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San Francisco Bay Area: Downturn Stresses Historically Stable Safety Net

San Francisco Bay Area Market Background

Approximately 4.2 million people reside in the San Francisco Bay Area (nearly 12 percent of the state's population), encompassing a rich diversity of cultures and ethnic backgrounds (see Table 1 on page 2). Fewer than half the residents are white, and 20 percent are Asian (almost double the statewide average of 12 percent). About 28 percent of residents are foreign born, and nearly 12 percent are 65 years or older, slightly higher than the California average of approximately 11 percent. Population growth in the last 10 years has been relatively low (close to 7 percent) in comparison to the nearly 14 percent growth rate in California's population overall. The proportion of Bay Area households with incomes above $50,000 is relatively high (62 percent versus a statewide average of 51 percent), as is the proportion of the population with a college degree (49 percent versus 36 percent statewide). It is estimated that about 8 percent of Bay Area residents do not have health insurance, considerably lower than the state average of just over 13 percent.

Historically, the Bay Area economy has been strong, buttressed by a number of Fortune 500 corporations such as Levi Strauss & Company, McKesson Corporation, and Wells Fargo & Company.[1] Tourism is a significant part of the economy in the city of San Francisco, where there is substantial employment in the service and retail sectors. In the broader Bay Area, high-tech industries have been an important source of employment over the past two decades, as have health care organizations. Unemployment in the Bay Area was estimated at 8.4 percent in January 2009 (compared to 10.6 percent statewide); this number is expected to rise as the economic downturn continues.

Hospital Systems Exert Leverage, Face Challenges

The Bay Area has 211 acute care hospital beds per 100,000 residents, somewhat higher than the California average (182), reflecting in part the area's prominence as a referral center. Kaiser Permanente and Sutter Health are the dominant hospital systems, each accounting for 20 to 25 percent of inpatient admissions. University of California San Francisco Medical Center (UCSF) and Catholic Healthcare West (CHW) also have a significant presence. In the East Bay, John Muir Health is a smaller but important system.

The present structure of hospital systems in the Bay Area is a result, in part, of significant hospital market consolidation that occurred in the 1990s. No recent hospital closures or mergers have occurred, but Sutter Health continues to reconfigure its system. California Pacific Medical Center (CPMC), the largest Sutter Health facility in the Bay Area, recently responded to public pressure to provide financial support to St. Luke's Hospital to keep it open. Sutter had planned to close St. Luke's this past year and convert it to an ambulatory care facility. This financially troubled hospital traditionally has served a low-income population drawn largely from San Francisco's Mission District and consequently has an unfavorable payer mix. Respondents believed keeping St. Luke's open was a requirement to obtain permission from the city for CPMC to

eventually develop a new location at Cathedral Hill, near downtown, where there is more room to expand.

Inpatient volume has generally been steady in Bay Area hospitals, with some facilities seeing substantial growth in outpatient services. Today, the hospitals and hospital systems can be characterized as more "competitive" than "cooperative," as they jockey to attract admissions from a relatively stable population, including residents that go outside of the market to seek care, such as from Stanford Hospital or Lucile Packard Children's Hospital, both in nearby Santa Clara County. Sutter's dominant market position reportedly gives the system substantial leverage in negotiating rates with health plans, while John Muir Health and UCSF also are perceived to have leverage in certain geographic and service areas.

Bay Area hospitals seek and often obtain higher commercial payment rates in an effort to offset growing losses on Medicare, Medi-Cal, and uninsured patients. Respondents noted that Medicare losses reflect, in part, low payment rates because of an unfavorable geographic adjustment. Respondents also observed that Medi-Cal rates are lower in relation to costs than Medicaid rates in other states, creating further pressure on hospitals to negotiate higher rates with private payers to subsidize the losses. However, some hospital respondents reported tempering negotiating demands for fear that health plans will lose market share to Kaiser if their premiums are too high, which could result in lower revenues for non-Kaiser hospitals in the long run.

