

Public Policy Forum



Researching Community Issues Since 1913

Public Policy Forum

The High Cost of Health Care in Milwaukee: *A Comparative Study of Milwaukee and 19 Other North Central Cities*

**Research by Merton D. Finkler Ph.D., Lawrence University and
Innovative Health Associates**

Summary by The Public Policy Forum

April 2003

The High Cost of Health Care in Milwaukee

Executive Summary

During the late 1990s, as health care costs nationally began to grow rapidly, health costs in metropolitan Milwaukee grew at an even faster pace. Merton D. Finkler, Professor of Economics at Lawrence University, assisted by the Public Policy Forum, explored if those costs in the Greater Milwaukee area were indeed well above average, and if so, by how much and for what reasons.

To get answers, Dr. Finkler, co-founder of Innovative Health Associates, compared the Greater Milwaukee area to 19 other metropolitan areas in the north central part of the United States. In particular, he focused on hospital and HMO competitiveness, the aging of respective populations, the suspected cost-shifting effect of relatively low Medicare payments and economic factors, among others. Finkler's inquiry ultimately centered on the diminished influence of managed care in the Greater Milwaukee area and the coincidental impact of physicians, especially specialists, grouping their practices and gaining pricing power. Dr. Finkler's research was then summarized and organized by the Public Policy Forum, a non-profit, non-partisan research organization in Milwaukee.

The overall conclusion of this research is that the Greater Milwaukee area health care costs have risen rapidly and are relatively high because HMOs, insurance companies and employers have given up market power to physicians, and to a lesser extent, hospitals. Most significant is the physician side of the story. More than elsewhere, physicians in the Greater Milwaukee area have formed large group practices. Since the Greater Milwaukee area features a relatively high number of specialists, these large groups have used their influence in the market place. And during the late 1990s, as these other changes occurred, capitation – the practice of paying doctors a fixed amount per patient in a plan – gave way to greater use of fee-for-service, or the more you do the more you are paid. In the late 1990s, in other words, pricing power in the Greater Milwaukee area went to the physicians.

Hospital costs also have contributed to relatively expensive health care in the Greater Milwaukee area. The explanation parallels that for the physicians, though not to the same degree. As insurers gave up market power in order to satisfy employer's coverage demands, hospitals filled the gap. Lower Medicare payments to this region and demographics also have a limited role in explaining the higher costs here.

Other Key Findings:

- Health care costs in the Greater Milwaukee area are at least 20 to 25 percent higher than in other major Midwestern metropolitan areas and may be even higher, as was pointed out last year in the Mercer Study that estimated the costs here at 55 percent higher.
- Medicare payments are relatively low in the north central part of the country and given their increased bargaining power, physicians in Milwaukee have been able to shift costs to commercial customers.
- Population is aging slightly faster than the average of the 20 areas studied, thus raising both insurance premiums and hospital payments.

The High Cost of Health Care in Milwaukee

A Comparative Study of Greater Milwaukee and 19 Other North Central Cities

Introduction

During the late 1990s and into the new century, spending on health care costs nationally grew, and grew at increasing rates. By 2001 health care spending nationally was growing at 8.7 percent a year, and had climbed to \$1.4 trillion, or about 14.1 percent of the nation's total economy. In the Greater Milwaukee area, many suspected that growth in health care costs was higher than the national rate and higher than other cities in the Midwest. One widely reported study claimed the Greater Milwaukee area's health care costs were 55 percent higher than in other midwestern cities. Another study said the rate of increase in those costs was 25 percent a year.

Across the country, the drivers of these costs were reportedly consumer demand; benefit-rich plans offered by employers; high costs of prescriptions drugs and new technology; the expense of government mandates; the price of litigation and risk management; overall rising provider expenses; the reduced role of managed care, and inflation. These explanations for the rise in health care costs nationally were being experienced in some measure everywhere. Why was the Greater Milwaukee area apparently striding away from the pack, and, particularly, why were the area's health costs apparently significantly more expensive than in other comparable cities in the Midwest?

