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The Challenge of Health Care Delivery in Connecticut

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CHAPTER SIX

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The policy issues confronting the health care industry in Connecticut mirror those facing the rest of the nation. Most pressing are development and maintenance of a qualified and diverse workforce, access and financing for care, and the rising costs of health care services due to price inflation associated with rising personnel costs, malpractice insurance rates, including prescription drugs, and technology.

Health Care Workforce Shortage

Health care workforce assessment requires data regarding the present and future supply of health care workers and the demand for the workforce. In Connecticut, supply information is available indirectly through licensure data for the thirty-nine health professions that are licensed within the state through the Connecticut Department of Public Health.[1] These data do not provide information about percent of work effort or setting. The Connecticut Department of Labor provides annual data on filled health care positions within the state, workforce growth based on retrospective employment data, and expected workforce needs based on projected industry growth. These data do not identify available workforce currently unemployed or underutilized.[2]

Health workforce demand data is far more difficult to ascertain. Population studies can describe the number of health professionals required by a population or the amount of service typically provided, e.g., 900 RNs employed per 100,000 population or 40-60 physical therapy referrals/1,000 population/year.[3] Vacancy and projected vacancy rates indicate immediate demand but may not represent actual needs for necessary care as vacancies are influenced by cost containment and reimbursement constraints that mask actual need. The Connecticut Department of Public Health has attempted to clarify this estimate of need for nursing by commissioning a study by an external agency to determine best methods of assessing nursing workforce supply and demand. In their report, the Health Care Decisions Group, Inc. provide the measurement strategies needs to quantify workforce shortage for nurses in Connecticut.[4] Currently, these data are mostly unavailable for nursing as well as most other health professions in the state.

In May 2002, the Department of Public Health conducted a series of hearings, which included presentations of perceptions and anecdotal information regarding the nature and severity of the health care worker shortage in the most severely affected disciplines. The study also considered possible causes of the shortage and suggested strategies to address these.[5] The shortage in most disciplines is described as cyclical although the current shortage is also noted to be one of the most severe in recent years. Several factors have contributed to the severity, including a gradual increase in the demand for health care services by the public, the aging health care workforce currently available in Connecticut, low enrollments and growing attrition for health career training programs, lack of faculty for health professions education, and the lack of resources in the health care industry available to respond to these shortages. These factors combine to create a more severe current shortage, a forecast of persisting shortages in the health care delivery system, and a sense of pessimism about addressing these shortages, given the lack of available resources.[6]

For example, positions for registered nurses in Connecticut totaled 30,560 in 2002 with an expected increase to 36,740 by 2010,

an increase of 20%. In 2002, 863 RN graduates became eligible for employment while 1,235 RN openings existed.[7] Existing shortages that year were 10.3%, up from 3.7% in 1997.[8] In spite of this growing demand, qualified nursing candidates have been turned away from training programs because of a lack of qualified faculty and other resources available to nursing programs in Connecticut.[9] With these trends continuing, the Health Resources and Service Administration of the U.S. Department of Health and Human Services projects the nursing shortage in Connecticut will be the fifth worst in the nation by 2020, with a 54.9% shortfall between supply and demand.[10]

Increased health care service demand is the product of more informed consumers, greater availability of technology, and an aging population. As public awareness, public health education, and consumerism increase, so does the patient/client demand for health services.[11] Even with the influence of managed care as a mediator to ration health care services, consumers have become more informed and more demanding in regard to health care services. Available technology offers more diagnostic tools and greater intervention options for consideration by both the health care provider and the patient. Also, as the national and state populations grow older, their health care needs increase. From 1990 to 2000 the Connecticut state population sharply decreased in the 15 to 34 year old category while increasing in the 35 to 54 year-old category.[12] Specifically, health care needs due to chronic illness and disease increase, requiring in particular, more health care services such as long-term and home health care, polypharmacy, and rehabilitation and social services.[13]

The aging health care workforce is an additional complication and is the result of several factors that demonstrate the complexity of the health care workforce shortage. These factors include greater alternative opportunity for traditional age female students as they enter post-secondary education (thus reducing those choosing health care as a career), a decrease in the desirability of health care as a career option for new students, and a greater number of older students entering health care training programs.[14] As a result, the current workforce continues to age with insufficient replacement of younger workers leading to an increased

workforce shortage in the future. For example, the average age of an RN working in Connecticut has reached forty-six years.[15]

