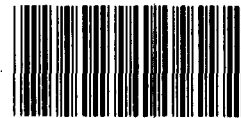


January 1993

HEALTH CARE

Rochester's Community Approach Yields Better Access, Lower Costs



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Human Resources Division

B-251507

January 29, 1993

The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

The Honorable William F. Clinger, Jr.
Ranking Minority Member
Committee on Government Operations
House of Representatives

Increasing health care costs and restricted access to health care services in the United States continue to concern the Congress and the nation. In search of solutions to these problems, the Congress has asked GAO to study health care systems in other nations, as well as initiatives in the states. For example, we recently found that Hawaii has expanded insurance coverage to a greater proportion of its residents than any other state while keeping its health care costs close to the national average.¹ To supplement these studies, Chairman Conyers and former Ranking Minority Member Frank Horton requested that we review the health care system in Rochester, New York, which has lower health care costs per capita and provides health insurance to a larger proportion of its residents than the nation as a whole.

Results in Brief

Rochester has succeeded in keeping health care costs lower than costs in other communities without sacrificing its residents' access to care. In 1991, health insurance costs per employee in Rochester were 33 percent lower than comparable costs in the nation and 45 percent lower than in New York State. Rochester's hospital costs per capita in 1990 were lower than hospital costs per capita in the nation, New York State, and other cities of similar size in New York.

At the same time, Rochester residents are more likely to have health insurance coverage than are the populations of other New York cities, New York State, and the nation. Between 1989 and 1991, the uninsured accounted for an average of 7.1 percent of the population in Rochester, compared to 13.7 percent in the nation, 11.4 percent in New York State, and about 8 percent in comparable cities.

People in Rochester express greater satisfaction with their health care system than does the general U.S. population and indicate that they have less difficulty in obtaining care than residents of other areas. Recently,

¹Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

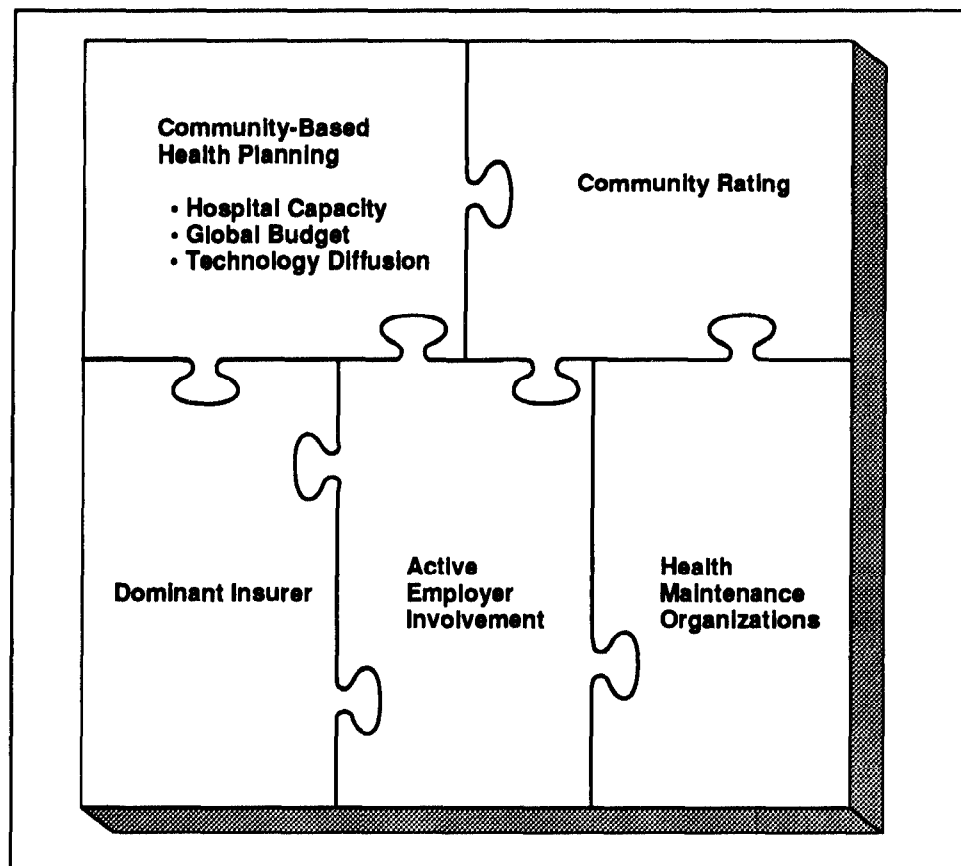
5 percent of Rochester's residents, compared with 13 percent nationally, reported they had gone without needed care in the previous year.

No single feature of Rochester's health care system is responsible for the community's performance. Rather, Rochester's system is distinguished by the interaction of several factors, beginning with a long history of community-based health planning. Rochester's planning initiatives have included limiting the expansion of hospital capacity, implementing an experiment of global budgeting that capped total hospital revenues for several years, and controlling the diffusion of medical technology. Rochester has largely maintained the practice of community rating of health insurance, in which premiums are based on the experience of the entire community rather than the demographic characteristics or health status of smaller groups of enrollees, resulting in increased health insurance coverage.

All of these initiatives have benefited from the active support of Rochester's employers, who have worked with insurers, providers, and government representatives to try to control health care costs and improve access to care. Rochester's dominant insurer, Blue Cross/Blue Shield, also has facilitated and supplemented the cost containment efforts of the business community. Health maintenance organizations, which cover the majority of Rochester's residents, are credited with reducing costs by decreasing the time residents spend in the hospital. (See fig. 1.)

