

INITIAL FINDINGS FROM HSC'S 2005 SITE VISITS: STAGE SET FOR GROWING HEALTH CARE COST AND ACCESS PROBLEMS

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Many developments in local health care markets appear to be setting the stage for additional health care cost increases and access-to-care problems, according to initial findings from the Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. Hospitals and physicians are competing more broadly and intensely for profitable specialty services, making costly investments to expand capacity and offer the latest medical technologies, especially in more affluent areas with well-insured populations. Employers and health plans have launched few initiatives to control rising costs beyond increasing patient cost sharing. As rapidly rising costs continue to push private health insurance out of reach for more people, state and local governments are struggling to meet the needs of low-income people and an increasing number of uninsured people.

Building Boom Continues

The most striking development in the 12 health care markets tracked by HSC is the ongoing building boom and rapid expansion of both inpatient and outpatient capacity (see Data Source). Many hospitals are expanding medical-surgical capacity, especially in profitable specialties and in affluent suburban areas with growing, well-insured populations. For example, in Indianapolis, the area's four major private hospital systems plan more than \$1 billion in combined renovations and new construction primarily in the community's growing suburbs.

Despite a history of perceived overcapacity in the health care system, a variety of factors are driving expansions today. During the peak of tightly managed care in the mid-1990s, many hospitals closed beds and shelved modernization projects in the face of declining service utilization, pricing pressures and the high cost of borrowing. As health plans relaxed administrative

controls on care use starting in 1999, utilization rates, especially for inpatient care, rebounded, straining capacity.

Today, overflowing emergency departments are a visible sign of tight hospital capacity and are a key area for investment. Expansions also have been driven by a desire to keep pace with demographic trends—responding both to the changing needs of an aging population and areas of rapid population growth. Low interest rates have contributed to the ongoing building boom, and many hospitals continue to use their considerable bargaining clout to obtain higher payment rates from health plans, giving hospitals greater financial stability and ability to shoulder debt.

Intense Service-Line Competition

Competitive positioning also is a major factor underlying expansions of inpatient and outpatient capacity. Competition among local hospitals—and between hospitals and physicians—has focused on key, profitable

service lines, including cardiac, orthopedic and cancer care.

While growth of stand-alone physician-owned specialty hospitals stalled as a result of the moratorium imposed under the 2003 Medicare Modernization Act, diagnostic and surgical services increasingly are being provided in physician offices and physician-owned ambulatory centers. Facing stagnant growth in professional fees and pressure from growing malpractice premiums and other practice expenses, physicians increasingly have sought facility fees as an important new revenue source. Marked disparities in the relative profitability of certain services under both Medicare and private plan reimbursement policies appear to be a major force driving competition for these key services.¹

For instance, one multispecialty medical group in the Phoenix area with a large retiree population added a positron emission tomography (PET) scanner to its

A Collaborative Effort

HSC conducted its 2005 site visits in collaboration with researchers from its sister organization, Mathematica Policy Research, Inc. (MPR), and other research organizations. Researchers are organized into three teams, each covering a major area of interest.

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practice because of the potential to increase revenue from Medicare. In Miami, single-specialty medical groups are being formed for the first time, with observers indicating that achieving the scale needed to offer profitable ancillary services within the practice is the prime motivation for these arrangements—even more important than gaining leverage with health plans. These financial incentives, coupled with continued technological advances that allow more procedures and diagnostic services to be performed profitably on a smaller scale, have led to a shift of a growing number of services from hospitals to physician offices and physician-owned facilities.

In many communities, hospitals view the growth of physician-owned facilities as the most serious competitive threat they face. For example, two Miami hospital systems reported dramatic declines in the volume of endoscopy procedures as a result of staff gastroenterologists opening competing endoscopy centers. Many hospitals across the 12 communities have responded by forming joint ventures with physicians to retain at least some of this revenue; in other cases, hospitals have responded by opening facilities separate from their main campus to directly compete with physicians for these lucrative services.

Competitive Fallout

Capacity expansions and intensified service-line competition have a number of consequences for local health care markets. Perhaps the most obvious effect is on costs. Whether meeting or creating new demand, these capacity expansions are destined to lead to higher rates of care use. Some of that additional use no doubt will provide increased access to beneficial care. However, there are concerns that physicians face strong financial incentives to recommend more services when they have an ownership interest in a facility, potentially leading to unnecessary care or care that adds little value or benefit to patients. The bricks-and-mortar expansions and acquisition of new technology also will increase demand for nurses and technicians already in short supply and whose compensation is being bid up.