Low enrollment in health professions programs is the product of more attractive career alternatives, particularly for health careers at the technical level. Stressful working conditions, low wages, and lack of career mobility are frequently cited by students as reasons to choose alternatives to technical level health care positions. For professional level careers, the cost of education, stressful and restrictive working conditions and the lack of professional recognition are cited as negative factors influencing enrollment in health care education programs. Growing attrition from all these programs is associated with limited student preparation in math and the sciences in middle and high school years, leading to less-qualified and more vulnerable students in health care education programs. In nursing, attrition in Connecticut has increased from 11% in 1995 to 18% in 2000.[16] Enrollment in health professions educational programs still does not adequately represent the diversity of the population, suggesting that recruitment from minority populations can still be significantly improved.[17] This is of particular concern when rural and inner-city health care settings often demonstrate the greatest need for health care personnel evidenced by their medically underserved designation, and yet students from those communities are not sufficiently represented.[18]

Faculty shortages and associated limitations of other resources have prevented health professions programs from rapidly responding to increased applicant pools. Program costs are high on a per student basis, and budget increases to expand programs have been limited in both public and independent institutions. Enrollments declined gradually throughout the 1990s for most health professions. Although classes have increased modestly in the past three years, they have not returned to the class sizes of a decade ago.[19] In the case of nursing applicants nationally, as many as 11,000 students annually have been denied admissions to nursing programs because of a lack of program resources, including qualified faculty, according to the American Association of Colleges of Nursing.[20] Ironically, some faculty members have left health professions education to return to the health care

workforce because salaries are more competitive and working conditions are more negotiable. This further constrains training of a future health care workforce.

New resources to address health care workforce shortages unfortunately are often used for the short-term solution such as enhancements to fill vacancies. Such short-term solutions (i.e., sign-on bonuses, hiring "traveling" or temp service health professionals) limits resources that can be used to improve working conditions and salaries for health care staff, provide retention incentives, and offer opportunities for professional development and career ladders.[21] As a result, these resource inefficiencies lead to a persistent shortage of resources and a cyclical nature to workforce problems.[22]

Disciplines most affected by the workforce shortages have been identified. These include nursing and home health aides, dental hygienists, emergency medical technicians, nurses (registered and practical), pharmacists, physical therapists, respiratory therapists, radiation technologist and sanitarians, physicians, and dentists.[23] Plans to understand and address the health workforce shortage have been outlined by the Connecticut Department of Public Health.[24] These have included the promotion of public education/health care industry collaborations for recruitment, training and placement of health care workers,[25] establishment of an Allied Health Workforce Policy board to monitor health professions workforce data, development of career ladder strategies within the state to promote recruitment and retention of qualified students,[26] and creation of a nursing faculty incentive program.[27] These efforts create infrastructure to begin to address shortages, but their impact on the current shortage is likely to be gradual.

Access to Health Care

Access to health care is determined by two issues: (1) availability and distribution of health services, and (2) health care coverage to pay for services. In Connecticut, the Office of Health Care Access (OHCA) monitors access to quality health care by examining the extent of health care coverage, measuring the numbers of uninsured Connecticut residents, and regulating access,

hospital utilization, and performance.[28] OHCA's primary functions are to advise governmental policy makers of health care issues, and design and direct health care system development.

Apart from non-emergency care, patients at Connecticut's hospitals are treated regardless of their ability to pay, resulting in uncompensated costs to hospitals.[29] OHCA balances the need for and access to health services with facilities' financial health through the administration of two programs: One is the Certificate of Need (CON) program, which ensures access to quality health care for Connecticut residents and regulates service duplication and availability. Hospitals and health care facilities are required to submit Letters of Intent (LOI) and CONs to OHCA to realign, consolidate, or terminate health care services at their facility.[30] The second program is the Disproportionate Share Hospital Program. Each year, Connecticut hospitals file financial data with OHCA, including uncompensated care costs. OHCA then distributes funds to the state's acute care hospitals based upon each hospital's care as a percentage of statewide totals. CONs and LOIs reflect major trends in the state's health care delivery system. OHCA then uses this information to advise policymakers.

