

San Diego, Calif.

Site Visit Report

Prepared by:

Institute for Health Policy Studies
University of California at San Francisco
San Francisco, California

Authors:

Robert H. Miller
Helene L. Lipton
Kathryn S. Duke
Harold S. Luft

The authors are on the staff of the Institute for Health Policy Studies (IHPS), University of California, San Francisco. Reviewers included Stanley Pappelbaum of Professional Health Consulting Group and Julianne Howell of the University of California, San Diego. The authors are solely responsible for the selection and interpretation of information in this report.



▼ ▲ ▼ Overview

San Diego is a self-contained, increasingly ethnically diverse metropolitan area with 2.6 million people. San Diego's economy is moving away from dependence on the military and military-related industry and toward high-tech activities and industries.

There is almost no way for health maintenance organizations (HMOs) new to San Diego to enter the San Diego market other than through merger or acquisition of an existing plan. HMO plan penetration is already about 50 percent of all insured enrollees, and half a dozen large HMOs control the capitated market. Because existing HMOs have operated for years, they benefit from name brand recognition and economies of scale. As a result, they are in a much better position to capture new HMO enrollees from indemnity insurance or from other HMO plans than are new HMOs.

The state legislature is unlikely to significantly change laws that were created in the old indemnity insurance system. Although legislation will move many Medi-Cal (California's Medicaid) enrollees into managed care, its impact will be felt in the future.

Purchaser and HMO negotiations outside San Diego have affected the San Diego health system. Over the past three years, assertive statewide purchasers negotiated with statewide HMOs to reduce premiums and led many local employers to expect that their premiums would decline as well. Meanwhile, over the past three years, HMOs have competed aggressively for market share, growing either through merger and acquisitions or through price-based competition. As a result, San Diego commercial insurance premiums declined from 1993 to 1995.

HMOs are divided into Kaiser and non-Kaiser health plans. Kaiser, an integrated health plan and delivery system, currently serves about 35 percent of San Diego's HMO enrollees and 14 percent of the San Diego population. After controlling a large percentage of San Diego's HMO market for decades, Kaiser's market share and power declined in the early 1990s because it failed to actively pursue rapid growth and had higher cost and rates than its competitors. Most other HMOs are distinctly separate from delivery systems. Seven non-Kaiser HMOs, including some smaller ones, now control nearly all of the non-Kaiser HMO market. They compete with Kaiser on the basis of price and network, with one another on the basis of price, and with preferred provider organizations (PPOs) on the basis of price and point of service (POS) plans.¹ Most non-Kaiser HMO plans are similar in price and network. Their quality of care is currently unknown.

¹A POS plan is a health plan with a network of providers whose services are available to enrollees at a lower cost than the services of non-network providers. POS enrollees must receive authorization from a primary care physician to use network services. POS plans typically do not pay for out-of-network referrals for primary care services.

Statewide non-Kaiser HMOs dominate the San Diego market, despite substantial local delivery system consolidation.² These statewide organizations can pass premium decreases to the San Diego non-Kaiser delivery systems and force them to cut costs because HMOs exploit large excess hospital and specialist capacity, account for a large part of the three non-Kaiser delivery system business, and, as statewide or national organizations, have greater financial resources and less at stake financially than the local San Diego delivery systems. Non-Kaiser HMOs force Kaiser to act like other delivery systems.

The San Diego health care delivery system is consolidated and very competitive. The four main delivery systems account for about 85 percent of capitated enrollment and more than 70 percent of discharges. Health plan market power is leading to consolidation of the delivery system. The health systems have used mergers and acquisitions and increased HMO enrollee market share to counter new health plan market power. Kaiser and Sharp Healthcare, the largest San Diego delivery systems, have made the greatest progress in integrating hospital and physician operations.

The economic power of the insurance industry in San Diego, which led to stagnant or declining capitation rates, has forced delivery systems to decrease hospital use, reduce payment to specialists, contain primary care physician (PCP) salaries, engage in more secondary prevention activities, and integrate clinical health care delivery. Sharp and Kaiser have done the most to change their delivery system operations. Insurers are straining delivery system finances, forcing Sharp and the University of California at San Diego (UCSD) to seek capital partners or part owners. Delivery system nonprofit (or, in the case of Kaiser Permanente, large and democratic) boards may slow delivery system responses to actions by mostly for-profit health plans.

No one knows if quality of care for insured and uninsured consumers has changed in the past several years because quality of care is not measured and reported. Funding for the uninsured has become increasingly inadequate and unpredictable. There are significant threats to funding sources for community clinics, including anti-illegal immigrant legislation.

²After this report was written, two major changes took place in the San Diego market. Sharp HealthCare merged its four hospitals with one owned by Columbia/HCA, and Scripps Clinic Medical Group severed its relationship with Scripps Hospitals. Neither change was a surprise. We did not have time to incorporate information about these developments into the text, other than to mention that they had occurred.

▼ ▲ ▼ **Community and Health System Background**

Demographics and the Economy

San Diego's population grew rapidly from World War II through the 1950s and then grew by 3 or 4 percent per year during the past 30 years until it reached its current level of 2,600,000. In the 1980s, much growth was related to employment-related immigration. Population growth has slowed considerably in recent years. Ethnic diversity has increased over time. The percentage of non-Hispanic whites dropped from more than 90 percent in 1950 to about 65 percent in 1990 and is expected to drop to 50 percent in 2015. The Latino (Hispanic) population comprises 20 percent of the population and is expected to comprise 30 percent by 2015. Asians and other populations comprise about 8 percent of the population, and African Americans comprise about 6 percent. Approximately 10 percent of the population is undocumented.

