CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

GREENVILLE • S.C.

NUMBER 10 OF 12 • NOVEMBER 2005

In May 2005, a team of researchers visited Greenville, S.C., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 50 leaders in the health care market. Greenville is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Greenville, in 1996, 1998, 2000 and 2003, provide trend information against which changes are tracked. The Greenville market encompasses Anderson, Cherokee, Greenville, Pickens and Spartanburg counties.

GROWTH FUELS HOSPITAL COMPETITION AND CHALLENGES GREENVILLE SAFETY NET

Developments in Greenville's health care market continue to be dominated by local hospital systems, complicating the efforts of health insurers to constrain payments to these facilities and their affiliated physicians. Population growth near the town of Greer, however, has become the object of increased competition between Greenville-based and nearby Spartanburg-based hospitals. At the same time, hospitals are pursuing stronger relationships with specialist physicians in an effort to capture additional patient volume for profitable hospital-based specialty services.

Other noteworthy developments include:

- BlueCross BlueShield of South Carolina has remained the dominant health insurer, but national carrier UnitedHealthcare has made recent inroads at the expense of several smaller plans.
- Small employers have begun to purchase health savings account (HSA) products in considerable numbers over the past year, while larger employers have taken more modest steps to contain health insurance costs.
- Greenville's safety net providers have seen significant increases in demand for care from the uninsured, leading to some expansions in service capacity.

Hospital Competition Intensifies

Hospital competition in the Greenville area has intensified over the past two years as the market's three largest hospital systems increasingly focus on the same geographic area for building service capacity. This area, located along the border between Greenville and Spartanburg counties near the town of Greer, is attractive to hospitals because of its growing population of middle-class, suburban residents.

The two Greenville-based hospital systems—Greenville Hospital System (GHS) and Bon Secours St. Francis Health System—are actively expanding in the Greer area along with Spartanburg's largest hospital, Spartanburg Regional Health System. GHS, the largest of the three, already owns a small hospital in the Greer area that will be moved to a more favorable location and expanded, thereby giving the system a new facility in the midst of the hotly contested area. GHS is also building a new hospital across the street from St. Francis' women's and family hospital on Greenville's east side, not far from Greer and the Spartanburg County border. In turn, St. Francis is planning a 20-bed expansion of its women's and family hospital and is considering building a short-stay surgical hospital, perhaps focusing on orthopedics, in the Greer area.

Meanwhile, Spartanburg Regional has built an ambulatory surgery center and a medical office building for its admitting physicians in the Greer area, and it recently received state approval to build a new 48-bed hospital

Greenville Demographics

Greenville	*Metropolitan Areas 200,000+ Population*
Population[1]	
994,562	
Persons Age 65 or Older[2]	
12.3%	*10%*
Median Family Income[2]	
$25,737	*$31,301*
Unemployment Rate[3]	
6.2%	*6.0%*
Persons Living in Poverty[2]	
14%	*13%*
Persons Without Health Insurance[2]	
14%	*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

in the same area, near the Greenville-Spartanburg airport. These expansions have helped Spartanburg Regional become a more formidable competitor.

Historically, hospital competition has been geographically segmented with an intense rivalry between the two Greenville-based hospitals contrasting with relative calm among the hospitals in the Spartanburg and Anderson County submarkets. This segmentation has been reinforced by the fact that both GHS and Spartanburg Regional are organized under state charters that confine their operations to a single county. A proposed merger between GHS, Spartanburg Regional and Anderson County's AnMed Health System failed during the mid-1990s, further strengthening the geographic segmentation of hospitals. Since then, competition between GHS and its smaller neighbor St. Francis has remained intense in Greenville, although some observers note that the antagonism has abated somewhat since the 2003 decision by area insurers to end the practice of excluding St. Francis from their provider networks to negotiate discounted pricing with GHS.

