Community Report | SYRACUSE · N.Y.
Fall 1998

In June 1998, a team of researchers visited Syracuse, N.Y., to study that community's health system, how it is changing and the impact on consumers. More than 40 leading people in the local health care market were interviewed by Health System Change and The Lewin Group as part of the Community Tracking Study. Syracuse is one of 12 communities that HSC tracks every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first site visit to Syracuse, in May 1996, provided baseline information against which changes are tracked. The Syracuse market includes Onondaga, Cayuga, Madison and Oswego counties.

Collaboration and Competition Coexist

THE SYRACUSE HEALTH CARE MARKET LOOKS SIGNIFICANTLY DIFFERENT TODAY FROM THE WAY IT DID TWO YEARS AGO. CHANGE, HOWEVER, UNFOLDED DIFFERENTLY FROM HOW THOSE IN THE MARKET EXPECTED. AT THE TIME, THERE WAS CONCERN THAT THE POWERFUL FORCES OF CHANGE ON THE HORIZON WOULD ERODE ONE OF THE HALLMARKS OF SYRACUSE'S HEALTH SYSTEM—ITS COLLABORATIVE CHARACTER—BUT THAT REMAINS INTACT. CHANGES CAUSING CONCERN IN 1996 INCLUDED THE DEMISE OF HOSPITAL RATE SETTING, MANDATORY MEDICAID MANAGED CARE, AN EMERGING PURCHASING COALITION AND THE ENTRY OF NATIONAL MANAGED COMPANIES INTO THE LOCAL MARKET. TO DATE, NONE OF THESE CHANGES HAS HAD THE IMPACT ANTICIPATED BECAUSE THEY EITHER WERE DELAYED OR DID NOT YIELD THE EXPECTED MARKET RESPONSE.

THE FOLLOWING ARE THE KEY CHANGES THAT HAVE TAKEN PLACE IN SYRACUSE'S HEALTH SYSTEM SINCE 1996:

- NEWLY FORMED PHYSICIAN GROUPS ARE BUILDING MARKET POWER.
- TWO OF THE FOUR LEADING HOSPITALS ARE CONSOLIDATING.
- PLANS ARE PURSUING REGIONAL PARTNERS.
- PREFERRED PROVIDER ORGANIZATIONS (PPOS) AND POINT-OF-SERVICE (POS) PLANS ARE GAINING ENROLLMENT.

Syracuse Demographics

Syracuse, N.Y.	*Metropolitan areas above 200,000 population*
Population, 1997 [1]	
740,771	*196,633,263*
Population Change, 1990-1997 [1]	
-0.4%	*6.7%*
Median Income [2]	
$24,855	*$26,646*
Persons Living in Poverty [2]	
16%	*15%*
Persons Age 65 or Older [2]	
14%	*12%*
Persons with No Health Insurance [2]	
9.1%	*14%*

Sources:
1. U.S. Census, 1997
2. Household Survey, Community Tracking Study, 1996-1997

Capitated payment arrangements were uncommon in Syracuse in 1996, but today physicians in IPAs are beginning to assume risk with the support of IPA structures.

Collaborative Structures Remain

The Syracuse health system continues to exhibit the strong collaborative spirit noted in 1996, with evidence of cooperative efforts across all sectors. The Hospital Executive Council (HEC), a long-standing group of hospital leaders, continues to pursue projects that benefit the four leading hospitals or the community-at-large, where no single hospital has "staked out turf." Representatives of three health plans have recently formed a quality of care committee to develop guidelines and programs for asthma, diabetes and other chronic illnesses. In addition, the local health department has solidified a partnership with Medicaid HMOs to rationalize the provision of services between health plans and the public health sector and is working to extend the partnership to include commercial HMOs.

Despite these ongoing collaborative efforts, there is increased competition within the physician, hospital and plan sectors of the health system, and it is reportedly becoming more difficult for organizations to find common ground.

Physician-Owned IPAs Replace PHOs

A recent change in state regulation removed a barrier to the growth of independent practitioner associations (IPAs). IPAs are organizations of physicians that facilitate joint contracting with health plans without changing the ownership structure of the individual practice. Prior to 1996, an IPA in New York State could contract with only one managed care organization. Now, IPAs can contract with multiple organizations, offering a more flexible and powerful way for physicians to organize in the Syracuse market.

At the time of HSC's first site visit, most of the hospitals were developing physician-hospital organizations (PHOs) as a way to link physicians and hospitals. Today, IPAs have become the primary way of organizing physicians. While the PHOs were hospital driven, physicians are playing the leading role in the new IPAs. Roughly 90 percent of the physicians in Onondaga County belong to one of the four major IPAs.