Rochester's experience provides important insights for other communities trying to gain control over rising health care costs and diminished access. It is important to note, however, that Rochester's successes result from a series of actions taken over several decades. While other cities might profit from emulating Rochester's use of community-based planning and community rating for health insurance, it is unclear whether they would match Rochester's record. Many of the problems Rochester has avoided, such as the excessive growth of hospital capacity and the erosion of coverage that current insurance practices generally produce, are entrenched in other communities. It may be more difficult to change practices that people are accustomed to than it was to prevent them from taking hold. A more detailed discussion of our findings is in appendix I.

Figure 1: Interlocking Elements of Rochester's Health Care System



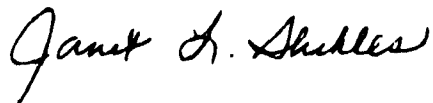
Scope and Methodology

To measure the performance of Rochester's health care system, we compared data on health care costs and insurance coverage for Rochester, other cities in New York State,² the state as a whole, and the nation. We used information from Blue Cross/Blue Shield of Rochester, the Eastman Kodak Company, the American Hospital Association, and the New York State Department of Health.

To describe Rochester's health care system and identify the features linked with its performance, we interviewed business representatives, insurers, providers, government officials, and consumer advocates inside and outside of Rochester. Our work was conducted between July and October 1992 in accordance with generally accepted government auditing standards.

²We chose cities in the state for comparison because they, like Rochester, are subject to New York health planning regulations. We chose Albany, Syracuse, and Buffalo as comparison cities because they are similar in size to Rochester.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to interested congressional committees and make copies available to others on request. If you or your staffs have any questions about this report, please call me on (202) 512-7119. Other major contributors are listed in appendix II.



Janet L. Shikles
Director, Health Financing
and Policy Issues

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Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEP	Hospital Experimental Payments Program
HMO	health maintenance organization
PPS	Prospective Payment System
RAHC	Rochester Area Hospitals Corporation

Rochester's Community Approach Yields Better Access, Lower Costs

Rochester, New York, has a long history of community-based health care planning and cooperation. Throughout this century, business leaders, health care providers, insurers, and government officials have worked together to create and maintain a regional health care system. In the 1930s, Rochester area hospital representatives began meeting formally to discuss administrative problems. Since 1961, a series of community organizations (including consumer, provider, government, and industry representatives) has assessed community health needs and sought to match health care resource investments with those needs. Between 1980 and 1987, government representatives, insurers, and providers worked together to manage community-wide hospital revenues and improve the solvency of area hospitals through the Hospital Experimental Payments Program (HEP). HEP established a global community-wide revenue cap for inpatient and outpatient care based in hospitals.

All hospitals in New York State operate within a highly regulated environment. New York has continued to require hospitals to obtain approval for many capital investments through a certificate-of-need process, even after many states repealed their certificate-of-need laws or made them less stringent.

Blue Cross/Blue Shield dominates the health insurance market in Rochester, providing more than 70 percent of the area's residents with health insurance, through both fee-for-service and health maintenance organization (HMO)¹ arrangements. Preferred Care, a local HMO, competes with Blue Cross/Blue Shield, providing health insurance to about 15 percent of Rochester's population. HMOs provide health insurance and health care to more than half of Rochester's residents.²

In contrast to insurers in many other parts of the nation, those in Rochester have continued to establish most insurance premiums based on a practice called community rating. Using this method, insurers charge all groups the same amount for the same coverage, without regard to the demographic characteristics or the history of medical service use—and consequent costs—of a particular group. In most other communities, insurers use demographic factors associated with health care costs (such as age and sex) or group-specific health experience to establish premiums.

¹HMOs are organizations that, unlike traditional health insurers, integrate the financing and delivery of health services by offering comprehensive care from an established panel of providers to an enrolled population on a prepaid capitated basis.

²Three HMOs exist in Rochester. Besides Preferred Care, two HMOs—Blue Choice and the Genesee Valley Group Health Association—are subsidiaries of Blue Cross/Blue Shield of the Rochester area.

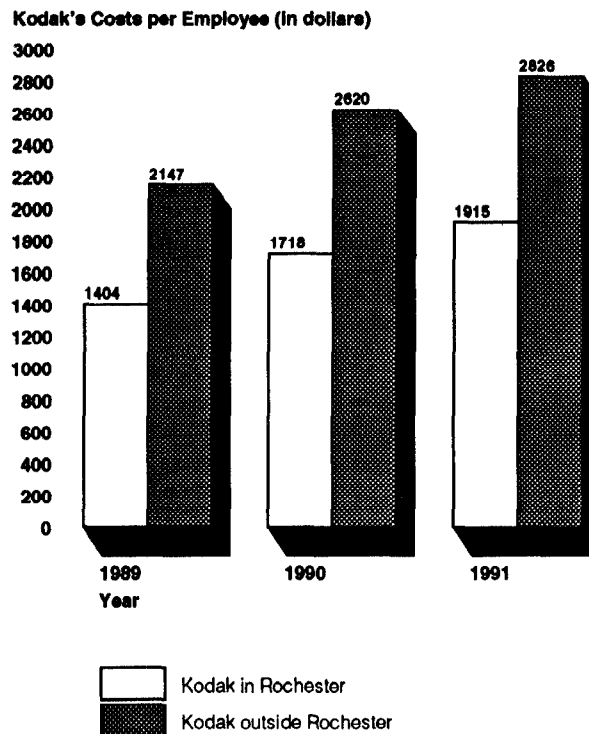
About half of the population within the city of Rochester receives primary care from a network of hospital-sponsored primary care practices, which charge fees on a sliding scale, and federally funded community health centers. Almost 30 percent of city residents obtain primary care services at the community health centers, an unusually large proportion for an urban area. These centers receive federal Migrant and Community Health Center Grants, but most of their funds come from other sources, including the Medicaid and Medicare programs, HMOS, and other third-party payers. Rochester does not have a public acute care hospital serving primarily indigent patients. Instead, indigent patients receive care at all area hospitals.

