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# UpDate

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## I. SPECIAL REPORT

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### The San Diego Health Care System: A Snapshot Of Change

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In this UpDate we summarize recent health system change in San Diego, a large market with high health maintenance organization (HMO) penetration and large delivery systems. Health care markets around the country are experiencing a similar shift in economic power toward purchasers and payers and away from providers. San Diego's experience can provide useful lessons to other large market areas, which often have lower levels of HMO market penetration and delivery system consolidation.

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#### Market Dynamics

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**Employers and employer coalitions.** Managed care has long been important to the San Diego health care system. After 1982 many employers began to offer employees preferred provider organizations (PPOs) and HMO plans other than Kaiser. About two-thirds of enrollees in employer-based plans are HMO members; other enrollees are divided among PPO, point-of-service, and indemnity insurance plans.<sup>7</sup> During the late

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1980s and early 1990s San Diego employer-based health plan premiums grew rapidly. However, since 1993 many premiums have remained unchanged or have decreased.<sup>7</sup>

Although the mostly medium- and small-size San Diego employers are not an organized purchasing force, they likely have benefited from the highly publicized premium reductions that statewide California purchasing coalitions have negotiated with HMOs for their large employer members. Employers also have benefited from strong price competition by HMOs striving to increase market size and share.

Beginning in 1992 the California Public Employees Retirement System (CalPERS) took an assertive bargaining stance with health plans on behalf of its one million state and local government enrollees. This led to HMO rate reductions of 0.4 percent in 1993-1994, 1.1 percent in 1994-1995, and 5.2 percent in 1995-1996. In 1994 a purchasing alliance of eleven large Pacific Business Group on Health (PBGH) member employers negotiated 1995 HMO rate reductions approaching 10 percent. In 1995 fifteen purchasing alliance members negotiated rate reductions averaging 4.3 percent.

Most San Diego employers that provide health insurance to employees offer at least one HMO and one PPO. Increasingly, employers offer a point-of-service plan (often an HMO with some out-of-plan coverage) as a way to move more PPO enrollees into HMOs. PPO and point-of-service plans generally cost more than HMO plans, but differing plan designs make premium comparisons difficult. Employers are shifting some costs to workers through increased enrollee copayments for HMO services, deductibles and copayments for non-HMO plans, and premium contributions.

For employers and enrollees, little differentiates most HMOs from one another. All plans tend to offer employers similar premiums, and top non-Kaiser HMOs offer similar physician networks. Reports on utilization and quality of care have little effect on choice, because most HMOs capitate medical groups or individual practice associations (IPAs) for their services and receive little detailed utilization information, while health plans do not report comparable quality measures. Quality of care is becoming a concern for some employers, who fear that gatekeeper disincentives for specialist referrals may be too strong.

**State and local governments as purchasers for the poor.** Over the past decade Medi-Cal (California Medicaid) spending grew rapidly while access to care diminished. This has led the state to begin to move Medi-Cal enrollees into managed care plans. In San Diego County's Medi-Cal managed care model, "Healthy San Diego," health plans will contract directly with the state, initially enrolling 225,000 Aid to Families with Dependent Children (AFDC) recipients. Although insurers and delivery systems are very interested in the \$650 million San Diego Medi-Cal market, rates negotiated with the state will determine the success of Medi-Cal managed care. Because capitation rates are based on current expenditures, providers fear low capitated payments; California is second to last in Medicaid payments per beneficiary in the nation, and San Diego is last in the state in Medi-Cal payments.

The local San Diego government is not an important health care purchaser for the poor, because San Diego has no public hospital and has reduced the limited amount of direct services it provides through clinics.

**Insurers and health plans.** As of mid-1995 HMOs accounted for about half of 2.1 million insured enrollees, including two-thirds of employment-based health insurance enrollees, 43 percent of Medicare enrollees, and about 17 percent of Medi-Cal enrollees. Kaiser takes the largest share of the HMO market (35 percent of enrollees in mid-1995). Aetna (14 percent), PacifiCare (13 percent), and Health Net (13 percent) are the three largest non-Kaiser plans, fol-

lowed by FHP/TakeCare (7 percent), Califormiacare (6 percent), CIGNA (5 percent), and Prudential (5 percent), each with more than 50,000 enrollees.

The HMO plan sector is divided into two: the Kaiser Foundation Health Plan, with its own provider network, and non-Kaiser HMOs. Kaiser was the dominant player in the HMO market until the early 1990s. A series of Kaiser miscues—including large premium increases, inattention to customer satisfaction, little effective marketing, and neglect of the lucrative Medicare market—invited other aggressive, for-profit HMO competitors to enter or expand in the market. The decline of larger San Diego corporations also hurt Kaiser. Kaiser now has 25,000 fewer enrollees than it had in 1992.

