

# State of the Industry 2005

The past year offered hope and relief for an industry desperately in need of both

by Ian R. Lazarus, FACHE

**W**ELCOME TO MANAGED HEALTHCARE EXECUTIVE'S State of the Industry Report, an annual assessment of the collective health of the healthcare industry with additional focus on the issues we expect to face in the coming year.

When discussing the state of the healthcare industry with anyone who has been around it for very long, it's tempting to call up the familiar refrain, "the more things change, the more they stay the same." However, this would be an unfair assessment of some real progress and promising developments made in the past year as we look to 2005. While it is premature to celebrate any significant breakthroughs in overcoming challenges related to access, cost and quality, at least things did not get any worse.

According to the Center for Studying Health System Change (HSC), healthcare spending for privately insured patients increased a total of just 7.4% last year. This is the second consecutive year that spending growth has slowed, down from 9.7% in 2002 and 10% the year before. Still, healthcare spending grew at nearly twice the rate of the overall economy and continues to outpace wage growth as well.

The industry also is demonstrating improvement in credit ratings published by such public finance analysts as Fitch Ratings ([www.fitchratings.com](http://www.fitchratings.com)). For the first time since MHE began tracking this metric for the State of the Industry report back

in 2000, the ratio of Fitch downgrades to upgrades has fallen below 2:1; in 2003 it stood at over 3:1 and was nearly 4:1 in 2002.

Fitch attributes the dramatic improvement in ratings to improved business strategies combined with lower cost of capital. However, it also notes that continued capital needs, rising labor costs, increased competition and increased cost containment legislation will create future uncertainty for the sector (see chart, page 32).

#### CAPITAL IDEA

Access to capital takes on greater importance in the years ahead as organizations prepare to make long-needed improvements in infrastructure while also responding to demands that they implement electronic medical records and other IT systems. The Healthcare Financial Management Assn. (HFMA) predicts that although spending was just 1% per year between 1997 and 2001, rates will rise 14% per year for the next five years.

Unfortunately, access to capital is not guaranteed. Hospitals are competing for fewer available dollars (down 29% from 2001 to 2002), and those with strong balance sheets and disciplined disclosure policies are best positioned to tap the capital markets.

While the public sector has seen a strengthening in its fiscal health, so too have the nation's insurers, particularly HMOs.

## Areas of improvement and opportunity

- Improved business strategies
- Better management practices
- Lower cost of capital
- Increased Medicare funding
- Improved financial disclosure

## Ongoing industry pressures and risks

- Continued labor shortages
- Growing capital needs/access
- Rising supply costs
- Increased competition with physicians & niche competitors
- Potential Medicaid funding cuts
- Rising bad debt expenses

Source: Fitch Ratings, 2004

During the first nine months of 2003, the sector reported earnings of \$6.7 billion, a 52% increase from the same period a year before. HMO performance has improved substantially since 1999, when following two years of losses, they had reported only \$524 million in collective earnings.

"The health of the industry has never been stronger, yet consumers are feeling weary from the skyrocketing costs of healthcare," notes Melissa Gannon, vice president of Weiss Ratings, an independent rating organization. "Until consumers can see how the industry's profitability can enhance their healthcare experience through the use of new technologies and improved treatment options, they will continue to question the rise in premiums."

Although health insurance premiums do continue to rise, HSC noted also that the 12% increase in 2004 marked the first reduction in growth since 1996. "It's good news, but not enough to get us to stop worrying," notes Paul Ginsburg, the Cen-

ter's president. In a study recently released by Hewitt Associates, health insurers said they plan to raise premiums next year by an average of 13.7%, though negotiation with large employers likely will reduce that figure.

### A LABOR OF LOVE?

Liability and labor costs are at the forefront of any full discussion of cost drivers that might stand in the way of a robust recovery of the health sector. Medical malpractice costs more than doubled between 1993 and 2002; defensive medicine is estimated to add \$70 billion to \$120 billion in costs each year. While responding quickly and openly can help hospitals, physicians and patients cope with malpractice, tort reform has attempted to suspend a cost trajectory out of control.

According to a study published by Weiss Ratings, states that imposed malpractice caps experienced payouts that were 15.7% lower than states without caps. The study also found, however, that despite the lower payouts, premium growth was actually higher in states *with* malpractice caps.

Weiss concludes that malpractice premiums are affected not by the presence or absence of caps, but by medical inflation, the insurance business cycle, declines in investment income and the impact of supply and demand with respect to malpractice products. As usual, what might appear to be an easy fix is not so easy at all.

