ARIZONA HEALTH FUTURES

health bullets

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INSIDE Hospitals | Health Insurance – National | Health Insurance – Arizona Trends in Health Insurance Coverage | Trends in Health Care Costs, Spending Arizona Healthcare Workforce | Public Attitudes on Health System Reform

Hospitals[1]

In the US there are 5,764 hospitals
employing 4.7 million full-time equivalent positions
to staff 965,000 beds
occupied by 36.6 million inpatients
which generate annual revenues of almost $500 billion.

- Arizona has higher adjusted hospital inpatient expenses per day than the US average. In 2004, Arizona daily hospital inpatient expenses were $1,678 compared to the U.S. average of $1,450, ranking Arizona 11th in the nation. However, with 485 inpatient days per 1,000 population, Arizona has fewer hospital acute-care inpatient days than the national average of 673.[2]
- Arizona – and the West generally – has fewer hospital beds than the national average:

Table 1: Arizona Staffed Beds, Population and Beds/1,000 Population

Years	1985	2003	2008 (Projected)
Total Staffed Beds	10,316	10,801	13,101
Population	3,183,539	5,579,222	6,320,874
Beds/1,000 Population	3.2	1.9	2.0

Source: American Hospital Association, US Census Bureau, Arizona Hospital and Healthcare Association (projections).

Table 2: Hospital Beds/1,000 Population

	1990	2000	2002	2003
US	3.7	2.9	2.8	2.8
Arizona	2.7	2.1	2.0	1.9
California	2.7	2.1	2.1	2.1
Nevada	2.8	1.9	2.1	1.9
New Mexico	2.8	1.9	1.9	2.0
Utah	2.6	1.9	1.9	1.9

Source: American Hospital Association.

- The pluralistic financing mechanism of hospitals encourages cost-shifting to payers with less market power.[3] The impact of differential payment-to-cost ratios on hospital charges is illustrative:[4]
  - The highest payment-to-cost ratio was in 1992, when private payers were charged 131.8% of cost. By 2003, that percentage had fallen to 122.0%.
  - In contrast, the payment-to-cost ratio for Medicare increased from a low of 88.5% in 1991 to 95.3% in 2003, while Medicaid increased from 81.9% to 92.3% of cost.
  - Using the 2003 ratio and extrapolating based on trends over the past few years, researchers estimate that in 2025 hospitals will have to charge private payers 138% of costs in order to maintain their 2003 operating margin of 3.3%.
  - If the payment-to-cost ratio were to return to 1991 levels, hospitals would have to charge private payers 157.4% of cost to maintain a 3.3% margin.

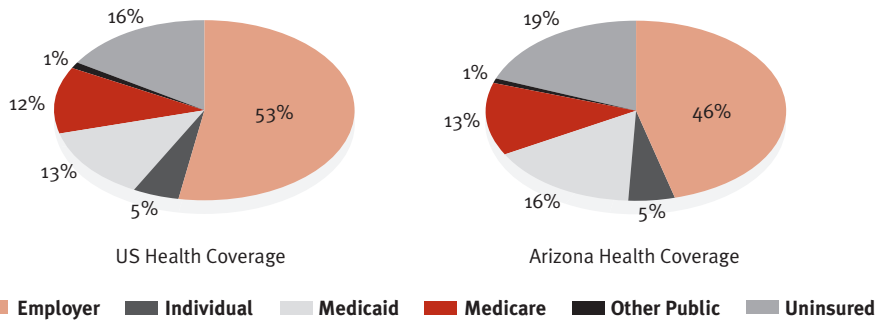
Health Insurance – National

- Employer-based insurance continues to decline:
  - Between 2000 and 2006, the percentage of workers covered through an employer-sponsored plan fell from 63% to 59%.[5]
  - Among small firms, the percent offering coverage decreased from 68% in 2000 to 60% in 2006. A small decline – 99% to 98% – occurred among large employers.[6]
- Contributing to the overall decline in worker coverage, premiums continue to increase:
  - Premium increases have averaged 10.6% per year since 2000 – a cumulative increase of 87%. By comparison, cumulative inflation and wage growth over the period were 18% and 20% respectively.[7]
  - The average annual premiums for employer-sponsored insurance (ESI) are $4,242 for single coverage and $11,480 for family coverage.[8]
  - The average worker contribution increased by $293 for single coverage and $1,354 for family coverage between 2000 and 2006.[9]
  - The average employee contribution for family coverage in a small firm is $3,550, compared to $2,658 for an employee of a large firm.[10]
  - The rate of increase in health insurance premiums has slowed from a high of 13.9% in 2003 to 7.7% in 2006. Based on an estimated increase in medical spending of 8.7%, the projected rate of increase for premiums in 2007 is 8.2%.[11]
- In response to the increasing cost of health insurance, employers report being very or somewhat likely to shift additional cost to employees:[12]
  - 49% plan to increase the employees' contribution to the cost of premiums;
  - 39% plan to increase deductibles;
  - 39% plan to increase office visit co-payments or co-insurance; and,
  - 39% plan to increase co-payments for prescription medications.

