COMMUNITY SNAPSHOTS PROJECT

Orange County, Calif.

Site Visit Report

Prepared by:

Institute for Health Policy Studies
University of Washington
Seattle, Washington

Authors:
Kathryn S. Duke
Robert H. Miller

The authors are on the staff of the Institute for Health Policy Studies (IHPS), University of California, San Francisco. This report was prepared with input and editorial assistance from Karen C. Hertz of IHPS. Reviewers included Harold S. Luft of IHPS, Samuel A. Roth of the Orange County Medical Association, and Jon D. Gilwee of the HealthCare Association of Southern California. The authors are solely responsible for the selection and interpretation of information in this report.

Overview

Orange County is an increasingly ethnically diverse region of southern California, and the income of its residents covers the extremes of wealth and poverty. It is a politically conservative stronghold with a government that has been more dedicated to fostering growth and development than to providing public and social services. The county's recent bankruptcy is bringing even greater pressure to publicly funded programs, especially those including health care, that are less popular with the voting public.

The health care market has high managed care penetration. According to some estimates, only 5 percent of commercially insured patients have traditional indemnity insurance; possibly 66 percent of people with employer-based insurance are enrolled in health maintenance organizations (HMOs). For the one in nine residents who are Medicaid beneficiaries, the county recently embarked on an ambitious plan, CalOPTIMA, that will enroll all of them in managed care plans offered by either HMOs or provider plans that CalOPTIMA calls physician-hospital consortia (PHCs).

Purchasers, health plans, and providers are not highly concentrated at the local level, and there is no local leadership for the health care market. The county's employers are still trying to organize themselves into a health insurance purchasing coalition that can negotiate with the 10 HMOs and numerous preferred provider organizations (PPOs) and indemnity carriers competing for market share. On the provider side, a clearly excessive number of hospitals operate without any dominant systems, many medical groups and Individual Practice Associations (IPAs) compete for capitated enrollees, and community health centers are deeply divided.

Within this fast-moving and decentralized market, the balance of economic power has shifted sharply away from providers to favor purchasers and health plans. This is because providers have excess capacity and the mostly nonprofit, locally based providers are negotiating with insurers that are larger, have greater resources, and have less at stake in the negotiations. As a result, hospitals, medical groups, and IPAs have been unable to differentiate themselves from competing providers by demonstrating quality differences and have seen their revenues stagnate or decrease. Even medical groups known for their pioneering emphasis on capitated managed care and sophisticated physician compensation systems find themselves scrambling to maintain and expand market share.

The county's new CalOPTIMA program moved approximately 180,000 of its Aid to Families with Dependent Children (AFDC) population into managed care in October 1995, with other categories of Medicaid recipients to follow in February and April 1996. This program has the potential to expand greatly the number of health plans and providers available to Medicaid

patients. However, there are concerns about the program's impact on the county's traditional and safety net providers and its implications for the financing and delivery of care to the indigents left outside the program. These concerns remain despite efforts to favor the traditional safety providers during the transition.

▼ ▲ ▼ Community and Health System Background

Demographics and the Economy

Orange County has approximately 2.6 million residents, making it and San Diego the largest counties in southern California after Los Angeles County. Until recently, population grew very rapidly. Although the population is predominantly white, recently the Asian and Latino populations have increased significantly. Although Orange County's boundaries do not define a self-contained health care market, most respondents view the county as a market area somewhat distinct from surrounding areas.

Orange County is a relatively wealthy community on a per capita basis, ranking sixth among the state's 58 counties. However, a growing percentage of the county's population lives in poverty. In 1991, 42 percent of its residents had adjusted gross incomes of below $18,000. Ethnic group members account for a disproportionate share of Medi-Cal (California's Medicaid program) beneficiaries: Latinos represent 23 percent of the population but 41 percent of Medi-Cal beneficiaries; Asians represent 10 percent of the population but 18 percent of Medi-Cal beneficiaries. The African-American population is small, comprising only 2 percent of the population and 3 percent of Medi-Cal beneficiaries. We obtained no reliable estimates for the number of undocumented persons.

Orange County's economy grew rapidly from World War II through the beginning of California's recession in 1990. The economy prospered with the growth of the entertainment industry (particularly the Disney Company), aerospace, high technology, and other industries. The growth of the federal, state, and local public sectors also fueled the economy.

In December 1994, Orange County filed for Chapter 9 bankruptcy protection after discovering that it had lost huge amounts of funds as a result of risky investment schemes. The loss to Orange County and other investors in the county's investment pool was estimated at $1.7 billion. Orange County's direct loss was estimated at up to half that amount, which exceeds its current annual general fund budget. The bankruptcy has severe implications for Orange County's county health care program. Local elected officials fear voter retaliation for any measures that would result in new taxes and are aware of voters interest in stronger, more costly law enforcement. The county's voters defeated a June 1995 ballot measure that would have raised the county's sales tax by a half cent and use those funds to avoid defaulting on its municipal

bonds. Several months later, state officials gave last minute approval for an aid plan that allows the county to meet its immediate obligations by shifting local funds from transportation, harbor, parks, flood control, and redevelopment districts. Although some analysts worried that relying on further borrowing only pushes the county's problems into the future, one county supervisor hailed it as a monumental and necessary milestone.

