

Community Report

THIRD VISIT
2000-2001

ORANGE COUNTY • CALIF.

Summer 2001



In January 2001, a team of researchers visited Orange County, Calif., to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 80 leaders in the health care market. Orange County is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to Orange County, in 1996 and 1998, provided baseline and initial trend information against which changes are tracked. The Orange County market encompasses an area of about 30 cities south of Los Angeles.

HMO Model Shaken but Remains Intact

Despite sustained turmoil in the Orange County health care market, health maintenance organizations (HMOs) continue to dominate. The market remains unique, not only because of extensive enrollment in HMOs, but also because large physician organizations assume much of the financial risk and care management that is typically within health plans' purview. Plans, providers and consumers have been comfortable with this arrangement, so Orange County has not yet seen the shift from HMOs to preferred provider organizations (PPOs) experienced elsewhere.

Nevertheless, turmoil among physician organizations shook the market two years ago, and several recent developments continue to threaten its stability:

- The market's largest physician practice management company (PPMC) declared bankruptcy, jeopardizing access and quality for patients.
- A premier hospital system, along with affiliated physicians, terminated its contract with the market's leading health plan, disrupting access to care.
- The market is bracing for a rapid rise in its historically low HMO premiums, which may result in higher consumer cost sharing and expansion of PPOs.

Orange County Demographics

Orange County Metropolitan areas above 200,000 population

Population, July 1, 1999¹

2,760,948

Population Change, 1990-1999²

15% 8.6%

Median Income³

\$30,635 \$27,843

Persons Living in Poverty³

11% 14%

Persons Age 65 or Older³

11% 11%

Sources:

1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

KPC's bankruptcy and St. Joseph's contract termination have increased concerns that provider network instability will jeopardize access, continuity of care and customer service.

Unstable Provider Networks Provoke Concerns

Since 1998, two major disruptions have shaken and destabilized provider networks in Orange County. The first was the bankruptcy in November 2000 of KPC Medical Management, the area's largest PPMC. The second was a decision by the largest provider, St. Joseph Health System, to drop several HMO contracts, including its contract with PacifiCare, one of the county's leading longtime health plans. These disruptions have heightened concerns among consumers, health plans and employers and increased regulatory scrutiny.

KPC's Demise. KPC's abrupt closure of 38 clinics and the subsequent bankruptcy temporarily disrupted access to medical care for up to 300,000 people. Furthermore, KPC's failure to transmit patient records and test results in a timely manner—attributed to the group's financial distress—raised concerns about quality of care.

The demise of KPC signaled the end of the PPMC model in Orange County. PPMCs were designed to organize large numbers of physicians into networks to accept financial risk, streamline practice management and negotiate with health plans. Once expected to flourish in Orange County, PPMCs have struggled since 1998. Two forerunners to KPC—MedPartners and FPA, Inc.—failed in 1998, disrupting patient care in the county and raising questions about the state's role in overseeing capitated payment arrangements between provider organizations and health plans.

KPC's financial difficulties ignited a political and public relations battle between state medical and health plan associations, and California policy makers took several steps to intervene. Gov. Gray Davis' administration encouraged several health plans to contribute to a financial assistance package to keep KPC operating. Although a \$30 million loan package was negotiated, KPC failed nonetheless. After KPC filed for bankruptcy protection, a judge installed

a new director of the organization to ensure that medical records were distributed to patients' new providers as quickly as possible to avoid the protracted problems that occurred two years ago.

The newly created state Department of Managed Health Care also stepped in to ensure access to care by working with health plans to facilitate the transfer of KPC patients to other providers. The agency was not able to be more proactive because KPC's operating status was not within the purview of California regulators. Newly issued rules requiring physician organizations to report financial data are intended to improve oversight and to avoid future problems.

St. Joseph and PacifiCare Part Ways. In a bold move, St. Joseph Health System announced in June 2000 that it would terminate all 14 of its existing HMO contracts and, through a competitive bidding process, select five plans with which it would establish five-year contracts. The system's decision to terminate its contract with PacifiCare, which St. Joseph says will stand for at least five years, ended a long-standing relationship between the two organizations. About half of the 100,000 PacifiCare members in Orange County who received care at St. Joseph may change insurers so they can remain with their St. Joseph provider when the current contract ends in July 2001.

