Sacramento Briefing Transcript

All Health Care Is Local: California's Diverse Health Care Economies

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Note: Transcript has been edited for clarity.

MICHELLE CABRERA: Good afternoon and welcome everyone. My name is Michelle Cabrera and I am a program officer of the California HealthCare Foundation. In the interest of transparency, I want to let everyone know that we are videotaping the session as it's being webcast simultaneously, and we will post the video to our website indefinitely. Know that you are on film.

I am very pleased to welcome my colleague from the Oakland office, Maribeth Shannon. She is director of our Market and Policy Monitor program. Thank you very much.

MARIBETH SHANNON: Thanks Michelle. I am thrilled to be here with Paul. He is a world-famous health economist. He started his career in academia and the RAND Corporation. He was the founding executive director of the Physician Payment Review Commission, a precursor to the MedPAC committee. He has a long history in health care and has studied health care markets across the country. In California, this is the second round of regional market reports that we've done with Paul and his team at the Center for Studying Health System Change. The earlier reports were released in 2009, and now, three years later, we are producing a new set of reports in the same markets. The reports you have in your packets are from two markets: Sacramento and San Bernardino/Riverside. We will have four more released in the coming weeks — Fresno, the San Francisco Bay Area, Los Angeles, and San Diego. In January, we will be releasing reports that look at crosscutting themes across the state, focused on payment reform and on the readiness of communities for coverage expansion.

I hope those will be topics of interest. They will be announced via email and can also be found on our website, www.chcf.org.

I think what you will find most interesting in these reports is how different these communities are. Politics is local and we believe health care is local. It doesn't matter on *average* what the quality or cost is, it matters what local quality and cost are, and the market differences are

interesting. With that, I will turn it over to Dr. Ginsburg. He would like to encourage audience participation, so feel free to ask questions. We are videotaping and producing this as a webinar, and we will ask people to use a microphone, if available, or he will repeat the question so we have a record of that. Feel free to raise your hand.

PAUL GINSBURG: I am looking forward to talking to you and I do want to emphasize that since we have a fair amount of time, this will go better if you ask me good questions or challenge me; and you will probably be right, because when you do this type of site visit work, your main source of information is people you interview. Many of you in the room are people who we have interviewed. We keep it confidential.

As Maribeth said, not only did we find variation across the six California communities but California is distinct from the rest of the country. One interesting note you will find: Fresno doesn't seem to belong to California.

[LAUGHTER]

Fresno's health care system is much more like what you find throughout the rest of the country. It is not odd — it is just not California. The other market reports reflect more typical aspects of California's unique health care system.

This is my agenda. I will talk about the communities before I talk about the cross-cutting themes. We began in early 1995 studying the organization and delivery of health care and how it is changing. We have always focused on communities for a lot of our work. I think we differ from other organizations because we are very active in dissemination and making sure the researchers write up their work in ways that are accessible to audiences in the worlds of policy and industry.

As she [Maribeth] said, this is the follow-up to work we did around three years ago. We went to the same communities, but this time around we had a narrower focus: hospitals and physicians and particularly the safety net. We did not have an emphasis on local insurance markets this time, although we talked to insurers about contracting with hospitals and physicians and other providers. We wanted to make sure to get the contracting in, but the main focus is on the delivery system in this study.

Each of these markets is defined by the metropolitan statistical area. For Fresno we went beyond the metropolitan statistical area to include a number of rural counties that surround Fresno. This was a way for us to get rural content into the study, including discussion of rural health clinics.

Let me review our methods. We interview health care leaders for major local organizations. We often use what we call triangulation, in that we don't write something up just because one person told us something — we want to get multiple perspectives. When we talk about contracting activities between hospitals and physicians and insurers, we want to make sure to hear from all of those parties. We also use a lot of quantitative data. Because it is California, the quantitative data we have, which are sprinkled liberally in our reports, are very useful and very rich.

This slide shows census data — how the markets vary in their socioeconomic profile. You see up at the top, Fresno, by far the poorest, has the majority of its population below two hundred percent of poverty. We group Fresno with Los Angeles and Riverside/San Bernardino, as those areas also have greater poverty than the state as a whole. The other three communities have less poverty, San Francisco Bay being the wealthiest area.