San Diego's economy is moving away from dependence on military-related activities and toward greater reliance on high-tech industries. In the past, employment varied with the changes in defense procurement contracts and military installation expenditures, which decreased significantly in the past five years. From 1990 to 1993, San Diego experienced its worst recession since the 1930s. Several corporate headquarters also closed, which hurt the area's employment.³ Since the mid-1970s, real per capita income has stagnated, and lower-paying service sector jobs have accounted for much employment growth. There is a substantial gap in income and education between the top and bottom third of the population.

Health System History

San Diego's 50 percent HMO market penetration among the insured population (including Medicare and Medicaid recipients) is attributable in part to its long history with Kaiser. Kaiser had a commanding presence in the San Diego market until the rapid growth of for-profit HMOs in the mid-1980s. Beginning in the 1990s, market power shifted to the major non-Kaiser HMOs. High premiums and cautious expansion plans led to stagnant Kaiser enrollment. Currently, a few large, for-profit insurer/health plans dominate the market.

³San Diego Association of Governments. "A Look at San Diego's Future." INFO, January/February 1994.

Over the past 15 years, Sharp and Scripps health systems acquired additional hospitals and competed against each other. In 1985, Sharp acquired the Rees-Stealy medical group, which was a pioneer in accepting capitated payment for enrollees. Sharp has continued to build its physician organizations. Scripps has a well-known reputation for quality medical care and research and has traditionally attracted more affluent enrollees. It recently merged with Scripps Clinic. As San Diego's only teaching hospital, UCSD has traditionally served a large share of the uninsured and Medi-Cal populations, especially when compared with its competitors.

▼ ▲ ▼ Health System Changes

Public Policymakers

With the exception of two legislative initiatives, California's legislation and regulation have changed little in the past three years. In 1991, recession in California created a state budget deficit that spurred the California Public Employees Retirement System (CalPERS), a California state and local government retirement system and health care purchaser, to take action to reverse premium growth. State legislation dropped a statutory premium contribution formula that had eliminated premium contributions by most of CalPERS enrollees. Because collective bargaining agreements, not statutes, determined enrollee contributions, the state negotiated contract language to make enrollees more conscious about the cost of health plan premiums.

Responding to market developments and continued state government deficits, 1993 legislation accelerated the movement of Medi-Cal enrollees into HMO plans. Most of the state's large and medium-sized counties had to choose between a county organized health system and a two-plan model (one commercial plan and one plan that favors existing safety net providers) to organize their Medi-Cal enrollees. Sacramento adopted a third model, geographic managed care, through which HMOs and local health plans contract directly with the state, and the county oversees quality of care. San Diego's model is most similar to that of Sacramento. The long-term effects of this legislation will be felt in the future.

After two years of operation, the state-sponsored Health Insurance Plan of California (HIPC), a California-wide small group purchasing organization, still has fewer than 100,000 enrollees, a very small percentage of which came from companies with no prior health insurance.

California health laws do not facilitate health system change. For example, California bans the corporate practice of medicine (employing physicians) and restricts full-risk contracting by physician groups. These laws have little effect,

but they encourage multiple layers of legal and administrative costs. California health care laws also lack administrative unity. Different state agencies administer Medi-Cal, the HIPC, indemnity insurers, and HMOs.

Funding for the underserved populations in California and San Diego is at significant risk. There are numerous anecdotes of postponed care having led to medical complications, and uninsured populations receiving second-class care. Funding is unpredictable and fluctuates partly as a result of arcane funding formulae and changes in political agendas. Providers that serve the most uninsured people do not receive sufficient funds. State legislative and regulatory changes have primarily had a negative effect on the uninsured. Over the past 13 years, the state has brought down payments for the indigent. Its Medically Indigent Adults program transferred responsibility to the counties without a corresponding transfer of revenue-raising authority, reducing access to care for the uninsured. Moreover, anti-illegal immigrant legislation poses a serious threat to funding, particularly for community health centers.

As state funding is cut, city and county budgets designed to support indigent care and public health activities have also decreased. One informant observed that funding cuts occurred in conjunction with prison expenditure increases. For two decades, the San Diego health department has provided very little direct care and is reducing its role in the future.

HMO capitation rates set by the Health Care Financing Administration (HCFA) have spurred the development of Medicare HMOs in San Diego. Even before the recent increase in Medicare HMO capitation rates, HCFA was paying higher rates than most other purchasers in the state.

Purchasers

In the past two years, California employers benefited from premium reductions that statewide purchasing coalitions negotiated with HMOs for their enrollees. These negotiations affected expectations about premiums; employers began to expect no change or premium decreases. Employers also benefited from strong price competition by HMO plans striving to increase their market size and share.

Employers and Employer Coalitions

Managed care is an important part of San Diego health care. Large San Diego employers have offered Kaiser health plan as an option for decades, which has helped other employers and enrollees become familiar with HMOs and has facilitated their move to managed care. After 1983, many employers began to offer PPO and additional HMO plans. Currently, about two-thirds of enrollees

in employer-based plans are HMO members; most of the others are divided between PPO and indemnity insurance plans.⁴

San Diego employer-based health plan premiums grew rapidly in the late 1980s and early 1990s. In 1993, premium increases slowed substantially, and by 1994/1995 most premiums remained unchanged or decreased. As a result of strong competition for employer business, health plan premiums offered to employers have tended to converge.

