CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

LITTLE ROCK • ARK.

NUMBER 3 OF 12 • JULY 2005

In February 2005, a team of researchers visited Little Rock, Ark., 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 65 leaders in the health care market. Little Rock 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 Little Rock, in 1996, 1998, 2000 and 2002, provide baseline and trend information against which changes are tracked. The Little Rock market encompasses Faulkner, Lonoke, Pulaski and Saline counties.

LITTLE ROCK PROVIDERS VIE FOR REVENUES, AS HIGH HEALTH CARE COSTS CONTINUE

Overall, little has changed in the last two years in the Little Rock health care market. Competition between Little Rock hospitals and physicians for profitable services continued amid ongoing financial pressures on providers' bottom lines. And, Little Rock remains a market where health care costs for purchasers and consumers, alike, are extremely high relative to incomes, leaving many low-income adults with inadequate access to health care. In contrast, low-income children have relatively good access, thanks largely to the Arkansas Medicaid program. Some employers and insurers are developing coverage products with larger deductibles and lower premiums that, along with somewhat moderating premium increases, may signal more competition among health plans.

Other important developments in Little Rock include:

- Ongoing shifting of treatment and diagnostic services from full-service hospitals to physician offices and specialty facilities.
- Rising numbers of uninsured adults, including undocumented immigrants, that challenge the capacity and responsiveness of the area's safety net.
- A new any-willing-provider law—supported by a few hospitals and many physcians and consumer groups but opposed by employers and health plans—that may affect health care costs and access.

Financial Pressures Propel Competition for Services

Financial pressure on providers is driving competition for profitable services between hospitals and physicians. The movement of more treatment and diagnostic services out of full-service hospitals into physicians' offices and specialty facilities is challenging hospitals to compete for key service lines. Yet, little has changed in organizational structure or market position among hospitals and physicians during the past two years, except for the opening of a second physician-owned specialty hospital. The exclusive contracting alliance between Baptist Health System and Arkansas Blue Cross Blue Shield (ABCBS) remained a barrier to major shifts in market share among Baptist, University of Arkansas for Medical Sciences (UAMS) and St. Vincent Health System. But change may be on the horizon, as the effects of the state's just-enacted any-willing-provider law unfold (see Box on Page 2).

As in recent years, both hospitals and physicians reported continuing financial pressures because of payment rates they say don't keep up with operating cost increases. Hospitals also

Little Rock Demographics

Little Rock	*Metropolitan Areas 200,000+ Population*
Population[1]	
600,899	
Persons Age 65 or Older[2]	
11%	*10%*
Median Family Income[2]	
$29,609	*$31,301*
Unemployment Rate[3]	
5.1%	*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

Any-Willing-Provider Law Hangs Over Little Rock

The any-willing-provider law, signed by the governor in March 2005, requires health plans to include any provider in their networks that agrees to the plans' contract terms. The state passed a similar law in 1995, but health plans and others challenged the measure, and it remains pending in federal appeals court. Since then, the U.S. Supreme Court upheld a similar Kentucky any-willing-provider law. The new Arkansas law is written to go into effect if the appeals court does not uphold the original 1995 law. The appeals court in late June ruled on the case finding that the original law applies to non-employer plans and fully insured employer plans but not self-funded employer plans.

If an any-willing-provider law leads to changes in the Baptist–Blue Cross exclusive alliance or the networks of QualChoice and UnitedHealthcare, both of which contract with UAMS and St. Vincent, consumers might shift where they obtain care. Most observers suggested that provider payment rates are likely to decline, but opinions varied about which, if any, hospitals would see increased admissions or whether the law would spur growth in physician-owned facilities.

Fearing the new law would force them to include providers who use too many services, leading to higher premiums, health plans were expected to either challenge the law in court, as they did before, or develop new contracting strategies to allow them to continue directing patients to preferred providers. Some observers suggested that plans—Blue Cross in particular—would establish criteria that could still exclude some providers, including specialty hospitals, for example, through performance-based tiered networks.

reported financial pressures increased in the last two years because of the growing burden of uncompensated care. In response, hospitals continued to compete for physicians and patients, particularly around profitable service lines, such as cardiology and orthopedics, to help offset financial pressures. For example, to compete against the Arkansas Heart Hospital, a joint venture of local physicians and the MedCath Corp., St. Vincent recently opened the Jackson T. Stephens Heart Center, a state-of-the-art cardiovascular center that replaced and consolidated cardiac services in the system's flagship hospital.