I will review briefly the round-one results for these communities and then talk about what changed. Actually, one thing that affected all of the regions was the severe recession. What I was really struck by as an economist in doing that [the first-round interviews] is how quickly the recession was felt in health care. There is literature about how the economy affects health care spending and utilization; it is usually done on an aggregate level. That literature emphasizes very long legs: If a recession occurs, you might have to wait a few years to see substantial effects in health care. I think for a number of reasons, this recession that we went through seemed to impact the health care delivery much more quickly. Some of the reasons could be the credit crunch, the fact that hospitals lost their ability to continue construction projects, and the fact that people have a lot more patient cost sharing in their insurance. They have to pay more for care out of pocket.

The economic downturn was a big deal in most of the communities and certainly in Fresno. Fresno had been growing rapidly as far as population and the market is geographically segmented. Even if we had not included the rural counties outside the city, we still would have found many distinct submarkets. I think a key thing that makes Fresno different is that Kaiser has much lower penetration in Fresno than in any of the other markets that we went to and also fewer patients in other HMOs. Another thing very specific to Fresno are the provider capacity constraints showing up and posing a real access problem for low-income people.

In updating Fresno in this review, we didn't see many major organizational changes. Most hospitals weathered the downturn fairly well. Unlike the rest of the state, where hospitals are trying very vigorously to align with physicians, little seemed to have been accomplished in Fresno. However, there was some substantial expansion in hospital capacity, although we perceive that the access problems for low-income people were persisting. Fresno trailed the other areas in a number of dimensions in preparing for coverage expansions, like formation of a low-income health plan [LIHP], which is the program to advance on the Medicaid expansion included in the Affordable Care Act. There has been very minimal participation in Fresno and little collaboration among providers to resolve problems of physician shortages.

Los Angeles is a different market. Los Angeles stands out because its hospital market is so fragmented. There are some large prominent hospitals in Los Angeles, like UCLA, but there are no dominant systems. There are a lot of independent hospitals in Los Angeles and they’re not really joined into systems at this point.

In round one, we perceived a growing gap between what we call the *have* and *have not* hospitals. People expect a *have* in their network when they buy health insurance, and if they don't have those hospitals, they don't want the products. This popularity means that hospitals can obtain a very high rate from the insurers. On the other hand, *have not* hospitals may not be distinctive in any way. There may be a lot of hospitals nearby that are similar in quality and cost, and insurers

don't have to have them in the network. So they have less clout. But the physician market is highly competitive. There are some very large physician organizations competing vigorously with each other in HMO products that have a very large market share.

Kaiser is significant in the LA market.

There is also a well-developed and strong safety net. By safety net, I mean public hospitals, community health centers etc., providers that are focused mostly on low-income people.

We found that the gaps between the *have* and *have not* hospitals persisted but they did not increase. One reason may be that payers are pushing back a lot more and resisting rate increases by the hospitals that had not had problems getting them before. I will go into some of the techniques that they are using. Hospitals are very actively pursuing physician integration, working at relationships to prepare for provider payment reform and creating integrated care models with physicians. In accountable care organization contracting, it has been physician organizations, like HealthCare Partners, that have been the leaders. They have been contracting as an ACO directly with the payer and taking on a shared-saving basis the risk for hospital use as well as physician services. One thing I should mention is in California — which has always had a lot of HMO enrollment and put physicians at risk through what we call the delegated model — for the last 10 or 15 years, physicians were only at risk for professional services. Hospital utilization was not something that physicians were at risk for. That's where the difference in California comes in with an ACO, now that hospital risk is included as well. Whether it is a joint initiative by a hospital and physician organization or even if it is just a physician organization like HealthCare Partners, they are taking some risk for use of hospital care.

We find the county safety net, which was strong before, particularly energized by new leadership—someone who was recruited from San Francisco and seen to bring significant redesign in care delivery to the safety net in LA.