Certificate of Need applications through 2002 indicated a significant shortage of behavioral health services throughout the state, with a 20% increase in demand for inpatient psychiatric services.[31] Private and public insurers reimburse behavioral health services at a rate less than the cost of care, so many facilities offering these services have decreased their bed capacity, terminated services, or closed.[32] This has resulted in an inadequate number of inpatient psychiatric beds to meet demand, requiring persons in need of behavioral health care to wait weeks for services. In addition, private insurers require advance mental health screenings, restrict treatment and impose large deductibles, which impedes access to behavioral health care that is equal to that of physical health care. Availability of behavioral health care services is anticipated to be a major health care issue into the future.

Other critical health care access issues facing Connecticut's future include: the establishment of full-service cardiac programs in community hospitals; procurement of new technology, such as

hyperbaric oxygen therapy and imaging equipment; the development of ambulatory surgical centers and standards for such; the overcrowding of emergency rooms and trauma centers in the state; and the restructuring of services and collaborative partnerships among providers.[33] The trend to increase the availability of complex technological and ambulatory surgical services to a greater number of hospitals in the state has the unintended consequence of contributing to the rising cost of health care.

Health insurance is essential to preventive care and reducing the cost of medical treatment through timely intervention for medical conditions and reducing lost work time. The Kaiser Family Foundation reported that half of uninsured adults postponed seeking medical treatment when they needed it.[34] Delaying treatment leads to serious consequences including increased mortality, more serious illnesses, health problems and delays in diagnosing diseases. Research conducted by the Institute of Medicine reports that the lack of health insurance results in the premature death of 18,000 Americans annually, and projects that the nation's mortality rate could be reduced by 5% to 15% if all persons had continuous health coverage.[35]

Quality health care is plentiful but the ability to pay for care is inequitably distributed, with approximately 17% of non-elderly U.S. residents lacking basic health care coverage; two thirds of whom are from low-income families.[36] According to the U.S. Census Bureau's Current Population Survey, the percentage of uninsured Connecticut residents rose from 9% in 1999 to 12% in 2003.[37] While less than the national average, it is the state's largest increase in more than ten years, resulting in an estimated 351,786 non-elderly persons in Connecticut lacking health insurance coverage.[38] The rise in the numbers of the state's uninsured is attributed to the 2001 economic downturn, when many of the state's residents lost their employer-sponsored insurance. Disproportionately more non-elderly adults than children are uninsured due to gaps and limits in both private and public health care coverage.[39] Virtually all elderly persons over 65 years of age are eligible for health coverage through Medicare, and the elderly poor may also be eligible for Medicaid. Medicaid and the State Children's Health Insurance Program (SCHIP) programs help fill

the gap created by the decrease in employer-sponsored coverage for children, however eligibility limits in these programs contribute to increasing the gap created by the loss of job-based coverage for non-elderly adults.

Sixty-one percent of Connecticut's employed residents receive health insurance coverage through their employers, 9% of these offer employee only coverage, and 39% of Connecticut's employers do not offer any health care coverage.[40] Three-quarters of the employer-sponsored health plans in the state have work-week hour eligibility requirements and waiting periods, qualifying 80% of their employees for health insurance at any given time. Of eligible employees, three-quarters enroll in their employer-sponsored health insurance programs.[41] Employees may elect not to enroll because they are covered under a spouse's plan, but many do not enroll because they cannot afford the premiums or deductibles.[42] The least expensive employer-sponsored health insurance premiums in Connecticut costs the employee an average of $88.41 per month for employee-only coverage, and $264.96 per month for dependent or family coverage.[43]

Health care for Uninsured Kids and Youth (HUSKY) is Connecticut's public health insurance program for children and teens under nineteen years of age. HUSKY was created by the state as a result of the national SCHIP program authorized by Congress under Title XXI of the Social Security Act, enabling states to implement health insurance programs with a mix of state and federal funds. It is administered by Connecticut's Department of Social Services (DSS) and includes three health coverage programs: HUSKY-A provides health services through the federal Medicaid program and is free for children in families with incomes up to 185% of the Federal Poverty Level (FPL); HUSKY-B was created specifically through SCHIP for children in higher income families with low-cost premiums scaled to family income and size; and HUSKY PLUS is a supplemental benefits plan for children with special physical or behavioral health care needs.[44]

