CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

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In January 2005, a team of researchers visited Indianapolis, Indiana, 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 95 leaders in the health care market. Indianapolis 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 Indianapolis, in 1996, 1998, 2000 and 2002, provide baseline and trend information against which changes are tracked. The Indianapolis market encompasses Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan and Shelby counties.

CONTINUED HOSPITAL EXPANSIONS RAISE COST CONCERNS IN INDIANAPOLIS

Intensifying competition among hospital systems and the entrepreneurial activities of physicians are raising questions about the affordability of Indianapolis' health care system. Two years ago, hospitals and medical groups were busy developing new specialty facilities and services, while health plans and employers took few steps to check rising costs and insurance premiums. Since then, hospital competition has continued to fuel facility expansions, but many providers also are collaborating on clinical data-sharing initiatives that hold promise for improving care delivery. This juxtaposition raises both concern and enthusiasm for the future of health care in Indianapolis.

Other significant market developments include:

- National health plans stimulated competition in the insurance market at the expense of some local plans and third-party administrators.
- An employer consortium pushed for provider performance reporting and new insurance products that reward quality and efficiency.
- Reforms at the county hospital alleviated financial difficulties and prompted changes in the local safety net.

Facility Expansions Transform Provider Landscape

The building spree that spawned four new heart facilities in Indianapolis two years ago has continued unabated, raising concerns that these expansions will generate further increases in health care costs. The area's four private hospital systems have committed more than $1 billion for current and planned projects to build new general hospital facilities, expand existing medical campuses and renovations.

Much of this activity is focused on the growing suburban areas of Indianapolis, where hospitals are intensifying competition for profitable, privately insured patients.

Clarian Health Partners, which lacked a presence outside the central city, has pursued one of the most aggressive expansion strategies. Clarian opened a new 80-bed hospital in the western suburbs at the end of 2004 and will open a new 175-bed facility in the northern suburbs in late 2005. These expansions are expected to improve the system's base of privately insured patients, which has eroded in recent years because of affluent residents moving to the suburbs and growing numbers of publicly insured and uninsured patients who are diverted to Clarian from the county-owned Wishard Hospital during periods of peak demand. Clarian also is upgrading facilities on its main campus downtown, including a new cancer hospital to replace an existing cancer center and a new tower at its children's hospital.

Clarian's competitors have followed suit with their own efforts to expand and improve facilities. Community

Indianapolis Demographics

Indianapolis	*Metropolitan Areas 200,000+ Population*
Population[1]	
1,674,493	
Persons Age 65 or Older[2]	
11.3%	*10.1%*
Median Family Income[2]	
$34,233	*$31,301*
Unemployment Rate[3]	
4.7%	*6.0%*
Persons Living in Poverty[2]	
14%	*13%*
Persons Without Health Insurance[2]	
9%	*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

Health Network is expanding its northern suburban campus from 200 to 350 beds at a cost of $170 million. Meanwhile, St. Vincent's Health System recently opened a new children's hospital, expanded its orthopedic surgical facilities, and acquired Women's Hospital for renovation and conversion to private obstetrical rooms. Finally, the St. Francis Hospital System recently completed a new facility in western Indianapolis and is expanding its existing campus in the southern part of the city.

This most recent wave of hospital expansions threatens to erode the geographic segmentation that historically has kept the four major hospital systems on relatively friendly terms. The St. Vincent's system, which has long dominated the northern suburban areas of the city, will soon face heightened competition from one of Clarian's new facilities and a physician-owned orthopedic hospital scheduled to open in 2005. Community Heath System's large expansion in the northeastern suburbs also may allow it to capture patients that formerly would have gone to St. Vincent's or Clarian facilities. Some observers speculated that the heightened hospital competition may provide health insurers with increased leverage in negotiating price concessions, potentially allowing the development of health plan networks that exclude one or more of the major systems. Others, however, expect that hospital systems' considerable geographic segmentation in other areas of the state, combined with strong consumer preferences for broad choice of providers, will allow hospitals to continue to resist selective contracting.

