Health Insurance Premiums in Daviess County

Why do we pay more than other Kentuckians? What can we do about it?

A report of the Public Life Foundation of Owensboro
August 2003

The PEOPLE'S Health Project

public concerns → citizen action

PUBLIC LIFE FOUNDATION

The Public Life Foundation is a private, nonpartisan, nonprofit corporation established by the John S. Hager family in 1996. The Foundation responds to citizen concerns, examines public issues, conducts research, promotes broad-based community dialogue, and supports grass-root citizen groups in an effort to develop civic capital and the empowerment of ordinary citizens.

Health care costs were identified as the top concern and impediment to health care by citizens in 52 public forums conducted by the Foundation in 2001-2002. During subsequent public meetings, many citizens — especially retired teachers and state employees — questioned why health insurance premiums are higher in Owensboro-Daviess County than other areas of Kentucky. At the same time, local employers who provide insurance for their workers reported higher health care costs as well. The Foundation commissioned this report in response to both concerns.

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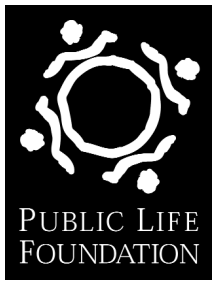

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Coverage can cost as much as 30 percent or $1,800 more in Owensboro than other areas in Kentucky.

Executive Summary

Are premiums really higher here?

- Yes, at least for state employees and teachers. Kentucky workers in Daviess and 10 other counties, most of them nearby, have the highest premiums in Kentucky.
- Anecdotally, premiums for other Daviess County employers are also high. But this report concentrates on public employees because it is hard to get objective information on private sector premiums.

Why are state employee premiums higher here?

- Medical costs to insurers are higher here. Doctors and hospitals in the Owensboro region bill more per employee to the state's insurance companies than do providers in other regions of the state.
- There is lack of competition among insurers, which may be tied to reluctance among physicians to participate in health plans with lower reimbursements.

There are two likely reasons that medical costs to insurers are higher here:

- More use of health care services, which means more claims are filed with insurance companies.
- Higher charges by the hospital and doctors to insurance companies compared to other parts of Kentucky.

Utilization factors may include:

- A lack of primary-care physicians to provide a lower-cost point of entry into the health care system and the resulting use of higher-cost emergency room and specialist care.
- The hospital's efforts to increase use of its facilities through advertising and new or updated services. This was after the merger of Owensboro Daviess County and Our Lady of Mercy hospitals.

  Although there are certainly significant health problems among the population, it does not appear that Daviess County has a higher proportion of sick people — who need more care and thus use the system more — than other parts of Kentucky.

Factors in higher charges may include:

- The hospital's financial considerations. OMHS loses money on Medicare patients, the biggest part of its patient population, although many other hospitals do not. It more than makes up for the losses, recording a healthy net income, at least in part through its charges to insurers.
- Lack of competition for the hospital and among doctors because of comparatively low numbers of doctors for the population.

- Higher overhead costs for specialists in the Owensboro area, where lower volume does not offset cost as much as in urban areas.

Factors in the lack of competition among insurance companies may include:

- The dynamics of the state insurance market. Carriers concentrate their business in different parts of the state and sometimes choose not to compete with each other.
- The general unwillingness of doctors in the Owensboro area to accept lower-paying health insurance plans.
- State and national trends that have left Kentucky with a few health insurance companies controlling most of the market.

What can be done to change the situation? Among the options:

- Reduce the use of higher-cost care.
- Add more primary care doctors.
- More efficiently direct people away from the emergency room to primary care.
- Give consumers more information about the health care system so they better understand the connection between cost and services.
- Expand consumer control over health care spending.
- Give employees financial incentives to improve their health.
- Reduce hospital and doctors' charges by reducing costs.
- Formalize community input into the hospital's capital spending decisions through public hearings and other means.
- Look at reforms that would help doctors afford and obtain medical malpractice insurance.
- Push for equitable Medicare and Medicaid reimbursements.
- Move toward market reform.
- Explore and examine alternatives for state insurance coverage for employees:
  - Consolidating risk with one insurer instead of several.
  - Allowing insurance companies to vary the premiums they charge by region.
  - Self-insuring the state's plan.
- Consider consumer-driven health care plans which give consumers more choices and control over their own health care spending.
- Consider universal or near-universal health care coverage that would give all Americans, Kentuckians or Daviess Countians access to basic services.

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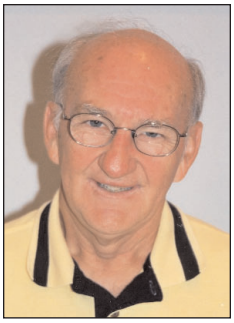

James Constant, retired science teacher

Introduction

Retired science teacher James Constant of Owensboro pays about $6,000 per year — about $500 per month — to provide health insurance for his wife under the state's plan for its employees and retirees.

If he lived in Covington or Somerset, his cost would be $1,600 less per year for the same coverage. If he lived in Paducah, it would be $1,800 less.

Mr. Constant is not alone. About 3,000 other working or retired teachers and state employees in Daviess County pay the highest insurance premiums in the state.

Why is this? And what can we do about it?

This report will explore these questions in order to:

- help citizens gain a better understanding of the causes of high health care costs
- provide information that will help citizens make personal decisions about health insurance coverage
- suggest ways the community might take action to stabilize, if not lower, local health insurance costs and premiums.

This report was prompted by citizen forums on health care conducted by the Public Life Foundation of Owensboro in 2001-02. The forums showed that the cost of health care was citizens' main concern. The impetus for examining insurance premiums in particular was the news in 2002 that the cost of health insurance for state employees and teachers in Owensboro would be the highest in the state, matched only by a few nearby counties and some in Northeastern Kentucky.

The forums also heard from local employers who expressed concerns about high premiums. But information is not readily available to compare premiums paid by the private sector in different parts of Kentucky. As a result, this report will primarily examine the factors affecting the state's health insurance plan, which covers employees in all 120 counties.

Why are premiums so important?

Health insurance premiums represent the "real cost" of health care to consumers. They are what individuals and employers pay to insurance companies for coverage of everything from major medical emergencies to routine office visits.

Premiums have been rising throughout the nation in recent years, largely because of increasing health care costs. While the economy was still strong and employers were competing for workers, they generally absorbed the premium increases instead of passing them along to employees.

Now that the economy and demand for workers have slowed, companies are passing along premium increases in various ways, primarily through higher deductibles and/or co-payments for medical care and prescription drugs. They are also restructuring health insurance plans.

Health insurance premium increases, once absorbed by many employers, are increasingly passed on.

What is the result of higher premiums?

Health insurance is becoming less affordable for employers, workers and others who have private insurance. In Owensboro, for instance, 63-year-old retired public school teacher James Constant went back to work this year as a full-time substitute to help pay the $1,200 per year increase in the health insurance premium for his wife, a homemaker.

In addition, there are consequences for society and the health care system as a whole. When fewer people can afford insurance coverage, the number of people without insurance increases. And the uninsured typically cost the health care system even more, partly because they delay seeing a physician until their medical problems are acute and treating them is more expensive. Ultimately, those costs are passed on to the insured through higher premiums.

Some retirees have had to go back to work to pay for health insurance premium increases.

How do insurance companies set premiums?

They consider their costs in a particular community or for a particular employer as well as their own profits. There are two primary cost drivers:

- How much people who live in a particular community or who work for a particular employer use health care (utilization).
- What doctors, hospitals and other health care providers charge them for medical services.

As more people drop their health insurance, their cost of care is often passed on to others.

Why is utilization important?

The more people go to the doctor or hospital, the more insurance claims are filed and the more the company must pay out.

Thus if a community has a higher than usual rate of diseases which send people to the hospital, that may drive up premiums. So could the fact that a community has access to, and uses, comparatively costly medical services.

Two things primarily drive the cost of health insurance premiums:

- **utilization**
- **provider charges**

Is it possible to compare utilization?

The claims experience for specific geographic areas or employers is considered by insurance companies to be private.

Insurance companies do file documents with the state's Department of Insurance on which they list "area factors" for the state's eight Medicaid regions (Owensboro is in Region 2). The "area factor" reflects how much above or below average the medical costs in a particular area are expected to be. This factor takes claims experience into account, along with other considerations. Anthem's area factor for the Owensboro region is comparatively high, for instance, but insurance companies which do little business here - and thus have limited claims experience - rate the region comparatively low.

What about hospital and doctors' charges?

Administrators with Owensboro Mercy Health System point out that the hospital's charges for medical care are low compared to other similar hospitals in Kentucky and nearby states.

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But they are referring to OMHS' "official" charges, not the discounted charges for insurance companies on which premiums are based.

Hospitals and doctors discount their charges for insurers because they get something in return — a guarantee of payment for services, and possibly additional patients through an insurer's network.

In fact, only a small percentage of patients at any hospital or doctor's office — those without private health insurance or government insurance such as Medicaid or Medicare — pay the official charge. At OMHS, for instance, that's about six percent of patients (and because many of those patients can't afford the official charge, it is often written off as bad debt).

Thus it is possible that a health care provider's official charge can be relatively low while the discounted charge is relatively high compared to other providers. This could affect the size of premiums in the area.

Is it possible to compare discounted charges to insurers?

Such a comparison is all but impossible. The insurance company and provider agree on the charges through private negotiations, and most health care providers, including OMHS and local doctors' offices, agree in their contracts with insurers not to publicly disclose their discounts. Insurers argue that public disclosure would damage their competitive positions in the marketplace. The Kentucky Supreme Court upheld this argument when it was challenged several years ago by the state Attorney General's office.

Nevertheless, those discounted charges are key to determining the "real cost" of health care in a particular community.

Only six percent of patients pay "official" or "published" charges; 94 percent pay what is negotiated with insurers including private companies, Medicare and Medicaid. These discounted charges are not disclosed to the public.

What about profits? Can insurance companies set premiums as high as they want to meet profit goals?

In Kentucky, there are checks on exorbitant profits: The state Department of Insurance must approve premiums as "reasonable." And the Attorney General's office monitors the information that insurers file with the Department of Insurance and represents consumers in rate proceedings before the department.

Otherwise, the market determines how much profit a company seeks and how high its premiums are.

Competition is one market factor: Insurance companies in heavily populated urban areas may have to vie for business with several other carriers, and thus keep their premiums as low as possible to appeal to consumers. That can lower their profits as well.

On the other hand, in some rural or smaller urban areas of Kentucky, including Owensboro, insurers don't have much competition.

In some rural or smaller urban areas of Kentucky, including Owensboro, insurers do not have much competition.

Why is information so hard to get?