The SCHIP and HUSKY programs have been extremely successful in assuring greater access to health care through its health care coverage programs for the nations' and Connecticut's

low-income children. Seventy-five percent of Medicaid insured children received well-child visits vs. only 46% of uninsured children.[45] The SCHIP program has been responsible for decreasing the percentage of the nation's uninsured poor children from 22.4% in 1997 to 15.4% in 2003.[46] Since HUSKY's implementation in 1998, enrollment increased steadily to its present number of 190,000 children participating in HUSKY-A.[47] Despite HUSKY's success, 71,000 Connecticut children remain uninsured.[48]

The HUSKY and Medicaid programs have been tremendously successful in assuring health care access to the state's children, but budget constraints are jeopardizing these programs. In August 2003, Connecticut's General Assembly passed its 2004-05 budgets, severely curtailing the Medicaid and HUSKY-A programs. Proposed changes include: instituting premiums; instituting co-payments on services for children; reduction of HUSKY-A benefits; and accepting a global cap on federal spending for the Medicaid program.[49] With the exception of the optional Medicaid program for "medically needy" persons (elders and disabled persons whose income is above Medicaid eligibility requirements but who have high medical expenses), the proposed changes require a federal waiver of Medicaid's minimum standards. Connecticut's Department of Social Services (DSS) is reportedly working on a plan to apply for a federal waiver, but as of August 21, 2004, the Governor's Legislative Office reports that DSS has not yet applied for the federal waiver.

The proposed changes to HUSKY-A and Medicaid spurred a flurry of bills presented to the Connecticut legislature in an attempt to reverse the negative effects of the proposed changes. The Connecticut Hospital Association and Georgetown University's Health Policy Institute testified before state legislators as to the consequences the proposed changes would have on the health of Connecticut's residents and its economy:[50]

- 86,000 people in Connecticut could be expected to lose health coverage.[51]
- 69% of these or 59,638 would be children.[52]

- 1,006 would be pregnant women who will have difficulty obtaining pre-natal care.[53] Their babies will not be automatically covered for well-baby care and immunizations.

- Half of those who lose coverage would be children and parents whose incomes fall below the FPL. The remainder would be children and parents whose incomes range from 100% to 184% of the FPL, further impeding the ability of financially struggling families to get their children health care.[54]

- 7,330 medically needy elderly and disabled persons can be expected to lose Medicaid.[55]

- Reduction of benefits and the elimination of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are likely to increase the number and severity of preventable childhood health problems.[56]

- Connecticut can expect to lose over $96 million in federal funding and experience an annual cost shift to hospitals of over $93 million as newly uninsured persons seek health care at their only remaining option, hospital emergency rooms.[57]

If the proposed changes should be implemented, Connecticut would earn the dubious distinction of being the first and only state to institute premiums for families with incomes under the FPL, the first to charge co-payments for all children in its Medicaid program, the first and only state to accept a global cap on federal Medicaid funding, and the first to abolish federal minimum standards for children's health care services.[58]

Access to prescription medications and the rising costs of those medications has captured the nation's attention. The lack of health insurance coverage for prescription medications are of particular concern to the public and legislators. Since 1992, the number of prescription drugs purchased by Americans increased from $1.9 billion to $3.3 billion; retail prices of these drugs

increased more than twice the rate of inflation each year for the past ten years; and the top selling prescription drugs are newer, higher-priced drugs that have replaced older, less-expensive drugs.[59] With rising prices, the share of prescription drug costs paid by both private and public insurers has increased steadily. In 2002, private insurers accounted for 48% and Medicaid accounted for 18% of drug payments.[60]

Still, prescription drug coverage offered by private insurers and employer-sponsored health plans varies from plan to plan and from company to company, leaving approximately 23% of America's non-elderly adults and children and 38% of the elderly without prescription drug coverage.[61] While the Medicaid and HUSKY programs offer prescription drug coverage, Medicare offers only a capped discount through the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). Each state will be responsible for a portion of the cost of MMA for elders who are eligible for both Medicaid and Medicare.[62] ConnPACE, Connecticut's prescription drug coverage program for low-income seniors, helps to fill in the gap. The chapter on Aging in this book more fully discusses the issue of prescription drug coverage for elders.