Currently, there is a wide range of profitability in Bay Area hospitals and,

Table 1. Demographic and Health System Characteristics: San Francisco Bay Region vs. California

POPULATION STATISTICS	San Francisco Bay	California
Total population	4,203,898	36,553,215
Population growth, 1997–2007	6.6%	13.6%
Population growth, 2002–2007	0.6%	4.1%
AGE OF POPULATION		
Persons under 5 years old	6.4%	7.3%
Persons under 18 years old	22.2%	26.9%
Persons 18 to 64 years old	65.9%	62.5%
Persons 65 years and older	11.9%	10.6%
RACE/ETHNICITY		
White non-Latino	46.2%	43.3%
African American non-Latino	8.3%	5.8%
Latino	20.8%	36.1%
Asian non-Latino	20.4%	11.8%
Other race non-Latino	4.2%	3.1%
Foreign-born	27.5%	25.7%
Limited/no English, adults	27.6%	35.2%
EDUCATION, ADULTS 25 AND OLDER		
High school degree or higher	89.7%	82.9%
College degree or higher	49.4%	35.7%
HEALTH STATUS		
Fair/poor health status	12.5%	15.8%
Diabetes	7.0%	7.8%
Asthma	14.6%	13.6%
Heart disease, adults	5.5%	6.3%
ECONOMIC INDICATORS		
Below 100% federal poverty level	11.0%	15.7%
Below 200% federal poverty level	22.4%	33.5%
Household income above $50,000	61.6%	51.1%
Unemployment rate, January 2009	8.4%	10.6%
HEALTH INSURANCE, ALL AGES		
Private insurance	69.3%	59.1%
Medicare	9.6%	8.5%
Medi-Cal and other public programs	13.4%	19.3%
Uninsured	7.8%	13.2%
SUPPLY OF HEALTH PROFESSIONALS, 2008		
Physicians per 100,000 population	239	174
Primary care physicians per 100,000 population	79	59
Dentists per 100,000 population	89	69
HOSPITALS		
Staffed community, acute care hospital beds per 100,000 population, 2006	211	182
Hospital concentration, 2006 (Herfindahl index)	1,176	1,380
Operating margin including net Disproportionate Share Hospital payments	3.4%	1.2%
Occupancy rate for licensed beds	56.4%	59.0%
Average length of stay (days)	4.9	4.5
Paid full-time equivalents per 1000 adjusted patient days	15.9	15.7
Total operating expense per adjusted patient day	$2,934	$2,376

Notes: All estimates pertain to 2007 unless otherwise noted. San Francisco Bay region includes Alameda, Contra Costa, Marin, San Francisco, and San Mateo 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.

consequently, a large contrast between financially advantaged "have" and financially disadvantaged "have-not" hospitals. For example, CPMC has a relatively favorable payer mix (low proportions of Medicare, Medi-Cal, and uninsured patients), while such hospitals as Doctors Medical Center in Richmond and St. Luke's Hospital struggle to remain financially viable. There is concern in the community about the possible impact that a collapse of one or more of the "have-not" hospitals would have on the health care system in general and the safety net in particular. This concern has been heightened recently by hospital reports of fewer elective procedures and an increased number of uninsured patients in emergency departments, both attributed to the worsening economy.

Hospitals are enthusiastic about efforts to improve quality, which recently have emphasized the use of physician profiling. Hospitals also are trying to reduce lengths of stay to free up beds more rapidly in a bed-constrained environment. Kaiser's quality improvement efforts have had an important impact on other hospitals in the market, setting market standards in some areas. Kaiser has invested heavily in information technology (IT), while most other hospital systems have not yet fully implemented electronic health record (EHR) or computerized physician order entry (CPOE) systems. A market observer noted, "If we don't emulate [Kaiser's IT strategy] quickly, we'll lose market share based on the patient experience."

Non-Kaiser hospitals are also trying to compete by using foundation models (some of which are in the early stage of development) to more tightly align with physicians, or by strengthening existing affiliations with physicians.[2] In doing so, hospitals hope to create a system of care spanning outpatient and inpatient services that will be attractive to patients. Across all hospitals, competition is especially intense for patients in the most profitable service lines, such as cardiology and neurology.

Bay Area hospitals face several significant operational issues in addition to maintaining a viable payer mix. The area's high cost of living exerts upward pressure on hospital staff wages, often resulting in contentious labor negotiations and, ultimately, pressure for higher hospital payment rates. A hospital respondent said, "San Francisco is a hotbed of organized labor, which drives costs up, whether you are heavily unionized or you are trying to keep the wages up so you don't become unionized."