Health Insurance – Arizona

- Arizona residents are less likely to receive health insurance coverage through an employer, and more likely to be uninsured or to receive coverage through the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program.

Figure 1: US, Arizona Health Insurance Coverage, 2005



Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Compared to national averages, people without health insurance in Arizona are much more likely to be members of an ethic minority and slightly more likely to be in the low income category (federal poverty level):

Figure 2: Non-Elderly Uninsured by Race/Ethnicity, 2005

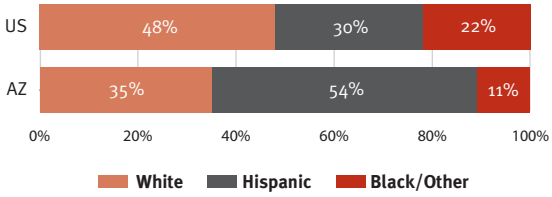
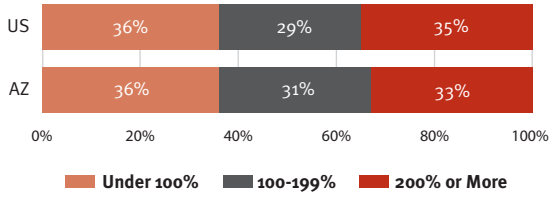


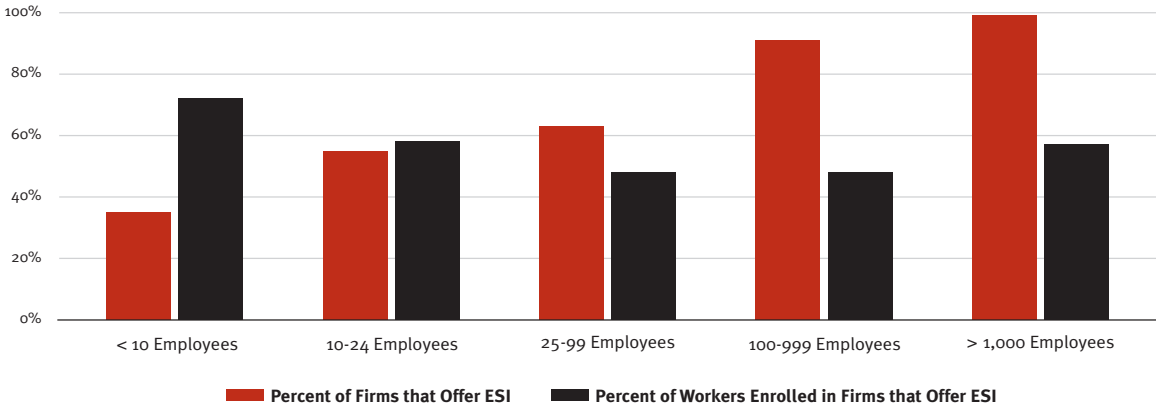
Figure 3: Non-Elderly Uninsured by FPL, 2005



Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Arizonans are less likely to be covered by employer-sponsored insurance:
  - Compared to the US average of 62.6%, only 54% of Arizona's private sector workers are enrolled in employer-sponsored health insurance.[13]
  - The smallest firms are least likely to offer coverage, but among small firms that do provide coverage a higher percentage of workers are enrolled when compared to larger firms (Figure 4).
  - The percentage of Arizona firms that offer health insurance declined from 62.9% in 2000 to 56.1% in 2004.[14] The biggest decline was among small employers (Table 3).

Figure 4: Employer Sponsored Health Insurance Coverage in Arizona, 2004



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2004 Medical Expenditure Panel Survey – Insurance Component; Tables II.A.2 and II.B.2.b.