For-profit, non-Kaiser HMOs are the most powerful force in San Diego's health care system. Controlling 650,000 HMO enrollees, these HMOs can exploit excess local hospital and specialist capacity. As large state- and nationwide entities, they have had "deeper pockets" and a smaller percentage of their business at stake than the four major local San Diego provider organizations—Sharp HealthCare, Scripps Health, Scripps Clinic Medical Group, and the University of California, San Diego (UCSD)—have had. As a result, non-Kaiser HMOs apparently can protect their profits by passing most or all premium decreases to providers.

Insurers remain dependent on continued relationships with the major delivery systems. Sharp has large numbers of HMO enrollees, whereas Scripps Health's and Scripps Clinic Medical Group's reputations for high-quality care are attractive to employees. HMOs see UCSD as a useful counterweight and competitor to Sharp, Scripps Health, and Scripps Clinic Medical Group. For example, in an attempt to differentiate its product and to capitalize on delivery system discontent with Health Net and Blue Cross, PacifiCare has created longer-term "partnerships" with larger medical groups and IPAs in southern California, including in San Diego.

In 1993 health plans determined that, to survive under the proposed Clinton plan,

they would have to become much larger. Mergers also provide health plans with greater bargaining leverage with providers, and many believe that mergers may lead to greater economies of scale. FHP acquired TakeCare, and Health Net (via Health Systems International, or HSI) acquired QualMed. Another merger attempt, between HSI and Blue Cross, collapsed recently. These mergers have greatly increased the concentration of California HMOs.

San Diego is virtually closed to new HMO entrants that want to become significant players, other than through acquisition. Existing, larger HMOs that benefit from name recognition and likely economies of scale are much better positioned to capture new HMO enrollees than are new HMOs.

HMOs in San Diego compete aggressively with each other and with PPOs to win market share. Because most competition is based on price, overall premium prices fell in the past three years and tended to equalize among HMOs. Plans also compete on the basis of how broad their provider networks are, although most non-Kaiser plans have similar networks. HMOs also compete by offering point-of-service products. Plans cannot compete on the basis of quality, because comparable measurement of quality and reporting of results do not exist. Some insurers believe that enrollees are much more interested in price than in quality.

**Providers.** Hospitals dominate three delivery systems in San Diego (Sharp HealthCare, Scripps Health, and UCSD), and physicians dominate two others (Kaiser and Scripps Clinic Medical Group). Only two systems have integrated hospital and physician operations (Kaiser and Sharp). The ability of for-profit HMOs to exploit excess provider capacity has driven many recent delivery system developments.

**Sharp Healthcare.** Sharp is the largest San Diego delivery system, with about \$800 million in revenues in 1994 and many more capitated enrollees than the three other major non-Kaiser delivery systems combined. Since its acquisition of the well-regarded Rees-Stealy Medical Group in 1985, Sharp has built its primary care physician base and HMO enrollment. In mid-1995 Sharp's two

medical groups, an affiliated IPA, and a network managed by FPA Medical Management served 309,000 capitated enrollees, or 30 percent of San Diego's HMO enrollees. With three different types of physician organizations, Sharp can appeal to a wide range of HMO enrollees, including those concerned about restrictions on choice of providers. Sharp also serves a large proportion of PPO enrollees. Sharp-run acute care hospitals accounted for about 25 percent of San Diego acute care hospital discharges in 1994.<sup>3</sup> Sharp likely provided care to about 25 percent of San Diego's population.

Intense competition forced nonprofit Sharp to create a joint venture entity with Columbia/HCA, merging the four hospitals that Sharp owns plus one of its medical groups with one hospital from Columbia/HCA. Sharp had been attempting to sell a portion of itself to other companies, to obtain capital for expansion and additional cost-cutting investments. Sharp was only marginally profitable in 1993 and 1994 and lost \$10 million during 1995, even after much cost cutting. Sharp's strategy of purchasing hospitals and thereby acquiring medical staffs had not been profitable, especially as excess hospital capacity increased in the community.

**Scripps Health.** Scripps Health is a higher-cost hospital system that has relied on its reputation for quality and substantial endowment to dominate the slowly dwindling noncapitated, upscale insured market. Scripps's six acute care hospitals accounted for 25 percent of San Diego acute care discharges in 1994. Scripps benefits in several ways from its international reputation for quality of care and research, including receiving higher capitation rates than does Sharp or UCSD. However, because of its past financial success, it was slow in its efforts to build capitated enrollment and cut costs. The three IPAs affiliated with Scripps Health served only 32,000 capitated enrollees as of mid-1995. Scripps was marginally profitable in 1994 only because of \$33 million in contributions and investment income. Scripps's hospital acquisitions also were costly in a period of shrinking hospital bed occupancy.

