Health System Change in Orange County, Calif.

Douglas L. Fountain *
Joy M. Grossman +
Srija Srinivasan *

**The Lewin Group*
+ Center for Studying Health System Change

Orange County, California, is one of the most competitive health care markets in the country. Physician-run organizations, hospitals and regional and national managed care companies all wield significant power and influence, so that competition among these sectors is fierce. In addition, the health care climate here has a strong business orientation because of the history of for-profit entities in the three major health care sectors; state regulation that encourages separation of provider and insurance functions and physician and hospital services; and the conservative tenor of local business and politics. Capitation has emerged as the dominant payment mechanism for primary care services and has influenced the structure of relationships among health plans and providers. Physician organizations, hospitals and health plans are all seeking to increase their size and leverage through acquisitions and mergers.

For many large health care corporations, Orange County is a piece of the Southern California and state markets, rather than a local health care market unto itself. Strategies pursued by plans and providers reflect a mix of decisions at the local, state and national levels. The county line has defined the market for some local physician groups and hospitals, as well as responsibility for administering a number of public programs. However, health insurers typically lump Orange County into their Southern California and/or state strategies, and competition plays out within the context of this larger market. Local private purchasing of health care is not consolidated, but statewide purchasing groups reportedly influence the regionalization of plans and providers that compete across the state.

Physician-run enterprises and HMOs have a long history in Orange County. The community is also home to 34 hospitals, many of which have been in operation for more than 50 years. The evolution of managed care here has contributed to the view that Orange County's experience forecasts the future for other communities experiencing managed care growth. The dynamics at work in this market include:

- extensive use of capitation to pay primary care physicians;
- organization of physicians into entities that can manage care under capitated arrangements;
- competition among hospitals seeking volume to cover their fixed costs; and
- recent growth of Medicare managed care and implementation of Medi-Cal managed care.

Health plans, physician groups and hospitals are pursuing horizontal consolidation strategies in attempts to bolster their own market leverage. Four of California's largest HMOs recently consolidated into two plans; three of the four have a strong presence in Orange County. Similarly, two national hospital chains with a presence in Orange County are consolidating through Tenet's purchase of OrNda, placing 11 of 34 local hospitals under one owner. Physician practices, too, are consolidating, including several mid-size to large entities.

State regulatory barriers prevent hospitals and physicians from achieving certain types of integration. California's corporate-practice-of-medicine law prohibits employment of physicians by corporations. In addition, the state's HMO law prevents hospitals and physicians from assuming risk for services outside their licensed service scope, although a recent modification allows such risk assumption with a limited HMO license.

However, hospitals and physician organizations have found mechanisms for sharing in the risks and rewards of capitation, and for bolstering their leverage with health plans. Hospitals have sought closer links to those physicians who act as gatekeepers and referrers to inpatient care by sponsoring IPAs and management service organizations (MSOs) that align physicians' incentives with their own. Joint risk pools, for example, are one way to accomplish the alignment of physicians and hospitals. In addition, hospitals and physicians are working to form county-wide contracting networks. Health plans have tried to temper the joint bargaining leverage of physician-hospital contracting arrangements by pursuing long-term contracts that lock in desirable provider reimbursement rates. In general, exclusive provider-plan relationships have been abandoned.

It is unclear how the balance of power will shake out between physician groups and hospitals or among the provider, insurer and purchaser sectors, or what impact this competition will have on Orange County's residents. Despite competitive pressure, respondents report that most health plans, hospitals and physician groups are running profitable businesses. Until now, their competition has produced hospital utilization rates and health care premiums well below national averages. It has also spurred ownership consolidation, but has not forced any major organizations to exit the market or close down. Some respondents cited potentially adverse impact on quality of care, such as apparent delays in referrals to specialty care. Primary care physicians, in particular, may be "at their limit" in terms of what they can do at prevailing market prices, respondents said.

Although CalOPTIMA, the county's managed care plan for Medi-Cal (the state's Medicaid program), has won praise for improving access and quality of care for Medi-Cal recipients, the indigent population is projected to grow while availability of services for this population is expected to shrink.

Amidst these market pressures, the makeup of the population is changing, and demands on safety net providers may increase. Although the county historically has been affluent and ethnically homogenous, the number of immigrants, many of whom work in low-wage jobs, is growing. In addition, respondents believe competitive

pricing and reduced funds for cross-subsidization may weaken the safety net. Although CalOPTIMA, the county's managed care plan for Medi-Cal (the state's Medicaid program), has won praise for improving access and quality of care for Medi-Cal recipients, the indigent population is projected to grow while availability of services for this population is expected to shrink. The health care system for the uninsured may be threatened while the rest of the health care system "dukes it out."

The Orange County Community

Orange County encompasses 798 square miles and borders on the counties of Los Angeles to the north, Riverside and San Bernardino to the east and San Diego to the south and the Pacific Ocean to the west. Its population is more than 2.5 million, making it the fifth most populated county in the country. The combined population of Los Angeles, Riverside and Orange counties is more than 14.5 million. The county includes 31 cities characterized as "sprawling" suburbs with no distinct urban centers. The largest population concentrations are in the cities of Santa Ana (13 percent) and Anaheim (12 percent).[1] The population has spread considerably into the southern reaches of the county during the past decade, resulting in the creation of new cities.

Compared with the nation as a whole, Orange County has a higher proportion of young to middle-aged residents, and a lower proportion of older residents. It also has a significantly higher proportion of Hispanic and Asian residents, and a lower proportion of African Americans than the national average. Education and income levels exceed the national averages, and the proportion of families living below the poverty level is about half the national average.[2] Unemployment in Orange County is also lower than in the nation as a whole. Despite this generally affluent economic picture, respondents report pockets of poverty. The proportion of Orange County's population covered by Medi-Cal and the proportion without any health insurance exceed the national averages.[3]

Overall, Orange County's health status is quite good. Age-adjusted total mortality is about 30 percent lower than the national average.[4] Overall infant mortality is 27 percent lower than the national average; among whites, it is 12 percent lower than the national average for whites, and among non-whites, it is 57 percent lower than the national average.[5] Given the county's relatively healthy population and history of managed care, it is not surprising that hospital utilization is relatively low. Hospital admissions per 1,000 and hospital days per 1,000 are 21 percent and 36 percent lower than the national averages, respectively.[6] Hospital capacity is 21 percent lower than the national average.[7] Physician supply, on the other hand, exceeds national averages; primary and specialty care physician supply is 20 percent and 18 percent higher, respectively, than the national average.[8]

THE HEALTH CARE MARKET

The market for health insurance in Orange County extends throughout Southern California and, in some cases, statewide. In contrast, the market for health services has remained relatively local. The broad market for health insurance reflects health plans' corporate strategies and the area's commuter culture. Many of the county's larger employers have operations elsewhere. Most of the health plans operating in Orange County have an Orange County sales

force that operates within a statewide or Southern California marketing strategy.

The market for health services is more defined within the county boundaries. Respondents describe separate but overlapping sub-markets in South County, Central County and North County. Each sub-market is home to full-service hospitals as well as physician groups and IPAs. A few provider systems span the entire county, including the St. Joseph's hospital system and its affiliated physicians and the newly formed Tenet/OrNda system. Memorial Health Services and MedPartners have providers in South County and North County and are aiming for county-wide coverage. A few provider systems reach into or from Los Angeles County.