The new heart facilities that opened in Indianapolis during the past two years have had relatively little impact on the financial performance of community hospitals to date, despite considerable fears to the contrary. Although four new facilities opened during this period, three of them were replacements for existing service lines, so the net increase in cardiac surgery capacity within Indianapolis has been modest. The fourth facility, a joint venture by St. Vincent's and a prominent cardiology group, has redirected a significant amount of patient volume from St. Vincent's main hospital to the new facility. Nevertheless, both partners in the joint venture appear satisfied with its performance and are already considering an expansion of the facility.

Joint ventures between Indianapolis hospitals and physicians have continued as physicians seek additional revenue from inpatient and outpatient facility fees and hospitals attempt to strengthen physician loyalty and avert competition from wholly physician-owned facilities. In the past, these ventures have focused primarily on developing specialty facilities, such as heart hospitals and ambulatory surgery and diagnostic centers, but several recent ventures have formed for the development of new general community hospitals. The new Clarian North and Clarian West suburban hospitals, for example, are both organized as for-profit joint ventures between individual physician investors and the nonprofit Clarian system.

The array of expensive capital expansion projects underway in Indianapolis threatens to push the already high cost of health care even higher. According to health plan respondents, hospitals already are demanding large payment rate increases to help finance expansions, and some observers feared that costs will accelerate further because of increased utilization stimulated by physician-owned facilities. On the other hand, some hospital systems are concerned that the expansions are generating excess capacity that ultimately will strengthen the ability of health plans to suppress provider payment rates.

Information Technology Initiatives Make Progress

Despite the increasingly competitive hospital environment, Indianapolis providers are working together on community-wide clinical data-sharing initiatives designed to improve

care delivery. These initiatives are an outgrowth of decades of work conducted by the Regenstrief Institute in Indianapolis, which was founded in 1969 by a local philanthropist.

Five data-sharing initiatives are currently underway, the most expansive of which is the clinical messaging system developed by a consortium of local physicians and other health care entities known as the Indiana Health Information Exchange (IHIE) in collaboration with the Institute. This system allows the secure transmission of laboratory and imaging tests and consultation data from any participating data provider to individual physician's offices, reducing the need for duplicative diagnostic tests and enhancing the coordination of care across settings. The data providers, which include laboratories, diagnostic facilities, hospitals and specialist physicians, pay a fee to subscribe and designate which physicians are to receive the clinical information they generate.

The system allows physicians to receive data into e-mail accounts or directly into electronic medical records and to forward data to other physicians, along with medication lists, patient notes and text messages. All four of Indianapolis' private hospital systems, plus the county-owned Wishard Health Services, are expected to participate in the effort. IHIE has enrolled approximately half of Indianapolis' 3,500 physicians as data users in the system and is expected to enroll the remainder of physicians during 2005.

Other community-wide data-sharing initiatives include:

- A clinical data repository for emergency department care that collects data from all five hospital systems and allows emergency physicians to access data to improve coordination of care;
- A surveillance system that compiles clinical data from emergency departments, ambulance runs, laboratories and pharmacies for use in detecting disease outbreaks; and
- The Indiana Network for Patient Care, a new initiative with the goal of developing a community-wide electronic medical record system.

Alongside these community-wide initiatives, Indianapolis providers are investing heavily in their own clinical information technology applications. All of the local hospital systems and several large medical groups have begun implementing some form of electronic medical record. The hospital systems also have developed various systems for sharing imaging and laboratory information across individual hospitals and with their affiliated physicians. Moreover, several of the new specialty hospitals are, or are expected to be, fully digital, with the capacity to transmit images, implement automated patient monitoring systems in critical care units and allow bedside electronic charting. Hospitals expect these information technology investments to strengthen their long-standing quality improvement efforts and foster participation in a range of quality reporting programs, including those maintained by accreditation agencies, Medicare and commercial insurers.

These clinical data-sharing initiatives place Indianapolis far ahead of most other communities in the use of information technology to enhance care delivery. These initiatives hold considerable promise for improving quality and efficiency over the long term as more providers adopt and use the technologies in routine clinical decision-making. However, few observers expect these initiatives to have much near-term impact on health care costs in Indianapolis.