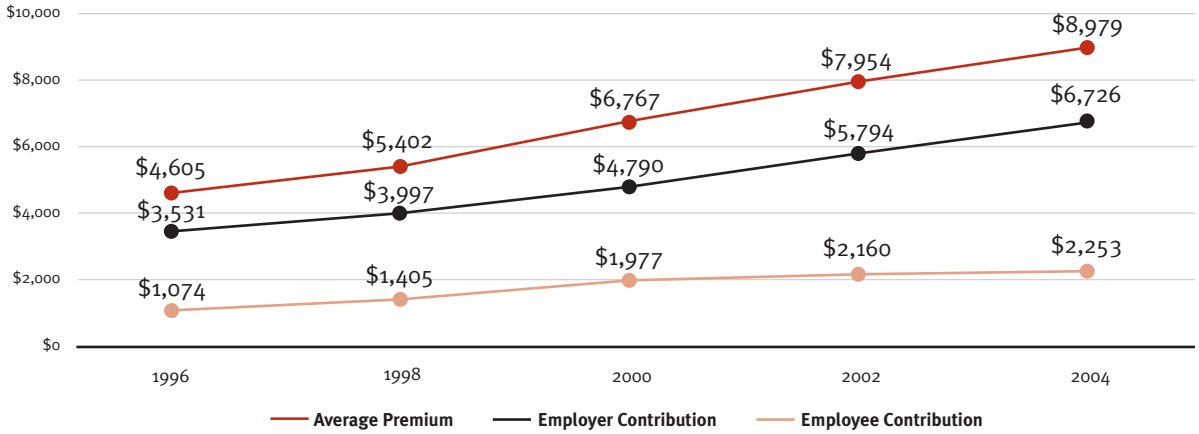
Table 3: Percent of Arizona Firms that Offer Health Insurance, 2000 and 2004

	2000	2004
Total	62.9%	56.1%
< 10	43.9%	33.2%
10-24	64.3%	53.2%
25-99	85.2%	63.8%
100-999	91.9%	90.3%
> 1000	100.0%	98.4%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2000; and 2004 Medical Expenditure Panel Survey – Insurance Component; Table II.A.2.

- In Arizona, premiums – and the employee's share of premium cost – continue to increase:[15]
  - In 2004, the average total family premium per enrolled employee was $8,979, significantly lower than the national average of $10,006. For single coverage, the difference was much smaller, $3,438 in Arizona v. $3,705 for the US.
  - Family coverage premiums charged to the smallest firms, those with fewer than ten employees, are significantly higher ($9,357) than the rates paid by medium-sized firms with 25-99 employees ($6,803).

Figure 5: Average Family Premium per Enrolled Employee, 1996-2004

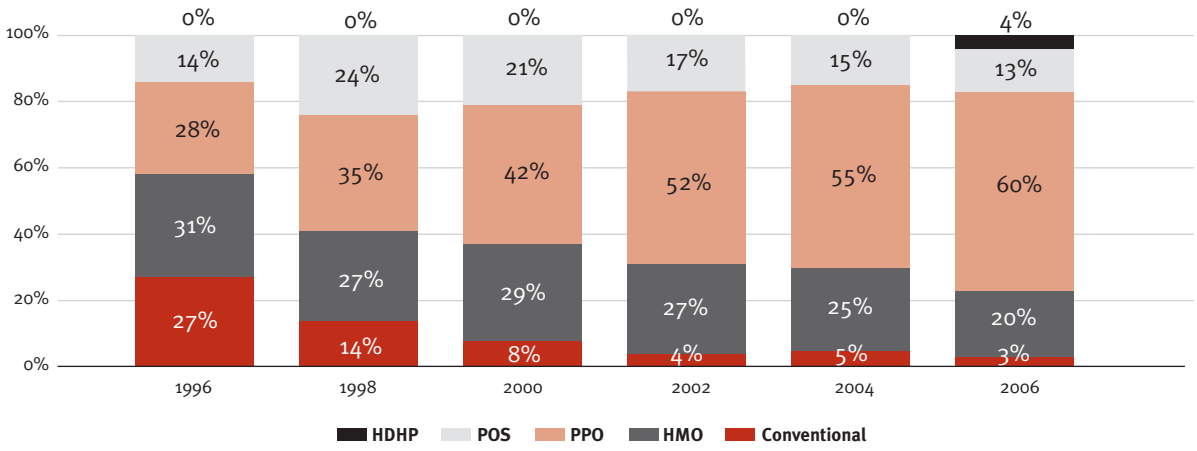


Source: Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey – Insurance Component, Tables II.D.1 and II.D.2; 1996-2004: SLHI analysis.

