CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

SEATTLE, WASH.

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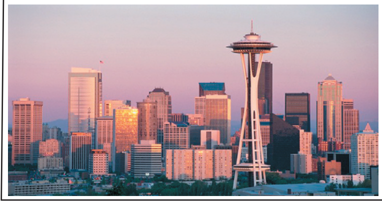


In March 2005, a team of researchers visited Seattle to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 100 leaders in the health care market. Seattle is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Seattle, in 1996, 1998, 2000 and 2003, provide trend information against which changes are tracked. The Seattle market encompasses Island, King and Snohomish counties.

COMMUNITY QUALITY EFFORTS EXPAND AS SEATTLE HEALTH PLAN PRODUCTS EVOLVE

An improving Seattle economy has eased pressures on employers, health plans and hospital systems, although the rising number of uninsured people continues to stress the local health care safety net. To slow health care cost growth and improve quality of care, employers and health plans are now pursuing new provider contracting strategies to directly influence provider quality and efficiency, instead of merely shifting more costs to consumers. At the same time, hospitals have added capacity and expanded particularly profitable services, such as cardiac care, but face increasing competition from physician-owned facilities for outpatient services.

Other noteworthy developments include:

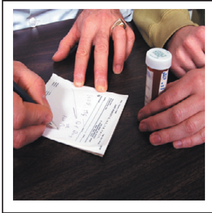
- Hospitals and large physician practices have continued an internal focus on quality improvement and are investing heavily in information technology.
- Access to physician services for low-income and uninsured people has deteriorated.
- Despite a close and contentious election for governor and an expected $1.7 billion deficit, the state has committed to maintaining health programs, including the restoration of lost federal Medicaid funds for mental health services.

Health Plan Products Evolve

Two years ago, Seattle employers were aggressively changing health benefit designs to shift more health care costs to employees, and health plans were developing new products to encourage consumers to choose higher-quality, lower-cost providers.

At that time, Premera Blue Cross, one of the state's largest insurers, introduced a tiered-network product that assigned hospitals and physicians with lower average costs for episodes of care to a preferred tier. Employees' premium and/or cost sharing at the point-of-service are higher for those seeking care from providers in the non-preferred tier. Some hospitals, however, discounted their prices for Premera to ensure assignment to the preferred tier. Although this led to cost savings and lower premiums, it reduced consumer financial incentives to choose providers based on quality and cost. Premera's preferred-tier network product is one of four network options available through Premera's Dimensions program. Along with the ability to select different networks, Dimensions allows employers to choose a variety of patient cost-sharing arrangements and benefit structures. Premiums vary based on the network, cost-sharing and benefit choices. Dimensions enrolls more than 1 million people, or about 85 percent of Premera's Washington members.

Some large employers also have worked to develop their own tiered networks, but find it difficult to achieve significant cost savings or provide large



Seattle Demographics

Seattle	Metropolitan Areas 200,000+ Population
Population[1]	
2,477,204	
Persons Age 65 or Older[2]	
11%	*10%*
Median Family Income[2]	
$39,054	*$31,301*
Unemployment Rate[3]	
7.1%	*6.0%*
Persons Living in Poverty[2]	
8%	*13%*
Persons Without Health Insurance[2]	
8%	*14%*

Sources:
[1] U.S. Census Bureau, County Population Estimates, 2003
[2] HSC Community Tracking Study Household Survey, 2003
[3] Bureau of Labor Statistics, average annual unemployment rate, 2003

enough financial incentives to influence employee choice of provider.

More recently, Aetna, serving primarily large self-insured national companies with headquarters in Seattle, introduced its Aexcel specialist network in the Seattle market. This high-performance network includes physicians from six medical specialties—cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology and orthopedics—who have met established clinical and efficiency measures. Patients pay less if they use physicians in the high-performance network. The Aexcel product has had triple the expected enrollment—roughly 100,000 members instead of 30,000. In particular, King County offers its employees this product as part of an effort to reduce health care costs. Critics of the Aexcel network, however, expect cost savings from the product to be less than anticipated because Aetna was not able to strictly define its network at the physician level. Most physician groups, such as Virginia Mason Medical Center, for example, required all of their physicians to be included in the network.