Health Care Costs Are Lower in Rochester

Health care costs are lower in Rochester than in other areas. Blue Cross/Blue Shield of Rochester reports that in 1991 the average health insurance cost per employee in Rochester was \$2,378,³ 33 percent less than the average cost in the nation (\$3,573) and 45 percent less than in New York State (\$4,361). For example, the Eastman Kodak Company, Rochester's largest employer, has lower health care costs per capita for its Rochester employees than for its employees outside of Rochester. In 1991, Eastman Kodak paid average annual health care costs of \$1,915 for its Rochester employees, significantly less than the average cost of \$2,826 it paid for its non-Rochester employees (see fig. I.1).

³This figure is for people insured by Blue Cross/Blue Shield. Because Blue Cross/Blue Shield insures over 70 percent of the Rochester population, however, this figure is representative of costs in the community as a whole.

Figure I.I: Lower Health Insurance
Costs for Kodak's Rochester
Employees



Note: Excludes employee share of insurance premium.

Source: Eastman Kodak.

The health insurance cost advantages in Rochester are even greater for small employers. In most other American communities, firms with fewer than 25 workers pay 10 to 40 percent more than large firms for health insurance premiums.⁴ Because of the preservation of community-rated insurance in Rochester, small firms there can purchase comparable coverage at the same price that larger firms like Eastman Kodak pay.

Lower hospital costs are a major contributor to Rochester's success in containing health costs. In 1990, total hospital costs per capita in the Rochester metropolitan statistical area were \$778, 5.0 percent less than the national average and 27.8 percent less than the average in New York State

⁴See *Employer-Based Health Insurance: High Costs, Wide Variation Threaten System* (GAO/HRD-92-125, Sept. 22, 1992).

(\$819 and \$1,077, respectively). Rochester's hospital costs per capita are also lower than costs in other metropolitan areas in New York State. In 1990, Rochester's costs, adjusted for standard of living,⁵ were about 12 percent lower than comparable costs in Albany and 22 percent lower than in Buffalo. The adjusted costs were 4 percent lower than in Syracuse, which like Rochester, has controlled hospital costs by limiting bed capacity and admissions.⁶

Residents of Rochester Have Better Access to Health Care

Rochester residents fare better than the nation as a whole on two measures of access to health care. They are more likely to have health insurance coverage and have less difficulty obtaining health care services.

Although Rochester falls short of universal insurance coverage, area residents are more likely to have health insurance than their counterparts in other locations. A 1992 survey of 1,000 adult residents and 300 employers in the Rochester area, conducted for Blue Cross/Blue Shield by Louis Harris and Associates,⁷ found that only 6 percent of Rochester's adults do not have health insurance. A comparable Louis Harris survey found that 14 percent of adults in the United States as a whole were uninsured. Similarly, U.S. Census information shows that between 1989 and 1991, the average rate of uninsured in Rochester was 7.1 percent, compared to a national average rate of 13.7 percent.

Rochester also has a smaller proportion of uninsured residents than do cities of comparable size in New York State. Between 1989 and 1991, an average of 7.1 percent of Rochester's population was uninsured, a rate lower than the statewide rate of 11.5 percent, and also lower than the rates in Albany, Buffalo, and Syracuse.⁸ (See fig. I.2.)

⁵The adjuster used was the Wage Index for Urban Areas, which the Health Care Financing Administration uses to adjust the labor portion of Medicare's base payment to hospitals.

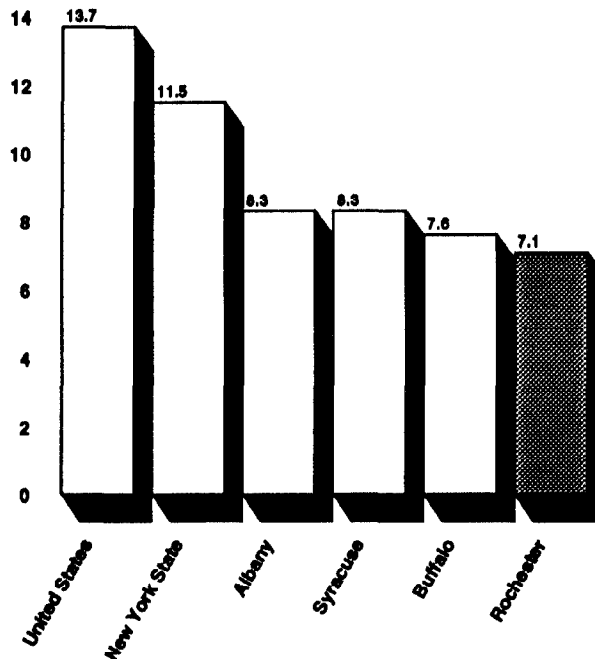
⁶These comparisons with other cities in New York are based on metropolitan statistical areas. For Buffalo, the consolidated metropolitan statistical area (which includes Buffalo and Niagara Falls) is used.

⁷Louis Harris and Associates, Rochester Health Care Experiences, Study No. 922018, Apr. 1992.

⁸Buffalo, like Rochester, has maintained community rating.

Figure I.2: Rochester Has a Smaller Proportion of Uninsured Residents Than Other Areas

Percent of Residents Without Health Insurance (average 1989-91)



Source: State of New York Department of Health (from Current Population Survey data).