Hospitals also pointed to the financial pressures — which have intensified with the economic downturn — of meeting new seismic requirements and installing new information systems as a justification for higher payment rates. While the implementation of health information technology has been a large operational issue for many Bay Area hospitals, the need to comply with seismic requirements has been an important challenge for all hospitals in the market, leading to the replacement of some facilities and upgrading of other facilities. For instance, CPMC reportedly will spend more than $2 billion on seismic upgrades over six years, Kaiser will spend more than $1 billion to replace its Oakland Medical Center, and voters passed an $887 million bond issue to rebuild most of San Francisco General Hospital to meet seismic requirements. A hospital respondent simply stated, "California's seismic standards drive capital." Hospitals fear that regulatory-driven demands for construction will outstrip the capacity of the few contractors with hospital construction expertise, making it difficult to meet regulatory deadlines.

Another significant challenge for Bay Area hospitals is Kaiser's continued market strength. Most hospitals view Kaiser as their main competitor. Bay Area residents enrolled in Kaiser's health plan, for the most part, are treated in Kaiser hospitals and are not part of the pool of potential patients for non-Kaiser hospitals. However, some Bay Area hospitals also view Kaiser as a customer, because Kaiser outsources some specialized care to them. As a hospital respondent said, "Kaiser is sort of a competitor, but it is also a customer because they purchase very high-end stuff from us. We have benefited from their growth, because we do their super-specialty stuff." Recently, however, Kaiser has developed internal capacity to offer some services that it previously

purchased from non-Kaiser hospitals. Some non-Kaiser hospital respondents argued that Kaiser has a competitive advantage because its hospitals serve fewer Medi-Cal and uninsured patients.

Physicians Seek Safety in Numbers

The Bay Area has a considerably larger number of physicians per 100,000 residents compared to the state average (239 versus 174). Outside of Kaiser and UCSF, physicians tend to practice either as solo practitioners or in small groups, reflecting physicians' historical emphasis on autonomy and independence. Many physicians participate in one or two large independent practice associations (IPAs), or their practices are part of hospital-sponsored foundations. Seeking IPA membership is a key competitive strategy for both primary care and specialty physicians, because IPAs provide some negotiating power with health plans, as well as practice support.

The Hill Physicians Medical Group is among the area's largest IPAs, with 800 primary care physicians and 1,800 specialists between the Bay Area and Sacramento; it contracts only with HMOs. Hill physicians provide inpatient care at a number of hospitals, including Children's Hospital and Research Center, CHW, John Muir Health, Sutter Health, UCSF Medical Center, and ValleyCare. Brown & Toland, another large IPA, has a network of 1,500 primary care and specialist physicians and contracts with HMOs, PPOs, and Medicare Advantage plans. About half of Brown & Toland's network physicians currently practice at UCSF, with most of the remaining physicians practicing at CPMC. However, due to a contract dispute, Brown & Toland is threatening not to renew its contract with UCSF when it expires in June 2009.[3]

The John Muir Physician Network consists of the John Muir Medical Group, with approximately 130 primary care physicians; and the Muir Medical Group IPA, which contracts with approximately 800 primary care and specialist physicians. CPMC recently formed Physician Foundation Medical Associates, a Sutter-owned foundation with 100 specialists with plans to add primary care physicians. There also are a number of large medical groups and IPAs affiliated with Sutter Health, including, for example, Berkeley/Oakland-based Alta Bates Medical Group with approximately 600 primary care and specialist physicians. Large groups not affiliated with hospitals include Bay Valley Medical Group and Physician Integrated Medical Group.

Even though Bay Area physicians value their independence, there is a general consensus that small, independent physician practices are becoming less viable. It is becoming increasingly common for existing physician groups to join larger medical groups or affiliate with hospital-sponsored foundations. Primary care physicians coming into the market are joining medical groups. As one respondent stated, "Physicians with more mature practices, particularly on the primary care side, find it untenable to practice as an independent physician." Hospitals feel compelled to create groups within their affiliated foundations to attract both younger physicians seeking a stable salary and established physicians no longer able to accommodate low reimbursement rates. There is a growing sense that "no one wants to hang a shingle up," with Kaiser providing an especially attractive practice option for young physicians in terms of income stability and regular work hours. A market observer noted, "Physicians are gravitating toward Kaiser and other large multi-specialty groups for lifestyle reasons and the ability to practice medicine without difficulty from insurance companies."