The 1997 opening of the Arkansas Heart Hospital increased competition for inpatient services, a trend that continues as another specialty hospital opened in April 2005 in a community north of Little Rock. The 16-bed Arkansas Surgical Hospital, owned by orthopedists, neurosurgeons and plastic surgeons, will provide selected services in those specialties, such as spine surgery, but not more complex trauma and head surgeries. Many observers expected Little Rock's three major health plans to exclude the new surgical hospital from plan networks—just as they have excluded the specialty heart hospital. The plans believe specialty hospitals are higher cost and a financial threat to full-service hospitals, but the new any-willing-provider law may impede attempts to exclude specialty facilities from plan networks.

In response to the new heart hospital, Baptist initiated a conflict-of-interest policy, allowing the hospital to

deny admitting privileges to physicians with an ownership interest in a hospital to which they admit patients. The involved physicians sued Baptist, and the case is pending. Nonetheless, six neurosurgeons who are investors in the Arkansas Surgical Hospital resigned from Baptist.

Local market observers believed that specialty facilities, individually, were unlikely to have major long-term effects on patient volume at other hospitals. Taken together, however, some feared specialty hospitals may undermine the financial well being of general acute care hospitals, which depend on profitable services to subsidize uncompensated care and money-losing services that specialty hospitals do not provide.

Hospital competition with physicians over outpatient services also continued, with many respondents noting that most growth in outpatient capacity was now in medical offices rather than in physician-owned freestanding outpatient facilities. Seeking ways to increase revenues, many larger specialty physician practices are offering additional treatment and diagnostic services in their offices to collect both their normal professional fees and additional facility fees. For example, most larger specialty practices have specialized scanners or other imaging equipment, and a cardiology group has its own catheterization labs; in both cases, these were formerly services provided in hospital outpatient departments. Another cardiology group, Heart Clinic Arkansas, took a different approach, leasing space and staff in St. Vincent's catheterization labs for a block of time each week; the physician practice must pay for the time whether they fill the schedule or not. As a result of this arrangement, the physicians are doing more catheterizations at St. Vincent, leading to more cardiac admissions for the hospital while allowing the physicians to collect both the professional and facility fees. As with the specialty hospitals, the major health plans do not contract with most of the freestanding facilities. But plans do not control what is being offered in physician offices, although some reports suggest that plans may increase oversite of ancillary services.

The opening of the new specialty hospital has compounded physician recruiting difficulties, reportedly a growing problem in recent years. Because Little Rock is the trauma center and regional referral center for the state, neurosurgeons face significant pressures to provide emergency department on-call coverage and perform large numbers of complex brain surgeries. These pressures helped drive a large proportion of the market's neurosurgeons to invest in the new surgical hospital, which in turn led Baptist, one of two designated trauma centers in Little Rock—along with UAMS—to recruit more neurosurgeons. Hospitals also are recruiting and employing or subsidizing other specialists—notably emergency physicians and anesthesiologists—to ensure adequate on-call coverage.

High Costs Threaten Access

Health insurance premium increases for Little Rock businesses reportedly have moderated during the past two years. Some observers attributed the slowdown in premium increases to purchaser efforts to reduce the scope of coverage and to moderating underlying costs. Others pointed to more competitive pricing by health plans, especially Arkansas Blue Cross Blue Shield, which some believe eased premium increases to spend down large reserves built up after years of rapid premium growth. Few, however, believe the moderation in premium increases will persist for long.

Employer-sponsored health coverage remained stagnant and costly rela-

Health System Characteristics

Little Rock	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
4.6#	*3.1*
Physicians per 1,000 Population[2]	
2.4	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
13%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$654	*$718*

# Indicates a 12-site high.

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

Little Rock	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
310#	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
18%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
76%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
4.7%	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
52%	*44%*

# Indicates a 12-site high.

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

tive to incomes in Little Rock, a market where many employees must pay a large share of premiums for single and, especially, family coverage. In part, this is because the area's economy is composed of mostly small and medium-sized businesses that can't afford large premium contributions.

In general, businesses made few significant changes to health benefits during the last two years, largely due to premium growth that was well below the national average. Three-tier prescription drug copayments, which emerged about two years ago, appear widespread now, and several respondents reported increased copayments. Employers also increased deductibles, office visit copayments and the share of employees' premium contributions, but the changes did not appear to be large. Plan options largely have not changed. Preferred provider organizations (PPOs) remain the most popular product in Little Rock, although employers have a significant portion of lower-wage employees in health maintenance organization (HMO) products.

In contrast, costs for public employers grew much faster over the past two years. The State and Public School Life and Health Insurance Board, which buys health benefits for state employees, public school teachers and UAMS, saw double-digit premium increases in 2005. State employees contribute about 30 percent of the premium for individual coverage and more than 40 percent for family coverage.