San Diego employers that offer health insurance to employees provide at least one HMO plan, and virtually all of them offer a PPO plan. Increasingly, employers are offering a POS plan, a PPO with a gatekeeper, or an HMO with some out-of-HMO service coverage. PPO and POS plans generally cost more than HMOs, but the plan designs make premium comparisons difficult. For larger employers, some HMOs adjust premiums to account for enrollee age and gender. Employers are shifting some costs to employees through enrollee copayments for HMO services, employee premium contributions that vary with the plan's premium, and additional deductibles and copayments for non-HMO plans. Retiree coverage appears to be the exception, not the rule. Multi-year insurance contracts with fixed future rates are rare.

San Diego employer purchasers are primarily small to medium in size and not well organized as a purchasing force. Large employers have decreased in size and purchasing power.

San Diego employers have not formed health care purchasing coalitions, but statewide purchasing coalitions have negotiated highly publicized premium reductions for their members. This has helped San Diego employers obtain lower premium increases or premium reductions. Statewide purchasing coalitions include CalPERS, the Pacific Business Group on Health (PBGH), and the Health Insurance Plan of California (HIPIC).

Beginning in 1992, CalPERS moved from a passive purchasing agent on behalf of 600 state and local government employers to a leadership role in bargaining with health plans, negotiating HMO rate increases of 6.9 percent in 1992/1993, -0.4 percent in 1993/1994, -1.1 percent in 1994/1995, and -5.2 percent in 1995/1996. CalPERS used the \$1.5 billion in premiums that it pays out for 1,000,000 enrollees, including 800,000 HMO enrollees, as a lever in negotiations.

In 1994, 11 PBGH members with 300,000 HMO enrollees participated in a purchasing alliance that negotiated rate reductions approaching 10 percent with 17 California HMOs.⁵ Alliance members agree to uniform benefit packages and receive information on uniform, although limited, quality improvement measures. Seventeen of the 29 current members are part of the alliance's 1996 rate negotiations with insurers/health plans. PBGH (formerly

⁴*Los Angeles Times*, August 31, 1995.

⁵*Pacific Currents*, May 1995, 1(1):1.

Bay Area Business Group on Health) consists mostly of employers with headquarters in the San Francisco Bay Area and Los Angeles, although employees work statewide. CalPERS is an employer member of PBGH, but not of the purchasing alliance.

The HIPC, which began in 1993 as a state-sponsored purchasing coalition that acts on behalf of employers with 5 to 50 employees, had 95,000 HMO enrollees at the end of 1995. It has negotiated premium reductions with HMOs and may have had an effect on purchasers in the small employer market.

Some observers believe that statewide purchaser coalitions have led many employers to expect HMOs to treat them in a similar manner. This has reduced the need for local purchasing coalitions. Others believe that coalition purchasing successes may result in cost-shifting, resulting in higher premiums.

There is very little difference in products since premium prices and physician networks are very similar. Issues of premium cost and availability of personal physicians are primary factors governing employers' and employees' choice of health plan. Most plans offer employers similar premiums. Most top non-Kaiser plans include Sharp, Scripps, and UCSD physicians in their networks, so enrollees can get access to the same physicians in different plans.

Quality of care plays virtually no role in San Diego employer/enrollee health plan choice because health plans do not report quality measures. Even use is not reported because most HMOs capitate medical groups or IPAs for their services and receive little detailed information. Quality of care is becoming a concern. In particular, some employers fear that gatekeeper disincentives for specialist referrals may be too strong.

Employers tend not to change plans unless the difference in premiums is significant (for example, more than 10 percent). This reluctance stems from employers' unwillingness to disrupt relationships employees have developed with primary care physician gatekeepers, as well as from concerns about the administrative burden associated with changing plans. Employers increasingly offer POS plans to combine their HMO and PPO offerings, simply their administrative burden, and move more PPO enrollees into HMO arrangements.

State and Local Government as Purchasers for Low-Income People

Over the past decade, Medi-Cal expenditures have grown rapidly and access to care has diminished. This has led the state to move Medi-Cal enrollees into managed care plans. "Healthy San Diego," San Diego's Medi-Cal managed care model, allows health plans to contract directly with the state and initially enrolled 225,000 San Diego Aid to Families with Dependent Children (AFDC) recipients.

Insurers and delivery systems are extremely interested in the \$650 million San Diego Medi-Cal market, especially as other insurance per diem, case rates, and capitation rates to providers stagnate or decrease. However, rates nego-

tiated with the California Medical Assistance Commission will determine the success of the shift to Medi-Cal managed care. Providers claim that California is second to last in Medicaid payments per beneficiary. San Diego providers receive the lowest Medicaid payments of all California counties. Since capitation rates are based on current expenditures, providers fear that low payments will be locked in over time.

The San Diego local government does little to purchase care for low-income workers. San Diego has no public hospital and has reduced its limited amount of direct service provision through clinics. The San Diego County Department of Health Services wants to oversee the shift to Medi-Cal managed care so as to be able to monitor quality of care, grievances, and information and data management.⁶

Insurers and Health Plans

As of mid-1995, HMOs accounted for 50 percent of San Diego's 2.1 million insured enrollees. HMO enrollment has increased steadily over time and currently accounts for about two-thirds of all employer-based health insurance enrollees, 43 percent of Medicare enrollees, and about 17 percent of Medi-Cal enrollees. PPOs account for perhaps 20 percent of the under-65 commercially insured population; traditional insurance accounts for about 16 percent of that population.

Although San Diego has a high level of HMO market penetration, it has not reached a point of HMO market saturation, and enrollment continues to grow. Nevertheless, some feel that enrollment will never get very close to 100 percent of the population.

