CALIFORNIA HEALTHCARE FOUNDATION

California's Regional Health Care Markets: Themes, Variation, and Policy Implications

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Today's Program

1. Study background
2. Demographic and health system background
3. Cross-cutting themes
4. Descriptions of six diverse communities

Center for Studying Health System Change (HSC)

- Analyzing local and national changes in financing and delivery of health care
  - Surveys of households, physicians
  - Site visits to 12 representative metropolitan areas
  - Additional quantitative and qualitative research
- Active dissemination program
  - Following in policy world, industry, researchers, educators
  - www.hschange.org
- Funding from foundations and government agencies

Project Context and Objectives

- Context
  - California is large and diverse
  - Health care is organized, delivered, and often financed differently across the state
- Objectives
  - To describe the organization, financing, and delivery of health care in six California communities
    - Chosen to reflect diversity of the state
  - To identify implications for policy, practice, and the public
- Publications
  - Six regional market issue briefs published by CHCF
  - Five cross-site analyses nearing completion

Markets Studied

Study Methods

- Site visits conducted between October and December 2008
- Approximately 50 interviews in each market
- Sites represent 68% of California's total population
- Approximately 300 representatives of:
  - Hospitals
  - Physician organizations
  - Health plans
  - Large public and private employers
  - Benefit consultants
  - Insurance brokers
  - Health centers and clinics
  - State and local policymakers
  - Other stakeholder organizations

California Socioeconomic Profile

	California	U.S.
Diverse population	56% non-white	33% non-white
Higher proportion college-educated	30%	28%
Lower proportion high-school educated	80%	85%
Higher income but more poverty		
Median household income	$57,988	$51,233
Poverty rate	20%	18%
Higher HMO enrollment One quarter of all HMO enrollees are in CA	52%	20%
Higher rate of uninsured	19%	16%
Higher unemployment (August 2009)	12%	10%
Fair/poor health status (state medians)	19%	14%

Note: Statistics for California differ from Community Reports because of national data sources.

Variation of Local Markets' Profiles

Market	Lower Socioeconomic Profile	Higher Socioeconomic Profile
Fresno	45% < 200% poverty	
Los Angeles	41% < 200% poverty	
Riverside/San Bernardino	35% < 200% poverty	
California	*34% < 200% poverty*	
Sacramento		26% < 200% poverty
San Diego		26% < 200% poverty
San Francisco Bay Area		22% < 200% poverty

General Public Sector Trends (1)

- Rising demand for health care services
  - Increasing pressure from recession
  - Access to some specialties challenging
- Range of strategies across communities
  - Riverside/San Bernardino
    - Telemedicine, health promotion, dialogue among public and private sector leaders
    - Few community-wide efforts to improve access and coordinate care

General Public Sector Trends (2)

- San Francisco area counties
  - Health center consortiums
  - Coordinate fundraising, developing programs to promote access and quality, contracting with Medi-Cal plans
- FQHC expansion in many

- Medi-Cal managed care delivered by counties through different models
  - County-organized health system: one county-run plan
  - Two-plan model: typically a county & a commercial plan
  - Geographic managed care: multiple commercial plans

Variation of Medi-Cal Managed Care Markets

Market	Geographic Managed Care (GMC)	Two Plan
Fresno		X*
Los Angeles		X
Riverside/San Bernardino		X
Sacramento	X*	
San Diego	X	
San Francisco Bay Area		X*

*Market includes other models in smaller counties.

County Role in the Safety Net (1)

- Large role: Operate their own hospitals, clinics, and Medicaid managed care plans
  - Alameda, Los Angeles, Riverside, San Bernardino, and San Francisco Counties
- Small role: Contract with UC and private hospitals, CHCs, and private health plans
  - Fresno, Madera, and San Diego Counties
- Counties with large role have more leverage with providers and plans to coordinate care, improve access

County Role in the Safety Net (2)

- Key factors shaping county role
  - State and local funding levels
    - Fresno has relatively low state realignment funding and total county funding to support the safety net
    - "*It becomes a self-fulfilling prophecy over time*."
  - Desired level of financial control
  - Political environment and existence of champions
    - Politically progressive electorate and organized advocates lead to large role
    - Pointing to a new hospital AIDS wing or community clinic expansion: "*This is what I have done for the community*."

General Provider Sector Trends

- Growing differences between "must-have" hospitals/systems and others
  - Low Medi-Cal rates magnify importance of payer mix
- Increasing economic pressures for all providers
  - Drop in demand, more uninsured patients
- Hospitals focus on tighter alignment with physicians
  - Physicians more receptive to employment-type arrangements
  - Establishment of foundations

Variation of Local Provider Markets

Market	More Fragmented	More Organized
Fresno	X	
Los Angeles	X	
Riverside/San Bernardino	X	
Sacramento		X
San Diego		X
San Francisco Bay Area		X

Hospital Seismic Requirements

- Requirement to meet enhanced seismic standard by 2013
  - Must be seismically sound and remain operational following an earthquake by 2030 (often replacement required)
  - Standards vary with geologic risk
- Many hospitals struggling with requirement
  - Damaged financing capacity from recession
  - Constrained specialized construction capacity
- Contribution to capacity constraints
  - Retrofitting/replacing rather than expanding
  - *"California's seismic standards drive capital"*

Growing Provider Leverage

- Developments over past 10 to 15 years
  - Growing capacity constraints in hospitals; physician shortages
  - Provider consolidation (hospitals, medical groups, IPAs)
    - Hospitals negotiate for physicians
  - Consumer preferences for broad provider choice
  - DMHC regulation adds to provider leverage in HMOs
- Moderating forces
  - Concern about eroding employer-based insurance
  - Competition with Kaiser Permanente
  - Provider desire to maintain viability of local plans