The pressures facing physician groups include low reimbursements (with Medi-Cal being the lowest payer) and the difficulty of recruiting new—especially primary care—physicians because of the Bay Area's high cost of living. Physicians in independent practices typically have little leverage with health plans; they are offered a fee schedule that they must accept to be included in health plan provider networks. Some highly regarded specialists are reportedly able to reject health plan rates and still generate sufficient revenues as out-of-network providers. Sutter

and other hospital systems use their leverage to negotiate favorable rates with health plans on behalf of their affiliated physicians.

Physicians and hospitals have developed a variety of financial relationships, aimed at aligning their interests while also allowing them to compete effectively in the market. Some physicians are building outpatient facilities that compete with hospital outpatient departments for patients. This type of activity has led to joint ventures between hospitals and physicians to build surgical centers, as hospitals try to protect revenue streams. One hospital respondent described the situation as follows, "If we hadn't [joint ventured with physicians], we would have lost a fortune. Now, we just lose some fortune." Overall, while there are "flare-ups" relationships between physicians and Bay Area hospitals were described as generally "tranquil."

Health Plans Struggle to Control Costs

Kaiser and Anthem Blue Cross are the dominant health plans in the Bay Area, followed by Blue Shield of California and Health Net. Large national plans operating in the Bay Area include Aetna, CIGNA, and UnitedHealthcare, with all having relatively smaller market shares. Kaiser is offered by most large employers. Anthem Blue Cross and Blue Shield of California compete in all market segments. The large national plans focus on serving national employers, including some that are headquartered in the Bay Area.

Kaiser continues to differentiate itself in the Bay Area health plan market, primarily through its integrated delivery system and a consistent marketing emphasis on maintaining members' health through preventive health care and wellness programs. Other plans' competitive strategies include offering a diverse array of product choices, pursuing aggressive pricing strategies in the small group market, and improving relations with brokers and agents. Overall, however, benefits consultants suggested there were few differences among the strategies of the non-Kaiser plans in the Bay Area or statewide; all attempt to offer broad provider networks, an array of products, some level of utilization management, wellness and disease management programs, and better information on the cost and quality of provider services for plan members.

In general, health plans have difficulty offering insured products in the Bay Area at premiums similar to the premium levels for the same products in other California communities. Health plan respondents described the Bay Area as a relatively high cost market compared with other areas of the state, because of the high underlying costs of delivering care and a high degree of provider consolidation.

Hospital concentration makes it difficult for plans to negotiate lower rates for hospital services (inpatient and outpatient); plans essentially must include all hospital systems in their PPO networks to meet employer demands, giving the hospital systems leverage in the negotiation process. A health plan respondent noted, "The hospitals are at full capacity, and a number of them have consolidated into very powerful systems. They enjoy significant monopoly leverage over all plans."

With respect to physicians, a similar dynamic is in place; it is difficult for plans to drop high-cost physicians from their networks because this would entail dropping entire physician groups, which would make the plans' products unattractive to employers. Recent rulings related to maintaining geographic coverage in plan networks from the state Department of Managed Health Care — the agency that regulates HMOs — were also cited by plans as limiting their ability to drop hospitals and physician groups from networks. As a result, plans believe that providers clearly have the upper hand in payment negotiations.

Further complicating this negotiating environment, plans fear the state will reduce already low Medi-Cal provider payment rates. This could intensify already aggressive provider efforts to "make up" losses incurred in treating Medicare, Medi-Cal, and uninsured patients by negotiating higher rates for private patients. Currently, private plans reportedly pay hospitals and physician groups with

negotiating leverage comparatively higher rates than paid by Medicare, while paying physicians who are not affiliated with larger organizations close to what Medicare pays.

Plans typically pay capitated rates (fixed per-patient, per-month payments) for professional services to physician groups serving their HMO enrollees and fee-for-service rates to physicians in their PPO networks. Hospitals are reimbursed for inpatient services according to a negotiated per diem schedule, but because they have been able to negotiate favorable stop-loss provisions in their contracts, a substantial portion of their reimbursement is based on some variant of billed charges. For example, after the stop-loss level is reached, hospitals may receive a percentage of billed charges for additional days or, in some cases, payment may be based on billed charges for the entire stay. For outpatient services, hospitals are typically reimbursed on a fee schedule or a percentage of billed charges, depending on the service.

