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Sacramento: Powerful Hospital Systems Dominate a Stable Market

Sacramento Market Background

The greater Sacramento area, with a total population of 2.1 million people in 2007 (5.7 percent of the state's population), has recently seen strong population growth: 26 percent in the past decade, compared with a state average of 14 percent, and 8 percent in the past five years, double the state average (see Table 1 on page 2).

Sacramento stands out from the rest of California on one demographic dimension: its racial and ethnic composition. The area has a much higher proportion of white non-Latino residents (60 percent versus 43 percent statewide) and a much lower proportion of Latino and foreign-born populations. Sacramento residents, whose age distribution is the same as that of the state at large, have moderately higher education and income levels than the state on average. Overall health status—as measured by the percentage of the population in self-reported fair or poor health—is better among Sacramento residents than Californians overall.

Sacramento's position as the seat of state government makes it unique. The state is the largest employer in the community, and its presence contributes to Sacramento's relatively favorable socioeconomic profile and health insurance payer mix. Sacramento residents are more likely to be privately insured and less likely to have Medi-Cal coverage or to be uninsured than state residents overall. Total government employment—federal, state, and local—accounts for more than a quarter of all non-farm employment in the greater Sacramento area.[1] In the private sector, Sacramento's four health systems are among its largest employers.

Over the past year, unemployment has spiked in Sacramento, as it has statewide. The unemployment rate reached 10.4 percent in Sacramento in January 2009—slightly lower than the state average of 10.6 percent—but markedly higher than Sacramento's January 2008 rate of 6.4 percent.

Four Strong Hospital Systems Dominate

Like much of northern California, Sacramento is dominated by powerful hospital systems with significant negotiating leverage over health plans. The four major hospital systems are Sutter Health Sacramento Sierra Region; Mercy Healthcare, an affiliate of Catholic Healthcare West (CHW); Kaiser Permanente; and University of California (UC) Davis Health System. Each of these systems is not-for-profit, strong and stable; this market has no large hospitals struggling for survival.

Primarily through consolidation in the 1990s, the Sacramento market has transitioned from 15 independent hospitals to the four systems that dominate the market today. Although almost all hospitals are in one of the large systems, market share is not particularly skewed toward any single system. Sutter has a 29 percent market share based on number of acute care beds, closely followed by CHW (28 percent), Kaiser (23 percent), and UC Davis (17 percent).

Competition among Sacramento's hospital systems has been characterized by market observers as "healthy…but steady…not volatile" and "lacking [the] animosity" or "combative… gloves-off element" seen in some other communities. Observers noted many examples of productive and cordial cooperation among the systems on issues ranging from community benefits to research funding to referral and technology sharing. Many attributed this cooperative dynamic to stable hospital leadership and the absence of for-profit systems in the market.

In addition, Sacramento's tight hospital capacity in recent years (with an occupancy rate of 71 percent versus 59 percent statewide) means that its hospitals have not had to compete vigorously for patients. However, all four systems are currently undertaking major construction projects to add capacity, develop more profitable service lines such as cardiac and orthopedic care, and comply with state seismic standards (although compliance is less demanding because the Sacramento area is a lower risk area than other areas, such as the Bay Area). Consequently, the market may again be headed toward excess capacity of hospital beds, which could intensify competition among hospitals for patients in the future.

One notable exception to the generally cordial competitive dynamic among the region's hospital systems was the 2007 battle between CHW and Kaiser for county approval to build a Level II Trauma Center. Observers described the clash — ultimately won by Kaiser — as "intense," "fierce," and "nasty," startling for being so "outside the norm" for hospitals in the Sacramento community.