Although looking for ways to slow health care cost growth, area employers have shown limited interest in health reimbursement arrangements (HRAs) and health savings accounts (HSAs) because of the administrative burdens associated with spending accounts and the high deductibles required by HSAs. In response, Regence Blue Shield has developed FourFront, a product that covers four physician office visits or diagnostic services before a deductible applies. This product maintains some first-dollar coverage, yet avoids the cost and hassle of spending account administration. Also, the employer can choose the deductible amount and transition to a higher deductible over time. Regence Blue Shield estimates that this design reduces an average employer's premiums by about 10 percent. Premera has developed a similar product that covers six physician office visits before the deductible.

At the same time, Group Health Cooperative, traditionally a staff/group model health maintenance organization (HMO), has developed and marketed plans with higher patient cost sharing, including deductibles. Group Health decided to offer products with deductibles, which have seen strong growth, because it found that, increasingly, it provided the most comprehensive benefit option in multi-product offerings by employers and that the least healthy employees were disproportionately choosing Group Health. Adding patient cost sharing and strong marketing of these products has improved Group Health's risk pool and contributed to a financial turnaround.

Health Plans Focus on Provider Network Performance

Two years ago, hospital, employer and health plan quality efforts focused on patient safety initiatives and Leap Frog, a national quality effort focusing on medication safety, improving care in intensive care units and data collection and reporting activities. While efforts to improve hospital quality continue, a new focus on ways to identify high-quality and efficient physicians has gained momentum. Within the next few years, health plans expect to implement pay-for-performance programs that provide higher payments to higher-quality and more efficient physicians. However, given the history of provider showdowns over contract negotiations in the Seattle market, the health plans are proceeding cautiously and developing measures collaboratively with physicians.

Premera has collaborated with six medical groups for several years to develop performance measures and incentives programs based on quality and pharmacy indicators. Premera has

Community Collaborates on Quality Improvement

The Puget Sound Health Alliance is a nonprofit organization that was created after Ron Sims, the King County executive, formed a task force to identify ways for purchasers to gain sufficient market leverage to reduce health care costs while improving quality. The Alliance membership includes the area's largest insurers, key physician group practices, public employers and a few of the area's large private employers, such as Boeing and Starbucks. The primary aim of the organization is to slow the rate of increase in health care costs by improving quality of care and decreasing wasteful spending. It expects to achieve this not only through quality improvement measurement and reporting, but by developing a culture of medical practice that makes evidence-based decision-making the community norm.

The Alliance differs from quality improvement efforts in other communities because it has brought together the spectrum of stakeholders from the outset. Also, its activities go beyond the collaborative effort of developing standardized performance measures for quality and cost measurement and reporting. The Alliance will also provide technical assistance to many of its members. For example, purchasers will gain support for redesigning health benefits to encourage consumers to use high-quality providers, comply with chronic disease management and participate in health promotion programs. The Alliance will also train providers on evidence-based protocols and assist them in the development of state-of-the-art technologies for patient care, including computer systems, efficient office procedures, and improvements in patient flow and scheduling practices.

initially released the scores to the medical groups, which have in turn met to identify and share ways to improve their scores. Strong financial incentives have not been tied to performance during this exploratory phase but are increasing over time.

Regence is also profiling physicians based on both cost and quality. Regence has shown the baseline measures to providers so that they can see where they stand relative to peers, but to date, there have been no financial consequences for poor performance. Regence plans to continue to develop and refine the measures in an open, non-hostile environment to foster trust and then transition slowly to a program with financial incentives for both physicians and consumers.

In addition, The Puget Sound Health Alliance recently formed and expects to develop its own evidence-based standardized quality improvement measures (see box above). Its key activities include: the development of uniform standards for clinical quality; sharing of a data warehouse that combines patient medical record and claims data from health plans and medical practices; ongoing objective measurement of performance; and, collaborative quality improvement efforts across medical practices. If successful, the Alliance may allay providers' concerns about multiple, and sometimes conflicting, quality measurements and standards across numerous health plans. At the same time, physicians in solo and small group practices may feel additional pressure to join integrated practices because larger medical practices—significant participants in the Alliance—will likely be better equipped to measure, improve and report performance.