Trends in Health Insurance Coverage

- Increasing numbers of employers are offering a variety of Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA) insurance products:
  - Industry estimates indicate that enrollment in HSA-eligible plans increased from just over one million in 2005 to almost 3.2 million in 2006.[16]
  - Independent estimates peg the HSA-eligible enrollment figure at 600,000 in 2005 and about 2 million in 2006, but also note enrollment of 2.9 million in HRA-based plans.[17]
  - The KFF/HRET *Employer Health Benefits Survey* estimated HDHP/HSA enrollment increased from 800,000 in 2005 to 1.4 million in 2006, with an additional 1.3 million enrolled in HDHP/HRA plans.[18]
  - As Health Maintenance Organization (HMO) and Point of Service (POS) plan enrollment has fallen, Preferred Provider Organization (PPO) and High Deductible Health plans (HDHPs) have grown (Figure 6).
  - The number of employers offering an HDHP option increased from 4% in 2005 to 7% in 2006. Large firms (>1,000 workers) are more likely to offer HDHPs; however, when a choice of plan types is provided, just 19% of workers choose the HDHP option.[19]
  - Two to four percent of firms said they were "very likely" and 22-25% said they were "somewhat likely" to offer an HDHP option in 2005-06. The actual increase in such plans among all firms was just 3%. In the coming year, 4-6% of firms report being "very likely" and 18-19% report being "somewhat likely" to offer an HDHP.[20]

Figure 6: Distribution of Employer-Sponsored Health Plan Enrollment, 1996-2006



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006.

- Differences in premiums and deductibles between HDHPs and other plan types (PPO, POS or HMO) may or may not be significant:

Table 4: Premiums and Worker's Share of Cost by Plan Type, 2006

	HMO		POS		PPO		HDHP/HRA		HDHP/HSA	
Average Annual Amount	**Single**	**Family**	**Single**	**Family**	**Single**	**Family**	**Single**	**Family**	**Single**	**Family**
Total Premium	4,049	11,278	4,168	11,107	4,385	11,765	3,666	10,482	3,176	8,515
Worker Premium Contribution	590	3,079	634	3,226	637	2,915	664	2,420	467	2,115
Deductible	352	751	553	1,227	473	1,034	1,442	2,985	2,011	4,008

Red = statistically significant difference from other plan types at p< .05.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006; SLHI analysis.

- 80% of employers who offer HDHPs report that they are at least somewhat effective at increasing employee involvement in healthcare decision-making, and 59% report that HDHPs are somewhat effective at controlling health care cost increases.[21]
- With a current estimated value of $1.5 billion and few monthly transactions, consumers may be using HSA tax-free products as savings vehicles rather than as spending accounts.[22] The anticipated convergence of financial services and health care assets in HSAs is predicted by some to exceed $75 billion by 2010.[23]
- Some actuarial simulation models predict that federal government proposals designed to encourage enrollment in HDHPs could actually *increase* the number of uninsured. One estimate puts the net increase in the number of uninsured at 600,000 "as those left uninsured through firm dropping of insurance exceed those who gain insurance through taking up tax-subsidized high-deductible plans attached to HSAs" – at a cost of $11.6 billion.[24]
- Attitudes – and enrollment – indicate that HDHPs are more appealing to a higher income and healthy population, concentrating the number of low-income persons and those with poorer health status in more traditional plans:
  - 53% of survey respondents who considered themselves to be in excellent or very good health prefer the HDHP configuration of lower premium and higher deductible, while only 31% of those in fair or poor health prefer such an arrangement.[25]
  - 55% of people in households with annual incomes of $100,000 or more prefer HDHP/HSA arrangements, compared to 41% of households with incomes under $25,000 and 46% of those with incomes between $25,000 and 50,000.[26]

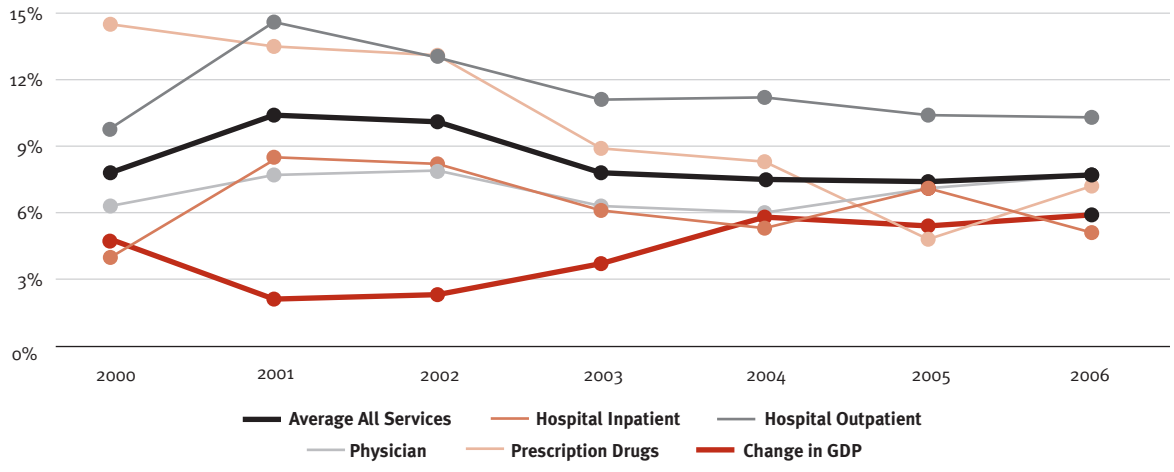
- Those enrolled in HDHPs/CDHPs (Consumer-Directed Health Plans) are slightly more likely to be in excellent or very good health (47% and 57% respectively) than are people enrolled in traditional comprehensive insurance plans (45%).[27]
- They are also less likely to smoke (14%) and more likely to exercise (85%) than people covered through other types of health insurance.[28]