Consumer Concerns Grow. KPC's bankruptcy and St. Joseph's contract termination have increased concerns among health plans and purchasers that provider network instability will jeopardize access, continuity of care and customer service. Some health plans, such as Blue Shield and CIGNA, have tried to pull members out of failing physician organizations to avert access and quality problems. To prevent organizational failures and improve physician organizations' overall financial and clinical performance, nearly all plans have devised surveillance and consultation strategies.

Employers are concerned that employees will have a diminishing choice of providers.

Some employers dropped PacifiCare when St. Joseph terminated its contract, but others have taken a wait-and-see approach. Because the St. Joseph/PacifiCare break occurred after many employers had made their 2001 plan offerings, its full effect on employees may not be seen until next year.

Capitated, Delegated Managed Care Survives—for Now

Managed care has long been widespread and aggressive in Orange County. HMO penetration hovers around 50 percent, and health plans continue to delegate considerable financial risk to providers—including not only physicians' fees, but also ancillary services and sometimes hospital care. The recent provider network instability and continued turmoil among physician organizations are a sign, however, that big changes may be on the horizon.

Hospitals in Orange County, like their counterparts nationally, have experienced financial hardship from reductions in Medicare revenue under the 1997 Balanced Budget Act and rising costs. In addition, many Orange County and other California hospitals must renovate facilities to comply with state seismic standards, an undertaking that could require as much as \$24 billion in hospital capital spending statewide (reportedly more than the total value of existing facilities) by 2030. Moreover, labor shortages, which have been driving up costs nationally, have been particularly severe in Orange County, where as many as 20 percent of hospital nursing positions are vacant.

In response to such pressures, many hospitals are refusing to accept capitated payment for their services. Tenet Healthcare Corp., which operates 10 hospitals in the county, and the University of California–Irvine Medical Center have decided to drop capitation payment as their HMO contracts come up for renewal. Similarly, St. Joseph has eliminated hospital capitation in newly negotiated contracts.

Meanwhile, physician organizations—which typically bear the lion's share of financial risk in the Orange County market—have continued to struggle under capitation rates that they contend have not kept pace with rising costs. Many are now trying to shed risk for ancillary services such as pharmacy or injectable drugs, which they view as too difficult and unpredictable to manage. Physician organizations are retaining risk for professional services but pushing for higher capitation rates to cover costs.

Market observers worry that providers' dramatic pushback on risk contracting and demand for higher payments eventually may undermine the substantial price advantage HMOs have enjoyed in the county and open the market to growth of more expensive and less aggressively managed products, such as PPOs. In fact, driven by fears of more provider network instability and already rising premiums, health plans are positioning themselves for a possible shift toward PPOs by preparing for fee-for-service contracts with individual physicians.

Any shift away from HMOs in Orange County is still down the road, because many physician organizations and health plans in the market remain firmly committed to the fully delegated model of capitated managed care. Indeed, large barriers stand in the way of such a shift: Physician organizations would have to greatly expand their ability to bill for services, and health plans would have to develop the capacity to manage service utilization now handled by physician practices.

Providers Redirect Market Strategies

In the late 1990s, provider efforts in Orange County and elsewhere emphasized integrating inpatient and outpatient services, thereby creating networks or systems that could take risk for and coordinate the whole range of medical care. The failure

Health Insurance Status

Orange County	Metropolitan areas above 200,000 population
<i>Persons under Age 65 with No Health Insurance</i> ¹	
18%	15%
<i>Children under Age 18 with No Health Insurance</i> ¹	
15%	11%
<i>Employees Working for Private Firms that Offer Coverage</i> ²	
81%	84%
<i>Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance</i> ²	
\$156	\$181

Sources:

1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

Orange County	Metropolitan areas above 200,000 population
<i>Staffed Hospital Beds per 1,000 Population</i> ¹	
2.1	2.8
<i>Physicians per 1,000 Population</i> ²	
2.2	2.3
<i>HMO Penetration, 1997</i> ³	
46%	32%
<i>HMO Penetration, 1999</i> ⁴	
46%	36%

Sources:

1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1



**Recent provider
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of risk-bearing intermediaries and growing pressures on revenues and capacity—from population increases, labor shortages and low payment rates—have led to a shift away from integration strategies among both hospitals and physicians.