Health System Characteristics

Seattle	Metropolitan Areas 200,000+ Population
Staffed Hospital Beds per 1,000 Population[1]	
*1.7**	*3.1*
Physicians per 1,000 Population[2]	
2.3	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
16%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$654	*$718*

* Indicates a 12-site low

Sources:

[1] American Hospital Association, 2002

[2] Area Resource File, 2003 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)

[3] Interstudy Competitive Edge, markets with population greater than 250,000

[4] Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.

Health Care Utilization

Seattle	Metropolitan Areas 200,000+ Population
Adjusted Inpatient Admissions per 1,000 Population[1]	
171	197
Persons with Any Emergency Room Visit in Past Year[2]	
18%	18%
Persons with Any Doctor Visit in Past Year[2]	
84%	78%
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
5.3%	5.7%
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
44%	44%

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

Seattle Hospitals Expand

Market positions of the major hospitals remained stable over the past two years, but several strategies for capacity expansion in the Seattle market have emerged. Responding to the rapid population growth in the Issaquah area east of Seattle, Swedish Medical Center opened a freestanding ambulatory center, including an emergency department, and filed a certificate of need to build a hospital in the area. Overlake Hospital, a suburban hospital in the area, has opened 80 new beds and filed its own certificate of need for an inpatient facility in Issaquah, in a move market observers characterized as predominantly defensive. In June, the state health agency turned down both requests, but the decisions may be appealed.

Swedish Health System has expanded capacity at its downtown campuses along particular profitable service lines. The hospital is expanding cardiac and neurosciences programs by consolidating services at other facilities into a new facility for each program at its downtown Providence campus. Officials see this as a strategy to both increase the visibility and reputation for each specialty area to consumers, as well as to provide services more effectively. Swedish had successfully pursued this strategy to create a single cancer institute and reported that patient volume increased substantially. Similarly, an orthopedic hospital is planned for the Swedish First Hill campus that will cost $75 million. Each of these expansions will free up space at existing facilities to expand other services.

In contrast, Virginia Mason Medical Center and the University of Washington Medical Center are reconfiguring existing facilities to gain additional capacity. Virginia Mason Medical Center also is counting on its adaptation of the manufacturing methods pioneered in Japan by Toyota to create new capacity by increasing efficiency and shortening lengths of stay. The hospital also has tentative plans to build another patient tower at its existing campus that will include a new operating room and emergency department.

The University of Washington Medical Center completed construction of a surgery pavilion and plans to convert administrative space to allow room for more beds. At one point, the hospital was operating beyond capacity. Other notable expansions include the emergency department, diagnostic radiology capacity and a digestive disease center. In addition to addressing capacity constraints, expansions are largely driven by a need to support the hospital's teaching programs and to shore up declining margins.

Pressures Mount for Physicians in Small Group Practices

Physicians in the Seattle market continue to pursue profitable ancillary services in a market with a high cost of living and historically low reimbursement for physician services. Two years ago, medical groups were building capacity to provide laboratory and imaging services in their practices. Physicians also had developed freestanding ambulatory surgery and diagnostic centers to capture the facility payments associated with these services. More recently, these revenue-enhancing activities have expanded to include sleep centers, vein clinics, and cash-based services such as laser surgery and liposuction.

Seattle physicians are facing increasing financial pressures as operating costs rise and health plans and public programs hold payment rates steady or to modest increases. Small private practices, in particular, feel the pinch as health plan payment rates increasingly depend on a physician group's market leverage or ability to demonstrate cost-effectiveness. In addition, larger practices such as Proaliance Surgeons can pool capital and gain efficiencies by sharing facilities and administrative costs. Furthermore, smaller practices have more problems weathering the

underwriting cycle for malpractice insurance, while some larger clinics and groups have moderated and stabilized their malpractice premium costs by self-insuring. Moreover, new health benefit designs that raise patients' cost sharing have begun to reduce patient demand for elective care. And, finally, with pay-for-performance programs on the horizon, physician practices face pressure to implement electronic medical records, another investment that favors larger practices.

