CALIFORNIA
HEALTH CARE ALMANAC
REGIONAL MARKETS ISSUE BRIEF JULY 2009

CALIFORNIA HEALTHCARE FOUNDATION

Fresno: Poor Economy, Poor Health Stress an Already Fragmented System

Fresno Market Background

The greater Fresno area, with a total population of 1.6 million people in 2007 (4.5 percent of the state's population), has recently seen strong growth: 22 percent in the past decade, compared with a state average of 14 percent, and 9 percent in the past five years, more than double the state average (see Table 1 on page 2).

Fresno, one of the poorest communities in California, is sometimes referred to as "the Appalachia of the West." Nearly half of the population has a family income below 200 percent of the federal poverty level, compared to one-third statewide. Moreover, the income gap between rich and poor residents is strikingly larger in Fresno than in California as a whole, and the gap has widened substantially in Fresno since 1980.[1] Educational attainment is also well below the California average: 22 percent of adults aged 25 and older hold college degrees, compared with 36 percent statewide. The Fresno area is characterized by a much higher proportion of Latinos and much lower proportions of whites and Asians than the state overall. The health status of Fresno residents is worse than average in the state, with more people self-reporting fair or poor health and living with chronic conditions such as asthma and diabetes.

Unemployment is high and rising in the greater Fresno area. The unemployment rate reached 15.5 percent in Fresno in January 2009 (substantially higher than the state average of 10.6 percent), representing a large increase from Fresno's rate in January 2008 of 10.6 percent.

The agricultural sector is an important part of the economy in the greater Fresno area. Although agriculture directly accounts for fewer than one in five jobs, it has a much greater impact on the area's economy when related businesses such as packing, processing, and transporting agricultural products are included.[2] The largest employers in the market tend to be public-sector employers, including the county, city, and school district of Fresno. The two major health systems, Community Medical Centers (CMC) and St. Agnes Medical Center (St. Agnes), are among the largest private, non-agricultural employers.

Hospitals Face Poor and Worsening Payer Mix

Nearly all of the hospitals in the greater Fresno area are not-for-profit or government district hospitals.[3] The community has acute care hospital bed capacity that is slightly lower than the state average (173 versus 182 beds per 100,000 residents), and a higher occupancy rate than the state average (68 versus 59 percent). According to respondents, major hospitals sometimes run near capacity during certain times of the year.

The major hospital systems in Fresno County are CMC, with nearly 800 beds in three hospitals (representing a 52 percent market share); St. Agnes, with more than 400 beds in one hospital (with a market share of 30 percent); and Kaiser, with 165 beds in one hospital (with a market share of 10 percent). These hospitals—particularly CMC and St. Agnes—serve a large geographic area and routinely receive referrals from neighboring counties.

Outside Fresno County, Children's Hospital of Central California in Madera County is a major presence. Children's Hospital receives many regional referrals, as most area hospitals have limited, if any, pediatric services. Tulare County, the most populous county after Fresno, has three hospitals; the largest is Kaweah Delta District Hospital in Visalia, with nearly 500 beds. In Kings and Madera counties, the largest hospitals are community hospitals with about 100 beds each; Mariposa County has a small community hospital.

The hospital market in the greater Fresno area is segmented, with certain hospitals — particularly in outlying areas — controlling distinct geographic areas. Within Fresno itself, the relationship between the two key players, CMC and St. Agnes, is characterized by little, if any, collaboration and long-standing competition, bordering on animosity, according to several respondents.

CMC, the largest system, operates the only Level I trauma center in the region and has a major teaching program affiliated with UCSF. St. Agnes has always been regarded as the premier hospital in the market; it is located in the more affluent north side of Fresno. However, recent, highly publicized outbreaks of methicillin-resistant staphylococcus aureus (MRSA) infections and Legionnaires' disease at St. Agnes have raised questions about patient care quality. The MRSA infections resulted in a temporary shutdown of St. Agnes' cardiac program, forcing Kaiser — which contracts with St. Agnes for cardiac care for its Fresno-area enrollees — to send enrollees either to a CMC facility or a Kaiser hospital elsewhere in the

Table 1. Demographic and Health System Characteristics: Fresno Region vs. California

POPULATION STATISTICS	Fresno	California
Total population	1,634,325	36,553,215
Population growth, 1997–2007	21.6%	13.6%
Population growth, 2002–2007	9.0%	4.1%
AGE OF POPULATION		
Persons under 5 years old	8.7%*	7.3%
Persons under 18 years old	30.6%*	26.9%
Persons 18 to 64 years old	60.3%*	62.5%
Persons 65 years and older	9.1%*	10.6%
RACE/ETHNICITY		
White non-Latino	37.4%*	43.3%
African American non-Latino	4.0%*	5.8%
Latino	50.8%*	36.1%
Asian non-Latino	5.3%*	11.8%
Other race non-Latino	2.6%*	3.1%
Foreign-born	20.4%*	25.7%
Limited/no English, adults	41.3%*	35.2%
EDUCATION, ADULTS 25 AND OLDER		
High school degree or higher	71.9%*	82.9%
College degree or higher	22.2%*	35.7%
HEALTH STATUS		
Fair/poor health status	19.8%*	15.8%
Diabetes	10.5%*	7.8%
Asthma	16.7%*	13.6%
Heart disease, adults	6.4%*	6.3%
ECONOMIC INDICATORS		
Below 100% federal poverty level	24.0%*	15.7%
Below 200% federal poverty level	45.1%*	33.5%
Household income above $50,000	39.7%*	51.1%
Unemployment rate, January 2009	15.5%	10.6%
HEALTH INSURANCE, ALL AGES		
Private insurance	46.8%*	59.1%
Medicare	7.0%*	8.5%
Medi-Cal and other public programs	30.5%*	19.3%
Uninsured	15.7%*	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008		
Physicians per 100,000 population	118	174
Primary care physicians per 100,000 population	45	59
Dentists per 100,000 population	43	69
HOSPITALS		
Staffed community, acute care hospital beds per 100,000 population, 2006	173	182
Hospital concentration, 2006 (Herfindahl index)	702	1,380
Operating margin including net Disproportionate Share Hospital payments	3.0%	1.2%
Occupancy rate for licensed beds	67.9%	59.0%
Average length of stay (days)	4.4	4.5
Paid full-time equivalents per 1000 adjusted patient days	15.0	15.7
Total operating expense per adjusted patient day	$1,883	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted. Fresno region includes Fresno, Kings, Madera, Mariposa and Tulare counties.