Health System History

For at least the past two decades, Orange County has had an abundance of physicians and hospitals. In the 1970s, the enactment of Medicare and Medicaid and an economic boom in Orange County spurred the development of numerous new hospitals. Now that managed care and capitated reimbursement are significantly increasing in the county, the abundance of health care providers has become a problem of excess capacity. Health plans have capitalized on this excess, forcing providers to accept lower payments.

Until quite recently, the county's Medi-Cal and indigent care system have had a dwindling number of providers. The primary impetus for the county's new Medi-Cal program has been to spread the distribution of indigent patients more evenly across providers rather than seeing further concentration of these patients into the University and Children's hospitals.

▼ ▲ ▼ Health System Change

Public Policymakers

The past decade has seen various proposals for comprehensive state-level health care reforms in California, many of which have failed to reach enactment. In addition to numerous legislative efforts, California voters chose to consider, but then defeated, two major health care reform ballot initiatives: a 1993 initiative for an employer mandate to provide health insurance and a 1994 single payer plan.

California's laws governing health care lack administrative or policy unity and have had little to do with the changes taking place among private plans and providers. For example, the state bans the corporate practice of medicine (i.e., employment of physicians), but most observers feel that the only real effect of this law has been to encourage multiple layers of legal entities and create employment for attorneys and consultants. Numerous state departments and boards have jurisdiction over health care plans and providers, but the Department of Corporations governs the managed care "health care service plans" that are responsible for care to a large and growing portion of California's population. Consumer advocates are becoming increasingly concerned about the department's wide-ranging oversight and enforcement responsibilities in light of its small budget for activities that affect health care. The most notable state influences over commercially insured people were the

1993 establishment of a state-sponsored purchasing coalition for small businesses, the Health Insurance Plan of California (HIPC) and the increasingly proactive role of the public employees' entity, the California Public Employees Retirement System (CalPERS), that aggressively has pursued premium reductions and quality measurement requirements for health plans that compete for the 1,000,000 enrollees that CalPERS represents.

In contrast to the limited influence the state government has had over the private health insurance market, several state laws or programs have had a major impact on people who rely on public or charity funds for their health care. One example of this resulted from state voters' approval of a 1988 ballot initiative that raised the cigarette tax by 25 cents. Most of these new revenues (approximately $500 million annually) have been used as direct payments to providers of indigent care, to establish and help fund a prenatal care insurance program for low-income women whose household incomes are above the Medi-Cal income eligibility guidelines, and to help fund a medical high risk insurance program. The state board that runs these two cigarette tax-funded insurance programs also governs California's HIPC.

California was one of the early states to secure a large source of new funds for indigent care providers through the development of a disproportionate-share hospital (DSH) program. Under California's DSH program, counties, hospital districts, and the University of California all contribute funds that bring qualifying hospitals approximately $850 million annually in additional revenues. Although the future of federal DSH funding is uncertain, the state continues to refine its DSH program.

The state government's greatest impact on publicly financed health care is through its power as purchaser of care for five million Medi-Cal beneficiaries. Currently, California is attempting to enroll roughly two thirds of Medi-Cal beneficiaries in capitated health plans. California had started in this direction in the 1970s, but scandals associated with that effort effectively stopped further major initiatives until Governor Wilson's 1993 proposal. Under the current plan, the state's large and medium-sized counties are moving toward one of three basic methods of organizing their Medi-Cal enrollees; Orange County is now operating a county organized health systems (COHS). A COHS is California's version of a health insuring organization (HIO). Although many counties were interested in obtaining permission to operate an HIO, federal law has allowed only a few counties to be selected for a COHS. In Orange County an agency independent of the county is managing enrollment of Medi-Cal beneficiaries into capitated plans.

Orange County divested its county hospital to University of California at Irvine (UCI) 20 years ago and does not directly provide health care services. It funds a relatively low level of public health activity. Bankruptcy-driven county health care program cuts put Orange County at the minimum allowed by state

law for funding indigent health care, and at the bottom of the list of per capita indigent health care spending among California's ten most populous counties.

Purchasers

Employers and Employer Coalitions

Orange County employers are not a powerful, organized market force. There is no employer purchasing group, and some larger employers downsized recently because of the weak California economy, reducing their market power. Moreover, because many of the larger Orange County employers are divisions of companies headquartered elsewhere, their health insurance benefit packages and contribution strategies are determined outside the county.

Although Orange County currently has no functioning employer purchasing group, there have been attempts to organize such a coalition. Two employer groups discussed health care issues over the past 18 months. However, the group consisting primarily of larger employers recently disbanded, attributable in part to recession-induced downsizing and to location of its headquarters in another part of the county. Nonetheless, the Orange County Business Council, composed primarily of medium and smaller employers, created a health care task force that has discussed a wide range of potential actions, including encouraging multi-year contracts, contracting directly with providers, and improving quality of care in definition, reporting, and evaluation. So far, the Task Force has not taken concrete steps to implement proposed activities.

The failure to bring the county's businesses together as health insurance purchasers has meant that people insured through Orange County businesses are governed to a large extent by actions and decisions made elsewhere. This does not always lead to problems for the employees. For example, one large, Ohio-based company, whose Orange County division is actively attempting to organize an employer purchasing coalition, offers its Orange County employees the same benefits package as its headquarters' employees. The company offers two HMOs, but 70 percent of the Orange County employees choose the company's self-funded PPO option that allows them greater choice of physicians, premium levels comparable to the HMOs, and less hassle because the company has a history of supporting employees who have problems with providers or claims.