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

POPULATION STATISTICS	Sacramento	California
Total population	2,091,120	36,553,215
Population growth, 1997–2007	26.3%	13.6%
Population growth, 2002–2007	8.3%	4.1%
AGE OF POPULATION		
Persons under 5 years old	6.8%	7.3%
Persons under 18 years old	26.4%	26.9%
Persons 18 to 64 years old	62.4%	62.5%
Persons 65 years and older	11.1%	10.6%
RACE/ETHNICITY		
White non-Latino	59.7%	43.3%
African American non-Latino	6.4%	5.8%
Latino	18.9%	36.1%
Asian non-Latino	10.4%	11.8%
Other race non-Latino	4.6%	3.1%
Foreign-born	15.1%	25.7%
Limited/no English, adults	28.5%	35.2%
EDUCATION, ADULTS 25 AND OLDER		
High school degree or higher	89.9%	82.9%
College degree or higher	38.3%	35.7%
HEALTH STATUS		
Fair/poor health status	12.3%	15.8%
Diabetes	6.5%	7.8%
Asthma	18.5%	13.6%
Heart disease, adults	6.5%	6.3%
ECONOMIC INDICATORS		
Below 100% federal poverty level	11.6%	15.7%
Below 200% federal poverty level	25.7%	33.5%
Household income above $50,000	54.9%	51.1%
Unemployment rate, January 2009	10.4%	10.6%
HEALTH INSURANCE, ALL AGES		
Private insurance	66.8%	59.1%
Medicare	9.4%	8.5%
Medi-Cal and other public programs	15.1%	19.3%
Uninsured	8.6%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008		
Physicians per 100,000 population	191	174
Primary care physicians per 100,000 population	63	59
Dentists per 100,000 population	74	69
HOSPITALS		
Staffed community, acute care hospital beds per 100,000 population, 2006	146	182
Hospital concentration, 2006 (Herfindahl index)	2,178	1,380
Operating margin including net Disproportionate Share Hospital payments	7.1%	1.2%
Occupancy rate for licensed beds	70.7%	59.0%
Average length of stay (days)	4.3	4.5
Paid full-time equivalents per 1000 adjusted patient days	17.3	15.7
Total operating expense per adjusted patient day	$2,731	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted. Sacramento region includes El Dorado, Placer, Sacramento, and Yolo counties.

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.

The financial performance of each hospital system has been strong, with operating margins conspicuously higher than the state average (7.1 percent average operating margin for non-Kaiser hospitals in Sacramento versus 1.2 percent statewide). However, hospital executives noted falling demand for services with the economic downturn — for example, a 20 percent decline in elective surgeries reported by Sutter — and they expressed concern about the financial fallout from the continuing economic decline.

Hospitals are also concerned about low payment rates from public payers, including Medicare rates that reflect a particularly unfavorable geographic adjustment and Medi-Cal rates that are very low — lower in relation to costs compared to other states. Hospitals also expressed concern about a deteriorating payer mix as increasing numbers of people lose their jobs and their insurance coverage. However, the problems with the uninsured and Medi-Cal are issues faced by hospitals statewide, not just in Sacramento. Indeed, despite hospital executives' concerns about the payer mix, Sacramento's payer mix is comparatively more favorable than many other California communities because the area has a relatively high proportion of privately insured people.

Executives at all the hospital systems reported strong pressure to contain costs because of recent insurer pushback on rate increases. Some noted that insurers and some large employers have been vocal in their dissatisfaction about having to subsidize low payment rates from public payers. Executives at the non-Kaiser systems recognized the need to contain costs to compete with Kaiser — that is, the need to keep their own demands for rate increases reasonable enough that the premiums of non-Kaiser insurers can remain competitive with Kaiser. Hospitals reported that cost containment has been extremely challenging given the other pressures that hospitals face, including labor unions' leverage, physician shortages, and state-mandated nurse-staffing ratios.

Sacramento hospitals have high costs ($2,731 total operating expenses per adjusted patient day versus $2,376 statewide), yet they still manage high operating margins, suggesting that the hospital systems to date have been able to pass on their high costs to commercial payers. This is consistent with respondents' views about relative leverage in the Sacramento market.