Alongside the growing geographic competition, area hospital systems have continued to develop specialty service lines to compete for patients needing care that is profitable for the hospitals, including cardiac services, oncology, orthopedics and obstetrics. Four of the local hospital systems serving the market have heart centers that offer interventional cardiology and cardiac surgery, and three of these systems have cancer centers and neonatal intensive care units. Rather than regionalizing high-cost, high-technology services in a single facility, all four of the region's largest hospital systems are developing their own specialty-care capacities. Greenville's status as the most populous and fastest-growing region of the state has helped hospitals successfully win state certificate-of-need approval for expansions.

Despite these developments, GHS remains the area's dominant provider of specialty care and hospital-based specialty services and has continued to strengthen its market position. GHS recently received designation as a university medical center in partnership with the medical schools and other health science programs at several state universities, but this development was expected to have little impact on the hospital system's overall market share.

Hospitals Seek Tighter Relationships with Specialists

To attract patients to their specialty services, hospitals are using several methods to forge closer relationships with the specialist physicians that control patient admissions. GHS reportedly has stepped up efforts to employ specialist physicians, leading many observers to expect that the hospital will eventually move to a closed medical staff model, where only its employed physicians have admitting privileges. By contrast, St. Francis has begun contracting with specialists to tie them more directly to the hospital, rather than employing them. Spartanburg Regional is developing joint ventures with specialty physicians for ambulatory and diagnostic facilities. Currently, many area specialists still maintain admitting privileges at multiple competing hospitals in the region—even physicians who are employed by one of the hospitals—but hospitals reportedly are using their employment and contractual relationships with physicians to influence admission decisions.

The hospitals' efforts have strengthened the already considerable influence that hospitals have on the local physician marketplace. Hospitals have employed the majority of primary care physicians in Greenville since at least the mid-1990s, although some hospitals subsequently divested unprofitable physician practices after managed care contracting failed to develop as expected in the market. In recent years,

rising medical malpractice insurance costs have made hospital employment increasingly attractive to physicians. This development has proved especially helpful to GHS in its bid to employ specialists, since its status as a state-chartered institution reportedly allows the hospital to purchase malpractice insurance for employed physicians at discounted rates. The state Legislature passed a malpractice tort reform law in 2005 that included caps on non-economic damages similar to that of a number of other states, but many observers think that high malpractice premiums, and the resulting incentives for hospital employment, will persist for the foreseeable future.

Some specialists have resisted the efforts of GHS and other hospitals to establish employment or contractual relationships with physicians. Several local cardiology groups have chosen to forgo GHS employment, the largest of which admits about 85 percent of its patients to GHS facilities. Most local orthopedists also have remained independent, leading GHS to develop an alliance with a multistate orthopedics group that began practicing in the area in 2004 through an affiliation with Spartanburg-based Mary Black Memorial Hospital. This development reportedly also has fostered closer ties between GHS and Mary Black, a hospital that has long served as Spartanburg Regional's smaller local competitor.

Several other events have highlighted the limits of hospital power over physicians. Half of the physicians who recently partnered with Spartanburg Regional to develop a new, joint-venture ambulatory surgery center near the town of Greer were affiliated with the competing hospital system, GHS. As another example of physician independence, 60 specialists from Spartanburg Regional recently formed an investor group to build a medical office building that will include imaging facilities, a sleep lab and a pulmonary function lab—all profitable ancillary services that would compete with the services offered by the hospital. The hospital reportedly has attempted to negotiate a joint-venture ownership share of the facility, but so far these efforts have been unsuccessful.

BlueCross Still Dominant but National Insurer Makes Inroads

Greenville's private health insurance market remains highly concentrated in products offered by the dominant BlueCross BlueShield of South Carolina, but national health insurer UnitedHealthcare has made recent inroads at the expense of several smaller health plans. BlueCross and its smaller health maintenance organization (HMO) subsidiary, Companion HealthCare, collectively serve more than 50 percent of the privately insured market, with the insurer's preferred provider organization (PPO) product remaining the most popular health insurance choice in Greenville. BlueCross' market share has continued to increase over the past two years based on its broad provider networks and its competitive pricing—an advantage it maintains in part through favorable contracts with selected hospitals and physicians.