Approximately 63% of hospital expenses are labor costs, according to the American Hospital Assn. (AHA). Work force shortages have given rise to a number of creative strategies to attract and retain staff. Spontaneous use of staffing pools and

other outsourcing options are a CFO's nightmare, but better forecasting, integration and strategic implementation of outsourcing can bring sensibility to these solutions. To spread more creative solutions across their constituency, AHA has launched a Web site, [www.healthcare-workforce.org](http://www.healthcare-workforce.org). Since launching the site in 2002, a total of 564 case studies have been published on how to combat existing shortages.

Treatment for mental illness also is a major driver of healthcare inflation, second only to heart disease among clinical diagnoses. A separate analysis of spending on psychotropic drugs showed that expenses for Medicaid recipients are twice those of the general population.

To combine solutions to cost and access challenges, many states are now looking to "carve out" mental health benefits and to solicit competitive bids for mental health separately. Steve Shulman, chairman and CEO, Magellan Health Services, points out that mental health patients now enjoy higher quality, greater access and lower cost than ever before. "It's a hat trick for the mental health industry," he claims, "a real victory for our segment."

**Hospitals have reduced reliance on investment returns by focusing instead on their core operations.**

### TAKING CHARGE

The upbeat messages from Fitch and Weiss Ratings are a welcome change from analysts' typically sober view of the industry. In its 2004 forecast of health system performance, Fitch Ratings recognizes that healthcare organizations are taking stock in their core competencies, divesting non-core assets, redefining business strategies, and achieving a more profitable service mix.

Hospitals in particular have reduced reliance on investment returns by focusing instead on core operations. The most

common clinical services that expanded in the past few years include cardiology, oncology, orthopedics, neuroscience, and diagnostic imaging. Out-patient surgery has grown steadily from 25% of total volume in 1984 to more than 70% today.

But perhaps the most visible litmus test for the economic health of the industry is how many people can afford health coverage, and how many actually have it. On this measure, we have made little progress.

The proportion of Americans under age 65

who are covered by an employer-sponsored health plan fell from 67% in 2001 to 63% last year. Loss in coverage results not only from job losses, but in the fact that employers continue to cut health benefits or to reduce the extent of coverage offered to their employees.

Fortunately, this significant decline was not matched by large increases in the uninsured, as Medicaid and State Children's Health Insurance (SCHIP) programs witnessed an increase in enrollment from 9% to 12% during the same period (source: HSC). SCHIP, enacted in 1997, has emerged as one of the most effective safety nets for this country's vulnerable children.

Public health programs such as these have come to be known as "countercyclical tools" whose vital importance grows during economic downturns, such as that experienced in 2001.

It's partially because Americans consider themselves increasingly at risk of becoming uninsured that this remains such a sensitive and political issue. Almost one in six people—43.6 million in 2002, according to the Census Bureau—lack health insurance, with 80% found among working families. More and more, Americans have come to realize that the face

of the uninsured is not so different from their own (see chart, page 36).

For its part, America's Health Insurance Plans (AHIP) has issued a statement reflecting its position on issues related to access, quality and affordability (see chart, this page). In its 18-page report released this March, AHIP provides the blueprint for resolving key challenges in all areas. Eight strategies provided for improving access call for the creation of tax credits and incentives, assigned risk pools, bridge loans

for families in transition, broader use of currently restricted federal funding such as SCHIP, and awareness programs to ensure all eligible Americans are in fact obtaining the coverage they need.

**The most viable litmus test ... is how many people can afford health coverage and how many actually have it.**

#### PROMISES, PROMISES

The upcoming election has included so

many promises that it's difficult to imagine such a perfect scenario unfolding before our eyes. At least the political agenda includes substantial dialogue around the healthcare system and how to overcome problems related to access, quality and cost.

The Kerry plan calls for—among other things—easing restrictions on the flow of pharmaceuticals from Canada to the United States, finally delivering a Patients' Bill of Rights, eliminating inequities that exist for minorities, women, mental health and disabled patients, and cutting the waste and inefficiency caused by excessive paperwork. This will result in families saving up to \$1,000 in health premiums and coverage for 95% of Americans, according to the campaign.

Bush's plan offers various financial strategies (tax credits, deductibility of health savings accounts, and medical liability reform) to reign in costs and improve affordability. The success of either effort will hinge on the final makeup of the House and Senate and their ability to pass compromise solutions.

#### EYE ON THE PRIZE

It's been said that "quality is like pornography—you know it when you see it." For healthcare organizations, one might argue, quality is not seen nearly often enough. The need to produce consistent quality in delivery of care and reproducibility in clinical outcomes has emerged as a recent platform for the Institute of Medicine and, more recently, central to the position taken by AHIP. This has given rise to a series of new initiatives within the payer sector, some with promising results.