Kaiser accounts for the largest share of the HMO market, with 35 percent of all enrollees in mid-1995. Aetna (14 percent of the market), Pacificare (13 percent), and HealthNet (13 percent) are the three largest non-Kaiser plans, while FHP/TakeCare (7 percent), California Care (6 percent), Cigna (5 percent), and Prudential (5 percent) have more than 50,000 enrollees each. Pacificare leads in Medicare HMO enrollment, and FHP has increased enrollment recently.

California HMO plan concentration increased significantly in the past two years as FHP acquired Take-Care and HealthNet (via Health Systems International) acquired Qual-Med. In 1993, health plans determined that, to survive under the proposed Clinton health plan, they would have to become substantially larger. Mergers also provide health plans greater bargaining leverage. Further, although there is no scientific evidence to support this contention, it is widely believed that mergers may lead to greater economies of scale.

⁶*Southern California Medicine*, May–June 1995.

San Diego is virtually closed to new HMO entrants that want to become significant players. Because existing large HMOs have operated for years, they benefit from name brand recognition and possibly from economies of scale, as well. As a result, they are in a much better position to attract new enrollees than are new HMOs.

HMO plans in San Diego compete aggressively with one another and with PPOs on the basis of price to win market share. In some cases, they offer very low rates to selected employers. As a result, overall premium levels stagnated or declined in the past two years, and premium prices tended to equalize among HMOs. HMO plans also compete by offering POS plans. There is not sufficient measurement and reporting of quality measures for competition to exist on the basis of quality of care. There is some competition on the basis of breadth of in-network providers, but most non-Kaiser plans have similar networks.

The HMO plan sector is divided into the Kaiser Health Plan, which offers its own provider network, and most of the remaining non-Kaiser HMOs, which offer provider networks that are similar to one another. Kaiser Health Plan was the dominant player in the HMO market until the early 1990s. For years it had little competition, and in the early 1980s its only HMO competitor went bankrupt. In conjunction with strong enrollment increases and its relatively high cost structure, Kaiser Health Plan effected a series of large premium increases. This halted Kaiser enrollment gains, which benefited its competitors. Moreover, Kaiser paid little attention to personal care and timely access to specialists, had no brokers for the small group market, had no effective marketing, and did not respond to the rapidly expanding and lucrative capitated Medicare market. This invited other aggressive, for-profit HMO competitors to enter the market. Kaiser now has 25,000 fewer enrollees than it had in 1992. Large San Diego corporations have declined in numbers and importance, which has hurt Kaiser further. Beginning in 1993, Kaiser in California began to revamp its operations to cut costs and raise enrollee satisfaction, thereby improving its marketing position.

For profit non-Kaiser HMOs have become the single most powerful force in today's San Diego market. Non-Kaiser HMOs apparently can protect their profits by passing most or all premium decreases to providers. The non-Kaiser HMOs, which control 650,000 HMO enrollees, can exploit excess hospital and specialist capacity in San Diego. As large state and nationwide entities, major non-Kaiser HMOs have greater financial resources and less at stake financially than do the major San Diego delivery systems. The top three HMOs, including California Care with HealthNet, control a majority of Sharp and Scripps HMO enrollees and account for a substantial share of Sharp and Scripps revenues.

Nevertheless, insurers remain dependent on continued relationships with Sharp and Scripps and, to a lesser extent, UCSD. Most HMOs need to include

Sharp and Scripps systems in their networks to keep employer business. Sharp has large numbers of HMO enrollees; Scripps has a quality of care reputation that is attractive to employees and employers who may want to use Scripps themselves. The HMOs see UCSD as an effective lever to use against Sharp and Scripps.

HMO plan insurance has become an undifferentiated commodity because the non-Kaiser networks and premium prices are mostly the same. Furthermore, employers and enrollees cannot choose plans based on quality or satisfaction measures because no reliable measurement tools and standardized reporting methods exist. To differentiate its product and capitalize on provider discontent with HealthNet and Blue Cross, Pacificare is entering into partnership relationships with larger medical groups and IPAs in southern California. It is difficult to determine how partnerships might work in San Diego because the largest HMOs are unlikely to drop either Sharp or Scripps. There seems to have been no attempt by an insurer to purchase a San Diego delivery system.

Health plans usually pay full medical capitated amounts to delivery system physician organizations—they capitate systems for all medical and outpatient ancillary services. They usually pay hospitals per diem or case-rate amounts. Delivery systems want capitation for all medical and hospital services, but insurers are afraid purchasers may see them as unnecessary because it underscores the fact that health plans devolve most management responsibilities to the major delivery systems.

Since quality control reporting requirements are minimal, none of the delivery systems or health plans have the capacity to adequately report quality. This eliminates the possibility of competition on the basis of measured quality. Some insurers believe enrollees are primarily concerned about price and not quality of care.

California HMOs have been profitable in the past several years.⁷ The media has publicized California HMO profits and overhead, as well as HMO executive compensation through salaries and stock ownership. In mid-1994, the California Medical Association published loss ratios for major California HMOs that showed that most HMOs paid out only 70 to 80 percent of the premium dollar to providers.⁸

Providers

The San Diego managed care provider system is consolidated and competitive. The four main delivery systems account for about 85 percent of capitated enrollment and more than 70 percent of all San Diego discharges. Health

⁷A.M. Best Company. "Best's Managed Care Reports, HMO, United States." Oldwick, NJ. 1995.

⁸California Medical Association. "Knox-Keene Plan Summary, FY 1993/94. Physician Information Package," 1995.

systems have tried to gain strength through mergers and acquisitions and use increased HMO enrollee market share as a lever to counter new health plan market power. Declining capitation and hospital per diem rates from health plans have forced delivery systems to cut costs.

