innovative approaches to providing home health care to improve its revenue base. This opened the door for the Palmetto Health District to partner with local hospitals to provide such care. Palmetto is looking forward to finding other opportunities to develop such public-private partnerships within the Columbia

[4]The population of the service area is about 37,000, with a 75 percent minority population, a 23
percent poverty rate, and a 1:6250 physician:patient ratio.

[5]The service area population is about 13,000, with an African-American population of greater than 90 percent, a poverty rate of about 44 percent and a physician ratio of 1:13,000.

market's newly developing managed care environment, partly to develop revenue streams that otherwise might be lost as managed care enrollment grows. Palmetto also is developing partnerships with schools to provide health education services.

Richland Memorial Hospital spearheaded a coalition to create an integrated health care delivery system for Columbia's low-income, underinsured, and uninsured citizens. The coalition includes the Richland Community Health Care Associates, DSS, DHEC, and Companion HMO (the Blue Cross and Blue Shield HMO). Richland Community Health Partners will be one of the first public-private entities in the nation to develop a risk-bearing product that can negotiate for capitated contracts for providing services to the poor.

Academic Medical Centers

South Carolina has two medical schools: the Medical University of South Carolina (MUSC), located in Charleston, and the USC School of Medicine, located in Columbia. MUSC is the older, larger, and better financed of the two. Some in the health care sector in South Carolina feel the USC medical school is unnecessary because one medical school, MUSC, is sufficient for such a small state.

The USC School of Medicine was created as a result of a mandate by Governor John West in the late 1970s. The school's residency program is run by Richland Memorial Hospital—the hospital owns the residency program, while the school employs the faculty. Consequently, revenues generated by the residency program go to the hospital first; then the medical school and faculty are reimbursed. This is the only academic medical center in the country organized in this fashion.

The medical education program at Richland consists of about 200 residents and fellows. About 52 percent of the school's residents remain to practice in South Carolina, and about 77 percent of residents who go into primary care practice remain in the state. The hospital gets financing for the residency program from a consortium of seven teaching hospitals in South Carolina that allocates state funds from the Commissioner of Higher Education. This process has been in place since the late 1970s. In 1994, the consortium decided to finance only primary care residents. This will effect Richland, which has about 45 percent of its residents in specialty training. Although the effect of the consortium's decision on Richland's residency program is not yet known, the consortium might allocate dollars for only the primary care portion of Richland's specialty training.

USC and Richland Memorial are restructuring the residency program at the hospital to survive the current turbulence in the market and impending financial pressures. The two institutions have a symbiotic relationship that requires that they both survive any changes that occur within the Columbia health care system. The hospital is concerned about the potential for loss of

patients and of historic financing streams; the school is concerned about loss of accreditation and students. The provider networks forming in the Columbia market—including both hospitals and physicians—could result in patients shifting from Richland Memorial to other hospitals. Medicaid managed care also could divert Medicaid patients, which are generated by the residency program, from Richland, as more physician providers compete for such clients. If capitation increases in the Columbia market, funds for teaching and research also could decline, as such efforts represent added expense. Finally, if patient volume drops too much, the accreditation of certain USC programs could be in jeopardy.

In response to these pressures, the hospital is reorganizing its teaching clinic system over the next five years to place more emphasis on primary care. More teaching will be conducted in an ambulatory setting, and teaching will focus more on outpatient services, continuity of care, and longitudinal care of patients (gatekeeper training). More residencies will be located in community clinics. Depending on the direction of the market and the viability of financing streams, some specialty programs might be discontinued and others could be combined.

Insurers and Health Plans

The low penetration of managed care in the Columbia market and the work of local hospitals as they develop strategies to maintain market share and create managed care products have increased the competition among insurers and health plans. This sector is trying to push the market away from indemnity insurance and toward managed care plans. Competition among insurers and health plans has been based primarily on price, including offering multi-year price guarantees, and this will probably continue. But competition is moving to include comprehensiveness and quality of services offered.

Hospitals have been creating alliances and joint ventures that can offer or participate in managed care products. This activity dovetails with the insurer and health plan push, but the two sectors do not appear to be coordinating their efforts yet. They also do not seem to be overtly influencing one another. Instead, these two sectors appear to be observing what the other is doing and moving independently toward creating a managed care environment in the market.