There are many barriers to the public's examining the reasons behind their high health insurance premiums:

- **Much information is considered to be proprietary by insurers and health care providers.** Insurance companies typically will not disclose their agreements with providers on rate reimbursement, and their contracts prohibit providers from discussing it either.

  The Kentucky Attorney General's office tried to require Anthem Blue Cross Blue Shield to disclose the information back in the mid-1990s, but lost at the Kentucky Supreme Court. Also, Kentucky's health insurance reforms of the early 1990s required physicians to publish the "official" charges for many of their common services, but that law was repealed.
- **The information that is available to the public is extremely complex and/or hard to get.**
  - Hospitals (but not physicians) are required to submit public financial reports to both the state and the federal governments listing in detail what they've paid and charged for services in the last year. These filings do not include specific information about insurance-company discounts, but they do offer a financial picture of a particular hospital. However the reports are written in such a way that only financial experts can translate the data.
  - Some organizations do look at financial data to draw conclusions about how hospitals operate. Among them is the American Hospital Directory, which was used for this report. However the directory provides only limited information free of charge; for a more detailed analysis, there is a fee. This is also the case with other such services.
  - Many insurance companies must by law publicly report information about their financial status. However they are not required to reveal details of their dealings with hospitals and doctors.
- **Information is released selectively by insurance companies and healthcare providers in support of their business aims rather than in support of objectively informing the public. For example:**
  - OMHS regularly gives the community information which heralds its comparatively low charges for medical services, yet only 6 percent of its patients pay them. The relevant charges, to the public, are what government and private insurers pay on their behalf, since that is what factors into premiums.
  - When Humana was asked questions for this report, its

Information is released selectively by insurance companies and healthcare providers in support of their business aims rather than in support of objectively informing the public.

spokeswoman Kristen Trenaman told colleagues in an email that she had tried to "put off" the questions but was being pressed, and so was asking for input based on what would be best in light of this year's bid for the state's business in Daviess County.

- Anthem Blue Cross/Blue Shield's spokeswoman, Suellen Brill, declined to answer any questions at all about the Owensboro region for this report — yet another Blue Cross/Blue Shield company in California, with different business interests, supplied a newspaper there with detailed data to allow a comparison of its payments to hospitals in metro areas of the state.

  Limited information about Anthem's experience in Daviess County did become available later when an Anthem executive spoke at a Leadership Owensboro event which was not open to the public.

- **Private employers affected by premiums are often not willing to discuss them publicly**. For instance one major employer in this region has said privately that premiums here are higher than at locations where it does business elsewhere in the U.S. - but would not substantiate that information for this report.

- **Beyond the data, the subject itself is so complex as to be overwhelming.**
  - The Greater Owensboro Chamber of Commerce started to look at the question of high insurance premiums last year but decided it was too big to tackle.
  - Eric Davis, the new president of Owensboro's Chamber and Industry, Inc., said he has tried to examine similar questions in every community where he's worked, but the issues have invariably been impossible to untangle.
  - Even Kentucky Personnel Secretary Carol Palmore, who is in charge of health benefits for state employees, says so many factors affect insurance rates that it's difficult to find any workable solutions.

To some, health care cost issues are:
…too big to tackle
…impossible to untangle
…so complex that it's difficult to find workable solutions

Are premiums really higher in Daviess County?

The short answer is yes, at least for state employees and teachers.

During 2002-2003, state employees in Daviess and a few nearby counties have paid one third to one half more for family coverage under the state's health insurance than employees elsewhere in Kentucky (the state pays the full cost of its employees' premiums but none of the cost for employees' families). Only five other counties, in the Ashland area, had premiums as high.

In dollars, premiums for the families of Daviess County's 3,000 employees were from $636 to $1,896 more per year than the next highest insurance option in the state plan.* (See Chart 1, page 42.)

The reason the premiums for Daviess and the other counties were so high was that they had only one insurer to choose, Anthem Blue Cross and Blue Shield. And Anthem has the highest premiums of four companies approved to sell insurance to state employees in various counties across Kentucky. The other companies are Humana, CHA Health and Bluegrass Family Health.

At the same time, the state-paid premium for single coverage for employees in Daviess and the 10 other counties was also the highest in the state, and about 36 percent higher than the next highest premium.

**This comparison refers to preferred provider plans, Option A, under the state system.*

How the state employee health insurance plan works

In 2002-03, insurance companies were allowed to bid to cover state employees in any of Kentucky's 120 counties. And there were several kinds of plans they could offer — preferred-provider plans (PPO), point-of-service plans (POS), exclusive provider plans (EPO), or health maintenance organizations (HMOs) .

The carriers could offer more than one kind of plan in each county. They could also offer different plans in different counties — only a PPO in Mercer County, for instance, and only an HMO in Fayette.

Nevertheless, the carriers were required to set the same premium for each kind of plan in all counties. For instance, an insurer's PPO plan would cost the same in all counties where it was offered, and its cheaper HMO plan would also cost the same in all counties where it was offered.

These costs are borne by the state of Kentucky and its employees: The state pays the full premium for each of its workers, but the employees pay the additional cost of any family coverage they choose.

State employees (including teachers) in Daviess County have only one insurer to choose from and its premiums are the highest of the four companies approved to sell insurance to state employees.

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Anthem ranks the Owensboro region's "area (cost) factors" the highest or second highest in the state.

Less information is available on premiums for the private sector.

Does this mean that premiums here are also higher for private employers? It's hard to say, because objective information comparing such premiums here and elsewhere in Kentucky is hard to come by.

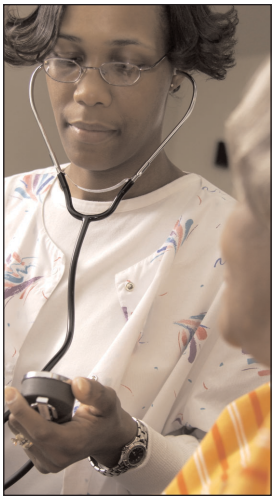
Health insurers do file documents with the state Department of Insurance which list "area factors" for regions of the state that reflect how much higher or lower than average they expect their costs to be there. Anthem ranks the Owensboro region among the highest or second highest in the state in its filings, as does CHA Health, which has been trying to break into the private health insurance market here.

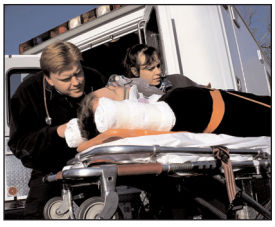
Humana, which has also been trying to gain a foothold locally, ranks the Owensboro region high, but at the same rate as several other regions. Other companies rank Owensboro comparatively low. That may be because they do little business here.

Paying for insurance is main problem for small businesses

For the first time in 20 years, small businesses ranked paying for health care coverage their top problem ahead of paying taxes, *USA Today* reported in April. The ranking came in a survey by the National Federation of Business. The newspaper also cites a Mercer Human Resources Consulting study which found premiums rising 15 percent a year for employers with 200 or fewer employees, compared to 13.5 percent for larger companies.

Why are premiums higher in Owensboro?





Based on interviews and reviews of documents and studies, there are two major reasons that health insurance costs are higher for state employees here than elsewhere: the cost of providers' fees paid by insurance companies and the lack of competition among insurers.

1. Insurance companies pay providers more in Daviess County.

One likely reason for the higher state employee premiums in Owensboro is that ***doctors and hospitals in the Owensboro region* bill more per employee than do health care providers in any of the state's other seven regions,*** according to an analysis of 2001 data by the Kentucky Group Health Insurance Board, which oversees the state employee health insurance plan. (See Chart 2, page 43.)

Even after gender and age are considered, the cost of claims per employee here is about 5 percent higher than the state overall and 15 percent higher than the lowest-cost region.

The board cannot state specifically why claims per person are higher here, but notes that possible reasons could be:

- how much people in the region use health care
- doctors' and hospitals' charges to insurance companies
- access to health-care providers and other considerations related to how physician practices operate

** The Owensboro region also includes the communities of Madisonville, Henderson, and Hopkinsville; the report does not break down the claims by county to determine whether Owensboro is higher than the others. However the communities of Madisonville, Henderson, and Hopkinsville do not have similarly high premiums.*

2. Insurance companies have less competition in Daviess County.

Daviess was one of only 14 counties with only one choice* under the state contract: a preferred provider plan (PPO) from the most expensive carrier, Anthem Blue Cross/Blue Shield. Humana submitted a bid for Daviess County, but did not have enough specialists signed up in its physician network to meet the state's requirements.

Humana's bid for Daviess County state employees has not been made

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Humana's bid for Daviess County was rejected because too few doctors signed on. It's likely that its premiums would have cost less than Anthem's.

public. However, Humana plans that were accepted in other counties included bids that were lower than Anthem's, state documents show. The state requires insurers to propose standard plans and premiums that would be the same in all counties where they choose to be. The state is required to accept the lowest-cost plan. It is likely that comparable coverage from Humana in Daviess County would have been cheaper than Anthem's.

So if Humana's bid been accepted, premiums in Daviess County would not have been the highest in the state. The state would have paid the full cost of single coverage under the Humana plan. The cost to employees who chose Humana's family coverage could have been up to $1,800 less than they currently pay for similar Anthem coverage.

**This refers to one choice in three categories — preferred provider (PPO), health maintenance (HMO) and point of service (POS).*

What if Humana's bid had been accepted?

Does the fact that Humana wanted to insure Daviess Countians for a cheaper price mean that local state employees perhaps aren't the most expensive to insure in Kentucky?

Only if Humana could have made a profit. And whether it would have made a profit is not clear: Humana spokeswoman Kristen Trenaman said that the company doesn't know the answer, since it has had no experience in Daviess County. The state bid was based on data from around Kentucky, she said.

But would-be competitors have obstacles.

In preparing last year's bid for state business in Daviess County, Humana started signing up specialists late in the process. Nevertheless, it did try to sign enough to meet the state's minimum requirement of 40 percent, and it reached an agreement with OMHS, with which it had signed a contract.

One reason for Humana's difficulty signing up specialists, however, is that Daviess County physicians have resisted accepting lower-paying insurance plans, including HMOs, for many years.

Resistance to HMOs is not uncommon in rural communities where a relatively smaller number of doctors do not have to compete for patients.

But Daviess County doctors have also played hardball with insurance companies on traditional coverage plans, even walking away from high-volume contracts that do not meet their financial terms.

Things began changing this year, however: Some doctors are working out agreements with Humana as well as CHA Health for private coverage; both carriers may bid for business in Daviess County.

Why? During a period of rising costs and declining reimbursements for both insurers and the medical community, the "take it or leave it" approach

Local physicians have resisted accepting lower-paying insurance plans for many years, but new carriers are showing more interest in Daviess County.

hasn't helped either side, said Ramona Osborne, who manages Ohio Valley Surgical Specialists. "What I've seen over the last few months was (the parties realizing), 'Well, that didn't work. Can we talk?'"