Among the factors some experts presumed to be behind Greater Milwaukee's position in health costs were that lower Medicare payments to the Milwaukee area than in other places were provoking cost shifting to commercial, or non-elderly, consumers; that the Greater Milwaukee area was losing population in the 20 to 34 age bracket, and gaining in the 45 to 64 age bracket, meaning higher premiums, and a suspicion that hospitals were gaining in market power and managed care was weakening as a bargaining force in the region.

In spring 2002 Merton D. Finkler, a professor of economics at Lawrence University whose primary interest is in health care, initiated a study with assistance by the Public Policy Forum.

Dr. Finkler has been a Robert Wood Johnson Fellow in Health Care Finance and has worked as a consultant in the Central Office and the Southern California Regional Office of Kaiser Permanente Medical Care Program. He has been involved in federal and state public health care research studies. He also co-founded and is a principal of Innovative Health Associates, a Menasha, Wisconsin health care consulting company.

The Public Policy Forum is a non-profit, non-partisan research organization in Milwaukee. The Public Policy Forum joined with Dr. Finkler to assist with research on the project, to organize and synthesize the research into a report, and to facilitate the communication of the project's findings. The Finkler study was underwritten by Cobalt Corporation, a member of the Public Policy Forum.

The goal of the project was to determine if health costs in the Milwaukee metropolitan area were indeed more expensive than in other metro areas. And if Milwaukee was higher, what was causing the increase. The research areas focused on the following:

- How expensive is health care in the Milwaukee metropolitan area compared to other cities?
- If the Milwaukee area is more expensive, how much more expensive is it?
- Are the relatively low Medicare payments in the region contributing to the problem, namely through cost shifting to commercial payers?
- Is there an aging population in the Greater Milwaukee area that is driving up costs relative to other cities?
- If Milwaukee is relatively more expensive, what is the primary cause of it?
- If causes for relatively higher costs are identified, are there policy responses that can be suggested?

Methodology

Twenty metropolitan areas were included in the study: Milwaukee, Chicago, Des Moines, Detroit, Indianapolis, Minneapolis-St. Paul, Akron, Cincinnati, Cleveland, Columbus, Dayton-Springfield, Fort Wayne, Grand Rapids, Kansas City, Louisville, Madison, Memphis, Omaha, Pittsburgh and St. Louis. They were selected to provide a breadth of information in the north central part of the United States. (All references to Milwaukee and other areas studied will be of metropolitan areas, not cities proper. Milwaukee's metropolitan area includes four counties: Milwaukee, Waukesha, Ozaukee and Washington.)

A database of key indicators for 1990, 1995, and 2000 for the 20 metropolitan statistical areas was constructed to examine patterns and rankings across the 1990s, and to identify any distinctions for Milwaukee. The database components included insurance coverage and cost; hospital structure and cost; physician structure and payment; Medicare and Medicaid characteristics, and state health care regulation. Analyzed was a national HMO database to determine the influence of bargaining power and Medicare cost shifting on commercial premiums, hospital pricing and ambulatory pricing. HMO penetration rates, profit margins, premium levels and hospital admissions were examined. The primary source for HMO data was Interstudy, a research institute that has collected data and published reports on the managed care industry since the 1970s. Assisting with HMO data was Professor Douglas R. Wholey, director of the Public Health Administration Program at the University of Minnesota. Hospital data, including profit margin, non-governmental discounts, expense per person and concentration, came from the American Hospital Association. Data on physician structure and payment came from several sources, among them Interstudy, the American Medical Association, and the Area Resource File, which is a county-specific national database.

The study's primary objective was to identify health care cost differences across metropolitan areas. Since no comprehensive representation of costs exists at the

metropolitan level, several different indicators were studied to gain a sense of different aspects of the marketplace. For those enrolled in HMOs, the premium per member per month captures primary differences across markets. Of course, HMO plans differ within and across markets, and the HMO penetration rate varies both across markets and over time. For example, in 2001, at one extreme, HMOs only captured 7 percent of the Memphis population while at the opposite extreme Madison featured a 56 percent penetration rate. Milwaukee's 28 percent puts it 26 percent above the 20 area average. Secondly, the study examined the hospital payment received from sources other than Medicare and Medicaid per non-elder (age less than 65). This indicator provides a comprehensive representation of commercial payments to hospitals. Finally, payments by the Federal Employee Health Benefits Plan per member per month were examined. This indicator features a common benefits plan and corrects for difference in case-mix but the number of beneficiaries, and, thus, payout varies markedly across cities and across time.