Orange County employers feel less urgency about organizing as purchasers partly because their premiums having stabilized, presumably as a result of substantial HMO premium reductions negotiated by powerful statewide purchasers in 1994. CalPERS and Pacific Business Group on Health (PBGH) have approximately 800,000 and 330,000 HMO enrollees, respectively, which is enough to provide them with substantial leverage in their HMO premium negotiations. The HIPC has negotiated similar premium reductions for its

small employer businesses, although its effect on the market is less clear. These reductions have probably led many employers to expect similar reductions.

While statewide purchasing groups were becoming proactive, Orange County HMOs stepped up their price competition for market share. As a result, after years of rising rapidly, HMO premiums fell by as much as 10 percent overall during the past two years. PPO and POS premiums either increased or decreased by less than did HMO premiums. For medium-sized businesses, the largest reductions were negotiated two years ago. Substantial switching took place among health plans, including HMOs, as competing carriers at times offered rates substantially below the incumbent carrier. As prices for plans in each product line equalized, switching among HMO plans slowed substantially. Multi-year HMO and POS premium rates have become common. However, there is substantial uncertainty about the future course of premium rates.

Large employers often offer multiple HMO, POS, and PPO options to employees; medium and small employers usually offer one HMO, one PPO, and, more frequently, a POS option. Often one health plan provides all three options. HMO premiums seem to be substantially lower than POS and PPO plans. In some cases, POS and PPO premiums are similar.

Contribution strategies vary greatly. In some cases, employers pay for 100 percent of a lower-cost HMO option; in other cases, employers pay a percentage of premiums. Some employers subsidize premiums of lower-paid employees.

Employers and employees choose health plans on the basis of price and, to some extent, network—although many networks are similar (with the exception of Kaiser). As is the case in San Diego and other California markets, quality of care reporting plays virtually no role in employer or enrollee health plan choice because health plans report few or no measurements of standardized quality of care. Quality of care concerns are emerging, partially in response to incentives to some physicians to reduce care. In the past, management focused on limiting health care use; it now encourages appropriate (including increased) use.

Although Orange County is not a community with sharply defined boundaries, many of its employers actively involved in health insurance purchasing take a local view of their objectives. They state that health care should be regionally controlled. Some employers decided not to join the statewide, large employers' purchasing group PBGH, arguing that PBGH's short-term viewpoint has had negative effects on them because decreasing rates for PBGH coalition members came at the expense of small businesses and everyone else in the community. This contradicts the view held by some that the statewide coalitions have played a positive role in containing premiums for all California employers.

State and Local Government as Purchasers for Low-Income People

After five years of planning, the first stage of a COHS for Orange County Medi-Cal enrollees began to operate on October 1, 1995. At that time, CalOPTIMA joined two other California counties with longer term COHS programs and two others that had just started them.[1] Although CalOPTIMA has many de facto ties with the County Board of Supervisors, it is a legally separate entity run by an independent, appointed board. CalOPTIMA was originally envisioned as a program serving the county's Medi-Cal and indigent medical care programs. However, it now focuses exclusively on the Medi-Cal program, on which Orange County spends about $600 million per year. The county's commitment of county funds (not state or federal pass-through funds) for indigent care is less than $10 million annually.

When fully operational, CalOPTIMA will provide care to Orange County's 300,000 Medi-Cal enrollees through a countywide managed care system that will be almost completely capitated.[2] In the county's former Medi-Cal program, only 41,000 Medi-Cal beneficiaries enrolled in prepaid health plans or primary care case management programs. Under CalOPTIMA, services will be provided through contractual arrangements with a variety of health plans, including HMOs and physician-hospital consortia. In its initial stage, the goal is to have all 170,000 AFDC-linked Medi-Cal enrollees in capitated plans. CalOPTIMA will be the largest Medi-Cal managed care initiative operating in the state. Six months after program start-up, the medically and administratively more challenging Medi-Cal populations (aged, blind, and disabled; long-term care; foster care and adoption assistance) are scheduled to be enrolled.

For now, CalOPTIMA appears to have succeeded in increasing the number of participating Medi-Cal providers. Out of 50 health plans and provider organizations that applied to participate in CalOPTIMA, 40 have been accepted and have executed contracts. The biggest questions about CalOPTIMA's impact are whether it actually will improve health care access and choice for the one in eight county residents insured by Medi-Cal, how it will affect the county's traditional and safety net providers, and what its impact will be on indigent people who are not eligible to enroll. Some observers are optimistic that CalOPTIMA will achieve its goals of improving enrollee access and choice while providing public cost savings and reducing the tendency to shift costs to the commercially insured. However, other observers fear that CalOPTIMA will contribute to the collapse of the county's already strained

[1]Santa Barbara (in southern California) and San Mateo (just south of San Francisco) had long-standing COHS programs, while Solano (northeast of San Francisco) and Santa Cruz (in the mid-coastal area) had just started.

[2]This number of eligibles represents roughly a 160 percent increase over the 102,800 eligibles in the county eight years ago.

safety net because of its failure to include vulnerable people that are not Medi-Cal enrollees and its effect on providers that have been serving large numbers of Medi-Cal and indigent enrollees.