On the other hand, it remains to be seen whether the state employee premiums in Owensboro will be lowered significantly by competition. The state may allow insurers to set their premium rates by region, rather than statewide, which could actually cause the premiums to increase in this area, even with competition.

For state workers, choice of insurers is a double-edged sword.

Even though teachers and state employees might have had lower premiums for family coverage if the Humana bid had been accepted for Daviess County last year, they might have had to pay even *more* out of pocket.

That's because of differences between the two insurers. Anthem has the largest network of physicians in the state, and many counties in which Anthem did not bid this year have complained bitterly to the Kentucky Personnel Cabinet about forcing state employees to go with insurers with smaller networks.

So it's possible that some state employees in Daviess County might have wanted to stick with Anthem even if Humana's bid had been accepted.

But the state pays only the cost of single coverage for the cheapest carrier in a county, which would have been Humana. Thus employees choosing Anthem would have had to pay the difference in cost for single coverage between Humana and Anthem plus the cost of any of the family plans they might have chosen.

Regional ratings may actually increase premiums in this area.

Lower premiums **can** *mean higher out-of-pocket expenses.*

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Insured patients are more likely to use health care, and Daviess County's rate of insured is higher than the state average. So it's good that more are insured, but unfortunately, this increases utilization and premiums.

Emergency room care is chosen by many people because they do not have a primary care physician. Owensboro-Daviess County has fewer primary care physicians than most Kentucky communities. Bowling Green-Warren County, for example, has 17 more primary care physicians than Owensboro-Daviess County; Madisonville has half as many for the population.

Local people use specialists more than people in other places.

Why are costs to insurers higher here?

1. Daviess Countians may use more medical services or more high-cost medical services.

The more people in a community use health care services, the more claims they file with insurance companies — and the higher premiums rise.

In fact, utilization of health care in the Daviess County area is higher than in other parts of Kentucky and the nation, said Greg Carlson, CEO of Owensboro Mercy Health System. He said that conclusion was borne out by a study a few years ago, when the hospital was operating its own health insurance plan, MedQuest. Hospital officials said they could not find the study to share its numbers.

The latest Kentucky statistics on utilization of hospitals do not show Daviess County as having the highest numbers in the state. They do, however, suggest *somewhat* high utilization here (See Chart 3, page 44.):

- OMHS and other hospitals in the Green River Area Development District had more privately insured inpatients, as a proportion of all inpatients, than any other part of Kentucky except the urban centers of Louisville, Lexington and Covington. Insured patients are more likely to use health care, and a 2000 survey by the University of Kentucky also found that Daviess County had more residents with health insurance than the state average. The county's rate of insured was 92 percent compared to a state average of 86 percent.
- OMHS had the third highest number of inpatient hospital days among the state's hospitals outside the urban centers where competition keeps premiums lower regardless of utilization.
- OMHS had the third most outpatient visits of any hospital in Kentucky, including the urban hospitals, largely because of emergency room visits.

Lack of primary care doctors, combined with high emergency room use and increasing availability of specialists, may contribute to people using higher-cost medical care.

One factor is the cost of the care used. Visits to a primary care doctor, for instance, are cheaper than visits to a hospital emergency room or to a specialist.

Yet patients in Owensboro may have more incentive than in other communities to choose the higher-cost options.

- Owensboro has the lowest number of primary care doctors for its population compared to several other counties with regional or urban hospitals. In Madisonville, for instance, there are nearly twice as many

primary care physicians for the population as there are in Owensboro. (See Chart 4, page 44.)

- It's harder, as a result, to get in to see a doctor. And that's true even if the patient is another doctor. Dr. Robert Schell, a general surgeon, said he's had to wait from two weeks to two months to get an appointment with his regular physician.
- Many people here go to the emergency room for regular medical care as well as true emergencies. OMHS has the busiest emergency room in the state besides Kosair Children's Hospital in Louisville, which also serves as an urgent care center for many of Louisville's poor families. OMHS records more than twice as many ER visits as most other hospitals in the state.

What about the ER?

OMHS has an unusually high number of emergency room visits compared to other communities. Part of the reason, says CEO Greg Carlson, is the low number of primary care doctors for the population. State statistics show that Owensboro actually has the lowest proportion of such doctors of any county with a comparable or larger hospital.

Also contributing to the high ER use is the fact that the hospital has an obligation to take all patients who show up, regardless of their ability to pay. Doctors' offices do not have the same obligation.

Yet in spite of the fact that it takes ER patients who can't pay, OMHS actually makes money on its emergency room because of the additional services that ER visits require, says OMHS senior vice president Bill Price.

Does that reduce the hospital's incentive, then, to actively recruit more primary care physicians?

Price and Carlson say no - but they also say it's not primarily the hospital's responsibility to do such recruiting. Its responsibility is to provide access, Carlson said, which is why it is funding a physician at the free McAuley Clinic. At the same time, OMHS has added a non-urgent track to its emergency room care and opened an off-site urgent-treatment center.

The hospital does actively recruit specialists, including some who function as primary care doctors such as obstetrician/gynecologists. In 2002, for instance, OMHS granted privileges to 12 new specialists and eight new primary care physicians, including internists, pediatricians and OB-GYNs. By mid-2003 it had granted privileges to 12 additional specialists and one family practice doctor.

With ancillary services, the Emergency Department is a profit center for OMHS.

Emergency room care is the most expensive form of care, and OMHS has one of the busiest emergency rooms in the state.

Patients here are more likely to visit specialists than primary care doctors, research shows.

After the city's two hospitals merged in 1995, OMHS actively recruited more specialists to the area so people wouldn't have to go to larger cities, and

other hospitals, for health care. And research by the Dartmouth Atlas of Health Care shows that the more specialized medical services available in a community, the more they will be used.

The Atlas, a resource for a variety of localized medical data across the United States, sheds some light on this issue in Owensboro.

Its analysis based on 1996 data showed that Owensboro had the fewest primary care physicians per 100,000 residents of 12 major cities in Kentucky and Tennessee and ranked last in the number of visits that patients made to them.

Yet the area ranked seventh in the number of specialists, and ***fourth*** in the number of visits patients make to specialists. Since then, many more specialists have been added.

The hospital merger may have increased utilization.

A growing number of specialists may also contribute to more use of the hospital, since specialists often admit patients for surgery and outpatient procedures.

In addition, Blue Cross Blue Shield released a report last year showing that health care costs are inevitably higher in communities where hospitals have merged, partly because of increased utilization.*

Some of the factors the report mentioned are present in Daviess County, including an increasing number of specialists, a consolidated hospital with a growing market share and a high outpatient count (compared to other Kentucky hospitals).

Since the first year after the 1996 merger, OMHS' market share has grown 40 percent; it now has 17 percent more inpatients and 30 percent more outpatients; and it performs 35 percent more surgeries, according to figures provided by OMHS to the *Messenger-Inquirer.*

Hospital officials disagree that the merger has contributed to higher utilization and health care costs. They say they have a goal of reducing utilization through patient education, prevention and wellness activities. In addition, Bill Price, the senior vice president of finance and treasurer at OMHS, said that the increasing market share and patient count don't necessarily mean that people here are using *more* health care. It is possible that they simply *switched* their usage of health care from out-of-town hospitals.

Nevertheless, OMHS has taken steps that could have increased utilization by aggressively advertising its services and incurring capital costs to increase its market share, including opening a new emergency room and new labor and delivery rooms.

**Source: "What's Behind the Rise: A Comprehensive Analysis of Healthcare Costs," published by Blue Cross Blue Shield Association, October 2002 (based on conducted by the University of Southern California, The Lewin Group and HealthShare Technology, Inc.)*

Blue Cross Blue Shield reports that health care costs are higher in communities where hospitals have merged. OMHS and the American Hospital Association disagree.

Does more volume at the hospital reflect higher utilization, or that more people are choosing OMHS over out-of-town hospitals?

High rates of smoking and obesity lead to more surgeries and higher costs, but local smoking and obesity rates are not higher than other areas of Kentucky. Some suggest that people in our area are more likely to use the health care that is available here, unlike more rural or remote areas where care is not as convenient

Insurers, hospitals fight war of words over hospital mergers and the cost of health care

Health care providers and insurance companies are often at odds over the causes of rising health care costs. So it was no surprise when the American Hospital Association strongly criticized a Blue Cross Blue Shield study of hospital mergers, released last year, that found that mergers have contributed to those costs.

Noting that the health insurance industry is extremely profitable, the hospital association said mergers have actually increased efficiency and are not to blame for rising costs, according to the Kaiser Family Foundation.

OMHS officials say the merger here lowered costs by avoiding duplication of facilities, expensive equipment and services.

Other research into hospital mergers also casts doubt on how much money they save. But it has also shown that mergers in communities such as Owensboro, without much managed-care activity, are more likely to save money than mergers in communities with more HMOs, according to the journal *Health Affairs.*

All this is now being debated in Washington, D.C. Even before the Blue Cross Blue Shield study was released, the Federal Trade Commission had begun examining hospital mergers and whether they are responsible in part for rising health care costs. The FTC has been holding hearings on the matter since February.

Utilization of some surgical procedures is comparatively high here.

There are also other indications of comparatively high utilization of specialist and hospital care in Daviess County.

The Dartmouth Atlas, for instance, compared the use of various medical procedures in Owensboro and the 12 other cities in Kentucky and Tennessee for 1999. In spite of having fewer per capita specialists and hospitals than many of them, Owensboro had the most surgeries for its population in three of eight categories, and had third most surgeries in a fourth category. (See Chart 5, p 45.)

Schell, a surgeon and past president of the Ohio Valley Physicians Association, said that the prevalence of some of the surgeries is related to a local population with high rates of smoking and obesity and the related problems of diabetes and heart disease.

While there may be an even higher incidence of these diseases in other areas of Kentucky where premiums are lower, such as Appalachia, Carlson of OMHS said people in those areas might be less likely to go to a doctor or may seek care in urban areas.

"We have good access" to sophisticated care in Owensboro, he said.

The PEOPLE'S Health Project

A local business reports that physicians' charges are 20 percent more for their Owensboro employees than those in Paducah.

Are we sicker than Paducah?

Another reason for high utilization in general is a population with lots of illness. And health care providers in Owensboro often say that the lifestyle of the population - which is prone to smoking and obesity - contributes to higher healthcare costs here compared to other parts of the state.

But state records on death and disease do not indicate that the Owensboro area has more health problems than other parts of Kentucky.