In addition to determination of how costly health care in Milwaukee has been, the study also sought to understand whether relatively high costs could be attributed to shifting the shortfall in payments from Medicare onto commercial payers. Particular conditions must be met for cost shifting to take place: either relative bargaining power (between purchasers and providers) changed or health care providers previously were not taking advantage of opportunities to price at what the market would bear and then chose to do so. To evaluate the results for hospitals, the study compares Medicare Part A payments with the non-governmental net revenues per non-elder (as noted above.) For physicians, Medicare Part B payments are compared to available data on physician contract prices.

Analysis

Cost Indicators

The salient cost indicators support and illustrate the Milwaukee metropolitan area's rise to the rank of most expensive in the north central United States for health care. Compared to the other 19 metropolitan areas studied, Milwaukee ranked first in HMO premiums per member per month in 2001 (see Table 1).

Table 1. HMO Premiums Per Member Per Month in 2001
 Greater Milwaukee area compared to 19 other metropolitan areas

Metropolitan Areas	2001
Milwaukee	\$207.62
Madison	\$191.54
Minneapolis -St. Paul	\$187.46
Indianapolis	\$186.56
Detroit	\$181.07
Louisville	\$174.44
Kansas City, MO and KS	\$174.01
Dayton-Springfield, OH	\$172.78
Cleveland	\$171.38
St. Louis	\$170.73
Columbus	\$166.78
Fort Wayne	\$166.61
Akron	\$164.08
Cincinnati	\$162.36
Grand Rapids	\$160.70
Chicago	\$160.57
Omaha	\$158.94
Memphis	\$156.30
Des Moines	\$134.13
Pittsburgh	\$133.88
Average	\$169.10

Ten years earlier, Milwaukee was 14th among the 20 in HMO premiums (see Table 2). Milwaukee climbed from 14th place in 1990 to third place in 2000 in commercial payments to hospitals. In 2000 commercial hospital payments per non-elderly person were 24 percent higher than the average for the 20 metropolitan areas. In another category, hospital expenditures per capita, the Milwaukee area ranked sixth in 2000 out of 20, and a decade before it was again 14th. And while there are no data available for the years prior to 1999, the Milwaukee metropolitan area ranked first in federal employees' health benefit plan expenses in 2002 among the 20 areas studied. Milwaukee was 60 percent more costly in federal employees' health benefit plan expenses per member per month than the average elsewhere in the study group.

Table 2. Primary Indicators of Higher Health Costs
Greater Milwaukee area compared to 19 other metropolitan areas

	1990	1995	2000	Growth (1990-2000)
Premium (per member per month)	\$89.21	\$135.14	\$175.50	96.7%
Milwaukee Rank	14	2	2	
Median	\$92.26	\$117.61	\$146.96	59.3%
Commercial Payment -Hospitals	\$591.42	\$799.27	\$1,110.45	87.8%
Milwaukee Rank	14	7	3	
Median	\$601.54	\$737.67	\$897.74	49.2%
Hospital Expenses/capita	\$862.77	\$1,285.91	\$1,620.00	87.8%
Milwaukee Rank	14	8	6	
Median	\$908.05	\$1,250.48	\$1,396.39	53.8%
FEHBP Expenses PMPM*	Na	Na	\$227.52	Na
Milwaukee Rank	Na	Na	1	Na
Median	Na	Na	\$141.85	Na

*Note: Federal Employees Health Benefit Plan Expenses per member per month

Demographics

The demographic picture suggests that the aging of the overall population in the Milwaukee metropolitan area is a small piece of the explanation for the area's high health care costs. The focus in this part of the study was on commercial premiums, or those premiums that are not Medicare and not Medicaid. The age groups compared were of people from age 20 to 34, and from age 45 to 64. The assumption is that older people pay higher premiums.