National Insurers Gain Ground

Historically, national health plans have had limited success in this market because of the dominance of Indianapolis-based Anthem BlueCross BlueShield, the considerable market leverage of local hospital systems and the strength of several provider-sponsored health plans affiliated with these systems. Over the past two years,

Health System Characteristics

Indianapolis	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
3.1	*3.1*
Physicians per 1,000 Population[2]	
2.1	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
21%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$655	*$718*

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

Indianapolis	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
207	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
18%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
82%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
6.4%#	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
54%	*44%*

# Indicates a 12-site high

Sources:

[1] American Hospital Association, 2002

[2] HSC Community Tracking Study Household Survey, 2003

Anthem has strengthened its position in the market, but several national health plans have made inroads in Indianapolis at the expense of local competitors. Observers expect that stronger national health plans could stimulate the development of new health insurance options for employers and consumers and place increased pressure on hospitals and physicians to contain costs.

Anthem has strengthened its long-dominant position by winning the accounts of several large local employers over the past year, including pharmaceutical company Eli Lilly and the Marsh Supermarkets chain. These employers formerly contracted with local third-party administrators (TPAs) to manage their self-funded health benefits. Employers and insurers attribute much of Anthem's recent membership growth to its ability to negotiate price discounts with hospitals and physician groups—an advantage that has become increasingly attractive to employers faced with annual, double-digit increases in health insurance premiums. Anthem reportedly maintains "most-favored nation" clauses in some of its provider contracts, which assure the plan of receiving the largest price discounts offered to any insurer in the market.

Anthem's 2005 merger with California-based WellPoint Health Networks has had little immediate impact on the insurer's market clout in Indianapolis. WellPoint had little membership in Indianapolis prior to the merger, so the merger did not increase Anthem's local market share significantly. Nevertheless, some hospitals and physicians expressed concern that the merger may lead the insurer to become more forceful in dealings with providers. Anthem so far has avoided aggressive cost-control tactics, such as selective contracting and tiered networks, and it has taken few steps to curb the costly facility expansions and improvements in Indianapolis. Anthem's ability to use its dominant market position for cost containment remains limited by the considerable market power of hospital systems across the state and by the reluctance of local employers to restrict consumers' choice of providers.

Several other national plans have expanded operations in Indianapolis, raising the possibility of increased competition among insurers. Several years of healthy profits reportedly have made insurers more willing to compete for market share, signaling a turn in the health insurance underwriting cycle. Both UnitedHealthcare and Aetna have stepped up marketing activities in Indianapolis after scaling back operations several years ago. Moreover, Humana recently entered the large-group market in Indianapolis by winning the health benefits contract for the employees of St. Vincent's, one of the largest employers in the market and co-owner of the provider-sponsored health plan that formerly held the contract. St. Vincent's decision to contract with Humana reflects a diminishing willingness to support its own health plan when lower cost options are available from other carriers.

The competitive pressures facing Indianapolis' provider-sponsored health plans have continued to increase over the past two years. Two of these plans—M-Plan, owned in part by the Clarian and Community hospital systems, and Advantage Health Solutions, owned in part by the St. Vincent's and St. Francis systems—primarily sell health maintenance organization (HMO) products to large and mid-size employers that offer these products alongside their more popular self-funded preferred provider organization (PPO) plans. In recent years, some large private employers have scaled back health plan offerings to simplify administrative processes and reduce costs, with some firms moving their health benefits to national, multi-product insurance carriers that typically offer premium discounts to employers that purchase coverage from a single carrier. As some business opportunities with large employers decline, both M-Plan and Advantage have begun to develop lower-cost products designed

to appeal to smaller employers, including HMOs with deductibles and high-deductible products with health savings accounts. Still, provider-sponsored plans remain popular insurance choices for Indianapolis' public employers and large private employers.

Employers Search for New Cost-Containment Strategies

Indianapolis' employers have had little success in reining in health care costs over the past two years and express growing concern about health insurance affordability. Many employers have experienced five to six straight years of double-digit health insurance premium increases.