While each of the hospital systems is strong, Kaiser and Sutter Health are widely regarded as the two most powerful systems in the community. Kaiser is perceived by each of the other hospital systems to be its main competitor. Kaiser enjoys an increasing reputation for high-quality care, and a sizable segment of consumers in the market is "fiercely loyal" to "the Kaiser model," which emphasizes primary and preventive care and information technology (IT) tools for patients, according to numerous non-Kaiser respondents. Sutter is widely regarded as the "must-have" system in provider networks for non-Kaiser insurance products, and Sutter reportedly negotiates aggressively with insurers on behalf of both its hospitals and affiliated physicians.

Physicians Tightly Aligned with Hospitals

Many respondents expressed concern about a physician shortage in the community, although Sacramento's supplies of total physicians and primary care physicians are both somewhat higher than the corresponding state averages. Overall physician supply estimates may mask shortages reported in particular specialties, including general surgery, orthopedic surgery, neurosurgery, gastroenterology, urology, anesthesiology, dermatology, and radiology.

Physicians — especially primary care physicians — are reportedly joining Kaiser (the Permanente Medical Group) at a faster rate than they are joining other groups and independent practices, attracted by the stability of salaried employment, strong benefits, and regular working hours. Other systems report that they find it difficult to compete with Kaiser in recruiting physicians, so they and their patients are more likely to feel the effects of a physician shortage.

The physician market in Sacramento, which experienced consolidation from the 1970s until the early 2000s, has since

largely settled into stable, segmented affiliations with hospital systems. Hospital-physician alignment continues to grow tighter. Most physicians are exclusively affiliated with one of the hospital systems, with Hill Physicians (an independent practice association, or IPA) and a few large single-specialty groups (neurosurgery, pediatrics, and radiology) standing out as the exceptions that practice at multiple hospital systems. In rate negotiations with insurers, the systems negotiate on behalf of all their hospitals, affiliated physician groups, and IPAs at the same time, extracting more favorable rates than physician organizations could obtain on their own.

UC Davis obtains its physicians through the university's School of Medicine, which employs them. Kaiser Permanente contracts with the Permanente Medical Group for its physicians; the Permanente Medical Group employs the physicians. However, Kaiser outsources many specialty services to the other hospital systems and their affiliated physicians. Sutter and CHW both have medical foundation models, under which physicians either contract with the foundation's IPA or are employed by the medical foundation through a professional services arrangement with the medical group. Historically, specialists remained outside of the foundation models, but as their reimbursement rates dropped and they faced competition from hospitals' foundations, a number of specialty groups have aligned themselves with one of the hospital systems.

Hospitalists — hospital-based physicians responsible for inpatient admissions and medical care — have long been prevalent in the Sacramento market. Most are employed by the medical groups affiliated with hospital systems. In the past few years, this market has seen an expansion of the hospitalist approach to include specialist hospitalists, with CHW, Sutter, and Kaiser all using them. Kaiser has been leading this trend, including otolaryngology, orthopedic, and neurology hospitalists among its hospital-based staff. The use of hospitalists has led to a decrease in the number of physicians with medical staff privileges, as more physicians remain in their outpatient practices and rely on hospitalists to admit their patients. Most respondents believed that hospitalists have improved the quality of care and reduced average lengths of stay.

The delegated capitation model — where a medical group receives capitated payments (fixed per-patient, per-month payments for a specified set of services) from health plans and assumes financial risk for delivering care to those enrollees — continues to be entrenched in Sacramento. Many physicians favor the delegated capitation model because they believe that their medical groups have the necessary infrastructure in place to manage enrollees' care and costs efficiently and profitably. Hospitals, for the most part, are not paid on a capitated basis but are paid under a variety of other mechanisms, with per diem arrangements the most prevalent for inpatient services.

HMOs Lose Ground, Although Remaining a Strong Presence

Sacramento historically has been a very strong HMO market. As of 2006, commercial HMO penetration was 67 percent and overall HMO penetration was 64 percent (compared with commercial HMO penetration of 46 percent and overall HMO penetration of 47 percent for California as a whole).[2] In recent years, however, HMOs have lost ground to both fully insured and self-insured PPOs. HMO premiums have increased comparatively faster than PPO premiums; as a result, the price advantage of HMOs has largely eroded. The increased use of PPOs and larger enrollee cost-sharing arrangements in PPOs have helped lessen premium increases in these products.