The region does rank high in the state in some diseases, such as lung cancer (it's fourth), but not in others; its diabetes and smoking rates, for instance, are about average for Kentucky.

The overall incidence of cancer is also about average: The Green River Area Development District ranked eighth among the state's 15 districts for incidence of cancer per 100,000 people in the population, according to the state's 2001 hospital utilization report. Cancer cases grew 14 percent between 1998 and 2002 in the GRADD, the report said. Eight other districts had larger increases.

Another public indicator of the health of the population, and how it might affect health care costs, is the hospital's "case mix index" for Medicare patients - a number that reflects how much sicker than average its Medicare patients are. When compared to 13 other regional hospitals in Kentucky and Southern Indiana (including three in Louisville and Lexington), the index for OMHS was lower than eight of them, according to the American Hospital Directory.

Some Daviess Countians also note that health care costs vary too much in the Western Kentucky area to be tied to illness rates.

Ed Riney, publisher of the *Messenger-Inquirer*, said that Owensboro doctors' charges to insurers were 20 percent higher than Paducah doctors' charges when the newspaper's owner compared them last year. Thus the argument that Daviess Countians' lifestyle contributes to higher health costs doesn't hold water with him. "I don't believe for a minute that our lifestyles are any different in Owensboro, Kentucky, than 100 miles west in Paducah," he said.

2. Hospital and doctors' charges to insurance companies may be higher here.

The cost of medical care is determined, in part, by how much hospitals and doctors charge insurance companies for their services. These charges are discounted from the "official" charges that are sometimes made public.

Because these discounted charges are considered private, it's hard to find out exactly how much OMHS and Owensboro doctors charge insurance companies, and whether those charges are higher than in other parts of the state, or how they compared to other hospitals and doctors in the region.

But there is anecdotal evidence that charges here are comparatively high.

OMHS' charges are higher than at hospitals in some other parts of Kentucky, according to Anthem, the primary commercial insurer in Daviess County. While Anthem will not disclose the terms of its contract with OMHS, Anthem regional vice president Mike Lorch will say this much: It costs Anthem 30 percent more to pay for the delivery of a baby in Owensboro than it does in Louisville.

OMHS' Bill Price said that, because he doesn't know the details of other hospitals' agreements with insurers, he has no documentation to prove Lorch wrong. But based on informal conversations with other hospitals, "I don't believe we're that far out of line," he said.

At the same time, he acknowledged that insurance companies do tell OMHS that charges here are higher than in other parts of the state. "When we negotiate, sure, they're going to tell us that," he said.

A presentation OMHS gave to the ODCH board of directors last year shows that, overall, it collects about 85 percent of its official charges from insurers, meaning its average discount was about 15 percent.

But this is not information that other hospitals typically disclose, so it's hard to know how OMHS compares with others.

Also, the discount percentage can be deceiving. According to Lorch, Owensboro keeps its official charges fairly low but "doesn't negotiate off that price much." Other hospitals may have higher "official" charges but give deeper discounts, resulting in lower charges to insurers.

Doctors' charges to insurers aren't as relevant as hospital charges when comparing region-to-region costs for a couple of reasons, at least in Anthem's case, Lorch said.

One is that hospital charges, in general, are the biggest part of health care costs in a community. Also, Anthem pays standard charges to physicians across the state, thus discounts in Owensboro would not be different than elsewhere, Lorch said.

Because Anthem dominates the insurance market in Daviess County, its experience is significant.

According to Anthem, it costs 30 percent more to deliver a baby in Owensboro than in Louisville.

Anthem says that OMHS keeps "official published" charges low, but doesn't negotiate off that price much, unlike some other hospitals.

Hospital charges affect health care costs more than physician charges.

The PEOPLE'S Health Project

OMHS has lost money on Medicare patients who account for about half the hospital's in-patient business.

In larger cities, Medicaid and uninsured patients are often treated at university hospitals that get larger government reimbursements than OMHS.

By making up losses from Medicare, Medicaid, and charity care by what they charge insurance companies, OMHS has maintained a healthy bottom line.

Nevertheless, there is anecdotal evidence that local physicians' charges to other insurers may be higher than other parts of the state:

- The Owensboro Community Health Network, set up by OMHS to negotiate discounted charges for doctors, was charging 20 percent more than two doctors' groups in the Paducah area when the company that owns the *Messenger-Inquirer* checked last summer for its self-funded insurance plan, said Publisher Ed Riney.
- Doctors' charges in Owensboro were "significantly higher" than those in Central Kentucky when this company did a comparison two years ago, said Darryl Hofe, an insurance broker with Acordia who works with Owensboro Municipal Utilities.

How do physicians negotiate charges?

There are two organizations in Owensboro, the Owensboro Community Health Network, set up by OMHS, and the Physician Hospital Organization of the Ohio Valley Physicians Association, which negotiate discounts with insurance companies on behalf of doctors in the area. At the same time, individual doctors' offices can choose to negotiate on their own.

Maintaining a healthy bottom line despite hospital losses on Medicare may factor into higher charges.

Medicare and Medicaid pay for the biggest portion of hospital services at OMHS - about two-thirds of inpatient days in 2001, according to state records on hospital utilization.

Because of the relatively high percentages of Medicare and Medicaid patients (Medicare patients account for about half of the hospital's inpatient business), OMHS gets additional funding from the federal and state governments as a "disproportionate share hospital."

Yet on average, an analysis by Data Advantage showed that OMHS lost money on its Medicare patients in 2001. (Data Advantage is a company that OMHS pays to look at its financial trends.)

OMHS fared worse financially than other hospitals with similar numbers of Medicare patients and worse than 30 of the 41other hospitals Data Advantage compared it to. (See Chart 6, page 46.)

The hospital also has lost money on its Medicaid cases, Carlson said. In addition, it is obligated to treat uninsured patients who cannot afford to pay the hospitals' charges.

That puts rural regional hospitals such as OMHS at a financial disadvantage compared to urban hospitals because Medicaid and uninsured patients in bigger communities are often treated at university teaching hospitals as part of the hospitals' mission, Anthem's Lorch said. In addition, those university hospitals get larger reimbursements from Medicaid to offset their costs.

Nevertheless, OMHS' overall bottom line has looked good in recent years. In 2001 it recorded a healthy net income compared to other rural and regional

hospitals, according to the American Hospital Directory. (See Chart 7, page 47.)

Carlson said that the hospital must make up in charges to commercial insurers what it loses on Medicaid and Medicare patients in order to break even, much less make money. OMHS' average reimbursement from Medicare is about 52 percent of its charge, according to the Data Advantage analysis. Its average payment from commercial insurers is about 85 percent.

"If we have 200 patients and 100 of them are Medicare/Medicaid combined, and on those patients we're losing $500 a case, well, to get to a break-even point we have got to subsidize (from) our commercial insurance by the equivalent of that just to break even," Carlson said.

If hospital charges are too low, resulting financial problems could be devastating to one-hospital towns like Owensboro.

Medicare losses related to wage index, hospital says

OMHS says that its losses on Medicare patients, at a time when most other hospitals it was compared to are not losing money on them, is tied to the wage index that Medicare uses to determine reimbursements. Here is what the hospital says about the wage index:

- The index uses the average hourly wage paid for health care services in a particular region or area. Urban hospitals typically pay higher wages, and thus receive higher reimbursements, than rural hospitals. On the other hand, some urban hospitals may pay lower wages than others in the area, but benefit from averaging their wages with other area hospitals which pay more. That is not the case in the Owensboro region; its only hospital is OMHS.
- Medicare allows some rural hospitals, such as those in Bowling Green and Paducah, to receive higher payments based on a nearby urban center's wage index (Nashville, Tenn.). Another Medicare rule allows hospitals with an unusually low wage index to get at least the minimum rate paid to rural hospitals, which may be higher (Deaconess and St. Mary's in Evansville, Ind.). According to OMHS financial analyst Russ Ranallo, that gives them an advantage over OMHS, which does not get an adjustment of its rate.
- Hospitals in large urban areas (and some rural hospitals which have their rates adjusted based on nearby urban centers) receive a higher base rate than hospitals in other urban areas, such as OMHS. A hospital in Louisville, for instance, would get about $700,000 more per year than OMHS would, Ranallo says.

But does this fully explain why OMHS is losing money on Medicare patients? It's hard to say. The information from Data Advantage, which OMHS pays to compare it with other hospitals, shows that about half had higher Medicare reimbursements while three fourths did better financially.

The PEOPLE'S Health Project

But is the hospital setting the charges in order to make unreasonable financial gains?

It does not appear so — although the hospital arguably may have to charge higher rates than other hospitals to make up for losses as well as to reach its net income targets.

A review of the net incomes of 14 regional and urban hospitals across Kentucky and in Evansville, based on information from the American Hospital Directory, showed that OMHS ranked fourth. It had a net income percentage of 6.59 for 2001 — slightly higher than St. Mary's and slightly lower than Deaconess, both in Evansville, Ind. Regional Medical Center in Madisonville also had a higher percentage at 9.8.

Schell argued that even if OMHS does have to charge insurers more than other similar hospitals to maintain a healthy bottom line, "it may be that the rate is correct for Owensboro" because a healthy bottom line is important.

Although competition in health care is often a good thing, he said, it can also drive charges dangerously low. Many bigger-city hospitals which have to compete for patients have hit hard times financially, a situation that would be devastating in a one-hospital town such as Owensboro. It could even raise the specter of a tax increase to fund the health care system, he said.

How does the hospital make money besides charges for medical care?

The hospital also counts on investment income to help its profitability, according to Bill Price, senior vice president finance. (See Chart 8, page 47.) For instance in the last year the hospital issued $201 million in bonds — its allotment for capital purchases such as buildings for three years — which it bought at a tax-exempt interest rate. It has invested the money at both variable and fixed rates of interest that are higher than its debt rate.

While the net income of OMHS is currently about 5 percent, it has dropped in the last two years, partly because of the effect of the stock market decline on investments, Price said. Its net income percentages for 1999 were 3.1 percent, 9.2 percent in 2000, 8.9 percent in 2001 and 5.2 percent in 2002. *

The drop in net income is also related to expenses that have been higher than expected for hiring nurses and other health professionals, malpractice insurance, charity care, and bad debt, according to Price.

Nevertheless, revenue continues to increase overall.

**OMHS figures its net income differently than the American Hospital Directory, so these figures are higher than net income percentages in another chart in this report.*

In recent years, OMHS investment losses have been significant. Personnel costs (including senior management compensation), malpractice insurance, charity care, and bad debt are also up.

Lack of competition for doctors and the hospital could also contribute to high charges.

Not only does Owensboro have just one hospital serving 99 percent of the Daviess County market, it has a low proportion of doctors for the population.