These IPAs range in size from 300 to over 800 physicians. Each IPA has one hospital with which it is most closely affiliated, but these affiliations typically are not legally binding, raising the potential for physicians to shift alliances in much bigger blocks than they could before.

The IPAs are broad and overlapping. Physicians are in multiple IPAs, health plans contract with multiple IPAs and individual physician members still execute contracts with plans. IPA contracts stipulate that primary care physicians limit their participation to one IPA, but this has not been enforced. This practice has led to confusion over which contract applies to a particular patient. Most IPAs do not restrict membership or demand exclusivity for specialists, although several intend to limit membership for specialists in the future. It is a period of experimentation as physicians try to work out the best strategies to secure their market position.

Capitated payment arrangements were uncommon in Syracuse in 1996, but today physicians in IPAs are beginning to assume risk with the support of IPA structures. The typical arrangements allow physicians to assume risk at the IPA level, instead of having individual physicians take full financial responsibility for the care of enrollees who select them. Some contracts include primary care only, some involve all professional services and others involve shared risk for hospital care. Most individual physicians are still paid on a fee-for-service basis, and any risk is held at the IPA level. However, one IPA reportedly is capitating individual primary care physicians and subcapitating specialty care. Innovative for the Syracuse market, this arrangement is supported by a contract with a national physician management firm that

provides the information infrastructure and experience to manage these contracts.

Because the health plan networks are typically broad and overlapping, they ostensibly give enrollees free choice of most physicians in town. The underlying physician arrangements, however, are increasingly keeping patients within more limited provider networks. Enrollee choice of primary care physician determines where they will be referred for specialty and hospital care. This differs by plan. Physicians Health Plan (PHP) enrollees currently choose among several subnetworks within the larger PHP network. In other health plans, physicians direct referrals to stay within their own subnetwork, which may be invisible to enrollees. Enrollees can still switch their primary care physician at will to access most providers, but the majority go where they have been referred.

IPA arrangements and associated health plan contracts have an impact on referrals beyond the relatively small number of covered lives involved. For example, a primary care group has contracted with selected specialists to handle referrals for a capitated rate. These specialists are likely to get all that group's referrals, not just those covered by the capitation contract, leading to fewer referrals to other specialists. So far, the IPAs have not attempted to influence physician care delivery patterns to reduce cost or improve quality.

There is no consensus about whether IPAs have increased the power of physicians in the market, increased competition among physicians and/or diminished the historical market prominence of the hospitals. Physicians are clearly becoming more proactive in the market, but the ultimate impact of their efforts remains to be seen.

Consolidation Leaves Three Hospital Systems

An affiliation between two of the four leading hospitals in the Syracuse area is underway. In 1996, respondents predicted hospital consolidation, but varied in their assessment of which entities would be involved. The way in which consolidation actually unfolded is as much a result of collaboration as competition.

Two local studies were undertaken to project the future need for hospital capacity in Syracuse, and both projected significant overcapacity in the near future. Bilateral talks about mergers and affiliations took place among various pairs of hospitals. The result was a plan to bring Community General Hospital and Crouse Health together as separate corporations in a single holding company. The two hospitals expect the arrangement to combine complementary geographic service areas, create economies of scale and improve their contracting position with health plans. Although the other hospitals in Syracuse reportedly do not perceive this affiliation as an immediate threat, one health plan respondent noted that with Crouse's recent operational improvements, low cost-position and savvy leadership, the new organization could be well positioned to seek volume at the expense of its competitors. Together, Crouse and Community General were responsible for just over half of the admissions to Syracuse hospitals in 1997.

Upsurge in Premiums, Plans Seek New Markets Regionally

After several years of aggressive competition and flat premiums, managed care plans in Syracuse are struggling to recoup operating losses. Opinions differ about who started the price war and whether the intent was to capture market share from managed care competitors or from traditional plans. Regardless, the result was an increased differential between HMO and indemnity plans, and HMO penetration increased. Despite reported enrollment gains, a number of health plans posted substantial financial losses last year and raised rates in 1998 by 9 to 16 percent. Health plans project further increases for 1999.