CalOPTIMA's director has implicitly acknowledged the potential conflict between its goal of providing greater access and the possibility that the program will take away dollars from organizations that have traditionally served indigent people. CalOPTIMA attempts to resolve this conflict by contracting with 40 providers, but setting a cap of 30,000 enrollees for most of its health plans/provider consortia, except the University of California at Irvine and Children's Hospital of Orange County. The program favors these two providers by assigning them enrollees who do not choose a plan themselves. Most observers anticipate the post-CalOPTIMA future will be difficult for the county's traditional safety net providers as their Medi-Cal funding, including payments made to disproportionate share hospitals (DSH), may drop significantly.

There is also concern about CalOPTIMA's effect on medical care for indigents not in the program. Two significant questions are: (1) what will be the impact of the program's exclusion of the current Alien Medi-Cal category that accounts for over 60 percent of Medi-Cal births? and (2) how will it affect the county's underfunded Medical Services for the Indigent (MSI) program that CalOPTIMA—in a departure from the original concept—now excludes MSI? As payment for indigent care declines relative to Medi-Cal rates, the shift to capitation encourages at least some safety net providers to move away from non-Medi-Cal indigents, leaving that population and the shrinking group of providers who serve them at greater risk. Moreover, any drop in Medi-Cal funding to safety-net providers reduces their ability to cross-subsidize indigent care through those revenues.

Insurers and Health Plans

HMO enrollment in Orange County is large and rapidly growing. Among the commercially insured, indemnity insurance is rare, and Medi-Cal beneficiaries are being moved into managed care plans. By the end of 1994, 1.2 million HMO enrollees in Orange County accounted for 43 percent of the county's population, probably a similar portion of the Medicare population, 54 percent of its insured population (assuming 20 percent of the population was uninsured), and possibly 66 percent of all employer-based insurance. HMO enrollment grew by 16 percent in 1994 and is expected to account for a substantial majority of the insured population within several years.

The HMO health plan market is not highly concentrated, although it is moving in that direction. The top five HMOs account for almost 65 percent of all enrollees. Kaiser remains the largest HMO, with 188,000 enrollees (17 percent of HMO enrollees). The remaining top HMO health plans in

enrollment/percent market share include FHP/TakeCare (179,000 enrollees and 16 percent of the market share); Health Net/Blue Cross (159,000 enrollees and 14 percent of the market, assuming a pending merger is finalized); Pacificare (100,000 enrollees and 9 percent of the market); and CIGNA (90,000 enrollees and 8 percent of the market). Four other HMOs each have 4 to 5 percent market share.

Most insurers offer the POS option. Even Kaiser has paired with Pacific Mutual to provide a triple-option plan. Unfortunately, we could not obtain POS enrollment statistics, and available PPO enrollment statistics are unreliable. For example, as of the end of 1994, PPOs reported more eligible enrollees than the total population in Orange County.

HMOs have difficulty differentiating their products, as most plans (other than Kaiser) offer similar prices and have wide and similar networks, and none can measure quality of care. As a result, HMO plan insurance has become an undifferentiated commodity product for most plans.

HMOs in Orange County are implementing highly divergent strategies for health plan/delivery system integration, ranging from complete integration to complete separation. These strategies reflect larger HMO corporate policy decisions that apply to multiple markets, and are not specific to Orange County.

- Kaiser is redesigning its model of a physician-driven, hospital/medical group delivery system that offers a health plan. To compete more effectively, Southern California Kaiser in Orange County is attempting to improve customer satisfaction, market more effectively, and lower its cost structure. Orange County accounts for less than 10 percent of Southern California Kaiser's entire enrollment.

- FHP/TakeCare and CIGNA are divesting their ownership stake in their delivery systems, in all markets for FHP, and in southern California for CIGNA. Both plans are maintaining their HMO enrollees on the health plan side. FHP is spinning off its hospital/physician delivery system to shareholders, whereas CIGNA is selling its delivery system to Caremark International (which owns the assets of Friendly Hills HealthCare Network). Both FHP/TakeCare and CIGNA had previously contracted with outside providers for some services, and will now contract for all services. This move reflects the health plans' estimation that they can buy services more cheaply than they can develop delivery systems.

- Prudential and Aetna are attempting to integrate their health plan with primary care physician (PCP) clinics by acquiring physician practices. Generally, this has been a slow process, and both also contract with outside providers. Aetna recently acquired an IPA in the LA/Orange County area.

- Pacificare, among all HMOs, has made the greatest effort to effect non-ownership, non-exclusive long-term integration "partnerships" (preferred relationships) with providers, by signing multiple year "partnership" agreements with selected medical groups and IPAs. Pacificare is offering a guaranteed share of premium to its "partners," while attempting to direct new enrollees to them, either through new enrollee growth or removal of physician organizations that are not its partners. This approach departs markedly from the often drawn out, year-by-year negotiations between health plans and provider organizations. Pacificare's strategy is to differentiate its HMO plan product from its competitors by differentiating its network without owning its delivery system. Pacificare is capitalizing on hostility between physician organizations and some other large HMOs in its attempt to create brand awareness through its network.
- HealthNet and Blue Cross (which are merging) remain completely separated from delivery systems. They engage in price-driven commodity vendor relationships with physician organizations and hospitals, and expect providers to take on many utilization and quality assurance functions. Their contracting relationships with physician organizations have changed from supportive to adversarial as more provider groups compete for HMO business and as the balance of market power has shifted in favor of health plans. In addition, some argue that HealthNet/Blue Cross has a strategy of building up independent IPAs as a counterweight to the medical groups and more assertive IPAs.