Another factor behind the erosion of the HMO price advantage has been more stringent interpretation of benefit mandates and broader regulatory scope by the Department of Managed Health Care (DMHC), which oversees HMOs, than the California Department of Insurance (CDI), which oversees most fully insured PPOs.[3,4] HMOs are at an even greater disadvantage compared with self-insured PPOs, which are not subject to benefit mandates and are minimally

regulated by the U.S. Department of Labor. Upcoming implementation of additional mandates, such as those concerning timely access to care and autism treatment, is expected to further affect the costs and competitive position of HMOs. In response, health plans have moved to create insured PPO products outside the regulatory reach of DMHC. One approach is to buy a life insurance company and create health insurance products under that subsidiary, under much less stringent CDI oversight.

Kaiser and Anthem Blue Cross are the dominant health plans in the market, followed by Blue Shield in solid third place in enrollment. Kaiser is dominant in the commercial HMO market, Anthem Blue Cross is dominant in the commercial PPO market, and Blue Shield ranks second in both HMO and PPO markets. Other plans active in the Sacramento market include UnitedHealthcare, Health Net, Aetna, CIGNA, and Western Health Advantage (WHA), a local HMO jointly owned by CHW, UC Davis, and NorthBay Healthcare.

Non-Kaiser plans compete vigorously on price and tend to replicate each other's new product designs. Some observers agreed with a prominent broker's view that the non-Kaiser plans are "just chasing each other's tails," but others perceived distinct strategies by individual plans. For example, Anthem Blue Cross reportedly uses its size to negotiate better rates with providers. Blue Shield is said to be gaining market share through aggressive pricing (though some suggest this is only cyclical and temporary) and focusing on its local presence to provide more responsive service to providers and enrollees than its major rival Anthem.

Kaiser no longer pursues a low-cost strategy as it did in the 1980s. Some observers suggest that Kaiser's sharply increased premiums reflect the need to finance its ambitious electronic health record (EHR) implementation and major construction projects. Kaiser's competitive strategy emphasizes its model of integrated care delivery, its use of IT (including EHRs and telemedicine) to improve the patient experience, its wellness program, and its superior quality ratings. It maintains a consistent marketing emphasis on wellness and preventative health care; the slogan of its "Thrive" ad campaign is, "We don't just take care of you when you get sick; we partner with you to keep you healthy."

All health plans in the market face the pressure of escalating costs — especially hospital costs — and the need to keep premium increases affordable. In particular, plans focused on the small group market are intensely aware of the need to keep premiums from increasing to such a level that small employers drop coverage altogether.

All plans have responded to the dual pressures of rising costs and need for premium affordability by introducing a broad array of new products that increase patient cost sharing in different ways. These products include consumer-directed health plans (CDHPs) — high-deductible plans linked to (or eligible for) health savings accounts (HSAs) or health reimbursement arrangements (HRAs), including some built on an HMO platform.[5] Many plans also have offered additional designs for conventional products, such as PPOs with "thin" benefits (e.g., exclusion of brand-name drugs or maternity coverage) and HMOs with moderate deductibles (in the $250 to $500 range). Many traditional products have seen increases in copayments for prescription drugs and office visits (e.g., $10 to $20), and dramatic increases in copayments for emergency department (ED) visits without a subsequent hospital admission; a $100 ED visit copayment has become more common and a $500 copayment has been imposed in some lower-premium products.

A pressure unique to Kaiser is the high costs incurred when its enrollees are admitted to non-Kaiser hospitals for emergency care. A Kaiser executive observed, "People get in accidents or have heart attacks and go to the closest hospital…We have very poor contracts with hospitals around us so they charge us full charges or give us 15 percent off." Kaiser has been moving aggressively to reduce its costs by developing internal capacity such as trauma care services to handle these types of cases.

