CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

LANSING, MICH.

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In May 2005, a team of researchers visited Lansing 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 nearly 70 leaders in the health care market. Lansing 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 Lansing, in 1996, 1998, 2000 and 2003, provide trend information against which changes are tracked. The Lansing market encompasses Clinton, Eaton and Ingham counties.

LANSING'S CALM HEALTH CARE MARKET BELIES INCREASED COMPETITION, ECONOMIC DOLDRUMS

A languishing economy continues to plague Lansing and the rest of Michigan, threatening workers' broad health care benefits and the ability of local and state agencies to sustain coverage for low-income people. Nonetheless, Lansing's health care market has been relatively calm compared with a few years ago when a conflict between Blue Cross Blue Shield of Michigan and Sparrow Health System threatened longstanding provider networks and consumers' preferred sources of care. Amid new local leadership, various collaborations have emerged. Still, the community's two hospital systems continue to compete aggressively with each other and with physician practices for profitable services.

Key Lansing developments include:

- Physician groups have become more active in seeking other revenue sources—in the form of services traditionally provided by hospitals—in response to financial pressures.
- Sparrow has maintained its market leadership position, but Ingham Regional Medical Center has become a stronger competitor as its merger with McLaren Health Care Corporation begins to pay off.
- The Ingham Health Plan, an innovative, limited benefits coverage program sponsored by Ingham County government, has expanded to cover an estimated 50 percent of the county's uninsured population and is serving as a model for other counties throughout Michigan.

Employee Benefits Still Broad, But Threatened By Weak Economy

The economies of the state and the Lansing area have not recovered from the 2001 recession, in part because of continued downturns in manufacturing, in general, and the auto industry, in particular. Unemployment in Michigan was 7.1 percent in May 2005, more than a two-percentage point increase from 2003 and two percentage points higher than the national average. The Bureau of Labor Statistics reported in January 2005 that the Lansing—East Lansing Metropolitan Area experienced the second largest yearlong employment loss (approximately 5,600 jobs) in the country, following only the Detroit area (approximately 24,000 jobs).

Lansing has a history of relatively comprehensive employee health benefits, brought about in part by collective bargaining agreements between the three large employers in town—General Motors, Michigan State University and the state of Michigan—and their respective unions. According to most respondents, benefits remain relatively rich in the community, particularly for those working for the large employers.

However, recent financial woes at General Motors spurred new discus-

Lansing Demographics

Lansing	*Metropolitan Areas 200,000+ Population*
Population[1]	
*455,836**	
Persons Age 65 or Older[2]	
*9.2%**	*10%*
Median Family Income[2]	
$33,478	*$31,301*
Unemployment Rate[3]	
4.9%	*6.0%*
Persons Living in Poverty[2]	
*8%**	*13%*
Persons Without Health Insurance[2]	
7%	*14%*

*Indicates a 12-site low.

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

sions with the UAW about health care benefits and costs. Several respondents suggested that GM's financial difficulties would be a catalyst for change in automobile workers' benefits, but such changes have not been made to date. A recent agreement between the UAW and DaimlerChrysler included a relatively small increase in patient cost sharing.

Small employers reportedly are purchasing health insurance products with higher deductibles and copayments and sharing the premium cost with employees more often than in the past. This is a recent development in Lansing, which lags behind other parts of the country in the implementation of these employer budget-cutting strategies. Some employers also are moving to plans with three-tiered drug benefits, a development that occurred in other markets years earlier. There is reportedly some interest among employers in consumer-directed health plan approaches—which involve high deductibles and spending accounts—but to date few have actually offered one of these plans.

Hospital Competition Continues Amid Regulatory Constraints

The two largest hospital systems in the market, Sparrow Health System and Ingham Regional Medical Center (IRMC), continue to compete aggressively for physicians and patients in profitable service lines, such as orthopedics, cardiac care, oncology and women's and children's health. This competition is partly in response to continuing financial pressures, as the hospitals report that reimbursement rate increases have not kept up with rising operating costs, at the same time hosptials face increasing uncompensated care and Medicaid loads. As a result of direct competition for patients and physicians in profitable service lines and aging physical plants, both hospitals initiated construction projects over the past two years and recently have embarked on substantially larger ones.

However, as Michigan's certificate of need (CON) law strictly controls the supply of inpatient beds, high-tech services and imaging, these projects mainly replace or upgrade existing facilities, with only small expansions of bed and high-tech service capacity. IRMC's projects include consolidating its orthopedics beds in a separate specialty hospital and breaking ground on a new heart and surgery center. Sparrow added a 30-bed medical/surgical unit in 2004 and opened a long-term care hospital in 2005. As part of a seven-year capital plan, Sparrow is renovating and expanding its emergency department, surgical facilities, critical care units and heart center.