Milwaukee followed a pattern with the median of the other 10 metropolitan areas, with the ratio of the older group to the younger group growing. Milwaukee's older group as compared to the younger group increased a little more than the median of the others, growing by about 47 percent compared to the median growth of about 43 percent between 1990 and 2000. The increase is explained by the transition of the baby boomer generation into middle age and upper middle age, but the difference is small. The percent of elderly people, 65 years old and older, as a share of the population in Milwaukee, however, remained fairly constant through the decade of the 1990s, with about 12.5 percent elderly in 1990, and about 12.6 percent elderly in 2000. During the 1990s, then, the Milwaukee area population got slightly older than the median of all the metropolitan areas (though less so than Pittsburgh, St. Louis, and Cleveland). There is probably some influence of the slightly aging Milwaukee population on commercial premiums, compared with the other metropolitan areas, but the effect appears to be small.

Medicare

Another suspect in Milwaukee's high costs of health has been Medicare. The argument is that Milwaukee receives lower payments in Medicare than elsewhere, and it has caused the health care industry here to make up the difference by charging more to commercial customers. There may be an argument for lower Medicare payments causing cost shifting, especially Medicare Part B payments — the Medicare payments to doctors — but the Medicare piece of the story does not fully explain Milwaukee's greater health care expense in the north central region. That is because the whole center part of the United States receives lower Medicare payments than on either coast of the country. Overall, Medicare's relative total payments per enrollee in Milwaukee rose a little less in the 1990s than the median of the metropolitan areas studied (see Table 3).

Table 3. Medicare Payments

Greater Milwaukee area compared to 19 other metropolitan areas and U.S. average

	1990	1995	2000	Growth (1990-2000)
Payment per enrollee	\$298.94	\$379.70	\$424.21	42%
Milwaukee Rank	9	14	11	
Median	\$295.45	\$397.77	\$429.20	45%
USPCC*	\$274.20	\$399.54	\$463.97	69%
Part B Pay per enrollee	\$116.91	\$127.65	\$166.65	43%
Milwaukee Rank	6	13	12	
Median	\$105.30	\$134.24	\$171.61	63%
USPCC	\$115.53	\$142.83	\$200.87	74%

*Note: United States average per capita cost for Medicare enrollees

Medicare payments per enrollee in Milwaukee increased 42 percent while the median increase for the metropolitan areas studied was 45 percent. For the entire United States on average, however, Medicare payments rose by 69 percent, or more than 50 percent greater than the growth rate of Milwaukee or the average of the regions studied. Notably, however, Medicare Part B payments to Milwaukee failed to keep pace with the increases in Part B payments to either the nation as a whole or when compared to the metropolitan areas studied. The growth in Part B payments to Milwaukee between 1990 and 2000 was only 43 percent compared to the average growth of 63 percent in the areas studied and a 74 percent growth on average nationally. The average national Part B Medicare payment in 2000 of \$200.87 and the median 2000 payment in the study group of \$171.61 were 21 percent and 3 percent greater, respectively, than the \$166.65 Part B payment in 2000 to Milwaukee.

The conclusion is that Medicare payments to the 20 metropolitan areas in the north central part of the country are similar to one another, though significantly below the national average. That's important to the north center of the country, but it does not explain Milwaukee's health care costs. The fact that Milwaukee is well below the national average in Part B payments, and somewhat below the other 19 areas studied,

suggests that cost shifting could be part of the explanation for Milwaukee's high costs, but not a big part.

Community Health and Economy

Other factors considered that may have an effect on the health care costs in the Greater Milwaukee area include the general health of the population and the region's economy. There are no available data on whether Milwaukee is less healthy than elsewhere.

Economic indicators show Milwaukee is a little better off than the average of the other metropolitan areas. Milwaukee's income per capita grew at a slightly higher rate than the average, and its unemployment rate between 1990 and 2000 dropped, but not quite as sharply as the median for the other 19 regions studied. Milwaukee's relative income growth had only a small influence on health care cost growth.

Decline of HMO Influence

The explanation for Milwaukee's expensive health care is not in demographics or the economy. Therefore, this study explored the relative market power of HMOs and providers. In the first part of the 1990s, HMOs exercised substantial influence in the control of health care dollars. One of the central practices in the managed care industry was to pay by capitation, or by a fixed amount for everyone that signed up in a given health plan. In large measure, the insurance industry was setting limits on the cost of health care, in addition to being more active as a gatekeeper of health care management. In the mid-1990s and into the late-1990s, however, with health care costs relatively flattened through managed care, and relatively low unemployment rates increasing the competition for workers, employers wanted to attract workers with less restrictive health plans. Insurers offered employers plans with fewer constraints, and the practice of capitation increasingly gave way to fee-for-service plans. HMOs were losing control of the payment structure, and providers of health care, the hospitals and physicians, especially those who were organizing into large single and multi-specialty groups, were gaining control.