No distinct tertiary care core draws referrals from surrounding hospitals. The University of California Irvine Medical Center, Hoag Memorial Hospital Presbyterian, St. Joseph's Hospital and Medical Center and Children's Hospital of Orange County all provide a significant amount of tertiary care. Respondents report that out-of-county migration to tertiary care facilities in Los Angeles and San Diego, such as UCLA, Cedars/Sinai and Scripps, has declined in recent years as local providers built their own tertiary care programs. Some indigent patients reportedly continue to use the public facilities of Los Angeles County.

Plans and purchasers view Orange County as a relatively low-cost health care market, and predict increased efficiency, especially as hospital consolidation continues. There is a strong business orientation to local health care. Health care leaders measure themselves and their competition in terms of premiums; profit margins; the number of capitated lives; per-member-per-month rates; and the split of capitation revenue among plans, hospitals and physician groups.

There was no clear consensus on the value of health services consumers receive. Respondents' views of the quality of care delivered within this market vary. Some hospital and physician group medical directors commented on the sophistication of care management techniques at the medical group level, and pointed to these mechanisms as evidence of high-quality care delivery. Others indicated that intensive competition has forced physicians to take shortcuts in care delivery that ultimately may lower quality of care.

LEADERSHIP AND DECISION MAKING

Leadership and decision making are dispersed throughout Orange County. There is no definitive "Orange County way" of doing business and no sense that the county defines itself as a single community. Sources of county-wide leadership are difficult to locate. Health care leadership emanates from specific organizations pursuing their market-driven agendas.

Asked about community leadership, several respondents spoke of decision making at the level of the county's 31 cities. Others spoke about the county's diffuse small businesses as the "fabric of the community." Still others reported that many of Los Angeles's prominent residents conduct business and exert influence in Orange County. Members of the local business community reportedly do not play a strong role in health care leadership.

Executives of the major health plans, hospitals and physician organizations operating in Orange County are the key health care leaders and decision makers. Respondents report that leaders of some of these organi-

zations are losing their local focus as their organizations target larger markets. A mix of nationally and locally based business leaders is at the helm of these organizations.

Health care consumers are not unified. The Healthcare Council is an umbrella entity with 73 member organizations focused on community-wide health care issues. It has not enjoyed community-based funding or support from county residents, who reportedly give more to arts charities than to health or social services. Several organizations focus on issues for specific populations, such as Latinos, Southeast Asians and the elderly, but consumer organization and advocacy are considered much stronger in neighboring Los Angeles County.

Respondents said the community generally addresses health care problems, such as the expected curtailment of Medi-Cal-funded prenatal care for undocumented immigrants, through collaboration among a few broad organizations. These organizations typically include provider associations, such as the Health Care Association of Southern California, the Orange County Medical Association and the Coalition of Community Clinics; safety net providers; local government; and a few not-for-profit groups, such as the United Way. Although the community's approach is not viewed as proactive, community actors have worked together at times to address crises.

External Forces Affecting the Health System

PUBLIC POLICY

Orange County's generally conservative political culture has emphasized reliance on the private sector to fulfill health care functions. Local public policy has been limited to those functions that the state delegates to counties. As one respondent described it: "Politicians have been more interested in real estate development and business development than health care." State law requires counties to meet the health care needs of the indigent, but the Orange County Board of Supervisors has interpreted this requirement relatively narrowly. County financial support for health care ranks among the lowest in the state, and is barely above the level required to receive state matching funds for mental health and indigent care. The Medical Services for the Indigent (MSI) program, the county's vehicle for fulfilling its legal responsibility to provide care for the uninsured, historically has been viewed as an underfunded mechanism to subsidize physicians and hospitals that treat the uninsured. The Orange County Health Care Agency is working on transferring administration of the MSI program to CalOPTIMA, the entity that administers Medi-Cal managed care for the county. This transfer is intended to incorporate managed care principles into the MSI program and improve care for uninsured patients.

Implementation of the state's mandate to enroll the Medi-Cal population in managed care is the most significant local health care policy issue. The State Department of Health Services has sponsored several models for moving Medi-Cal recipients into managed care. Five counties, including Orange County, were granted authority to enroll all their Medi-Cal in one health-insuring organization that contracts with the state to provide capitated Medi-Cal services. In 1993, the Orange County Board of Supervisors created CalOPTIMA to contract with the state of California to serve Medi-Cal beneficiaries. All Medi-Cal beneficiaries are required to enroll in

CalOPTIMA, which in turn contracts with 19 health plans, including licensed HMOs and Medi-Cal-specific physician-hospital consortia, and operates a direct provider contracting program, CalOPTIMA Direct.

CalOPTIMA instituted several measures to protect the role of traditional Medi-Cal and indigent care providers. It established physician-hospital consortia as a direct vehicle for traditional safety net provider participation without identification with a particular licensed HMO. CalOPTIMA capped health plan enrollment at 30,000 members to distribute Medi-Cal membership,[9] required health plans to include safety net providers and adopted an auto-assignment policy for beneficiaries who do not select a primary care provider. This policy favors traditional Medi-Cal and indigent care providers.

State and federal governments have been the source of other significant public policies affecting health care organizations. Two examples involve California's implementation of the federal welfare reform law and its citizen-backed Proposition 187, both of which target certain immigrants' eligibility for health care coverage. Respondents estimate that more than 50,000 Orange County residents could lose their Medi-Cal eligibility and be forced to rely instead on the county's underfunded MSI program. Federal caps on Medicaid's disproportionate share hospital (DSH) program, which has provided some relief to safety net providers serving Medi-Cal and indigent patients, is another significant policy issue.

State regulation also affects organization of care in the broader health care marketplace. The state's Corporate Practice of Medicine Law, which is actively enforced, bars employment of physicians by corporations. Further, the state's Knox-Keene law, which governs HMOs and risk assumption, precludes organizations from assuming risk for services that they are not licensed to sell. As a result, health plan payments to providers generally are structured through separate contracts for physician and hospital services. These regulations have spawned cumbersome physician-hospital contracting structures, as hospitals seek to align their financial incentives with those of their medical staffs and to share risk for the provision of care. An alternative approach allowed by law and employed by one system in the county is the hospital-owned medical foundation. A few large physician groups in the state, including at least one in Orange County, recently received limited Knox-Keene licensure that enables them to accept global capitation for hospital and physician services through a single health plan contract.

State regulation also affects organization of care in the broader health care marketplace.

PURCHASING

Health care purchasing has been driven largely by price considerations, although demand for broad geographic networks and more flexible benefits has also been important. Services for the indigent are purchased by the county's Medical Services for the Indigent (MSI) program, and services for Medi-Cal eligibles are purchased by CalOPTIMA on behalf of the county.

• Private Purchasing

Respondents characterize Orange County as a business community of small to mid-size firms. Only five local employers have 5,000 or more employees. Many of the large firms in Orange County are head-

quartered elsewhere or have operations that span several locations. These companies typically make their purchasing decisions based on national or regional coverage considerations rather than on local market conditions. Respondents report that purchasing decisions for small and large employers alike are driven by price concerns.