Providers

Providers in Orange County face significant challenges that will increase in the future. The large hospital and specialist physician capacity, which reflected the county's relatively recent growth and prosperity, has now become a major contributor to providers' loss of economic power. Furthermore, most providers are largely fragmented and county based, in contrast to some powerful purchasers and increasingly concentrated HMOs that have regional or California-wide strategies, much greater resources, and much less at stake than providers in negotiations about payment rates. Those local provider organizations that attempt to develop provider-based HMOs and engage in direct contracting have had to back down because they are not large enough to risk retaliation, including contract terminations, by HMOs. For example, the St. Joseph Health System had to sell off its own HMO several years ago. Competition among insurers has slowed insurer/provider partnership agreements because if a provider organization affiliates too closely with an HMO, other HMOs may send their enrollees to competing provider organizations.

Hospitals

Orange County's 34 acute care hospitals have excess hospital bed capacity, declining patient days, low hospital market concentration, and little hospital/delivery system integration. This puts them in a weak bargaining position with HMOs. As a result, total profits are only about 1 percent of revenues in 1993. County hospitals are concentrating on a small range of survival strategies, including cost cutting, creation of integrated delivery systems, and attempts to become a necessary provider within insurance networks through a critical mass of market share and a reputation for quality.

The hospital market is not highly concentrated. Not-for-profit hospitals account for a substantial majority of hospital days and revenues, and eight of the 10 largest hospitals are not-for-profit. Seven hospitals or hospital chains account for 80 percent of non-Kaiser hospital revenues and bed days. The Sisters of St. Joseph of Orange health system has three hospitals that account for 20 percent of Orange County acute care hospital days and revenues. Hoag (two hospitals), University of California at Irvine Medical Center (UCIMC), Tenet (four hospitals), and OrNda (four hospitals) each account for about 10 percent of hospital days and revenues. Unihealth (a not-for-profit chain in the LA area that is part-owner of Pacificare) and Columbia/HCA have a small presence with approximately 5 percent market share each.

With 519 licensed beds and $151 million in net patient revenues, St. Joseph (flagship hospital of the Sisters of St. Joseph of Orange) is the largest hospital in the county. Its parent organization owns three large and well-regarded hospitals in Orange County, as well as some hospitals elsewhere in California and in Texas. The St. Joseph system partially owns a medical practice foundation, is acquiring additional medical groups, and controls two hospital-based IPAs with nearly 140,000 capitated enrollees. It is affiliated with Hoag Hospital (the county's third largest hospital) and its 80,000 capitated enrollees and has started a joint venture with a local IPA.

St. Joseph Hospital created some controversy earlier this year when it used its shared services agreement with Children's Hospital of Orange County to request that CalOPTIMA grant it the same traditional and safety net provider status as other hospitals that had historically served a large portion of Medi-Cal recipients, thereby exempting it from the 10,000 Medi-Cal enrollee limit just as those other hospitals are exempted. St. Joseph's request was denied after intense opposition from most of the county's other providers, who protested that this request came from a hospital that had essentially shut out the Medi-Cal population.[3] Hospitals have become territorial about any potential block of patients, even those with capitation rates lower than commercially insured patients.

[3]Under California's selective contracting system established in 1982, hospitals in many areas that want to receive Medi-Cal reimbursement for anything but emergency services must first negotiate a state contract. St. Joseph's did not have a full-service Medi-Cal contract until 1994.

The St. Joseph health system is making aggressive moves to win both hospital and physician market share and create an integrated delivery system. Its strategy is to acquire or affiliate with enough well-located, well-regarded hospitals and enough capitated enrollees in physician organizations to become a must-have network for HMO plans, enabling it to command higher capitation rates or per diems than its competitors. Nevertheless, like the Friendly Hills and Bristol Park medical groups, St. Joseph may be reaching the limits of what a mostly local system can accomplish, considering statewide insurers and constraints of capital and management expertise.

UCI Medical Center, which has 462 licensed beds and $195 million in patient revenues, has the second largest number of hospital beds in the county, but surpasses St. Joseph's in net revenues. UCIMC is attempting to create an integrated delivery system by acquiring some physician practices and building a network of other affiliated PCPs. This attempt at repositioning for an increasingly managed care market is a major change of strategy for UCIMC. As recently as mid-1992, UCIMC had no managed care contracts, a high cost structure, and little orientation to patient satisfaction. As of early 1995, it still only had 10,000 (fully) capitated enrollees, although it significantly increased the number of managed care contracts and volume of PPO enrollees.

Three for-profit chains control nearly 25 percent of the Orange County hospital market, but only OrNda appears to have a strategy for developing a strong market presence. Two of its four hospitals are well regarded, and it acquired an IPA with more than 30,000 HMO enrollees. Tenet's and Columbia/HCA's Orange County hospitals appear to be unimportant to their national growth strategies in markets elsewhere.