Increasing Diversity of Benefit Structures

Employers who offer health care coverage in the Sacramento area typically offer a choice between Kaiser and a non-Kaiser HMO and a PPO from the non-Kaiser carrier. For core (lowest-cost) products, employers still commonly pay the full premium for employee-only coverage and none of the additional premium for family coverage. However, this has been in flux in the past few years, with more large and mid-sized employers moving toward paying a set percentage of the premiums regardless of the product chosen or whether dependent coverage is purchased — an approach that has long been prevalent elsewhere in the United States.

Health plans and brokers are increasingly encouraging employers, particularly those in the small group market, to offer all their plans under a single carrier's umbrella. A Kaiser option, however, is often offered alongside the single carrier's products. In this market, other insurers accept that Kaiser is a major presence and are willing to allow their products to be offered along with a Kaiser product.

Across all ranges of firm size, some employers have begun to offer consumer-directed health plans, but adoption by employers and take up by employees have both been modest. The California Public Employees' Retirement System (CalPERS), by far the largest purchaser in the market, does not yet offer any CDHPs and does not appear poised to do so in the near future. Few, if any, employers in the Sacramento area have gone to full replacement of conventional HMO or PPO products. The adoption of health reimbursement arrangements (HRAs) has been even more modest than HSAs, with one benefits consultant commenting that "[HRAs] are…a rarity here. The big [employers] don't tend to use [HRA contributions] as vehicles for wellness incentives like they do in other places."

CalPERS, which provides health benefits to both current and retired state employees, works in close partnership with its participating health plans, especially Blue Shield.[6] The narrow-network NetValue HMO, which excludes Sutter hospitals and physicians, was developed by Blue Shield in response to CalPERS' dissatisfaction with high payment rates to Sutter. After the NetValue HMO was introduced in 2004, a significant number of CalPERS members switched to the PPO to remain with their Sutter physicians.

Other large employers in the market watch CalPERS' rate negotiations and network selection, but believe they lack the clout to impose the same kind of changes on their employees. For example, most believe they cannot exclude Sutter from their networks unless there are larger price gaps between products with and without Sutter. According to some benefits consultants, some large employers do not even consider excluding Sutter because the company executives who make benefits decisions are Sutter patients themselves.

Large employers increasingly are demanding wellness and health promotion programs, but the strategies, approaches, and incentives of these programs vary so much that one broker called them the "wild, wild west" of health benefits. Many large employers prefer to offer these programs through a third-party vendor specializing in wellness programs rather than their insurance carrier. Among the health plans, Kaiser is seen by many benefits consultants and brokers as having the most robust and integrated wellness programs, marketed under its "Thrive" ad campaign.

As is typical of many small employers — particularly those with low-wage workers — small employers in Sacramento focus almost exclusively on price and affordability of health insurance. As a result, many small employers have been more receptive than large employers to high-deductible products because of the premium savings offered by these options.

For the small group market, most insurers now offer a broad array of insurance products, and small employers in turn have the option of presenting the full range of up to two dozen or so offerings to their employees — encompassing all types of traditional HMOs and PPOs, as well as new CDHPs. This broad-portfolio approach — called EmployeeElect by Anthem and Pick-A-Plan by Aetna — is available to small employers who guarantee the carrier a certain share of their eligible enrollees (e.g., a minimum of

75 percent). The employer typically chooses a core premium contribution, and employees who opt for more expensive products are responsible for paying the difference; conversely, employees selecting a less costly option might be able to apply the premium credit toward dependent coverage.

Anthem introduced this broad-portfolio approach to the Sacramento small group market a few years ago, and most insurers have followed suit. Some brokers enthusiastically endorse this approach, but others believe it overwhelms consumers with too many options and urge small employers to reduce the number of choices to three or so offerings. Although only a minority of small employers presents the full portfolio of benefit options to their employees, the introduction of the broad-portfolio approach to the small group market means that in Sacramento, as elsewhere in California, employees of small groups are sometimes presented with many more benefit options than their counterparts in larger companies.