Despite this competition, Sparrow has maintained its dominant position—currently about double IRMC's market share—but Ingham Regional has become a stronger competitor since merging with McLaren Health Care Corp. in 1997. The benefits of this merger are beginning to pay off, as IRMC now has more negotiating leverage with payers, specifically Blue Cross Blue Shield of Michigan (BCBSM), and significantly reduced costs through increased purchasing power. IRMC's efforts to compete with Sparrow by developing centers of excellence in key areas, such as cardiac care and orthopedics, and partnering with physician groups, in tandem with the benefits of merging with McLaren, reportedly have helped it to gain several percentage points in market share over the past two to three years.

Doctors Seek Additional Sources of Revenue to Increase Incomes

At the same time, competition between hospitals and physician groups has grown, particularly over outpatient surgery, as perceived financial pres-

sures spur providers to seek new revenue streams and market niches. In a period of relatively flat reimbursement rates and rising costs, physician groups reported seeking other sources of revenues beside professional fees to help maintain or enhance income. Because CON approval is required for projects with capital costs that exceed $2.5 million, however, this market has not seen a proliferation of physician-owned ambulatory surgery centers (ASCs) or high-end imaging equipment, as has been the case in other parts of the country. Three physician-owned ASCs—two owned by the same physicians—have operated for about four years.

The ASCs now have reportedly hit their stride, seeing increasing volume and solid financial performance over the past two years as physicians and patients have started to accept this type of care. ASC volume also may have increased because of BCBSM's decision about two years ago to begin reimbursing ASCs, which the health plan had resisted at first. And hospitals reported the ASCs were starting to take away market share; for example, IRMC noted a decline in outpatient surgery of 3 percent between 2003 and 2004.

Because the ASCs have become more of a competitive threat, the two major hospitals are revisiting a strategy they had abandoned earlier of partnering with existing and new ASCs to continue to capture at least a portion of the revenue. IRMC is acquiring an ownership stake in two of the ASCs, and the hospital is in discussions with another medical practice about a proposed ASC that does not yet have CON approval.

In addition, Michigan State University's faculty practice, the MSU Health Team, is stepping up efforts to vie for outpatient services in the Lansing market. MSU, which does not have an academic medical center or hospital, has completed an analysis of facility needs to enhance multidisciplinary outpatient services on campus. The MSU Health Team also has proposed a joint venture for an ASC with both IRMC and Sparrow, and market observers expected both hospitals to be interested. However, IRMC's new ASC ownership arrangements have precluded it from participating in this project. MSU also is committing funds to expand sports medicine clinical services on campus. MSU sees these projects as revenue sources that can be used to cross-subsidize primary care and other less profitable services and the ASC, in particular, as a recruiting tool to attract new physicians to the faculty.

Despite Increased Competition, Cooperation Strengthens

Against this backdrop of ongoing provider competition, the recent departure of Sparrow's long-time CEO—as well as community reaction to a proposed plan to move significant resources of the MSU medical school out of Lansing—has provided new opportunities for collaboration to address local health care needs. Many respondents viewed this as a significant change from two years ago, when BCBSM and Sparrow were locked in a protracted, acrimonious battle over payment rates, and relations among the hospitals and physicians were sometimes contentious.

Debate over the university's controversial plan to expand the College of Human Medicine to Grand Rapids has provided a platform for discussions among the key actors on community-wide health care needs. Over the past year, this proposal—in which MSU was courted by wealthy donors in Grand Rapids—was a major focus in the health care market. The hospitals, joined by local elected officials, expressed concern that the proposal to move all or a large portion of its clinical faculty to Grand Rapids would

Health System Characteristics

Lansing	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
2.1	*3.1*
Physicians per 1,000 Population[2]	
*1.3**	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
31%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$659	*$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

Lansing	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
228	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
20%#	*18%*
Persons with Any Doctor Visit in Past Year[2]	
81%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
3.7%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
40%	*44%*

# Indicates a 12-site high.

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

create access problems for patients and give the appearance of reduced quality of care in Lansing. MSU has since revised its proposal and now is expected to develop plans to build a campus for second-year students, a practice plan and a new medical education and research program in Grand Rapids, none of which would involve moving faculty from Lansing.