CEOs have been frustrated by the results of their efforts in performance improvement, either because the gains achieved were not sustainable or because they could not leverage their staff to achieve the potential they believe existed if the right people were working on the right problems. In the past year, however,

#### AHIP Board of Directors' Statement

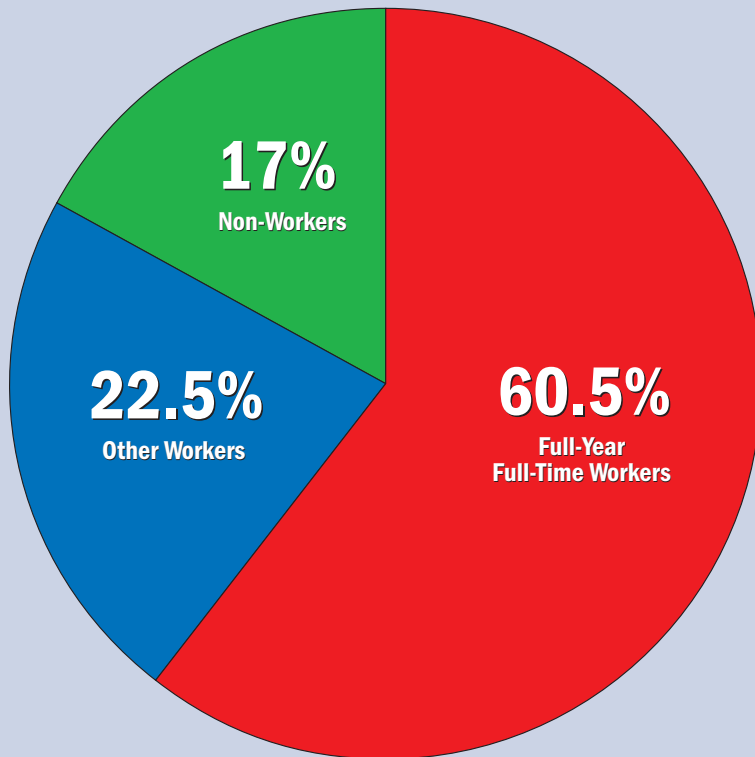
**Access.** Use targeted strategies to give all Americans access through public and private coverage and through support for the public health infrastructure.

**Quality.** Make evidence-based medicine the standard for healthcare; advance quality and transparency to improve outcomes, eliminate errors, reduce costs and help consumers make informed choices.

**Affordability.** Maximize savings achieved through improvements in access and quality, and take additional steps to make healthcare more affordable through regulatory, legal and other reforms.

Source: America's Health Insurance Plans, 2004

## Families of uninsured Americans



MHE Source: Employee Benefit Research Institute (2004).  
Estimates from the March Current Population Survey, 2003 Supplement

more and more healthcare organizations have adopted more rigorous performance improvement methodologies, such as Six Sigma and Lean.

“Six Sigma motivates us to reach for the stars rather than to settle for what’s average, and it legitimized our efforts to achieve best practice in clinical care,” notes John Grah, chief executive of Scripps Memorial Hospital in Chula Vista, Calif. So far this year, six national conferences on the application of Six Sigma to healthcare have taken place, testimony to the tremendous potential of this data-

driven methodology to reduce waste, improve outcomes and boost patient satisfaction.

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Magellan Health Services is also betting heavily on its Six Sigma-rated data warehouse. “We recognize the tremendous variation in the delivery of health services, as [Dr. John] Wennberg did, and are focusing on our data warehouse to allow us to generate actionable data,” Shulman says.

More recently, the Malcolm Baldrige National Quality Award has become the subject of great interest among healthcare or-

ganizations—if not as a trophy to be earned, then as a template for assessing internal competencies. The Baldrige award was established in 1988 as an official federal act to encourage American companies to improve quality and productivity, to reward those that do, and to provide guidelines to others that will provide for an effective internal assessment.

According to Harry Hertz, the program’s director, healthcare organizations can use Baldrige criteria to align their Six Sigma efforts in performance improvement with those outcomes most important to achieving strategic goals, which will result in effectively competing for the national award. While only three healthcare organizations have actually achieved Baldrige recognition since the first healthcare award in 2002, its mere existence has enlightened many organizations to raise the bar.

### SEE-THROUGH PERFORMANCE

What was once a form of presentation media is now an unofficial mandate for healthcare organizations. The concept of “transparency” is behind the growing movement to encourage public reporting of outcomes and costs. Initial efforts such as the Leapfrog Group and HealthGrades have been joined by a variety of statewide initiatives.