In addition to being more widely insured, Rochester residents report having less difficulty obtaining health care than do people in other areas. According to the Louis Harris survey, 5 percent of Rochester area residents, compared with 13 percent nationally, reported they had gone without needed health care in the previous 12 months. In addition, 18 percent of Rochester area residents, compared with 30 percent nationally, reported having put off or postponed seeking care in the past year because they could not pay. A 1986 study found that, in Rochester, race and poverty status were not predictors of disabled students' access to health care, while they were predictors in other cities.⁹

⁹See Singer and others, "Health Care Access and Use Among Handicapped Students in Five Public School Systems," *Medical Care*, Vol. 24, pp. 1-13 (1986).

Better Access and Lower Costs Contribute to Greater Consumer Satisfaction

In Rochester's environment of better access and lower costs, it is not surprising that the community's health care consumers express greater satisfaction with their health care system than does the general U.S. population. Louis Harris and Associates reports that 84 percent of Rochester residents are at least somewhat satisfied with the health care services they receive, compared to 71 percent of those surveyed across the nation. Within those groups, 42 percent of Rochester residents were very satisfied, compared to 30 percent nationally.

The relatively high level of satisfaction expressed by Rochester residents mirrors results of a similar survey conducted in Hawaii.¹⁰ (See table I.1.) Like Rochester, Hawaii has a smaller uninsured population and a better record of cost containment than other areas. Hawaii also shares some of the features integral to the Rochester system: it has two dominant insurers, and they use an adjusted community-rating system in setting insurance premiums.¹¹

Table I.1: Similarities Between Rochester and Hawaii

Numbers in percents			
	Rochester	Hawaii	U.S.
Residents very satisfied with health care services	42	40	30
Residents somewhat satisfied or very satisfied with health care services	84	82	71
Residents reporting no health insurance	6	7	14
Residents reporting they did not get needed health care in past year	5	7	13
Residents reporting postponing needed care in past year because could not afford it	18	17	30

Source: Louis Harris and Associates, Inc., for Blue Cross/Blue Shield of the Rochester area and The Henry J. Kaiser Family Foundation/The Queen Emma Foundation. National survey sponsored by the Kaiser Family Foundation and The Commonwealth Fund. All surveys were conducted in 1992.

¹⁰Louis Harris and Associates, for the Henry J. Kaiser Family Foundation and The Queen Emma Foundation, June 1992.

¹¹Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992). The fact that two insurers dominate the market in Hawaii strengthens their ability to negotiate favorable reimbursement rates. The role of a single dominant insurer in Rochester is discussed in the following section of this report.

Several Factors Linked to Rochester's Lower Health Costs and Increased Access to Care

Given Rochester's lower health costs, better access to health insurance, and greater consumer satisfaction, we tried to identify the characteristics of the community's health care system that contribute to these results. Key participants in Rochester's health care system emphasize that no single factor is responsible for the community's performance. Rather, it is the interaction of several features that distinguishes Rochester's system. These include health planning efforts, the practice of community rating of insurance, the involvement of employers, the presence of a dominant insurer, and the penetration of HMOs into the insurance market.

Extensive Health Planning Central to Rochester's Health Care System

Extensive community-wide health planning is a major component of the health care system in Rochester. This planning has not been centrally directed by government; rather, business leaders, local government officials, health providers, health insurers, and health planners have worked cooperatively to develop and maintain a regional system to meet the health care needs of Rochester's residents. As early as the 1920s, Rochester's Community Chest Plan began to review requests for capital-fund drives. Since that time, community health planning in Rochester has enjoyed sustained attention. Table I.2 outlines health planning activities in Rochester over the past seven decades.¹²

¹²For a detailed discussion of the history of health care in Rochester, see Patricia Taylor's *The Health Care System of Rochester, New York: Its History and Achievements* (Finger Lakes Health Systems Agency, Oct. 1987).

Appendix I
Rochester's Community Approach Yields
Better Access, Lower Costs

Table I.2: Health Planning Activities in Rochester

Year	Activity
1918	The Community Chest Plan is formed. By the 1920s, its executive committee reviews requests for hospital capital fund drives.
1930s	Administrators of six local hospitals begin to meet formally to discuss problems.
1936	The Community Chest commissions a series of studies of health care in Rochester.
1939	The Rochester Hospital Council is incorporated by six local hospitals.
1946	The Council of Rochester Regional Hospitals is formed to upgrade health care in rural hospitals.
1960-61	Marion Folsom of Kodak creates the Patient Care Planning Council to plan for Rochester's health care needs. It commissions a study of hospital utilization and restricts hospital expansion. It is followed by other planning organizations, including Finger Lakes Health Systems Agency.
1962	The public hospital, Rochester Municipal Hospital, is merged into the university medical center, Strong Memorial Hospital. Home care benefit is added to local insurance coverage, easing pressure on hospital beds.
1967	The Wadsworth Committee is formed to study health service needs of the inner city and recommends creating a network of neighborhood health centers.
1973	With the support of business leaders, three HMOs become operational in Rochester.
1978	The Rochester Area Hospitals Corporation (RAHC) is established to promote continued cooperative planning among hospitals.
1980-90	Three phases of the Hospital Experimental Payment (HEP) project are implemented.
1990-present	Hospital administrators and business leaders cooperate to implement Total Quality Management in area hospitals.
1992	Blue Cross/Blue Shield of Rochester proposes to expand health planning process by managing reimbursement of non-institutionally-based capital and high technology, based on determination of community need.