A Fragmented Safety Net

Sacramento County lacks a county hospital responsible for treating low-income people. UC Davis Medical Center has served as the main safety-net hospital, providing the majority of care to the uninsured and medically indigent populations, and a relatively high proportion of Medi-Cal patients in the market. Sutter and CHW also play important safety-net roles by providing emergency and inpatient charity care at their hospitals. Both systems also provide funding to community clinics, and Mercy Hospital (part of CHW) operates some safety-net clinics directly. Many observers consider Kaiser's safety-net role negligible, but others give Kaiser credit for funding safety-net providers to support such activities as chronic care management, and bringing some low-income people into their system by participating in local coverage expansion efforts, such as the Healthy Kids Program.[7]

The direct role played by Sacramento County in the safety net is limited to funding and care provision for the approximately 50,000 medically indigent county residents—typically childless adults who earn less than 200 percent of the federal poverty level but are not eligible for Medi-Cal. The county provides them primary, dental, and mental health care services through county clinics. Until recently, the county contracted with UC Davis to provide most of the specialty, inpatient, and emergency care for the medically indigent. That contract was terminated in 2008 in favor of using a third-party administrator to contract with hospitals at lower payment rates—a move that may result in a broader hospital safety net and reduced county funding for UC Davis. Instead of controlling costs for the county as intended, however, the new contract reportedly is over budget and payments to UC Davis have been delayed.[8]

Recent significant budget shortfalls in Sacramento County, following a steep decline in property and sales tax revenues, have led to reductions in capacity at the county clinics. In mid-2008, the county curtailed operating hours and staffing levels at three of its six clinic sites—a move that safety-net respondents considered a severe cutback. In the months that followed, UC Davis detected more uninsured people presenting to the ED. Under additional budget strain, the county completely closed its three part-time clinics at the end of February 2009, further limiting primary care options for the medically indigent population.

Medi-Cal beneficiaries and uninsured residents who do not qualify for medically indigent status receive primary care mainly from private safety-net clinics. Sacramento has approximately seven not-for-profit health center organizations (with 13 facilities) and a for-profit Medi-Cal practice, the Sacramento Family Medical Clinic, with multiple sites. The not-for-profit clinics are typically small, and many focus on a particular ethnic or immigrant group. Some small clinics offer specialized services (e.g., family planning) rather than comprehensive primary care.

In contrast to the county clinics, some of the private primary care clinics are expanding. Until recently, many clinics had relied on private foundations and hospitals for financial support because of the absence of federal funding.

Increasingly, the not-for-profit clinics are trying to achieve federally qualified health center (FQHC) status to gain federal funding and higher payment rates for Medi-Cal patients, allowing them to serve a broader population. In the past year, two health centers gained FQHC "look-alike" status — meaning they receive enhanced Medi-Cal rates but not federal funding. The enhanced Medi-Cal rates vary by region and reflect in part historical utilization patterns.

Low Medi-Cal Reimbursement

The Medi-Cal program in Sacramento County operates under the geographic managed care (GMC) model, with the state contracting with multiple managed care plans and paying each plan on a capitated basis. Enrollment in managed care is mandatory for all but low-income seniors and people who have qualified on the basis of disability. Currently, five health plans participate in the GMC market in Sacramento. Anthem Blue Cross has about half of the market of approximately 170,000 Medi-Cal managed care enrollees. Health Net, Kaiser, Molina, and Western Health Advantage cover the rest of the Medi-Cal HMO population. The GMC model will be expanding to counties previously operating under fee for service, with Placer County scheduled to roll out GMC in 2009.

Views are mixed on the impact of GMC in Sacramento County, in contrast to the two-plan model used in many other California counties, in which one plan is a local public entity and the other is a private health plan. Some respondents assert that GMC has added to care fragmentation, with the county using the implementation of GMC as an opportunity to remove itself from providing care for Medi-Cal enrollees. Under the Sacramento GMC, county and other local stakeholders lack information on provider participation, beneficiary utilization, and quality of care because the health plans contract directly with the state.