This summer, the Joint Commission on Accreditation of Health Organizations began publishing disease-specific certification on its Web site, along with other quality indicators. The Quality Initiative, a joint project co-sponsored by the AHA, the Centers for Medicare and Medicaid Services and others, now includes nearly 3,500 hospitals. And in California this year, hospitals must begin publishing their prices and charge masters for the public.

While most agree that transparency in principle is a good thing, the current movement raises several critical issues. First, there is no standardization across the initiatives, and some efforts actually may misrepresent certain participants if not adjusted for case mix, for example. Second,

## Myth or Fact?

- **Myth:** People without health coverage don't work.  
**Fact:** Eight out of 10 people who are uninsured are in working families.<sup>1</sup>
- **Myth:** Most uninsured people in the U.S. are minorities.  
**Fact:** Non-Hispanic whites make up three-fourths of the uninsured.<sup>2</sup>
- **Myth:** Most people without health insurance are poor.  
**Fact:** Almost 29 million of the uninsured in 2002 had household incomes of \$25,000 or more compared with 14.8 million in households earning less.<sup>3</sup> (The federal poverty guideline for a family of four in 2002 was \$18,100. That has increased to \$18,850 for 2004.)
- **Myth:** It doesn't really matter whether a person has health insurance.  
**Fact:** About 18,000 Americans die each year of treatable diseases because they don't have health coverage, according to the Institute of Medicine.<sup>4</sup>
- **Myth:** Virtually everyone who works for a large employer has health coverage.  
**Fact:** More than one in four of the nation's uninsured in 2001 (nearly 10 million people) either worked for a firm with 500 or more employees or were dependents of someone who worked for a large firm.<sup>5</sup>

<sup>1</sup>Kaiser Commission on Medicaid and the Uninsured (2003). "The Uninsured: A Primer—Key Facts About Americans Without Health Insurance," December, p. 4.

<sup>2</sup>U.S. Census Bureau (2003). "Historic Health Insurance Tables: Table HI-1: Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1987 to 2002."

<sup>3</sup>U.S. Census Bureau (2003). "Health Insurance Coverage in the United States: 2002," p. 21.

<sup>4</sup>Institute of Medicine (2004). "Final Report Release Event—Insuring America's Health: Principles and Recommendations," January 14.

<sup>5</sup>The Commonwealth Fund (2003). "Number of Workers in Large Firms Without Health Insurance Growing Significantly," News release, October 21.

MHE Source: *Health Care Coverage in America: Understanding the issues and proposed solutions*, Alliance for Health Reform and The Robert Wood Johnson Foundation, 2004.

no single initiative covers all metrics of interest.

Ken Kizer, MD, president of the National Quality Forum, cited ambulatory care as a prominent example of what's missing, and where such measures do exist, they haven't been tested for reliability.

"Public reporting is valuable, but the proliferation of different models is not productive," says Chris Van Gorder, CEO, of Scripps Health, a health system in San Diego.

"We have to devote resources to studying, evaluating and participating in each one of these initiatives, and it's adding an administrative burden with so many different programs out there." Van Gorder

says the best programs will attract better participation, ultimately leading to some form of consolidation.

Some of the payer-sponsored initiatives now include financial incentives for demonstrable improvements in quality. While the payouts are modest in relation to the provider's total revenue, they have certainly gotten the attention of the provider community.

Most of the initiatives taken remain without the active participation of providers, and until there is an active collaboration on public reporting, the providers will have a valid argument that they cannot participate in or support certain efforts.

"Pay-for-performance can be an ef-

fective tool as long as it is not a zero-sum game," Van Gorder warns. "If certain organizations benefit while others are unfairly penalized, we have done a greater disservice to our public by threatening the viability of their public health infrastructure."

### BUILT TO LAST

Nineteenth-century British Prime Minister Benjamin Disraeli once said, "the secrecy to success is constancy to purpose." When things could not get much worse, our industry embodied this thinking, found its purpose, and took charge of change.

It's time to step back and reflect on the remarkable tenacity and creativity in addressing problems faced over the past decade; the value created by these efforts often is not appreciated when cost, access and quality are looked at in isolation.

Although the flight path still will include substantial turbulence, we should celebrate key victories in both controlling costs and building the infrastructure for improved quality.

Once we maximize the gains from efforts in these areas, improvements in access will be more easily accommodated and with better outcomes.

In his landmark book, *Good to Great*, author Jim Collins describes the concept of a "giant, heavy flywheel" that must be moved with pressure over and over again, until it generates momentum, force, productive energy and finally breakthrough ("greatness"). This metaphor is being illustrated in the developments within the healthcare industry, which slowly is moving its collective flywheel to new levels of achievement. **MHE**

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