There are reportedly more than 80,000 small businesses in Orange County.[10] These small and mid-size companies rely on brokers to make their health care purchasing decisions. Health plans operating in the county consider brokers an "essential market" and have targeted their marketing and information specifically to the broker community. In addition, the state has established a health insurance purchasing cooperative, the Health Insurance Plan of California (HIPC), for businesses of up to 50 employees seeking health insurance. With the statewide HIPC in place, small businesses reportedly have little incentive to organize purchasing coalitions.

Statewide health insurance purchasing by the California Public Employees Retirement System (CalPERS), on behalf of state employees and retirees, and by the Pacific Business Group on Health, a coalition of large businesses that operates across the state, has produced public information on health insurance premiums. This information has had an effect on local markets such as Orange County, where employers can obtain competitive premiums without active involvement in or understanding of the local health care market.

A few years ago, several mid-size and large firms in Orange County attempted to establish a purchasing cooperative called the Orange County Coalition. Participating companies intended to contract directly with providers and/or develop consolidated contracts with a few health plans. They determined, however, that direct or selective contracting would enable them to achieve only small price reductions. At the same time, participants believed that they might expose themselves to employee backlash if they offered limited provider networks. Logistically, direct contracting probably would be difficult, because many employees commute long distances, making widely dispersed provider networks a necessity. For these reasons, the coalition ultimately dissolved.

Employers that offer health insurance have included HMOs in their offerings for quite some time. HMOs reportedly dominate the commercial market, although PPOs have maintained a strong presence. According to respondents, there is very little traditional indemnity insurance. Opinions varied on the growth potential for HMO and PPO products. While some respondents believed that the already high HMO penetration would make continued HMO growth difficult, others reported that PPO products could not be priced competitively in this market.

Consumers demand choice and broad geographic networks from their health plans. Once they select primary care providers, however, many consumers are expected to remain within relatively tightly controlled sub-networks of physicians and hospitals that have been carefully constructed around joint marketing and shared risk strategies. Respondents reported that consumers are starting to express discontent with gatekeeper arrangements that impede their ability to see physicians other than their primary care provider. In response, plans are developing point-of-service (POS) and hybrid products, as well as products with "speedy referral" processes that

enable HMO enrollees to "go around" their gatekeeper.

Some plans have sought greater feedback and participation from their largest customers or brokers. These plans report heightened interest among purchasers in all facets of plan activity, including the design of plan forms and brochures, provider contracting and utilization information on plan providers. Informants reported that Cigna is providing physician-level profiling information to some of its large employers.

• Public Purchasing

Recent managed care growth has been most rapid in the Medi-Cal and Medicare programs. As discussed, the implementation of CalOPTIMA in 1995 moved all Medi-Cal beneficiaries into managed care arrangements; previously, the proportion enrolled in HMOs was less than 2 percent. Medicare HMO penetration reportedly has been growing rapidly as well. CalPERS's purchasing strategy for public employees have relied on HMOs and a managed competition approach for several years.

CalOPTIMA conducted an inclusive bidding process for contracting with licensed HMOs and Medi-Cal-specific local physician-hospital consortia. CalOPTIMA received 45 bids in response to its first request for proposals in 1995, and awarded 36 contracts to HMOs and physician-hospital consortia. These contractors have subsequently "consolidated" through attrition or aggregation of small plans into 19 contracted plans, including five HMOs and 14 physician-hospital consortia. These 19 plans serve 250,000 people. Furthermore, CalOPTIMA Direct is a direct provider contracting program for beneficiaries who have not yet enrolled in health plans or who have limited "special" eligibility for Medi-Cal (e.g., dual eligibles and undocumented immigrants who only qualify for Medi-Cal coverage for prenatal care and deliveries). Approximately 50,000 individuals are served through CalOPTIMA Direct.

Beneficiaries select their primary care provider and plan within CalOPTIMA, and they appear to prefer certain providers and plans. CalOPTIMA officials report that Medi-Cal beneficiaries overwhelmingly made their plan selections on the basis of specific physicians. The physician-hospital consortia participating in CalOPTIMA reportedly are more experienced with serving the Medi-Cal-eligible population than commercial health plans operating in CalOPTIMA. Accordingly, the physician-hospital consortia have had much higher enrollment than the participating HMOs that serve the commercial market.

In contrast to Medi-Cal, respondents believe that Medicare beneficiaries select plans on the basis of cost,[11] scope of benefits and perceived quality of affiliated medical groups and hospitals. PacifiCare, FHP and Kaiser historically have competed for Medicare beneficiaries with benefit enticements. Respondents estimate that the recent acquisition of FHP by PacifiCare concentrates approximately two-thirds of Orange County's Medicare risk enrollment into this one entity.

CalPERS has influenced the health insurance market through publication of the premiums it negotiates for its nearly one million members statewide. For 1998, CalPERS negotiated an average rate increase of almost 3 percent for the 11 HMOs with which it contracts, its first premium increases in five years. CalPERS also announced a three-year agreement with Orange County-based PacifiCare, the only HMO that agreed to a multiyear contract. Under this agreement, a portion of the premium CalPERS pays each year will be placed at risk, based on member

satisfaction and the completion of selected quality initiatives.

Organization of the Health Care System

The Orange County health system has experienced considerable consolidation within the hospital, physician and health plan sectors during the past two years, and this horizontal consolidation is expected to continue, especially among hospitals. Health plan-provider integration efforts, in the form of ownership arrangements, have been largely abandoned in favor of contractual relationships to coordinate the health care delivery and insurance functions. Despite the impediments posed by California's Corporate Practice of Medicine and Knox-Keene laws, hospital-physician integration is being pursued in various forms. Respondents expressed varying opinions about how vertical relationships between providers and plans and between physicians and hospitals will continue to evolve.

The Orange County health system has experienced considerable consolidation within the hospital, physician and health plan sectors during the past two years, and this horizontal consolidation is expected to continue, especially among hospitals.

Locally based and nationally headquartered hospital systems have been consolidating their ownership of Orange County facilities. Currently, only six of 34 hospitals are not affiliated with larger hospital systems and at least two of these are evaluating consolidation options. Physicians in general and primary care physicians in particular have also consolidated, typically to increase their bargaining power in negotiating managed care contracts. Mid-size and large IPAs and medical groups are now powerful players in this market. The health plan market has also become more concentrated, as plans merge to amass market share and economies of scale. Two of the three largest HMOs operating in Orange County have completed mergers within the last two years.

Health plans such as Cigna and FHP have sold off their staff-model groups and hospitals and moved to network-model contracting because they have found it cheaper to contract with physician groups and hospitals than to own and manage providers themselves. There is one successful integrated provider and insurer organization—the Kaiser Foundation Health Plan and its affiliated Kaiser Permanente Medical Group and Kaiser Foundation Hospitals. But even Kaiser, in its statewide strategy, is reducing its reliance on its own hospitals and reportedly has considered contracting with non-Permanente Medical Group physicians. There are few examples of provider ownership of health plans in this market. One hospital system, Columbia/HCA, recently purchased a local PPO.