*Scripps Clinic Medical Group.* This group (with 80,000 HMO enrollees) merged in 1993 with Scripps Memorial Hospitals to form Scripps Health, but the merger failed. Scripps Clinic Medical Group recently found a new, for-profit venture capital partner and became a separate delivery system.

*Kaiser.* The Kaiser delivery system remains the largest HMO provider. It consists of the Kaiser Foundation Hospitals and the San Diego part of the Southern California Permanente Medical Group. In mid-1995 Kaiser accounted for about 365,000 HMO enrollees and 9 percent of San Diego hospital discharges. Although Kaiser's previous utilization levels and operational procedures created benchmarks for other delivery systems, its success created future problems. As a nonprofit, physician-dominated organization with a health plan, Kaiser viewed its substantial enrollment growth in the late 1980s and early 1990s as a problem as well as an opportunity. Kaiser did not aggressively expand, partly because Permanente Medical Group physicians would not gain financially through rapid growth, unlike physicians with marketable equity in some emerging, larger medical groups, and partly because it could not recruit its own physicians and build its own facilities fast enough. Success led physicians to believe that growth was inevitable and change not urgent.

As non-Kaiser HMOs put pressure on the other San Diego delivery systems, Kaiser's cost structure became increasingly uncompetitive. Kaiser's unionized personnel compensation is higher than that of its competitors. As a physician-driven organization, the medical group has found it difficult to cut physicians' pay (which likely is higher than that of its competitors) or to lay off underused, "tenured" specialists. Physicians' fear of declining income led Kaiser to begin to reengineer its delivery system operations statewide in 1993, in an effort to raise customer satisfaction and reduce costs, and thereby improve its marketing position. In the process, it is further integrating its clinical operations.

*UCSD Healthcare.* UCSD emerged as a viable capitated delivery system over the past three years. It traditionally has served a

large share of the uninsured and Medi-Cal populations. Driven by a declining paying patient base and indigent care funds, UCSD developed a competitive physician network that served more than 100,000 capitated enrollees by mid-1995. The UCSD Health-care network includes the faculty medical group and fourteen other physician organizations, including several that it owns. The network includes two UCSD-owned hospitals and clinics and three affiliated hospitals that accounted for 21 percent of San Diego discharges in 1993.

UCSD's strategy is to build a common marketing and contracting structure for its network physicians and to enter into increasingly exclusive management service organization arrangements with primary care physician practices. UCSD has benefited from physicians' dissatisfaction with Sharp's and Scripps's IPAs, as well as from insurers' need for a counterweight to Sharp and Scripps. Nevertheless, UCSD's relationships with some of its physician groups and affiliated hospitals are tenuous, and it lacks sufficient capital for expansion and clinical information systems. UCSD Medical Center reported a \$3 million loss in 1994, despite \$17 million in disproportionate-share hospital funds from Medicaid.<sup>4</sup>

Increased health plan market power is driving delivery system consolidation and cost cutting, to counter health plans' power. Access to financial resources has become a critical determinant of a system's ability to acquire medical groups, develop networks, and invest in information systems. Sharp had many discussions with several merger and capital partners before announcing its joint hospital venture with Columbia/HCA. UCSD, which also lacks capital, discussed a possible merger with Scripps Health until talks foundered. After many discussions, Scripps Clinic Medical Group found a capital partner that could help it to buy independence from Scripps Health, which had lent the clinic substantial sums. Neither Kaiser nor Scripps Health appears to have problems in gaining access to capital.

Health plans usually pay hospitals per diem or case-rate amounts and pay physician organizations full capitation for all medical

and outpatient ancillary services. Payment rates are stagnant or declining. Large provider organizations want full-risk contracts-capitation for all medical and hospital services-but insurers are concerned that purchasers may see them as unnecessary, because such contracts underscore the fact that plans devolve most management of care responsibilities to the major delivery systems.

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### Shape Of Change Thus Far

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**Cost cutting and integration.** Delivery systems vary in the extent to which they have cut costs and achieved clinical, physician/system, and functional (administrative) integration.<sup>5</sup> Sharp and Kaiser generally appear to be most advanced in cost cutting and integration. Despite Sharp's national reputation for its efforts to clinically integrate its operations, major functional, physician/system, and clinical integration has not yet occurred. Systems with hospitals have cut upper and middle management, reduced the number of skilled nursing personnel, adopted disease-specific care pathways, substituted nurses for physicians, used the same core group of internists to do all admitting, and operated specialized equipment and facilities on weekends. All systems have contained or cut physician salaries and nurse and other staff compensation. Nevertheless, although hospital closures can achieve more cost savings than reducing beds in existing hospitals can achieve, no hospitals have been closed, because of a desire for comprehensive geographic coverage, unwillingness to concede areas to other systems, or nonprofit boards that are sensitive to negative community reaction.