Employers have responded by transferring more costs to employees through increased premium contributions, higher deductibles and copayments, and more restrictions on spousal coverage. Several large employers, for example, introduced new higher-deductible health plan options for the first time in 2004 and 2005 so that employees would have lower-cost alternatives to their traditional health insurance products. Similarly, the state has encouraged its employees to enroll in products with higher copayments in exchange for lower premiums. Some small employers reportedly have discontinued coverage altogether in response to premium increases, adding to the growing uninsured population in Indianapolis.

Employers have engaged in a number of past efforts to reform the health care system collectively through purchaser coalitions, but none has met with much success because of divergent employer interests and priorities. Most recently, a consortium of local employers, insurers and health care providers, known as the Employers' Forum of Central Indiana, has tried to stimulate improvements in the quality and efficiency of health care delivery in Indianapolis. During the past two years the Forum has expanded its membership to include many local public and private employers, the Chamber of Commerce, the Indiana Manufacturers Association, the state, and major health plans and providers. Eli Lilly and General Motors, two of the market's largest employers, are very active in the Forum.

A major focus of the Forum has been the development of insurance products that use tiered-provider networks or limited networks to steer consumers to efficient and high-quality providers. During 2004, the Forum launched an initiative to generate and report measures of clinical quality and satisfaction for each of the physician networks affiliated with Indianapolis' major hospital systems. The two provider-sponsored health plans—M-Plan and Advantage Health Solutions—pooled data to generate these reports, which the Forum hopes to use as a basis for developing tiered-network health insurance products that offer differential premiums and copayments based on the quality and efficiency of the provider network.

To date, these two health plans have been the only insurers willing to participate in the Forum's quality reporting project, and employers have shown little willingness to introduce performance reporting and tiered-network arrangements into the self-funded PPO products that serve most of their employees. Moreover, many local hospitals and physicians continue to resist the development of tiered networks, and they face few incentives for participating in such arrangements as long as consumers can avoid these networks by choosing the self-funded PPO options offered by their employers. As a result, the Forum's activities are likely to have relatively little impact unless they are implemented by larger numbers of health insurers and adopted by employers in both fully insured and self-funded products.

With few promising solutions on the horizon, some local respondents fear that rising health care costs will soon become an economic development issue in Indianapolis as businesses look to lower-cost regions to locate and expand. Health care costs in Indianapolis and across the state

Indianapolis' employers have experienced little success in reining in health care costs over the past two years and express growing concern about the affordability of health insurance.

Safety net providers in Indianapolis have struggled to accommodate recent increases in the demand for their services and changes in the distribution of patients across providers.

reportedly are significantly higher than in neighboring states, placing the area at a competitive disadvantage in attracting new businesses. General Motors, for example, has publicly identified Indiana as one of its highest-cost markets for purchasing health care, and observers fear this fact will drive future decisions about plant expansions and closures. Indianapolis has lost a number of Fortune 500 companies in recent years, heightening worries about further job losses.

These concerns, combined with the lack of successful private-sector solutions, have led employers and others to advocate for stronger legislative and regulatory responses to health care costs. The state Legislature already has begun to consider bills that would reinstate certificate-of-need (CON) reviews for new health care facilities and limit the ability of physicians to refer patients to facilities in which they have an ownership interest.

Financial Difficulties Stress Safety Net Providers

Safety net providers in Indianapolis have struggled to accommodate recent increases in the demand for their services and changes in the distribution of patients across providers. Indianapolis' major safety net hospitals and community health centers have experienced increases in patient volume over the past two years that they attribute at least in part to the economic downturn and resulting increases in the uninsured population. Adding to this problem, the state eliminated a policy of continuous eligibility for Medicaid in 2004 because of budget difficulties, generating concerns that Medicaid-eligible individuals are losing coverage and causing safety net providers to expend more resources to help eligible patients re-enroll. With more patients to serve and more responsibilities to assume, providers have looked for ways to leverage limited resources to expand capacity.