In one-hospital towns, "the cost to commercial customers (insurers) is often lower than when competition does not exist," said Anthem regional vice president Mike Lorch.

At the same time, doctors generally do not have to compete for patients. That means they have less incentive to accept lower-paying HMOs or other health insurance plans. (OMHS, on the other hand, did make agreements with all insurers interested in bidding for last year's state employee contract.)

"I think that factors in" to local doctors' ability to command higher reimbursement rates, said Brenda Clayton, executive director of the Ohio Valley Physicians Association, which helps negotiate insurance rates for many doctors in the area.

So does the fact that there aren't many employers with enough employees/patients to negotiate persuasively with physicians (through their insurers) for a volume discount, said Schell, the surgeon.

Both Carlson of OMHS and Schell also said that Owensboro may have to pay physicians more than some other towns to attract them to a rural community.

Of course recruiting physicians is a problem for most rural communities, including those with lower premiums, because newly-minted doctors often want to practice in bigger cities with more medical resources and amenities. But Owensboro has been aggressive, since the hospitals were merged, in recruiting specialists who will use OMHS for various procedures.

Schell said the ability to attract good doctors is worth the trade off even if doctors' charges in Owensboro are higher than in other nearby communities - and that lowering them wouldn't make a significant difference since doctors' charges account for a smaller percentage of premiums than hospitals' charges do.

"Yes, you can wring some more out of the system. But I'm not sure that that ultimately serves anybody very well," he said. That's because it would be harder to recruit the best and brightest physicians to this area and Owensboro might be left with physicians who are "less motivated, less committed, less dedicated."

The less the competition, the less the incentive to negotiate.

Small employers have little leverage to negotiate with health care providers or insurance companies.

Some believe we may have to pay more to attract and keep quality physicians in Daviess County.

The PEOPLE'S Health Project

A lower volume for medical specialties in a community our size, compared to urban areas, may mean higher charges to recover equipment and overhead costs.

Overhead for doctors could also affect costs to insurers

Being a regional center for medical care may be a mixed blessing for the Daviess County health care system. Since the merger of Owensboro's two hospitals in 1995, specialists have been recruited to Daviess County so patients in Owensboro and surrounding counties would be more likely to use the hospital here than seek care elsewhere.

However specialists generally need more advanced medical equipment than family doctors, which increases their overhead costs. Is it possible, then, that the new specialists in a smaller town such as Owensboro might have to charge more to pay for equipment than specialists in larger cities with a larger volume of patients to offset the costs?

Indeed an individual specialist might have higher costs than a group of specialists doing the same thing in a bigger city, said Schell, the surgeon.

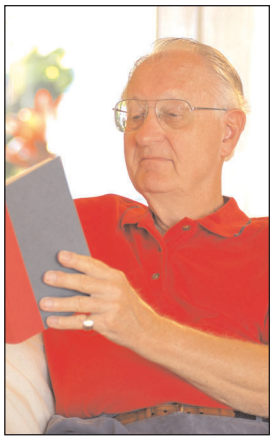
But that may be money well spent on behalf of the overall community, he said. For one thing, it might be harder for charity patients to get care for complex medical problems because it's harder to convince specialists in other cities to take non-paying patients.

Why aren't there more insurers in Daviess County?

Kentucky has four major insurance companies which seek state employee contract business - Anthem, Humana, CHA (affiliated with the University of Kentucky) and Bluegrass Health Care (affiliated with the Baptist hospital system).

But this hasn't necessarily led to a competitive market. In fact, some of the carriers have limited their business to certain regions or counties.

For this past year's state employee plan, Anthem dramatically reduced the number of counties it serves. In 76 percent of their locations, they were the only choice.



The state's health insurance companies generally pick and choose their counties.

For instance in the county-by-county bidding last year, Anthem bid mainly in counties where it would have no competition. Previously it had offered insurance in more than half the state's 120 counties. This year, it is offering plans in only 16 — and in 11 of those counties, Anthem is the only insurance company available.

That strategy helped Anthem spread out its financial risk. In counties with lower-cost plans competing with Anthem plans, younger and healthier people may tend to choose the low-cost option, not Anthem.

But older, sicker people may tend to choose Anthem because of its broader networks of doctors and specialists. That would leave Anthem to assume more risk, and with more claims to pay.

(According to Anthem spokeswoman Suellen Brill, the insurer's decision was also based on issues such as the design of the state's benefit plans, the number of retirees the state covers and utilization rates for state employees. Anthem originally bid in only 11 counties, but later added five more at the state's request, Brill said.)

Humana, though it tried to bid successfully in Daviess County, has historically concentrated its business in Central Kentucky.

Kentucky Personnel Secretary Carol Palmore oversees the state employee health insurance contract. She doesn't believe there is collusion among insurers about territories they will cover, but that their familiarity with the market makes it likely that they know where they will be most successful.

At the same time, Daviess may be a particularly hard market to break into, which could contribute to the lack of competition here, either for state insurance carriers or those interested in the private sector.

Mark Birdwhistell, CHA Health CEO, has been trying to sign up doctors for its network in order to sell insurance to employers and associations in the large group market.

"We don't have an abundant network of physicians," he said in late 2002. "We do have the hospital." (The situation may have changed recently as some

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Insurers have been reducing reimbursements to doctors less every year for the last five.

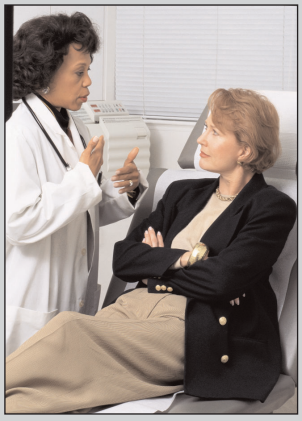
doctors' offices have been negotiating with CHA and Humana.)

The company did succeed in signing up physicians for its contracts with self-insured employers*, which it tried before pursuing the large group market, Birdwhistell said.

That is perhaps partly because payments to doctors and hospitals are generally higher in self-insured arrangements, he said. "Some physicians are more accepting of that higher fee schedule," he said.

Nevertheless, said Schell, insurers have been reimbursing doctors less every year for the last five. So even if charges in Daviess County are higher than in other communities, insurers are in the driver's seat, he said.

**In self-insured arrangements, employers share the risk with the insurance companies and cover the administrative costs.*



Is the cost gap with urban areas closing?

Brenda Clayton, executive director of the Ohio Valley Physicians Association, has analyzed the cost of insurance for her physician members in Owensboro and Louisville. "There's a difference, but it's not like $5,000," she said. "Those gaps are narrowing all the time."

Dr. Robert Schell, a general surgeon and past president of the OVPA, said doctors, too, have an interest in more insurance company competition because they have to buy insurance for their own employees. "We would like to see three or four major insurance players in the area and those players can give people more choice."

Forty-eight health insurance companies left the state in the 1990s, but most had only 100 to 200 policyholders and few Kentuckians felt the impact.

State and national trends contribute to a lack of competition.

Some health care providers such as Schell believe that a lack of health insurers doing business in Kentucky overall contribute to the lack of competition in Owensboro.

It's true that 48 companies selling health insurance left Kentucky as a result of the health care reforms of the 1990s. However the vast majority had only 100 to 200 policyholders, most of them in the individual market (as opposed to the group market, which serves employers and other organizations). That means relatively few Kentuckians felt the impact.

On the other hand, Kentucky has fewer licensed carriers than many other states and the District of Columbia, based on 2000 figures from the National Center for Policy Analysis. Besides the departure of companies due to insurance reforms, Kentucky lost two competing companies to merger in recent years.

Still, that comparison may not be particularly significant because many states are dominated by a few large health insurance carriers. In 25 states, including Kentucky, the five largest health insurers control two-thirds or more of the market, the Center for Policy Analysis notes.

Not only does that reduce competition, but the availability of alternatives is shrinking: The trend toward managed care organizations (HMOs) of several years ago has now reversed because of growing opposition to the limits HMOs put on coverage and choice of doctors.

This directly affected the Owensboro market in the late 1990s when the hospital operated a low-cost HMO, MedQuest. Nationally, only a third of HMOs were profitable in 1997, and in 1998, more than half the 17 HMOs in Kentucky lost money, according to the Kentucky Legislative Research Commission. Ultimately, in 1999, MedQuest went under.

Yet another reason why Kentucky doesn't have more health insurers today is its demographics. The state is relatively poorer and sicker with a smaller and less educated population than the rest of the nation, and, as a result, is not a particularly attractive market for an insurer wanting to increase profits.

And that is a key concern of insurers today. The hospital industry points out that insurers are making up for losses of investment income in the stock market, as well as poor returns in past years that weren't anticipated in their underwriting cycles. For the last three years, premium increases to employers have exceeded rising medical costs.

Yet many of the nation's larger insurers are thriving. Two of the major group insurers in Kentucky, Anthem and Humana, have been reporting healthy gains in net income in recent quarters. Both are active in the Owensboro area.

Kentucky premiums are lower than some places

Eric Davis, the new president of Owensboro's Chamber of Commerce and Industry Inc., moved here from Sherman, Texas, recently and experienced great savings in health insurance premiums. "My rates for my family went down over $150 a month," he said. "I'm finding rates to be cheaper here than where I came from."

Many states are dominated by a few larger insurance carriers.

HMOs have not fared well in Kentucky. Our local HMO, Medquest, went bankrupt in 1999. OMHS reported a $17 million loss.

Kentucky — with its poor, sick, less educated population that is not growing — is not an attractive market for insurance companies.

For three years, health insurance premiums have increased more than medical costs.

Insurance premiums are even higher in other places.

The PEOPLE'S Health Project

Why are health insurance premiums higher here:

…lack of competition

…physicians here have been able to command higher insurance co-payments

…our physicians and hospital must absorb all the charity care

Perspectives: Why are premiums higher in Owensboro?

The health care providers, insurance companies and employers who are the major players in the health insurance field tend to analyze this question differently.

Many cite lack of competition, for instance, but they differ on whether the problem is too few competing insurance companies, the existence of only one hospital, or the general refusal of the physician community, at least in the past, to accept lower-paying health care plans.

Others point to market strategies by insurance companies or the costs associated with Owensboro's status as a regional medical center drawing the sickest people from surrounding counties, as contributing factors.

Mark Birdwhistell, CHA Health chief executive officer, which is associated with University of Kentucky's HMO:

Higher premiums in this area are "directly attributable to the fact that there is limited competition among health insurers." In Central Kentucky, the abundant supply of providers and health plans creates a competitive market both for premiums and reimbursement rates.

"Until such time as there are multiple payers (insurance companies) in that market ... it's going to be unlikely that there will be any leveling of the playing field or leveling of the costs in that area."

What about more competition for providers?