Having already reaped easier cost-cutting gains, the three large and well-established medical groups (Permanente Medical Group, Sharp Rees-Stealy, and Scripps Clinic Medical Group) have led more complicated cost-cutting efforts, attempting to change medical practice through greater clinical integration. Each group is investing heavily in information systems, hoping that clinical integration will lower costs and raise quality of care.

Because the newly powerful non-Kaiser HMOs want to prevent provider organizations from creating their own plans, only Kaiser is integrated with a large health plan. Sharp has not expanded its small HMO because HMOs that are important to Sharp threaten to "punish" it by withdrawing some or all of their business. Similarly, an insurer also would be cautious about acquiring Sharp, Scripps Health, or Scripps Clinic Medical Group, in part because it could not make up for enrollees that other HMOs might send to another system. Moreover, it likely is cheaper now for insurers to contract with delivery systems than to own them. As a result, no insurer has discussed purchasing a large San Diego provider system.

**Management expertise.** Several legacies of the old San Diego health care system may be slowing health system change today. Although some observers praise existing managers, others argue that there is a shortage of management expertise, as most managers have experience in the less demanding indemnity insurance/fee-for-service system. New management expertise is deemed essential, particularly for physicians.

Moreover, boards of the nonprofit delivery systems that developed under the old system may be slow to act in a fast-moving market, putting those systems at a disadvantage with for-profit HMOs. For example, Sharp's governance structure of multiple nonprofit boards may have prevented it from moving quickly on some needed mergers or hospital closures. Similarly, Kaiser's democratic, but laborious, multiple-step decision-making process is designed for gradual, continuous change. UCSD is hampered by the governance split between its hospital/network and the medical school, and by oversight by UC Regents.

**Indigent care.** Delivery systems in San Diego share the burden of under- or uncompensated indigent care unequally, which affects their competitive position. UCSD provides the most such care, followed by Sharp and Scripps. Kaiser provides some indigent care, but none of the non-Kaiser insurers contribute to uncompensated care costs.

Twenty-two community health centers in San Diego provide services to Medi-Cal

enrollees and the uninsured. Community health centers obtain up to half of their funds through Medi-Cal—their best payer source. Medi-Cal's shift to managed care threatens these centers' ability to cross-subsidize care for the uninsured, if the state sets low capitation rates and other providers attract Medi-Cal enrollees. Centers also are concerned about possible Medicaid block grants, funding cuts for prenatal and other services to undocumented immigrants, and the possible loss of federally qualified health center funding. Moreover, uninsurance has increased as public funding has dwindled.

Community health centers are working collectively to respond to changing circumstances. The Council of Community Clinics (CCC) has developed the CCC Health Network to compete for Medi-Cal HMO enrollees. Fourteen participating community health centers serve 35,000 Medi-Cal HMO enrollees in one plan, and the CCC is now contracting with seven other HMOs. Community health centers are attempting to improve their payer mix by attracting Medicare and commercial enrollees. Some centers have aligned themselves with the major delivery systems, which provide hospital and specialist services to Medi-Cal enrollees while diverting some emergency room patients to the community health centers.

**Quality of care.** Delivery systems vary in their quality-of-care initiatives. Many observers argue that quality improvement is the flip side of thoughtful cost reduction, following the motto "do it right and do it once." Regardless of quality initiatives, health care systems undertake little comparable quality measurement and reporting, and so do not compete on that basis.

Without useful measures, it is impossible to determine whether health system changes have altered quality of care for either the insured or the uninsured. There is no groundswell of highly publicized discontent with perceived quality of care in HMO plans, and continued increases in commercial and Medicare HMO enrollment suggest that, for many persons, perceived problems with quality of care are outweighed by the financial benefits of HMO enrollment.

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## Conclusion

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San Diego is an example of a market with a long history of managed care, high HMO market penetration, and large, relatively sophisticated provider organizations that still is undergoing rapid health system change. As is the case in many other markets, forces from outside the community are helping to shape change. Statewide purchasing coalitions are negotiating with statewide HMOs, affecting local employers' expectations about premium increases. The current economic power imbalance between statewide for-profit health plans and local nonprofit delivery systems is forcing delivery systems to engage in more sophisticated clinical and organizational integration, and in joint ventures or partnerships with for-profit entities outside of San Diego that have capital. The San Diego market of the future will remain a valuable natural experiment on the effect of managed care on health system change.

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## NOTES

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2. Authors' interviews with several insurers, health plan brokers, and providers.
3. California Office of Statewide Health Planning and Development, "Quarterly Individual Hospital Data for California, 1989-1993" (Sacramento: OSHPD, 1994).
4. University of California, San Diego Medical Center, 1993-1994 *Annual Report to the Regents* (San Diego: UCSD, 1994).
5. R.R. Gillies et al., "Conceptualizing and Measuring Integration: Findings from the Health Systems Integration Study," *Hospital and Health Services Administration* (Winter 1993): 467-489.