In Riverside, San Bernardino, what strikes you is the vastness of the geographic area, and this does lead to a lot of little health care markets rather than one big metropolitan health care market because of the distances involved. The market had been growing rapidly but was already experiencing the housing crash when we visited in 2008. One of the main issues facing providers was concern about losing patients seeking specialty care to Los Angeles next door. There is very strong political support for the local safety net, from the San Bernardino and Riverside county governments. For some reason, FQHC growth has been slower in Riverside/San Bernardino than other markets, maybe a reflection of the leaders of the organizations and their abilities to pull down federal grant funds for expansion.

PARTICIPANT: I'm interested in the idea of strong county systems in Los Angeles and San Bernardino. Do you think that is inhibiting the growth of these independent community clinics, because there is a strong county presence and so they are not developing as much?

GINSBURG: That is not a problem in Los Angeles, as they have had a lot of growth in private agencies, but I think that is an interesting point about San Bernardino.

PARTICIPANT: The finding in Los Angeles of physician organizations taking the lead in developing ACOs and taking hospital risk. Tell us how that fits with the rest of the country.

GINSBURG: It's always struck me that, if you can modulate the risk enough, physician organizations — where they exist and where they are real — can do a much better job in managing costs in an ACO structure than a hospital can. For one thing, they have an opportunity to benefit enormously by reducing hospital admissions. Hospitals can be conflicted about that — they need to fill the beds. But I remember talking to a hospital in a rapidly growing area — not in California — who entered into an ACO contract with Blue Cross. They said, "This area is growing rapidly and we struggle to raise capital — not having to build another tower looks good to us. We are fine about reducing admissions." But generally, I think physician organizations can be better organized around efficiency and also have the ability to steer their patients to lower-cost and more efficient hospitals.

PARTICIPANT: [indiscernible]

GINSBURG: Elsewhere in the country? The one thing I saw in the second rounds of Medicare shared-savings ACO awards was that a surprising number of those are physician organizations.

Moving on to Sacramento. This market has seen rapid population growth. It also has high income, well-educated areas, and powerful not-for-profit hospital systems each with aligned physician groups. In a sense, Sacramento is the most organized of all of these markets as far as the hospitals are in systems, the physicians are in physician organizations — either group practices or IPAs — and the physician organizations are aligned with the hospitals. Kaiser is strong here, and the HMO product continues to be very popular in Sacramento. CalPERS has a large impact on this market.

The contrast is when it comes to safety net: it is small. Part of the explanation for this is because the area is well off, doesn't have as many low-income people as a percentage of population as other areas. Community health care centers are limited, and here is a case where there is no public hospital.

The dominance of Kaiser appears to be increasing and, to us, Sacramento is the petri dish for new contracting and payment arrangements. There is a lot in the way of network products, global payments. And because this market is well organized, I think it makes it well-positioned to do this type of innovation.

PARTICIPANT: Can you explain what you mean by global payments?

GINSBURG: I was thinking about some of the ACOs, like the one between Hill physicians and Blue Shield. They use global payments. They continue to get paid the usual way, but calculations are made on how they are doing on spending per person, and that is what is shared if there are savings. That is what I would think of as global payment. Actually, a number of the ACOs that I have learned about in California are not something I would have called ACO, but ACO is a fashionable term now. The models in California are more like the Alternative Quality Contracts in Massachusetts with Blue Cross and Blue Shield, and other major carriers are doing similar

things. The concepts are pretty similar, but they started that before Congress defined what ACO was and they never called it ACO. It is similar to what we see in Sacramento.

I mentioned how the pressure on the capacity of the safety net on the outpatient side seems to be limited. But there is also no safety net hospital. All of the hospitals do some care for the uninsured. The FQHCs are concerned about losing patients…though they had been growing since the managed care contracting done by Medi-Cal.

San Diego: another area with a well-insured population. Here, as in Sacramento, large hospital systems operated but with very tight inpatient capacity. Health plans historically have had very weak leverage with providers, and they were already turning to narrow-network products in 2008. Even as Scripps was shifting away from capitation for fee-for-service payments so they could get paid more, health plans retained the commitment to capitation. I think Scripps has not come out well from this.