Delivery Systems

San Diego is one of only a few large markets that has high levels of HMO market penetration and a few large delivery systems that control a large percentage of health care delivery. Three of the systems are hospital dominated (Sharp, Scripps, UCSD), and one is physician controlled (Kaiser). Two systems have integrated hospital and physician operations (Kaiser and Sharp).

Sharp Healthcare is the largest San Diego delivery system, with more than \$800 million in revenues in 1994 and substantially more capitated enrollees than its two non-Kaiser delivery system competitors combined. Sharp acquired the Rees-Stealy medical group in 1985 and subsequently continued to build its primary care physician base and HMO enrollment. As of mid-1995, its two medical groups, an affiliated IPA, and a network managed by FPA served 309,000 capitated enrollees, which represents about 30 percent of all San Diego HMO enrollees. Sharp also serves a substantial proportion of PPO enrollees. One source estimated that Sharp provided care to 25 percent of San Diego's population.

Sharp's one specialty and six acute care hospitals accounted for about 25 percent of all San Diego acute care hospital discharges in 1994.⁹ Although Sharp has gained a national reputation for its efforts to clinically integrate its operations, functional, physician-system, and clinical practice integration has not yet occurred. After struggling to break even in the past two years, Sharp is reportedly losing millions of dollars and faces flat revenues. Sharp's strategy of purchasing hospitals and acquiring medical staffs was costly, especially with the increasing number of empty hospital wards. Sharp has lacked capital for expansion.¹⁰

Scripps Health is a higher cost hospital system that has relied on its quality of care reputation and a substantial endowment to continue to dominate the slowly dwindling non-capitated, upscale, insured market. Although it is the second largest system, with more than \$600 million in income in 1994, it was the slowest to build up its capitated enrollment. Scripps Clinic Medical Group and three IPAs affiliated with Scripps Health served 112,000 capitated enrollees as of mid-1995. However, although Scripps Memorial Hospitals and

⁹Office of Statewide Health Planning & Development, State of California. "Quarterly Individual Hospital Data for California, 1989-1993." Sacramento, CA, 1994.

¹⁰In late 1995 (after this report was written) Sharp and Columbia created a new joint venture, merging the four hospitals that Sharp owns with the one hospital that the FP Columbia/HCA owns.

Scripps Clinic merged in 1993, Scripps Clinic (which accounts for 80,000 HMO enrollees) is looking for a new owner or capital partner.¹¹ Scripps now has six acute care hospitals that accounted for 25 percent of all San Diego acute care discharges in 1994. In that same year Scripps showed some profit, including \$33 million in contributions and investment income. Scripps' hospital acquisitions proved to be costly in a period of decreasing hospital bed occupancy.

Scripps benefits in several ways from its international reputation for quality of care and research; a primary factor is that it receives a higher capitation rate for medical services than does Sharp or UCSD. However, its continued success in the shrinking indemnity insurance/fee-for-service system and sizeable endowment may have reduced the pace and urgency of its cost-cutting efforts and orientation to capitation. This may result in a decreased market share.

The Kaiser delivery system, which consists of the Kaiser Foundation Hospitals and the San Diego part of the Southern California Permanente Medical Group, remains the largest HMO provider and has 365,000 HMO enrollees and 9 percent of all San Diego discharges as of mid-1995. Although Kaiser does not break out revenue and profit by market area, its San Diego delivery system revenue may be more than \$400 million, almost all of which is attributable to capitation. Kaiser has been profitable systemwide.

Although Kaiser's utilization management and operational procedures were a benchmark for delivery systems in other markets, its success led to future problems. As a nonprofit physician-dominated organization with a health plan, Kaiser viewed substantial enrollment growth in the late 1980s and early 1990s as a problem as well as an opportunity. Kaiser did not aggressively expand, partly because, unlike physicians with marketable equity in some of the emerging large medical groups, Kaiser Permanente Medical Group physicians would not gain financially by the rapid growth of their Group and affiliated health plan. Moreover, success led physicians to expect that growth was inevitable and change was not urgent, despite Kaiser's increasingly uncompetitive cost structure. Although it contracts for some services, Kaiser abandoned some opportunities because it could not grow its physicians and facilities fast enough.

Physicians' concerns that their incomes might decline if the plan did not become more competitive led Kaiser to revamp its operations in 1993. It attempted to improve customer satisfaction including reducing waiting times

¹¹After this report was written, Scripps Clinic Medical Group found a capital partner and became a separate entity from Scripps Health.

for specialist referrals and working to ensure that each patient can see the same PCP from visit to visit.

UCSD Healthcare emerged as a viable capitated delivery system competitor in the past two years. Driven by a declining paying patient base and shrinking indigent care funds, UCSD developed a competitive physician network that served more than 100,000 capitated enrollees by mid-1995. The UCSD Healthcare Network includes the UCSD faculty medical group and 14 other physician organizations. UCSD owns several of the organizations, provides administrative services to some, and has more exclusive, management services organization (MSO) relationships with the others. UCSD Healthcare Network includes two UCSD-owned hospitals and clinics and three affiliated hospitals, which accounted for 8 percent and 21 percent of all San Diego discharges in 1993. UCSD Medical Center reported a \$3 million loss in 1994, even after receiving \$17 million in disproportionate share funds.¹¹

UCSD's strategy is to build a common marketing and contracting structure for its network physicians and enter into increasingly exclusive MSO arrangements with its PCP practices. UCSD has benefited from physician dissatisfaction with Sharp's and Scripps' IPAs, as well as the insurers' need for an alternative to Sharp and Scripps. Nevertheless, UCSD's relationships with some of its physician groups and affiliated hospitals are tenuous, and it lacks sufficient capital for expansion and clinical information systems.