Respondents expressed skepticism that exclusive relationships between providers and plans would be viable in this market. Neither hospitals nor physician organizations in Orange County believe that they can afford to rely solely on any one health plan for their revenue and patient volume. Providers depend on the revenues from multiple plan contracts to earn profits within a competitive, capitated market. It is common, for example, for a mid-size to large physician group or IPA to contract with more than a dozen health plans, even though most of its revenues may come from just a few of those plans. Respondents noted that the market's

continual consolidation makes it particularly important to maintain relationships with all major plans. Even provider groups that have obtained limited Knox-Keene licenses report reluctance to compete with their health plan partners.

There are signs, however, that tighter relationships are forming between providers and plans. Longer-term contractual relationships have formed between several health plans and providers. PacifiCare, for example, has established 5- to- 10-year contracts with selected medical groups and hospitals in Orange County, including a recently announced 10-year contract with Memorial Health Services. Some plans have established preferential terms with the providers with which most of their business is concentrated. Other arrangements typically trade off some level of provider price discount for guaranteed business over time. These activities reflect the relative leverage of the parties involved rather than attempts to achieve financial or clinical integration.

Health plans have been able to win price concessions from providers competing to maintain their share of patient volume amidst excess hospital and physician capacity. This, in turn, is driving hospitals and physicians to find ways both separately and jointly to improve their relative bargaining positions.

There are indications of tighter vertical relationships between hospitals and physicians, although some respondents cast doubt on the long-term viability of exclusive vertical relationships. For example, long-term relationships have formed between some hospital and physician entities, including St. Joseph's and its St. Jude Heritage Health Foundation and Tenet and MedPartners. On the other hand, many providers and plans dismiss the likelihood of exclusivity between physicians and hospitals. Physicians and hospitals want to achieve the size and geographic breadth necessary to be viewed as indispensable and to ensure that they are included in plan networks at favorable terms. They express discomfort, however, with structuring arrangements that rely on a single partner and the potential bargaining power such reliance would give that exclusive partner.

Finally, the pursuit of limited Knox-Keene licenses by several physician groups may alter the relationships among physicians, hospitals and health plans. Limited Knox-Keene licenses are essentially limited state HMO licenses that allow physician groups or hospitals to assume global risk for health care services from health plans. MedPartners, for example, holds a limited Knox-Keene license that enables it to receive global capitation for physician and hospital services and provide care by using its own hospital and contracting with other local hospitals. An advantage of Knox-Keene licensure is that the holder of global risk may be able to establish contractual terms with other providers (e.g., hospitals) that are more favorable than those available through joint contracting. Management service organizations (MSOs) and other contracting structures are required to hold separate physician and hospital contracts by the state law's prohibition on assumption of risk by non-licensed entities, even though these organizations often are formed to facilitate joint hospital-physician contracting. Some of these organizations behave virtually identically to other entities that assume global risk in terms of how they structure their contracts and negotiate with health plans. Several providers, including some physicians and a hospital system, reportedly are pursuing limited Knox-Keene licensure to assume global risk under one health plan contract.

PROVIDERS

• Physician Organization and Changes

Many respondents report that Orange County's mid-size to large physician groups and IPAs have developed sophisticated mechanisms for managing care under capitation. Physicians outside the group and IPA contracting arrangements are finding it difficult to remain independent as increasingly influential managed care plans funnel contracts through these large physician organizations, especially primary care groups. Some of the most prominent physician organizations—MedPartners, the St. Jude Heritage Health Foundation and the Monarch IPA—hold significant leverage with hospitals and health plans, according to respondents.[12]

Many respondents report that Orange County's mid-size to large physician groups and IPAs have developed sophisticated mechanisms for managing care under capitation.

In general, physicians are affiliating through a variety of contractual and ownership arrangements designed to give them leverage in health plan contracting. The strength of physician entities is calibrated in terms of how many physicians they include and how many capitated lives they serve. Together, MedPartners, St. Jude Heritage Health Foundation, Southern California Permanente Medical Group, St. Joseph's Medical Corporation and Monarch reportedly have contracts for a significant share of the county's capitated covered lives.

For example, one health plan respondent described MedPartners as the entity other competitors were "most likely to lose sleep over" because of its strength. MedPartners, a publicly traded national physician management corporation, holds contracts for more than one million capitated lives in Southern California and reportedly exerts great influence with health plans. MedPartners buys the assets and assumes the liabilities of physician groups and IPAs, and enters into long-term contracts with their physicians.[13] MedPartners employs non-physician personnel, including nurses, to administer these physician practices.

MedPartners has arrangements with more than 600 physicians in Orange County. Its Southern California network includes more than 3,000 physicians.[14] MedPartners is the second-largest physician organization in Southern California, after the Southern California Permanente Medical Group. MedPartners entered the Southern California market through its 1996 acquisition of Mulliken Medical Centers' physician practices, a large physician group that owns a hospital in neighboring southern Los Angeles County. When MedPartners merged with CareMark, another national physician management company, the Orange County-based Friendly Hills Medical Group and the former Cigna staff-model group also came under MedPartners ownership.

Other large physician organizations include:

- the Monarch IPA, which was recently created through consolidation of three local hospital-affiliated IPAs representing about 300 physicians, and the bulk of whose physicians are in the southern part of the county;
- the St. Jude Heritage Health Foundation, which has more than 400 physicians in medical groups and IPAs affiliated with the St. Joseph's Health System;

- the St. Joseph's Medical Corporation, which has 250 physicians in a medical group and an IPA affiliated with the St. Joseph's Health System; and

- the Southern California Permanente Medical Group, which has 250 physician employees in Orange County.

There are three physician organization structures for employing, supervising and compensating physicians: the IPA, the medical foundation and the medical group. Each structure uses different mechanisms for contracting with health plans. Although physicians who belong to IPAs generally maintain their independent practices and may belong to several—sometimes competing—IPAs, several IPAs offer preferential payment rates to physicians who contract solely with their organization. This practice blurs the distinction between the medical group and IPA forms. In general, IPAs carry much less overhead, and, as a result, they can negotiate very competitively with plans. On the other hand, IPAs generally do not offer as much practice support and are less able to coordinate care across their practices.

New physicians who do not want to invest in the start-up costs of establishing a practice are attracted to medical groups. Some respondents expect that as the proportion of HMO business grows, medical groups will start to look more attractive because they are better able to manage care. Unlike IPAs or medical groups, practice management companies rely more heavily on non-physician administrators—so-called "MBA types"—to administer physician services, including health plan contracting. These companies usually offer physicians an equity interest. Physicians participating in IPAs and medical groups may receive similar services from contracted MSOs, and they may choose to invest in those MSOs.

• Hospital Organization and Changes

Consolidation prevails in the hospital sector. Almost every acute care facility is affiliated with a larger system. More than half of the county's 34 facilities are owned by four hospital "systems"—the St. Joseph's system, the Tenet/OrNda system, the Memorial system and the UniHealth system—and more than two-thirds of its 6,500 beds are owned by five systems. Many respondents expect only three or four systems to survive long-term. A number of the remaining independent hospitals, including the University of California Irvine Medical Center (UCIMC) and South Coast Medical Center, are actively considering affiliation. These hospitals, too, however, are considering the importance of size in negotiating with health plans and physician groups to ensure that they are not left out of contracting agreements.

Consolidation prevails in the hospital sector. Almost every acute care facility is affiliated with a larger system.