Many public school teachers must contribute even more because the Legislature allocated less money to cover school employees' health benefits. In a state where teachers' salaries rank among the nation's lowest, many teachers contribute more than $190 a month for single coverage and more than $700 for family coverage for the lowest-priced coverage option. Teachers in Little Rock pay less because the local school district has chosen to make higher contributions toward their premiums. But as teachers in other parts of the state drop out of the program because of high premiums, there are concerns that the state health insurance program could face a "death spiral" of ever-rising costs for a sicker and sicker population. At the time of the site visit, lawmakers were considering a proposal to raise the schools' subsidy level to entice more teachers into the program to help stabilize its financial future.

Blue Cross Dominates Market

In a state of approximately 2.6 million people, about 1.4 million have private insurance, and Arkansas Blue Cross Blue Shield reportedly enrolls almost half of that total. The next largest competitor is UnitedHealthcare with perhaps as much as 25 percent of the Little Rock market. The remaining privately insured market is split among QualChoice, a small locally owned HMO, several national for-profit managed care companies, notably Aetna and CIGNA, and other carriers.

Arkansas Blue Cross continues a long-held role as the market share leader, but observers noted that United has increased focus on Arkansas. And QualChoice has turned around earlier financial challenges. United is expanding its network statewide and, as part of a national effort, positioning itself to offer consumer-driven health plan products. Although the market shares of the three major plans appear to have changed little in the past two years, plans reportedly have been pricing more aggressively and trading accounts more than in the past.

Perceptions of intensified competition in Little Rock may have been shaped by the significant amount of jockeying to serve the market for consumer-driven health plan products. In response to growing employer inquiries, all of the major health plans have

developed products linked to health savings accounts (HSAs) under the assumption that the market will soon move in that direction. Observers viewed United as being well positioned for such a shift, because it bought Golden Rule and Definity Health, companies that both focus on high-deductible consumer-driven products tied to spending accounts. United markets a range of customizable HSA options with a high-deductible PPO product to individuals and groups, and Blue Cross offers products in both the individual and group markets, with various levels of deductibles and choices, including prescription drug coverage.

While health plans offered these products in 2005, there reportedly was little take up, with many employers pulling out of discussions at the last minute. Blue Cross enrolled fewer than 10 groups and about 2,000 nongroup individuals statewide, and few state employees chose the new high-deductible plan and HSA offered to them.

Employers are not organized around health care issues in Little Rock, and few collective efforts exist to influence health plans or the health care market in general. One exception is a North Little Rock Chamber of Commerce initiative to establish a Health Insurance Purchasing Group for its members.

After approaching several carriers, the chamber entered into a five-year exclusive relationship with QualChoice Health Plan to offer an innovative $5,000 deductible policy—with first-dollar coverage for many preventive services—to small businesses that agree to cover all employees. The high-deductible product, which meets federal requirements for HSAs, is priced so that the employer's contribution covers the entire premium, thus essentially guaranteeing that all employees will have at least some minimum coverage. Higher premium options are available that offer lower deductibles and more comprehensive coverage. The promise of bringing uninsured workers into the insurance pool garnered the support of state insurance regulators who had to approve the program.

Kids Benefit As Safety Net Challenges Grow

In contrast with the private sector's inability to address cost and access problems, Arkansas' Medicaid program for children, ARKids First, continued to be viewed as a dramatic success with broad support across the political spectrum. ARKids enrolled 341,000 in 2005, about half of the state's children.

The growth of ARKids, which predated the national State Children's Health Insurance Program, has wide-ranging implications for access to care for children and payment for those who care for them. Unlike low-income adults, children from low-income families are more likely to have health coverage and access to a range of services, although dental and some specialty care remain difficult to obtain. In addition, the expansion of children's coverage has served to strengthen the financial position of the Arkansas Children's Hospital, a key resource for families. Only 10 percent to 15 percent of the hospital's patients are uninsured today, less than half the proportion nine years ago, despite serving a steady increase of undocumented immigrant families.

In the fall of 2004, the state Medicaid agency extended ARKids coverage to undocumented pregnant women. Many expected this new policy to improve pregnancy outcomes and provide a critical link to health services for immigrant families. The state also recently launched the Angel Program through the UAMS obstetrics department, a telemedicine consultation and monitoring program for high-risk pregnant women.