The GMC model also increases the administrative burden on providers by requiring them to contract with multiple plans as opposed to only one or two. Yet, as the state considers implementing managed care in the counties surrounding Sacramento County through the GMC model, respondents suggest that GMC can increase access compared to fee for service because private managed care plans theoretically have full provider networks, and plans can negotiate higher rates with specialists to get them to participate in their networks (which also is also the case for both the local and private plans in the two-plan model).

Medi-Cal reimbursement rates to providers historically have been lower relative to costs than Medicaid rates paid by other states. As one state official observed, "California is rich on eligibility and benefits but thin on reimbursement." As California's budget problems have worsened, the state has taken steps to cut already low Medi-Cal provider payment rates. 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, already inadequate Medi-Cal provider participation likely would be reduced.

In 2008, California began requiring mid-year income status reports for children to remain in the Medi-Cal program the entire year. In March 2009, the state removed this requirement in order to receive the increased Federal Medical Assistance Percentage provided under the federal economic stimulus package. However, federal stimulus funds were not sufficient to prevent cuts such as the elimination of Medi-Cal coverage for certain services, including adult dental care and eye exams, slated to take effect in July 2009.

Access Gaps for Low-Income People

Emergency department use has been rising in Sacramento, a development that respondents attributed, in part, to the economic downturn and the increasing difficulty in finding private practitioners willing to take low-income

patients either as charity care or at Medi-Cal rates. Safety-net respondents noted that access problems are especially acute for specialty, mental health, and dental care. Low-income people largely rely on UC Davis physicians for specialty care, but appointment availability is limited. Services are in place for low-income people with serious mental illness, but capacity is limited, and services for more basic behavioral health needs such as anxiety and depression are in particularly short supply. The safety net for dental services is limited to hygienist schools and a county clinic for the medically indigent, leaving EDs to treat many dental complaints, many of which they are ill-equipped to handle.

There is widespread recognition that the capacity and financial health of the Sacramento safety net pale in comparison to many other California counties, and local stakeholders recognize the need to collaborate to improve access to care and strengthen the safety net. Several efforts are underway, including boosting the availability of specialists for low-income people by placing specialists in clinics and developing telemedicine. The community also is working to redirect frequent ED users, with a particular focus on helping people access available housing, mental health care, and substance abuse treatment through the T3 program (Triage, Transport and Treatment), a partnership of Sutter Health, The Effort Community Health Center, and county housing services.

Significant reform of the safety net may be on the horizon. Since 2007, hospitals, clinics, foundations, and others have come together through the Sacramento Health Care Improvement Project (SHIP) to restructure the safety net. This group has compiled an inventory of the community's safety-net services. SHIP's goals include improving access to specific services and strengthening and expanding safety-net providers to create a more seamless, coordinated system for low-income people, whether they have public insurance, qualify for medically indigent status, or lack coverage altogether. It remains to be seen whether this will prompt changes in funding streams and help build partnerships to restructure the system.

Issues to Track

To date, Sacramento's strong and stable hospital systems have managed to maintain a generally cooperative environment while competing with one another. Their financial strength and Sacramento's relatively favorable payer mix have made this community better equipped to compensate for a fragmented safety net than other communities with failing hospitals and weaker socioeconomic profiles. But looming problems threaten the Sacramento market's relative stability—including the economic downturn and sharply rising unemployment; state and local fiscal woes; increasing costs of financing hospital expansion projects; and intensifying commercial payer pushback on rising hospital rates. The following are among the key issues to track:

- Will the current capacity expansions by the hospital systems lead to excess capacity in the future? How will the increased capacity affect the competitive dynamic among the systems, the relative leverage between systems and health plans, and the financial health of hospitals?
- Will the enrollment shift from HMOs to PPOs and CDHPs gain momentum? If so, what effect will there be on the delegated model of managed care?
- Will a new county contract for indigent care, enhanced Medi-Cal rates for health centers, and emerging collaboration to improve the safety net have an impact on access and care for low-income people?
- How will the economic downturn play out for the health care system? Will the state's budget crisis force it to further reduce Medi-Cal rates? If so, to what extent can hospitals continue to exercise their leverage against a shrinking commercial base to force increased subsidization of public payers and charity care?