BlueCross' dominant market position, combined with the considerable negotiating leverage of local hospitals, has historically discouraged new health plans from entering the market and made it difficult for BlueCross' existing competitors to increase their presence in the market. In fact, two of BlueCross' closest competitors, the national carrier Cigna Health Care and the South Carolina-based HMO Carolina Care Plan, have struggled with operational problems in recent years that have caused them to lose membership. Another insurer, Spartanburg-based Employer's Life, has exited the market altogether after only a few years of operation, reportedly because of financial difficulties precipitated by its attempts to attract

Health System Characteristics

Greenville	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
2.5	*3.1*
Physicians per 1,000 Population[2]	
1.7	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
8.7%*	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$654	*$718*

** HMO penetration rate reported for Greenville County MSA, the largest MSA within the Greenville market. HMO penetration rates for the other MSAs comprising the Greenville market are as follows: Spartanburg County MSA 5.5%, Anderson County MSA 3.4%.*

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

Greenville	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
193	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
18%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
78%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
6.1%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
52%	*44%*

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

membership through aggressive price competition.

These developments created the opportunity for United to increase its presence in the Greenville market. Until recently United operated in South Carolina only via a contract to provide administrative services for Carolina Care Plan, formerly known as Physician's Health Plan. After this seven-year contract expired in 2003, United developed its own provider network and began marketing its own line of health insurance products. Over the past two years United has reportedly gained considerable membership in Greenville based on the growing popularity of its PPO and health savings account (HSA) products.

United's expanded presence in the market has reportedly stimulated the development of new strategies for competing on health plan cost and quality. United recently introduced its Premium Program in the Greenville market, which designates a subset of its providers as "high-performing" physicians and hospitals based on measures of quality and efficiency of care in specialty areas such as oncology, cardiac care and orthopedics. These designations are intended to encourage consumers to seek care from high-performing providers and thereby constrain health care costs.

In a similar vein, BlueCross is implementing a provider recognition program for physicians and hospitals that will allow providers to earn financial incentives and a special designation within the BlueCross network for meeting established quality standards. Physicians will receive up to $5,000 for achieving national accreditation standards for the management of diabetes, cardiovascular disease and hypertension, using standards developed through the National Committee for Quality Assurance (NCQA), the national Bridges to Excellence Program and the American Society for Hypertension. Hospitals will receive payment increases for achieving 90th percentile performance in any four of the 10 quality measures established by the federal Centers for Medicare and Medicaid Services (CMS), and for participating in the Leapfrog Group hospital quality and safety reporting program. Additionally, hospitals will receive a one-time award of $50,000 for full implementation of a computerized physician order entry (CPOE) system. Provider responses to these new incentive programs remain to be seen, as do the impact of these programs on health care quality and costs.

Yet the contracting environment between health plans and providers has remained contentious in Greenville, which health plans attribute to the considerable negotiating leverage of hospitals in the area, particularly GHS and AnMed Health System—the only system serving Anderson County.

Moreover, several hospitals continue to use physician-hospital organizations (PHOs) as contracting vehicles to gain negotiating leverage with insurers, although the Federal Trade Commission recently ordered two Greenville-area PHOs to discontinue operations because of anticompetitive practices. The demise of exclusive contracting arrangements with GHS several years ago reportedly has allowed GHS to secure even higher payment rates from insurers since it is no longer required to offer discounts in exchange for insurers excluding St. Francis from their networks.

Despite the contentious contracting environment, there have been few reported instances of network disruptions because health plans have generally offered the payment concessions necessary to keep all Greenville area hospitals in their networks. As one notable exception, Spartanburg Regional Health System recently dropped out of United's network after the insurer failed to reach agreement on new contracting terms with the hospital and its PHO, leaving the smaller

Mary Black Memorial Hospital as United's only in-network hospital in Spartanburg. This action may signal a growing willingness among insurers to resist hospital demands for payment increases and other beneficial contracting terms.