Hospitals Build, Specialize. As Orange County hospitals move away from capitated payment arrangements, they increasingly have focused on building revenue-generating services. This strategy is motivated in part by changed financial incentives and in part by newly emerging capacity problems. After trying to reduce excess capacity for years, many prominent hospitals apparently now face capacity constraints. Hospitals attribute this change to labor shortages, growing demand for services and, thanks to more accommodating HMO products, greater consumer leeway in choosing providers.

Hospitals have responded by turning their attention to building inpatient and outpatient capacity, improving their brand identities in both geographic and product markets and developing specialty-focused, centers of excellence. For example:

- Hoag Memorial is planning to build a new patient tower with an obstetrics/gynecology focus and outpatient cardiology and oncology facilities.
- Similarly, St. Joseph Hospital is building a new patient care tower and new cardiology and oncology outpatient units in partnership with specialty physicians.
- MemorialCare, which has increased its capacity by buying two hospitals, is striving to establish its identity as the county's premier, high-quality hospital system.

Physician Organizations Largely Intact. The physician market in Orange County remains highly organized, despite KPC's demise. Large primary care or multispecialty physician groups and independent practice associations (IPAs)—some of which were part of KPC—continue to dominate the county's landscape and wield considerable clout with health plans.

For example, Monarch Healthcare IPA, the largest independent physician organization in the market, contracts with 800 physicians, including 250 primary care physicians, most of whom practice in small groups or solo practices. Monarch serves about 150,000 HMO enrollees, including 20,000 Medicare+Choice enrollees. The IPA has substantial negotiating leverage with health plans and strong leverage over local physicians practicing in southern Orange County.

Damage from the MedPartners/KPC downfall and historically low fees continue to affect physician practices, and many of the preexisting groups have shrunk. Most of the physician organizations that were acquired by MedPartners have become independent again, but many physicians in these organizations have moved to smaller practices. Moreover, physician organizations are widely perceived to be in worse financial condition as a result of years of inadequate investment and the need for more working capital than usual because of late payments from plans.

Plans See Enrollment Shifts, Employers Face Premium Hikes

Although the number of major health plans in Orange County has changed little in the past two years, turbulence in provider contracts and impending health plan premium increases have created instability and uncertainty in the health plan market (see box). Indeed, by March 2001, PacifiCare's large Medicare product, Secure Horizons, had already lost 10,000 members in Orange County. Adding to PacifiCare's woes nationally were leadership turnover, strict federal caps on Medicare payment increases and a sharp drop in its stock price.

Recent federal limits on payment increases for Medicare managed care plans also are a cause of concern. Though the Medicare+Choice market in Orange County is still attractive to health plans

and beneficiaries—42 percent are in HMOs—plans are trimming benefits and putting enrollees on notice for more changes down the line. PacifiCare, whose Secure Horizons is the nation’s largest Medicare HMO and covers more than 60,000 enrollees in Orange County, reduced its prescription drug benefit, and Kaiser added a \$20 monthly premium for its 23,000 Medicare beneficiaries. Observers expect these types of changes to increase enrollment shifts among major health plans in the local Medicare market.

More turmoil is expected in the county’s commercial market as employers brace for double-digit premium increases from health plans. Some employers are trying to hold down cost increases in the short term through benefit modifications, such as increasing consumer copayments and deductibles and instituting three-tiered pharmacy benefits. For example, the California Public Employees’ Retirement System (CalPERS)—viewed as a bellwether for employer benefit strategies locally and nationally—responded to proposed double-digit premium increases for its fully insured HMO products in 2002 by rejecting all HMO contracts and requesting new bids.

This tactic, along with increased copayments for office visits and prescription drugs, allowed CalPERS to hold its HMO premium increases to 6 percent.

Employers worry that the higher payment rates obtained by St. Joseph and other providers, along with increased utilization rates and prescription drugs costs, will push premiums up even faster over the next few years. Meanwhile, dissatisfaction with the quality of customer service by carriers is rising among both employers and employees, adding impetus for a potential move away from HMOs in favor of more loosely managed products such as PPOs.