Health System Characteristics

Syracuse compared with the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

STAFFED HOSPITAL BEDS† PER 1,000 POPULATION, 1996

Syracuse, N.Y.	*3.4*
Little Rock, Ark.	*5.3*
Seattle, Wash.	*1.9*
Metropolitan Areas	*3.2*

Source: American Hospital Association
†At nonfederal institutions designated as community hospitals

PHYSICIANS†† PER 1,000 POPULATION, 1997

Syracuse, N.Y.	*1.8*
Boston, Mass.	*2.6*
Greenville, S.C.	*1.5*
Metropolitan Areas	*1.9*

Source: American Medical Association and American Osteopathic Association
††Nonfederal, patient care physicians, excluding certain specialties—e.g., radiology, anesthesiology, pathology

HMO PENETRATION, 1997

Syracuse, N.Y.	*19%*
Miami, Fla.	*64%*
Greenville, S.C.	*8.4%*
Metropolitan Areas	*32%*

Source: InterStudy Competitive Edge 8.1

At the same time, the high single- to double-digit premium increases have led plans to introduce tighter network products so that employers can avoid some of the cost increases associated with current broad network products.

Several developments spurred by the price war have changed what had been a landscape dominated by strong local players.

- The position of PHP, the historically dominant local HMO started by four Syracuse hospitals, was weakened due to underwriting losses fueled by the price war, lower returns on a large contract than expected and the distraction of management by its merger discussions. PHP's recently announced merger with Health Care Plan of Buffalo may dilute the local character of PHP, but becoming a regional player may also help it survive.

- Blue Cross and Blue Shield of Central New York (BCBSCNY), which covers the Syracuse area, recently merged with the Rochester and Utica-Watertown Blues plans. The new organization is pricing its managed care products more competitively and lowering payment rates to physicians.

- Several national health plans have entered the Syracuse market by acquiring plans with a local presence, including CIGNA, United HealthCare, Kaiser Permanente and Aetna/U.S. Healthcare. To date, however, the growth of national health plans in Syracuse has been held back by internal issues related to mergers and lack of effective local marketing strategies.

The period of flat to declining premiums following the 1996 site visit may partly explain why purchaser activity did not progress as expected. At that time, the Purchasing Coalition of Central New York was attracting considerable attention. Some viewed the emergence of this group as a sign that businesses were attempting to drive down costs. In late 1996, the coalition granted PHP an exclusive contract for administrative services only. Since then, some of the original coalition members dropped out. While a few new ones have been recruited, the PHP contract covers only 20,000 lives, well short of the coalition's goal of 50,000.

Purchasers, however, are beginning to react to the recent premium increases. One large national employer offered to meet with local providers to help one plan bring down its costs. This is an unusual move in a market populated by branch offices of national firms that have not typically played a role in local health care dynamics.

The recent rate increases are eroding the differential that had developed between the cost of traditional benefit plans and HMOs. Consequently, employers—many of whom pass premium changes along to their employees—are reportedly experiencing an enrollment trend away from managed care benefit offerings.

At the same time, the high single- to double-digit premium increases have led plans to introduce tighter network products so that employers can avoid some of the cost increases associated with current broad network products. So far, these tighter network products have been popular only with smaller, more cost-conscious employers. But plans expect more employers to offer these products in 1999 and more employees to switch if they face increased cost sharing.

Despite all the activity among managed care plans and the focus of the provider community on positioning for managed care, the majority of the population in Syracuse is still covered under non-HMO health insurance plans. Current managed care penetration is estimated to be 19 percent, compared with 14 percent in 1996.

Cautious Response to Deregulation

In 1996, it was expected that deregulation of hospital rates would increase competition among hospitals in the Syracuse market, lower hospital rates and put

graduate medical education programs in jeopardy. Since deregulation's implementation in 1997, however, its actual effect has been more moderate. Both hospitals and health plans were largely unprepared for the rate negotiation process in terms of information infrastructure and management experience. Syracuse hospitals took steps to reduce costs in anticipation of the need to offer more competitive rates, but did not move to undercut their competitors in the first two cycles of negotiations since rate setting ended. The health plans appear to have limited leverage in negotiations because of the small number of hospitals in Syracuse, their different mix of services and market demand for choice.

There are differing opinions about how hospitals and health plans in Syracuse fared under deregulation. Health plans claim they are paying more for hospital services today than under rate regulation, and hospitals claim they are getting less. Rural hospitals—usually the only players in a community—have more leverage and reportedly negotiated more favorable rates. Overall, hospitals are doing better financially than they were in 1996, while many of the health plans have incurred substantial losses. However, these trends are similar to what is happening on the national level for hospitals and plans, so deregulation may not be the primary driver with respect to financial position.