Small Employers Show Interest in Health Savings Accounts

Private health insurance premiums have continued to increase at double-digit annual rates, according to Greenville-area insurers and employers, although premium trends for 2005 were somewhat lower than in 2004. In response to rising premiums, small employers have begun to purchase health savings account products in considerable numbers over the past year, while larger employers have implemented more modest health benefit changes. Several insurers report that HSA products now represent as much as 15 percent to 25 percent of new sales in the small-group market, suggesting that Greenville may be ahead of other markets in the take up of these products. Observers attribute the growing popularity of HSAs to the fact that many consumers in this market are already accustomed to plan designs with relatively large deductibles and coinsurance requirements—features that small employers introduced in previous years to limit premium increases. As a consequence, the transition to HSA-compatible high-deductible health plans is relatively easy for these consumers.

By contrast, most large employers continue to offer traditional PPO products but have increased employee cost sharing over the past two years. These changes include increasing the share of employee premium contributions and higher deductibles and maximum out-of-pocket limits. Some large employers have begun to offer optional HSAs, but few make contributions to the spending accounts—reportedly because of concerns that employees can take the employer-contributed funds when they leave the company. Consequently, enrollment in the HSA products offered by large employers has been very limited to date.

As one prominent example, the state of South Carolina introduced a high-deductible HSA product as a lower-cost option for state employees beginning in 2005. The product includes a $3,000 deductible for individual coverage ($6,000 for family coverage) and requires employee premiums that are less than 10 percent of the premiums required for the state's standard PPO and HMO product offerings. Nevertheless, the state chose not to contribute funds to employee spending accounts, and only 1.8 percent of state employees have signed up for the product.

Some observers expressed skepticism about the long-term viability of HSA products in Greenville given the high prevalence of relatively low-wage workers with limited ability to contribute to spending accounts. Those workers who enroll in HSAs may be unable to meet the deductible requirements and therefore may forgo needed care or require uncompensated care from local providers. Still, other observers noted that HSAs are allowing some employers to continue offering some level of health benefits to employees at a time when standard HMO and PPO products have become increasingly unaffordable. For these employers, HSAs are serving as a safety net health insurance product for firms that can no longer afford a more generous benefit design.

Growing Demand Challenges Greenville's Safety Net

Greenville's major safety net providers have experienced continued increases in demand for care over the past two years, challenging their ability to ensure timely access to care. Local safety net clinics have seen annual increases in patient volume of more

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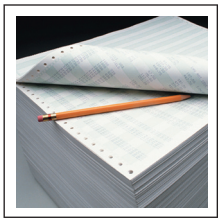

Greenville's major safety net providers have experienced continued increases in demand for care over the past two years, challenging their ability to ensure timely access to care.

than 30 percent during this period, particularly among uninsured patients. In many cases the available funding for local safety net providers has not kept pace with this rising demand, resulting in capacity constraints and longer waiting times for appointments.

Market observers attribute the growth in demand for safety net care to several factors. First, Medicaid enrollment has declined somewhat over the past two years, with approximately 50,000 fewer people covered statewide. This decline is reportedly because of state reductions in outreach services, making it more difficult for eligible individuals to obtain and maintain enrollment in the program. Safety net providers in Greenville reported that declines in state outreach have contributed to a reduced proportion of patients with Medicaid coverage. Also, South Carolina has sought cost savings by instituting a preferred drug list, more strictly enforcing monthly prescription limits, adding copayments for some beneficiaries and more proactively removing enrollees who become ineligible for the program.