The declining number of uninsured

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children means that many Little Rock safety-net providers, such as community health centers and free clinics, are now providing care mainly to uninsured adults. Compared with ARKids eligibility for children ages 0-19 with family incomes up to 200 percent of the federal poverty line, or $38,700, for a family of four in 2005, Medicaid coverage for adults is extremely restrictive. In 2005, adults in families with children covered by ARKids First were ineligible for Medicaid unless their family incomes were at or below 20 percent of the poverty level, or $3,870 for a family of four in 2005. Moreover, with the exception of pregnant women, no public coverage is available for undocumented immigrant adults, many of whom work in service industry jobs that do not offer health insurance.

As uncompensated care has increased over the past two years, the result is growing pressure on the finances and capacity of some safety net providers. UAMS remains the primary provider of emergency, inpatient and specialty services for uninsured adults in Little Rock and much of the state. The number of uninsured adult patients treated at the hospital has increased, often pushing the emergency department past capacity and leading to waits of six to nine months for specialist appointments. The Arkansas Health Care Access Foundation, which refers uninsured patients to volunteer physicians, has seen a 60 percent increase in requests for assistance in the last three years to 16,000 in 2004. And about half of the patients seen at the Jefferson Comprehensive Care System's three Little Rock clinics are uninsured adults, a proportion that is growing even as the organization's government funding has remained static.

Various respondents characterized the growing population of undocumented Latino immigrants in Little Rock as just the beginning of what's expected to be much faster growth in the future. To prepare, along with a longstanding weekly clinic, Catholic Charities recently added a monthly clinic for Latinos, where patients can receive free medical consultations and prescription drugs. Up to 40 percent of patients at the Jefferson system's Little Rock clinic are Latino, up from almost none just three years ago. In response, the system hired an interpreter and a Latino health educator who also functions as a liaison with Latino organizations. Likewise, Children's Hospital is developing a weekly evening children's clinic staffed by a bilingual nurse.

Whether access for low-income residents improves or gets worse will largely depend on the state budget. The Legislature has struggled to meet competing financial demands, including large court-ordered capital investments in public schools and teachers' compensation and benefits. In the face of such demands, continued growth in Medicaid coverage and expenditures may be difficult to sustain, although the Legislature did move to increase Medicaid payments to hospitals.

Governor Pushes Healthy Living

The high costs of health insurance and high rates of uninsurance may play a role in what is widely considered the generally poor health of Arkansans. In 2003, state legislators responded to this concern by passing a law making the reduction of childhood obesity a statewide priority. The law requires body mass index measurements of all schoolchildren as a way to highlight the need for proper nutrition and exercise. Combined with Gov. Mike Huckabee's own highly publicized weight loss of nearly 100 pounds, the 2003 legislation has increased the state's public health focus on nutrition, exercise and obesity. While the law emphasizes better nutrition for schoolchildren, early efforts to reduce access to junk food and sodas at

public schools have pitted public health advocates against food vendors whose contracts generate considerable income for schools.

Despite Huckabee's push for a healthier Arkansas, interest in health promotion had not spread widely to the private sector, perhaps revealing the challenge of shifting the traditional medical system's focus from illness care to health improvement. Few firms have employee wellness programs, and health plan-based initiatives were almost nonexistent. On the other hand, public employers, notably the Insurance Board and UAMS, made some inroads in encouraging healthy employee lifestyles. The board introduced a risk assessment survey in the past year, offering a $10 a month premium discount to workers completing the survey. The participation rate approached 50 percent, and the information from the survey will be used to identify individual health concerns. UAMS recently went smoke-free across its entire campus, the first hospital in the state to do so; the Legislature subsequently mandated that all hospitals follow suit. UAMS also developed an incentive program for employees to join a new onsite fitness club and initiated a contract with TrestleTree, an Arkansas firm that offers health coaching to employees with specific health concerns. Reportedly, 10 percent to 15 percent of employees are participating.

Issues to Track

In light of the very low incomes of people in Arkansas, Little Rock remains a high-cost health care market that shows signs of declining access for low-income uninsured adults. The state has made a solid commitment to assure children have access to medical care and to promote their health and well-being. Few major changes have occurred in the health care system, either in the market balance among the three major health plans or among the three major hospital systems, although competition for profitable inpatient and outpatient services continues. Most employers that sponsor coverage remain conservative in their approach to purchasing health benefits for their workers.

Key issues to track include:

- Will the North Little Rock Chamber of Commerce expand enrollment in its innovative health insurance product and appreciably reduce the number of uninsured people?
- Will interest in health savings accounts translate into significant enrollment among private and public employees?
- What effect will the new surgical hospital have on quality, costs and access?
- Will the widespread public and state support of children's health care continue in the face of considerable state budget pressures?
- If the new any-willing-provider law is implemented, how will it affect health plan-provider networks, costs and access?

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Little Rock 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.