"Obviously that would help, but it may not be a prerequisite ... I don't think it's a supply problem, and I don't think it's the fact that there's one hospital in town, either. There are no market forces at play to assist the situation."

State Representative Brian Crall, who sponsored a bill to change the way the state employee insurance contract is bid:

Owensboro has a "fairly close knit though somewhat unraveling physician fabric" and a stable population. Thus physicians "have been able by and large to withstand the incursion of managed care" and to command higher insurance-company payments than physicians in the Golden Triangle.

On the other hand, the physicians and OMHS must absorb the cost of caring for the sickest and poorest patients in a broader region. This region, unlike the Golden Triangle, does not have state-supported hospitals for the indigent such as the medical centers at UK and U of L.

Kentucky Employers Health Benefits Coalition (which is part of the Kentucky Chamber of Commerce):

"Lack of competition among providers in rural areas leads to higher prices and unfortunately leaves many Kentuckians unable to afford health services."

"Record levels of consolidation took place among hospitals during the mid-to-late 1990s ... Hospital mergers and rising admission levels have shifted negotiating leverage to major hospital systems, especially in rural areas with only one hospital.

"The lack of competition allows consolidated network hospitals to demand higher reimbursement rates, increasing costs to payers (insurance companies). However the ultimate payers are the employers and employees, who must absorb the higher costs in higher premiums."

The coalition also cites state-mandated health benefits as a factor in high premiums in Kentucky.

…hospital mergers have shifted negotiating leverage

…lack of competition

…state-mandated health benefits

Kentucky Group Health Insurance Board (which oversees the state employee health insurance program).

In Region 2, which includes Owensboro, "factors other than demographics — the health status of individuals in that region, the cost per service charged by the providers used by individuals in that region, provider practice patterns, or access to health care providers — is affecting health insurance costs. As additional data becomes available, OPEHI (the Office of Public Employee Health Insurance) will seek to ascertain the factors that are causing regional costs to differ."

There are actually four regions of the state for which this is true, the analysis says. Two of them have *lower* state employee insurance costs than would be justified by demographics. But Owensboro and the Ashland areas both have higher state employee insurance costs than would be justified by demographics, with Owensboro showing the biggest gap.

…poor health status

…provider charges

Bill Price, senior vice president of finance, Owensboro Mercy Health System:

"There could be a variety/mix of factors that are influencing the premiums. Insurance companies may be faced with losses/reduced gains on their investments and are raising premiums to offset shortfalls. Insurance companies that lost money in prior years may have raised rates to cover losses. Utilization for the population may be higher."

Also, rates for the state employee insurance contract here might have been lower had the state not rejected Humana's bid in the area. (The bid was rejected because Humana had not signed up the required number of specialists for its physician network.)

…increased premiums to offset insurance company investment losses.

…high utilization

…poor health of the community

Brenda Clayton, executive director, Ohio Valley Physicians Association (which includes most area doctors):

Is part of the reason that doctors in Owensboro don't have to compete as much for patients, and thus don't have to make deals with insurance companies offering lower reimbursements and offering lower rates?

"I think that factors in."

Another issue may be the health of the community, she said, noting that rural communities tend to be less healthy than urban ones.

…insurance companies, exodus of insurance companies

…threat of malpractice suites which leads to more medical testing

Robert Schell, general surgeon and president of the Ohio Valley Physicians Association:

The size of premiums is within the control of insurance companies, which decide what doctors are paid and they have been reducing payments in recent years. The health care reforms of the 1990s in Kentucky, which caused insurance companies to leave the state, have also affected the market. As for the doctors' part in higher premiums, they're only a small part of the issue. Owensboro does have to pay doctors more to locate here because the best and brightest are more likely to want to practice in bigger cities, but that's a necessary expense. In addition, medical malpractice reform would help contain physician costs better and would perhaps affect utilization rates by reducing the practice of "defensive medicine" in which physicians do more testing than necessary to protect themselves against liability lawsuits.

…hospital costs

…one-hospital town

…lack of a university hospital to absorb losses for Medicaid and uninsured patients

Mike Lorch, Anthem regional vice president:

The largest dollar driver of insurance premium increases is hospital costs, although pharmaceutical costs have gotten much of the press recently. And "one-hospital towns have higher costs and higher premiums. ... It costs 30 percent less to deliver a baby in Louisville than it does here." Part of the reason is that urban communities have university hospitals to absorb the financial losses of treating Medicaid and uninsured patients, while rural regional hospitals such as OMHS do not. That being said, "In communities where there is competition (among hospitals), the cost to commercial customers is often lower than when competition does not exist." Also, the hospitals "often do not have to negotiate as aggressively with commercial payers."

This situation is not unique to Owensboro, but in some other communities the hospital chooses to operate on a smaller margin. At the same time, the additional margins allow the hospital to provide many valuable community services.

…lack of competition

Kristen Trenaman, spokesperson for Humana, which failed in a bid to get state employee business in Humana in the current contract year:

"Similar to other areas of business, competition (among insurers) drives down costs; likewise a lack of competition can have the opposite effect."

Eric Davis, president of Owensboro's Chamber of Commerce and Industry Inc. who has worked in other places across the nation:

"Every small town that I've dealt in that has a big hospital" seems to have higher costs. "The more health care you've got, it seems like the rates get higher." It's a "middle-sized market issue."

…a middle-sized market issue

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The community could provide more early detection and preventive care by
• adding primary care doctors
•more efficiently directing people to primary care
• adding clinical medical services

What can be done about high premiums?

While it may be that hospitals, doctors and insurance companies have remained profitable in the face of rising health care costs and premiums, employers and consumers aren't faring nearly so well. Is there anything they can do to change the situation?

A variety of options have been proposed.

1. Reduce utilization.

Add more primary care doctors or more efficiently direct people away from the emergency room to primary care.

It is possible that connecting more patients to primary care doctors in Owensboro would reduce higher-cost utilization. That's because if more people had ready access to a doctor, they might get the kind of early detection and preventive care that can lower their (and the system's) health care costs down the road. Also, they may be less likely to go to the OMHS emergency room with a minor problem or to local specialists with problems that could be handled by less expensive family doctors.

On the other hand, the more health care that is available in a community, the more it is utilized, research shows. The question is whether more primary care doctors would add to utilization, shift utilization from higher-cost to lower-cost medical services, or ultimately reduce utilization by providing more preventive care at the outset, making serious illnesses less likely in the future.

On balance, more primary care doctors would benefit the community by redirecting people to lower-cost services, said Carlson, the OMHS chief executive.

Ramona Osborne, executive director of Ohio Valley Surgical Specialists, suggested that the community look at disincentives for primary care doctors to locate here — and address them.

In addition, she said, the community may also have to find ways to cope with a cultural tendency here for people to seek care in the emergency room as a first resort. Patients "have to understand that emergency room care is really expensive," she said.

Yet the medical community is not of one mind on whether more doctors are needed. Dr. Gary Wahl of Owensboro Family Medicine, a practice of primary care doctors, said he doesn't believe Daviess County has a shortage. "I think most people can find a primary care physician," he said. "There are primary care physicians that advertise weekly in the newspaper and there are three walk-in clinics that are open seven days a week that have opened in the last few years ... I feel like the main reason people are choosing the emergency

room is that they have no insurance and they are not required to pay up front at the emergency room as compared to walk-in clinics or physicians' offices."

The proposed DC-CAP program is an attempt to coordinate and equitably distribute the care of uninsured patients into existing primary care resources and away from the emergency room

Better inform consumers about health care spending; expand consumer control over health care spending.

If people made more careful choices about using health care, that could lower the health care costs that contribute to higher premiums.

Indeed, "Many health policy experts argue that tackling health care inflation will require a fundamental cultural shift in the American approach to medicine," *The New York Times* said in an analysis of rising health care costs last summer.

"They say doctors and patients must begin taking cost into account when making treatment decisions. They say Americans must limit themselves to treatments that are proven to work and accept the premise that more care does not necessarily mean better care."

But how to put such a cultural shift in motion? Possibilities include:

Patients and doctors could take cost into account in health care decisions by:
• demanding more information, comparisons, choices
• forming a coalition to tackle costs
• sharing in decision making about treatment options

Open up the "secret society" of health care spending information. Some states and communities publish hospital "report cards" to allow consumers to compare quality and services. While some such report cards have been criticized as incomplete or misleading, the fact is that consumers are now demanding, and getting, more information about health care systems and providers. Part of the reason is that the Internet allows patients to get more health information in general.

In addition, some economists maintain that the current top-down approach toward medical spending decisions (made by insurance companies or providers) has not only *not* worked — it has been counterproductive. Instead, consumers should make more of their own decisions, says Regina E. Herzlinger of Harvard Business School. And providing them with more information is key, she said in a recent presentation to the Federal Trade Commission, which is looking at antitrust issues surrounding hospital mergers and health care.

Start a collaborative community discussion about how to reduce health care costs. The Health Improvement Collaborative of Cincinnati is a coalition of community leaders from the physician, insurer, employer, hospital, government, education and consumer sectors which tackles specific health problems (such as low birth weight babies, flu immunization and depression) as a way of improving both the quality of care provided and the health of the community. A comparable local-regional coalition could be effective in addressing cost issues as well.

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Institute "shared decision making" among doctors and patients. Researchers at the Dartmouth Atlas of Health Care have found that utilization of health care may vary by region as a result of geographic differences in doctors' attitudes and availability. At the same time they have found that consumers, if given more information about their choices of care, might opt out of more expensive treatment options. Thus they recommend an approach called **"shared decision making."** Doctors use a variety of patient education materials, such as videotapes, to give patients the details of the pros and cons of particular treatment options; the patient and doctor then decide, together, if the procedure is for them.

Shared decision making results

"Several studies have found that the level of demand for surgery that results from shared decision making is different and sometimes substantially less than in circumstances in which patients are not involved in decisions about surgical options. When informed about the risks and benefits of the alternative treatments, and invited to make decisions according to their own preferences, patients with benign prostatic hyperplasia and coronary artery disease demanded more conservative treatments and less surgery than was being performed before shared decision making was implemented."

—Dartmouth Atlas of Health Care, 1999

Give employees financial incentives, in the form of premium credits, to improve their health. Employers who provide health care coverage have the option of developing insurance plans that would give employees credit for certain lifestyle choices that will improve their health — such as not smoking and exercising. One reason such options aren't common is that employers must invest both time and money in setting them up — up-front costs employers often choose to forego in the absence of proof they'll save money later.

Dan Davis of Owensboro, who brokers employee benefit packages between employers and insurers, said healthy lifestyle credits have been more popular in the Evansville area than in Owensboro. But some local employers do use them, or other kinds of financial incentives. For instance The Anderson Group, Davis' company, pays the full cost of HealthPark membership for employees who use the facility at least seven times a month, he said.