As new inpatient capacity has come online, San Diego is no longer considered under-bedded. There is increasing competition for patients in affluent geographic submarkets for lucrative specialty service lines.

Specialty access for low-income people came up a lot in San Diego. There is a concern that it may be getting worse, particularly as some of the facilities are increasing capacity in more affluent areas.

We are seeing an increasing use of narrow-network HMO products, and here in San Diego is where we are seeing PPO-based ACO models as opposed to HMO ACO models. Scripps is starting to move back towards risk sharing.

The Bay Area: highly educated, high-income diverse population. Kaiser has a strong presence. If you ask some people who is their major competitor, they will say Kaiser, and they won't talk about another hospital system. I think there is a consciousness among hospitals in both Sacramento and the Bay Area that if their rates go too high and they get expensive, they will lose out to Kaiser, and there will be few people enrolled in the plans that are contracting with them.

Unlike San Diego and Sacramento, the Bay Area still has small physician practices, although there is a lot of interest in expanding medical groups, hospital foundations, and independent practice associations. There is also very strong county support for a well-developed safety net.

There was substantial organizational change in the provider sector since we went there in 2008. There are very large IPAs…now operating on both sides of the Bay. That doesn't mean that many patients are going to travel across the Bay, but provider relationships are much broader than they used to be. The independent practice associations have been as vulnerable to the decline in enrollment in HMO products, but new payment reform pilots that they are involved in are bringing new life to them. Usually they cannot do much for PPO patients, but under payment reform, where they are sharing risk for those patients, they can do a lot.

Some of the smaller safety net hospitals outside of San Francisco and Oakland are struggling financially, and it has been a worry — in both report rounds — about what happens if one of the hospitals closes, what kind of shift and burdens will come to other nearby hospitals.

Here are some of the crosscutting market themes seen from round one:
Aggressive Kaiser growth: we found that Kaiser is continuing to gain market share. One of the areas they are competing effectively is in recruiting young physicians who find the combination of the salary, the regular hours, and the IT to be attractive. Kaiser is attractive to young physicians. They like the practice model. Kaiser invested substantially over the past few years focusing on ambulatory care and fully implemented its IT system…on the second try. They had been pursuing a strategy throughout California of in-sourcing, in a sense, bringing more specialty care into the organization. When talking to Kaiser people about it, a key factor is the IT system; they want to get everything into the system on a real-time basis. It is pervasive.

Physician alignment: Hospitals are more and more focused on physician alignment. This is not as easy in California as it is in other areas of the country because of corporate-practice-of-medicine restrictions. Hospitals are not permitted to employ physicians in California.

But there are alternatives: Hospitals have been able to create foundations associated with the hospital that can support physician groups and IPAs. It is expensive to do that. Larger hospitals have done it, but it's not available to the smaller hospital systems. As hospital medical foundations have been growing, there has been more exclusivity in the relationships, particularly primary care physicians focusing increasingly on a single IPA.

One other thing I want to mention, the seismic deadline in 2013 was a big deal three years ago. A lot of respondents told me they didn't see how it could be achieved, both because of the amount of capital needed to meet the requirements and because of bottlenecks in the hospital construction industry — not enough contractor capacity with specialized knowledge to build a hospital. We are back and see the deadline was relaxed, although a lot of construction is continuing that was spurred by the original deadline.

There has been an expansion of hospital capacity in California, with some concern there could be overcapacity in some markets. The ACA provides opportunities to shift from inpatient to ambulatory. If you're replacing a facility, you don't have to build as many beds in a new facility…if you have more ambulatory facilities.

Provider leverage: we have seen some tapering off of provider leverage as far as more pushback by plans. I think providers are realizing they will lose share to Kaiser if they don't. I think that has been responsible for some interest on the part of providers in innovative contracting in order to keep costs down.

I mentioned before the delegated model, which seems to be something unique to California. It grew up during the 1980s, maybe 1990s. It was retained during the managed care backlash. I mention in the context of delegated model that ACOs and other contracts are in a sense broadening out the scope of services with risks being taken; risk is being taken to go beyond the professional capitation used in the delegated model.