Hospital beds have become mostly commodity products in Orange County. Although a hospital's reputation for high quality care may affect negotiations with HMOs, price appears to be the decisive factor in determining which hospitals gain the business of HMOs and medical groups. Decreasing profits and a drive to lower prices contribute to the market picture. Hospital payments have fallen by more than 5 percent per year in the past three years, and one insurer/health plan recently demanded a 25 percent price reduction.

The combination of lower per diem rates and declining bed days have pushed hospitals to cut inpatient costs and expand use of outpatient services. Hospitals have reduced administrative and purchasing costs, cut patient care and housekeeping support staff, economized on supplies, combined departments, and postponed purchases of new equipment. On the clinical side, many hospitals have adopted clinical pathways. These measures appear to be getting results. Growth in expense per adjusted patient day dropped from nearly 11 percent in 1990 to about 3 percent in 1993, and growth dropped even further in 1994.

As commercial payers have brought down their payments, hospitals also are increasing their marketing efforts aimed at such patient populations as Medicare and Medi-Cal beneficiaries. St. Joseph's request for non-capped CalOPTIMA enrollment—and other hospitals' opposition to this request—highlights some hospitals' attempts to also attract Medi-Cal patients. Medi-Cal patients at least cover hospital variable operating costs, and some can make some contribution to overhead expenses.

Despite various organizational and marketing strategies to attract patients, hospital occupancy rates average about 40 percent for the county as a whole, and are as low as 20 percent for some facilities. Some observers were surprised that only seven hospitals had closed or converted to other uses over the past five years and feel that more than half of the remaining hospitals could close without affecting quality of care or services. However, some hospitals appear to survive by cutting corners in replacing their physical plant and equipment. Unfortunately, a few reportedly are lowering quality of care to cut costs. At least one observer wondered if public intervention is necessary to determine which hospitals survive.

Physicians

As the Orange County market moves toward capitated enrollment, more physicians are joining organizations that can send them enrollees, help spread their administrative costs, and possibly reduce their financial risk. Many physicians have joined IPAs, which account for about half of Orange County's capitated enrollees.[4] In addition to the two IPAs associated with St. Joseph's Health System, at least four IPAs that operate in Orange County also operate elsewhere in southern California. There is no pattern to the way IPAs and medical groups pay physicians. Different organizations use different combinations of capitation, salary, some form of fee-for-service (FFS), and performance bonus.

Other physicians have joined medical groups,[5] including some that are considered national leaders in physician management and clinical integration. The three largest Orange County medical groups are Kaiser Permanente (188,000 capitated enrollees), Friendly Hills (160,000 capitated enrollees in Los Angeles and Orange counties, with 60,000 in Orange), and Bristol Park (110,000 capitated enrollees). St. Joseph's Health System indirectly employs a sizable

[4]IPAs are organizations that contract with solo or small group physicians to provide services to capitated enrollees. In some cases, an IPA is owned by an HMO and contracts exclusively with that HMO; in other cases, an IPA contracts with multiple HMOs. IPAs usually account for only a minority share of a network physician's income.

[5]In contrast to IPAs, medical groups account for most or (usually) all of a member physician's income.

number of medical group physicians. Mullikin and Pacific Physicians Services have a presence in Orange County as part of their larger Los Angeles area operations. Aetna, Prudential, and the CIGNA and FHP delivery systems employ some staff physicians. The UCI Clinical Practice Group is large, but it has few capitated enrollees.

Despite the growth of IPAs and medical groups, no one physician organization has a commanding share of HMO enrollment. As a result, even leading groups must maintain working relationships with the many health plans that can bring them patients.

Despite superior clinical integration in some medical groups, IPAs are obtaining the largest share of new HMO enrollment growth. IPA physicians serve about half of Orange County's capitated enrollees. Some respondents believe this is because of a competitive strategy by insurer/health plans, which favor IPAs with marketing and financial support to counter the potential bargaining power of large medical groups. Generally, IPAs are weaker organizationally and financially than are medical groups, and therefore presumably are less likely to become future rivals to HMOs through contracting directly with employers or through acquisition by a rival HMO. Other respondents argue that IPA growth reflects patients' preferences for wider physician choice and better local access, as well as the widespread belief that IPA physicians spend more time with patients than do medical group physicians. IPAs are seen by many patients as providing more personal service than do clinically integrated medical groups, with their unproven claims of higher quality of care.

The price of primary care physician (PCP) practices has risen sharply because of demand from local medical groups, as well as out of county medical groups and physician management organizations, hospitals, and insurer/health plans. Some respondents predict that the competition for PCP practices will not last. Although there is a shortage of Vietnamese, Latino, and other ethnic group physicians, there is no consensus on a shortage of other PCPs. One respondent observed that PCPs cannot assume they are automatically more secure than specialists. There is a demonstratable excess supply of specialists, especially in such areas as pulmonology, oncology, and cardiology. For some specialists, incomes have reportedly plunged as specialists compete with one another to gain referrals from capitated organizations.

A physician-driven organization, Southern California Kaiser Permanente Medical Group in Orange County long held a paramount position in the HMO market. But the organization's sluggish response to growth opportunities, insufficient regard for customer satisfaction, and relatively high cost structure led to a rapid loss of market share and substantial disenrollment in the early 1990's. Since 1994, Kaiser's enrollment appears to have stabilized. Kaiser's Health Plan has restructured its marketing, and the Permanente Medical Group has improved patient satisfaction and extensively restructured

its clinical operations. Although Permanente Medical Group still has an excess of "tenured" specialists and probably pays both PCPs and unionized non-physician staff more than its competitors do, Kaiser Health Plan appears to have improved the competitiveness of its premiums.