Delivery systems vary substantially in the extent to which they have cut costs and achieved clinical, physician-system, and functional (administrative) integration.¹³ Although precise measurement is impossible, Sharp has achieved the greatest success in integration and cost cutting. All four delivery systems are cutting middle management, reducing nursing personnel, and ending duplication of services within each organization. Each system is expanding its physician and outpatient service capacity.

Over the past several years, despite many discussions about delivery system mergers, capital partnerships, and acquisitions, no changes have occurred. Nevertheless, Sharp and Scripps have acquired hospitals, Sharp and UCSD have acquired physician practices, and UCSD has expanded its physician network. The merger of Scripps Memorial with Scripps Clinic did not lead to integration of those organizations.

Increased health plan market power is driving delivery system consolidation and forcing each delivery system to increase market share to respond to the new health plan power. Sharp and UCSD have sought to improve their

¹²University of California, San Diego Medical Center. "1993-1994 Annual Report to the Regents." San Diego, CA, 1994.

¹³Shortell, S.M., et al. "Creating organized delivery systems: The barriers and facilitators." *Hospital & Health Services Administration*, 38(4):447-466

financial strength in the face of revenue stagnation and invest in information systems and acquisition of medical groups or network development. Sharp has had the greatest need for financial resources.¹⁴ Over the past three years, Sharp and Scripps discussed a possible merger, as did UCSD and Scripps, but nothing occurred. The Scripps Clinic has tried to sell an interest in itself to various potential capital partners, including Sharp, but it is hampered by its relatively high cost structure and its substantial debts to a parent hospital system that does not want to lose it to competitor systems. Kaiser and Scripps Healthcare do not appear to have problems in accessing capital.

It was impossible to assess whether a dearth of management expertise is impeding health system change. Although some informants praised existing managers, others argued that most managers had experience in the indemnity insurance/fee-for-service system that made fewer demands on managers and that new management expertise was essential.

Only Kaiser is integrated with a large health plan, partially because HMOs would attempt to block a health system from creating its own plan. Sharp has not expanded its small HMO, which includes only its employees and their dependents, because HMOs that are critical to Sharp might withdraw some or all of their business. An insurer also would be cautious about acquiring Sharp or Scripps because it could not make up for the enrollees other HMOs would threaten to send to another delivery system. It is also cheaper for insurers to contract with delivery systems than to own them. As indicated above, Pacificare has discussed partnership arrangements with Sharp and others, but the terms considered have not been made public.

Governance structures of nonprofit delivery systems may put them at a competitive disadvantage vis-à-vis the leading for-profit HMOs. In particular, boards that developed under the old indemnity insurance/fee-for-service system may be slow to move in a fast-moving capitation market. Sharp's governance structure of multiple nonprofit boards may have prevented it from making some of the merger or hospital closure moves that were necessary. Kaiser's democratic but laborious, multiple-step decision-making process may also be a barrier to progress. Kaiser's system of governance is set up for gradual, continuous change, rather than for discontinuous, rapid change. The same may be true for the other systems, including Scripps. UCSD is hampered by the governance split between its hospital/network and the Medical School and by the oversight of the UC regents.

Delivery systems unequally share the burden of uncompensated indigent care, which affects their competitive positions. UCSD provides the most indigent care, then Sharp and Scripps. Kaiser provides some indigent care, whereas none of the non-Kaiser insurers contribute to the cost of uncompensated care.

¹⁴See previous footnote on the Sharp and Columbia/HCA joint venture.

Hospitals

The economic position of hospitals as a group has weakened as excess capacity has grown. Hospital occupancy rates fell from 72 percent in 1989 to 58 percent in 1994, and hospital discharges have also fallen. The four major delivery systems own approximately half of the 25 general acute hospitals and account for more than two-thirds of all discharges. The remaining hospitals are a mix of nonprofit and for-profit organizations. In 1993, inpatient use days in San Diego were 225 per 1,000 population for commercial plans compared with a national average of 490 per 1,000; Medicare inpatient days per 1,000 were 1,070 in San Diego compared with a national total of 2,925.¹⁵

Non-Kaiser health plan insurers usually pay hospitals on a per diem or per case basis. The non-Kaiser delivery systems want more hospital capitation because it would better align incentives of hospitals and the already capitated physician organizations. Hospital inpatient per diem rates and case rates are stagnant or declining.

Sharp and Scripps substantially expanded their hospital systems over the past 15 years. Sharp grew from one general acute hospital in 1981 to six acute and one specialty hospital in 1995. Scripps grew from three to six hospitals between 1986 and 1994. Catholic Healthcare West, a large California delivery system, now owns a minority stake in Scripps in return for the latter's recent acquisition of Mercy Hospital. Some question the financial logic of these acquisitions, and one new UCSD hospital, in an era of declining bed censuses. Aggressive expansion may have wasted nonprofit community resources and seems to reflect a lack of community focus and collaboration.

Although hospitals have their own internal quality assurance programs, they have almost no uniform quality of care reporting requirements. As a result, hospital reputation plays a significant role in choice of hospital.