New contracting arrangements: I think we counted eight Medicare ACOs in California. I think six were in the sites we work covering. There was a lot of interest among people we talked to in bundled payment contracting with Medicare.

We are finding public employers have been the key in initiating the commercial contracting innovations. By public employers I mean CalPERS, the city of San Francisco, and lately, the city of Los Angeles. They seem to have been in the lead in crafting products with their carriers and provider organizations to do global payments.

The model tends to be a three-way sharing of global risk on top of existing payment methods. It is also often coupled with a narrow network. In a sense, part of being in an ACO in California is that often you are also going to be a part of a narrow-network product. Enrollees will be driven to your organization by the more attractive premium for the insurance product that is engaging in this narrow network with the ACO payment. The critical element, which is standard for all ACO payments, is data sharing; providers are usually pretty blind as to what is happening with their patients outside of their own facilities.

Medicare has not been able to do it [data sharing] yet. I think some private carriers have. There is a need for the private carrier to provide real-time information to the providers engaged in ACO on their patients. They need to know if the patients are showing up in someone else's emergency room because otherwise, there is no way they will know.

There is also a lot of interest in new benefit design, including narrow-network products that either exclude or provide financial disincentives to limit use of high-cost providers. Scripps in San Diego is excluded from certain products by many major health plans. This has resulted in a shift in the market share of Sharp.

There are also products that limit networks to one full-service provider in exchange for lower rates, such as the one in Sacramento between Health Net and Sutter.

There is also the reference pricing project with CalPERS for hip and knee replacement. Anthem and CalPERS decided which hospitals that do joint replacements meet a minimum set of quality standards and also have negotiated rates lower than a specified threshold. They have provided participants with lists of the fifty-two hospitals that have meet quality and cost standards and that they could go to without paying extra for joint replacement.

As far as safety nets — themes include:

Continued growth and demand for services, more uninsured people, and more Medi-Cal enrollees, and safety net capacity has not been able to keep pace with utilization trends.

Real challenges in availability of specialty, dental, and mental health services.

The role of county government, there is a lot in providing services and programs for low-income people. I don't think it lines up with political orientation; there must be other things besides it.

There are strong county systems in Riverside/San Bernardino, LA, and San Francisco and more of a private sector safety net in Sacramento, Fresno, and San Diego. I don't know how you put those together. Perhaps this goes back a long way.

And there has been an infusion of federal money to expand access. I think federally qualified health centers have had the good fortune that both the Bush administration and Obama administration put expansion of those organizations as fairly high on their health policy agenda.

We also heard about the California hospital fee program, to get additional funding to support the safety net.

And adoption of low-income health plans. This is the Medi-Cal bridge reform.

PARTICIPANT: Welcome to Sacramento. This is Albert. I want to mention the main reason for distinction in the county safety-net themes is that San Francisco, Riverside/San Bernardino have very strong local initiative Medi-Cal plans that bolster their county health departments. The other three counties do not. They are either geographic managed care models, or, in Fresno County, they subcontract the public side to private health plans.

GINSBURG: Yes, I think that is a factor, thanks for bringing that up, Albert. While I haven't seen you in 30 years.

[LAUGHTER]

PARTICIPANT: [indiscernible]

GINSBURG: Community health centers in California have emphasized the medical home model. I doubt that is different from other parts of the country. As well, there are initiatives to integrate behavioral and mental health services better with primary care. It is easy to forget how — in the various payment reform agendas with ACO and bundled payment and medical homes — that either Medicaid programs or the safety net providers have often been pioneers in them. I think they have perceived the potential for them faster than other providers.

Safety net providers are collaborating with each other more, sometimes to craft ACO agreements and also trying to get some health information exchange. I think this can make a difference in identifying people who show up in different emergency rooms. Their [safety net] clinics will not know about it without data sharing from hospitals.

A few comments about low-income health plans. Most counties have set eligibility at a hundred and thirty-three percent of federal policy level, which is where the Affordable Care Act will kick in in 2014. Some counties like Sacramento have set stringent levels and some counties like San Bernardino and Riverside have set enrollment caps based on funding and capacity. They are very low. In a sense, this plan functions a lot more in some areas than others.