Employers could provide financial incentives to improve health by:
- *reducing employee premiums for not smoking, starting exercise, etc.*
- *offering health club memberships for employees*

2. Reduce hospital and doctors' charges by reducing costs.

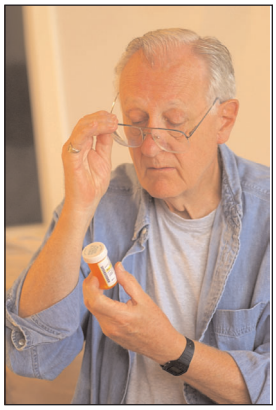
Formalize community input into providers' health care spending decisions.

OMHS is constantly looking at ways to lower its costs, which could lead to lower charges for insurers. However many issues are beyond its control — labor costs for nurses and other health professionals who are in short supply in parts of Kentucky and the U.S., expensive technology, the rising cost of prescription drugs.

At the same time, the hospital does have discretion over some major cost decisions — such as spending on major facilities or expansions, or equipment to add more options for treatment.

Already the community has some input through publicly elected representatives who serve on the hospital board. But a broader effort to get citizens' input into major health care spending decisions, through public hearings and other means, could guide OMHS toward priorities the community supports — and away from costly choices which don't have community buy-in. These kinds of formal hearing processes are already in use by government agencies when major decisions are at hand. And while the hospital is not now a government agency, it essentially belongs to the public, which pays taxes to support it through the government's Medicare and Medicaid programs.

The hospital could seek more public input before major spending occurs (facilities, equipment).



Look at reforms for the malpractice insurance industry, not malpractice court awards.

Many doctors and hospitals advocate capping the punitive damages that consumers can receive in lawsuits against health care providers as the best way to lower their costs, and the cost of health care, right now.

The problem they cite is the increasing cost, and decreasing availability, of malpractice insurance coverage for some health care providers. The issue is getting lots of national attention, and the U.S. House of Representatives has already passed a bill to cap punitive court awards; it awaits action in the Senate.

However consumer groups such as Public Citizen argue that rising malpractice premiums are a result of the insurance companies' business cycle, not damage awards to people hurt by negligent medical care. As for reducing overall health care costs, a report by the Congressional Budget Office, cited by USA Today, found that caps on punitive damages "would translate into very small savings — .4 percent — on overall insurance health premiums for the general public. That's not much, given that consumer health insurance premiums are rising by about 15 percent a year."

A report for the Kentucky General Assembly came up with similar findings. Staff for the Legislative Research Commission found that limits on jury awards do not reduce medical malpractice premiums and that premiums

We all could work to reduce the cost of medical malpractice insurance.

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generally are not lower in states that cap noneconomic damages.

That doesn't mean that malpractice rates aren't causing a problem for doctors, including those in Kentucky, which has been designated one of 18 crisis states by the American Medical Association. Not only are doctors reportedly leaving their practices earlier than they'd planned because of difficulty getting insurance, but they're also harder to recruit to the state.

Yet there are alternatives to capping consumer damages, including greater oversight of malpractice insurers and efforts to reduce medical mistakes. The Kentucky Department of Insurance, for instance, has proposed three reforms:

- a mandatory screening panel to determine if an alleged injury resulted from negligence before a lawsuit is filed;
- limits on fees that plaintiffs' attorneys may receive in a lawsuit against a health care provider;
- continuing education efforts to help doctors and hospitals reduce incidents of malpractice and malpractice claims.

How much are medical malpractice premiums?

According to *USA Today*:

- On average, doctors spend less on malpractice insurance, about 3.2 percent of their revenue, than on rent.
- Large jury awards play a limited role in rising malpractice premiums. The primary reason settlement payouts are up is because of increases in economic damages, which would not be capped in medical malpractice reform proposals.
- Malpractice insurance companies are boosting rates partly to make up for price wars in the 1990s.

We all could push for equitable Medicare and Medicaid reimbursements, including the same reimbursements as university hospitals receive for absorbing charity care.

3. Push for equitable Medicare and Medicaid reimbursements.

OMHS, physicians, and patients should not be penalized because a university does not serve Owensboro-Daviess County. Local providers should receive the same reimbursements for care as any other institution or provider group, particularly since they absorb the cost of uninsured, Medicaid, and charity care for our region. Local, state, and federal elected officials should push for funding formula changes to eliminate disparities.

4. Move toward market reform.

Changing the dynamics of the market for state employee health insurance could make a difference — although it's not clear how much.

Becoming one of the state's carriers of health insurance for employees

"assists carriers in entering the market" in general, said CHA's Birdwhistell, whose company has been trying to break into the large group market in Daviess County. "If you have the state employee group, that's a critical mass to assist you in creating networks" of providers, he said.

Thus more state carriers in Daviess County could lead to more carriers in general - although not necessarily lower premiums.

State Rep. Brian Crall of Owensboro is the author of a new Kentucky law that is designed to encourage more insurance companies to bid for the state employee contract in Daviess and other counties. His hope is that more competition will keep premiums from rising so fast.

Under existing law, insurance companies may bid for any county in the state, but their plans must be the same price everywhere.

Thus some companies don't bid in counties where medical costs are high. That's because their premiums and profit margins are kept low to compete with other insurers in lower-cost parts of the state, such as Central Kentucky.

The new "regional rating" law would allow companies to set different prices for the state's eight different regions. An insurer would offer all counties in a region the same price, but prices could differ from region to region.

The up side is that more carriers might bid in regions such as Daviess County's. The down side is all of them might set high premiums.

Even Crall doesn't believe this will lower premiums in Daviess and other counties. And he acknowledges that premiums could go up at first. His hope is that over time, competition in the area will at least stabilize premiums or keep them from rising so fast.

On the other hand, it may be that regional rating won't be an issue at all — while Crall's law requires the state to seek bids under a regional rating scenario, the state isn't bound to accept them if the bids are higher than the other scenarios the state seeks bids on. Those will include the existing approach in which carriers must charge the same rates statewide and a "fully insured" approach in which one carrier serves the entire state.

Personnel Secretary Palmore, a Daviess County native, believes the best way for the state to offer fair coverage throughout Kentucky while maintaining financial stability may be to become "fully insured" by one carrier, thus consolidating its risk.

But that option, she said, is like everything else connected to the state employee health insurance contract: Endlessly complicated. Choosing just one insurance company for the state contract could cause smaller insurance companies that depend on state employee business to have financial problems — and Kentucky already has too few health insurance companies.

"It's like pushing in a balloon," she said. "You're pushing in on one side, and it's pushing out on the other."

The community could:
- *Reduce barriers to competition*
- *Expand consumer-driven health plans*
- *Examine plans for basic health insurance coverage for all*

Some economists support consumer-driven health care plans, although they are not yet proven or popular.

Employers are now beginning to experiment with defined contribution health insurance plans which give employees more power to decide what kind of insurance and medical care they want.

The idea is for an employer to give employees a certain amount of money to spend on health care rather than spending the money on the employee's behalf; insurance companies would then allow consumers to customize plans that fit their needs. Once the initial money was spent, employees would pay health expenses out of pocket up to a predetermined limit, when a more traditional policy would take effect.

Economists who favor such plans say they could revolutionize the nation's health system by forcing health providers to focus on quality, convenience and information for consumers. Arguably that would make it easier for consumers to get the lower-cost preventive care they need — care which would also eventually lower overall health care costs. And providers would be motivated to improve quality and keep costs low to attract consumers' business.

Such plans have not yet caught on widely and do not have enough of a track record to claim cost savings, higher quality health care or consumer satisfaction.

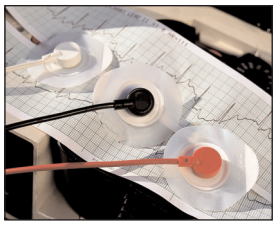
Some market changes controversial

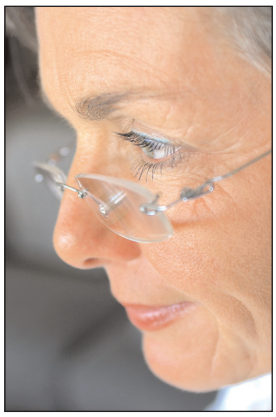
- **Employers across the nation are beginning to turn to lower-cost basic benefit plans for employees in low-wage or part-time jobs.** Critics say this could lead to a tiered system of health care that treats low-income workers differently.
- **Pointing out that small businesses and their employees are hit harder by rising premiums, some health insurance experts advocate changing federal law to encourage the expansion of "Association Health Plans," or AHPs.** These are health plans offered through large groups or associations which represent small business owners across the country. One barrier to such plans is that insurance coverage mandates vary from state to state. Advocates say more AHPs could be encouraged if the government would exempt them from some state regulations, including mandated benefits.

  On the other hand, 36 state attorney generals have weighed in against legislation that would authorize such plans, arguing they would hurt consumers by leading to inadequate health plans, according to the Kaiser Family Foundation.
- **The California Public Employees' Retirement System, which according to the Kaiser Family Foundation is the country's second-largest health care insurance purchaser, is considering entering into longer-term contracts with insurers to try to lock in premiums,** as well as to allow insurers to adopt regional pricing of health care coverage.

Public doesn't trust insurance industry, supports more regulation
Recently the Harris Interactive Survey looked at whether the public considers certain players in the health care industry trustworthy, and whether the industry should be regulated more by government, according to the Kaiser Family Foundation. Here are the results:

Industry	Percentage of people who trust the industry	Percentage believing the industry needs more regulation
Health insurance	7	59
Managed care	4	60
Drug manufacturers	13	57
Hospitals	34	35





Universal or near-universal health care coverage would address the problem of the uninsured.

Discussion still continues — at the federal level and in at least one state — of how to contain health care costs and premiums through more government intervention.

The chairman and CEO of Blue Shield of California, for instance, has proposed a statewide universal health coverage plan to provide basic benefits to every California resident. Both public and private insurers would participate, and costs would be borne by the state, businesses and individuals (most businesses would be required to provide coverage, and individuals without coverage would be required to buy it, with subsidies for those who can't afford it). While the idea has been received positively by the medical community, employers are less enthusiastic.

In addition, many of the Democratic candidates for president are debating whether the federal government should mandate universal health care coverage. Proposals range from "near-universal" plans to a single-payer system operated by the federal government, eliminating the role of private insurers.

While universal health care is not a popular issue with the Republicans who now dominate the decision-making in the House, Senate and White House, the general idea is being discussed more seriously than it has in the years since the Clinton health plan fell apart in the early 1990s.