ENDNOTES

1. Maglinte, Janet, *Economic Profile: Greater Sacramento Region,* California Regional Economies Project, Sacramento, CA (October 2008).

2. Cattaneo & Stroud, Inc., *2006 California Statewide HMO & Special Programs Enrollment Study,* Burlingame, CA (2008).

3. While most PPOs are regulated by CDI, most Blue Cross and Blue Shield PPO products operate under Knox-Keene licensure, putting them under DMHC regulatory control. See Roth, Debra L., and Kelch, Deborah Reidy, *Making Sense of Managed Care Regulation in California,* California HealthCare Foundation Report, The California HealthCare Foundation (CHCF), Oakland, CA (November 2001).

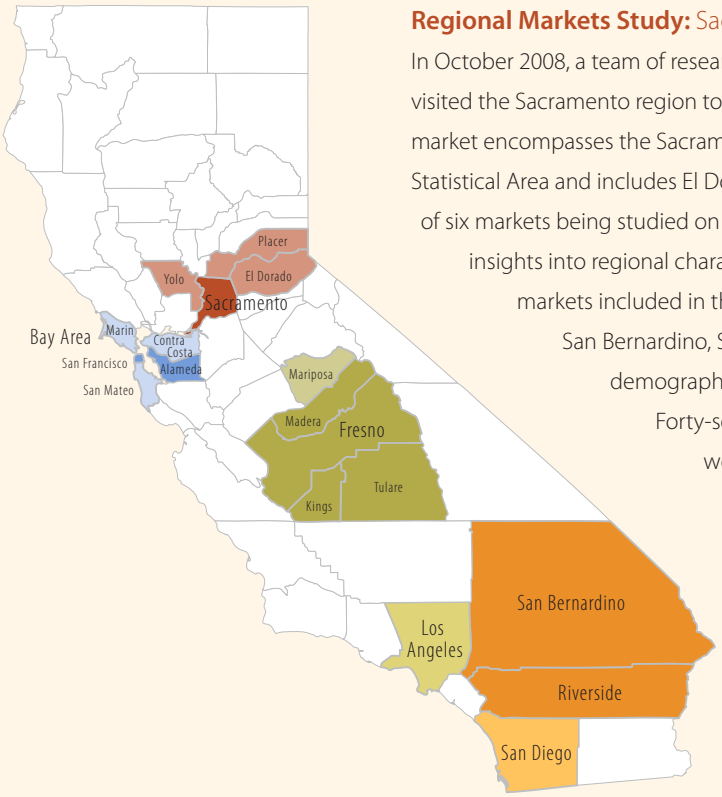
4. For example, DMHC's regulatory scope includes quality of care while CDI's does not. Also, products under DMHC jurisdiction are required to provide all "medically necessary basic health care services," including services such as maternity; products under CDI jurisdiction have no equivalent requirement.

5. 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.

6. The CalPERS program covers state employees by law. Local public agencies and school districts in California can choose whether to purchase their own health insurance or participate in CalPERS.

7. The Healthy Kids Program provides health insurance coverage for low-income children (in households with incomes at or below 300 percent of the federal poverty level) who are ineligible for public programs such as Medi-Cal.

8. Lewis, Robert, "Promises of Lower Medical Bills for Sacramento County Prove Costly Instead," *The Sacramento Bee* (April 15, 2009).



Regional Markets Study: Sacramento

In October 2008, a team of researchers from the Center for Studying Health System Change (HSC) visited the Sacramento region to study that market's local health care system. The Sacramento market encompasses the Sacramento — Arden-Arcade — Roseville, California, Metropolitan Statistical Area and includes El Dorado, Placer, Sacramento, and Yolo counties. Sacramento 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-seven interviews of leaders of the Sacramento health care market were conducted to inform this report. Because the interviews were conducted primarily in Sacramento County, this report is best read as a description of that county's health care system.

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ABOUT THE AUTHORS

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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.