By the year 2000 power in the Milwaukee health care marketplace had surely shifted. This power shift from HMOs and purchasers to providers was true in other cities as well, but the shift was more dramatic in Milwaukee with more dramatic results.

Milwaukee started the 1990s with more HMO power than elsewhere and with more capitation than other places. When that power and the use of capitation declined, the impact felt in the Milwaukee area was greater. Illustrating the shift in power, in part, is HMO data showing that the number of HMOs servicing Milwaukee area residents actually grew in the 1990s from nine HMOs to 15, or an increase of about 67 percent (see Table 4). At the same time, however, the penetration rate dropped in the Milwaukee metropolitan area by 11 percent. The median penetration for the other 19 metropolitan areas grew during this same period by nearly 44 percent.

Table 4. HMO Presence and Competitive Power
Greater Milwaukee area compared to 19 other metropolitan areas

	1990	1995	2000	Growth (1990-2000)
Number of HMOs	9	12	15	67%
Milwaukee Rank	10	11	8	
Median	8.5	12.5	14	65%
HMO Penetration Rate	0.334	0.279	0.297	-11%
Milwaukee Rank	3	4	6	
Median	0.167	0.19	0.24	44%
HMO Penetration*	3.01	3.35	4.45	48%
Milwaukee Rank	3	6	5	
Median	1.54	2.46	3.39	120%

*Note: A competitive market measure determined by multiplying the number of HMOs by the penetration rate.

A measure of market influence and competitiveness is found by multiplying the number of HMOs by the penetration rate. A high value suggests a competitive HMO market with a substantial influence on cost containment. Milwaukee was fifth in competitiveness among the 20 metropolitan areas in 2000, according to this measure. Although not appearing in the table above, Milwaukee dropped to 12th among the group of the 20 metro areas in 2001. Table 4 shows that a decade earlier HMOs in the Milwaukee metropolitan area were third most influential.

Hospital Market

A focus of many reports in Milwaukee has been on the role hospital costs have had on the overall health care cost picture. As stated earlier, from 1990 to 2000 Milwaukee jumped from 14th among the 20 metropolitan areas to third in commercial payments to hospitals, and its commercial costs per non-elder person were 24 percent higher than the average cost among the 20 metropolitan areas. Milwaukee climbed in the same period from 14th to sixth in hospital expenses per capita.

What sent Milwaukee up in these categories? It has a few more hospitals than the median number in the study group and ranked eighth in number of hospitals (see Table 5). Hospital admissions per 1,000 people were only five percent above the median. The number of operations per 1,000 people was about average. These numbers do not suggest any explanation for Milwaukee's higher costs. Hospital use in Milwaukee is not appreciably different from elsewhere.

Table 5. Hospital Presence and Competitive Power
Greater Milwaukee area compared to 19 other metropolitan areas

	1990	1995	2000	Growth (1990-2000)
Number of Hospitals	21	22	19	-10%
Milwaukee Rank	8	8	8	
Median	12	13	13	8%
Percent Commercial Admits	59%	49%	48%	-19%
Milwaukee Rank	5	5	8	
Median	53.2%	46.9%	47.3%	-11%
Hospital Herfindahl	1087	1801	1603	48%
Milwaukee Rank	14	10	17	
Median	1299	1737	2132	64%

An argument for reportedly high health care costs in Milwaukee has been that hospitals here have market power significant enough to control costs. A way to measure market power is the Herfindahl index, which for hospitals is a calculation involving market share of commercial hospital admissions. The Herfindahl index is a standard measurement of concentration of any industry. The index is obtained by squaring the market share of all the firms in an industry and then adding those squares. Two firms with equal market share in one industry, for instance, would mean squaring 50 (for 50% of the market) for each firm, and adding the numbers. The index would be 5,000. A perfect monopoly would be 10,000 in this scale. Based on standards used by the United States Department of Justice, a Herfindahl index of 2000 or greater suggests real market power.