- The ability of consumers to shoulder higher premiums or higher deductibles is a cause for concern:
  - While rates of health care use between people enrolled in HDHP/CDHPs and traditional/comprehensive plans were similar, out-of-pocket costs were significantly higher for persons in HDHPs, where 45% of those with incomes under $50,000 spent 5% or more of their income on out-of-pocket costs, and 15% spent more than 10%. Among people in the same income group enrolled in comprehensive insurance, only 14% spent more than 5%, and just 3% spent more than 10%.[29]
  - When people enroll in an HSA-qualified HDHP, they often delay establishing the savings account or are unable to make sufficient contributions to it before incurring medical expenses.[30]
  - 39% of respondents to a survey designed to gauge readiness for the expansion of HDHP/HSA plans have no money saved to cover future health care costs, and an additional 26% could not meet a $2,000 deductible with existing savings.[31] 64% of persons with individual HDHP coverage report having a deductible between $1,000 and $1,999.[32]

Trends in Health Care Costs, Spending

- At the national level, spending trends vary among service categories:[33]
  - Hospital outpatient services exhibited the highest annual rate of increase, averaging 11.8% between 2001 and 2006.
  - Prescription medications had the highest annual increase of all services in 2001 (13.5%) and 2002 (13.1%), after which the rate of increase declined to an average of 7.3% per year from 2003 to 2006.
  - The average annual increase in costs related to physician services between 2001 and 2006 was 7.1%, and appears to be the most stable with annual increases ranging between 6.0% and 7.9%.

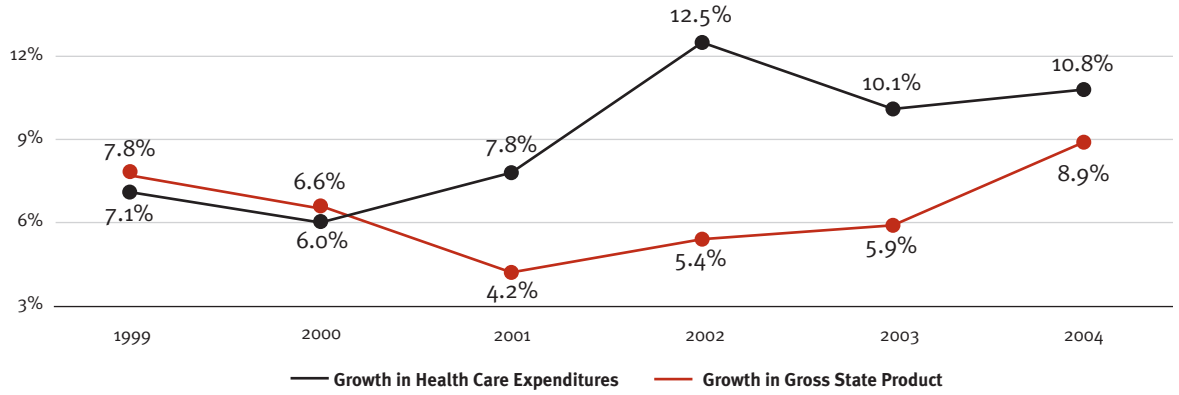
Figure 7: Annual Percent Increase in Spending by Type of Service, 2000-2006



Source: Ginsburg, et al., analysis of health care spending data from the Milliman Health Cost Index 2005 Series and GDP data from the US Department of Commerce, Bureau of Economic Analysis.

- In Arizona, the gap between increases in health care expenditures and overall economic growth mirrors the gap seen at the national level:

Figure 8: Annual Growth in Health Care Expenditures and Gross State Product in Arizona, 1999-2005



Source: Kaiser Family Foundation analysis of National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; June 2, 2006.