Employers Explore New Benefits Offerings

Enrollment levels in HMO and PPO products are about equal in the Bay Area. As of 2006, commercial HMO penetration was 58 percent while overall HMO penetration was 55 percent (compared to commercial HMO penetration of 46 percent and overall HMO penetration of 47 percent for California as a whole).[4] PPOs appear to be more common in the health benefits offerings of large employers. Large employers typically offer an HMO and a PPO product to their employees, and increasingly some form of consumer-directed health plan (CDHP): a high-deductible plan with (or eligible for) either a health savings account (HSA) or a health reimbursement arrangement (HRA).[5] Some large employers offer a non-Kaiser HMO option along with the same plan's PPO, but they also offer Kaiser as a third option.

The traditional price advantage of the HMO products offered by non-Kaiser plans, relative to PPOs, has eroded. Provider discounts are becoming harder for non-Kaiser plans to negotiate, putting upward pressure on HMO premiums. In PPO products, there is more flexibility to raise deductibles and coinsurance rates to keep premiums at competitive levels.

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.[6,7] HMOs are at an even greater disadvantage compared to self-insured PPOs, which are not subject to benefit mandates and are minimally regulated by the U.S. Department of Labor. 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.

Given their perceived lack of leverage in provider negotiations, all plans are offering employers more benefit designs that feature greater patient cost sharing in an effort to hold down increases in employer costs. Even Kaiser, long committed to HMOs, has recently introduced plans that have high deductibles and is preparing to offer administrative services and other products to self-insured employers.

Price-sensitive small employers have moved to benefit designs with increased cost- sharing requirements, but this has done little to hold down double-digit premium increases. However, small employers reportedly are enthusiastic about CDHPs because of their lower premiums. Where the products include health savings accounts, benefits consultants reported that small employers often make no contribution to the accounts. Some employers that offer these products contribute to a separate account that they establish for employees to mitigate the impact of the deductible. The existence of these accounts, managed by a third party and sometimes not disclosed to health plans, makes it difficult for the plans to accurately price their product. The price set by plans for the CDHP assumes that enrollee utilization is dampened by having to pay for all costs up to the amount of the deductible. When a savings account covers some of these costs, however, utilization may be higher than the

plans expected when they initially set the premiums. In response, health plans are now refusing to offer CDHPs when employers establish separate spending accounts for employees.

Overall, there is no general agreement about the future of CDHPs in the Bay Area. Some respondents believed that these products are less attractive in California than in other states because California does not offer the same favorable tax treatment for HSA contributions as offered by the federal government. To date, enrollment in CDHPs offered by large employers has been relatively low.

There is some interest among Bay Area employers and health plans in "narrow-network" products, whereby the health plan creates a new product that excludes a provider system with rates that are viewed as too high. An employer could offer a narrow-network product alongside a broader-network product that does include the system, but costs more, with the employee paying the additional cost. In the Bay Area, discussion of narrow networks typically focuses on Sutter Health as the excluded entity, because CalPERS (the purchasing group for state and many local government employees) has offered such a product through Blue Shield of California.[8] But some health plans are reportedly reluctant to exclude Sutter, concerned that Sutter will demand higher payment rates for those products in which it does participate. Most employers also appear hesitant to offer any product that excludes Sutter, and the price advantage of these products may not be large enough to attract unenthusiastic employers.

Strong Safety Net Faces Budget Challenges

Compared to other California communities, the health care safety net for low-income people in San Francisco County is extensive and relatively stable. The safety net benefits from a strong commitment on the part of elected officials and community residents to provide health care for vulnerable populations. According to one respondent, "The political will in this county to provide [health care] access to the uninsured has been demonstrated over and over again." However, the economic downturn has resulted in local budget shortfalls that affect safety-net funding; federal funding from the American Recovery and Reinvestment Act of 2009 is expected to offer some relief.[9]

San Francisco General Hospital (SFGH), a public hospital owned and operated by the city and county of San Francisco Department of Public Health (the city and county of San Francisco are the same entity), is the main safety-net hospital in San Francisco. UCSF Medical Center's key safety-net role is to provide faculty members to treat low-income patients at SFGH. St. Luke's Hospital remains an important safety-net hospital by virtue of its location in a relatively low-income neighborhood, with CPMC providing financial support to St. Luke's and some community clinics. St. Francis Memorial Hospital, part of CHW, provides a significant amount of uncompensated care, as does St. Mary's Medical Center, also part of CHW.

