

Policy Perspective

By John Steen

Specialty Hospitals

In a study published online by *Health Affairs* on July 26, 2006 ["Specialty-Service Lines: Salvos In The New Medical Arms Race," *Health Affairs* 25 (2006): w337–w343; <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w344v1>], the researchers, Robert A. Berenson, Thomas Bodenheimer, and Hoangmai H. Pham, found that specialty hospitals that focus on such areas as heart disease and cancer can lead to increased health care costs in markets in which they compete with traditional full-service facilities. Although specialty hospitals have increased competition in many markets, they compete on services rather than prices, so they do not lead to reduced health care costs in most cases. The study confirms that, much as in the pre-managed care era of the 1980s, contrary to "mainstream economic theory, hospitals in more competitive environments had higher costs per case and per day than those in less competitive environments, when other factors were controlled for." Full-service hospitals to date have compensated for the loss of market share to specialty facilities "by raising prices for profitable specialty-lines."

Furthermore, increased availability of certain services, in combination with marketing to consumers, might increase demand for medically unnecessary procedures. The study authors find that, "it seems clear that the intent of the Stark law limitations on physician self-referral has not been achieved, largely because physicians have figured out how to take advantage of the broad exception in the law for services provided by self-referral that occurs within their own practices or for services they personally provide."

There are implications for erosion of quality here too.

Theoretically, service-line competition could cause quality erosions if a continued or even increased dispersion of cases among many competing facilities compromises the volume-outcome relationship that exists for many technologically oriented services, such as complex surgery.* In addition, quality could be compromised if more patients receive inappropriate services that a service-line provider is in business to promote.

Not all of these specialty-service lines are freestanding specialty hospitals; more are centers within a general hospital and include physician specialists; and an increasing number are physician-owned ambulatory specialty facilities. The authors foresee these changes as creating growing problems for hospitals in maintaining control of their financial integrity.

Hospitals still have sufficient control over many profitable service lines and continued contracting leverage with managed care plans, such that rate increases from private health plans make up for losses of business to competing hospitals and physician-owned ambulatory facilities. However, as more care moves to physician-owned ambulatory sites of service through gene therapy, robotic surgery, and other "disruptive technologies," the role of the hospital in the health care system could change markedly.

The Medicare Payment Advisory Commission updated its March 2005 report at the end of August, noting that the number of physician-owned specialty hospitals had doubled between 2002 and 2004. [*Report to the Congress: Physician-Owned Specialty Hospitals Revisited*. MEDPAC, August 2006. http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf.] Among its new findings is that orthopedic/surgical hospitals' inpatient costs per discharge are roughly 20 percent higher than those at competing community hospitals, and both heart and orthopedic/surgical hospitals have 20 percent to 25 percent shorter lengths of stay than community hospitals. The potential savings from the shorter length of stay however, was not enough to offset the higher costs per discharge for orthopedic/surgical hospitals. In general, physician-owned heart hospitals are also associated with a 6 percent increase in the number of cardiac surgeries per 1,000 Medicare beneficiaries. Heart hospitals also have 26 percent of the cardiac surgery market in 2004, and obtained the majority of their market share by diverting patients from community hospitals.

Nevertheless, it also found that (p.9):

While the specialty hospitals took profitable surgical patients from the competitor community hospitals (slowing Medicare revenue growth at some hospitals), most competitor community hospitals appeared to compensate for this lost revenue. From our site visits in 2004, we learned that in some cases competitor community hospitals cut costs by cutting staff; in some cases they instituted "aggressive pricing strategies" to raise revenue from private payers; and in many cases they expanded profitable business lines such as imaging, rehabilitation, pain management, cardiology, and neurosurgery. These responses to the specialty hospital challenge coupled with population growth in many of the markets where specialty hospitals operate combined to allow competitor community hospitals to maintain profit margins that are in line with national averages.