Several joint initiatives have unfolded between the two hospitals and MSU. For example, discussions among the MSU Health Team, IRMC and Sparrow about physician recruiting in needed subspecialties is expected to result in a formal consortium on graduate medical education, as well as joint recruiting efforts for plastic and bariatric surgeons, urologists, pediatric orthopedists and endocrinologists, among other specialties. Also, the hospitals, university and other organizations are working together under the auspices of the Capital Area Health Alliance on public health activities and a community-wide health information exchange. In addition, IRMC and Sparrow are collaborating with the area's two Medicaid plans, owned by the hospital systems, on a lead-testing program.

Lansing's Health Plan Market Sees Few Recent Changes

The market positions of Lansing's major health plans have changed little over the last several years. Blue Cross and Blue Shield of Michigan, along with its HMO subsidiary Blue Care Network (BCN), continue to dominate all segments of the market. BCBSM reportedly has a market share of more than 65 percent, while the HMOs—Blue Care Network and Physician Health Plan (PHP), owned by Sparrow and the only health plan besides Blue Cross to have significant enrollment in Lansing—hold just under 30 percent of the market. Although the plans' market shares have changed little, their financial positions have improved. A relatively new entrant, McLaren Health Plan, which operates as a Medicaid health plan and has limited commercial enrollment in Lansing, is planning to offer commercial products more widely in the market later in 2005.

Health plans are developing new products in an effort to improve or maintain their competitive positions. Each has developed plan options with higher patient cost sharing to meet employer demands for more affordable products. PHP, which has primarily been an HMO provider, has broadened its product line by creating a product without a gatekeeper and by moving into the self-insured business. Health plans also are offering or developing health savings account (HSA)-qualified options, although they report little takeup in the market to date.

A potentially important development for health plans was the enactment of a small group market reform law, which took effect in January 2004. The law, supported by BCBSM and a response to complaints by small businesses about steeply increasing premiums, defines what a small group is—two to 50 employees—and defines case characteristics that different types of carriers (BCBSM, HMOs and commercial carriers) can use in setting rates.

An important outcome of the new law is that BCBSM, which has long acted as the insurer of last resort in the individual and small group markets, is now permitted to use additional rating characteristics such as age and industry. Previously, BCBSM was not allowed to use such rating factors, which made the plan more attractive to higher-cost groups than lower-cost groups. Some observers believe that the new law has helped hold down premium increases for small employers by easing the cost burden on BCBSM, but this view was not universally held.

On the other hand, dire predictions that the new law would cause carriers to leave the state, thus reducing the number of choices available to small employers, appear not to have come to fruition.

Bad News for Health Care Programs for Low-Income People

Michigan's slow economic recovery has led to persistent state budget problems that threaten major cuts in public health insurance programs in 2005. Revenues have consistently fallen below levels needed to maintain human service programs, and as a result, program funding has not kept up with cost increases. Some policy makers attribute the state's revenue shortfall to a "structural deficit" created by tax cuts during the previous 12-year Engler administration.

Gov. Jennifer Granholm took office in 2003 with a pledge to protect public program eligibility, and she has largely kept that promise even while reportedly making more than $3 billion in state budget cuts. Nonetheless, the Medicaid program has eliminated some benefits (adult dental services, for example), frozen enrollment in a federal Medicaid expansion waiver program for uninsured adults approved in early 2004, and in May 2005 implemented a 4 percent cut in provider payments. At the same time, Medicaid enrollment has continued to grow, opening an estimated $40 million deficit for Michigan's fiscal year 2005 budget. To make things worse, Michigan may incur higher prescription drug costs if the new Medicare drug program results in the state losing the significant discounts from pharmaceutical companies it now receives.

With the federal government seeking to cut Medicaid spending and an additional loss of funding due to a cut in the federal Medicaid matching rate for the state, the state has few good options for filling this gap. The governor has proposed a 2.3 percent tax on physician practice revenue (similar to hospital and Medicaid health plan taxes already in place), but most respondents viewed the prospects for this proposal as bleak, given opposition from physicians and others.

The state also is planning to request a waiver that would exempt it from the federal requirement that the rates paid to Medicaid plans must be "actuarially sound." If these two proposals are unsuccessful, more draconian Medicaid cuts are expected. The governor's proposals for a major tax overhaul to put future funding on more solid ground have found little support.

Some Good News for Lansing's Safety Net Programs

Notwithstanding the state's serious financial difficulties, the Ingham Health Plan (IHP), which is managed by the Ingham County Health Department, continues to be a successful local financing model for providing access to health care for low-income residents. IHP pays for a limited service benefit package for uninsured individuals who do not qualify for traditional Medicaid, including those in the state's Adult Benefit Waiver program (childless adults with incomes below 35 percent of the federal poverty level), other people with incomes up to 250 percent of the poverty level, and a "third-share" insurance product in which employers, individuals and the county fund premiums with equal shares.