Medicaid Managed Care Delayed

In 1996, it was expected that Medicaid managed care would be a key driver of the market move toward managed care, but this has not been borne out. Voluntary enrollment in Medicaid managed care, in place in some form since 1988, has declined over the past two years. New York State received federal approval to implement mandatory Medicaid managed care in 1997, but delayed statewide implementation due to administrative complexities. The state is focusing its efforts on New York City and is proceeding county by county. Implementation in Onondaga County, where Syracuse is located, is awaiting results of a recent Health Care Financing Administration site visit.

Overall, Medicaid managed care enrollment has declined in Syracuse since 1996. Since that time, the state reduced its Medicaid payment rates. A number of health plans serving Syracuse's Medicaid population dropped out because of the rate decreases and the restrictions on marketing practices that made it difficult and costly to attract enrollees. The state then increased rates, but has not attracted reentrants or new Medicaid plans to Syracuse. The health plan sponsored by the local community health center expanded its provider network, but did not absorb all the displaced enrollees.

Although Medicaid managed care has been limited in Syracuse, it may have had a positive impact on access to primary care for the Medicaid population. The local health department reports less demand for preventive health services, which it attributes to better access to care through Medicaid managed care plans. Fears that Medicaid managed care would result in a shift in volume away from the area community health center and harm its ability to care for the uninsured poor have not materialized, largely because much of the Medicaid managed care enrollment is in Total Care, the health plan sponsored by the community health center. Other health plans are not actively competing for enrollment at this time.

Consumers Get Patient Protection Laws, More Choice in Plans

At the same time that it has been deregulating the hospital sector, New York State has enacted one of the most comprehensive managed care consumer protection laws in the country. These laws address information disclosure, external and internal appeals and grievance procedures, gag clauses, due

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process protections, procedures to determine medical necessity, 48-hour stays for deliveries and mastectomies, chiropractic care, direct access to specialists and prompt settlement of health care claims.

There is widespread perception that there has been little public demand locally for these regulations. As one respondent put it, "Syracuse plans were not engaging in the restrictive practices addressed by this legislation." With the exception of the chiropractic mandate, respondents indicated that these regulations have not had a dramatic effect on plan policies, procedures or costs other than increasing the administrative burden on health plans.

While legislative changes reportedly have had little impact on health plan structure, they have helped to foster growth of less restrictive products. One direct by-product of hospital rate deregulation is the emergence of PPO products. Under New York State's previous rate regulation system, only licensed HMOs could negotiate rates with hospitals, so there was no incentive to form PPOs. Now that this restriction has been eliminated, national carriers are introducing PPO products, which are beginning to build an enrollment base in Syracuse.

POS products are also becoming more popular despite the fact that most health plans contract with all of the hospitals and most of the physicians. United HealthCare has introduced an open access product with no gatekeepers, and Blue Cross and Blue Shield offers a triple-option product in which enrollees can choose among varying levels of benefits and broader or more narrow networks at the point of service.

The new options appeal to employers and consumers who value provider choice and easier access to specialty care. However, expected premium increases may again push the market toward the more restrictive managed care products.

In addition, many plans have introduced new administrative-services-only products to serve the increasing number of employers who self-insure. There are differing opinions as to whether the new legislation, coupled with other regulations, including community rating, is driving employers to self-insure.

Issues to Track

Although change has not unfolded as predicted, the Syracuse market looks significantly different from how it did two years ago. New organizations have emerged, the balance of power is shifting and referral patterns are becoming more distinct. As HSC documents change in communities across the United States, key trends to track in Syracuse include the following:

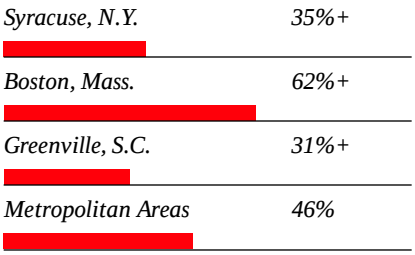
- What impact will physician organizations have on the Syracuse market?
- Will competition overtake the collaborative nature of the health care community?
- What will be the impact of deregulation—and new regulation—on the market?
- How will purchasers respond to premium increases: Will more restrictive forms of managed care take hold?
- How will all these changes affect residents in Syracuse?