About 80 percent of South Carolina's population is covered by either private (60 percent) or public (20 percent) health insurance. Estimates suggest that 35 percent of those covered by health insurance are members of PPOs, but since such plans are not regulated by the state, the Office of the Insurance Commissioner cannot develop accurate numbers of PPO enrollees. About 5 percent of state residents covered by insurance are enrolled in HMOs (figures quoted vary from 4 percent to 8 percent). The HMOs offered in the Columbia

market are Individual Practice Association (IPA) model; this means that the HMO has a network of private practice physicians with which it contracts to provide health care services for a negotiated fee. The balance of insured state residents are covered by indemnity insurance.

Insurers and health plans headquartered in Columbia consider their market to be statewide, as do plans located outside the Columbia region. This is largely because the state population is relatively small (3.6 million). Three managed care plans are local to the Columbia market: Companion, the Columbia-based Blue Cross and Blue Shield HMO; Healthsource South Carolina Inc., headquartered in Charleston with a branch office in Columbia; and Physicians Health Plan (PHP), a Columbia-based plan owned and managed by United HealthCare Corporation.[6] Combined, they cover approximately 200,000 people, about 30 percent of whom reside in the Columbia region.

Companion, Healthsource, and PHP are IPA-model HMOs. Companion has 2,200 physicians (out of approximately 6,000 in the state) and approximately 83,000 enrollees statewide. The plan uses primary care physician gatekeepers and is the only NCQA-accredited HMO in South Carolina. Healthsource South Carolina, Inc. (a subsidiary of Healthsource, Inc., a national company that operates affiliate managed care plans) also uses gatekeepers. The plan has 3,000 physicians and 77,000 enrollees statewide. Physicians Health Plan is a not-for-profit plan with 2,000 physicians and 41,000 enrollees in 44 of 47 South Carolina counties. PHP provides health care services to enrollees on a modified fee-for-service basis; a significant amount of its business is in an open-access (non-gatekeeper) IPA-model HMO.

Competition in the insurance sector of the Columbia market is shifting from the indemnity offerings of insurers such as Provident and Aetna to the managed care products offered by Healthsource and PHP. Blue Cross and Blue Shield still is the largest health insurance carrier in the state, with about 23 percent of the statewide insurance market and between 20 percent and 25 percent of the Midlands market. Blue Cross and Blue Shield is also shifting its focus to managed care and expects to offer a variety of HMO products, in addition to its Companion HMO, within the next few years. In a strategy that has upset the marketplace, Blue Cross and Blue Shield announced it will enforce its most favored nation (MFN) clause in all its provider contracts. This strategy guarantees Blue Cross and Blue Shield provider rates that do not

[6]On the day of the project team site visit, United Health Care announced it had purchased Metropolitan Life Insurance Co., making UHC the largest managed care company in the country.

exceed those paid by any other health plan. The move is risky, however, as Columbia-area providers perceive MFN as unfair and so are looking for other ways to maintain their client base.

All managed care plans in South Carolina are watching the marketplace for new health plan entrants. The state's low managed care penetration rate is an attraction, and the Section 1115 waiver application impressed some plans outside the state. At least seven new applications for South Carolina HMO licenses were submitted by out-of-state insurers, including applications from Aetna, Kaiser, Partners, and U.S. Healthcare. U.S. Healthcare, the only one to identify Richland County in its application, represents the greatest threat to the Columbia market, but any national HMO is a potential concern.

Insurers and health plans in the market are not sure whether to tie their marketing strategies to the activities of the local hospitals. The market has considerable duplication of health care services; to capture as much of the market as possible, insurers and health plans have historically contracted with most (or all) of the hospitals and specialist groups. The health plans have also created very broad provider panels to entice consumers into managed care with as little disruption as possible in the way they receive health care services. The common wisdom is that consumers fear that HMOs, or managed care, will limit their choice of physician. Consequently, there is little difference in the provider panels of the larger health plans: a consumer can move from Blue Cross and Blue Shield indemnity to Healthsource to Companion without changing his or her physician.

As the hospitals move toward forming alliances and provider networks, insurers and health plans are reevaluating their cover-all-the-bases strategy and are considering the possibility of moving toward exclusive provider contracts. Currently, they question how substantive the hospital alliances and networks are and whether they have potential longevity. Consequently, although Healthsource has an exclusive contract with Baptist Hospital, few of the other insurers and plans have products with exclusive contracts with specific hospitals or provider groups.