Friendly Hills and Bristol Park are medical groups with national reputations for their physician management and clinical integration expertise. Both depend on full-risk hospital and physician capitation for most of their revenues. Friendly Hills owns its own hospital. Bristol Park is an example of an integrated delivery system in which a medical group has integrated its operations with those of hospitals it does not own.

Recently, Friendly Hills and Bristol Park confronted the limits of what a small, locally owned physician-based integrated delivery system with less than 10 percent local HMO market share could accomplish in a market with powerful statewide purchasers and health plans. Friendly Hills sold itself to Caremark, partly to obtain the capital that it needs to acquire information systems and transfer its knowledge to opportunities elsewhere in southern California. Caremark, which acquired several large medical groups elsewhere, recently bought CIGNA's southern California clinics. This has enabled Friendly Hills to add seven clinics and 48,000 capitated enrollees in Orange County and as many as 250,000 capitated enrollees elsewhere in southern California. Bristol Park is seeking capital partners or a new owner because it needs capital for information systems, physician practice acquisition, and expansion in other areas.

Friendly Hills and Bristol Park medical groups are considered to be in the forefront of physician management and clinical integration, and therefore capable of more sophisticated cost-cutting and quality enhancement. For example, Bristol Park manages physician behavior with a combination of a sophisticated compensation methodology; ongoing audits, evaluations, and feedback to physicians; a physician-driven use management process; peer pressure; relatively open communications; and quality incentive awards. It carefully selects physicians, then closely monitors and educates new physicians during a two-year probation period. After the probation, the physician is encouraged to acquire an equity stake in the medical group.

Friendly Hills uses Multidisciplinary Action Plans (MAPs), based on treatment protocols, to drive patient care. The MAP includes a patient schedule for various clinical activities, including actions by sub-specialists and ancillary personnel (like pharmacists and dietitians) and patient education. The MAP extends across all sites of care, including the patient's home. Friendly Hills is integrated thoroughly with a hospital that it owns. Bristol Park identifies and case-manages high cost cases, uses a small group of internists to admit all hospital patients, coordinates its information systems with those of the hospitals that it uses, and employs various secondary prevention techniques, including automatic appointment scheduling, to regulate care for

persons with chronic conditions. One limit to clinical integration is an adequate information system. Neither Friendly Hills nor Bristol Park have computerized patient records.

Safety Net Providers

Orange County provides no indigent medical care directly; its entire safety net system relies on a shrinking number of physicians, hospitals, and clinics willing to contract with the county to care for its indigent patients. So far, this arrangement has worked to the county's advantage, allowing it to fulfill its responsibility under state law as a health care provider of last resort while funding only a small portion of the costs of caring for indigents. However, as the county continues to reduce its historically low levels of safety net provider funding, serious questions arise about these providers' willingness and financial ability to continue service to these populations. Health plans have virtually no responsibility for indigent care.

The most significant safety net provider is the UCIMC, which acquired the county's public hospital in 1976. At that time, UCI accepted the transfer of the county hospital as part of a larger agreement between the governor's office, counties, and the entire University of California (UC) system.[6] In the last two decades, UCIMC has served a steadily growing share of the Medi-Cal and MSI patients. Medi-Cal patient days now account for roughly 15 percent of all patient days in Orange County, but 55 percent of patient days at UCIMC. Similarly, the UCIMC system serves approximately 40 percent of the MSI population. Reportedly, the county pays only about 10 percent of charges for MSI patients.

Despite efforts by CalOPTIMA to recognize and reward the traditional safety net role played so far by UCIMC and Children's Hospital, UCIMC may see a major drop in its revenues as Medi-Cal patients choose from the expanded list of CalOPTIMA providers. A reduction in Medi-Cal inpatient days caused by implementation of CalOPTIMA and the results of managed care would bring major reductions in the DSH funds that have made the critical difference in UCIMC's finances. This reduction would occur at the same time that the county is unable to provide UCIMC with any financial assistance. UCIMC will also probably see increased numbers of the more underfunded MSI patients who are redirected from other providers.

To survive within these new realities, UCIMC has moved to reduce costs by cutting about 600 staff members and reorganizing its operations more systematically. Reportedly there is pressure for UCIMC to use private management,

[6]At this time, the University of Calfornia also accepted the transfer of two other county hospitals—those for Sacramento and San Diego counties. Several UC regents advised against this agreement, arguing that it could be financially devastating.

but for now its new CEO is pursuing his own reorganization measures,[7] including a case management program designed to improve clinical use through decreased average length of stay and reduced resource consumption. UCIMC has also designed competency-based performance management programs and intends to broaden the Together Everyone Achieves More (TEAM) project, through which employees and management staff participate in courses on customer service, performance management, and managing change. UCIMC is seeking to attract private pay patients with remodeled facilities, improved patient convenience, increased access to primary care sites, and association with the prestige of its clinical faculty. It is also taking steps toward a closer relationship with Children's Hospital via a shared CalOPTIMA network.