To cut costs, hospitals in the major delivery systems have cut hospital upper and middle management, reduced the number of registered nurses (RNs) and changed the personnel mix, adopted disease-specific care pathways, substituted nurses for physicians on some inpatient tasks, used the same core group of internists to do all admitting, operated specialized equipment on the weekends, and determined optimal timing for tests and reporting of results. Sharp and Kaiser seem to be furthest along in these activities; Scripps has made little progress. Kaiser appears to have a significant cost disadvantage because of unionized nursing and non-nursing personnel compensation, which is higher than its competitors.

¹⁵Pappelbaum, Stanley. Presentation in San Diego. April 1995.

Although closing a hospital can achieve substantially more cost-savings than reducing beds in existing hospitals, no hospitals have been closed. Reasons for not closing hospitals include desire for comprehensive geographic coverage, an unwillingness to concede market territory to other systems, and multiple boards that are sensitive to negative community reaction to closures. However, several facilities and numerous pieces of equipment are redundant within systems and among systems.

Physicians

San Diego has more active specialists and fewer active PCPs than the national average. In 1993, it had 155 specialists per 1,000 residents, compared to the national average of 128, and 81 PCPs per 1,000 residents, compared to the national average of 99.¹⁶ There is an oversupply of specialists in the San Diego area.

San Diego has three large, long-established medical groups, including Kaiser Permanente Medical Group (365,000 capitated enrollees), Scripps Clinic (80,000 capitated enrollees), and Sharp-Rees-Stealy (140,000 capitated enrollees). Kaiser has more than 400 employed or affiliated physicians; the other two groups have more than 250 physicians each. Sharp also owns a smaller medical group with 50,000 capitated enrollees. The percentage of medical group revenues from capitation ranges widely from nearly 100 percent for Kaiser to 50 percent for Scripps Clinic. UCSD's Medical Group includes 300 faculty that spend more than 25 percent of their time in specialist-dominated clinical practice.

Sharp is closely affiliated with one IPA (70,000 HMO enrollees), while Scripps Health is associated with three IPAs (30,000 HMO enrollees). There are several other, smaller IPAs. Sharp also contracts with physicians managed by FPA, which has approximately 30,000 HMO enrollees. UCSD's network, which has more than 100,000 enrollees, functions like an IPA.

Physician-system integration varies greatly. The most advanced physician-system integration is between Permanente Medical Group and the Kaiser health plan and hospitals. Although Sharp has achieved substantial integration, Sharp's two medical groups and IPA are not substantially integrated functionally and they compete with each other for new enrollees. Clearly, this limits the extent of cooperation. Nevertheless, by owning or affiliating with three different types of physician organizations, including an IPA, Sharp can appeal to a wide range of enrollees, including those concerned about provider choice. Scripps Clinic and Scripps Health appear to have much less physician-system integration.

¹⁶Roback, Gene, et al. "Physician Characteristics and Distribution in the U.S." American Medical Association, Chicago, IL, 1994.

The large physician medical groups cut costs because of the HMOs' demands for capitation reductions. Most have instituted outpatient care pathways; substituted nurses for physicians for certain tests, procedures, exams, and history taking; attempted to use specialists to manage specific diseases; and contained or cut physician salaries and nurses' and other staff's compensation.

Observers state that the easy cost-cutting gains are over for each organization. The three largest medical groups must change how medicine is practiced through greater clinical integration. To cut costs further, they have had to rely on integrated clinical care, which requires more capital and management expertise, as well as additional changes in physician culture. To attain clinical integration and coordination, each group is investing in information technology systems, hoping for lower costs and a higher quality of care.

Kaiser Permanente Medical Group has had to address several unique physician issues. Its PCP salaries likely are higher than its competitors, and it has an excess supply of tenured specialists. As a physician-run organization, Kaiser has difficulty cutting physician pay or eliminating underused specialists. Because Kaiser also attracted physicians that were concerned about lifestyle issues, including having predictable and normal work hours, physician flexibility about patient access times has been difficult to obtain. Kaiser is attempting to address these issues and reengineer its operations to improve the efficiency of its medical care delivery.

Safety Net Providers

In addition to the three non-Kaiser delivery systems, 22 community health centers (CHCs) provide services to the uninsured, including the undocumented, as well as for many Medi-Cal enrollees. The number of uninsured residents has increased as public funding has decreased. Economic and political developments threaten the CHCs and the care for the uninsured. Medi-Cal's shift to managed care could reduce funds to cross-subsidize care for the uninsured if capitation rates are low and other providers attract Medi-Cal enrollees. Currently, CHCs obtain 40 to 50 percent of their funds through Medi-Cal, which is their best payer source. CHCs are concerned about possible Medicaid block grants, funding cuts for prenatal and other services to the undocumented, and the possible loss of Federally Qualified Health Center (FQHC) funding.

Nevertheless, many of the CHCs are working collectively to respond to changing circumstances. The Council of Community Clinics (CCC), an umbrella organization for all but one of the CHCs, has developed the CCC Health Network, which is positioned to compete for Medi-Cal HMO enrollees. Currently CCC consists of 14 CHCs with 85 PCPs and 55 mid-level personnel at 50 locations with PCP capitation for 35,000 Medi-Cal HMO

enrollees in the Community Health Group plan. CCC has begun contracting with seven other HMOs, intends to create a management service organization, and will assume additional risk for specialty services in the future. In the process, the CHCs are trying to improve their payer mix by getting access to Medicare and commercial enrollees. They also are attempting to integrate their operations vertically and horizontally. Some have aligned themselves with the major health systems; health systems provide Medi-Cal patients hospital and specialist services and can divert some emergency room patients to the CHCs.