SFGH receives significant local funding to care for San Francisco's medically indigent and other uninsured patients; SFGH represents approximately half of the local health department's budget. However, funding challenges have led SFGH to cut some services, including reducing the number of inpatient psychiatric beds and reducing evening clinic hours. The hospital has become increasingly reliant on grants from private foundations, which have, for example, allowed the hospital to pursue initiatives focused on the care of elderly patients. Other hospitals receive minimal local funding to care for medically indigent patients in their emergency departments. The city's proposed 2009–2010 budget includes cuts to health department services including HIV/AIDS, mental health and substance abuse programs, and cuts to nursing and other staff.

In Alameda County, the Alameda County Medical Center (ACMC) is the county's public hospital system, with its Highland Hospital serving as the main safety-net hospital and providing about half the uncompensated care in the area. Secondary safety-net hospitals in Oakland include Alta Bates, St. Rose, and the Children's Hospital and Research

Center. ACMC is highly dependent on Alameda County for funding because its payer mix consists of over half Medi-Cal and almost one-third medically indigent and uncompensated care. The growing gap between Medi-Cal rates and hospital costs presents a major financial challenge. Local funding in Alameda County — both through a program for the medically indigent to receive health care and a dedicated half-penny sales tax — helps support safety-net providers. However, these revenue streams have declined because of the bad economy, and funding for each provider is capped and often is insufficient to meet demand.

San Francisco County has 25 primary care clinics that serve low-income people; half are county facilities and half are private, not-for-profit community health centers (CHCs). Alameda County has three primary care clinics operated by ACMC and eight private, not-for-profit CHCs with multiple sites. In Alameda County, the not-for-profit CHCs play a bigger role than do the ACMC clinics. Health center consortia in both counties bring the centers together to partner on activities such as fundraising, developing programs to promote access and quality, and contracting with Medi-Cal plans.

Many health centers and county clinics in San Francisco and Alameda counties benefit financially from their status as federally qualified health centers (FQHCs), which provides direct federal funding and enhanced Medi-Cal rates; or FQHC "look-alike" status, which provides just the enhanced Medi-Cal rates. The enhanced Medi-Cal rates vary by region of the state and reflect, in part, historical utilization patterns. Alameda clinics and health centers also receive funding from the State Health Care Coverage Initiative, a demonstration program negotiated under a 2005 Medicaid hospital financing waiver due to expire in 2010, in which 10 counties (including Alameda, Contra Costa, San Francisco, and San Mateo) receive federal matching funds to pay for health services for low-income, uninsured people. In San Francisco, these funds are used to support the Healthy San Francisco program (see below).

Gaps in Access for Low-Income People

Despite the relative strength of the local safety net, providing access to care for low-income people continues to be a challenge. Overall, the demand for care has been increasing relative to available resources, and there is concern that the economic downturn will continue to strain access to care.

In Alameda County, Highland Hospital provides hospital care, but there may be long waits for patients admitted through the emergency department (ED). In San Francisco, low-income people appear to have reasonable access to hospital care through SFGH. The hospital operates an urgent care center, allowing the ED to focus on more seriously ill patients. In contrast, the Highland Hospital ED is crowded, with about half of the patients visiting for non-urgent care.

Access to primary care is seen as relatively good across the Bay Area, although respondents reported demand has been increasing, and some respondents in Alameda noted concern about long wait times for primary care appointments. Many of San Francisco's clinics and CHCs have expanded their hours to accommodate additional patients. Alameda's CHCs also have expanded significantly in recent years, although two of ACMC's clinics were closed approximately five years ago because of county financial problems.

Access to specialty care, however, is a longstanding problem for low-income people throughout the Bay Area. A number of efforts are underway in San Francisco and Alameda counties to improve access to specialists, including integrating specialists into CHCs. Safety-net providers also are using information technology to improve the specialty referral process. San Francisco General Hospital, for example, uses a program called eReferral, which facilitates communication and coordination among UCSF physicians to ensure that a referral is necessary and given appropriate priority. Mental health providers are often at capacity, with access becoming more difficult in recent years, especially for people with less severe problems.

Healthy San Francisco Targets Uninsured

Implemented in 2007, the Healthy San Francisco (HSF) program is intended to give low-income, uninsured adults access to a "medical home" that provides primary care and coordinates access to other services, including specialty care, as needed. The medical home is the health care provider an enrollee chooses to be the first point of contact and where she or he receives basic medical care. The medical home provider refers the enrollee to other providers as needed for other services, such as hospital care.