*Estimate does not include Mariposa County because the California Health Interview Survey public-use dataset does not report separate estimates for very small counties such as Mariposa.

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.

state. The Kaiser contract reportedly accounted for about 40 percent of St. Agnes' cardiac business.

Hospital respondents universally reported an unfavorable payer mix—a reflection of the community's high levels of poverty, lack of insurance, and Medi-Cal coverage relative to its commercial payer base. St. Agnes reported that its patient base is 20 to 25 percent Medi-Cal, while CMC reported a base of more than 40 percent Medi-Cal.

Despite the community's poor payer mix, most hospitals in the Fresno area were at least breaking even financially as of 2007. Financial performance varied, however, with outlying hospitals generally having weaker results than hospitals in the immediate Fresno area. Over the past several years, CMC turned around its negative financial performance and has become profitable. Still, CMC continues to lose money on a 30-year contract with Fresno County to provide medically indigent care. The contract pays $19 million annually for services that reportedly cost $40 to $45 million. St. Agnes, described by one respondent as "the cash cow of [the parent corporation] Trinity Health's 40 hospitals," continues to be profitable, although the recent quality problems and subsequent decline in patient volume have reportedly had a negative impact on financial performance.

With the exception of Kaiser, the major hospitals share some key competitive strategies. First, they are expanding capacity to respond to population growth. CMC recently opened 160 new beds on its Community Regional Medical Center (CRMC) campus, including 56 neonatal intensive care beds. St. Agnes, which opened a new patient tower in 2005, plans to add 36 neurosurgery and critical care beds. Kaweah Delta has a $1.5 billion master plan to expand its campus; the first phase is a $140 million, 130-bed expansion slated for completion in 2009. In some cases, new hospital construction has also focused on complying with state seismic standards, but this has often been secondary to capacity expansion because seismic compliance is less demanding for the Fresno area than for higher-risk communities such as the Bay Area.

Hospitals are adding new services and expanding existing services, in large part to stem the exodus of potential patients to other markets, such as Los Angeles and the Bay Area. A CMC respondent cited a 2004 University of California at Merced analysis showing nearly $500 million of medical care services leaving the greater Fresno area annually. Patients seek care in other areas for a variety of reasons, including: certain services are not available locally; long wait times because of physician shortages; and perceptions that the quality of care of some local providers is poor. Among the new services being launched are neurosciences, robotics, and radio-surgery programs at both CMC and St. Agnes. CMC also is launching a breast cancer center and expanding its orthopedic surgery lines.

Hospitals also are developing and emphasizing affiliations with academic teaching programs. CMC, as mentioned previously, is affiliated with UCSF; Kaweah Delta is beginning to work with UC Irvine; and St. Agnes has an affiliation with Stanford for cardiac services, with plans to add neurosciences soon. Reasons for these affiliations vary but include supporting training programs, improving the quality of care, enhancing hospital reputations, and bringing more physicians into the market.

Respondents' characterizations of the quality of care provided in the Fresno area varied widely, ranging from poor to good. One hospital respondent described it as "good, but not world-renowned," while another said, "If I got really sick, put me on a bird to Stanford." Respondents agreed that the poor health status of much of the population, coupled with poor socioeconomic dynamics, posed particular quality challenges. Several respondents also cited the market's low managed care penetration as a factor contributing to the variable quality. This is in contrast to other California communities where a strong managed care presence has been instrumental in increasing providers' accountability for the quality of care they provide.

Physicians in Short Supply, Difficult to Recruit

The Fresno community has a serious shortage of both primary care and specialist physicians—an acute problem in the immediate Fresno area and worse in outlying areas. Overall, the greater Fresno area has 45 primary care physicians per 100,000 residents, compared with 59 statewide; and 118 physicians overall per 100,000 residents, compared with 174 statewide. Not only is the current physician supply inadequate, but physicians are aging, leading market observers to expect shortages to worsen. Nurses and dentists are also in short supply, and the federal government classifies most of the market as a health professional shortage area. When recruiting new physicians and dentists, provider organizations sometimes compete with the state prison system, whose higher salaries reportedly have driven up labor costs for some hospitals.

Among the specialties cited as being in short supply were neurosurgery; general surgery; cardiology; gastroenterology; plastic surgery for trauma care; dermatology; oncology; ear, nose and throat; ophthalmology; and psychiatry. Physician shortages often result in long appointment wait times—a key reason for many insured patients to seek medical care outside the local market. For example, wait times for dermatologist appointments are reportedly nine to 12 months.