Several efforts exemplify health planning in Rochester, including the limiting of hospital capacity expansion in the 1960s, a global budgeting reimbursement experiment in the 1980s, and current efforts to limit high-technology expenditures outside of the hospital setting.

Limiting Hospital Capacity Expansion in the 1960s

In 1959, Rochester area hospitals initiated a drive to raise more than \$30 million to finance 500 additional hospital beds. Former Secretary of

Health, Education, and Welfare Marion Folsom, then Vice President of Kodak, served as chairman of the drive. He organized a committee of consumers, hospital administrators, physicians, and business and government representatives to assess objectively the capacity needs of Rochester's hospitals. Based partly on the results of a bed utilization study, the committee reduced the hospital drive's objective from \$30 to \$14 million, and reduced the number of additional hospital beds from 500 to 140.¹³

Global Budgeting of Hospital Revenues in the 1980s

In 1980, Rochester hospitals, Blue Cross/Blue Shield of the Rochester area, New York State, and the federal Health Care Financing Administration (HCFA) began a hospital reimbursement experiment called the Hospital Experimental Payments Program.¹⁴ Rochester area hospitals, with the support of the business community, initiated HEP as a means to control the rate of increase in hospital costs while ensuring the financial solvency of participating hospitals. It was administered by the Rochester Area Hospitals Corporation (RAHC), a nonprofit corporation comprising area hospitals and the University of Rochester School of Medicine and Dentistry.

HEP had three phases. During the first two (1980-87), Blue Cross/Blue Shield, New York State, and HCFA provided Rochester hospitals with an annual global budget under which each hospital's revenues were limited to costs in a base year (1978) plus annual inflation adjustments. Hospitals whose costs exceeded their allocated budget lost money, while hospitals that kept costs under their budgets retained the surpluses.

Throughout the HEP experiment, planning decisions for major capital investments were made by the hospitals as a group. RAHC reviewed the operating costs of proposed hospital projects and then submitted projects it approved for consideration under the state's certificate-of-need process. During the second phase of HEP (1985-87), RAHC reviewed both the operating and capital costs of projects.

During this period of global budgeting under HEP, hospital cost inflation in Rochester was constrained. Between 1980 and 1987, real costs per capita

¹³Hospital capacity is, among other health care capacity measures, associated with higher health care costs in *Health Care Spending: Nonpolicy Factors Account for Most State Differences* (GAO/HRD-92-36, Feb. 13, 1992). Rochester has fewer hospital beds per 1,000 residents than Albany, Buffalo, and New York State. Syracuse, which, like Rochester, has a history of health planning that has limited hospital bed capacity and has relatively low hospital costs per capita, has fewer hospital beds per thousand than Rochester.

¹⁴A similar payment experiment, called the Finger Lakes Hospital Experimental Payment Program, was implemented in rural areas around Rochester.

for HEP hospitals grew at an annual rate of 2.1 percent, compared with real annual growth of 4.0 percent in New York State and nationally. Between 1987—when global budgeting under HEP ended—and 1990, Rochester hospitals experienced real annual growth in costs per capita of 7.3 percent, compared with 6.1 percent in New York State and 4.9 percent in the nation. Medicare payments to Rochester hospitals rose at an annual rate of 7 percent during the 8-year demonstration program, compared with national Medicare payment increases of 12.6 percent per year.

HEP's savings to the entire health care system were limited, because HEP applied only to hospital expenditures. It did not address the growing segment of health care costs that are incurred outside of hospitals.

HEP's global budgeting contracts helped to foster the continuation of community-wide planning efforts. Capital investment decisions under HEP were made by hospitals as a group. As a result, hospitals in Rochester avoided duplication of services by developing expertise in specific services. Only two hospitals, for example, perform open-heart surgery. Pediatrics also is concentrated in two hospitals.

These planning efforts do not seem to have limited access to needed care in Rochester. For a brief period during the mid-1980s, there were waiting lists for a few services, particularly heart surgery, due to a shortage of intensive care unit beds. This situation was resolved through the planning process, however, when intensive care beds decertified at one hospital were used to augment capacity at another hospital. Providers and consumers of health care in Rochester told us that there is no problem of queuing for health services now.

The global budgeting experiment provided participating hospitals with predictable incomes. Furthermore, Rochester hospitals had positive operating margins for five of eight HEP years, while hospitals in New York State did so for two of the eight years.

Global budgeting under HEP ended for several reasons. The federal and state governments were moving in a different direction, with HCFA implementing the case-based Prospective Payment System (PPS) and New York also using a case-based system. Although RAHC would not have been able to continue the global budget experiment as a HCFA demonstration project, it could have requested permission to continue the experiment under a HCFA operating waiver. However, Rochester area hospitals, recognizing that they could make more money under the PPS system than

under the HEP global budgeting system, decided to end global budgeting. Some members of the Rochester health care community believe an additional factor contributing to the end of the experiment was the 1987 withdrawal from HEP of one of the participating hospitals.

During the third phase of HEP (1988-90), when hospital reimbursement was based on the case-based PPS, RAHC attempted to adjust reimbursement levels on the basis of clinical outcomes. Despite extensive data collection, however, this system resulted in minimal changes to hospitals' reimbursement.

New Initiative to Limit Reimbursement of High-Technology Services Outside of Hospitals

Blue Cross/Blue Shield of Rochester is planning a new initiative that would limit the proliferation of unproven technologies and extend the community's health planning system to facilities and services not currently subject to the state's certificate-of-need process.¹⁵ By the spring of 1993, Blue Cross/Blue Shield plans to create a community-based technology assessment board that would include business, consumer, provider, and payer representatives. The proposed board would review new—and new uses of existing—technologies, including procedures and drugs, and would assess their cost-effectiveness as well as Rochester's need for them. The insurer proposes to pay only for those technologies that the community technology board judges to be appropriate and necessary.