The hospital Herfindahl index for Chicago is 416, or relatively little market power. The Herfindahl for Cincinnati is 4,000, which is significant market power. In Milwaukee in the year 2000 the hospital Herfindahl was 1,600. And though Milwaukee's market power climbed from about 1,000 a decade earlier, Milwaukee's hospitals became less concentrated compared to the other 19 metropolitan areas. While the median market power in the other cities grew by 64 percent to a median Herfindahl of 2,132, Milwaukee's Herfindahl grew by 48 percent. Milwaukee ranked 17th out of the 20 areas in the year 2000 in the Herfindahl measurement.

In other words, hospital use, competitiveness, or market share does not explain health cost increases here relative to elsewhere. Pricing; however, clearly does since Milwaukee was 24 percent more expensive in hospital payments per person than the average. Also, part of the answer with respect to hospitals, as well as physicians, is again the diminished influence of HMOs and the erosion of capitation.

Influence of Physicians in the Marketplace

The final piece in this inquiry is the role of the community of physicians on overall health care costs. The demographics of physicians in a metropolitan area begin to tell the story. The number of doctors in the Milwaukee area grew in the 1990s relative to the

other metropolitan areas. Between 1990 and 2000 the number of physicians per capita in Milwaukee grew by 22 percent, compared to a median growth of nine percent elsewhere (see Table 6).

Table 6. Physician Population and Market Influence
Greater Milwaukee area compared to 19 other metropolitan areas

	1990	1995	2000	Growth (1990-2000)
Physicians/1,000	2.3	2.7	2.8	22%
Milwaukee Rank	8	6	5	
Median	2.2	2.5	2.4	9%
Specialists/1,000	na	1.9	1.9	0.0%
Milwaukee Rank	na	6	4	
Median	na	1.7	1.6	-6%
Capitation-% of Revenue	na	0.428	0.139	-68%
Milwaukee Rank	na	2	10-11	
Median	na	0.182	0.139	-24%

The Milwaukee area also has a relatively high number of specialists. Of the other 19 metropolitan areas, only three other areas had more: Madison, which has a large university hospital in a relatively small metropolitan area; Cleveland, which has the Cleveland Clinic and is a center for specialists; and Pittsburgh, which has a large elderly population. Significantly, specialists drive the health care industry. In most instances, primary doctors do not do hospital admissions, specialists do.

In the 1990s not only did the number of physicians and specialists grow relative to other places but more than elsewhere, physicians in Milwaukee grouped together. By grouping together, physicians have the potential to reduce administrative costs; purchase expensive equipment that allows high-tech diagnostics to be done in their offices instead of hospitals; improve execution of services and continuum of care in multi-specialty groups; and create substantial contracting entities. Large groups of physicians could go to insurance companies and bargain with clout, as well as demand more money and more favorable payment structures. They could make a case with authority for fee-for-service at the same time employers were demanding less restrictive benefit plans. Insurance companies were caught in the middle. They wanted to satisfy employers and both get and keep physicians in their plans.

HMOs lost power and physicians gained it. In the early 1990s the penetration rate of HMOs in Milwaukee was fairly high, about twice as high as the median in the other metropolitan areas. By 2001, this measure of power showed a marked decline. Milwaukee's penetration rate was still higher in 2001 than the median in the other cities, but not by nearly as much. The penetration rate had fallen from being double the median to only 26 percent higher.

At the same time, payment structure to physicians shifted away from capitation, meaning again power from the HMOs and power to the doctors, especially to specialists (See Table 6). In 1995, the percentage of revenues that specialists contracting with HMOs got from capitation, or fixed in advance, was 43 percent. By the year 2000 the percentage of revenues from capitation had dropped to 14 percent. That translates as pricing power in the hands of physicians. Put differently, capitated revenues dropped by more than two-thirds in five years. A total of \$2 of every \$5 that HMOs had fixed in advance in 1995 had dropped to \$1 of every \$7. In the same period, HMOs went from having a third of the market to a quarter of the market. It meant the purchasers' side of the market in the Milwaukee area had weakened. It meant the purchasers would pay higher prices.

Physicians are the key driver of health care costs in Milwaukee in the last part of the 1990s.