In general, the hospital systems have not centralized many hospital functions yet, although respondents report interest in greater centralization of health plan contracting and other administrative functions as merger plans are implemented. Despite provider ownership consolidation, respondents suggest that significant hospital overcapacity remains. The market has not experienced a great deal of hospital downsizing or closure; average hospital occupancy is below 50 percent.[15]

The St. Joseph's Health System was founded in the 1920s to serve the Catholic mission of the Sisters of St. Joseph of Orange. It is characterized by many respondents as the most

prominent hospital system in the county due to its long history, reputation for quality and economic stability. The system owns three hospitals in Orange County—St. Joseph's, St. Jude and Mission—with a total of more than 1,100 beds, and has an affiliation agreement with the 192-bed Children's Hospital of Orange County. The system recently added Mission Hospital to achieve county-wide geographic coverage. In addition, the system owns seven hospitals in Los Angeles, other parts of California, Texas and New Mexico. The system's three Orange County hospitals own the St. Jude Heritage Health Foundation with more than 400 physicians, and have a minority interest in the St. Joseph's Medical Corporation with 250 physicians. These arrangements are intended to better align the financial incentives of hospitals and physicians providing care to St. Joseph's patients.

The Tenet/OrNda system consists of four Tenet hospitals and seven OrNda hospitals in Orange County, which together account for about 1,900 of the market's total 6,500 beds. Of these 11 hospitals, six "came into" either the Tenet or OrNda fold within the last two years.[16] Tenet announced the purchase of OrNda in 1996, but the new entity has not yet implemented a singular strategy for the Orange County market. Currently, each of the 11 hospitals operates fairly independently and negotiates separately with health plans. Tenet manages the Nobel Physicians IPA. Nevertheless, Tenet and OrNda each own hospitals in neighboring Los Angeles and San Diego counties, as well as other parts of the state and the country. Tenet/OrNda's bargaining leverage with health plans that want any of these 11 hospitals in their networks is potentially very strong.

The not-for-profit Memorial system formed two years ago and is based in Long Beach. Two of the system's three hospitals are located within Orange County (one in North County and one in South County). These hospital executives, too, saw the need to increase geographic coverage and size in order to preserve inclusion in health plan contracts. UniHealth, a large Los Angeles-based system, owns two hospitals in the county. Orange County also includes three relatively small hospitals owned by Columbia/HCA, one hospital owned by Kaiser Foundation Hospitals and one hospital owned by MedPartners' Friendly Hills Medical Group.

UCIMC is the local academic medical center. Its mission is driven by medical education and research, and it offers a broad range of tertiary services. Since its purchase of the county hospital in the 1970s, UCIMC has served as an almost de facto public hospital because of the large indigent care load it has shouldered. It operates the only Level 1 trauma center in the county. It is staffed predominately by the UCI Faculty Practice Group, and is considering affiliating with either Columbia/HCA or Tenet/OrNda. Several respondents believe that the "commercialization" of UCIMC would alter the institution's role as a safety net provider and medical education center.

Hoag Memorial Hospital Presbyterian is a stand-alone tertiary hospital with a national reputation for clinical excellence and a "carved-out" geographic niche in Newport Beach. It has relied on the Greater Newport IPA for most of its physician services. Hoag is aligning with the St. Joseph's Health System for joint health plan contracting. South Coast Medical Center, a small stand-alone hospital in South County, is in the process of merging with Adventist Health, a large system predominantly in Northern California.

• Physician and Hospital Integration

In addition to horizontal consolidation, Orange County hospitals are pursuing strategies to align themselves more closely with physicians. The St. Joseph's Health System, in particular, has carried out a physician-hospital integration strategy. The St. Jude Heritage Health Foundation's purchase of the Bristol Park medical group's assets and its MSO helped move the St. Joseph's Health System toward a county-wide, integrated delivery system. The addition of Bristol Park Medical Group resulted in 120 new physicians in 13 Central and South Orange County sites. St. Joseph's has added other groups and an IPA to the foundation, and is minority owner of the St. Joseph's Medical Corporation, another physician entity with a large group, an IPA and its own MSO. Although physician-hospital alignment seems to be farthest advanced at this system, to date, physicians affiliated with the foundation do not have exclusive relationships with the St. Joseph's hospitals.

Plans are consolidating into a few large entities in terms of ownership. At the operational level, however, individual plans are altering the structure of their health plan products, as well as their provider payment approaches and mechanisms.

Earlier this year, the Tenet system announced its affiliation with MedPartners for a Southern California contracting network. Details of the agreement have not been disclosed, but the affiliation reportedly will improve both organizations' ability to negotiate with managed care plans in Southern California. As physician practices have become attractive purchases, many physicians are responding to the lure of "cashing out" their practices. Hospitals pursuing physician-hospital integration have offered physicians new financial incentives. For example, some "equity" MSOs are jointly owned by physicians and a hospital, and provide money-making opportunities for their owners.

Meanwhile, providers continue to refine their methods for distributing capitation revenues between physicians and hospitals through the split of the capitated dollar and through physician-hospital risk pools. Respondents generally reported that the "money to be made" was in savings achieved by managing hospital utilization. These savings often are shared by physicians and hospitals via physician-hospital risk pools. Shared risk pools are used as mechanisms to align physician and hospital incentives so that they don't compete for health plan premium dollars. At St. Joseph's Health System, increased physician-hospital alignment is leading to system-level standards on how capitation revenue is split and on distribution of hospital risk pool payments between participating physicians and hospitals. Similarly, health plans that want or need to do business with MedPartners physicians are forced to accept MedPartners' terms for physician compensation because of MedPartners' increasing market strength. As MedPartners amasses more physicians and covered lives, health plans that contract with it and separately with hospitals will be less flexible in the portion of the capitated dollar they can pay contracting hospitals.

INSURERS AND HEALTH PLANS

Orange County has a long history of managed care, with locally based HMOs and others based in neighboring Los Angeles.

National plans (e.g., Aetna, Cigna) have also served Orange County through either multi-site accounts or their Southern California regional strategy. Overall, HMO penetration is estimated at 47.5 percent, compared with a national average of only 20 percent.[17] More recent estimates accounting for the shift of virtually all Medi-Cal enrollees into managed care place this figure closer to 60 percent. In addition, a few of the country's largest PPOs are headquartered in Orange County. Very little indemnity insurance exists in the county. The health plan sector is undergoing a combination of ownership and operational changes.

Plans are consolidating into a few large entities in terms of ownership. At the operational level, however, individual plans are altering the structure of their health plan products, as well as their provider payment approaches and mechanisms.

Local HMO enrollment is becoming concentrated among three plans. The largest health plan is the combined PacifiCare/FHP entity, which formed in 1997 when PacifiCare's acquisition of FHP was approved. Both PacifiCare and FHP are headquartered in Orange County. This organization is best known for its Medicare business, which reportedly includes more than two-thirds of the county's Medicare risk enrollees and 90 percent of South County's Medicare risk enrollees. It serves a large commercial base as well. PacifiCare/FHP offers HMO and PPO products and a POS HMO product. FHP owned a local hospital, which it sold to the Memorial system, and spun off its physician group.