Respondents reported that recruiting new physicians to the Fresno area is extremely challenging because of such factors as poor payer mix, poor reimbursement, call-coverage obligations, and quality-of-life considerations, including poor air quality and lack of cultural opportunities. Recruiting efforts also face resistance from physicians already in the Fresno market. According to one hospital executive, "[Physicians] are overworked, but there is no interest in bringing in more people. It's all about the money."

The physician shortage would be even more acute if not for the substantial number of foreign-born physicians practicing in the greater Fresno area. Respondents cited, for example, the high concentration of Indian and Pakistani physicians in the area. These physicians, reportedly attracted to the Fresno region by the sizable ethnic communities already established there, often focus their medical practices on patients from the same ethnic background.

Fresno has few large physician practices, and the outlying areas have virtually none. Physicians often practice either solo or in small groups of fewer than five physicians, and single specialty is the dominant practice type. Santé Community Physicians, affiliated with CMC, is the dominant physician organization in the market; it is an independent practice association (IPA) that represents about 1,200 physicians—at least 90 percent of the practicing physicians in the area. While there are other entities identifying themselves as IPAs, a Santé respondent noted that Santé IPA was the only "real" IPA, "if you define 'real' as…accepting risk [via capitation] from a health plan and managing that risk and paying physicians."

Tensions, Lack of Alignment Between Hospitals and Physicians

Although physicians often have privileges at multiple hospitals, they tend to concentrate their practices at one hospital. Call coverage has been a source of friction between hospitals and physicians. Because of physician shortages, most hospitals must pay stipends to physicians to provide call coverage. Per diems vary widely, with general surgeons and neurosurgeons reportedly receiving the largest stipends, often ranging from $2,000 to $4,000 per day. Hospitals are increasing their use of hospitalists to address call-coverage issues.

Unlike many other California markets, there is limited formal integration between hospitals and physicians. Relationships historically have been contentious and distrustful, although the degree of conflict and cooperation tends to fluctuate over time with individual hospitals and physicians. CMC's relationship with its physicians reportedly improved recently, while St. Agnes' has deteriorated. New leadership at CMC has focused on improving physician

relationships, while much of the tension at St. Agnes has revolved around leadership turmoil and significant quality problems. St. Agnes entered into an agreement with Stanford to help improve the quality of its cardiac program, but a hospital respondent noted: "It's been controversial. [The physicians] were making a nice living because they were all there was in town and then we brought in the big guns. That wasn't well taken. In hindsight, it's been rough."

The market has seen a longstanding and extensive movement of some services — including imaging, orthopedics, plastic surgery, and endoscopies — out of hospitals to physicians' offices or physician-owned facilities. Many respondents suggested that physicians' historical and ongoing dissatisfaction with the area's hospitals is at the root of this trend. One hospital executive said, "This is the wild, wild west. Within the area around St. Agnes Medical Center, there are 15 ambulatory surgi-centers within two miles." However, the market may have reached a saturation point for ambulatory surgery centers, with some facilities recently going out of business.

California's prohibition of the corporate practice of medicine limits options for hospital-physician alignment, as hospitals generally cannot employ physicians directly. Unlike hospitals in other California communities that have successfully used the foundation model to recruit and align more closely with physicians, there are no existing foundations in the Fresno area, although several hospitals reportedly are exploring the feasibility of pursuing such a strategy.[4] Hospitals' efforts to align with physicians have focused on joint ventures, but many such initiatives have failed. For example, Plaza Surgery Center, a joint venture between St. Agnes and a large surgical group, was abandoned in 2007 because it was not financially viable. Fresno Heart and Surgical Hospital, formerly a joint venture between CMC and a group of cardiologists and cardiac surgeons, could not break even financially; CMC eventually bought out the physicians' share of the business.

A Fragmented, Inadequate Safety Net

Fresno's safety net is generally considered weak, fragmented, and inadequate relative to the needs of the population. Demands on the safety net are higher than in most other California communities because of disproportionate levels of poverty — mirrored by a large Medi-Cal population, unemployment, lack of insurance, and poor health. The community's unfavorable payer mix means that there is a small commercial payer base to cross-subsidize care for low-income people.

An additional pressure on the safety net, according to many respondents, is the lower funding that the Fresno community receives from the state for health care on a per capita basis compared with many other California communities. Medi-Cal fee-for-service rates are constant throughout the state, but payment for federally qualified health centers (FQHCs), although enhanced, varies by region of the state and reflects, in part, historical utilization patterns. Respondents reported that Medi-Cal funding is generally lower in the greater Fresno market because of historic underutilization of services and lower negotiated provider reimbursement rates.

Health care is considered a low priority for county governments, especially Fresno. California counties use state realignment funds to support medically indigent programs, but Fresno reportedly is one of only a few California counties to use a portion of its realignment funds to pay for prison health care.[5] In addition, eligibility for Fresno County's medically indigent program is restricted to adults aged 21 to 64 with incomes below 63 percent of poverty — the most stringent income eligibility level of all California counties. A public advocacy group has sued to challenge the low eligibility standard. Tulare and Madera counties have higher income limits for their medically indigent programs — 275 percent and 200 percent of poverty, respectively — but undocumented immigrants are excluded from eligibility, while they are eligible in Fresno County.