Tobacco Money Galvanizes Safety Net

Orange County’s fragile safety net system appears to be getting stronger and more organized. Many are optimistic that the state’s new tobacco-related funds, along with existing and expanding public insurance programs, will help improve the overall capacity of both community clinics and major safety net hospitals. On the other hand, local political conflicts, potential state



The failure of risk-bearing intermediaries and growing pressures on revenues and capacity have led to a shift away from integration strategies among both hospitals and physicians.

Instability and Uncertainty among Health Plans: Who Benefits?

With PacifiCare under duress, the pole position among Orange County health plans appears to be shifting to Kaiser, which has grown steadily over the past five years to more than 300,000 enrollees. Kaiser has bounced back from the financial stress and capacity problems that were evident in 1998. Furthermore, it has escaped—and, indeed, benefited from—provider network stability issues because of its group-model structure built around an exclusive relationship with a single large medical group and affiliated hospitals. Kaiser reportedly is ahead of its competitors in its use of disease management initiatives and Web-based communications with consumers, in part because members stay with the health plan for an average of 12 years.

Other health plans may benefit from shifts and uncertainty in Orange County’s health insurance market. Some health plans that already offer PPOs—such as Wellpoint’s Blue Cross of California, Blue Shield of California, CIGNA and Aetna—may be more agile in the changing health plan market. These plans have developed individual, nonrisk contracts with physicians under PPOs, as well as utilization management programs, that would allow them to grow if and when the market shifts away from HMOs. PPOs may be less susceptible to large-scale disruptions from provider pushback because they rely on individual contracts with physicians.



Many are optimistic that California's new tobacco-related funds, along with existing and expanding public insurance programs, will help to improve the overall capacity of community clinics and safety net hospitals.

and federal program budget constraints and a possible economic downturn could threaten the well-being of safety net providers and uninsured families alike.

Funds from the new state tobacco tax and the state's tobacco settlement promise important gains for the local safety net. Orange County has set aside part of its \$50 million allocation from the state tobacco tax to develop comprehensive health and early childhood development programs for children under 6. This money will help to expand access at the region's two major safety net hospitals, Children's Hospital of Orange County and University of California–Irvine Medical Center. The state also plans to allocate \$24 million a year in tobacco settlement funds to health services that will benefit safety net providers as well. Community clinics in Orange County, for example, will receive about \$3.5 million for expansions.

In addition, the State Children's Health Insurance Program (SCHIP), Healthy Families, has expanded coverage to about one-third of the county's estimated 90,000 uninsured children, thanks largely to targeted outreach efforts by community organizations. A recent expansion of eligibility for children and a newly submitted federal waiver to expand Healthy Families to the parents of eligible children are expected to help even more. CalOPTIMA, a quasi-public agency that oversees the county's Medicaid managed care program, has been instrumental in the success of Healthy Families—and the continued strength of the safety net—in coordinating outreach and new strategies to address the uninsured.

Despite these improvements, the safety net and uninsured families in Orange County remain vulnerable. First and foremost, many observers fear that if the economy worsens, uninsurance will grow beyond the already high rate of one in five people. The rising number of non-English-speaking immigrants presents an added challenge to the local safety net. Many advocates worry that the county's limited medically indigent

program leaves many needy people without care and, because of its low payment levels, increases the charity care burden on providers. And while advocates are buoyed by expanded public programs and funding, they worry that tobacco revenues will dry up and that federal or state budget decisions—perhaps as fallout from the state's energy crisis—will jeopardize recent coverage expansions.

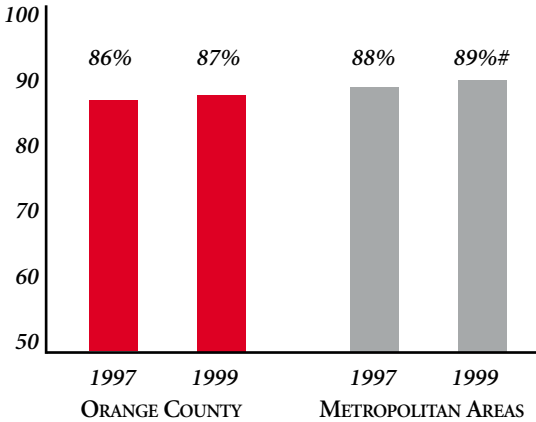
Issues to Track

The Orange County health market is a place of contrasts. All players—providers, insurers, purchasers and consumers—continue to rely on HMO products and delegated risk and care management. In addition, managed care is highly successful and stable in the Medicare, Medicaid and SCHIP programs. But the ongoing turmoil in physician organizations and in provider-health plan relations may lead to dramatic changes. As the market continues to unfold, the following issues will be important to track:

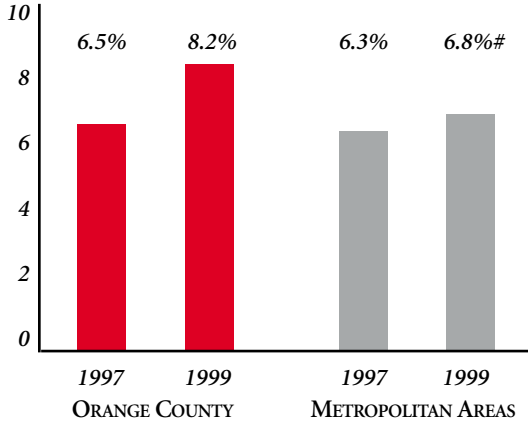
- Will increasing provider payment and scrutiny of physician organization finances help to stabilize the provider market? If so, how will health plan premiums and consumer access to care be affected?
- Will purchasers respond to rising premiums by reducing benefits or shifting costs to consumers?
- To what extent will PPOs and other less restricted network products emerge, and how will they be received by purchasers, consumers and providers long accustomed to HMOs?
- Will collaborations involving new tobacco-related funding be sustained and result in stronger and more widely accessible safety net services?

Orange County's Experience with the Local Health System, 1997 and 1999

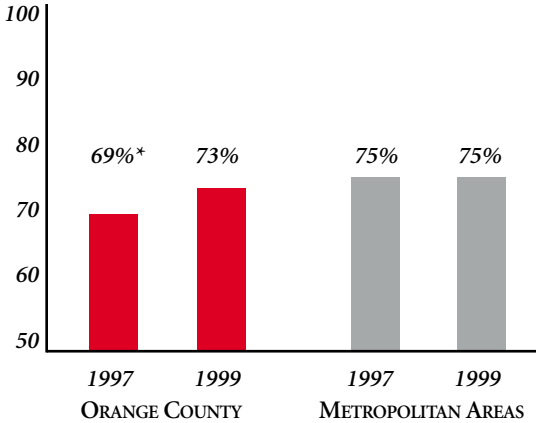
PERSONS SATISFIED WITH THE HEALTH CARE THEY RECEIVED IN THE LAST 12 MONTHS



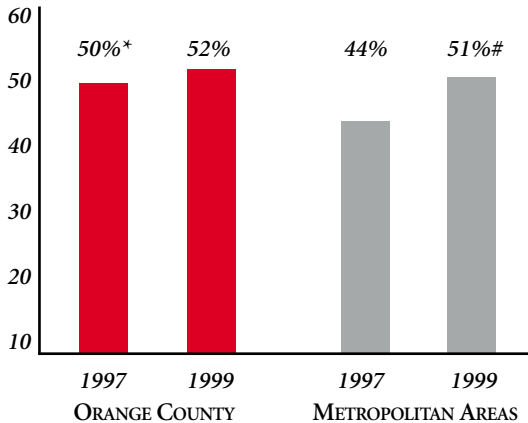
PERSONS WHO DID NOT GET NEEDED MEDICAL CARE IN THE LAST 12 MONTHS



PHYSICIANS AGREEING THAT IT IS POSSIBLE TO PROVIDE HIGH-QUALITY CARE TO THEIR PATIENTS



PERSONS WITH INSURANCE THAT REQUIRES GATEKEEPING



* Site value is significantly different from the mean for metropolitan areas over 200,000 population.
 # Statistically significant difference between 1997 and 1999 at $p < .05$.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.



The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in *Issue Briefs*, *Data Bulletins* and peer-reviewed journals. These publications are available at www.hschange.org.

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