In theory, some of these cost impacts could be offset by renewed health plan leverage to negotiate discounts with hospitals and physicians, stemming from increased numbers of competitors to deliver these services or the re-emergence of excess capacity. Some health plan executives have suggested that this may come to pass down the road, but no signs had emerged during HSC's recent visits to the 12 communities.

The intense competition for profitable services also potentially can influence the availability of health care services and patients' access to care. While many hospitals are expanding emergency department capacity, increasingly hospitals, especially those serving many uninsured patients, are struggling to get physician specialists to provide on-call coverage for emergency department evaluations and trauma care. In some cases, hospitals are paying physicians to provide on-call coverage—historically part of physicians' obligation in return for hospital privileges. As specialists provide more services in their practices or in facilities they have a financial interest in, they become less dependent on having privileges at hospitals, potentially diminishing access to specialty care for some patients.

Indeed, the movement of profitable services out of hospitals and into physician practices and physician-owned facilities poses a threat to some hospitals' ability to subsidize care for less profitable services and for low-income patients. And, as hospitals expand lucrative services, some are cutting back on less profitable ones such as inpatient psychiatric care, placing more pressure on safety net hospitals to provide this care.

Moreover, the build up of specialty services is occurring at the same time that many inner-city hospitals caring for large numbers of uninsured patients continue to struggle financially. For example, in northern New Jersey, suburban hospitals have aggressively expanded capacity, particularly in key niche service lines, but hospitals in declining urban areas—especially those without direct state support or alliances with the suburban systems—have struggled to upgrade existing facilities. Unable to access the capital needed to modernize or

replace out-dated facilities, many hospitals find themselves in a vicious cycle as they become less attractive to privately insured patients.

Few Cost-Control Strategies

Despite continued double-digit annual health insurance premium increases² and growing anxiety about how to pay for health benefits, plans and employers have had few initiatives other than increased patient cost sharing to control cost growth. Since traditional managed care tools, such as utilization controls and selective provider contracting, have fallen into disfavor as a result of the managed care backlash, health plans largely have focused on new product designs aimed at engaging consumers to make more cost-conscious decisions about service use and choice of providers.

Plans across the 12 markets quickly developed consumer-driven products—high-deductible coverage linked to spending accounts, including health savings accounts (HSAs) and health reimbursement accounts (HRAs), but enrollment to date is limited. Notably, employers offering such products have generally not dropped their current health maintenance organization (HMO) or preferred provider organization (PPO) products. Few of the consumer-driven products available today offer information to help patients differentiate effectively between types of services or choose providers that deliver the best combination of price and quality.

Some plans have experimented with new approaches to selective contracting, with tiered-network or narrow-network designs, but few of these products have taken off, largely because of difficulty in differentiating providers based on cost and quality. Now, health plans are focusing on high-performance networks, a relatively new narrow-network product that selects individual physician practices for preferred status on a specialty-by-specialty basis according to measures of quality and efficiency of care. For example, in Seattle, Aetna's high-performance network has gained much higher enrollment than expected. However, observers noted that the plan was unable to exclude some physi-

cians in large group practices regardless of their quality and efficiency scores because the groups require the plan to contract with all or none of their physicians.

While new product designs have not yet panned out as hoped, many plans are developing pay-for-performance (P4P) initiatives to reward providers that meet certain cost, quality and patient-satisfaction goals. In a small number of the 12 markets, providers have received initial payments under these programs on the basis of measured improvements in care delivery. But in most markets, plans appear to be moving slowly in the development and rollout of P4P to allow time to wrestle with the complexity of measuring performance and to win provider acceptance. An inherent limitation is that most plans represent only a small fraction of a medical group's patients, giving plans limited leverage to move P4P forward. A notable exception is seen in Orange County, Calif., where the Integrated Healthcare Association has facilitated use of the same performance measures by a number of health plans to ease administrative burdens on participating providers.

In the absence of significant innovation to control health care spending growth, plans and employers have continued to focus primarily on shifting costs to consumers as the key response to rising premiums. One result of rising premiums has been more people becoming uninsured. Some small employers reportedly are dropping health benefits, while in other cases, increased employee premium contributions have led to lower rates of take up of health insurance.

Growing Safety Net Distress

While health care costs continue to rise and health insurance becomes less affordable, the public sector has fewer resources to respond to growing needs for coverage or subsidized care. The combination of ongoing state budget constraints, unwillingness to raise taxes and federal budget pressures has left state and local governments hard pressed to keep up with growing needs for coverage and care.