Community Rating Improves Access to Insurance

Insurers in Rochester, unlike those in other parts of the nation, use a community-rating system to establish premiums for 85 percent of their policyholders.¹⁶ Community rating of health insurance premiums was widespread in the 1940s and 1950s. It began to be replaced with experience rating in the 1960s, as insurers marketed their products to companies looking for lower health insurance costs. Rochester is one of the few areas that has retained community rating.

Using community rating, insurers in Rochester charge the same premium for the same benefit package to all groups, regardless of their occupation,

¹⁵In Rochester, hospital capital expenditure proposals are submitted to the Finger Lakes Health Systems Agency under the New York State certificate-of-need law. Review of certificate-of-need proposals by the Agency and its predecessor organizations has restricted these expenditures since the 1960s.

¹⁶Some policyholders receive experience-rated policies or self-insure. Blue Cross/Blue Shield experience-rates for less than 10 percent of its enrollees. These experience-rated policies include firms that purchase policies for employees outside of Rochester. Bausch and Lomb, which has about half of its 7,500 employees in Rochester, self-insures through a corporate-wide indemnity program.

age and sex composition, or health experience.¹⁷ Rochester's system of insurance rating comes closest to pure community rating. Several states have recently enacted community-rating laws for small groups that generally require insurers to use modified, or adjusted, community rating. This method permits limited variation in insurance rates, which may be based on such factors as age or type of business.¹⁸

Rochester's continued use of pure community rating has resulted in improved access to health insurance. Because the practice of community rating reduces the cost of health insurance for many individual purchasers and small groups, it is easier for them to obtain affordable coverage.¹⁹ A study done by a Rochester-based citizen's group simulated the effect of a shift from community rating to experience rating of health insurance in Rochester.²⁰ The study found that such a shift would cause a transfer of premium expenses from large to small employers, some of whom would drop or defer the purchase of health insurance because of this increase in cost. This would lead to a loss of insurance coverage for some Rochester residents.

Some participants in Rochester's health care system believe that in addition to contributing to increased access, community rating also helps to reduce the cost of health care. For example, community rating encourages Rochester's businesses and insurers to control aggregate health care costs because increases in community-wide costs would be directly reflected in the insurance rates paid by all businesses. Without community rating, businesses might choose to focus cost-control efforts only on their own employees, taking steps to control costs for their employees without regard to—and possibly at the expense of—community-wide health care costs.²¹

¹⁷Blue Cross/Blue Shield applies these community-rating principles to individuals as well as groups.

¹⁸In 1992, New York enacted a law requiring community rating for individual and small group health insurance. The law prohibits rating on the basis of age, sex, health status, or occupation.

¹⁹For a discussion of community rating and small group insurance, see Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

²⁰Health Futures for Rochester, Community Interest/Self Interest: Setting Health Insurance Premiums for the Rochester Region (July 1987).

²¹Employers might, for example, channel patients to ambulatory surgery centers because such centers might perform surgeries at lower costs per procedure than traditional surgery facilities. If such channeling resulted in the expansion of ambulatory health care centers while traditional surgery facilities remained in operation, community-wide health care costs could increase while a specific employer's health care costs decreased.

**Employer Involvement
Fundamental to
Rochester's Approach**

Active employer participation is one of the hallmarks of Rochester's health care system. Leaders from the business community have worked to develop accessible, affordable health care for Rochester's residents and have been active in health planning. For example, they worked with Community Chest directors in the 1930s to study Rochester's health care system and to decide how charitable contributions would be allocated. In the early 1960s, Marion Folsom of Eastman Kodak was instrumental in limiting the expansion of hospital bed capacity. In 1982, the business community supported funding for the Finger Lakes Health Systems Agency to allow it to continue its health planning activities despite reduced federal funding.

The business community created Blue Cross as the primary insurer in Rochester. Unlike Blue Cross plans in other parts of the nation, which were formed by hospitals attempting to ensure payment of hospital bills, Blue Cross in Rochester was established in 1935 by the business community in conjunction with a hospital executive. By 1941, with the support of employers, 44 percent of Rochester's population had health insurance, compared to only 10 percent of workers in the nation.

Rochester's employers have supported the continuation of community rating in Rochester. Despite the potential to reduce health insurance premiums for its employees in the short term, for example, Eastman Kodak has continued to purchase community-rated insurance.

Representatives of Rochester employers are active on the boards of directors of health care institutions, where they have been vocal advocates of a reasonably priced health care system that provides high-quality care. The activities of the business community serve to constrain influences that inflate health care costs elsewhere, such as efforts to expand hospital bed capacity. Cooperative leadership among employer purchasers of health insurance and health care leaders, such as hospital administrators and medical educators, underscores the importance of a total community effort in Rochester.

**Dominant Insurer
Contributes to Rochester's
Efforts to Control Costs,
Increase Access**

Blue Cross/Blue Shield uses its position as dominant health insurer in Rochester to cooperate with community efforts to control health care costs and improve access to health care. It provides health insurance to more than 70 percent of Rochester area residents, and has assumed a large role in Rochester's community-based health care system. Blue Cross/Blue Shield has emphasized controlling costs in the entire Rochester

community rather than focusing only on the costs of its enrollees.²² Blue Cross/Blue Shield serves as a mediator between the business community, which relies on it to control health care costs, and health care providers, which rely on it to pay for health care services.