- Arizona annual health care expenditures in 2005 differed in selected categories from the US Average:

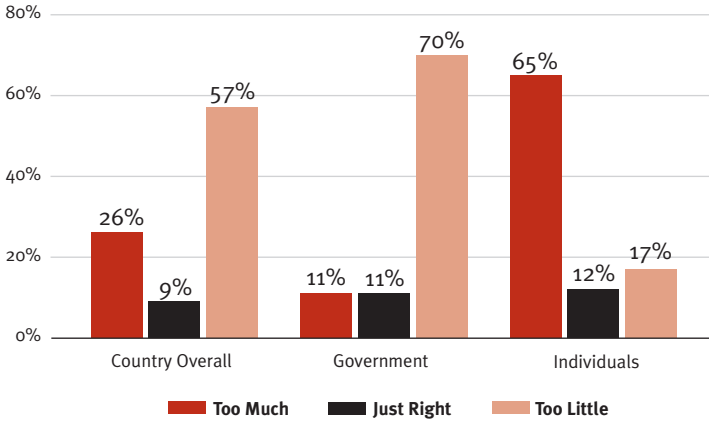
Table 5: Average Annual Health Care Expenditures in Arizona, 2005 (in millions)

	Arizona		US	
	Expenditures	Percent of Total	Expenditures	Percent of Total
Hospital Care	8,672	35.6%	570,756	36.6%
Physician & Other Professional Services	8,255	33.9%	452,603	29.0%
Prescription Drugs	2,736	11.2%	188,452	12.1%
Nursing Home Care	1,055	4.3%	115,210	7.4%
Dental Services	1,507	6.2%	81,532	5.2%
Home & Personal Health Care	1,062	4.3%	66,132	6.2%
Medical Durables & Non-durables	1,057	4.3%	55,235	3.6%
Total	$ 24,344	100%	$ 1,529,920	100%

Source: Kaiser Family Foundation analysis of National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; June 2, 2006.

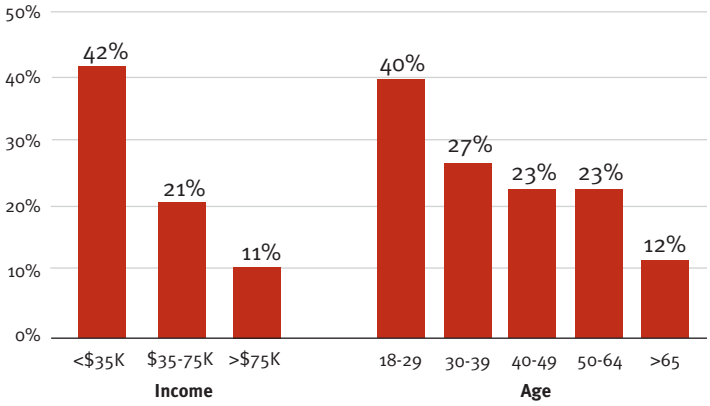
- While the public favors increased spending on health care, people are concerned about the impact of rising health care costs on families. The perceived negative impact of increased insurance premiums, deductibles, co-payments and direct payments for goods and services on families far outweigh concerns about aggregate spending:

Figure 9: Public Views on National Health Care Spending, 2006



Source: Blendon, et al; analysis of Harvard School of Public Health/ Robert Wood Johnson Foundation Survey of Americans' Views of the Healthcare System; April 2006.

Figure 10: Americans Who Had Problems Paying Medical Bills by Age and Income, 2006



Source: ABC News/Kaiser Family Foundation/USA Today HealthCare in America Survey, September 2006.

- Some employers do better than others in controlling health care costs among employees. Those companies who are the best at cost containment experienced increases that were 8.5% lower than their peers. As such, they were more likely to use a combination of strategies. The best performing companies were:[34]
  - 32% more likely to focus on quality.
  - 24% more likely to have programs that assist employees to manage their health.
  - 23% more likely to use evidence-based strategies.
  - 16% more likely to provide information and incentives for appropriate use of services.
- The issue of cost looms large for many Americans. When asked if they or another family member in their household had problems paying medical bills in the past 12 months, 25% responded that they had. Young people and those with lower household incomes were most likely to report being negatively affected (Figure 10).

Arizona Health Care Workforce (selected)

Physicians[35]

- The ratio of physicians in Arizona per 100,000 people increased from 207 in 2004 to 219 in 2005 – but remains well below the estimated national average of 293.
- Overall, the number of physicians increased from 12,024 in 2004 to 13,215 in 2005. However the geographic distribution of physicians throughout the state ranges from just 7 in Greenlee County to 8,501 in Maricopa County.
- Similar variation is found in the number of physicians per 100,000 population, which varies from a low of 50 in Apache County to a high of 292 in Pima County.
- Adequacy of physician services is a function of the absolute number and productivity. For primary care physicians, productivity often varies with financial incentives. For example, self-employed primary care physicians in Arizona saw an average of 102.6 patients per week in 2005, compared to 91.2 for employee-physicians and 88.2 for those who were salaried. Those who received a salary with an incentive averaged 103.3 patients per week.
- Primary care physician productivity is also influenced by the type of practice arrangement. Solo practitioners averaged 96.8 patients per week, while the weekly average for physicians in a group practice setting was 104.9.