Unlike Medi-Cal, HSF does not provide insurance coverage, but instead seeks to organize and coordinate the care of uninsured individuals and encourage the use of primary care providers instead of emergency departments. Operated by the San Francisco Health Department, HSF is open to residents of San Francisco with incomes less than 500 percent of the federal poverty level (a recent expansion from 300 percent), or $54,150 for an individual, regardless of immigration status, employment status, or pre-existing conditions, who are not otherwise eligible for public insurance, such as Medi-Cal.

Funds for the program come primarily from city and county dollars that support SFGH and county clinics; federal and state funding from the Medicaid waiver; and participants, who pay both quarterly and point-of-service fees. SFGH provides most of the hospital services to HSF enrollees. HSF does not reimburse non-county providers for treating HSF enrollees, but other hospitals have begun to treat enrollees as charity care patients. The county clinics and CHCs serve as medical homes for HSF participants. HSF also provides grants for clinics and health centers to expand their capacity to serve enrollees—for example, by adding staff to help enroll people in the program and expanding hours of operation—but the program has imposed additional administrative burdens on these providers. There also is concern that patient cost sharing under HSF impedes access to care for some enrollees, even though required enrollee payments are adjusted by income level.

As of July 2009, more than 43,000 uninsured adults were enrolled in HSF—more than half of the estimated number of uninsured adults in San Francisco—and enrollment continues to grow. Many of the initial enrollees already were being treated in the safety-net system. At full enrollment, HSF is expected to cost $200 million annually.

The most controversial part of HSF's financing approach is an assessment on employers (with 20 or more employees) that are not providing workers with health insurance. They currently make a payment of $1.23 to $1.85 per hour worked, depending on their size, for each uninsured employee; these rates will increase to $1.31 to $1.96 per hour in 2010. Small employers argue that, as currently structured, HSF dramatically increases their employee compensation costs and could result in lost jobs in the city's service sector. Some employers advocate increasing the city's sales tax to provide a broader funding base for the program.

Low Medi-Cal Payment Rates, Declining Provider Participation

Historically, Medi-Cal has been relatively generous in terms of eligibility and benefits, but Medi-Cal provider payment rates are among the lowest in the country. Bay Area physician participation in Medi-Cal reportedly is shrinking because of low payment rates and, in Alameda, the retirement of physicians who treated significant numbers of Medi-Cal patients. As one respondent surmised, "Our physicians and hospitals are paid lower than any other state for services, which is why you'll find very few individual physicians, specialists especially, that take Medi-Cal." As a result, more Medi-Cal patients are being served in safety-net clinics.

Additionally, given serious budget shortfalls, the state is attempting to reduce Medi-Cal rates for many providers and services. 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 will likely shrink further.

Approximately 13 percent of individuals in the Bay Area are enrolled in Medi-Cal or other public programs, compared with the state average of 19 percent. A significant number of people eligible for Medi-Cal are not enrolled, and new rules have made enrolling and staying in Medi-Cal more difficult. However, there is some optimism that the One-E-App system — a Web-based application that allows county agencies, community providers, and county health plans in Alameda, San Francisco, and San Mateo to screen uninsured people for state and local programs and submit applications electronically — will help overcome these barriers.

Both San Francisco and Alameda counties have a two-plan Medi-Cal managed care model, consisting of a county-run plan (the San Francisco Health Plan and the Alameda Alliance for Health, respectively) and a commercial plan (Anthem Blue Cross). The intent is to provide enrollees with a choice of plans and to generate competition for members. County plans rely heavily on safety-net providers to serve enrollees and appear to enjoy significant public support. Their networks are relatively broad, including all types of providers. Primary care physician participation in the public plans reportedly is good, but maintaining specialist participation is financially challenging, with plans often needing to pay above state Medi-Cal reimbursement rates to some types of physicians to secure their participation. As one plan executive explained, "We pay 125 to 175 percent of the Medi-Cal schedule, depending on the scarcity of the specialty." Reportedly, this has strained the plans' financial reserves.