Providers and business representatives say that Blue Cross/Blue Shield has used its market power to restrict provider reimbursement rates. This control of reimbursement rates has a major effect on health care costs in Rochester because the vast majority of providers accept Blue Cross/Blue Shield rates as payment in full and because other insurers base their reimbursement rates on those achieved by Blue Cross/Blue Shield. The insurer's dominance of the market may also reduce health care administration costs by reducing paperwork for providers.

Blue Cross/Blue Shield is an advocate of community rating and continues to set rates for most of its customers on this basis. This results in lower cost insurance for individuals and small businesses and increased insurance coverage for these groups. Blue Cross/Blue Shield has also helped to expand access by working with physicians and hospitals to offer an affordable health insurance product to people who earn too much to qualify for Medicaid but not enough to afford health insurance on their own. Blue Cross/Blue Shield has an incentive to increase health insurance coverage in Rochester. Because it is the dominant insurer, it bears most of the cost of care for the uninsured that is shifted to other payers.

Health Maintenance Organizations Have Large Presence in Rochester

HMOs, including those that are subsidiaries of Blue Cross/Blue Shield, cover more than half of Rochester's residents. It is difficult to evaluate to what degree HMOs have helped control health care costs or increased access to care in Rochester. For example, before the advent of HMOs, Rochester already had relatively low hospital costs and conservative physician practice patterns, which minimized the savings HMOs could achieve. Employers and other participants in Rochester's health system do not believe area HMOs are responsible for a large amount of savings, because they provide generous benefits packages and engage in limited utilization review.

HMOs are, however, credited with reducing health care costs by decreasing the time Rochester residents spend in the hospital. A Blue Cross/Blue Shield official told us that in addition to reducing hospital stays for their

²²Blue Cross/Blue Shield, by controlling system-wide costs, does not rely as heavily as it otherwise might on patient- and procedure-specific utilization review techniques to control costs.

own patients, HMOs may also have reduced physicians' reliance on hospital stays for non-HMO patients, because Rochester physicians treat both HMO and non-HMO patients and do not differentiate treatment based on insurance source.

Relative Importance of Factors Contributing to Lower Health Care Costs and Increased Access to Health Care

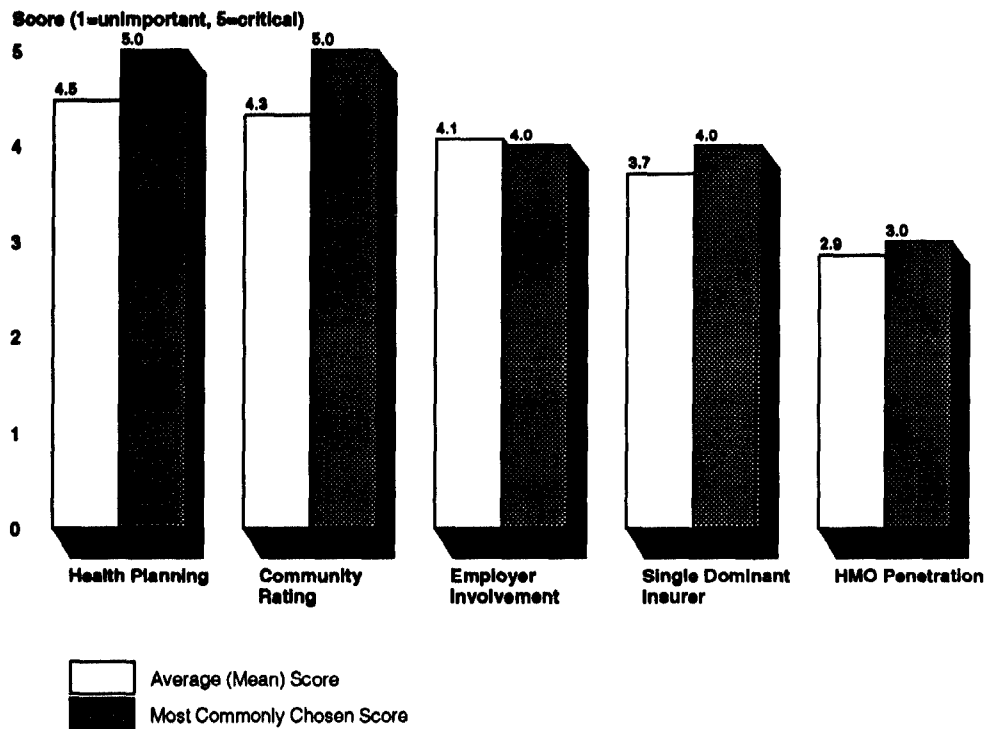
The interaction of the various elements of Rochester's health care system made it impossible to quantify the contribution of individual factors to Rochester's lower costs and wider access. However, we did obtain the views of participants in the system regarding the relative roles of these features. We asked business representatives, insurers, and providers in Rochester to rate the importance of several factors in controlling health care costs and increasing access to health care in Rochester.²³ They identified (1) health planning as the most important factor contributing to cost control and (2) community rating as the most important factor contributing to increased access.

The factors we asked the community leaders to rate were health planning, a single dominant insurer, the penetration of HMOs, community rating, and employer involvement. Each respondent gave each factor a score from 1 (unimportant) to 5 (critical) for both controlling costs and improving access.

After health planning, respondents ranked the factors contributing to cost control in the following decreasing order of importance: community rating, employer involvement, a single dominant insurer, and the penetration of HMOs (see fig. I.3). With the exception of the penetration of HMOs, all factors were considered very important.

²³Twenty-one people rated the importance of these factors to controlling cost or increasing access to health care in Rochester. Those interviewed included four representatives of the business community, four insurance representatives, eight from the provider community, and five others, including area health planners.