- While an adequate supply of primary care physicians is a concern for Arizona hospitals, the availability or lack of specialists is often a bigger worry. Many Arizona counties do not have any physicians practicing in certain medical and surgical specialties, and are not able to attract or support them due to the lack of necessary medical facilities.

Nurse Practitioners, Physician Assistants

- In rural Arizona, primary care needs are often met by advanced practice nurses (NPs) and physician assistants (PAs), where they can account for 30% to 50% of the medical workforce.[36]

Table 6: Distribution of Physicians, NPs and PAs in Arizona, 2005

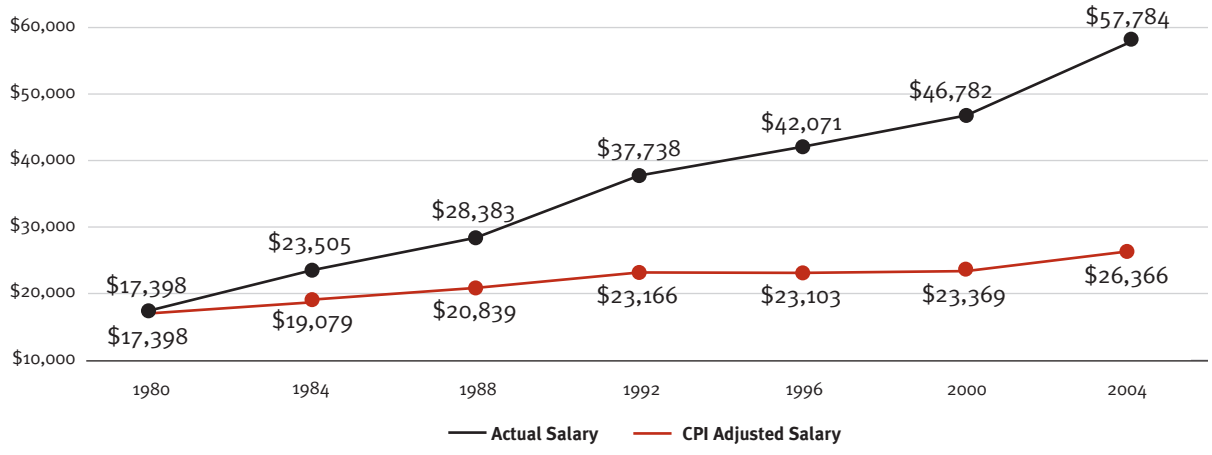
	Physician (MD/DO)		Nurse Practitioner		Physician Assistant	
	Number	Percent	Number	Percent	Number	Percent
Rural	1,882	71.3%	433	16.4%	323	12.2%
Urban	11,299	80.3%	1,871	13.3%	909	6.5%

Source: Rimsza, et al. (2006) The Arizona Physician Workforce Study, Part II.

Nurses

- With a ratio of 681 nurses to 100,000 residents, Arizona ranks 45th in the nation in terms of its registered nurse workforce (2004). While this is an improvement, Arizona remains far below the national average of 782 nurses per 100,000.[37]
- If left unaddressed, Arizona's demand for nurses will exceed the available supply by 25% in 2010 and by 32% in 2015.[38]
- Research by the ASU College of Nursing and Healthcare Innovation notes that while the number of newly licensed nurses and enrollment in schools of nursing has increased, nursing workforce turnover remains high. Hospitals' 14.9% turnover and 15.8% vacancy rates exceed those found in other industries.[39]
- At an average of $54,620 annually,[40] nursing salaries in Arizona (2004) are somewhat lower than the national average of $57,784.[41] Nationally, nursing salaries increased by 12.8% between 2000 and 2004 after adjusting for inflation (Figure 11).[42] Nursing salaries in Arizona increased by an unadjusted average of 23% between 2001 and 2005,[43] comparable to the national rate when adjusted for inflation.

Figure 11: Actual and Adjusted Average Annual RN Salaries in the US



Source: HRSA, National Sample Survey of Registered Nurses, 2004.