Monthly employee contribution to preferred provider insurance plan (PPO) for one parent plus dependents (Option A)	$199 (Daviess, Henderson, Union, McLean, Hancock, Trigg, Greenup, Boyd, Carter, Elliott, Lawrence)
Next highest premiums for employees in other counties	$146, $139, $135
Difference between employee costs in Owensboro and elsewhere for one parent plus dependents PPO	**$53 to $64 per month, or $636 to $768 per year**
Monthly employee contribution to PPO plan for both parents plus dependents (A)	$596 (Daviess, etc.)
Next highest premiums for employees in other counties	$438, $418, $404
Difference between employee costs in Owensboro and elsewhere for two parents plus dependents PPO	**$158 to $192 per month, or $1,896 to $2,304 per year**
State contribution for single coverage	$397 (Daviess and 14 other counties)
Next highest premium for single coverage	$292, $279, $269
Difference between state costs in Owensboro and elsewhere	**$105 to $172 per month, or $1,260 to $2,064 per year**

Chart 1. Source: Kentucky Personnel Cabinet

Region (Owensboro's region includes 11 other counties including Henderson, Madisonville and Hopkinsville)	**2001 average monthly claim paid by insurance company per member** (employees, retirees, dependents)	**Expected relation to state employee group after age and gender taken into account**	**Actual relation of average monthly claim per member to state employee group overall**
Region 1 (Paducah)	$238	103%	104%
Region 2 (Owensboro)	$244	102%	107%
Region 3 (Louisville)	$230	102%	101%
Region 4 (Bowling Green)	$211	100%	92%
Region 5 (Lexington)	$219	98%	96%
Region 6 (Covington)	$210	101%	92%
Region 7 (Ashland)	$232	99%	102%
Region 8 (Hazard)	$217	96%	95%

Chart 2. Source: The Kentucky Group Health Insurance Board.

2001 Hospital Utilization and Services Report	Inpatient occupancy	Inpatient Days Private Pay	Inpatient Days Medicare	Inpatient Days Medicaid	Outpatient Visits	ER Outpatient visits	Surgeries	CT scans
OMHS	49.7%	36.1%	50.4%	13.5%				
Ranking compared to other Kentucky hospitals	36th of 105 (top third)	22nd of 109 (top fifth)	7th of 109 (top tenth)	56th of 109 (bottom half)	3rd of 105 (top three)	2nd *	11th of 99	11th of 101
Actual numbers	71,139 inpatient days	25,686	35,848	9,605	217,981	78,031	13,088	21,266

** Chart 3. Source: 2001 Kentucky Annual Hospital Utilization and Services Report. The chart shows that OMHS was in the top third of Kentucky hospitals for inpatient occupancy and reported the third most outpatient visits in the state. It had the second most emergency room visits — by a wide margin. Only a few hospitals in the state had even half as many ER visits as OMHS did (Kosair Children's Hospital in Louisville, which had its own ER outpatient clinic in 2001, ranked first in the state in ER visits).*

Most relevant for purposes of health insurance premiums is that OMHS was in the top fifth of hospitals for the percentage of private-pay insured inpatients they treat (this includes commercial patients and also self-paying patients, a very small percentage). And the Green River Area Development District, which includes Owensboro, had the highest percentage of private-pay inpatient days of any ADD except those in the urban centers of Lexington, Louisville and Northern Kentucky, where there is more competition among insurance companies.

	Daviess	McCracken	Hopkins	Warren	Christian	Pulaski	Perry	Jefferson	Fayette	Boyd
Number of primary care doctors *	65	71	60	92	55	57	47	902	459	81
Number per 1,000 population	.7	1	1.3	1	.8	1	1.6	1.3	1.8	1.6
Number of specialists	130	170	64	174	58	68	43	1,697	1031	157
Ratio per 1,000 population	1.4	2.6	1.4	1.9	.8	1.2	1.5	1.9	3.9	3.1
Population	91,793	64,790	46,327	93,232	71,649	56,774	29,279	692,910	260,414	49,727

*Chart 4. *Primary care doctors include family practitioners, general practitioners, internists, pediatricians and obstetricians/gynecologists.*
Source: Kentucky Licensed Physicians by Specialty, September 2002, published by Cabinet for Health Services; population figures from U.S. Census Bureau State and County Quick Facts.

	Knee joint replacement	Surgery for back pain	Endarter-ectomy for carotid artery disease	Lower extremity bypass surgery	Radical Prostatectomy for prostate cancer	Coronary artery bypass grafting surgery	Mastectomy for breast cancer	Surgery for benign prostatic hyperplasia
Owensboro	5.1 (3rd)	5.3 (1st)	5.3 (1st)	1.3 (10th)	2.4 (1st)	7.6 (9th)	1.4 (10th)	6.8 (8th)
Paducah	5.7	4.5	5.3	2.6	1.4	8.4	2.1	7.3
Louisville	5.1	3.5	3.8	1.8	1.3	8.3	2.1	7
Lexington	3.2	2.6	2.5	1.5	.9	9	1.5	6.9
Covington	4.2	3.2	3.5	1.4	1	9.3	1.6	6.5
Knoxville	4.4	2.5	4	1.8	1.9	7	1.9	7
Johnson City	3.6	2.4	3.7	1.3	1	8.4	.9	3.6
Kingsport	2.9	2.5	3	1.6	.9	5.6	1.3	5.4
Nashville	4.5	4.7	3.6	2.3	2	7.6	1.7	6.1
Jackson	3.5	3.2	2.9	1.1	NA	8.4	2.1	7.7
Memphis	3.6	3.3	4	1.6	1.3	8.6	1.9	8.2
Chattanooga	5.6	4.1	3.7	1.6	1.1	8.9	2	6.9

Chart 5. Source: Dartmouth Atlas of Health Care, 1999 numbers.

Hospitals (Medicare info)	Cases	Avg Length of Stay	Avg Official Charge	Avg Reimburse-ment	Avg Estimated Cost	Profit	Case Mix Index
OMHS	8,634	5.2	11,994	5,984 (50 percent)	6,242 (52 percent)	-258	1.4088
St. Joseph, Lexington	9,427	5.9	19,703	8,899 (45 percent)	7,677 (39 percent)	1,222	1.9655
Baptist East, Louisville	10,362	5.9	12,294	6,826 (56 percent)	6,257 (51 percent)	569	1.5699
Kings Daughters, Ashland	8,287	5.2	12,917	7,666 (59 percent)	7,423 (57 percent)	243	1.5036
Jewish, Louisville	10,429	6.6	27,060	11,305 (42 percent)	10,914 (40 percent)	391	2.0965
St. Elizabeth, Covington	8,491	5.1	15,819	7,694 (48 percent)	7,797 (49 percent)	-103	1.5320

Chart 6. This data is from Data Advantage, a company which OMHS pays to analyze financial trends. Data Advantage compared OMHS' experience with Medicare patients to 41 other Kentucky hospitals; OMHS had more Medicare patients than all but three of them, all in urban areas.

In the table, OMHS is compared to those three hospitals plus two others with close to the same number of Medicare patients. OMHS had the worst financial experience of the six (only two, including OMHS, lost money, and OMHS lost the most). Of the 42 hospitals, 30 had higher profits (or smaller losses) than OMHS.

Hospitals	American Hospital Directory (net income percentage estimates for 2001)
OMHS	6.59
Regional Medical, Madisonville	9.8
Methodist, Henderson	1.9
Lake Cumberland Regional Hospital, Somerset	24.07
Jennie Stuart Medical Center, Hopkinsville	4.56
The Medical Center, Bowling Green	1.33
Western Baptist, Paducah	3.87
Baptist East, Louisville	4.16
Central Baptist, Lexington	1.18
Samaritan, Lexington	-12.49
ARH, Hazard	.91
Deaconess, Evansville	6.67
St. Mary's, Evansville	6.56
Lourdes, Paducah	1.47

Chart 7. Source: American Hospital Directory (online).

OMHS	2002	2001	2000
Investment and other non-operating income	$503,000	$10,872,000	$4,860,000
Total net income	$10,311,000	$17,192,000	$15,592,000

Chart 8. Source: OMHS. This shows that the hospital in the past has had significant income from its investments, and that that income contributed to the hospital's bottom line. According to Bill Price, senior vice president finance, the drop between 2001 and 2001 is a result of the stock market downturn. The hospital has more recently issued $201 million in bonds in order to invest much of the money.

2001 Major heart procedures	Cases	Avg Length of Stay (Days)	Charge	Reimbursement	Estimated Cost	Profit
OMHS	63	8.3	38,785	17,726	19,058	-1,332
Kings Daughters, Ashland	51	9.3	42,618	22,085	23,320	-1,235
St. Elizabeth, Covington	49	7.6	39,217	21,795	18,184	3,611
Medical Center, Bowling Green	41	8.9	41,826	19,797	16,256	3,541
Baptist East, Louisville	97	7	34,8116	18,529	15,657	2,872
Western Baptist, Paducah	57	6.5	33,131	18,065	16,798	1,287
Jewish Hospital, Louisville	86	11.3	60,389	23,695	24,684	-989
St. Joseph, Lexington	106	8.8	36,361	18,427	14,361	4,066

Chart 9. Source: Data Advantage. This compares OMHS to other hospitals with similar numbers of patients in regard to their Medicare profits or losses on major cardiac procedures. Overall, 14 of 22 hospitals compared by Data Advantage had lower costs. 18 of 22 had higher profits (or fewer losses). 18 of 22 also had higher reimbursements.

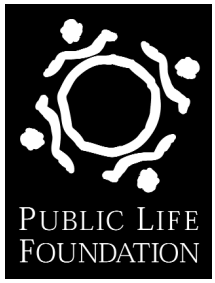
2001 Pacemaker/ other	Cases	Avg Length of Stay (Days)	Charge	Reimbursement	Estimated Cost	Profit
OMHS	322	3.2	20,995	10,175	10,646	-471
Kings Daughters, Ashland	460	2.9	16,289	12,062	9,649	2,413
St. Elizabeth, Covington	388	3.1	22,362	11,556	9,458	2,098
Lourdes	303	3.4	27,349	9,926	13,709	-3,283
Medical Center, Bowling Green	149	4.5	24,076	10,498	9,087	1,411
Medical Center, Madisonville	153	3.6	22,213	11,018	9,398	1,840
Marymount	147	3.4	24,834	10,128	10,500	-471
Baptist East, Louisville	239	3.7	24,443	10,541	10,133	408
St. Joseph, Lexington	739	2.6	24,138	10,613	8,914	1,699
Jewish Hospital, Louisville	981	3.1	29,426	12,079	11,520	559

Chart 10. Source: Data Advantage.

The **PEOPLE'S**
Health Project

NOTES:

public concerns → citizen action



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