I have always had trouble figuring out this slide.

[LAUGHTER]

Let me skip it.

[LAUGHTER]

Other highlights:

The California health care system is distinctive. I think at the top of my list, the large presence of Kaiser and how it impacts the rest of the delivery system. I was doing an interview in Oregon, which has a large presence of Kaiser, and you see the same phenomena. Oregon, outside of Kaiser, is a heavily HMO market.

I think even more unique in California are independent practice associations. I think the reason you have IPAs here is because of the delegated model; otherwise, there wouldn't be anything for them to do. With the delegated model, there is an opportunity to play an important role. HMO products declined a little bit with the managed-care backlash, but they are still very important in California. In California, HMO products have more mainstream providers in them than you find in other areas.

I mentioned county leadership and safety net in some areas.

And of course you have state regulatory issues. The seismic standards for hospitals is unique to California.

I also mentioned the corporate practice of medicine.

The way that HMOs are regulated by the Department of Managed Health Care is also somewhat unique to California. I remember talking about some of the requirements for health plans that dropped a provider from their network. They make it pretty much impossible.

Variations by community are important. Variations in physician practice settings — large groups and small practices — and different degrees of alignment with hospitals.

The uniform concern about physician shortages.

A lot of support for the HMO…Fresno stands out probably because not having a large Kaiser presence means not having much support for the HMO model.

Very active payment innovation, building on distinct features of the health care system in different communities — I think the motivation has been competing with Kaiser.

Some barriers to integration between physicians and hospitals are probably more significant in California than other places. Thank you.

[APPLAUSE]

PARTICIPANT: Let me start off with one. I was struck by comments about the dominance of Kaiser and that, how that shaped California. It is this idea of relatively rich benefit plan and tightly coordinated group of providers. How do you think that fits with growth in much more highly deductible health plans with more financial responsibility on the part of consumers, which is a trend that is in conflict with Kaiser?

GINSBURG: We didn't talk to health insurers about benefits this round but my recollection from the last round is that Kaiser introduced a lot of cost sharing into its products because Kaiser feared coming out on the wrong end of the selection pattern. If you could only buy rich comprehensive and if it's from Kaiser, the healthy people would not do it. I don't know where they are today, but I suspect they have followed along and developed systems where they could process and calculate cost sharing. They want to be in a position that you may have a large deductible and still buy into the Kaiser delivery system.

PARTICIPANT: In many places when an employer offered multiple products, Kaiser was lowest. But now the lowest-cost plan is often a PPO plan with a high deductible that is inducing healthy people to make different choices.

GINSBURG: That is a good point. Yes.

PARTICIPANT: What is the price differential you found throughout the state between Kaiser and other HMO products. How much percentagewise?

GINSBURG: I can't tell you. Probably hard to compare because they will be different in details of coverage. Many people in California have said Kaiser has always shadow priced. By that I mean, What premium should I set to be comparable to what the competitors are doing to get the enrollment that I am seeking? I think what Kaiser would like is for people to either opt for the Kaiser system or opt not for the Kaiser system in a sense. I remember Kaiser never permitted its plan to be offered as the sole offering by an employer because the people who would not put up with the Kaiser system, they would just as soon not have them. With most other choices today, whether HMO or PPO products, you have more choices and also more decisions. What happens when I go out of network? Do I need to have a primary care physician? With Kaiser, you buy into the entire system.

I think that is what dictates people's choices of Kaiser or not — how they feel about the delivery system. One thing I should mention from the first round. Many people — physicians and hospital executives outside of Kaiser — commented about how much higher Kaiser's quality is now than it used to be and how much more serious a competitor they are because of that. I think Kaiser has really transformed itself in many ways and has, of course, become a much more worrisome competitor to the rest of the delivery system.

PARTICIPANT: I am fascinated by the work you're doing nationally and would like to hear some of your contextual information about how our managed care differed from the nation and what your analysis here has been compared to our national situation for managed care.