- Data from the Community Tracking Study (CTS),[44] which includes representative facilities from the Phoenix area, illustrate the short- and long-term strategies that hospitals are using to address the shortage of nurses. Short-term strategies include:
  - 75% of hospitals in CTS communities utilize temporary staff, while 31% utilize internal agencies and 19% use foreign nurses.
  - Overall, 78% of hospitals use pay and benefit strategies such as making salaries more competitive (69%), paying sign-on, retention or referral bonuses (44%), providing flexible scheduling (34%) or providing other benefits (13%).
- Many of the long-term strategies employed by hospitals in the CTS communities focus on education:
  - 69% of hospitals are expanding training capacity or opening new schools of nursing.
  - Other educational strategies include extended orientation programs for new nurses (41%), collaborative efforts to support or partner with nursing schools (34%) providing faculty support (28%) or clinical rotation experiences (25%) for nursing students, or other educational efforts.
- Beyond increasing staffing levels, hospitals are seeking ways to redesign work processes and nursing roles to take full advantage of support staff and to recognize the expertise of the experienced nurse:
  - 59% of CTS hospitals report making change to care delivery processes; 50% have made changes to the physical environment.
  - 50% of CTS hospitals report obtaining or seeking to obtain 'magnet hospital' credentialing status based on the higher retention, greater patient satisfaction and improved patient outcomes associated with magnet facilities.
- Hospitals in the Phoenix area report less robust efforts focused on the work environment and retention compared to other CTS communities. The mix of strategies employed in the Phoenix area include:
  - 48% of primary strategies focused on short-term efforts.
  - 40% of primary strategies focused on nurse education.
  - 12% of primary strategies focused on work environment and retention.
- Citing a study published in the *American Journal of Managed Care*, the Arizona Hospital and Healthcare Association notes that nurses constitute 44% of direct costs associated with inpatient care, and that each percentage point increase in the nursing shortage translates to a 0.96% increase in hospital inpatient costs per member for managed care organizations.[45]

Public Attitudes on Health System Reform

- According to a national survey, the two most important healthcare system issues government should address, health care costs and the lack of health insurance topped the list. There was considerably less interest in government addressing overall organization of the system, lawsuits, waste and care provided to illegal immigrants:[46]

1. Health care costs 43%
2. Uninsured/access to care 34%
3. Medicare/prescription drug program. . 15%
4. Lack of high-quality health care 11%
5. Government role in health care 8%
6. Illegal immigrants getting health care 3%
7. Waste/greed. 3%
8. Lawsuits 2%
9. Organization of the system 1%
10. Other 12%

- The congressionally mandated Citizens' Healthcare Working Group conducted a series of public forums across the country, including Phoenix and Tucson. Although the ordering was slightly different, participants in both events had similar rankings for options to increase access to care:[47]

Ten Proposed Options	Phoenix Ranking	Tucson Ranking
Create a National Health Program	1	2
Establish an Individual Insurance Mandate	3	1
Expand Neighborhood Health Clinics	2	3
Expand Medicare/FEHBP (Federal Employee Health Benefits Plan) Buy-In	5	4
Establish an Employer Insurance Mandate	4	9

Ten Proposed Options	Phoenix Ranking	Tucson Ranking
Expand Medicaid/SCHIP Buy-In	9	5
Expand Employer Tax Incentives	6	8
Establish Individual Tax Incentives	7	7
Increase State Program Flexibility	8	6
Rely on the Free Market	10	10

- The findings in Phoenix and Tucson are not outliers. In 16 of the 19 citizen forums, creating a national health program ranked as the #1 choice. Reliance on the free market was the least favorite option, ranking #10 of the ten options by participants in 16 of the 19 forums.[48]
- When asked where Arizona should place its public spending priorities to reach the goal of "health care that works for all Americans," Phoenix participants ranked the options as:*

1. Guarantee health insurance for all.
2. Invest in public health.
3. Improve access for minorities.
4. Guarantee enough providers.
5. Biomedical and technological research.
6. Develop health information technology.
7. Preserve Medicare and Medicaid.
8. Ensure health care for all, including safety net programs for the poor.

* Participants in the Tucson forum were not asked this question.

- Arizonans, like the rest of the country, are divided on whether public policy should continue to use tax rules to encourage employers to provide health insurance:[49]
  - In Phoenix, 53.1% of participants supported further tax policy incentives for employer-sponsored health insurance, while in Tucson the level of support for employer tax breaks was 50%.
  - Arizona was more supportive than the rest of the country on this issue. Nationally, 41.4% of forum participants supported public policy that used tax rules to encourage employer-based insurance. However, there was considerable variation in the level of support, ranging from 23.1% in Detroit to 86.8% in Baton Rouge.

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