In recent years the increasing volume of low-income patients, combined with rising health care costs and strained federal funding, has produced multi-million-dollar annual deficits at county-owned Wishard Health Services, Indianapolis' leading safety net hospital and community clinic network. To address these financial difficulties, the hospital adopted strategies to boost revenues and cut costs, including stepped-up collection and billing practices from third-party payers and some staff reductions through attrition. These strategies are credited with reducing Wishard's deficit significantly, while allowing the organization to maintain clinical capacity. In fact, Wishard recently opened a new health center to serve the community's growing Latino population.

As another part of its turnaround strategy, Wishard recently increased cost-sharing requirements for uninsured patients participating in its Health Advantage program. Health Advantage provides comprehensive health care for low-income uninsured people through Wishard Hospital and affiliated community health centers. The program has expanded considerably over the past two years and now provides health care to more than 50,000 people, or half of the uninsured in Marion County. To encourage patients to seek care appropriately in cost-effective settings, Wishard has increased copayments. For example, copayments are now $10 for a primary care visit and $100 for a visit to the emergency department, which is waived if the patient is admitted to the hospital.

Many community respondents view the new cost-sharing expectations as a reasonable strategy to maintain the safety net and encourage the appropriate use of services, yet there are still concerns about the impact of copayments on access to care. Though providers will still treat patients who don't have money for copayments, they acknowledge that cost-sharing expectations likely have led some patients to delay or forgo care or to seek care elsewhere. For instance, a free clinic that does not charge for most services reported a significant influx of patients following Wishard's copayment increases.

Health Advantage enrollees are

receiving care from a broader array of safety net providers for reasons that go beyond the recent copayment increases. While Wishard continues to treat the majority of Health Advantage enrollees, the program's primary care network has expanded since 2001 to include clinics operated by the St. Francis, St. Vincent's and Clarian hospital systems and most of the community's independent health centers. These providers receive $10 per month from Wishard for each Health Advantage enrollee who selects them as a medical home. Most of the network providers reportedly charge copayments that are comparable to Wishard's, but often can offer earlier appointment availability and more convenient locations, leading some patients to choose them over Wishard.

For the most part, the non-Wishard providers in the Health Advantage network have accommodated additional patients without difficulty. For example, HealthNet, a federally qualified community health center, has expanded to meet growing needs over the last few years and welcomes new Health Advantage patients. However, recent increases in Health Advantage patients reportedly have strained the capacity of at least some providers—including a hospital emergency department that does not participate in the Health Advantage network.

While Health Advantage has broadened the network of primary care providers serving the uninsured in Marion County, access to specialty care remains a challenge. Reportedly, it is not uncommon for Wishard patients to face waits of four to six months to access non-emergent specialty care. To help connect low-income patients with specialty services more quickly, the Indianapolis Medical Society Foundation launched a program called Project Health. Modeled after a similar program in Asheville, N.C., Project Health connects low-income Indianapolis residents with donated specialty care, prescriptions (with a copayment) and ancillary services. The program began in May 2004 and currently has approximately 300 patients enrolled. Though still small, the program appears to reduce wait times for specialty care dramatically, but it continues to face challenges getting certain types of specialists to participate.

Despite Wishard's recent financial improvements and other safety net expansions, safety net providers in Indianapolis face significant uncertainties about the future. Indiana currently faces large budget shortfalls for its public programs, and many observers expect that the governor will seek additional cuts to the Medicaid program as a result. Plus, there are concerns that external federal, state and local funding support for Wishard is not keeping pace with demand for care. At the same time, continued increases in health care costs threaten to further erode private health insurance coverage in Indianapolis, placing added strain on safety net providers.

Issues to Track

The prospect of continued growth in costs has many observers concerned about the affordability of health care in Indianapolis. Important issues to track include:

- How will hospital expansions and the growth of physician-owned facilities affect health care quality, costs and utilization?
- What effects will Indianapolis' community-wide clinical data-sharing initiatives have on health care quality and efficiency?
- How will the expansion of national health plans and the planned initiatives of the Employers' Forum affect health insurance premiums and plan-provider relations?
- How will Medicaid and safety net health care programs fare under the new state administration and proposed budget cuts?

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

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