Rising Health Care Costs

Health care spending in the United States exceeded $1 trillion in 2002. Expenditures represented 14.9% of the GDP in 2002 and is increasing at a rate twice that of the GDP.[63] A comparison of U.S. spending to that of other industrial countries indicates that while the U.S. spends more, the U.S. was below the median on measures of utilization (physician visits, hospital admissions, average length of stay, and so on).[64]

Hospital spending, the largest category of health care expenditures, approached $5 billion in 2002.[65] While some of the increase in hospital spending is attributed to an increase in volume and intensity of services, the dominant source is price inflation. A large share of price inflation is attributed to rising personnel costs (exacerbated by the nursing shortage) and medical liability insurance costs.[66] Despite the continued increase in spending for

hospital services, many hospitals are challenged to achieve a positive operating margin. This is especially true for hospitals in Connecticut.

Over the past ten years Connecticut hospitals have struggled financially. From 1994 to 2003, the consolidated operating margin for Connecticut acute care hospitals ranged from a high of 2.48% in 1996 to a low of -0.98% in 2000, where a 3% to 5% margin is considered an indicator of long-term financial health.[67] In FY 2003, the median operating margin for Connecticut acute care hospitals was 0.3%, with thirteen out of thirty-one hospitals reporting losses.[68] Statewide median total margins for Connecticut acute care hospitals declined from 3.1 in FY 2001 to 0.1% in FY 2002, and increased slightly to 0.4% in FY 2003.[69]

Low operating margins in Connecticut hospitals are attributed to rising costs for personnel (salaries, pensions, and employee benefits) and technology, high insurance premiums, and increased demand for services.[70] In FY 2003, pension expenses increased 63%, employee fringe benefits increased 17%, and malpractice insurance premiums increased 65% over FY 2002 costs.[71] Forecasts by the OHCA predict an average 6% increase per year for hospital expenses through 2007 with the largest single expense (58%) being attributed to non-physician salaries and fringe benefits and the fastest growing sector (11% growth per year) being supply and drug expenditures.[72]

In addition to rising costs, operating budgets are negatively affected by revenue-related issues, such as low reimbursement rates from federal and state funded programs, uncompensated care, and the 2002 drop in the stock market.[73] Uncompensated care costs as a percent of total hospital expenses averaged 3.5% for Connecticut hospitals from FY 1999 to FY 2001 and dropped slightly to 2.1% in FY 2003. Reimbursements from public programs, as measured by payment to cost ratios, have remained at relatively steady but inadequate levels. While non-government reimbursement payment to cost ratios for FY 2001 to FY 2003 were between 1.0 and 1.2, reimbursement ratios for the Medicare program range were between 0.9 and 1.0, and were between 0.70 and 0.80 for the Medicaid program.[74]

Total net revenue increases of 8.5% barely kept pace with an increase in total hospital expenses of 8.33% in FY 2003, as income

from development activities and appreciation of assets offset low or negative operating margins.[75] The Connecticut Hospital Association (CHA) on behalf of its membership has developed an ambitious legislative agenda in which the improvement of Medicaid reimbursement rates for hospitals and relief from increasing medical costs of medical liability insurance play prominent roles.[76] While there was much activity during the 2003 and 2004 legislative sessions, proposals for reform received strong support and strong opposition. Lobbying to achieve adequate increase in Medicaid reimbursement has had limited success as the state struggles with its own fiscal issues. This issue is likely to remain on the front burner for key stake-holders for the foreseeable future. Similarly, reform of the medical liability system is a controversial topic. Medical malpractice insurance will remain as a key issue for consideration by the state legislature during the next legislative session.[77] One proposal (SB-61) for malpractice insurance reform remained alive during the 2004 state legislative session despite considerable revisions. This bill, if approved, would establish a "Healthy Connecticut Fund" that would allow health providers to deduct their medical liability premiums on their income taxes and provide for a reinsurance fund to cover a percentage of the costs of medical malpractice awards or settlements for physicians and hospitals that exceed a certain amount.[78]