As physician-owned entities capture more profitable service lines, the effect on community hospitals may increase. However, we found that community hospitals' profit margins appeared stable through 2004, even in markets where physician-owned hospitals captured more than 10 percent of all admissions.

Reporting and Regulating Medical Practice

The vast amounts of data collected and published by the Pennsylvania Health Care Cost Containment Council (PHC4) provide evidence of medical practice trends with implications for state regulators, while regulation, and the absence of it, strongly influences those same trends. The public reporting of PHC4 and of the New Jersey Department of Health is described in another article in this issue ("A Brief History of 'Report Cards'").

As previously reported here, the number of open-heart surgeries has been declining nationally, a trend noted in the Philadelphia region. In the first nine months of last year, open-heart surgeries in South Jersey and Southeastern Pennsylvania declined by 8.6 percent, and bypasses by 15 percent. Many bypasses are now done without stopping the heart and using a heart-lung machine to add oxygen to the blood and

circulate it through the patient's body. So-called "off-pump" bypasses are performed while the patient's heart continues to beat, potentially reducing the memory loss that can occur when a heart-lung machine is used. And bypasses have continued to become safer. According to PHC4, the mortality rate in Pennsylvania in 1991 was 4.9 percent (while it was 4.0 percent in New York), but by 2004, it had declined to about 2.0 percent. New Jersey shows similar results.

But the improvements made in stenting, together with the growing patient preference for less invasive angioplasty, are what are driving this trend. In South Jersey between 1997 and 2004, angioplasty volume increased by 71 percent while bypass surgeries declined by 52 percent. The declining utilization of open-heart surgery is resulting in lower volumes at the hospitals performing them. New Jersey both regionalizes open-heart surgery through its CON program, and regulates it through licensure. Across the Delaware River from Southeastern Pennsylvania, only three hospitals in South Jersey are licensed for bypass surgery (and angioplasty), and in order to maintain their programs, they must perform at least 350 open-heart surgeries per year or meet certain quality standards.

Pennsylvania does neither. Ten years ago, its CON program lapsed, and the inevitable result was that these services which had been concentrated in Philadelphia proliferated in its suburban hospitals. In 1996, suburban Chester County was served by hospitals in Philadelphia, but now four of the county's five hospitals have their own cardiac surgery. Meanwhile, Philadelphia's inner city hospital programs have experienced steep declines in volume. Hahnemann University Hospital's open-heart cases dropped by 76 percent, from 1,463 in 1997 to 357 in 2004. At Temple University Hospital, open-heart surgeries fell by 64 percent, from 571 in 1997 to 203 in 2004. And today, there are 21 hospitals in Southeastern Pennsylvania doing open-heart surgery, only six of which would have met New Jersey's 350 surgeries standard in 2004.

St. Mary Hospital, a 327 bed community hospital in suburban Bucks County on Philadelphia's northeastern border, is a good case in point. In 1996, St. Mary offered neither angioplasty nor open-heart surgery. In 2004, according to PHC4, it performed 1,272 angioplasty procedures, and it had the fifth-busiest open-heart surgery program in Southeastern Pennsylvania. In that year, it earned a surplus of \$18.2 million on \$226 million in revenues.

Another effect of improved heart care for regulators to monitor is that it has reduced the necessity for heart transplantation. The national rate has been declining slowly since 1998. This is already an issue in Philadelphia which has five hospitals doing them. In 1997, its then three hospitals performed 172 operations, but the five hospitals did only 93 in 2005. For the base population, two would easily suffice, and consequently four of these programs did no more than 13 transplants in 2005; only the Hospital of the University of Pennsylvania (HUP) had the volume for greatest proficiency – 49. Each of the three lowest volume hospitals performed fewer than 12 heart transplants. That is the minimum number of operations new transplant programs must have in a year to qualify for Medicare funding. And outcomes follow suit. At HUP, the one-year survival rate for 110 patients (2003-2004) was 90 percent, while at Hahnemann with 20 patients, it was 75 percent. HUP's heart transplantation program is the sixth largest in the nation.**

Universal Health Care in Pennsylvania?