Community Regional Medical Center (CRMC) and its nine outpatient clinics serve as Fresno County's primary safety-net provider; CRMC also is the main tertiary care safety-net provider for the greater Fresno area. Additionally, Fresno County has a number of well-established FQHCs. The largest is United Health Centers, which operates seven sites and serves a primarily rural population. Sequoia Community Health Centers, which served primarily urban Fresno residents, was another major FQHC; it declared bankruptcy in 2008 and subsequently was taken over by Clinica Sierra Vista, another FQHC based in Kern County. The FQHCs in Fresno County all treat uninsured and Medi-Cal patients, but they do not receive reimbursement from the county indigent care program, which has an exclusive contract with CMC.

The safety nets in neighboring counties are structured differently than in Fresno. In Tulare County, for example, all three hospitals are government district hospitals and, therefore, provide some care to low-income uninsured, indigent, and Medi-Cal patients. The bulk of safety-net care in Tulare County is provided by Kaweah Delta Medical Center. In the past two years, Tulare County closed four of its six clinics because of budget cuts; two have since been reopened by Tulare District Hospital as rural health clinics. Other safety-net providers in Tulare include Family HealthCare Network, an FQHC that operates 11 clinics; Tulare Community Health Clinic, an FQHC with two clinics; and several independent rural clinics.

In Madera County, the major safety-net providers are Children's Hospital (which also provides safety-net pediatric specialty services for a broader area in the Central Valley) and Camarena Health Centers, an FQHC that operates three sites. Many low-income and uninsured patients also use the Madera Community Hospital emergency department (ED).

One defining feature of the Fresno-area safety net is the lack of coordination between county governments and safety-net providers, as well as among individual safety-net providers. This is in sharp contrast to the strong coordination seen in some other California communities such as San Francisco. Among the few collaborative safety-net efforts in the community, some have shown promise but were discontinued after funding ran out. For example, Tulare County's three hospitals formed the Bridge Program in 2005 to redirect frequent emergency department users to primary care and outpatient specialty care providers. After the program lost grant funding in 2008, only Kaweah Delta — the largest of the participating hospitals — continued to offer the program on a smaller scale, using its own funds.

Most safety-net hospitals in the greater Fresno area have managed to at least break even financially. The FQHCs (with the exception of Sequoia) have also managed to break even, but they tend to have slim margins and are vulnerable to funding disruptions — even more so with the current economic decline. The recent state budget impasse, which delayed Medi-Cal payments, forced some clinics to put off expansion plans and to obtain loans to meet payroll. Moreover, in July 2008, the state reduced Medi-Cal rates for many providers and services (excluding FQHCs and some inpatient services) by 10 percent, but federal court injunctions blocked implementation of the reductions. In February 2009, the law authorizing those cuts expired and was replaced by 5 percent reductions, which also have been blocked by federal courts. If payment cuts are implemented in the future, there is great concern that the impact on non-FQHC clinics will be severe, possibly forcing some to curtail services or close altogether. In the past year, Fresno County already reduced services, including closing immunization and HIV clinics and mobile dental vans.

Access Gaps for Low-Income People

While shortages of physicians and other health professionals create serious challenges for the Fresno population overall, they pose particularly severe problems for low-income residents.

Respondents reported that finding private-practice physicians and dentists willing to accept Medi-Cal patients

has become increasingly difficult. Challenges in finding private providers willing to treat Medi-Cal patients, combined with the closures of some clinics and reduced hours at other clinics, have seriously hampered access to primary care for many low-income people, increasingly causing them to turn to EDs for non-emergency care. EDs are reporting problems meeting increased demand—problems that respondents generally attributed to the lack of convenient access to primary care.

Specialty care presents even greater access challenges. As noted earlier, the Fresno market has such severe specialist shortages that even privately insured patients have long waits to see some specialists, leading many to seek care outside the market. The problems are even more acute for low-income patients, whom fewer specialists are willing to treat and for whom out-of-town referrals present particular challenges, given their often severely limited transportation options. However, Medi-Cal managed care plans do provide van service to other markets for their enrollees.

In an effort to improve specialty care access, several county and private clinics have begun contracting with specialists. The Fresno Health Communities Access Partners (FHCAP) program has worked to improve access to specialty care, including the use of telemedicine. UC Davis reportedly has been successful in providing specialists for telemedicine sites in the area, and this effort may be expanded through partnerships with UC Merced and UCSF.

Mental health services are provided primarily by the counties, but budget cuts over the past decade have steadily reduced services. As a result, the county programs are now reserved mainly for the severely mentally ill. Private clinics provide only limited services. Because of the scarcity of services locally, EDs often must hold patients with mental health conditions for days until they can be transferred to an appropriate facility—sometimes as far away as Sacramento or San Diego.

Although the safety net is fragmented overall, respondents noted that the FHCAP coalition has made some progress in improving coordination and access. In addition to its telemedicine initiative, the coalition has organized efforts to expand coverage, including: Fresno Healthy Kids, a program that uses government and charitable grants to provide insurance for undocumented children; and One-E-App, a Web-based system to simplify the process for determining eligibility for families applying for various children's health insurance programs. Although approximately 8,000 Fresno County children have gained coverage largely as a result of these initiatives, there are an estimated 31,000 children who remain uninsured.