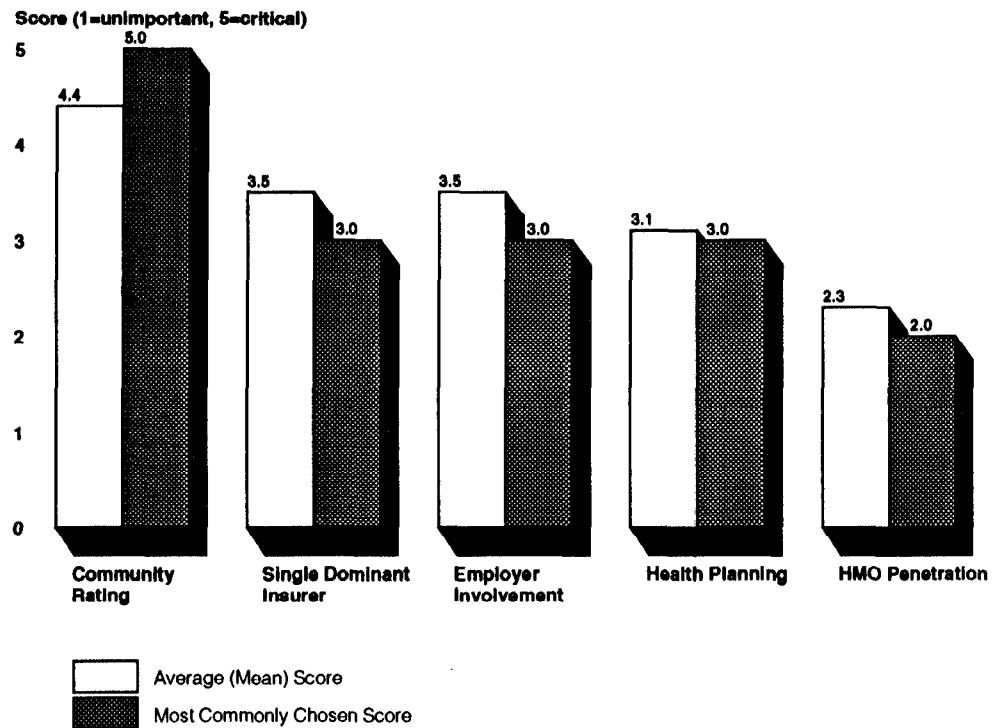
Figure I.3: Factors Identified as Controlling Health Care Costs in Rochester



Note: HMO penetration received scores of 2 and 3 in equal numbers.

After community rating, respondents identified the dominance of a single insurer and employer involvement as equally important factors contributing to increased access, followed by health planning and the penetration of HMOs (see fig. I.4). They distinguished community rating as much more important than the other factors in improving access to health care.

Figure I.4: Factors Identified as Increasing Access to Health Care in Rochester



Health Care Achievements in Rochester May Be Threatened

There are indications that Rochester may have difficulty in maintaining its cost and access advantages, as factors that have contributed to the success of Rochester's health care system erode. Examples of this erosion include the following:

- **Reductions in hospital planning:** After the second phase of the HEP experiments ended in 1987, Rochester returned to case-based hospital reimbursement. Because the current system has volume-driven incentives, hospitals in Rochester have increased their requests for capital expansions and now compete more aggressively for patients. Additionally, capital equipment is increasingly purchased and set up in nonhospital settings, where the Finger Lakes Health Systems Agency does not have control through the state certificate-of-need law.
- **Continued pressure by businesses for experience-rated insurance:** Larger businesses that can achieve lower insurance rates because of favorable demographics (e.g., young employees) and experience (e.g., relatively low use of health care services) have shifted to self-insurance or insurance

policies based on experience rating. The vast majority (85 percent) of insurance policies in Rochester are still community rated, but insurers report that there is pressure from some employers who request experience-rated policies.

- Reduced employer involvement in local health care issues: Some companies traditionally based in Rochester have been purchased by outside firms or have relocated corporate headquarters to other areas and, consequently, have become less interested and involved in local health care planning efforts.

Conclusions

The Rochester area has an unusual history of concerted community-wide efforts to constrain costs and improve access in the health care system. The business community, working with Blue Cross/Blue Shield and collaborating with providers, has exerted its influence in this undertaking. In its efforts to control health care costs, Rochester has used health planning, which linked capacity with community needs, and global budgeting, which limited total health care expenditures. The presence of a dominant insurer has also facilitated efforts to expand access and control costs. Rochester's experience with community rating suggests that this practice, by redistributing costs from small groups and individuals to large groups, increases health insurance coverage and access to health care.

The history of Rochester's health care system also demonstrates the difficulty of isolated health care reform. The global budgeting component of HEP was discontinued, in part, because hospital reimbursement at the state and national levels moved in a different direction. In addition, Rochester's efforts to control hospital costs began to have a proportionally smaller impact on general health care costs because expenditures shifted from the hospital to other settings. Influences external to Rochester also contributed to the reduction of employer involvement in health care issues and pressures to shift away from community rating.

Rochester's experience provides important insights for other communities trying to gain control over rising health care costs and diminished access. It is important to note, however, that Rochester's successes result from a series of actions taken over several decades. While other cities might profit from emulating Rochester's use of community-based planning and community rating for health insurance, it is unclear whether they would match Rochester's record. Many of the problems Rochester has avoided, such as the excessive growth of hospital capacity and the erosion of

Appendix I
Rochester's Community Approach Yields
Better Access, Lower Costs

coverage that current insurance practices generally produce, are entrenched in other communities. It may be more difficult to change practices that people are accustomed to than it was to prevent them from taking hold.

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