Syracuse Compared to Other Communities HSC Tracks

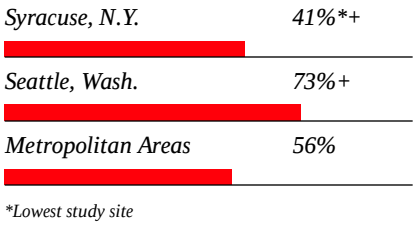
Syracuse, the highest and lowest HSC study sites and metropolitan areas with over 200,000 population

Gatekeeping and Compensation Arrangements

Insured Persons Covered Under Gatekeeping Arrangements



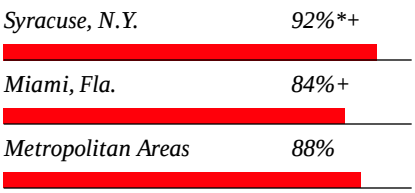
Physicians Receiving Capitation for at Least Some of Their Patients



*Lowest study site

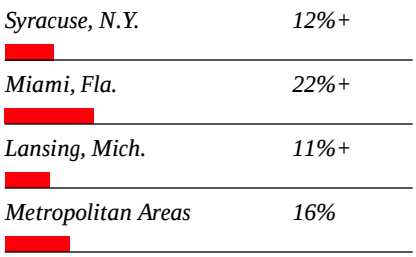
Consumer Perceptions of Access to Care

Families Satisfied with the Health Care Received in the Last 12 Months



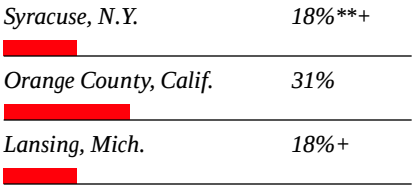
*Highest study site

Patients Agreeing That Their Doctor Might Not Refer Them to a Specialist When Needed



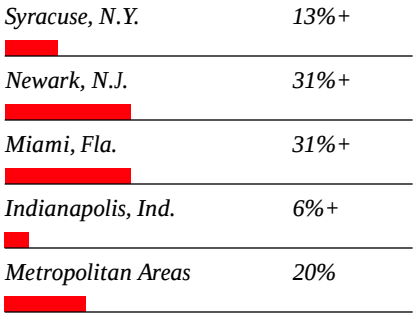
Physician Perceptions of Access to Care

Physicians Not Agreeing That It Is Possible to Provide High-Quality Care to All of Their Patients



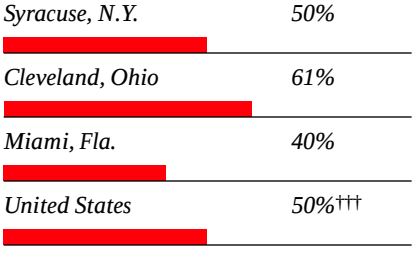
**Tied with Lansing for lowest study site

Primary Care Physicians Reporting That They Cannot Always or Almost Always Obtain Referrals to High-Quality Specialists When Medically Necessary



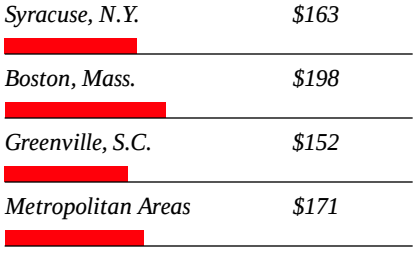
Employers and Health Insurance‡

Employers Offering Health Insurance



†††Metropolitan area data not available

Average Monthly Premium for Employer-Sponsored Insurance



‡Based on preliminary data.

There are no significance tests for results reported.

The Community Tracking Study, the major effort of 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 the following 12 communities:

- *Boston, Mass.*
- *Cleveland, Ohio*
- *Greenville, S.C.*
- *Indianapolis, Ind.*
- *Lansing, Mich.*
- *Little Rock, Ark.*
- *Miami, Fla.*
- *Newark, N.J.*
- *Orange County, Calif.*
- *Phoenix, Ariz.*
- *Seattle, Wash.*
- *Syracuse, N.Y.*

+Site value is significantly different from the mean for metropolitan areas over 200,000 population.

The information in these graphs comes from the Household, Physician and Employer Surveys conducted in 1996 and 1997 as part of HSC's Community Tracking Study. The margins of error depend on the community and survey question and include +/- 2 percent to +/- 5 percent for the Household Survey, +/-3 percent to +/-9 percent for the Physician Survey and +/-4 percent to +/-8 percent for the Employer Survey.

Health System Change (HSC), a nonpartisan research organization, seeks to provide objective, incisive analyses about health system change that lead to sound policy and management decisions, with the ultimate goal of improving the health of the American public.

Findings from the first round of the Community Tracking Study site visits are documented in *Health System Change in 12 Communities*. The Community Report series documents the findings from the second round. HSC conducts site visits in 12 communities in collaboration with The Lewin Group.

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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.com.

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