The second-largest health plan, by enrollment size, is Kaiser Foundation Health Plan, which, as noted, operates a group-model HMO built around an exclusive relationship with the Southern California Permanente Medical Group and the Kaiser Foundation Hospitals (including one in Orange County), as well as referral relationships with a few contracted providers. Kaiser competes in the commercial, Medicare and Medi-Cal markets. Although it historically has concentrated on the large employer market, its recent growth has been with small and mid-size employer groups. In January 1997, Kaiser announced a decision to merge its Southern and Northern California branches into one statewide organization.

The third-largest HMO is Southern California-based Foundation Health Systems, which is the result of a merger at the national level by Health Systems International and Foundation Health Plan. HSI previously had acquired Southern California-based HealthNet, its California HMO subsidiary, in 1992. Respondents describe HealthNet as the largest network-model HMO in California. It also offers a PPO product, although enrollment is quite small. HealthNet competes in the commercial and Medicare markets.

A few other HMOs have local enrollment estimated at 50,000 or greater. These include Los Angeles-based Blue Cross of California's California Care product[18] and plans offered by Cigna, Prudential and Aetna. Some of the largest PPOs in the country are headquartered in Orange County—including Beach Street and Capp Care—but Orange County represents a very small proportion of their overall business. San Francisco-based Blue Shield also has a sizable PPO presence in Orange County. HMOs with POS products sometimes contract with these PPOs for network development, payment and other functions.

Each of the top three HMOs is undergoing some type of consolidation, driven by regional, statewide and national marketing strategies. All three plans report that their recent mergers will enable them to compete efficiently across California and in other markets. As of September 1996, these three plans enrolled nine million of California's 13 million HMO enrollees.[19] Respondents estimate that within Orange County, these top three HMOs cover more than 600,000 lives, which is more than one-third of the county's combined commercial and Medicare populations. Health plan size (and associated number of covered lives) is important in establishing bargaining leverage with providers, and in establishing administrative efficiencies necessary to offer competitive premiums to purchasers.

Health plan networks are broad and overlapping, with the exception of the Kaiser Foundation Health Plan. The mid-size and large physician groups and IPAs and the major hospital systems (as well as Hoag and UCIMC) have been included in all the major plans' panels. Plan respondents report that the largest physician groups continue to carry "brand-name" recognition, and thus generally are included on all health plan panels. The breadth of networks does not translate to liberal access to providers. Primary care physician gatekeepers tightly control the number of referrals to non-primary care providers and whom their patients see for non-primary care.

Plans are pursuing changes in plan and network design. Respondents report that consumers are dissatisfied with overly restrictive gatekeeping. Plans are offering POS products that allow enrollees to bypass their gatekeepers and self-refer to specialists by paying a fee. Plans are also working on shortening the time required to approve referral requests, and on improving their overall levels of customer service. Plans are collecting and analyzing utilization and other information at the physician level to make decisions about network development for their plans. Some plans are actively recruiting ethnic minority physicians with specific language skills.

For the most part, plans have competed on the basis of price. Broad, overlapping networks have made it difficult for purchasers to evaluate other criteria in making their plan selections. Respondents estimate that commercial premiums hover around $100 to $120 per member per month and that the spread between the most expensive and least expensive HMO products is relatively narrow.

For the most part, plans have competed on the basis of price. Broad, overlapping networks have made it difficult for purchasers to evaluate other criteria in making their plan selections.

Health plans operating in Orange County have adopted different strategies for negotiating with providers. Blue Cross of California issued a statewide, competitive bid for hospital services. Competitors and providers report that Blue Cross has placed "all its eggs" into the basket of cutting hospital payment rates to produce competitive premiums. Kaiser Permanente, which owns most of the hospitals it uses, has implemented systemwide internal cost reduction targets, and has focused much of its attention on consolidating and streamlining its cost structure (in clinical and administrative services). Kaiser is considering altering its physician salary structure to put more compensation at risk, and altering its strategy for hospital services to include greater purchasing of hospital services from non-Kaiser facilities. Network and IPA-

model HMOs such as PacifiCare/FHP and Foundation Health Systems seem to rely on a combination of bargaining leverage with contracted providers and internal administrative restructuring (e.g., reengineering, streamlining administrative staffing) to produce competitively priced premiums.

Like the local providers, health plans are changing the manner in which they divide the premium dollar. Some plans are considering rewarding provider groups in which their business is concentrated through a combination of longer-term contracts (e.g., 5 or 10 years), more advantageous payment rates and new provider support services, such as members' enrollment and benefits information. PacifiCare, for example, recently executed a 10-year contract with the Memorial Health System for hospital services. Some plans have adopted percent-of-premium contracts under which they share the up- and downsides of premium-level risk with their contracted providers. Some plans are also considering altering their incentive-based bonuses to more explicitly reward superior outcomes and quality, in addition to productivity.

HMOs have relied on capitation to reimburse primary care physicians, but they use different mechanisms for paying specialists and hospitals. Normally, an intermediary organization—the physician group or IPA—between the health plan and individual physicians receives capitated compensation. Physician capitation usually includes "full professional risk" (i.e., responsibility for primary care and specialty physician services), and intermediaries adopt different mechanisms for paying primary care providers and specialists (salary, bonus, fee-for-service or sub-capitation). While ancillary services such as pharmacy, vision and mental health historically have not been included under primary care physicians' capitation, plans report that physicians are requesting control over these services. While specialists continue to be reimbursed predominantly through fee-for-service, they increasingly are being brought into capitated contracts, particularly with large physician groups and IPAs.

Hospital payment has been based mainly on per diems and DRGs, and may come from the plan or from the medical group/MSO contracting structure. MSOs manage the contracts with health plans and pass on payment to providers. Some hospitals and health plans reportedly are interested in capitating hospitals. Physician groups report reluctance to capitate hospitals because they contend that physicians, not hospitals, control hospital utilization; therefore the physicians should benefit from any savings in this area through their share of the physician-hospital risk pool. Hospitals, on the other hand, are uncomfortable with being "at the last step of the food chain," but believe it is in their best interest to share hospital utilization savings with physicians to preserve patient flow. Shared physician-hospital risk pools with hospital utilization targets are common; the relative sharing or payout between hospitals and physicians is often close to 50/50, but varies depending on the relative leverage of specific hospitals and physician organizations.

Clinical Practice and Delivery of Care

Changes in care delivery have evolved over a long history of care management by physician organizations. Increased managed care penetration has served as a strong impetus for physicians to refine their practice efficiency. Financial incentives have prompted primary care providers to retain

as much of the scope of care as possible. Referral patterns to specialists are strongly influenced by the manner in which these services are reimbursed. Organizational changes may produce greater uniformity in clinical service delivery patterns as the physician organizations that are growing in size attempt to disseminate best practices across their organizations.

Respondents said that physicians are in the driver's seat in controlling care delivery. Physician groups and IPAs have developed techniques to deliver and manage care under capitation. HMOs, where possible, have delegated substantial care management responsibilities to these physician groups or IPAs with whom they contract. Some health plans have retained responsibility for collecting physician-level information to share with contracted providers.

Physician management companies, such as MedPartners, do not tightly control or monitor clinical management decisions; they leave considerable latitude to their subsidiary groups. IPAs report difficulty in integrating or directing care across multiple, distinct practices. Within a medical group, individual physician autonomy is subsumed, in part, by the group's policies for referrals and utilization management. In groups that receive a large share of their revenue through capitation, physicians have implemented stringent gatekeeping norms and rules to preserve the group's financial viability. Independent physicians, particularly specialists, who contract with groups or IPAs refer to them as "managed care organizations" because they construct sub-networks for contracting with specialists and then act as the referral agent and the utilization reviewers.