Consumers

Consumers have not had an influence in the Columbia health care market, and so far they have not been significantly affected by the changes occurring in the hospital/physician and insurance/health plan sectors. Enrollment in managed care products is low. Since these products are PPOs and IPA-model HMOs with broad provider panels, consumers have noticed very little change in the way health care services are provided. Advocates for vulnerable populations are distrustful of managed care in general, and the convergence in

Columbia of a change in their health care system and a completely restructured political system leaves many wondering whether, and how, the voice of the consumer will be heard.

HMO enrollees are the only consumers in the Columbia market likely to have experienced any change in their health care services. Such consumers might have noticed in the past 12 to 18 months that they have less choice in the physicians they can see. Interview respondents indicated that this suggestion is largely conjecture, but there are cases of plans not renewing contracts with popular physician groups. Restrictions in choice do not come from insurers or health plans forming exclusive arrangements with provider networks or groups, but from insurers and health plans beginning to reduce the comprehensiveness of their provider panels.

Advocates for vulnerable populations in the Columbia market are extremely wary of managed care and are concerned about the direction of the hospital and insurer/health plan activity. They are concerned that managed care plans will limit access to care for poor and disenfranchised people. Private, not-for-profit advocacy organizations are concerned that capitated provider networks will not include them; with their financing reduced or eliminated, they may have to reduce or eliminate their services.

Advocates for such populations are also concerned that the new state legislature and the privatization inclinations of Governor Beasley will result in cuts in, or elimination of, programs for the poor, elderly, chronically ill, and children—in the guise of health care reform.

▼ ▲ ▼ Future Developments

Participants in the Columbia health care market believe that theirs is the last market—or nearly so—to undergo reform. According to many, change will not come quickly to South Carolina, and the most threatening changes that could occur in their health care market, such as capitation, will take the longest to find a home.

Hospitals and physicians are expected to continue positioning themselves to compete. Most interview respondents believe that the two emerging hospital alliances will continue to strengthen their market share, but a few suggested that the alliances are empty, paper agreements that have no substance. The effect of the Columbia/HCA joint venture with Providence on the other hospitals in the market is not known. Many of those interviewed wonder how the national company's ownership of Providence will affect the hospital's alliance with Baptist Medical Center, and how its operational philosophy might affect clinical practice and service rates across the market. Respondents suggested that the specter of Columbia/HCA would haunt the market only until the

joint venture with the Sisters of Charity received final approval; now that that has occurred, the slow pace of the Columbia market could undergo a dramatic change.

Columbia/HCA owns four other medical facilities in South Carolina and has signed a letter of intent for a partnership with the Medical University of South Carolina in Charleston.[7]

To some of those interviewed, this implies a statewide strategy. Some suggest that of the four hospitals, Providence could not survive in a managed care environment without either its venture with Columbia/HCA or its alliance with Baptist Medical Center, because it is too specialized. They point out that the Columbia/HCA joint venture might result in the closure of one of the four hospitals. The alliances formed by the four hospitals, Richland/Lexington and Providence/Baptist, might protect them from a hospital shakeout caused by Columbia/HCA or by significant growth in capitated managed care.

HMO enrollment and capitation, which do not yet go hand in hand in Columbia, are expected to increase slowly. One respondent suggested that because there is not much interest in capitation, its growth will not increase for several years. Estimates of growth in HMO enrollment range from doubling—to 10 percent—in 18 months to doubling in five years. Some respondents suggested that provider-based HMOs, such as those being considered by some of the hospital alliances, will not survive because they work only for local employers, which is too small a client base. Many respondents predict that the market will continue to strenuously resist the entry of outside HMOs and will employ political pressure on the conservative legislature if necessary. A multistate initiative, involving North and South Carolina and Georgia, to convert the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), a health insurance plan sponsored by the Department of Defense for families of military personnel and military retirees, to capitated managed care is expected to go out for bid in late 1995; this initiative might be a factor in the market in the future.

The Columbia market has begun to move carefully toward creating integrated, managed health care delivery systems. Participants interviewed for this analysis nearly uniformly suggested that self preservation is behind these first, tentative steps. If Columbia's health care system must change, market players will do it on their own terms in their own way, without the participation of outside players. Market participants are creating change in a culture with a tradition of moving slowly and carefully. Their activities, combined with the Columbia/HCA-Providence Hospital deal, create an interesting, unpredictable future for Columbia's health care system.

[7]The partnership agreement was finalized in October 1995.