GINSBURG: For managed care, I would say California has never abandoned real managed care. What I mean by that is having the delegated model, with the capitated payment of physician organizations, whether it is group or IPA, meant that California never lost the essence of managed care. I don't think many other states ever had it, but they gave it up readily in the late 1990s in response to the backlash.

You are not the only area though. Minnesota has it. The Boston area has very high HMO enrollment, though it is less tightly managed. That is the result of a historical quirk and is reflected in the nature of the HMOs. Massachusetts used to have hospital rate setting and a particular wrinkle of their hospital rate-setting system was that most plans could not negotiate — the rates were not ceilings, they were rates. This is what you paid. However, if you were an HMO, you were allowed to negotiate a lower rate if you could. So a lot of plans became HMOs to get lower-cost hospital care. They continue to this day. They didn't do much management. I think the main reason for being HMO was to get around that regulation.

The ACOs in the rest of the country had been oriented toward Medicare beneficiaries and PPO models, whereas in California, it is much more based on the HMO platform.

PARTICIPANT: Thank you and welcome to Sacramento. Thank you for an interesting overview of recent trends in California. As I recall, in your round one work looking at the Sacramento and Bay Area markets, you highlighted the importance of hospital clout, the leverage of these multihospital systems in demanding higher prices for hospital services than what was prevalent in southern California. I gather from your interviews that you see some moderation of that trend, some pushback. Could you elaborate on that? What is the mechanism? Obviously the dominant share of those multihospital systems in the market hasn't changed, so what other factors are allowing health plans to push back against the provider clout?

GINSBURG: In northern California, it may be as much an issue of self restraint by the providers rather than the plans pushing them back, because you are right, the structure has not changed. The concern is that they year by year lose share to Kaiser. Some people think that is the reason that there is so much innovation in contracting with the ACO products…Such a network gets a way of, dealing with the situation and avoids being priced out of the market.

PARTICIPANT: I was wondering if you could comment — there have been dramatic changes in hospital revenue over the past year and one has reportedly reported an eighty-six percent reduction in revenue. This is major hospital systems. Other net revenues are expected to decline. How could you link that to regional trends?

GINSBURG: I wish I had a better sense of what was behind the revenues, whether it was just they were not getting rate increases or whether there are other factors behind it. The Dignity revenue decline, was that for California or nationally?

PARTICIPANT: It was nationally, though the system’s hospitals are mostly West Coast.

GINSBURG: I wish I had a good answer. During another project, talking to hospitals in Orange County, they were telling me that under health reform, plans were going to become tougher

negotiators. Because the federal subsidy for people on the exchange is a fixed contribution, every penny of premium difference between plans, you pay that. Given that it is a relatively low-income population, this means premium differences across plans are going to be important. Plans have to keep their premium down to do well in the exchange. I think they will be very innovative as far as pursuing network products. It may be that they negotiate separately, different products as they have done for Medicare Advantage. I would not be surprised if there was a distinct negotiation for exchange plans.

PARTICIPANT: If we do this again in three years and look at the same markets again, what do you think we should watch for? The key issues on the three-year period? Drive lower costs or improve access?

GINSBURG: One thing I think is the big worry that respondents have is about primary care capacity. How will that be resolved? Will all the systems fight over primary care physicians, and what are the implications for patients in areas where there are shortages?

In three years, probably, I hope to see a maturing of many contracting innovations. Also as struggles with capacity expansion against demands for care by newly insured patients. I would also watch what in the world the federal government going to do to reduce its budget deficit. That will have ramifications probably more dramatic than any reforms we talk about now.

PARTICIPANT: Should policymakers do something to try to address the disparities in Fresno region or do you think it should self-correct at some point?

GINSBURG: I don't think it's going to correct. I think it has been there for a long time. I'm not sure what policymakers do. Certainly, health care reform, by reducing disparity and proportion of people with insurance, I think is going to do a lot toward pumping more money into the Fresno delivery system, which can lead to expanded access once more people have insurance.

I think the concern should be on the capacity side as to, perhaps, if there was a way for policy to facilitate capacity expansion.

PARTICIPANT: Great. Thank you. This has been informative.

[APPLAUSE]