Policy Implications

Purchasing Power

In a market environment where costs are high and evidence shows pricing power is with the providers, an appropriate market response is for purchasers to regain a greater degree of power. As this study demonstrates, purchasers of health care in the Milwaukee metropolitan area gave up much of their power in the mid-1990s. The practice of capitation declined. And physicians, particularly specialists, grouped together and assumed more control of pricing. In this environment, hospitals, too, enjoyed greater pricing power.

To gain better control of the purchasing of care, purchasers need to consolidate. Purchasers can sign up with HMOs for bargaining power or create purchasing coalitions of businesses and do it on their own. However purchasers choose to consolidate, the balance of market power could then shift back toward purchasers to lower the Milwaukee area's health care costs.

HMO Power

Businesses have two primary choices. They can select an HMO and let the HMO use its market penetration to restrict payments and choices, or they can join other businesses in order to develop purchasing power. The former has led to both a market and a political backlash against HMOs. The latter has been difficult to do because successful coalitions must agree on a number of conditions — including benefits packages and payment structures — if they are to act as if are one large unit. If either is successful in including a large number of beneficiaries, then they could use such market power to selectively contract with health systems or provider groups as well as employ risk-sharing payment structures.

Medicare Part B payments

The entire region in the sample, from Omaha in the west to Pittsburgh in the east, to Memphis in the south and Minneapolis in the north, received lower increases in Medicare payments than the national average, about 15% less. The result is that in the region, physicians feel they can't catch up and they increasingly feel they can't afford Medicare patients. The natural tendency is to shift costs to the commercial side. Milliman USA studies on physician pricing, as well as interviews with HMOs in several of the markets studied, suggest that in Milwaukee such cost shifting has been successful. Medicare reform should be sought to correct these payment differences and end the cost shifting.

State Policy

- Purchasers need information both on the price and quality of care to determine which health care providers offer the most cost-effective care. To achieve this, there must be disclosure about the cost of services from each provider, and some measure of quality. Such purchaser information would create an environment of financial incentives from providers, thereby helping to contain costs and increase the quality of care.
- Although this study did not focus on the impact of mandated benefits, it is a subject that merits more study. Mandated benefits nationwide have helped drive health care costs up. A study by the Minnesota Department of Health, for instance, suggests that mandates add six to seven percent, on average, to group premiums. To control premium costs, mandated benefits should be scrutinized and added with care, so as to reduce the possibility of pricing managed care organizations out of the market.
- Another issue not studied here, but also meriting study, are certificates of need. It is an issue that states are beginning to consider as a possible way of reining in health care costs. The theory is that certificates of need, which faded as a regulatory device in the mid-1980s, can be a way to control the entry of new providers into the system and thereby control costs. There is no evidence, however, that certificates of need in fact help to control costs. Certificates of need simply tend to grant market power to existing providers. Certificates of need should not be reinstated.

Summary

As this study demonstrates, health care costs in the Greater Milwaukee area have outpaced the increases of the other 19 cities in the north central United States. Milwaukee is the most expensive place in the region for health care, and the costs continue to climb. The increases have been caused by a constellation of factors, some of them experienced regionally, such as lower Part B Medicare payments and also the diminished role of managed care in the control of costs. But some of the factors raising prices are more specific to the Greater Milwaukee area, such as a growing number of

physicians clustering into groups, particularly specialists, and the concomitant decline in the practice of capitation. Exactly how much responsibility falls to which factor cannot be known with certainty.

One estimate blamed two-thirds of Milwaukee's higher than average health care costs on provider pricing. Regardless of that estimate, however, market power has shifted since the mid-1990s in the Greater Milwaukee area to providers, and most of all to physicians. To control costs, the most critical change needed is to shift some significant degree of market power to the employers of Milwaukee who buy health care plans, to HMOs who serve as the employers' agents in the purchase of plans, and finally to the individual consumer of health care who gains power in the marketplace by gaining knowledge of the cost and quality of services from providers.



Public Policy Forum
633 West Wisconsin Avenue, Suite 406
Milwaukee, Wisconsin 53203

Phone: (414) 276-8240
Fax: (414) 276-9962
E-mail: ppf@execpc.com
Internet: www.publicpolicyforum.org