In stark contrast to Fresno County, Tulare County—which lacks a coalition akin to FHCAP—has been unsuccessful in enrolling children in its Healthy Kids program. Fewer than 300 children have been enrolled out of an estimated 6,500 eligible children. According to one respondent, outreach costs were high relative to direct expenses for insurance premiums. As a result, Tulare County changed its approach and reallocated its Healthy Kids funding to pay for local pediatric specialists to treat any child, regardless of insurance or documentation status. This change was recently instituted, and respondents are optimistic that paying providers directly will have more impact and result in lower administrative costs than implementing a new insurance program.

Medi-Cal Challenges Include Low Provider Participation, Friction Between Plans and Providers

Medi-Cal enrollment is high in the Fresno area, with about one in three residents enrolled in Fresno and Tulare counties. Enrollment in Fresno County has steadily increased by 7 percent to 12 percent per year for the past eight years, a trend that respondents attributed to aggressive outreach efforts, including efforts by the Children's Health Initiative, a program whose goals include improving coverage and access for young children. In Tulare County, Medi-Cal enrollment has remained flat as a proportion of the population but is expected to increase with the recession.

Both Fresno and Tulare counties have a two-plan Medi-Cal managed care model, offering two commercial plans: Anthem Blue Cross and Health Net. This is different from other California counties where one of the plans is typically a local public entity. Respondents indicated that when the two-plan model was launched, there was insufficient political support for implementing a publicly run health plan. Anthem Blue Cross has approximately 10 times as many enrollees as Health Net, but the two plans have similar provider networks, which both plans have struggled to maintain. The problems appear to stem from low provider payment rates and a general shortage of physicians and dentists in the market.

Negotiations between the Medi-Cal plans and providers have been contentious. In Tulare County, for example, all hospitals have historically refused to contract with Medi-Cal managed care plans, instead demanding Medicaid fee-for-service rates. Children's Hospital refused to contract with Anthem Blue Cross in the summer of 2008 because of low reimbursement rates, and Medi-Cal patients had to go to other hospitals, sometimes as far away as Los Angeles. Eventually, Children's Hospital and Anthem reached an agreement. Over the past few years, Medi-Cal rate negotiations between Anthem Blue Cross and CMC and its affiliated physician organizations, Santé IPA and Central California Faculty Medical Group (CCFMG), have been contentious. Contract terminations and claims denials have resulted in CCFMG advising Medi-Cal patients who want to keep their physician to switch from Anthem to Health Net in an effort to minimize disruptions in care.

Kings, Madera, and Mariposa counties currently operate under Medi-Cal fee for service. As part of a statewide initiative to expand managed care, state officials initially proposed a geographic managed care (GMC) model for the tri-county area of Fresno, Kings, and Madera counties with sparsely populated Mariposa County remaining under fee for service.[6] However, provider resistance to GMC resulted in the decision to launch a two-plan model in the tri-county area, beginning in mid-2010. One of the plans will likely be a local initiative plan, which local policy makers hope will provide greater local control and allow them to respond more quickly to provider complaints and contract disputes.

Weak and Declining HMO Presence

In sharp contrast to other California markets, the greater Fresno area historically has been a weak HMO market, both resistant to and "ignored by" managed care, according to one respondent. Even at their peak in the 1990s, HMOs never achieved dominance in the Fresno area, and their presence continues to shrink, from an estimated commercial HMO penetration of 30 percent in 2000 to 25 percent in 2006 (compared to commercial HMO penetration of 46 percent for California as a whole).[7]

The absence of a strong HMO presence means that many health system features characteristic of other California communities — formation of large multi-specialty physician groups; tight hospital-physician alignment; provider familiarity with and responsiveness to performance and quality measurement and reporting; and aggressive care management and utilization management — have not been pervasive in the Fresno market.

Respondents suggested that the market's cultural bias against HMOs ("the dislike of [utilization] controls imposed by outsiders…and the lack of choice") has been reinforced by the challenge of using limited provider networks in an area that is "vast, rural…and [geographically] dispersed." A responded noted, "When you get outside [the city of] Fresno, even the rest of [Fresno County] is very rural…It's a long drive to get anywhere."

Anthem Blue Cross and Blue Shield of California are the leading health insurers in the greater Fresno market. Anthem Blue Cross is the leader in self-insured and fully insured PPO products, while Blue Shield ranks second in those products and also ranks second behind Kaiser in HMO enrollment. Unlike other areas of California, Kaiser has a comparatively modest presence in the Fresno area's commercial market.

Other commercial insurers in the area include Aetna, CIGNA, UnitedHealthcare, and Health Net.

As in other California markets, health plans face strong pressure to moderate premium trends. There is consensus that doing so will be extremely challenging in the face of escalating provider costs — primarily hospital costs. Because some hospitals are considered "must-haves" by employer purchasers and other hospitals have geographic monopolies, hospitals exercise strong negotiating leverage with health plans. In addition, low reimbursement from public payers (especially Medi-Cal) prompts providers to try negotiating higher commercial rates to subsidize below-cost public payment rates. While this is a statewide issue, it is a particular concern for the Fresno area given its poor and deteriorating payer mix.

Health plans also feel pressure to maintain enrollment in the face of the economic downturn, which respondents described as particularly severe in Fresno because of the poor state of the housing and job markets even before the downturn. With some employers laying off workers, others remaining in business but dropping coverage, and still others going out of business altogether, an already small commercial enrollment base is shrinking further.