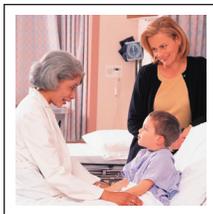
Although Medicaid and the State Children's Health Insurance Program

(SCHIP) account for a substantial and growing portion of state budgets, remarkably these programs have been spared major cuts to date in most states. Yet states have raised barriers to enrollment through reintroduction of six-month recertification requirements, other changes in the eligibility process and a reduction in resources devoted to outreach. Virtually all planned expansions have stalled, and many states now are considering more far-reaching changes, such as reducing covered services and eligibility levels—primarily for adults—lowering provider payment rates, introducing patient cost sharing and requiring aged and disabled people to enroll in managed care.

Meanwhile, reports from providers caring for uninsured patients suggest that there already has been a noticeable uptick in demand for services from people without coverage. While many communities have expanded safety net primary care capacity over the past few years, thanks in part to federal expansion grants, providers are struggling to keep up with growing demand for these services. Many community health centers and safety net hospitals report that funding support has not kept pace with the increasing numbers of uninsured patients they treat.

For example, the county hospital system in Miami is facing significant deficits stemming in part from charity care needs growing faster than the system's funding from a dedicated half-penny sales tax.

At the same time, access to specialty care for both Medicaid and uninsured patients appears to be declining. As many private physicians feel squeezed by low reimbursements for professional services, they reportedly are more reluctant to treat low-income patients, resulting in greater demands on safety net providers. In several communities, waiting times for specialty clinic appointments at safety net hospitals have increased, with average waits of six months reportedly not uncommon. In communities with a substantial number of undocumented immigrants who cannot qualify for publicly sponsored programs, these pressures are even more intense.



Data Source

Every two years, HSC conducts site visits in 12 nationally representative communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Approximately 1,000 total interviews are conducted in the 12 communities with representatives of local health plans, hospitals, physician organizations, major employers, benefit consultants, insurance brokers, community health centers, consumer advocates and state and local policy makers.

HSC recently completed its fifth round of site visits; field work began in January 2005 and was completed in June 2005. This Issue Brief is based on initial findings from the 12 communities. Shortly after each site visit, HSC issues a Community Report describing the major changes in each community since the previous site visit. As each Community Report is released it is available on the HSC Web site at www.hschange.org.

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Quality Improvement and IT Investment Gain Traction

Despite the generally bleak picture emerging from local health care markets, some developments promise positive change for the future. First, increased attention has been paid to hospital quality improvement over the past two years. Some hospitals, especially those that lagged in adopting quality improvement initiatives, pointed to Medicare's linking a portion of the hospital inpatient payment update to public reporting of data on the quality of care as an important catalyst. This initiative has helped focus hospital quality improvement efforts. Indeed, many hospitals expect payer and patient demand for demonstrated quality to increase and, therefore, view these activities as important investments to be able to compete in the future.

At the same time, information technology (IT) investment has increased, but the scope is more limited than some policy makers and industry proponents would suggest. Hospitals and a handful of large physician groups are at the forefront of significant IT investment. One focus is on improving communication and documentation of patient care within individual organizations and between hospitals and their medical staffs. Examples of IT systems being developed to share information on a community-wide basis exist—in Indianapolis, for instance—but are rare. In addition, there appears to be little development of IT aimed at assisting consumer decision-making about use of services or selection of providers. Improved efficiency and quality will likely result from the IT investments that are being made but given the scope of these activities, they may well be slower and more modest than touted.

In addition, some observers note growing disparities in hospitals' capacity to invest in the most resource-intensive information technology and quality improvement activities, which threaten to widen the performance gap between institutions catering to the affluent and those primarily serving the poor. This situation may, in fact, worsen under public and private payer initiatives to link reimbursement to clinical

performance. For example, hospitals could be penalized with lower payments if they lack resources to invest in adequate staff to coordinate quality improvement activities or health IT to track performance and allow feedback to clinical staff.

Implications

Overall, the promise of quality improvement initiatives and IT investments pales in comparison to the scope of the cost and access problems confronting the health care system today.

If current trends continue unabated, communities are likely to face growing numbers of uninsured people and increasing disparities in access to care by income and geographic location. Looking forward, all health care stakeholders, policy makers and the public will have to more explicitly address the problems underlying these trends and either revisit solutions that have been discarded, get serious about developing new ones, or accept the implications of continuing the status quo.

Notes

1. Ginsburg, Paul B. and Joy M. Grossman, "When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," *Health Affairs*, Web Exclusive (Aug. 9, 2005).
2. Strunk, Bradley C., Paul B. Ginsburg, and John P. Cookson, "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," *Health Affairs*, Web Exclusive (June 21, 2005).