Private Insurer Trends

- Health plans shift to national strategies
  - PacifiCare → UnitedHealth Group
  - Blue Cross of California → Anthem Blue Cross
- Continued popularity of Kaiser HMO
- Continued strong HMO enrollment but gradual shift to PPOs
  - PPO growth coming mostly from non-Kaiser HMO products
- Fewer residents with employer-sponsored coverage
  - 65% in 1987 (70% nationally) down to 57% in 2007 (62% nationally)
  - More Medi-Cal and uninsured residents

Variation of Managed Care Markets

	2006 Commercial HMO Enrollment		
Market	**Low**	**Medium**	**High**
Fresno	25%		
Los Angeles		45%	
Riverside/San Bernardino		49%	
California	*46%*		
Sacramento			67%
San Diego		46%	
San Francisco Bay Area			58%

Source: Cattaneo & Stroud, *2006 Statewide HMO and Special Programs Enrollment Study.*

Insurance Product Design

- Narrow network products have increased but not large factor
  - CalPERS HMO option excluding Sutter Health
  - Products excluding Scripps Health offered in San Diego
- High-deductible health plans have some importance in small group and individual markets
  - Expectations have exceeded enrollment numbers

Erosion of Delegated Model

- Delegation of utilization management, other responsibilities to medical groups and IPAs unique to California
- Delegated model threatened by three developments:
  - Enrollment shift from HMO to PPO
  - Health plan management (Blue Cross, PacifiCare) shifted outside the market
  - Diminished enthusiasm by some physicians -- potentially reflecting changes in provider leverage
    - "Pure and simple FFS capitalism"
- Ironic contrast with ACO enthusiasm in Washington

Kaiser Permanente

- Highly influential in all study communities; less in Fresno
- Increasing respect for quality of care and consumer friendliness by provider competitors
  - Large investments in HIT
- Large advantage in recruiting primary care physicians: higher pay, attractive environment
- Gaining market share in HMO products
- New benefit designs will challenge organization
  - Motivated by fear of adverse selection
  - Collecting patient cost sharing
  - Limited take up to date

Fresno: *Fresno, Tulare, Kings, Madera, and Mariposa Counties* (1)

- Rapid population growth
- Historically low managed-care penetration
  - Late arrival of Kaiser Permanente
- Geographically segmented hospital market
- Inadequate and aging physician workforce
  - *"[Physicians] are overworked, but there is no interest in bringing in more people. It's all about the money."*

Fresno: *Fresno, Tulare, Kings, Madera, and Mariposa Counties* (2)

Economic downturn intensifying poverty, unemployment, and lack of health insurance

- "*Appalachia of the West*"

Fragmented safety net

- Little coordination among providers, with local governments

Serious access to care problems for low-income people

Los Angeles: *Los Angeles County*

- Fragmented hospital market; no dominant health system
  - Growing gap between "haves" and "have-not" hospitals
  - Closure of nearly a dozen hospitals over the past six years
- Highly competitive physician market
  - Physicians looking to joint-ventures or other arrangements for income
- HMO popularity remains strong
- Well-developed, strong safety net; some gaps remain
  - *"Once people get into the system it works for them. It is getting into the system [in the first place that is difficult]."*

Riverside/San Bernardino:
Riverside and San Bernardino Counties

- Vast geographic area and fragmented health care market
- Significant population growth; housing crash
  - *"With the housing boom there was a surge of [health plan] membership…[the recession] has created a [wave] of disenrollment."*
- Providers compete but work together to prevent patient migration to Los Angeles
- Health plans compete around health and wellness; HIT
- PPO products important in rural areas – access to out-of-network care essential
- County safety net hospitals evidence of political support for local health care programs

Sacramento: *El Dorado, Placer, Sacramento, and Yolo Counties*

- Rapid population growth in high-income, well-educated area
- Four powerful not-for-profit hospital systems
  - Competition "*healthy…but steady...not volatile*"; notable cooperation
  - Physicians practice in large groups aligned with a hospital system
    - Benefit from hospitals' negotiating rates with health plans
- More physicians per capita than the California average
- HMOs remain strong
  - Large impact of CalPERS
- Small, fragmented safety net, limited outpatient capacity
  - Most community clinics not FQHCs
  - No county hospital

San Diego: *San Diego County*

- High-income, insured population
- Four large hospital systems ("*four two-hundred pound gorillas*")
  - Close affiliations with physician groups
  - Tight inpatient capacity: "*If someone said, 'I'll hand you 15 percent of our market share,' our response operationally would be 'Where would I put it?*'"
  - Scripps shift to FFS; Sharp retains commitment to capitation
- Plans have weak leverage with providers; turning to narrow-network products
- No county-owned hospitals or clinics
- Extensive network of non-profit CHCs, initiatives to link with EDs to promote coordination

San Francisco Bay Area: *Alameda, Marin, San Francisco, San Mateo, and Contra Costa Counties*

- Stable, highly educated, and diverse population
- Kaiser and Sutter systems dominate; very competitive
- Tradition of small practices, but low payment rates, desire for salaried platform steering physicians towards medical groups/hospital foundations
- Strong county support for safety net
  - "*The political will in this county to provide [health care] access to the uninsured has been demonstrated over and over again.*"
- Healthy San Francisco for low-income, uninsured adults
  - Many optimistic; some small employers challenged by costs

Concluding Thoughts

- State health care system distinctive
  - Kaiser Permanente
  - Independent practice associations
  - Continued resilience of HMO products
  - Role of counties in the safety net
  - State regulations:
    - Seismic standards for hospitals
    - Corporate practice of medicine prohibitions
    - Nurse staff ratios
- Important variations by community
  - Physician practice settings — large versus small practice
  - Support for HMO model: Kaiser and delegated model
  - County role and support of safety net