Recommendations

Solutions for the continuing workforce shortage are complex. More resources, while necessary, is not the singular solution, as health care expenditures in the United States already exceed any other industrialized country in per capita spending, yet result in average or below average indicators of health in the nation's population. Policy changes combined with resources are needed. First, opportunities for current health care workers, such as professional development resources, career ladders, and work schedules that accommodate family and community, are needed to aid in recruitment. Second, establishment of career tracks beginning in middle and high school, including early exposure to health professions, role modeling, and sufficient math and science

preparation will help create a greater pool of qualified and motivated students. Third, resources for workforce enhancement must be redirected toward longer-term solutions that promote retention, professional development, and workforce satisfaction, rather than short-term solutions that inflate health care costs without achieving workforce stability.

Information regarding the health care workforce must become a readily available resource for the policymaking bodies of the state, if they are to manage rather than react to health workforce shortages, and develop long-term solutions rather than short-term fixes. First, licensure agencies for health care workers within the Secretary of State's office must provide data on the numbers of health care workers and workforce demographics, types of employment settings, current vacancies and projected workforce as indicated by currently enrolled health care students. Second, the Department of Public Health should develop health care needs projections based on population demographics, health indicators, and health care facilities and services. Trends in changing health care demands, technology, and health care financing should also be studied. Finally, the Department of Higher Education should develop plans to assist educational institutions, both public and private, to provide needed health professions education programs, student financial aid, and educational opportunities for health career advancement for the current workforce. Currently, much of the data needed for these initiatives are available through existing sources if collected, organized, and analyzed for these purposes. Similarly, resources for these initiatives may already exist but are directed elsewhere. The health care workforce shortage is a significant, persisting, and growing concern for Connecticut policy makers. It will require priority status in the distribution of the state's resources and efforts in the coming years.

In regard to access, availability, and distribution of high quality health care services is more than adequate to serve the residents of the state, except for behavioral health services. Connecticut leads the nation in immunizations for children and boasts numbers of uninsured persons less than the national average. Despite this good news, approximately 351,000 of Connecticut's residents still lack health insurance coverage. This number is likely to

rise by another 86,000 if the proposed changes to the state's Medicaid and HUSKY programs become a reality. A coordinated system of health care coverage is needed in the state that will provide incentives for participation of small companies, reduce costs for individuals currently covered, and extend coverage to those who are uninsured.

Availability of inpatient psychiatric beds remains a critical access issue in the state. Legislation is needed that requires public and private health insurers reimbursement rates to cover the cost of care and eventually achieve parity with reimbursement for physical health care. Otherwise, hospitals are motivated to decrease their psychiatric bed capacity.

Under the current systems of delivery of health care in Connecticut, hospitals and other facilities and individual practitioners will continue to experience climbing costs threatening their ability to provide quality services to the citizens of the state. As costs climb, so will prices, making services less affordable. The health care workforce will suffer as a result as health providers seek ways to cut their leading expense: personnel. If left unchecked, workforce shortages will worsen, due to an aging health care workforce, an aging health professions faculty, and the lack of resources to expand program enrollments in educational institutions. The state government and other payers will continue to contain costs by decreasing accessibility and limiting eligibility for health care services. The poor, the elderly, and the disabled, who are the primary beneficiaries of publicly-funded health care, will bear the burden. Systemic change is needed to ensure quality health care will be available when it is needed. Simply seeking increases in reimbursement rates or shifting the costs of malpractice insurance premiums from health care providers to tax payers is not likely to result in long-term solutions. Both providers and those who pay for services and goods will need to collaborate more than they have in the past to use their buying power to bring down prices. The approach to solving the malpractice crisis may also need to change its focus from capping awards and shifting the costs of malpractice premiums to taxpayers to reducing the monopoly that allows insurers to raise prices unchecked. Finding ways to create realistic expectations and improving satisfaction among consumers may also lead to a decrease in litigation.

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