As seen elsewhere in the state, plans have tried to mitigate premium trends by expanding product offerings, with a focus on new products that increase patient cost sharing. These new products include consumer-directed health plans (CDHPs) — high-deductible plans linked to (or eligible for) health savings accounts (HSAs) or health reimbursement arrangements (HRAs).[8] For conventional products, many plans are offering PPOs with "thin" benefits (such as the exclusion of brand-name drugs and maternity coverage) and HMOs with moderate deductibles (in the $250 to $500 range).

Respondents see little difference in non-Kaiser health plan strategies. The plans generally compete vigorously on price and mimic one another's new product offerings, benefit designs, and provider networks. A few benefits consultants did suggest that Blue Shield takes a more flexible approach in dealing with providers and enrollees. According to one benefits consultant, "[Blue Shield] tends to be more open to patient-specific exceptions…[and] would be more willing to go off-formulary…For certain medical procedures, providers have reported they have an easier time gaining approval [from Blue Shield]…for complex imaging and in orthopedic outpatient services."

It is not clear what strategy Kaiser is following in the Fresno market. Consistent with its approach in other markets, Kaiser does not compete aggressively on price and typically adopts a "take it or leave it" stance when renewing contracts with employers. At the same time, Kaiser does not seem to be pushing its Thrive marketing campaign, which emphasizes wellness and preventative health care, nearly as strongly in this market as it does in other California metropolitan areas. One respondent suggested that Kaiser simply pays less attention to this market than it does to other more lucrative and HMO-friendly markets.

Employers Explore Options to Contain Costs, Maintain Coverage

Large national employers have little, if any, presence in the greater Fresno area. As a result, the market has relatively little activity in programs that large national employers typically demand from insurers or, in some cases, purchase from third-party vendors; such programs include wellness, health promotion, clinical care management, and price and quality transparency.

Self-insurance historically has been more common in the greater Fresno area than in other California markets. According to one broker, "Large employers in the [Central] Valley are more risk-takers than they would be in San Francisco, San Diego, or Los Angeles; in those areas, large employers look upon HMOs very favorably, but here in the Valley there's more resistance. Historically, employers like choice and large employers like the creativity that comes with self-funded plans and knowing they have a funding

mechanism to hold onto dollars until [those dollars] are needed for claims." Despite the low HMO penetration, it is common for large employers in the market to offer a choice between an HMO and a PPO.

Until recently, many large employers did not require any employee premium contribution for employee-only coverage. But large employers have been increasing employees' share of premium contributions and offering additional, leaner benefit plans at a lower cost. Some also have recently added a CDHP as an option and have begun to make it the offering with the highest employer premium contribution.

The sophistication of large employers' cost-containment strategies varies greatly. For example, several self-insured employers have introduced benefit designs where copayments are reduced or eliminated for certain maintenance medications and medical supplies to encourage better patient compliance. Along the same lines, some employers are fine-tuning benefit structures by increasing ED copayments substantially (to $250, for example), while reducing copayments for visits to urgent care facilities to the level of physician office visit copayments. In contrast, other large employers are increasing copayments across the board, without assessing whether doubling physician office-visit and pharmacy copayments might result in reduced patient compliance, increased complications, and avoidable hospitalizations.

Agricultural employers are substantially less likely to offer health benefits than other employers in the market. When they do offer health benefits, the benefit structures often differ markedly from those of other large employers. One large agricultural company, for example, instead of providing health insurance, offers claims payment for any medical service from any provider, up to a maximum amount of $25,000 per year for an employee and spouse. While the coverage amount provided by this company is considered generous by industry standards, the general approach of simply paying claims rather than providing insurance coverage is not uncommon.

Many small employers do not offer health benefits, especially in the agricultural and low-wage service sectors. Small employers that do offer health insurance often offer a choice between two HMO products — including one Kaiser option — and one PPO product. Small employers often pay most, or all, of the employee-only premium, largely because health plans require a high take-up rate before they will write a small group policy. With small employers focusing almost exclusively on the price and affordability aspects of insurance, many have displayed greater enthusiasm for CDHPs than larger employers and view the potential cost savings from these new products as the only viable way for them to continue offering coverage.

Issues to Track

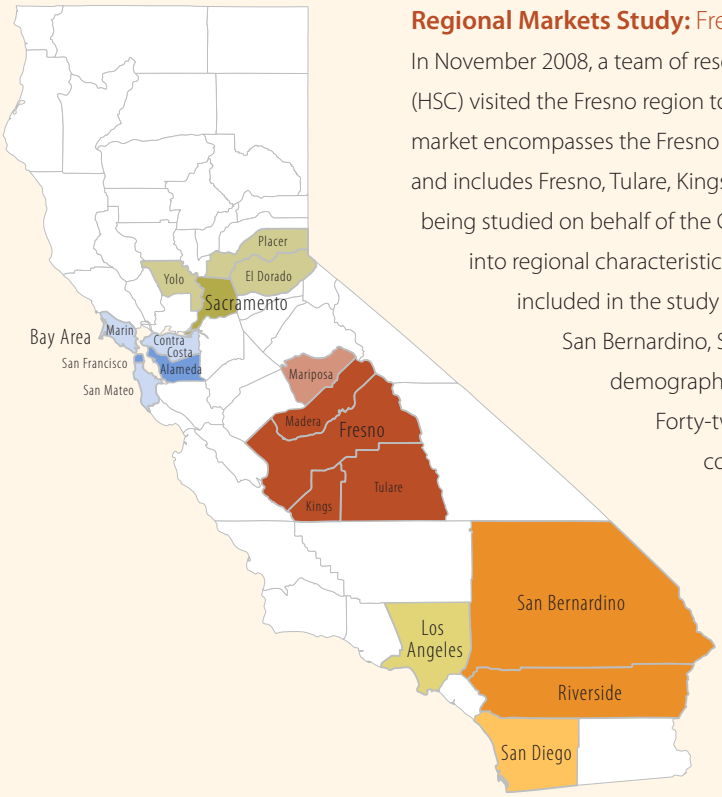
The greater Fresno area's already weak baseline economy of low wages, high unemployment, and poverty has been hard-hit by the current economic downturn. Market observers noted that the recession will not just result in employers curtailing or eliminating health benefits, but "a lot of these vulnerable [firms] are just going to disappear, period." The deterioration of an already small commercial insurance base is of grave concern not only to insurers but also providers. Many providers noted that a shrinking commercial insurance base will exacerbate their already unfavorable payer mix and further reduce the willingness of commercial payers to subsidize uncompensated care and inadequate public reimbursement, at a time when the demands on the safety net are expected to reach new levels. The following are among the key issues to track:

- To what extent will Fresno's commercial insurance base contract in the economic downturn? What will be the impact of such a contraction on the financial health of providers in the market and their ability and willingness to continue providing care for Medi-Cal and other low-income patients?

- As unemployment and uninsured rates increase, how will the county governments and safety-net providers cope with increasing demands on safety-net services? To what extent will Medi-Cal reduce payment rates and covered services, and what impact will these cutbacks have on the market? Will there be increased pressure on Fresno County to increase eligibility for its indigent care program?
- What impact will the growing physician shortage have on the market, and how will the market respond?
- How will the recent problems experienced by St. Agnes affect its competitive position in the market and the strategies it pursues? Will the quality of care issues at St. Agnes help raise awareness about quality and prompt collaborative efforts to improve quality in the market more broadly?
- Among employers who continue to offer health insurance, will there be a more pronounced shift toward products with fewer benefits and higher cost-sharing arrangements as a cost-containment strategy?

ENDNOTES

1. Chubb, Amy, *A Study of Income Inequality in Fresno County and the Metropolitan Statistical Area,* Fresno Works for Better Health Advocacy Center, Fresno, CA (October 2008).
2. California Employment Development Department, Labor Market Info, Industry Employment Data Search Tool (Sacramento, CA). "Industry Employment — Official Monthly Estimates (CES)," **www.labormarketinfo.edd.ca.gov** (accessed February 17, 2009).
3. Government health care districts are governed by an elected body separate from the local government and have the authority to impose property taxes to pay for the operation of the hospital. Because the district board is responsible to the community, the hospital often provides services for the underserved.
4. Under a medical foundation model, the foundation is sponsored by a hospital or hospital system, and physicians either contract with the foundation's IPA or are employed by the foundation through a professional services arrangement with the medical group.
5. Realignment funds, derived from state sales taxes and vehicle license fees, were allocated to the counties when the state shifted responsibility for health and social services to the county governments. The formula for distribution of the funds was based on historical spending levels and is not updated each year based on population and population in poverty.
6. Under the geographic managed care model, the state contracts with multiple private managed care plans and pays each plan on a capitated (fixed per-enrollee, per-month payment) basis.
7. Cattaneo & Stroud, Inc., *2006 California Statewide HMO & Special Programs Enrollment Study,* Burlingame, CA (2008).
8. HSAs are tax-favored accounts that must be linked to health plans with minimum deductibles of $1,100 for self-only coverage and $2,200 for family coverage in 2008. HRAs are accounts funded and owned by the employer; no companion health plan is required. HRA contributions are not subject to business income tax, and unused funds revert to the employer when the employee retires or leaves the company.



Regional Markets Study: Fresno

In November 2008, a team of researchers from the Center for Studying Health System Change (HSC) visited the Fresno region to study that market's local health care system. The Fresno market encompasses the Fresno economic area as defined by the Bureau of Economic Analysis and includes Fresno, Tulare, Kings, Madera, and Mariposa counties. Fresno is one of six markets being studied on behalf of the California HealthCare Foundation to gain important insights into regional characteristics in health care affordability, access, and quality. The six markets included in the study — Fresno, Los Angeles, Oakland/San Francisco, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions in California. Forty-two interviews of leaders in the Fresno health care market were conducted to inform this report; no interviews were conducted in Mariposa County.

▶ ACCESS THE ENTIRE REGIONAL MARKETS SERIES HERE.

ABOUT THE AUTHORS

Ha T. Tu, Debra A. Draper, Peter J. Cunningham, Nicole M. Kemper, Genna R. Cohen, and Johanna R. Lauer, **Center for Studying Health System Change (HSC)**. HSC is a nonpartisan policy research organization that designs and conducts studies focused on the U.S. health care system to inform the thinking and decisions of policy makers in government and private industry. More information is available at **www.hschange.org**.

ABOUT THE FOUNDATION

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit **www.chcf.org**.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to **www.chcf.org/topics/almanac**.