As a result of these financial pressures, physicians are leaving small practices to join larger groups, seeking employment with hospital systems, and in a few instances, leaving the profession. In addition, physicians are less willing to see Medicaid patients or to provide emergency department on-call coverage without extra payments.

Some physicians also have felt threatened as Swedish Medical Center, one of the few hospital systems that offers admitting privileges to community physicians, has begun to employ specialty physicians as part of its service-line strategy and to cover its emergency department. Because community physicians on the medical staff feared that increasing employment of specialists would undermine the private-practice model, they filed a motion of "no confidence" against the hospital CEO, but the CEO prevailed in this vote by a small margin.

Quality and Information Technology Efforts Expand

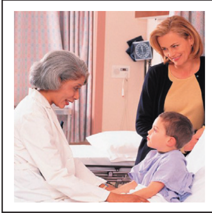
Seattle hospitals report an expanded emphasis on improving patient safety and quality. Quality improvement is characterized as both something that physicians are eager to do and a preparation for future broad dissemination of quality indicators that might affect hospitals' attractiveness to patients and their physicians. Centers for Medicare and Medicaid Services' (CMS) reporting incentives have sent a signal to hospitals that quality reporting will be important in the future. Many of the hospitals also were actively engaged in Institute for Healthcare Improvement (IHI) programs and were enthusiastic about them.

In addition, hospitals and large medical groups are making significant investments in information technology to share medical information. Swedish Health System is developing an electronic medical record (EMR) and calls it the largest single capital project in the hospital's history, with an estimated $110 million price tag. The EMR will be implemented on all three campuses and at Swedish Physicians, the hospital-owned medical practice, along with being available to any community physician who wants it. However, the cost to physician practices of participating could prove to be a significant barrier.

The University of Washington Medical Center currently has a system to share information—including diagnostic pathology and radiology results and patient notes—that includes Harborview Medical Center and the Fred Hutchinson Cancer Center. The hospital is now implementing the Cerner Enterprise EMR, which will include computerized physician order entry (CPOE) capability. This system allows sharing of diagnostic results in pathology, radiology and procedures, as well as patient notes. Already more than two years into its implementation, completion of the Cerner project is expected within the next few years. Virginia Mason Medical Center began implementing the Cerner EMR in 2001.

In Seattle, virtually all of the sharing of clinical information is within hospital systems. With a high degree of integrated delivery and large groups of physicians who practice at a single hospital, Seattle appears to have fewer needs for information sharing across institutional affiliations than other communities.

As a result of these financial pressures, physicians are leaving small practices to join larger groups, seeking employment with hospital systems, and in a few instances, leaving the profession.



Over the past two years, an increasing number of physicians reportedly have refused to see Medicaid and uninsured patients, and the problem is particularly acute for specialty care

Access Problems Grow for Low-Income and Uninsured People

Two years ago, state and local budget deficits, as well as growing numbers of uninsured persons, were increasing the pressure on the health care safety net and threatening access to care for low-income people. Also, it was reported that many mainstream health care providers were scaling back caring for Medicaid patients because of low payment rates, which also were limiting the ability to cross-subsidize charity care for the uninsured.

These problems have persisted over the past two years and reportedly have resulted in reduced access to many specialty services for Medicaid patients and uninsured people. Over the past two years, an increasing number of physicians reportedly have refused to see Medicaid and uninsured patients, and the problem is particularly acute for specialty care, especially orthopedics and neurology. For example, Proaliance Surgeons, the market's largest orthopedic group, stopped contracting with Medicaid. In addition, Harborview Medical Center, one of the primary sources of specialty care for uninsured persons, is at full capacity and has difficulty finding specialists to treat uninsured persons other than for emergencies.

In addition, the state has reduced funding for a variety of treatment, residential, and vocational services for Medicaid beneficiaries with serious mental illness as a result of changes in the way funds are allocated between urban and rural areas. These cutbacks have severely reduced the ability of local mental health providers to use Medicaid funds to cross-subsidize care for uninsured persons with serious mental illness. Some hospitals also have closed psychiatric beds, thereby reducing access to inpatient mental health services. The state is expected to lose an additional $82 million in federal Medicaid funds for serious mental illness because of stricter interpretation of federal policy regarding the use of Medicaid funds for residential services and for persons without Medicaid coverage. However, the state Legislature restored $80 million of the lost funds, relieving concern about the elimination of services for uninsured persons with serious mental illness.