Second, the Greenville area continues to be one of the fastest growing regions of the state, leading to further increases in demand for safety net services. This population growth includes immigrants attracted to the manufacturing and agricultural jobs in the region, many of which reportedly do not provide insurance coverage. The rapidly growing Latino population accounts for much of the state's immigrant growth. According to the University of South Carolina, census data indicate that South Carolina's Latino population growth rate from 2000 to 2002 outpaced all but three other states. And, the growth in the Latino population has been particularly concentrated in the Greenville area. Undocumented immigrants, who experience unique difficulties accessing health care because they are ineligible for public insurance programs, have reportedly increased in number as well. In response to these demographic trends, safety net providers have tried to provide culturally and linguistically appropriate care for the increasingly diverse population they serve.

Third, while GHS remains the main hospital for low-income people in the region, its role as a safety net provider reportedly has continued to change as it transitions into a university medical center. While GHS has maintained its in-kind support for the safety net, such as staffing assistance for community clinics and free laboratory and diagnostic testing for uninsured people, market observers report that the hospital has been limiting its specialty service capacity for low-income people. Outpatient safety net providers report that some of their recent increases in volume are a result of growing reluctance of private providers, such as GHS, to serve low-income people. For example, respondents noted that some patients are referred for follow-up care to community clinics, which often are not equipped to provide such specialized care. To attempt to fill this gap, community clinics are trying to recruit more specialty physician volunteers or establish paid contracts for their services.

In response to growing demand, several safety net providers have expanded over the last two years, with the help of ongoing collaboration fostered by Greenville's Community Health Alliance. Much of this expansion has been concentrated in the Greer area between Greenville and Spartanburg, which has experienced growth in low-income populations as well as in more affluent residents. The three major outpatient safety-net providers—the local health department, New Horizon Family Health Services (a federally-qualified community health center) and the Greenville Free Clinic—have collocated additional

services at a facility in Greer, which is expected to reduce appointment waiting times that reportedly had reached three months for primary care visits.

In addition, New Horizon has received a federal expansion grant to create a health care program for the homeless population, and the St. Francis Health System donated a mobile unit for this effort. The program will serve 13 counties in South Carolina's Upstate region, including the Greenville area, and will have the capacity to serve 4,000 people annually. The health center also is working to expand access to dental care by collaborating with other area providers and teaching institutions to develop a dental program that would provide services to uninsured patients on a sliding-fee basis and also to Medicaid and privately insured patients. And, the Community Health Alliance has established new priorities for the community, including creating a local health insurance coverage plan for small businesses, encouraging healthy lifestyles through health education and promoting the availability of affordable pharmaceuticals.

Yet there are concerns that South Carolina's Medicaid waiver proposal, if approved, could hinder access to services and further stress safety net providers. The proposal is centered on providing Medicaid beneficiaries with a personal health account to select a managed care plan, employer-sponsored insurance coverage or a medical home network—a group of primary care doctors who serve as gatekeepers for specialty care, prescription drugs and other needed care. Additionally, the proposal includes a pilot program in which a small group of beneficiaries could instead select a health savings account with a high-deductible plan.

The proposal has received much public criticism from advocates and state legislators, and some market observers fear it would leave Medicaid beneficiaries with less coverage and safety net providers with a higher proportion of uninsured patients. A similar Medicaid waiver proposed by the state of Florida received rapid federal approval, suggesting that South Carolina's reforms may encounter little federal resistance.

Issues to Track

Signs of increased competition have emerged in Greenville despite the fact that powerful local hospitals and a dominant BlueCross BlueShield carrier exercise considerable influence over the market. These developments so far have had little visible effects on health care costs, quality and accessibility, but they raise several key issues to track for the future:

- How will hospital expansions in the Greer area affect local hospital competition and contracting relationships with health plans?
- How will hospital alliances with specialty physicians affect the accessibility and cost of specialty care in Greenville?
- What impact will United Healthcare's expanded presence in the market have on health insurance premiums and product designs?
- If approved, how will South Carolina's Medicaid waiver affect Medicaid beneficiaries and safety net providers?
- How will Greenville's safety net providers support growing demands for care?

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

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