Community Clinics

Unlike other regions in the state and country, Orange County's community clinics have failed to put together a true countywide network with a unified response to health care changes. The fragmentation of the county's 13-member Coalition of Community Clinics is attributed by some to clinic administrators' diverse backgrounds and resistance to following directives from a centralized program.

Preparations for CalOPTIMA increased the strain on the coalition, effectively splitting its members into two groups. One group consists of CalOPTIMA-oriented clinics that are each trying to position themselves to pursue CalOPTIMA patients by developing special relationships with selected hospitals and moving away from services for non-CalOPTIMA indigents. This year, one of the largest clinics in this group formally withdrew from the coalition. Meanwhile, another group of free clinics see themselves as the last hope for people without even public insurance. These clinics probably will not survive without a special relationship with a hospital that can provide financial and in-kind support.

Some low-income people are also experiencing growing hostility toward undocumented residents. When California voters approved Proposition 187 in the November 1994 elections, they enacted provisions reflecting a substantial hostility toward undocumented people.[8] Health care providers who have taken a public stand against excluding undocumented people from medical care or

[7]The former CEO, who had received significant criticism for pursuing some cost-cutting measures, was fired in June 1995 because of alleged misconduct in UCI's infertility clinic and subsequent mishandling of the employees who made the allegations public.

[8]Proposition 187 requires government agencies to verify that only American citizens or legal residents receive the benefits of publicly funded education, social services, and non-emergency medical care. Publicly funded health care providers are now caught between Governor Wilson's admonition to implement the new law and several court orders and pending lawsuits that would bar enforcement of major portions of its provisions.

who simply continue to serve this population face a backlash from groups whose support they need. For example, there is physician anger with the major Catholic hospital whose management opposed Proposition 187, and neighborhood opposition to a free clinic that refuses to turn away undocumented patients and is now worried about its conditional use permit to operate in that location. The growing ethnic diversity of Orange County coming from legal and illegal migration alike ensures that the question of undocumented residents and legal immigrants will become a major policy and perhaps ethical issue for the public and private providers who have so far been part of Orange County's medical care safety net.

Academic Medical Centers

Although few academic medical centers appear to have a secure future, UCIMC appears to be especially vulnerable. In a market with high managed care penetration, UCIMC is having difficulty with the diminished use of commercial insurance payments to cross-subsidize medical education. UCI's financial picture grows bleaker as it contemplates growing losses in serving Orange County's medical indigents, as well as the possible loss of large numbers of Medi-Cal patients and DSH funding when CalOPTIMA is in effect.

UCIMC also faces challenges in the financing of medical education because it can no longer obtain a premium for its teaching. HMOs won't pay a dime more for teaching. Moreover, UCIMC's staff physicians include faculty specialists who were unaccustomed to a cost-conscious approach to resource use. UCIMC lacks capital for expansion, especially for creating a secure PCP network.

The UCI College of Medicine and the Medical Center have engaged in a partnership to help create an integrated delivery system that focuses on expanding ambulatory care services and inpatient market share. The Clinical Practice Group, a multispecialty medical group of 276 UCI physician faculty members and approximately 30 employed physicians in the Primary Care Group, are working with the Medical Center to establish relationships with external primary care groups to broaden UCIMC's geographic coverage and expand its primary care capabilities.

Consumers

There is growing disparity between access to health care for low-income Orange County residents and those with modest or higher incomes. In a 1994 survey of Orange County residents, low-income residents reported not receiving treatment for their chronic illnesses at twice the rate (41 percent

compared to 20 percent) as those with higher incomes.[9] Approximately 43 percent of Orange County residents living in poverty reported that they lacked a regular source of care, an increase from 25 percent in the same survey four years earlier. People with incomes above 200 percent of the federal poverty level (FPL) experienced the opposite. Approximately 9 percent lacked a regular source of care in 1994, compared with 19 percent in 1988. Opinion is strongly divided about the impact CalOPTIMA will have on health care access for its enrollees and on the county's larger safety net.[10]

▼ ▲ ▼ Future Developments

In the next three years, HMO market penetration will continue to increase, possibly rapidly. Statewide purchasers and HMOs will increase their size and market power, and premium decreases (either real or nominal) are possible. Ownership of local hospitals will become more concentrated, as statewide delivery systems increasingly bargain with HMOs. Various types of insurer/provider partnership arrangements will be formed, as insurers attempt to differentiate their insurance products. Health plans will continue to compete for enrollees on the basis of price, although quality-of-care measures of unclear validity may affect enrollee choice.

It is impossible to predict the effect of health system change on overall quality of care for the insured. More integrated organizations may provide enhanced quality of care, and less integrated organizations may provide the opposite. It is unlikely that major health care legislation will be enacted. State-funded Medi-Cal capitation rates will determine the success of the county's managed care program. The number of uninsured residents may increase, while access to care for the uninsured—especially the undocumented—will continue to decrease in the absence of new political initiatives. The growing ethnic diversity of Orange County from legal and illegal migration ensures that the question of undocumented residents and legal immigrants will become a major policy and perhaps ethical issue for the county.

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[9]"Health Care Inequities in Orange County, California: A Growing Nightmare for the Poor." Study Conducted by the United Way of Orange County Health Care Council, 1994, Executive Summary, pp. 2–3.
[10]*Idem*, p. 10.