IHP has grown over the past two years by more than one-third, despite fluctuations in state and local funding and now provides access to more than 16,000 people, an estimated 50 percent of all uninsured people in Ingham County. By most accounts, the program is well regarded by health care providers and consumers, alike. This view is

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Ingham Model Replicated Throughout State

The strength and success of the Ingham Health Plan (IHP) has made it an attractive model in other parts of Michigan. As of early 2005, it has been replicated in 14 county or multi-county regions that, in total, provide access to medical services to more than 80,000 people (about half of whom are enrolled in the Medicaid Adult Waiver Benefit program and half are otherwise low-income and uninsured), and plans are underway to create similar initiatives in nearly all parts of the state. Not only has the IHP model been adopted elsewhere, but the ability of the Ingham County Health Department to effectively manage all aspects of the program—from provider contracts to outreach and eligibility—has brought other counties to Ingham's door for advice. In fact, several counties contract with Ingham County to administer their programs, and Ingham runs three county programs as subsidiaries. The proliferation of the IHP program has, however, met with some skepticism. Some respondents noted "donor fatigue," the hesitancy among some physicians in counties considering or implementing such programs to serve this additional population on top of the services they already provide to low-income individuals.

especially significant since IHP pays only for ambulatory care and a limited prescription drug list but does not pay for inpatient hospital care; Sparrow and IRMC provide those services to IHP patients as charity care. The program has reimbursed providers at Medicaid rates but decided not to implement the 4 percent Medicaid provider reimbursement cut to ensure continued participation by providers. The overall success of the IHP model has led to its replication in many other Michigan communities (see box above).

IHP has provided a substantial infusion of dollars to support local health care providers serving the uninsured. Another positive development for the Lansing area is that the Ingham County Health Department has received a federal health center designation that now qualifies its clinics for enhanced Medicaid reimbursement. This status will raise the payment per visit from approximately $35 to more than $125, providing the county with considerably more patient care revenues. It plans to use these added funds to expand services, improve support of some community mental health services and strengthen ties to the MSU pediatric residency program.

From the beginning, IHP has intended to offer a "third-share" product, underwritten by an insurance company, aimed at low-income workers. The idea, pioneered in Wayne County, Mich., is to share the costs of health insurance coverage for mostly small business employees among the employee, employer and community, which can fund its share through taxes, grants or other means. The product, however, has been very hard to sell; by early 2005, the IHP product had only about 25 enrollees after two years of development. To promote its growth, the county is planning a potential $250,000 marketing campaign. Opinions vary on whether the lack of success is due to marketing or lack of employer interest. Some officials expressed discomfort with such a large expenditure, when such funds could be used to expand access for many more individuals through the regular IHP program. Others, however, see the third-share product as an essential

offering to sustain community support for IHP among those who want to see private offerings succeed.

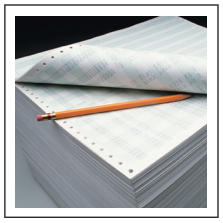
Counteracting the strengthening of health department services and IHP growth is the financial decline at two community-based health centers, Cristo Rey and Gateway. Both organizations have suffered from reduced local public and private funding, which has produced deficits and forced them to curtail service hours. Cristo Rey, an important medical provider to the Latino and migrant worker communities, is expected to see an even steeper decline in the near future as the pediatric residency program it has shared with MSU moves to the Ingham County Health Department. The reason for the move is mainly because the health department's new federal reimbursement status will bring in more money for the residency program, which Cristo Rey cannot match. Cristo Rey is not federally qualified and, because of its affiliation with the Catholic diocese, cannot pursue qualification because of strictures on providing family planning and reproductive health services.

Issues to Track

The health care market remains relatively stable in Lansing. Public and private employers are making modest changes in the health benefits they provide employees, and hospitals and physicians are seeking market advantages for specific services. But these trends appear less strong and have developed much later than in other parts of the country. Michigan's continued economic stagnation, however, seems likely to lead to greater efforts to reduce employer health care spending and to cause changes in key safety net programs and providers.

Key issues to track in Lansing include:

- Will the two major hospital systems' new construction projects and other strategic initiatives escalate competition for physicians and patients and, if so, how will that competition affect costs and access for consumers?
- Will efforts at cooperation in Lansing continue to evolve? Will it result in improved access and quality while reducing costs?
- What will be the resolution of GM-UAW contract talks, and how will it affect health care benefits and costs in Lansing?
- Will Michigan's economy and state budget picture improve, and with what effects on funding for public health care programs?
- Will increased funding for the Ingham County Health Department and resulting program expansions be sufficient to offset the deteriorating situations at Cristo Rey and Gateway?



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

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