Academic Medical Centers

Clinically active faculty at UCSD face a difficult market environment. There is very substantial excess supply of specialists in San Diego, and about 85 percent of 300 clinically active faculty, those who spend more than 25 percent time practicing, are specialists. The Medical Group depends on Medi-Cal for 22 percent of its revenue, indigents or self-payers for 7 percent, and Medicare for 20 percent.

Some of the other delivery systems are taking Medi-Cal patients, the state and county are tightening indigent care payments, and Medicare is paying less per dollar of charges than PPOs or HMOs. Having purchased the old San Diego county hospital in 1971, UCSD provides about 35 percent of all indigent care, much more than Sharp or Scripps. UCSD obtains only about \$0.13 per dollar of charges for that care, or half of Medicaid and one quarter of HMO enrollees. Additionally, HMO capitation amounted to only 17 percent of revenues in FY 1995, compared with 50 to almost 100 percent for the three other large San Diego medical groups. The governance structure is not ready to cope with this market environment since decision-making authority is split between the School of Medicine clinical department chairs, who pay faculty salaries, and UCSD Medical Center, where faculty undertake most of their clinical work. On the other hand, the market affects fewer faculty than do most other academic medical centers, since research accounts for more than half of School of Medicine revenues.

In response to these market challenges, the UCSD Medical Center rapidly built a community PCP-centered network that now contracts with all the major HMO plans. UCSD faculty objections to use of scarce “gown” funds to build a “town” network have diminished as the network sends patients to UCSD Medical Group specialists, prepares UCSD for the Medi-Cal shift to managed care, and increases private insurance enrollees. Responding to governance challenges, a new set of medical group bylaws would create a democratically elected board of clinically active faculty to run the group as a multi-specialty medical group business. As a result, UCSD is reexamining the role of the department and the medical group, especially with respect to faculty compensation.

UCSD is shifting some new residency slots from specialty programs into family practice, although family practice still accounts for relatively few residency slots. Similarly, UCSD has doubled primary care physician faculty, including family practice, general internal medicine, general pediatrics, and adolescent medicine. However, PCPs still account for a small minority of faculty positions. Meanwhile, UCSD has focused its training on outpatient settings. Despite the adverse market environment, UCSD has not eliminated faculty positions, but the hospital cut 400 hospital staff positions over the past two years.

Consumers

Experts disagreed about whether health system changes had changed quality of care for the insured or uninsured. Without useful measurement criteria, there is no way to determine quality. There does not seem to be public discontent with perceived quality of managed care or HMO plans. Continued increases in commercial and Medicare HMO enrollment indicates that perceived problems with quality of care are outweighed by the financial benefits of HMO enrollment, which are particularly great for the Medicare population. Consumer benefit from overall premium reductions, including lower enrollee premium contributions and potentially higher wages, is balanced by employer tendency to shift more costs onto employees.

Although informants hoped that the Healthy San Diego initiative would improve access to care for Medi-Cal enrollees, many were concerned that the state would set capitation rates so low that Medi-Cal enrollees would continue to have problems accessing quality care. Most observers are concerned about the uninsured, especially undocumented immigrants, since anti-immigrant legislation restricts access to care and there are cutbacks in funding streams for the uninsured.

▼ ▲ ▼ Future Developments

Over the next few years, several trends will continue, although discontinuous change also is likely. CalPERS, PBGH, and other large statewide purchasers will probably continue to press for premium reductions, as long as HMOs compete for market share and can exploit large excess provider capacity. Their actions will affect other purchasers, including those in San Diego. Their demands for premium reductions may lessen if there are publicized concerns about quality of care. Statewide purchasers will ask for more data on quality of care and services. They may pressure HMOs to cut their administrative costs and reduce their profits to increase the HMO loss ratios. Large purchasers

could engage in direct contracting with statewide delivery systems. Such a development could profoundly change the market landscape in San Diego.

Continued HMO consolidation through mergers, acquisitions, and vigorous price-competition will be driven by lucrative opportunities and the need to acquire market power against increasingly large competitors, purchasers, and delivery systems. Continued delivery system consolidation will be driven primarily by the desire to overcome excess provider supply and counter HMO increased power, as well as acquiring additional capital for clinical integration and cost-cutting investments. A local delivery system may gain enough power to generate substantial profits (surplus), despite increased market size and cost-cutting. Statewide and cross-state systems may acquire existing local players to counter the power of statewide purchasers and HMOs. HMOs, other delivery systems from outside the area, pharmaceutical companies, and other financially sound organizations could also acquire existing systems or parts of those systems.

Delivery system players may test the legal limits of consolidation, triggering antitrust investigations or action. For Sharp and Scripps, hospital antitrust issues may preclude a merger, although either could acquire physician organizations.

HMOs will attempt to differentiate their product on the basis of network and price by trying to establish increasingly exclusive partnerships with selected delivery systems. The content of these partnerships will vary widely. HMOs will probably attempt to compete on the basis of quality, but quality measurements may be inadequate for informed consumer choice.

Nonprofit HMOs and provider entities will continue to convert to for-profit status, partially because of acquisition by for-profit entities. The quality and speed of decision making by nonprofit boards may improve.

The effect of change on overall quality of care is unknown. Much will depend on whether purchasers demand the development and reporting of standardized, useful quality-of-care measures. Quality of care change will most likely be uneven—for example, quality of care may improve in some provider organizations and deteriorate in others. Quality of services may improve, but some of that change may be cosmetic.

Much of the Medi-Cal population will enroll in capitated plans. Capitation rate levels will determine the future success of Medi-Cal managed care. Uninsurances rates may increase slowly, while funding for care for the uninsured likely will decline, especially for undocumented persons.