Direction of business to non-primary care providers reportedly is tightly controlled by the primary care physician gatekeepers within a beneficiary's selected plan. The Friendly Hills Medical Group, Bristol Park Medical Group and Monarch IPA, for example, have different referral patterns for inpatient care. The details of each physician-hospital risk pool agreement provide physician organizations with different incentives for choosing specific hospitals to concentrate their business. As discussed, physician-hospital alignment historically has been quite loose. In particular, the St. Joseph's Health System is attempting to increase the level of physician-hospital business integration through contracting arrangements it has structured through its medical foundation.

Concerns about the future of the local safety net for the uninsured center on UCIMC's mounting financial pressures and the impact of UCIMC's possible for-profit affiliation on its policy of providing indigent care.

Physicians have developed and relied on a variety of measures to aid them in delivering and managing care. Many physician organizations, hospitals and health plans report that they have developed and implemented practice guidelines within the past four years. Plans and hospitals typically provide guidelines on a voluntary basis; some physician organizations are more likely to require their use. Clinical protocols are used to manage costs of complicated, high-cost and high-risk procedures, such as bypass surgery, or clinical conditions, such as congestive heart failure. Some hospitals and physician organizations reported having more than 60 guidelines, with still more in development.

Respondents described a trend among some medical groups and IPAs to maintain hospital-based admitting teams that specialize in managing the care of inpatients and can control utilization.

Having picked off the "low-hanging fruit" by shortening hospital stays and moving services to outpatient settings and reducing ancillary use, disease management programs are viewed as the next frontier to managing utilization. Providers and health plans are designing disease management programs; some are already applying disease management to asthma and diabetes and are looking to expand this approach to other diseases. Specific disease management tools include developing mechanisms to identify disease management candidates, providing intensive case management and patient education, compiling literature and clinical information on specific disease categories and developing monitoring approaches, including telemonitoring. The focus is on targeting patients at risk for high service use and costs and developing mechanisms to reduce costs while improving outcomes.

Financial incentives tied to utilization or practice style are common, and reportedly play a strong role in influencing physician behavior. The scope of primary care depends in part on whether specialists are paid on a sub-capitated, salaried or fee-for-service basis. Physician and physician-hospital risk pools that stipulate payouts based on specific utilization targets (e.g., length-of-stay targets, hospital admission targets) are prevalent. Some plans report that physicians are seeking more responsibility (through expanded scope of services and capitation) for ancillary services such as pharmacy, vision and mental health services.

Some physician respondents expressed concern regarding the impact of widely used financial incentives on the ultimate quality of care. A few respondents are worried that financial incentives are already resulting in late referrals by primary care providers trying to manage their financial liabilities. Continued financial pressure may exacerbate these trends.

Physician organizations, plans and hospitals conduct physician profiling to provide feedback to physicians, monitor performance and perform credentialing. In particular, physician organizations, especially the longest-standing groups, collect a large amount of data at the physician level. Previously, physicians used this information mainly to compare their practice patterns and cost with those of their peers. Some provider groups are incorporating quality-associated measures into their physician bonuses. Such measures include consumer satisfaction, appointment waiting times, specific chart review results, peer surveys or reviews, productivity, cost, utilization and outside referrals.

While community-wide information is available on health insurance premiums and health plan HEDIS measures, community-wide, provider-specific information reportedly is lacking. Individual organizations, including physician groups and health plans, collect and control use of this information.

Although ownership of providers and health plans is consolidating, clinical services are not integrated across practice sites or organizations. Within hospital systems, each facility manages its own clinical programs. There was no evidence of joint clinical programs, standardization of guidelines or sharing of information across hospitals within provider systems. Within physician corporations, each physician group or IPA

remains responsible for its own clinical protocols, utilization review and quality assurance, although some information may be shared within the organization. Much information is collected by physician organizations, but not all of it is computerized. Information collection efforts are duplicated across different organizations.

The Kaiser system is an exception to this general rule. Kaiser has planned a systemwide electronic medical record that will enable physicians to share information across the organization. Kaiser has initiated systemwide health promotion and disease management programs that follow members across sites of care. The St. Joseph's Health System is also planning a major investment in a joint physician-hospital information system.

Care of the Poor

Although Orange County is seen as a relatively affluent community, almost 300,000 residents rely on Medi-Cal for their health coverage, and respondents report that the uninsured population is large and growing. Respondents generally identified distinct provider systems serving the Medi-Cal population and the indigent population. Many providers participate in the Medi-Cal program through CalOPTIMA. Indigent care is heavily concentrated at UCIMC, which purchased the county hospital more than 20 years ago and has shouldered much of the indigent care burden ever since. Publicly owned or publicly funded community health centers operate in some communities, but funding has been very limited and several have either closed recently or are reportedly about to close. Some hospitals (e.g., Hoag and St. Joseph's System) also support community clinics. Public health and mental health responsibilities are supported in part by the Orange County Health Care Agency, but Orange County ranks among the lowest in the state for categorical health funding for public and mental health care services.

Although ownership of providers and health plans is consolidating, clinical services are not integrated across practice sites or organizations. Within hospital systems, each facility manages its own clinical programs.

MEDI-CAL

For Medi-Cal beneficiaries, care has been mainstreamed through the implementation of CalOPTIMA. Most hospitals and community health centers and some physicians accept Medi-Cal patients through the private plans or physician-hospital consortia with which CalOPTIMA contracts. In general, respondents praise CalOPTIMA for improving care by assigning each beneficiary to a primary care provider and broadening the Medi-Cal provider network.

Despite CalOPTIMA's explicit attention to preservation of traditional safety net providers, some community health centers have faced decreases in Medi-Cal volume, making it more difficult for them to subsidize care for the uninsured. In addition, respondents expressed concern about the limited number of Medi-Cal beneficiaries who have chosen the UCIMC physician-hospital consortium, and worry that UCIMC's ability to subsidize care for the indigent has been compromised. UCIMC must maintain an adequate level of Medi-Cal volume to continue to receive the disproportionate share revenue it relies on to subsidize indigent care. Respondents also expressed concern about the participation

level of specialists. While access to specialists reportedly has improved considerably under CalOPTIMA, respondents report that not enough specialists participate in the CalOPTIMA Direct program.

CARE OF THE INDIGENT

The viability of the safety net for the uninsured appears to be much weaker than for the Medi-Cal population. Local funding for indigent care through the MSI program has been minimal. Other sources of funding, including disproportionate share revenue, and cross-subsidization from other payers, have decreased in recent years. Demands on the MSI program are projected to grow, particularly as the federal welfare reform law, which eliminates Medi-Cal eligibility for some populations, is implemented and Orange County continues to experience immigration of low-income populations.