Table A. Demographic and Health System Characteristics: Six Selected Regions vs. California (SUPPLEMENT TO THE *CALIFORNIA HEALTH CARE ALMANAC REGIONAL MARKETS* ISSUE BRIEF SERIES)

POPULATION STATISTICS	Fresno	Los Angeles	Riverside/ San Bernardino	Sacramento	San Diego	San Francisco Bay Area	California
Total population	1,634,325	9,878,554	4,081,371	2,091,120	2,974,859	4,203,898	36,553,215
Population growth, 1997–2007	21.6%	8.4%	33.9%	26.3%	9.2%	6.6%	13.6%
Population growth, 2002–2007	9.0%	0.7%	16.1%	8.3%	2.3%	0.6%	4.1%
AGE OF POPULATION							
Persons under 5 years old	8.7%*	7.4%	7.6%	6.8%	7.4%	6.4%	7.3%
Persons under 18 years old	30.6%*	27.8%	29.7%	26.4%	26.7%	22.2%	26.9%
Persons 18 to 64 years old	60.3%*	62.0%	60.9%	62.4%	62.7%	65.9%	62.5%
Persons 65 years and older	9.1%*	10.2%	9.4%	11.1%	10.6%	11.9%	10.6%
RACE/ETHNICITY							
White non-Latino	37.4%*	28.7%	42.0%	59.7%	53.7%	46.2%	43.3%
African American non-Latino	4.0%*	8.4%	7.1%	6.4%	5.3%	8.3%	5.8%
Latino	50.8%*	47.6%	42.9%	18.9%	29.0%	20.8%	36.1%
Asian non-Latino	5.3%*	13.1%	5.3%	10.4%	8.7%	20.4%	11.8%
Other race non-Latino	2.6%*	1.8%	2.7%	4.6%	3.3%	4.2%	3.1%
Foreign-born	20.4%*	33.8%	20.9%	15.1%	20.3%	27.5%	25.7%
Limited/no English, adults	41.3%*	38.7%	30.5%	28.5%	26.1%	27.6%	35.2%
EDUCATION, ADULTS 25 AND OLDER							
High school degree or higher	71.9%*	78.2%	81.5%	89.9%	87.6%	89.7%	82.9%
College degree or higher	22.2%*	32.8%	24.5%	38.3%	40.6%	49.4%	35.7%
HEALTH STATUS							
Fair/poor health status	19.8%*	18.4%	15.0%	12.3%	12.3%	12.5%	15.8%
Diabetes	10.5%*	8.8%	8.5%	6.5%	6.3%	7.0%	7.8%
Asthma	16.7%*	11.8%	13.0%	18.5%	12.8%	14.6%	13.6%
Heart disease, adults	6.4%*	6.2%	6.3%	6.5%	6.4%	5.5%	6.3%
ECONOMIC INDICATORS							
Below 100% federal poverty level	24.0%*	20.8%	14.8%	11.6%	11.0%	11.0%	15.7%
Below 200% federal poverty level	45.1%*	41.2%	35.2%	25.7%	26.4%	22.4%	33.5%
Household income above $50,000	39.7%*	44.3%	50.9%	54.9%	56.7%	61.6%	51.1%
Unemployment rate, January 2009	15.5%	10.8%	11.8%	10.4%	8.6%	8.4%	10.6%
HEALTH INSURANCE, ALL AGES							
Private insurance	46.8%*	52.8%	58.7%	66.8%	63.9%	69.3%	59.1%
Medicare	7.0%*	7.2%	7.7%	9.4%	8.8%	9.6%	8.5%
Medi-Cal and other public programs	30.5%*	23.8%	18.5%	15.1%	14.9%	13.4%	19.3%
Uninsured	15.7%*	16.1%	15.1%	8.6%	12.5%	7.8%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008							
Physicians per 100,000 population	118	176	110	191	187	239	174
Primary care physicians per 100,000 population	45	58	40	63	60	79	59
Dentists per 100,000 population	43	64	47	74	70	89	69
HOSPITALS							
Staffed community, acute care hospital beds per 100,000 population, 2006	173	214	142	146	171	211	182
Hospital concentration, 2006 (Herfindahl index)	702	310	542	2,178	1,468	1,176	1,380
Operating margin including net Disproportionate Share Hospital payments	3.0%	–5.3%	1.3%	7.1%	5.3%	3.4%	1.2%
Occupancy rate for licensed beds	67.9%	58.5%	64.0%	70.7%	67.4%	56.4%	59.0%
Average length of stay (days)	4.4	4.8	4.3	4.3	4.4	4.9	4.5
Paid full-time equivalents per 1000 adjusted patient days	15.0	16.0	15.0	17.3	14.9	15.9	15.7
Total operating expense per adjusted patient day	$1,883	$2,245	$2,110	$2,731	$2,182	$2,934	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted. Fresno region includes Fresno, Kings, Madera, Mariposa and Tulare counties. Sacramento region includes El Dorado, Placer, Sacramento, and Yolo counties. San Francisco Bay region includes Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties.

*Estimate does not include Mariposa County because the California Health Interview Survey public-use dataset does not report separate estimates for very small counties such as Mariposa.

Sources: U.S. Census Bureau, Population Estimates, 2007; California Health Interview Survey, 2007; State of California Employment Development Department, Labor Market Information Division, "Monthly Labor Force Data for Counties: January 2009 — Preliminary, March 2008 Benchmark," March 5, 2009; California HealthCare Foundation, "Fewer and More Specialized: A New Assessment of Physician Supply in California," June 2009; UCLA Center for Health Policy Research, "Distribution and Characteristics of Dentists Licensed to Practice in California, 2008," May 2009; American Hospital Association Annual Survey Database, Fiscal Year 2006; California Office of Statewide Health Planning and Development, Healthcare Information Division — Annual Financial Data, 2007.