Bills have been introduced in both houses of the Pennsylvania legislature to establish a single-payer, state insurance plan supported chiefly by a 10 percent levy on employer payrolls and a 3 percent individual wellness tax on all personal income. The \$40-to-\$45 billion bipartisan package would extend full health, dental and prescription drug coverage to every citizen while eliminating co-payments, caps and deductibles. It would also offer tax rebates to volunteer emergency responders and defuse the medical malpractice crisis with a no-fault program. The bills spring from a plan unveiled last year by Pennsylvania HealthCare Solutions Coalition, a grass roots organization pushing for universal coverage. A feature of the legislation is that a state agency would set payment rates, and certificate of need would be reestablished for new health care facilities.

However, it is highly doubtful that the legislation will survive the lobbying of the state's insurance industry.

California Stands Up for UHI!

Senate Bill 840, authored by State Senator Sheila Kuehl, has passed both houses of the California State Legislature. The bill now goes to Gov. Schwarzenegger's desk. The state has between 6 and 7 million uninsured, and Governor Schwarzenegger has no alternative plan to address that, but he is opposed to single payer plans in principle. Sen. Kuehl called the passage of the bill historic because it was the first time both houses of the Legislature have passed a universal healthcare bill.

Several times recently I've written in this column about this truly progressive legislation which is projected to save the citizens of California almost \$8 billion in its very first year by replacing all private health insurers, but preserving the status of healthcare providers, hospitals, and pharmacies as private, competitive businesses, and emphasizing preventative and primary care.*** The result would be a state "Medicare-for-all," where the elimination of private insurance and the state's negotiating/purchasing power over pharmaceuticals and medical equipment can realize the savings to make the plan financially feasible. An analysis by the Lewin Group, an independent healthcare consulting firm, found that more than enough is already being spent on healthcare in California to cover everyone under this legislation. That means that the total of federal, state, business, and personal funds now being spent there can be restructured into a new integrated system that covers everyone. Business would no longer need to allocate funds for health benefits, and consumers would no longer bear the costs for insurance premiums, healthcare payments, and co-payments. Instead, there would be new public funding through mechanisms such as an 8 percent payroll tax and a 3 percent individual income tax. Financing of the new system would require separate new legislation. Funding was not included in the bill because it would then have required approval from two-thirds of the Legislature, something that was not possible because of opposition from Republican legislators. And the governor will likely veto this bill, but that action will guarantee a major airing of the issue in this fall's governor's race. Consequently, UHI in California still has a long political road ahead of it.

* A. Gandjour, A. Bannenberg, and K.W. Lauterbach, "Threshold Volumes Associated with Higher Survival in Health Care: A Systematic Review," *Medical Care* 41, no. 10 (2003): 1129-1141; and E.A. Halm, C. Lee, and M.R. Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature," *Annals of Internal Medicine* 137, no. 6 (2002): 511-520.

** The source for outcomes by hospital is the Scientific Registry of Transplant Recipients. <http://www.ustransplant.org/>. The source for all other heart transplantation statistics is the United Network for Organ Sharing. <http://www.unos.org/>.

*** Steffie Woolhandler and David Himmelstein argue that a **national** single-payer system could save \$300 billion annually – more than enough to cover all of our 46.6 million uninsured. See for example, Woolhandler S, Campbell T, Himmelstein DU. Costs of Health Care Administration in the United States and Canada. *NEJM* 2003; 349:768-775. <http://content.nejm.org/cgi/content/abstract/349/8/768>. They and other physicians in the Physicians for a National Health Program have long argued for a U.S. system like that now being advanced in California. See, Woolhandler S, Himmelstein DU, Angell M, Young QD. Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. *JAMA* 2003; 290:798-805. <http://jama.ama-assn.org/cgi/content/full/290/6/798>.