At the same time, competitive pressures are affecting providers' ability to deliver uncompensated or undercompensated care. As noted, the county-run MSI program is being transferred to CalOPTIMA to apply managed care contracting strategies and improve the program's administration. Opinions vary on this planned transfer. While most respondents anticipate positive results because of CalOPTIMA's managed care expertise and existing provider network, a few respondents expressed skepticism that CalOPTIMA would be able to improve the MSI program markedly without significant additional funding. CalOPTIMA says the MSI program needs $45 million in addition to its current $35 million budget, but a funding source has not been identified. Respondents also expect the indigent population to grow more quickly than funding for the MSI program.

UCIMC provides much of the indigent care, especially specialty care, along with Children's Hospital of Orange County, the community health centers and some individual physicians. Most other hospitals reportedly accept indigent patients in their emergency rooms, as required by law, but do not provide much referral care to the indigent population. Two free clinics target the poorest uninsured Orange County residents, including those who do not qualify for the MSI program. Concerns about the future of the local safety net for the uninsured center on UCIMC's mounting financial pressures and the impact of UCIMC's possible for-profit affiliation on its policy of providing indigent care.

Issues to Track

Change in the Orange County health system appears to be driven by market leaders in each sector. The intense competition among large health plans, physician groups and hospitals has created a complex, rapidly changing market. It is unclear yet how this organizational maneuvering ultimately will affect the residents of Orange County in terms of their access to care and the cost and quality of health care services.

A study of Orange County conducted in 1995[20] raised the possibility of consolidation and concerted local action by purchasers, which has not materialized. Since that time, the markets for health insurance and health services have become increasingly concentrated among a few large organizations. Mergers and consolidations at the national and local levels have involved each of Orange County's dominant plans, hospitals and physician organizations.

In particular, the relative power of the provider sector appears to have grown considerably. Hospital and physician consolida-

tion have enabled the largest provider organizations to gain some clout in negotiating with health plans. Large-scale moves such as the national consolidation of the Tenet and OrNda hospitals and MedPartners' entry into the Orange County market have altered the balance of power between providers and plans.

While the large health plans seemed to be in the driver's seat two years ago as they played providers off against each other to achieve price reductions, providers appear to be holding their own now in some instances. Respondents reported examples of health plans offering to fund new physician entities to counter the bargaining potential of the larger, older physician organizations. In addition, plans, hospitals and physician groups are considering long-term contracts that lock in terms as a hedge against the potential fallout of continued competition. This may signal a move toward tighter, more stable relationships between providers and plans.

It is unclear how much farther price-driven competition can go. It is unclear whether premium, price and cost reductions are being passed on to consumers, but they reportedly have imposed cost pressures on providers. Respondents report that physician incomes are flat or decreasing, particularly for specialists. Several hospitals reportedly have implemented reengineering strategies, and have been forced to impose layoffs. Some respondents point to significant excess capacity remaining in the hospital sector. Others, especially primary care physicians, wonder with how much less providers can survive. It will be interesting to see whether consolidation ultimately reduces provider capacity and, if so, where and with what effect.

Reports of the impact of financial pressures on quality of care are mixed. Purchasers are beginning to seek information at the physician level that should allow them to see the impact of competitive dynamics on quality. Health plans and providers are looking for ways to achieve further cost savings. While some respondents speculate that such savings will have to come out of profits, others cited examples of cuts in services by plans (i.e., reduced benefit packages) and providers (reduced staffing levels, less time spent with patients).

On the other hand, adoption of care management strategies, emergence of quality as a factor in physician compensation and enhanced coordination of care among larger groups may bolster health care quality in Orange County. Care management strategies that include clinical protocols and disease management techniques are being implemented in many large hospitals, physician groups and IPAs. Physician compensation plans are being restructured to include quality-of-care factors in establishing salaries or bonus levels. Finally, large physician entities that emerge through horizontal consolidation have greater internal ability to provide comprehensive case management.

The availability and analysis of physician-level data may allow consumers and purchasers to differentiate providers based on quality. This may serve as an impetus to greater network selectivity among plans and greater provider-plan alignment. It will be important to monitor the effect of continued changes on patient care and the quality of clinical services. There is already some uneasiness about the impact of tough financial pressures on quality, and it remains to be seen how these concerns will be heightened or mitigated by the competitive dynamics of the local market.

The local safety net for the uninsured appears to face some significant chal-

lenges. How will the transfer of the MSI program to CalOPTIMA affect care for the uninsured? How will providers distribute indigent care responsibilities, especially if UCIMC relinquishes this responsibility? Access to care for the indigent reportedly has suffered as providers have become less able to absorb uncompensated care costs. Respondents expect the overall level of health insurance coverage to decline because of:

- continued immigration of low-wage earners who will not receive health benefits;
- declining employer coverage of dependents; and
- legislative changes (e.g., welfare reform) limiting Medi-Cal eligibility.

The exception to these pessimistic reports is the positive impact of CalOPTIMA on quality of care for Medi-Cal beneficiaries. In particular, CalOPTIMA has broadened the network of participating specialists and has assigned beneficiaries to a medical "home." Respondents report that emergency room use for non-emergency care has already decreased as a result of implementing managed care for Medi-Cal. It will be important to continue to monitor CalOPTIMA's impact on access to and quality of health care for Medi-Cal beneficiaries.

NOTES

1 Orange County Economic Development Consortium, World Wide Web site, 1996 (http://www.orange-countyedc.com).

2 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Resources.

3 Employee Benefits Research Institute, Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1996 Current Population Survey. EBRI Issue Brief Number 179. November 1996.

4 National Center for Health Statistics, Centers for Disease Control and Prevention, March 1997. Year of data is 1994.

5 Area Resource File as of February 1996, Office of Research and Planning, Bureau of Health Professions, U.S. Department of Health and Human Services. Data are a five-year annual average from 1988 to 1992.

6 American Hospital Association, database of the 1995 Annual Survey of Hospitals. Figures do not include long-term care units in hospitals.

7 *Ibid.*

8 Estimates are based on the 1996 American Medical Association Master File and the 1996 American Osteopathic Association Master File. Includes physicians in direct patient care, excluding some specialties (radiology, anesthesiology, pathology), residents and fellows.

9 Exemptions to the enrollment cap were granted to the University of California at Irvine Medical Center and Children's Hospital of Orange County.

10 Orange County Business Council, 1996.

11 Most are zero premium products that include prescription drug and other "free" benefits.

12 Large physician organizations such as MedPartners and St. Jude Heritage Health Foundation include medical groups and IPAs within their structure.

13 Physicians continue to maintain the employment relationships they had prior to MedPartners' purchase of their assets (e.g., in their relevant own professional corporation).

14 "The Future of Practice Management," *Integrated Healthcare Report.* April 1996.

15 "Orange County Hospitals Feeling the Competitive Squeeze," *Orange County Business Times.* July 29, 1996.

16 Four local hospitals joined when two national hospital corporations merged to form Tenet Health Corporation. Two facilities—Western Medical Center and Hospital-Anaheim and Western Medical Center Santa Ana—formerly were owned by the not-for-profit United Western system. OrNda acquired this system in 1996.

17 InterStudy Competitive Edge Regional Market Analysis 6.2, February 1997.

18 Blue Cross of California converted to for-profit status and launched the holding company, WellPoint Health Systems, for operations outside of California.

19 *Integrated Healthcare Report*, September 1996.

20 Ginsburg, P.B., and N.J. Fasciano, eds., *The Community Snapshots Project*, The Robert Wood Johnson Foundation, 1996.