Issues to Track

Bay Area hospital systems are relatively stable, but some financially weak hospitals are vulnerable and may be unable to weather the financial downturn or generate the necessary capital to meet seismic requirements. The health plan market also appears stable, at least with respect to the number of plans. However, plans are struggling to hold down costs, and their main strategy to respond to employer demands is to introduce products with increased patient cost-sharing requirements. The biggest future challenge to the Bay Area health care market may be maintaining a longstanding commitment to a strong safety net for residents, in the face of rising numbers of uninsured and potential reductions in Medi-Cal payment rates. The following are among the key issues to track:

- Will other Bay Area health care systems be able to compete effectively with Kaiser on dimensions such as attracting and retaining physicians and in implementing information technology to improve quality of care?
- To what degree will effects of the economic crisis — declining patient volumes and frozen capital markets — preclude hospitals from implementing their plans to meet seismic standards, and will regulators allow additional time or force closures in response?
- Will affiliations between Bay Area physicians and hospital systems grow stronger and, if so, what impact will this have on health care quality and costs?
- How will employer strategies to contain health care costs through leaner benefits and increased cost sharing requirements affect patients' use of services and health care providers' revenues? To what extent will HMO products remain competitive in this environment?
- Can Bay Area safety-net providers cope with increasing numbers of uninsured residents coupled with eroding funding? Will Medi-Cal payment rates be reduced and will this result in further decreases in physician and other provider participation and a decline in access for enrollees?

ENDNOTES

1. Hoovers, Inc., "Fortune 500 Companies," **www.hoovers.com** (accessed March 16, 2009).

2. 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.

3. Rauber, Chris, "Fight Strains Relations at UCSF, Brown & Toland," *San Francisco Business Times* (December 12, 2008).

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

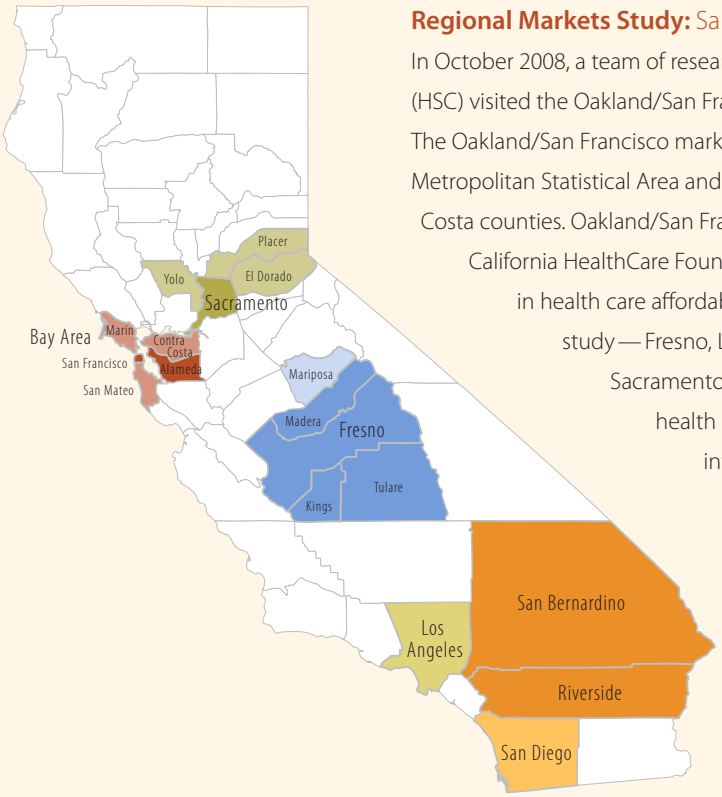
5. HSAs are tax-favored accounts that must be linked to health plans with minimum deductibles of $1,100 for self-only coverage and $2,200 for family coverage in 2008. HRAs are accounts funded and owned by the employer; no companion health plan is required. HRA contributions are not subject to business income tax, and unused funds revert to the employer when the employee retires or leaves the company.

6. 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, Oakland, CA (December 2001), **www.chcf.org**.

7. 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.

8. 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.

9. *What California Stands to Gain: The Impact of the Stimulus Package on Health Care,* California HealthCare Foundation, Oakland, CA (March 2009), **www.chcf.org**.



Regional Markets Study: San Francisco Bay Area

In October 2008, a team of researchers from the Center for Studying Health System Change (HSC) visited the Oakland/San Francisco region to study that market's local health care system. The Oakland/San Francisco market encompasses the San Francisco-Oakland-Fremont, California, Metropolitan Statistical Area and includes Alameda, Marin, San Francisco, San Mateo, and Contra Costa counties. Oakland/San Francisco 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. Fifty-five interviews of leaders in the Oakland/San Francisco health care market were conducted to inform this report. Because the interviews were conducted primarily in San Francisco and Alameda counties, this report is best read as a description of those counties' health care systems.

▶ ACCESS THE ENTIRE REGIONAL MARKETS SERIES HERE.

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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.