In contrast to declining access for specialty care and mental health services, access to hospital and primary care services has been fairly stable, with some expansions. Despite increases in the number of uninsured and rising uncompensated care, Harborview Medical Center has maintained its bottom line through administrative efficiencies. SeaMar Community Health Center has increased staffing by 30 percent to 40 percent in the past few years, and opened new clinics outside of Seattle with the help of federal expansion grants. Puget Sound Neighborhood Health Centers has expanded by merging with other clinics, such as the Pike Market Medical Clinic. Major expansions of community health centers (CHCs) in Seattle appear to be constrained by the federal government's current focus on expanding CHCs into new areas. Seattle is unlikely to receive additional federal expansion grants because of the extensive CHC network already in the community.

Nevertheless, safety net providers are under pressure from continued increases in the number of uninsured patients they see. One CHC reported an increase of more than 40 percent in the number of visits by uninsured persons in the past three years, and all safety net providers reported increases in the amount of charity or uncompensated care they provide. Because of capacity constraints, Harborview Medical Center has started restricting access to nonemergency care for out-of-county residents.

Safety net providers cite cuts in public coverage programs, as well as

continued erosion of private insurance coverage among workers as reasons for the increase in the volume of uninsured patients. In 2002, the state eliminated a Medicaid look-alike program that covered about 28,000 undocumented immigrants—primarily children—and required enrollees to seek coverage under the Basic Health Plan, a state-sponsored insurance program for low-income people with no other source of coverage. Respondents estimated that only about half of those who lost coverage actually enrolled in the Basic Health Plan, in part because Basic Health requires a premium payment while Medicaid does not. Enrollment freezes in the Basic Health Plan and movement from a 12- to six-month eligibility redetermination period for children on Medicaid also are believed to have increased the number of uninsured people. And while the local economy has stabilized and employment has grown since the 2001 recession, the sense is that many new jobs don't include health insurance coverage.

A new governor, Christine Gregoire, took office after a close election and contentious recounts to face a $1.7 billion deficit. She has committed to maintaining health programs as much as possible, especially for children. For example, one of her first actions as governor was to change the Medicaid rules for eligibility redetermination back to 12 months, which should help reverse the increase in the number of uninsured children that resulted from the earlier change. A $26 billion budget was recently passed with increased taxes on alcohol and cigarettes, plus a reinstated estate tax and other revenue bills. The budget maintains the eligibility redetermination change, delays implementation of newly approved premiums for children on Medicaid in families with incomes between 150-200 percent of the federal poverty level—between $29,025 and $38,700 for a family of four in 2005—increases provider payment rates, and restores the Children's Health Program for poor children whose immigration status makes them ineligible for Medicaid.

Issues to Track

Health plans in the Seattle market continue to develop new health plan products and provider performance measures in hopes of slowing health care cost growth and improving health care quality. At the same time, hospital systems have pursued expansions and emphasized efficiency improvements. In response to increasing financial pressures, physicians in smaller private practices are less willing to care for Medicaid patients and to provide emergency department on-call coverage.

The following issues are important to track:

- How will relationships between hospitals and physician groups evolve? Will employment of physicians by hospitals become important or will joint ventures between hospitals and physicians become more important? How will the recent focus on service lines at Swedish Health System and elsewhere affect competition in the market?
- Will hospital reporting of quality become an important competitive factor across Seattle hospital systems?
- What, if any, provider pushback will health plans face as they move forward with high-performance networks and other provider contracting strategies? How successful will the Puget Sound Health Alliance's effort be at paving the way for effective pay-for-performance programs?
- How will safety net providers fare under increasing demand by uninsured persons? Will availability of specialty care continue to deteriorate and with what impact on access to care for low-income people?

While the local economy has stabilized and employment has grown since the 2001 recession, the sense is that many new jobs don't included health insurance coverage.

Seattle is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

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